

Guidelines for Family Physicians Working with Formerly Incarcerated People

The Collaborating Centre for Prison Health and Education

School of Population and Public Health

The University of British Columbia



CCPHE
THE COLLABORATING
CENTRE FOR PRISON
HEALTH & EDUCATION

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Guidelines for Family Physicians Working with Formerly Incarcerated People

Mission

The Collaborating Centre for Prison Health and Education is a group committed to encouraging and facilitating collaborative opportunities for health, education, research, service and advocacy, to enhance the social well-being and (re)integration of incarcerated and formerly incarcerated people, their families and communities.

Objective

Participants and peer health mentors in the “Supporting the Achievement of Health Goals by Formerly Incarcerated Men” project identified the development of guidelines for family physicians working with the formerly incarcerated population as a priority knowledge translation activity given their personal healthcare experiences. The guidelines aim to increase awareness of this patient population and ultimately improve the experiences of formerly incarcerated people with the healthcare system.

Background

Family physicians are often the first point of contact with the health care system for many formerly incarcerated people reintegrating into the community. As formerly incarcerated people are overrepresented among those living with chronic conditions, developmental disabilities, such as Fetal Alcohol Spectrum Disorder/Fetal Alcohol Effects (FASD/FAE), chronic pain, mental health, and substance use issues, it is helpful for family physicians to have up to date knowledge and respond proactively to the unique health needs of this population.

Many of the challenges faced by formerly incarcerated people during their reintegration into the community stem from issues related to the social determinants of health, such as poverty, isolation, formal and informal discrimination, shame and stigma related to being imprisoned, adverse childhood events, and, in the case of Indigenous peoples who are overrepresented within the prison system, the ongoing experience of colonization, intergenerational trauma, and its effects. In addition, formerly incarcerated people face challenges accessing family physicians, obtaining identification cards, birth certificates, housing, employment, and education as well as (re)building relationships with family, friends, and community. More broadly, systems are not supportive of the coordination of care between prison and the community, resulting in difficulties such as in transferring medical records from prison to the community. These basic necessities are the foundation of the social determinants of health.

This document is not intended to answer all questions that may arise during patient encounters with formerly incarcerated people; however, this document aims to provide a foundation for lifelong inquiry into how to better serve formerly incarcerated people within the health care setting. Formerly incarcerated people are usually a small portion of a family physician’s overall patient panel and there are many other competing priorities and needs. It is not expected that family physicians meet all the needs of formerly incarcerated people, but instead provide longitudinal care and coordinate interprofessional teams to facilitate those needs being met by other allied health and social service professionals.

Advisory Group

The guidelines were collaboratively developed with focused participation from physicians who work with current and formerly incarcerated people to bridge the gap in service delivery. The advisory committee's role was to critically analyze the draft guidelines, suggest edits, and establish connections to existing resources.

Dr. Brenda Hardie
Dr. Carolyn Hall
Dr. David Tu
Dr. Nader Sharifi
Dr. Paul Gross
Dr. Peg Robertson
Dr. Steve Beerman

Peer Review

There was an identified need to reach out to academics, partners, and community organizations for a broader perspective.

Alycia Fridkin, Provincial Health Services Authority, San'yas Indigenous Cultural Safety Training
Catherine Latimer, John Howard Society of Canada
Dr. Jane Buxton, BC Centre for Disease Control
Janet Rowe, Prisoners' HIV/AIDS Support Action Network
Janine Stevenson, First Nations Health Authority
Jen Metcalfe, West Coast Prison Justice Society
Jenni Martin, John Howard Society of the Lower Mainland of BC
Kim Pate, Canadian Association of Elizabeth Fry Societies
Larry Howett, Long Term Inmates Now in the Community
Dr. Linda Healey, Correctional Service Canada
Mark Goheen, Fraser Health
Michelle DeGroot, First Nations Health Authority
Mo Korchinski, Unlocking the Gates
Dr. Naomi Dove, BC Centre for Disease Control
Trish Garner, Poverty Reduction Coalition

Resourcing

The guidelines were developed through CCPHE project staff and volunteer time.

Overview of Development Process

1. Invited advisory group to participate in the development process (August 2016)
2. Developed draft outline of the guidelines (August/September 2016)
3. Solicited the Advisory Group for input on the draft outline, specific items to include, and important considerations (September 2016)
4. Drafted guidelines (October 2016)
5. Presented and circulated draft for edits at the Family Medicine Forum (November 2016)

6. Disseminated draft of guidelines for peer review and external review (December/January 2017)
7. Made suggested edits and changes (January/February 2017)
8. Re-connected with stakeholders to finalize the document (March 2017)
9. Published guidelines (May 2017)

Guidelines for Family Physicians Working with Formerly Incarcerated People

Key Terms

Cisgender

A person whose gender identity aligns with their sex assigned at birth (e.g. a person who identifies as a woman and was assigned female at birth).

Colonization

The action or process of settling among and establishing control over the indigenous people of an area.

Federal Corrections

Prisons run by Correctional Service of Canada. Incarcerated people serve sentences of two years or more.

Formerly Incarcerated Person

Someone who has been incarcerated in a provincial or federal prison and is now in the community.

Provincial/Territorial Corrections

Prisons run by Provincial/Territorial Corrections. Incarcerated people serve sentences of two years less a day.

Systemic Racism

Racism that is structured into political and social institutions, which advantages whiteness and disadvantages people of colour and Indigenous peoples. Systemic racism can be explicitly or implicitly expressed.

Transgender

A person whose gender identity does not align with their sex assigned at birth (e.g. a person who identifies as a man and was assigned female at birth).

An Epidemiological Overview of the Population

Demographic Profile

The formerly incarcerated population is diverse; however, formerly incarcerated people are overrepresented among those living below of the poverty line, receiving social and disability assistance, and working in precarious employment arrangements^{1 2}. Formerly incarcerated people in Canada are overwhelmingly more likely to be people of colour and Indigenous peoples^{3 4}. The overrepresentation of Indigenous people within the prison system in Canada is underpinned by historical and ongoing colonization, land dispossession, child apprehension, the Sixties Scoop, intergenerational trauma and its effects⁵. Policy changes such as mandatory minimum sentencing regulations have disproportionately impacted Indigenous people, especially Indigenous women, contributing to their overrepresentation in the prison system⁶. Similarly, systemic racism, the legacy of slavery, redlining (the practice of directly or indirectly denying services to residents of certain areas based on race or ethnicity), police brutality, mandatory minimum sentencing, intergenerational trauma, and its effects are all related to the overrepresentation of Black Canadians in the prison system⁷.

Formerly incarcerated people are much more likely to have experienced childhood trauma, including abuse, neglect, and household dysfunction, than the general population⁸. Among formerly incarcerated women, experiences of intimate partner violence, rape, and sexual assault are significantly higher than among people who have not been incarcerated⁹. These life experiences impact relationships and behaviours across the life course¹⁰.

