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Author/s:

Kinner, SA;Young, JT;Carroll, M

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The pivotal role of primary care in meeting the health needs of people recently released from prison

Stuart A. Kinner, NHMRC Senior Research Fellow and Professor^{1,2,3,4}
Jesse T. Young, Research Fellow and PhD Candidate^{2,5,6}
Megan Carroll, Research Fellow and PhD Candidate²

¹ Griffith Criminology Institute & Menzies Health Institute Queensland, Griffith University

² Melbourne School of Population and Global Health, University of Melbourne

³ School of Medicine, University of Queensland

⁴ Centre for Adolescent Health, Murdoch Childrens Research Institute

⁵ Centre for Health Services Research, School of Population Health, The University of Western Australia

⁶ National Drug Research Institute, Curtin University

CORRESPONDING AUTHOR

Professor Stuart A. Kinner
Griffith Criminology Institute, Griffith University
176 Messines Ridge Rd.
Mt Gravatt QLD 4122
Phone +61 (0)7 3875 1782
Email s.kinner@griffith.edu.au

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DISCLOSURE

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ABSTRACT

Objective: Australia's prison population is growing at a rate well in excess of population growth. Indigenous Australians are over-represented by a factor of 13. Prisoners are a profoundly marginalised group characterised by complex health and social needs. Despite improvements in health during incarceration, poor health outcomes after release are common, and the net effect of incarceration is usually health depleting. Given the need for effective care coordination, primary care plays a pivotal role in meeting the health needs of this population. In this paper we review what is known about patterns of primary care utilisation in ex-prisoners, identify evidence-based strategies for increasing access to primary care in ex-prisoners, and consider how such contact may shape subsequent health service outcomes.

Conclusions: Primary care is a necessary but not sufficient condition for effective post-release support. Positive outcomes may depend more on the quality than the quantity of care received. Given massive over-representation of Indigenous people in Australia's prisons, and compelling evidence of preventable morbidity and mortality after release from prison, effective models of care for this population are an important component of closing the gap in Indigenous life expectancy.

KEYWORDS: prisoners, primary health care, mental health, health services, case management

INTRODUCTION

Australia's prison population is growing at a rate well in excess of population growth – by 10% in the year to 30 June 2014, when there were 33,791 adults in custody. Indigenous Australians are increasingly over-represented in prison, now by an age-adjusted factor of 13.¹ Recognising the profoundly harmful effects of mass incarceration, the 2015 Closing the Gap Progress Report recommended setting clear and measurable targets for reducing Indigenous incarceration in the coming years.² Because Indigenous people cycle through prisons more rapidly than their non-Indigenous counterparts, such targets should focus on reducing 'flow' through the system, rather than simply reducing the daily number.³

The health of prisoners

Prison entrants typically present with complex health and psychosocial needs, often untreated or under-treated in the community.⁴ Epidemiological studies in Australia and elsewhere have identified a high prevalence of mental disorder, substance dependence, cognitive impairment, and communicable and non-communicable disease; these co-occurring and chronic health conditions are typically set against a backdrop of entrenched poverty and social disadvantage.^{5, 6} Indigenous people are less likely than their non-Indigenous counterparts to report engagement with health services prior to incarceration, and less likely to report a diagnosed mental disorder on reception into prison.⁶ However, a recent study of Indigenous prisoners in Queensland estimated that the 12 month prevalence of any mental disorder was 86% for women and 73% for men.⁷ Prisoners with a mental disorder are more likely than other prisoners to have a co-occurring substance use disorder, intellectual disability and/or poor physical health.⁸⁻¹⁰

For many people, prisons provide the first opportunity for unmet health needs to be identified and treated. Given their often complex health problems, effectively meeting the health needs of prisoners necessitates a higher level of care than is found in most community settings.¹¹ Although there are clear gaps in the scope and scale of prison health

services, notably in delivery of mental health care and culturally secure health services, there is some evidence to support the widely held view that most prisoners – Indigenous and non-Indigenous – experience measurable health improvements in custody.

Unfortunately, these health gains in custody may come at a price, with prison health services distinguished by their passive, disempowering nature. For example, a recent snapshot of visits to prison health clinics across Australia found that 70% of presentations related to mental disorder were initiated by prison staff.⁶ Similarly, a study of more than 1,200 soon-to-be-released prisoners in Queensland found that although almost one in three was being treated with psychotropic medication, many lacked even a basic knowledge of the medications they were taking; medication knowledge was particularly poor for Indigenous prisoners.¹² The disempowering nature of prison health services may have important consequences for individuals' capacity to self-manage their health needs once they return to the community.

