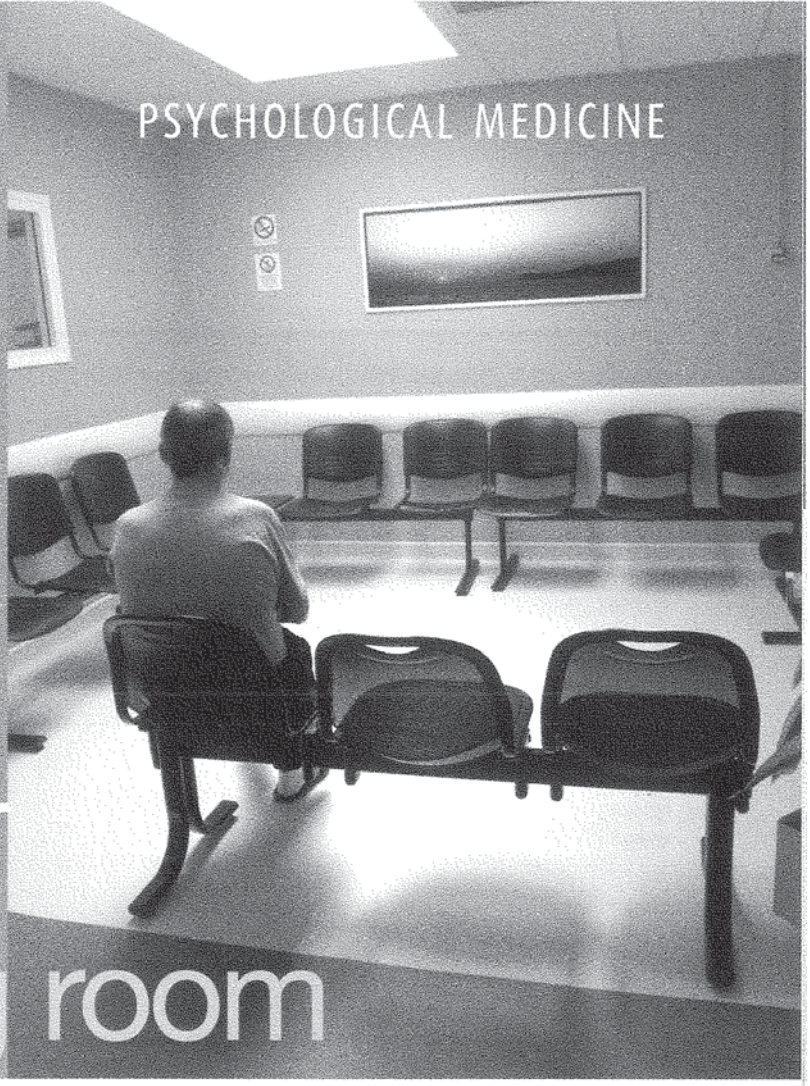

There's an ex-prisoner in the waiting room

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Due to the health risks of incarceration and 'risky' lifestyle choices that ex-prisoners might continue to engage in, there are specific management issues to consider in this patient group. A nonjudgemental approach is essential.

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'Have no fear of robbers or murderers. They are external dangers, petty dangers. We should fear ourselves. Prejudices are the real robbers; vices the real murderers. The great dangers are within us. Why worry about what threatens our heads or purses? Let us think instead of what threatens our souls.'

Victor Hugo

WHO ARE AUSTRALIA'S (EX-)PRISONERS?

As of 30 June 2010, there were 29,700 prisoners (sentenced and unsentenced) incarcerated across Australia.[1] Because the average period in custody is about six months, the number of Australians returning to the community in any year is even higher. In 2006, an estimated 44,000 individuals were released from Australian prisons.[2]

Men account for 95% of the prison population. Australian inmates are most commonly aged between 18 and 35 years; there are few inmates over the age of 50 years.[1] Low education achievement, unemployment and unstable accommodation are common.