While formerly incarcerated people are accountable for their actions, understanding common early life experiences can provide context for these actions. Adverse life circumstances, including experiences of stigma and discrimination, can impact trust, interpersonal relationships, control over decisions impacting one's own life and the ability for social participation. Structural factors, such as poverty, lack of educational opportunities, and discrimination, can reinforce these adverse life circumstances and create barriers to employment, social support, and community building. Together, adverse life circumstances and structural barriers multiply disadvantage, which can limit the array of options available to resolve challenges, constraining choices, and resulting in the disproportionate representation of some of the most marginalized people in prisons¹¹.

Involvement in informal economies, such as sex work, drug trafficking and gangs, are some of the only options for people who do not complete formal education, are precariously employed, or are homeless or marginally housed. Informal economies are often criminalized. Rather than addressing the structures that lead people to make these choices, institutions tend to focus on individual responsibility. Reintegrating back into the community with a criminal record is difficult. Formerly incarcerated people can legally be discriminated against for housing, employment, and education¹². The reduction in options available to formerly incarcerated people often results in their return to informal economies and recidivism¹³.

Lastly, everyone has experiences of both oppression and privilege, which influence their own protective and risk factors for incarceration. For those who experience oppression, marginalized identities (e.g. being a woman, person of colour, Indigenous person, LGBTQ+ person, person of low socioeconomic status, and/or a person living with disabilities) intersect to intensify disadvantage and increase the likelihood of incarceration. For those who experience privilege, dominant identities (e.g.

being a man, white person, heterosexual person, person of high socioeconomic status, and/or an able-bodied person) intensify advantage and decrease the likelihood of incarceration. Systems sustain and maintain inequity through both policy and practice, disadvantaging those who identify as people of colour, Indigenous, queer or trans, disabled, working class or poor, and other marginalized identities while advantaging those who identify as white, heterosexual, cisgender, able-bodied, middle to upper class, and other dominant identities.

Priority Health Issues

Formerly incarcerated people are overrepresented among those living with chronic conditions, developmental disabilities, such as FASD, chronic pain, mental health, and substance use issues¹⁴. In particular, mental health and substance use issues are 2-3 times more prevalent in persons who are incarcerated than in the community, indicating missed opportunities for treatment and prevention of mental health and substance use disorders that may have contributed to risk of incarceration.

Many of the challenges faced by formerly incarcerated people during their reintegration into the community stem from poverty, isolation, formal and informal discrimination, shame and stigma related to being imprisoned, adverse childhood events, and, in the case of Indigenous peoples who are overrepresented within the prison system, the ongoing experience of colonization, intergenerational trauma, and its effects. Stereotypes of Indigenous patients are linked to systemic racism against Indigenous peoples in Canada and result in poor health care outcomes. Many Indigenous patients delay or choose not to seek care over fear of discrimination based on their race¹⁵. More details will be covered on Indigenous health in the guidelines.

Risk and Protective Factors

Concerning reintegration into the community, a variety of risk and protective factors have been outlined that either contribute to 1) overall health and reintegration, or 2) contribute to illness and recidivism. Systemic factors, such as jurisdictional divisions between justice and health care, the broader social determinants of health, and the legacy of colonization, contribute to health outcomes but are often seen as out of the scope of primary care; however, there are many tangible approaches family physicians can take where they can make a difference in the individual lives of patients and support the achievement of health goals while recognizing that systemic factors that impact health status.

- Protective Factors
 - Individual
 - Secure, safe, and affordable housing
 - Meaningful, well-paid employment with benefits or adequate social or disability assistance
 - Attachment to a compassionate family physician or other primary care provider
 - Continuity of care between prison and the community
 - Social support network
 - Engagement in volunteer activities/pro-social behaviours
 - Access to affordable and healthy food options

- Appreciative inquiry into mental health and substance use concerns
 - Positive sense of cultural identity and connection to cultural practices
- Community
 - Promotion of social inclusion
 - Provision of work opportunities for people with criminal records
 - Prioritization of supporting the formerly incarcerated population
 - Supportive programs and policies in the areas of housing, education, and employment
- Risk factors
 - Individual
 - Lack of housing
 - Lack of employment or social or disability assistance
 - Social isolation and stigmatization
 - Inadequate or lack of connection to primary health care
 - Untreated health conditions
 - Lack of continuity of care between prison and the community
 - Lack of connection to community/lack of pro-social behaviours
 - Dismissal of mental health and/or substance use concerns
 - Community
 - Social isolation and stigmatization
 - Lack of navigational aids for complex systems
 - Lack of infrastructure for people to practice cultural traditions (e.g. lack of physical space or opportunities)
 - Gaps in services
 - Added complexity for people in rural and remote locations

Role of Family Physician during Reintegration

- Utilize an inclusive, patient-centered, trauma-informed, culturally safe, and harm reduction approach to care
- Support patient to achieve immediate reintegration needs (e.g. obtaining personal documentation, accessing dental care, procuring an eye exam, etc.)
- During intake, strive to:
 - Take a medical and social events history
 - Screen for mental health and substance use disorders
 - Take a comprehensive sexual health history
 - As needed, offer harm reduction supports, including naloxone
- As much as possible, ensure that prison medical records are available for comprehensive case management
- Provide longitudinal care for the formerly incarcerated individual, leading case management within an interprofessional team of allied health and social service providers

Recommended Approaches to Care

For family physicians working with formerly incarcerated people in the community

1.1 Social Inclusion and Stigma Reduction

It is common for formerly incarcerated people to feel isolated, ostracized, and excluded from their communities during reintegration, which is reinforced by both formal and informal discrimination in employment, housing, and education as well as by family, friends, and the general public.

Family physicians are often uncertain about taking on new patients with criminal records and can harbour a bias that this population is malingering, deceitful, and drug-seeking. Moreover, physicians may be concerned for their safety and the safety of their other patients and staff. Family physicians may feel that formerly incarcerated people do not take good care of their health (e.g. poor self-maintenance); however, access to care while inside prison is limited and heavily regimented, so people may be unable to access the timely care they need as they would in the community

While family physicians may feel cautious about taking on formerly incarcerated patients, formerly incarcerated patients themselves are often guarded when meeting family physicians and are worried that they will be dismissed, receive sub-standard care, or feel unsafe sharing their incarceration history. Formerly incarcerated people may have had negative experiences with doctors inside prison, and/or may feel that prison doctors or psychiatrists were complicit in traumatic experiences, such as prolonged solitary confinement. A strong, trusting relationship built on compassion and mutual respect is necessary to combat the social stigma attached to incarceration.

“This is a question I ask all my patients and I only ask so that I can provide the best care that I can. Have you ever completed a sentence at a provincial or federal prison?”

Note: you may choose to wait until a trusting relationship is established before asking this question. Formerly incarcerated people may choose not to disclose due to experiences of stigma and discrimination, especially from people in positions of authority.

1.2 Patient-Centered Care

In the prison context, autonomy is removed from incarcerated people. When people are admitted to prison, there is a shift towards risk-based assessment of the individual, which focuses on deficits in functioning, behaviour, and health. In the community, there is a tremendous opportunity to transform the relationship between institutions and the individual. Rather than using paternalistic approaches, family physicians can collaborate with patients to

engender ownership of health care decision-making. It is crucial to acknowledge the power imbalance between patient and provider and work to minimize its effects by privileging the patient's agenda, listening, learning, and working together. Rather than focusing on risks or deficits, family physicians can focus on strengths and abilities.