The health of ex-prisoners

Despite improvements in health during episodes of incarceration, many people experience rapidly deteriorating health after release from prison, such that the net effect of incarceration is typically health-depleting. One well-established consequence of this is a dramatically increased risk of death after release from prison, with the risk increasing after each episode of incarceration in a dose-dependent fashion. The majority of deaths in those recently released from prison are due to drug overdose, suicide or injury.^{13, 14} Psychiatric history increases the risk of death in ex-prisoners,¹⁵ although the epidemiology of mortality after release from prison may be markedly different for Indigenous and non-Indigenous people.¹⁶ A recent study estimated that the number of deaths within a year of release from prison in Australia is around ten times the annual number of deaths in custody.¹⁷

Less is known about non-fatal morbidity in ex-prisoners although one study in Western Australia found that one in five ex-prisoners was hospitalised within a year of release; a rate

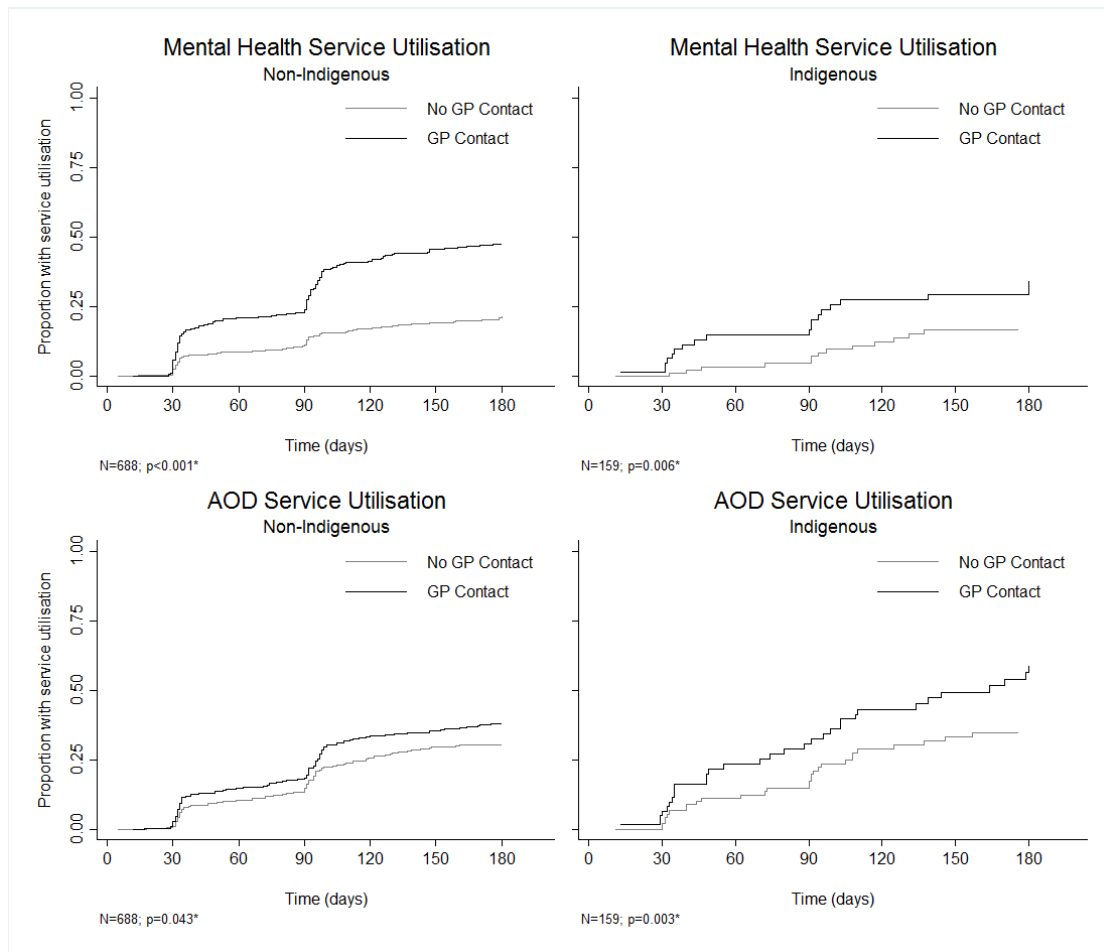
70% higher than in the general population. More than a third of hospital bed days in the cohort was attributed to mental and behavioural disorders.¹⁸ Another study in Queensland found that in a cohort of more than 1,300 adults followed for six months after release from prison, a history of mental disorder was associated with increased risk of hazardous drinking, injecting drug use and poor mental health. These findings persisted after adjustment for pre-existing risk, suggesting that people with a history of mental disorder find the transition from prison to community particularly challenging.¹⁹ Given their over-representation among those cycling through prisons, these poor health outcomes disproportionately affect Indigenous Australians and the communities to which they return. Given the links between poor health outcomes and recidivism,²⁰ and the substantial health and criminal justice costs associated with poor outcomes after release from prison, there are compelling arguments to improve the health of ex-prisoners on human rights, public health, public safety and economic grounds.²¹ Meaningfully improving outcomes for ex-prisoners with multiple and complex needs will require a new paradigm focussed on integration of criminal justice, healthcare and social agencies.