The punishment 'deprivation of liberty' implies severe social dislocation – with all the adverse health consequences that that brings with it. Alcohol dependence, illicit drug use and benzodiazepine dependence are common examples of drug abuse in the histories of inmates. Polypharmacy is the rule. Indeed, approximately 75% of female inmates and 50%

MANAGING THE EX-PRISONER PATIENT: PRACTICAL POINTS

- Given the current nature of our justice and mental health systems, and the laws regarding prohibition of certain drugs, ex-prisoners tend to exhibit higher rates of certain medical conditions than 'general' members of society.
- Unless there are specific aspects of the time in prison that a patient wishes to discuss, details of the incarceration should have little ongoing impact on the provision of medical care.
- Health practitioners in prison are your professional colleagues 'behind the walls'. When seeing an ex-inmate for the first time, it is appropriate to contact the previous treating doctor at the relevant prison facility to discuss the patient and obtain medical notes for the purposes of handover of care.
- An ex-inmate may have test results that were not provided to him or her before leaving custody or a discharge summary that was not taken or was discarded before coming to your practice. The patient may also have a pre-existing mental health care plan or dental health care plan. These issues are easily addressed by contacting the prison health service.
- Medicare eligibility is interrupted while an individual is in custody and needs to be reinstated upon release.
- It is important to consider the impacts that incarceration may have had on a patient's family, including children, during and after release.

of male inmates are imprisoned for offences that are drug-related. A lifestyle of drug dependence lends itself to increased risk of infectious diseases and other illnesses.

PRISON HEALTH SERVICES

The medical services available to inmates provide an excellent opportunity for doctors to provide brief, acute interventions, but also for patients to re-engage with medical services.[3] A lot of prisoners have not voluntarily sought the help of a medical professional for a number of years, and many have had negative experiences and feel disempowered by the medical profession as a whole. Thus, the provision of non-judgemental care to patients whilst incarcerated goes a long way to increasing rates of follow-up with a doctor on release.

The medical services provided within the Australian prison environment are not related to custodial services (except in Western Australia).[4] That is, the attending doctors are not 'under the thumb' of the prison system. Their professional standards and competencies are equal to those of health practitioners in the community, and the medical services they provide are equivalent to those in the community. Therefore, when seeing an ex-inmate for the first time it is appropriate to contact the medical centre at the relevant prison facility to discuss the patient with the previous treating doctor and to obtain medical notes for the purposes of handover of care. Health records are independent of custodial records; there is no inappropriate dis - closure of information. Once appropriate consent has been provided by the patient, prison health records can be shared with health providers in the community. (In Western Australia, the situation is different administratively only – the health service acts independently of the custodial arm and confidentiality is well maintained.)

A HELPFUL APPROACH TO THE CONSULTATION

Being an ex-inmate carries broad social stigmas, and unfortunately the medical profession is not immune from perpetuating this stigmatisation. Most doctors in Australia will have been directly involved in the treatment of ex-inmates without ever realising the history of incarceration and will treat them like any other member of 'normal' society. It is only when a patient's criminal history is revealed that medical professionals may form judgements and be less eager or willing to treat the patient. Ex-prisoners are often regarded in the medical community as difficult, disruptive patients who are using medical services primarily to further some personal agenda, such as accessing drugs or unwarranted social services.

However, apart from being a dangerous position to adopt, and a questionable professional view, this approach demeans a heterogeneous patient group. For most ex-inmates, their prison experience is a small slice of their life story, and it does not define them or provide any real predictive value about their personality and actions in broader clinical and social contexts. Making judgements about a patient based on a history of incarceration is no more valid or useful than judging character by some other life experience or social attribute.

If an ex-inmate volunteers a history of incarceration, it is important to address this early on in the consultation process. Patients must be allowed to freely express feelings about the period of incarceration, without feeling that doctors are judging them or probing for their own curiosity. Many ex-inmates will openly discuss their time in prison; others never elaborate. Unless there are specific aspects of the incarceration that they wish to discuss, the details should have little ongoing impact in the provision of medical care.

It is necessary to keep in mind that many ex-prisoners have had a limited

amount of formal education, and their literacy skills may not be well developed. This is important if a patient is required to read and sign documents for consent or to use written educational information. Many prisoners are quite self-conscious of their limited literacy and numeracy skills, so being frank, direct and nonjudgemental is usually the best course of action.

MANAGEMENT ISSUES

Due to the health risks of incarceration and the 'risky' lifestyle choices that an ex-prisoner might continue to engage in, there are several specific management issues that must be addressed in this patient group. Some practical points regarding the management of ex-prisoners are summarised in the box on page 68.