In patient-centered care, the focus is on the importance of the doctor-patient relationship and communication skills. This approach is most effective when both the physician and the patient acknowledge and understand the disease (identified through differential diagnosis) and the illness (the subjective experience of the patient). Patient-centered care involves actively engaging the patient in the management of the disease/illness through discussing further tests and treatment options as well as confirming the patient's understanding of the treatment plan and willingness to participate in the process.

Patient-Centered Inquiry

- 1) "What matters to you?"
- 2) "Is there anything you're worried or concerned about?"
- 3) "What should I know about you that's not in your medical chart?"
- 4) "What do you want to be doing in six months that you can't do now?"
- 5) "What does a good day look like?"
- 6) "What are your goals for treatment?"

Additional Resources

- CFPC Patient Centered Approach
<http://www.cfpc.ca/uploadedFiles/Education/The%20Patient-Centred%20Approach.pdf>

1.3 Trauma-Informed Practice

Trauma-Informed Practice (TIP) is an approach to care that aims to support people who have experienced trauma. TIP recognizes how abuse, neglect, and household dysfunction impact development, relationships, and behaviours. Trauma is both an event and a response to an event, which can be triggered by familiar conditions, words, sensations, scents, sounds, and scenery. Evidence suggests that childhood trauma has wide-ranging effects into adulthood, including impacts on physical and mental health.¹⁶ Further, emerging epigenetic evidence indicates that childhood trauma can alter the expression of genes, which can be passed down to children, increasing the likelihood

Asking about trauma requires a relationship built on trust and respect. Wait until the relationship is well-established before asking about trauma. In the meantime, treat all patients with a trauma-informed practice approach. We never know who has experienced trauma.

that children whose parents have experienced trauma exhibit behaviours such as heightened awareness and hypervigilance¹⁷.

Power differentials between physician and patient can trigger and/or reinforce trauma. TIP advises that each encounter should be built on safety, trust, reliability, patient autonomy, and acceptance of people as they are. The key to a TIP approach is providing patients with control and choice within each encounter. In TIP, healing is about re-connection and building healthy relationships with others. The role of health care providers in trauma-informed care is first and foremost to listen, honour, and validate patients' experiences of trauma.

Evidence shows that social connection is a protective factor that aids in recovery from and resilience to trauma¹⁸. Most people recover from trauma. The development of Post-Traumatic Stress Disorder (PTSD) and related diagnoses are the exception, not the rule. The role of the physician is not to be a counsellor but to present focused strategies for coping and systems navigation.

Additional Resources

- Trauma-Informed Practice Guide (BCEWH)
<https://bccewh.bc.ca/2014/02/trauma-informed-practice-guide/>
- Becoming Trauma Informed (CAMH)
http://www.camh.ca/en/education/about/camh_publications/Pages/becoming_trauma_informed.aspx

1.4 Cultural Safety for Indigenous Peoples

There is an overrepresentation of Indigenous peoples within the formerly incarcerated population and a need for culturally safe approaches to health care due to Aboriginal determinants of health, including racism, social exclusion, and trauma¹⁹.

Cultural safety "is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care."²⁰ Crucial to cultural safety is the need for ongoing self-reflection and evaluation. Cultural safety is about ensuring that the care you are providing is not doing harm. This can be difficult because recognizing systemic violence is not

*"Where are you from?"
Asking self-identified Indigenous patients this question provides an opportunity for connection and recognizes the interdependencies between ancestral territory, identity, culture, and health*

Note: Many Indigenous people do not feel safe to identify because of lived experiences of discrimination, stereotyping, and systemic racism in our social systems.

part of medical training. Systemic violence against Indigenous peoples requires physicians to acknowledge that the colonial system is rooted in racism and harm against Indigenous peoples and that this history continues into the present, underpinning many health concerns seen in family practice. Expanding on the social determinants of health, the Aboriginal determinants of health include racism, social exclusion, and intergenerational trauma and its effects²¹.

Beyond doing no harm, there is a need to engage effectively with cultural practices, recognizing cultural practices as an option for the individual within their treatment plan. To be culturally effective, one needs to create space and opportunity for people to connect with traditional approaches to health care within family practice if they so choose²². The impacts of colonization on Indigenous people varies as does one's connection or desire for connection to one's Indigenous culture, traditional practices, and identity. It is important to become familiar with the resources available to Indigenous peoples within the community, form relationships with people working in these organizations, and work together collaboratively.

At the management and leadership levels of organizations, there is a need to adopt a culturally safe approach. Applying the lens of cultural safety to an organization may include changes such as altering building regulations to allow for smudging to take place in health care settings, supporting extended family to join appointments, and creating more inclusive and intentional hiring practices to address a lack of Indigenous people within staff teams and enable space for Indigenous leadership.

Overall, a culturally safe approach is a life-long and ongoing practice. When considering additional layers such as the lack of systemic power, the impact of the colonial legacy, the stigma associated with being in prison, stereotyping harm, systemic racism and structural violence that Indigenous people experience, the onus is on the service provider to actively promote trust and relationship building for Indigenous people.

Additional Resources

- CFPC Health and Health Care Implications of Systemic Racism on Indigenous Peoples in Canada - Indigenous Health Working Group

Truth and Reconciliation Commission of Canada: Calls to Action:

#18. We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.

#22. We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients

http://www.cfpc.ca/uploadedFiles/Resources/PDFs/SystemicRacism_ENG.pdf

- The Inconvenient Indian: A Curious Account of Native People in North America by Thomas King
- Dying from Improvement: Inquests and Inquiries into Indigenous Deaths in Custody by Sherene H. Razack

1.5 Harm Reduction

According to the Harm Reduction Coalition, harm reduction is “a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs”²³. Harm reduction principles apply to both prescribed and illicit substances.

“Talking about substance use is hard. I want you to know that I do not judge people who use drugs. I need to know if you’re using substances so I can support you in keeping yourself safe and healthy.”

Harm reduction aims to meet people where they are at with open arms, acceptance, and compassion - not judgment or shame. Harm reduction recognizes that every life is valuable and that substance use is complex and challenging. A harm reduction approach respects the autonomy of people who use drugs, provides information to aid in decision-making, and takes their lead on entering detox, treatment, and other health services. Additional information on harm reduction is provided with regard to specific health needs later on in the guidelines.