The role of primary care

Primary care in Australia has been defined as “socially appropriate, universally accessible, scientifically sound first-level care provided by a suitably trained workforce supported by integrated referral systems and in a way that gives priority to those most in need, maximises community and individual self-reliance and participation, and involves collaboration with other sectors” (p. 22).²² Although in practice this definition may be more aspirational than descriptive, it closely approximates the model of care endorsed by Aboriginal Community Controlled Health Services. Effective, culturally secure primary care is pivotal to improving health outcomes for people released from prison,²³ however almost nothing is known about the epidemiology of primary care utilisation in ex-prisoners.

One qualitative study of 35 male prisoners in the UK found that the majority would not contact a GP about mental health problems after release from prison; key reasons included perceived stigma associated with diagnosis, an entrenched pattern of avoidance, and a deep distrust of the medication-oriented 'system'.²⁴ Establishment of trust early in the ex-prisoner/physician relationship is associated with increased primary care use²⁵ and improvements in healthcare seeking behavior.²⁶ A non-judgemental, non-stigmatising approach is essential.²⁷ Consistent with this, a randomised trial in the United States found that contact with primary care physicians who had experience working with correctional populations, supported by a peer worker, reduced emergency department presentations in ex-prisoners with a chronic disease.²⁸

Findings from other countries may not be directly applicable in Australia. With funding support from the National Health and Medical Research Council we are currently undertaking a large, prospective study of health service utilisation in a cohort of ex-prisoners in Queensland and Western Australia, using a combination of surveys and data linkage. Preliminary analysis of data from Queensland indicate a high incidence of health care utilisation post-release, with the vast majority of this contact being with primary care providers. Although the incidence of primary care contact appears to be higher for non-Indigenous ex-prisoners, contact with a GP within one month of release from prison is associated with significantly increased odds of later engagement with both mental health and alcohol and other drug (AOD) services, in both Indigenous and non-Indigenous people, even after controlling for baseline risk factors (Figure 1).²⁹



*Log-rank test of equality.

Source: Adapted from Young et al (2015). *BMJ Open*.²⁹

Figure 1. Cumulative incidence of health service contact within six months of release from prison for Indigenous and non-Indigenous ex-prisoners, as a function of early GP contact

Although these findings are encouraging, contact with health services is not a panacea. This fact is persuasively illustrated by a recent Western Australian study that found people with a mental disorder had lower life expectancy and greater morbidity, despite higher rates of GP use.³⁰ One explanation for these findings is that for these individuals, primary care contacts tend to focus only on mental disorder and associated medications, at the expense of other health needs.³⁰ Indeed, there is evidence that, particularly in disadvantaged areas, primary care patients can expect shorter consultations, less health promotion and a greater emphasis on the prescription of (sometimes unaffordable) medications.³¹ Addressing the

complex needs of ex-prisoners, particularly those with mental disorder, will require more intensive and holistic models of care.

Conclusions

People who cycle through prisons in Australia have significant and complex health needs, including a remarkably high prevalence of mental disorder. Episodes of incarceration are typically associated with improvements in general and mental health, although prison healthcare is distinctly passive and biomedical in character. For many who cycle through prisons, the net effect of incarceration is health depleting. Health outcomes after release from prison are predictably poor, and have implications for public health, public safety and the public purse. Primary care is a gateway to more specialised care for this population but access to care alone is not a panacea. Good outcomes are contingent on quality care that is culturally secure, non-judgemental, focussed on health promotion and delivers effective care coordination encompassing mental health and social services. Given the dramatic and increasing over-representation of Indigenous Australians in our prison systems, success in this regard is critical to closing the gap in life expectancy for Australia's first peoples.

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