Infectious diseases

Hepatitis C is endemic among intravenous drug users in prison so ongoing hepatitis C testing, plus a future decision to commence treatment, is paramount in the care of these patients. Most Australian inmates are screened (with consent) for bloodborne viruses on admission to prison, and those found to have no immunity to hepatitis B are vaccinated. Inmates with hepatitis C who are not immune to hepatitis A are also vaccinated against hepatitis A.[5] Both hepatitis A and B vaccines are given over a number of weeks, and if a patient is released from custody prior to completing the course of vaccination then it is critical that this be completed after release.

Screening for sexually transmitted infections (STIs) and other infectious diseases should be undertaken, according to the in-prison risks that a patient has disclosed.[6,7] It is important to allow any disclosures to be made in stages, and to adapt the diagnostic care accordingly.

Drug and alcohol problems

Although it is true that inmates are likely to resume old patterns of drug use after leaving prison, the time spent in prison can potentially be a period of stabilisation and rehabilitation. However, drug abuse tends to be an ongoing problem. Intravenous drug use is especially hazardous given the lack of clean injecting equipment in prisons, and the consequent poor habits that may have been reinforced during incarceration.

Many patients released from prison will have an opioid management plan. Across Australia, there is variable jurisdictional access to methadone and buprenorphine, but generally access is enhanced compared to that in the general community – this reflects the higher prevalence of opiate abuse in this population group. Benzodiazepine prescribing in prison is intensely restricted, but when an individual is back in the community a pragmatic and structured approach to the prescription of benzodiazepines can be taken.

Many patients enter prison having had long-term dangerous alcohol intake. In

fact, this is highly predictive of violent crimes that may lead to incarceration. The relatively abstinent environment of prison may mask the importance of this situation, prior to release. When an individual is reintroduced to alcohol, prior habits may become resurgent. GPs should revisit the subject of safer alcohol use on a number of occasions, as the full impact of alcohol (re)use may be delayed on re-entry to the community.

General lifestyle issues

It is worthwhile addressing basic lifestyle factors, such as appropriate diet, sleep hygiene, exercise and potentially relaxation techniques, with ex-inmates. It is difficult for inmates to control their diet while incarcerated, and many experience significant weight gain while in prison. Poor sleep is virtually universal among both prisoners and ex-prisoners.

Smoking cessation should also be discussed. Smoking in prisons is normative behaviour, which is decreasingly the case in the general community. Many patients will have attempted quitting while incarcerated, using nicotine replacement therapy or oral medications, but the highly stressful nature of the prison environment does not easily facilitate cessation of smoking. It is worthwhile, therefore, revisiting this issue when the patient has returned to the general community.[8]

Dental problems

Many ex-inmates have extremely poor dentition. A short prison sentence may allow a partial remedy, but ongoing treatment will often be necessary for both oral hygiene and analgesic management.

Psychological issues

Ex-prisoners tend to have more frequent tragic histories of trauma, including physical, emotional and sexual trauma (in childhood and as adults). They also tend to have higher rates of mental illness (across the diagnostic spectrum) and drug and alcohol use and abuse.[9] These are often directly related to the reason for the patient's incarceration, and ongoing management after release in a nonjudgemental medical setting is vital to providing supportive care to help minimise reoffending due to these primary health issues. If, for example, a patient's opiate or benzodiazepine abuse is addressed appropriately and with compassion, one of the many triggers that can result in re-offending behaviour may have been reduced.

Family issues

Australian prisoners have an average of two children. Family relations, even if previously stable, will have been disrupted by the period of incarceration. Families coping with the enforced separation of a member, and the reintegration of that person, face enormous pressures, compounded by loss of income, difficulty in re-entering the workforce and parole conditions. It is best for medical practitioners to allow for these issues to be raised and offer appropriate referrals to community services.

FINAL POINTS

Although some ex-inmates can exhibit challenging behaviours, they can be a richly rewarding patient group to treat if they are approached with the same compassion, consideration and lack of judgement as the general population. Caregivers in the general community need to help raise this population group from its predicament of being misunderstood and undervalued. Any common characteristics should not be used to denigrate or deligitimise, but rather to guide the support of their present and future roles in the community. MT

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