Additional Resources

- Canadian Centre for Substance Abuse – Harm Reduction – What’s in a Name?
<http://www.ccsa.ca/Resource%20Library/ccsa0115302008e.pdf>
- Respectful Language And Stigma Regarding People Who Use Substances
http://towardtheheart.com/assets/naloxone/respectful-language-and-stigma-final_244.pdf

Recommendations for Population Health

Indigenous Health

2.1 Indigenous Health

- Indigenous people are significantly overrepresented among the incarcerated population
- In 2015, Indigenous incarcerated people represented 24.4% of the total federal incarcerated population while comprising only 4.3% of the Canadian population²⁴
- This overrepresentation has its roots in the legacy of colonial violence against Indigenous peoples, including the experiences of land dispossession, child apprehension, residential schools, Indian hospitals, the Sixties Scoop, intergenerational trauma, systemic racism, and its effects
- Previous and ongoing traumatic experiences contribute to a well-warranted distrust in health and social service providers as well as government workers
- The most effective health care providers are self-reflective of their own heritage, privileges, and experiences of oppression in order to engage meaningfully with Indigenous peoples
- The most effective health care providers work alongside Indigenous patients as partners, respecting autonomy and placing choice and control in their hands

Recommendations

- Family physicians engage in cultural safety training with the intention that this is the beginning of a lifelong course of learning in how to work in partnership and collaboration with Indigenous peoples, including additional trainings and learning opportunities
- Family physicians review the Calls to Action from the Truth and Reconciliation Commission of Canada Report, especially those that relate to health care
- Family physicians use the privilege of their standing as medical practitioners to advocate alongside Indigenous peoples, taking their lead

Additional Resources

- Truth and Reconciliation Commission of Canada: Calls to Action
http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Calls_to_Action_English2.pdf

Women's Health

3.1 Women's Population Health Needs

- There are significantly different issues for Indigenous women given colonial history and also the persistence of stereotyping today, especially around substance misuse. The high rate of Indigenous children in care is another reason that Indigenous women may have well-warranted mistrust and concern when interacting with service providers²⁵. There is a specific section on Indigenous health in the guidelines.
- Lesbian, bisexual, and other women have sex with women, are significantly overrepresented among incarcerated women²⁶.
- Transgender women are overrepresented among women in prison and often placed in men's institutions that do not align with their gender identity, resulting in an increased risk

of sexual assault and mistreatment compared to other incarcerated people²⁷. There is a specific section on the transgender population in the guidelines.

Recommendations

- Family physicians familiarize themselves with supports and approaches to care that are specific to Indigenous women
- Family physicians familiarize themselves with supports and approaches to care that are specific to lesbian, bisexual, and transgender women

Additional Resources

- Health Professionals working with First Nations, Inuit, and Métis Consensus Guideline (Society of Obstetricians and Gynecologists of Canada)
https://sogc.org/wp-content/uploads/2013/06/June-JOGC-2013-CPG293_Supplement_Eng_Online-Final_NO-cropmarks_REV-F.pdf
- Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide
http://www.jointcommission.org/assets/1/18/LGBTFieldGuide_WEB_LINKED_VER.pdf

3.2 Pregnancy, Birth, and Early Childhood

- Mother-child units or nurseries in prisons enable attachment between mother and child, which is associated with better outcomes for both mothers and children
- Pregnant women giving birth in provincial/territorial custody and Correctional Service Canada custody (federal, two years or more) may have programs available whereby they can give birth and raise their child in prison through an on-site nursery while they complete their sentence
- However, pregnant mothers usually give birth offsite at hospitals where local child protective workers then determine whether or not the child will remain with the mother
- Lack of understanding the importance of the mother-child bond from birth onwards and the fear of making a decision that may put the child at 'risk' has led to mothers to routinely have their children removed by child protective services and placed in care despite mother-child programs being in place in women's prisons
- Apprehending children can be devastating for the mothers, resulting in decompensated mental health status and self-harm as well as loss of attachment between mother and child
- Many women who have cycled in and out of prison may be sensitive to questions regarding their children, who may have been taken into protective custody or are living with other relatives. Women in these situations often experience shame and despair over their precarious relationship with their children
- Pregnancy, childbirth, and parenting may trigger traumatic memories, including experiences of rape, sexual assault, neglect, and abuse, which require a trauma-informed practice approach

Recommendations

- Family physicians support women as they so choose in their desire to reconnect with children, family, friends, and other social supports

- Family physicians support women in accessing parenting, early childhood development, and other social services

Additional Resources

- Trauma-Informed Practice Guide
http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf
- Guidelines for the Implementation of Mother-Child Units in Canadian Correctional Facilities
http://med-fom-familymed-ccphe.sites.olt.ubc.ca/files/2012/05/MCUGuidelines_Nov15_FINAL.pdf
- Second Chances: A Guidebook for Parents Wishing to Reunite with their Children
https://multco.us/sites/default/files/dcj/documents/second_chances_master012510.pdf

Men's Health

4.1 Men's Health

- Over 90% of federal and provincial incarcerated population is male. 23.2% of federally incarcerated men are Indigenous²⁸
- Men experience higher prevalence and incidence of physical health issues, mental illness, suicide, and substance use
- Many men lose connection with family and friends and restoring these relationships can better support their reintegration into the community
- Care-seeking is much less common among men due to gender norms, which dictate that men who seek care are weak²⁹
- There is an opportunity to re-write this social script and recognize the strength it takes for men to seek care and take charge of their health
- Transgender men are overrepresented among men in prison and often placed in women's institutions that do not align with their gender identity, resulting in an increased risk of mistreatment compared to other incarcerated people³⁰. There is a specific section on the transgender population in the guidelines.

Recommendations

- Family physicians validate men who are seeking care by recognizing their strength and seize the opportunity to engage them in a meaningful way
- Family physicians familiarize themselves with resources available to men in the community for referral purposes

Additional Resources

- Health Canada – Men's Health
<http://www.hc-sc.gc.ca/hl-vs/jfy-spv/men-hommes-eng.php>
- Men's Health Online Resource - Don't Change Much
<http://dontchangemuch.ca/>

Transgender Health

5.1 Transgender Health

- Transgender people are overrepresented among incarcerated people³¹
- Incarcerated transgender people are often placed in facilities that do not align with their gender identity, resulting in an increased risk of sexual assault and maltreatment compared to other incarcerated people³²
- Life-saving hormone therapy is often disrupted or discontinued for many incarcerated transgender people
- Correctional Service Canada now has a policy that mandates transgender people are assigned to the prison that aligns with their gender identity rather than their sex assigned at birth
- Policies on the assignment of incarcerated people based on gender identity varies across provincial and territorial prisons

Recommendations

- Family physicians familiarize themselves with supports and approaches to care for transgender and non-binary people

Additional Resources

- Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People – World Professional Association for Transgender Health
<http://www.phsa.ca/transgender/Documents/Standards%20of%20Care%2c%20V7%20Full%20Book.pdf>
- Guidelines and Protocols for Hormone Therapy and Primary Health Care for Trans Clients - Sherbourne Health Centre
<http://sherbourne.on.ca/wp-content/uploads/2014/02/Guidelines-and-Protocols-for-Comprehensive-Primary-Care-for-Trans-Clients-2015.pdf>

Recommendations for Systems Navigation

6.1 Transferring Medical Records from Prison to the Community

- Provide the patient with a consent form to sign for the release of their medical records to you
- Mail the consent form and a letter requesting the patient's medical records to the facility from which the patient was previously released
- It is recommended that you write "ATTN: HEALTH CARE" on the envelope
- The prison will receive the letter and send the requested files to your office
- As you review the prison medical records, consider that the patient has likely changed since their initial sentence and references to poor conduct may be out-dated or biased
- Be prepared to review any part of the prison medical record with the patient. In particular, discuss any part that might suggest unprofessional conduct and ways that you and the patient can work together to address these

Recommendations

- Family physicians obtain patient medical records from prison as needed, utilizing an informed consent process

Additional Resources

- Contact information for Correctional Service Canada (federal) prisons:
<http://www.csc-scc.gc.ca/institutions/index-eng.shtml>
- Contact your provincial or territorial correctional branch for a list of provincial or territorial prisons

6.2 Continuity of Care during Re-Incarceration

- Send a letter to the prison marked "Health Care" offering support; if your patient is not there, the letters will be returned
- Phone the facility. If your patient is not there, the booking clerk will inform you

Recommendations

- Family physicians reach out to provincial and federal prisons to support continuity of care for a patient who has been re-incarcerated

Additional Resources

- Contact information for Correctional Service Canada (federal) prisons:
<http://www.csc-scc.gc.ca/institutions/index-eng.shtml>
- Contact your provincial or territorial correctional branch for a list of provincial or territorial prisons

6.3 Supporting People in Poverty

- Formerly incarcerated people are overrepresented among those living on low and fixed incomes, including those on social or disability assistance
- Poverty impacts health on a gradient and is a risk factor for many health concerns
- Poverty is not always self-evident. Family physicians need to be pro-active and sensitive with patients when inquiring about poverty and suggesting additional supports
- People with low socio-economic status are more likely to be hospitalized for conditions, which could have been avoided with earlier disease management and reducing barriers to access
- The role of the family physician can appear limited in addressing poverty. Connecting patients to existing community resources and governmental supports as suggested in the Poverty Screening tool is one approach to addressing this gap in care.

“Do you ever have difficulty making ends meet at the end of the month?”

(Sensitivity 98%, Specificity 64% for living below the poverty line)

Recommendations

- Family physicians familiarize themselves with the Poverty Screening Tool, which asks family physicians to:
 - 1) Inquire about poverty when screening all patients³³
 - 2) Include poverty as a health risk factor
 - 3) Inquire about family status, including asking if children live in the home to be inclusive of family poverty
 - 4) Intervene to address poverty-related issues (using the Poverty Screening Tool provided in the link below)

Additional Resources

- Poverty - A Clinical Tool for Primary Care Providers
<http://ocfp.on.ca/cpd/povertytool>

6.4 Dental

- In prison, often only emergency dental procedures are provided
- In the community, low-cost dental clinics offer free services, reduced rates, and special programs for people on social assistance, disability, or low or fixed incomes.
- Dental coverage may be provided by provincial or territorial social and/or disability assistance
- Non-Insured Health Benefits provides dental coverage for Status First Nations based on specific criteria
- Advocate for patients to talk to their dentist to negotiate a way to pay for care whether it is at a reduced cost or on a payment schedule
- Patients can also check their local food bank or outreach clinic for additional services

Recommendations

- Family physicians inquire with formerly incarcerated patients regarding dental pain and dental hygiene
- Family physicians refer formerly incarcerated patients to low-cost and free dental care as needed
- Provide information on how dental problems, if left, can lead to physical health problems
- Recognize there is just as much hesitation involved with accessing any services with a doctor and there the possibility of past trauma

Additional Resources

- Governmental Dental Programs
<http://www.caphd.ca/programs-and-resources/government-dental-programs>
- Canada Benefits Finder
<http://www.canadabenefits.gc.ca/f.1.2c.6.3z.1rdq.5.2st.3.4ns@.jsp?lang=en>
- Health Canada – Non-Insured Health Benefits (for Status First Nations)
<http://www.hc-sc.gc.ca/contact/fniah-spnia/fnih-spni/nihbr-ssnar-eng.php>

6.5 Eye Examinations

- Vision care is a significant health priority among formerly incarcerated people due to the high prevalence of chronic health issues, including those associated with significant ocular risk, such as diabetes
- Many formerly incarcerated people are on low or fixed incomes, so the extra expense of an eye exam is out of reach
- Eye exam coverage varies across provinces and territories and coverage may be extended to people on social and/or disability assistance

Recommendations

- Family physicians familiarize themselves with vision care services available to those on low or fixed incomes, social assistance, and disability assistance
- Family physicians inquire about vision care with formerly incarcerated patients

Additional Resources

- Health Canada – Non-Insured Health Benefits (for Status First Nations)
<http://www.hc-sc.gc.ca/contact/fniah-spnia/fnih-spni/nihbr-ssnar-eng.php>
- Canada Benefits Finder
<http://www.canadabenefits.gc.ca/f.1.2c.6.3z.1rdq.5.2st.3.4ns@.jsp?lang=en>

6.6 Medication Coverage

- If available in your area, PharmaNet or a similar service can be used to verify a patient's medications
- A patient's medication list should also be included in their medical record from prison. This can be requested from the prison by mail. See recommendation 2.1.
- The federal formulary list governs what is available to incarcerated people. Upon release, medications may need to be switched based on coverage by provincial/territorial pharmaceutical plans or extended health plans.
- People living in Community Correctional Centres funded by Correctional Service Canada (e.g. John Howard Society Halfway Houses) are covered under the federal formulary (on day parole, not statutory release with residency)
- Status First Nations people can sign up for coverage through Health Canada's Non-Insured Health Benefits program
- Encourage patients to sign up for Provincial or Territorial Pharmaceutical plans

Recommendations

- Family physicians familiarize themselves with the federal formulary, Non-Insured Health Benefits for Status First Nations, and Provincial or Territorial pharmaceutical plans

Additional Resources

- Free Tax Preparation Clinics in your area (taxes may need to be submitted before registration in provincial and territorial health care programs):
<http://www.cra-arc.gc.ca/tx/ndvdl/vlntr/clncs/menu-eng.html>
- Register for Provincial or Territorial Pharmacare:
<http://www.hc-sc.gc.ca/hcs-sss/pharma/acces/ptprog-eng.php>
- Health Canada – Non-Insured Health Benefits (for Status First Nations)
<http://www.hc-sc.gc.ca/contact/fniah-spnia/fnih-spni/nihbr-ssnar-eng.php>

Recommendations for Managing Issues Surrounding Recidivism

7.1 Reporting Intent to Commit Crimes

- Patients may make physicians aware of their plans to commit an offense. Under certain circumstances, there is a mandatory duty to report. In circumstances where there is not a duty to report, it is up to the discretion of the physician to report to the authorities

Recommendations

- Family physicians follow existing policies and procedures on mandatory reporting. Specifically, patient information can only be provided to law enforcement in four cases : 1) with express consent, 2) via court order, 3) as required by statute (e.g. Duty to Report), or 4) by public safety exception
- Family physicians consider available community-based supports as well as the impact of re-incarceration on health and well-being when making discretionary decisions on reporting to authorities
- *With consent of the patient*, family physicians connect with members of the individual's support team, including, but not limited to, their probation or parole officer, attending physician, case worker, friends/family, and/or other supports

Additional Resources

- College of Family Physicians of Canada - Professionalism:
<http://www.cfpc.ca/uploadedFiles/Education/Professionalism.pdf>
- Wellness Recovery Action Plan:
<http://www.workingtogetherforrecovery.co.uk/Documents/Wellness%20Recovery%20Action%20Plan.pdf>
- List of Correctional Service Canada Parole Offices (Federal)
<http://www.csc-scc.gc.ca/institutions/001002-0001-eng.shtml>

Communicable Disease

8.1 HIV

- Estimates of HIV prevalence among incarcerated populations in Canadian federal and provincial prisons range from 2% to 8%, which is ten times the general population prevalence³⁴
- As there is a stigma attached to both drug use and sexual behaviour, this is a sensitive topic to discuss that requires a relationship built on trust
- People who consistently take appropriate anti-retroviral therapy can maintain an undetectable viral load and so greatly reduce the risk of HIV transmission³⁵
- PharmaNet does not list the names of anti-retroviral medications on a patient's file. Instead, anti-retroviral medications show up as "non-benefit drugs" on PharmaNet. This may be true for similar programs where anti-retrovirals
- It is common for disruptions in medication usage to occur when an HIV-positive individual transitions from the community into prison and/or from prison into the community. This can result in a spike in the viral load and an increased risk of transmission to others.

Recommendations

- Family physicians caring for formerly incarcerated patients inquire about HIV risk factors to assess the need for HIV testing
- Family physicians register for PharmaNet and are aware that anti-retroviral medications show up as "non-benefit drugs" on PharmaNet. This may be true for similar services as well

Additional Resources

- Primary Care Guidelines for the Management of HIV/AIDS
http://www.cfenet.ubc.ca/sites/default/files/uploads/primary-care-guidelines/primary-care-guidelines_015-09-15.pdf

8.2 Hepatitis B

- Rates of contraction of hepatitis B have increased since the 1990s in prisons in Canada³⁶
- Hepatitis B vaccination may have been initiated in prison

Recommendations

- Family physicians inquire about risk and protective factors for hepatitis B for formerly incarcerated patients
- Family physicians complete the vaccination schedule for those patients who have initiated hepatitis B vaccination in prison and are now reintegrating into the community

Additional Resources

- Primary Care Management of Hepatitis B – Quick Reference
http://www.liver.ca/files/Professional_Education_Partnerships/Information_Resources_for_HCP/HBV-QR-EN-FINAL_Web.pdf

- Management of chronic hepatitis B: Canadian Association for the Study of the Liver consensus guidelines
http://www.liver.ca/files/Professional_Education_Partnerships/Information_Resources_for_HCP/2012_CASL_Consensus_Guidelines_for_Hepatitis_B.pdf

8.3 Hepatitis C

- A peer-led study of the prevalence of injection drug use inside one federal prison found that 35% of men reported current injection drug use³⁷ and 21% of provincially incarcerated women reported current injection drug use³⁸
- Due to the absence of prison-based needle and syringe programs in prisons, there is a high prevalence of needle sharing. In addition, unsafe tattooing practices are also very common. Both activities are risk factors for Hep C transmission.
- Hep C treatments are changing and there are new anti-viral drugs that have been approved by Health Canada with cure rates more than 90% that are all-oral, short-course, interferon-free treatments
- HCV treatment may occur in federal corrections, so re-establishing treatment in the community for those who have started treatment in prison is essential

Recommendations

- Family physicians caring for formerly incarcerated people inquire about risk factors for Hep C to determine the need for testing, treatment, and support

Additional Resources

- An Update on the Management of Chronic Hepatitis C: 2015 Consensus Guidelines from the Canadian Association for the Study of the Liver:
http://www.liver.ca/files/Professional_Education_Partnerships/Information_Resources_for_HCP/CASL_Hep_C_Consensus_Guidelines_Update_-_Jan_2015.pdf

8.4 Tuberculosis (TB)

- TB is easily transmitted in prisons where people are in close contact with one another
- Approximately 16% to 22% of federally incarcerated people have latent TB infection³⁹
- Many formerly incarcerated people are interested in knowing if they have active or latent TB
- TB is often co-morbid with HIV and/or Hep C
- Active TB diagnoses are reportable
- Continuity of care between the community and prisons remains a challenge
- Specific to First Nations peoples, there is a need to better coordinate care with First Nations communities (on-reserve health care)

Recommendations

- Family physicians working with formerly incarcerated people familiarize themselves with TB prevention, screening, and treatment as this health concern is not as common in general family practice but is overrepresented among the formerly incarcerated population

Additional Resources

- Canadian Tuberculosis Standards
<http://www.respiratoryguidelines.ca/tb-standards-2013>
- Health Canada – First Nations Inuit Health
<http://www.hc-sc.gc.ca/fniah-spnia/index-eng.php>

8.5 Sexually Transmitted Infections (STIs)

- There is a stigma around STIs in prison, especially in men’s prisons given the association between STI transmission and exchange sex (exchanging sex for goods, protection, etc.)⁴⁰
- STIs are more common among the incarcerated and formerly incarcerated populations⁴¹
- STIs are more common among those who have engaged in substance use and sex work, especially among formerly incarcerated women and Aboriginal men⁴²
- Ideally, STIs are diagnosed and treated in prison; however, there is some evidence to suggest that people with untreated STIs may transmit to their partners when they are released⁴³

Recommendations

- Family physicians facilitate a comprehensive sexual history with their new formerly incarcerated patients as they would with any new patient

Additional Resources

- Canadian Guidelines on Sexually Transmitted Infections (Public Health Agency of Canada)
<http://www.phac-aspc.gc.ca/std-mts/sti-its/cgsti-ldcits/index-eng.php>

Mental Health

9.1 Mental health

- Mental health disorders are 2-3 times more prevalent in the prison population than in the general population⁴⁴
- Prison practices, such as solitary confinement, can have particularly harmful effects on mental health and can exacerbate existing mental illnesses and maladaptive coping behaviours, such as self-medicating with substances⁴⁵
- People with lived prison experience are more likely to report higher incidences of childhood trauma, including abuse, neglect, and household dysfunction, which is associated with an increased likelihood of developing a mental illness later in life^{46 47}
- You may receive questions about prescribed marijuana for anxiety

Recommendations

- Family physicians screen formerly incarcerated patients’ mental health during primary care visits as part of regular intake for all patients
- Family physicians screen patients for concurrent substance disorders if a mental health disorder is also suspected

Additional Resources

- Dual Diagnosis Toolkit for Primary Care Providers (CAMH)
<https://dualdiagnosis.camh.ca/Pages/default.aspx>
- DFC Open Resources for Family Medicine – Mental Health (University of Toronto)
<http://dfcmopen.com/item-category/clinical-by-topic/mental-health/>
- Authorizing Medical Cannabis for Chronic Pain or Anxiety (CFPC)
<http://www.cfpc.ca/uploadedFiles/Resources/PDFs/Authorizing%20Dried%20Cannabis%20for%20Chronic%20Pain%20or%20Anxiety.pdf>

9.2 Suicide prevention, Intervention, and Follow-up

- The incidence of suicide has been shown to be 8 to 18 times higher among the formerly incarcerated population compared to the general population^{48 49 50}
- Feelings of isolation, disconnection, and social marginalization are common among formerly incarcerated people, especially when reintegrating into the community after release
- The stigma of incarceration impacts people long after their release, limiting options for employment, housing, education, and relationships
- Risk factors for suicide among formerly incarcerated people include a history of past suicide attempts and a diagnosis with a substance use disorder
- The risk of suicide is especially high in the first months after release, making the transition between prison and the community a particularly vulnerable period

Recommendations

- Family physicians are aware of early warning signs of suicidal ideation and are prepared to intervene early to collaboratively develop a safety plan

Additional Resources

- Suicide Prevention and Assessment Handbook (CAMH)
https://www.camh.ca/en/hospital/health_information/a_z_mental_health_and_addiction_information/suicide/Documents/sp_handbook_final_feb_2011.pdf
- Holistic Crisis Planning Toolkit
<https://www.porticonetwork.ca/tools/toolkits/hcp-toolkit>

9.3 Social Support and Relationships

- Inside prison, many people find social support in other incarcerated people
- Once released, formerly incarcerated people can feel isolated and disconnected from their families, friends, and social support networks – some of whom may have willfully excluded them from their lives
- Meeting with peers, people who also have lived prison experience, is one option to connect and develop meaningful relationships once people are back in the community
- Many formerly incarcerated people find social support through volunteering or giving back to their communities
- Social support is a protective factor against depression, suicide, and self-harm

“When something happens, who do you go to for support?”

Recommendations

- Family physicians inquire about social supports with formerly incarcerated patients and assist in systems navigation as needed

Additional Resources

- John Howard Society of Canada
<http://www.johnhoward.ca/>

Substance Use

10.1 Harm Reduction

- Harm reduction is an approach that minimizes the harms associated with drug use and respects the lives of people who use drugs
- A doctor-patient relationship founded on respect, compassion, and acceptance is essential to a harm reduction approach and promotes social inclusion, lessening stigma and shame.
- Harm reduction engages people in care and meets people where they are at
- Harm reduction supplies include but are not limited to sterile needles and syringes, acidifier (vitamin C), cookers, tourniquets, condoms, lubricant, sterile water, swabs, sharps containers, crack pipe mouthpieces, crack pipe screens, push sticks, and naloxone
- PharmaCare Plan G (Psychiatric Medications) covers the cost of methadone maintenance therapy and buprenorphine/naloxone.

Recommendations

- Family physicians proactively engage with formerly incarcerated patients regarding their need for harm reduction supplies, education, and training

Additional Resources

- Best Practice Recommendations for Canadian Harm Reduction Programs that Provide Service to People Who Use Drugs and are at Risk for HIV, HCV, and Other Harms: Part 1
<http://www.catie.ca/en/programming/best-practices-harm-reduction>

10.2 Substance Use Disorders

- Many people are incarcerated for crimes committed while under the influence of substances, especially people in provincial prison and formerly incarcerated women
- Substance use exists on a continuum from beneficial to harmful use
- Substance abuse is an extreme desire to obtain and use increasing amounts of one or more substances; whereas, substance use disorder is the inability to stop using the drug despite numerous attempts to quit, impacting relationships, work, education, and other obligations
- Substance use disorders can be driven by experiences of adverse childhood events and trauma, including intergenerational trauma and residential school experience
- Substances provide a means of coping, offer an escape, and allow people a way of surviving in difficult circumstances

- Respect, compassion, and acceptance are needed to build trusting relationships with people experiencing a substance use disorder
- It is important to respect the autonomy of people who use drugs, provide information for decision-making, and facilitate referrals to services where appropriate
- Recovery from substance use disorders is complex, non-linear, and specific to each person
- The opposite of substance use disorders is not sobriety, it is connection and self-defined recovery, including managing use, reducing use, and/or engaging in harm reduction
- The patient and physician are equal partners in treating substance use disorders
- Stigma and discrimination towards individuals who use substances within and outside the health system result in significant barriers in access to care and disclosure, impacting utilization of treatment and harm reduction services

Recommendations

- Family physicians familiarize themselves with current clinical practice guidelines for the diagnosis and treatment of substance use disorders in primary care settings
- Family physicians screen patients for concurrent mental health disorders if a substance use disorder is suspected

Additional Resources

- Primary Care Addiction Toolkit (CAMH)
<https://www.porticonetwork.ca/tools/toolkits/pcat>
- Dual Diagnosis Toolkit for Primary Care Providers (CAMH)
<https://dualdiagnosis.camh.ca/Pages/default.aspx>
- DFC Open Resources for Family Medicine – Addictions Medicine (University of Toronto)
<http://dfcmopen.com/item-category/clinical-by-topic/addiction-medicine/>
- Alcohol Screening, Brief Intervention, and Referral
<http://www.sbir-diba.ca/>

10.3 Opioid Overdose Prevention

- Multiple studies show increased overdose deaths among individuals recently released from prison, especially within the first 2 weeks^{51 52}
- In response to the fentanyl crisis, access to harm reduction has been expanded, including naloxone
- Naloxone restores breathing in those having an opioid overdose
- Coverage and accessibility of naloxone kits varies across provinces and territories.

Recommendations

- Family physicians educate formerly incarcerated people with current or past opioid use about lowered opioid tolerance after a period of reduced use and provide take home naloxone training and kits as needed
- Family physicians assist patients as needed in finding a harm reduction site for harm reduction supplies and training

Additional Resources

- Availability of “Take Home Naloxone” Programs in Canada
<http://www.ccsa.ca/Resource%20Library/CCSA-CCENDU-Take-Home-Naloxone-Canada-2016-en.pdf>

10.4 Opioid Substitution Therapy (methadone and suboxone)

- Opioid Substitution Therapy is offered in provincial and federal prisons, requiring continuity of care after release
- Methadone and buprenorphine prevent withdrawal from opioids and reduce or eliminate cravings, allowing people to stabilize their lives
- Depending on your location, the cost associated with opioid substitution therapy may be publicly covered or covered by social or disability assistance
- Prescribing privileges vary across provinces and territories

Recommendations

- Family physicians familiarize themselves with current protocols for opioid substitution therapy

Additional Resources

- Health Canada – Methadone Program
<http://www.hc-sc.gc.ca/hc-ps/substancontrol/exemptions/methadone-eng.php>
- Suboxone Prescribing Training Program
<https://www.suboxonecme.ca>

Injury/Disability

11.1 Injury and Rehabilitation

- Injuries requiring rehabilitation are more common among the incarcerated and formerly incarcerated populations
- Disabilities are common among formerly incarcerated people and lack of access to comprehensive medical care can result in many unmet health needs for this population
- Pain management is another common concern for people who have sustained injuries and require rehabilitation, which is complicated by biases and prejudice toward people with prison experience (please see section 12.1)

- Rehabilitation services are less likely to be publicly covered and formerly incarcerated people are more likely to live on low or fixed incomes, so referring to low-cost or publicly covered services is most appropriate

Recommendations

- Family physicians become familiar with the application process for disability assistance if available
- Family physicians become familiar with public and low-cost rehabilitative services available in their region
- Family physicians become familiar with community resources for people living with disabilities to assist in systems navigation

Additional Resources

- Disability Benefits:
<https://www.canada.ca/en/services/benefits/disability.html>

11.2 Disability

- People living with disabilities are overrepresented within the incarcerated and formerly incarcerated populations
- Disabilities include autism, blindness, deafness, emotional disturbance, hearing impairment, intellectual disability, orthopedic impairment, impaired health, learning disabilities, speech or language impairment, traumatic brain injury, visual impairment, and multiple disabilities
- In particular, Fetal Alcohol Spectrum Disorder (FASD), Fetal Alcohol Effects (FAE), Alcohol-Related Neurodevelopmental Disorder (ARND) and Alcohol-Related Birth Defects (ARBD), are more common among formerly incarcerated people and are often undiagnosed⁵³
- Systems navigation, especially access to disability assistance or social assistance, is a major concern

Recommendations

- Family physicians:
 - Utilize person-first language (e.g. people living with disabilities)
 - Focus on the strengths of the patient (e.g. what the patient *can* do)
 - Avoid deficit-based and pathologizing language (e.g. instead of “decreased anterior pelvic tilt,” you can say “you lean forward when you walk”)
 - Recognize that success is defined differently by each patient
 - Support patients in meeting and maintaining their activities of daily living
- Family physicians familiarize themselves with the application process for disability assistance (if available) and support formerly incarcerated patients who meet criteria to apply

Additional Resources

- Disability Benefits:
<https://www.canada.ca/en/services/benefits/disability.html>
- College of Family Physicians of Canada - Developmental Disabilities Program Committee
http://www.cfpc.ca/Developmental_Disabilities_Program_Committee/
- Primary Care of Adults with Developmental Disabilities: Canadian Consensus Guidelines
<http://www.cfp.ca/content/57/5/541.full.pdf+html>
- Tools for Primary Care Providers – Developmental Disabilities
<http://www.surreyplace.on.ca/resources-publications/primary-care/tools-for-primary-care-providers/>
- Fetal Alcohol Spectrum Disorder: Canadian Guidelines for Diagnosis:
<http://www.faslink.org/Canadian%20guidelines%20for%20diagnosis%20of%20FASD.htm>

Chronic Pain

12.1 Treatment of Chronic Pain

- Chronic pain is a common concern among formerly incarcerated people
- People with lived prison experience who are presenting with chronic pain are often read by health care providers as deceitful, malingering, and drug-seeking
- In addition, women are more likely to be undertreated for pain and to have their pain dismissed than men⁵⁴
- People of colour are more likely to be undertreated for pain than white people⁵⁵
- Formerly incarcerated people routinely face the stigma associated with the treatment of chronic pain and this topic can be very triggering for both patient and provider
- Validating a patient's pain as legitimate and conservatively addressing pain management can support the establishment of a trusting relationship while you both look for root causes and manage symptoms with a focus on regaining functioning for daily living
- You may receive questions from patients about the use of prescribed marijuana for chronic pain management

Recommendations

- Family physicians reflect on their own biases towards the treatment of chronic pain among formerly incarcerated people. Identifying and acknowledging biases allows for more objective treatment of the health issue.
- Family physicians familiarize themselves with current clinical practice guidelines for the treatment of chronic, non-cancer pain

Additional Resources

- Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain
<http://nationalpaincentre.mcmaster.ca/opioid/documents.html>
- Pharmacological management of chronic neuropathic pain: Revised consensus statement from the Canadian Pain Society
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4273712/pdf/prm-19-328.pdf>
- College of Family Physicians of Canada – Chronic Pain Program Committee
http://www.cfpc.ca/Chronic_Non_Cancer_Pain_What_s_New/
- Authorizing Medical Cannabis for Chronic Pain or Anxiety
(Although this is not recommended as a first-line treatment, this guideline provides information on responsible prescribing)
http://www.cfpc.ca/uploadedFiles/Resources/_PDFs/Authorizing%20Dried%20Cannabis%20for%20Chronic%20Pain%20or%20Anxiety.pdf

Chronic Disease

13.1 Chronic Disease Management

- Chronic disease, including heart disease and diabetes, is increasingly common among the incarcerated and formerly incarcerated populations
- Research suggests that the physiological age of the incarcerated population is 10-15 years older than their chronological age⁵⁶
- Overall, the incarcerated population is aging with more people over 65 than ever before
- Approximately 80% of incarcerated people smoke and 93% of incarcerated smokers reporting tobacco use inside prison despite smoking bans in federal and provincial prisons⁵⁷
- The quality of nutrition varies across prisons and there is limited access to physical activity, especially at medium and high security prisons

Recommendations

- Family physicians apply the same standards of care for the prevention, screening, and treatment of chronic disease among the incarcerated population as the general population

Additional Resources

- Prevention in Hand: Evidence-Based Clinical Practice Guidelines (CFPC web and mobile app)
<http://www.preventioninhand.com/default.aspx?lang=en-CA>
- Public Health Agency of Canada: Canadian Best Practices Portal – Chronic Diseases
<http://cbpp-pcpe.phac-aspc.gc.ca/>
- Transforming Care for Canadians with Chronic Health Conditions: Put People First, Expect the Best, Manage the Results (Canadian Academy of Health Sciences)
<http://www.caahs-acss.ca/wp-content/uploads/2011/09/cdm-final-English.pdf>

Cancer

14.1 Cancer

- Cancer is the leading natural cause of death among federally incarcerated people in Canada⁵⁸
- Overall, the incarcerated population is aging with more people over 65 than ever before
- Approximately 80% of incarcerated people smoke and 93% of incarcerated smokers reporting tobacco use inside prison despite smoking bans in federal and provincial prisons⁵⁹
- The quality of nutrition varies across prisons and there is limited access to physical activity, especially at medium and high security prisons
- Cancer screening is less common inside prisons where the focus is often on immediate health needs rather than preventive care
- Invasive screenings can trigger formerly incarcerated people with experiences of trauma; therefore, a trauma-informed practice approach is needed (See section 1.3)

Recommendations

- Family physicians follow current cancer screening, diagnosis, and treatment protocols
- Family physicians utilize a trauma-informed practice approach when screening people with incarceration experience for cancer

Additional Resources

- College of Family Physicians of Canada - Cancer Care Committee:
http://www.cfpc.ca/Cancer_care/
- CCPHE Cancer Walks Free Documentary:
<https://www.youtube.com/watch?v=vJKloTHFAko&list=PLwTqMyAQ47SYqi2dHi4oXdXgiPwlpMKan>
- Trauma-Informed Practice Guide (BCCEWH)
<https://bccewh.bc.ca/2014/02/trauma-informed-practice-guide/>

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