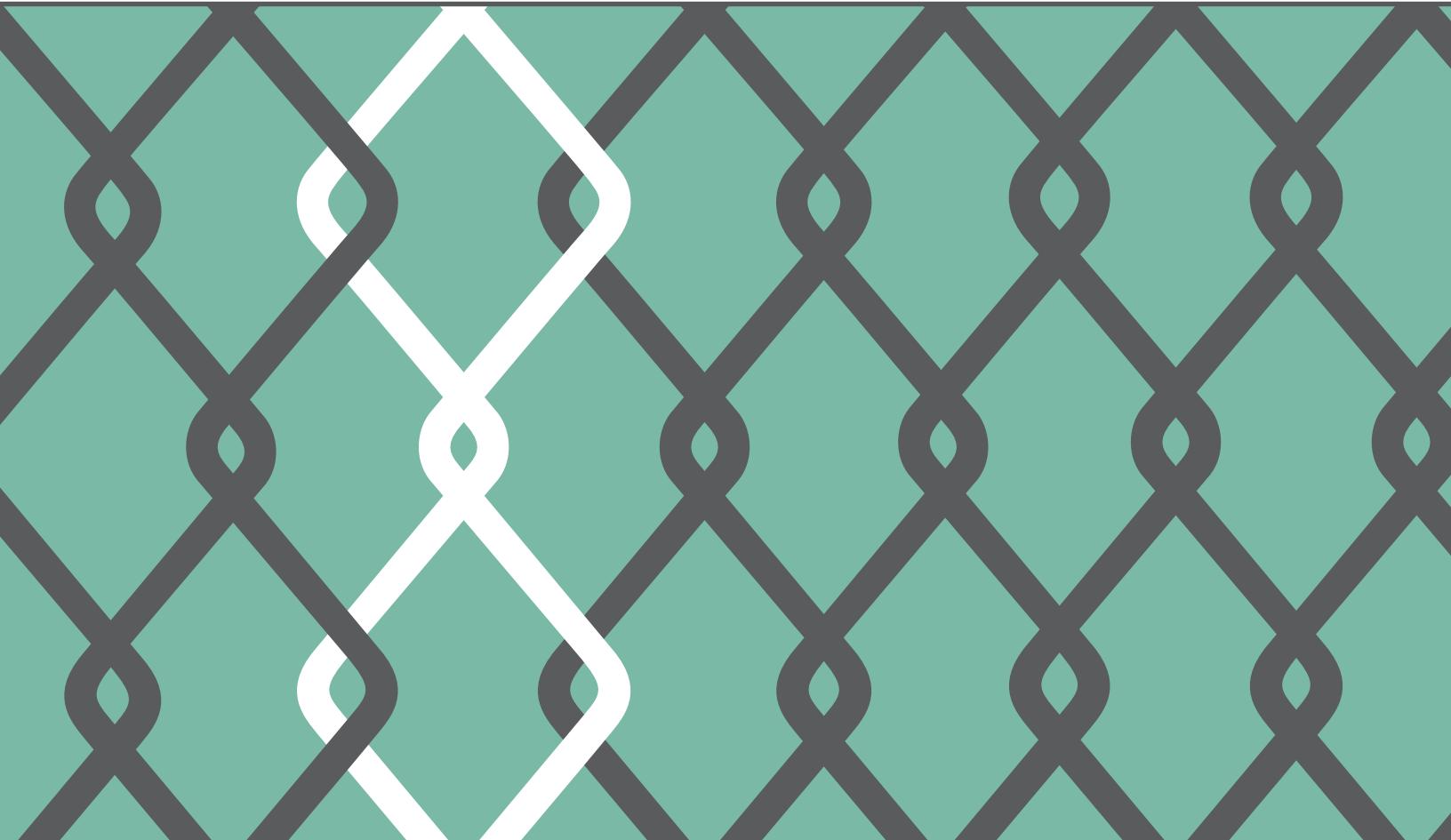




Guidelines for Family Physicians Working with Formerly Incarcerated People





CCPHE
THE COLLABORATING
CENTRE FOR PRISON
HEALTH & EDUCATION



THE UNIVERSITY OF BRITISH COLUMBIA

John Howard
THE JOHN HOWARD SOCIETY OF CANADA
La SOCIÉTÉ JOHN HOWARD DU CANADA

Copyright © 2017. Collaborating Centre for Prison Health and Education (CCPHE). Guidelines for Family Physicians Working with Formerly Incarcerated People.

Author: Collaborating Centre for Prison Health and Education

Publisher Information:

Collaborating Centre for Prison Health and Education
School of Population and Public Health
University of British Columbia
2206 East Mall
Vancouver, BC V6T 1Z3
CANADA

Email: ccphe@spph.ubc.ca
Website: ccphe.ubc.ca

Printed in Canada

This document has been made possible through funding from:
the Michael Smith Foundation for Health Research, the Vancouver Foundation, the Peter Wall Institute for Advanced Studies, and the Face the World Foundation.



MICHAEL SMITH FOUNDATION
FOR HEALTH RESEARCH

Discover. Connect. Engage.


FACE THE WORLD
foundation
THE IDEA IS GIVING

vancouver
foundation

PETER
WALL
INSTITUTE FOR ADVANCED STUDIES
THE UNIVERSITY OF BRITISH COLUMBIA VANCOUVER

Endorsed July 2018 by The College of Family Physicians of Canada.

THE COLLEGE OF
FAMILY PHYSICIANS
OF CANADA  LE COLLÈGE DES
MÉDECINS DE FAMILLE
DU CANADA

Contents

1	Overview	1
1.1	Background	1
1.2	Development Process	2
1.3	Key Terms	3
2	An Epidemiological Overview	4
2.1	Demographic Profile	4
2.2	Priority Health Issues	5
2.3	Role of Family Physician during Reintegration	5
2.4	Risk and Protective Factors	6
3	Recommended Approaches to Care	7
3.1	Social Inclusion and Stigma Reduction	7
3.2	Patient-Centered Care	7
3.3	Trauma-Informed Practice	8
3.4	Cultural Safety for Indigenous Peoples	9
3.5	Harm Reduction	10
4	Recommendations for Population Health	11
4.1	Indigenous Health	11
4.2	Women's Health	11
4.3	Men's Health	13
4.4	Transgender Health	13
5	Recommendations for Systems Navigation	15
5.1	Transferring Medical Records from Prison to the Community	15
5.2	Supporting People in Poverty	15
5.3	Dental	16
5.4	Eye Examinations	17
5.5	Medication Coverage	17
6	Recommendations for Managing Issues Surrounding Recidivism	18
6.1	Reporting Intent to Commit Crimes	18
6.2	Continuity of Care during Re-Incarceration	18
7	Recommendations for Clinical Practice	19
7.1	Communicable Disease	19
7.2	Mental Health	21
7.3	Substance Use	23
7.4	Injury/Disability	25
7.5	Chronic Pain	26
7.6	Chronic Disease	27
7.7	Cancer	28
8	References	29

1 Overview

1.1 BACKGROUND

The Collaborating Centre for Prison Health and Education (CCPHE) was established in 2006 to address the distinct health needs of incarcerated and formerly incarcerated individuals. CCPHE is committed to encouraging and facilitating education, research, service, and advocacy to enhance the health and social well-being of individuals transitioning from prison into their communities. This includes fostering collaboration and partnerships among universities, prisons, the justice system, and communities to reduce health disparities that negatively affect those with incarceration experience. Individuals in custody or who are reintegrating back into communities represent a population that is most deserving of a strong voice with regards to policy, research, and education concerning the improvement of conditions for those temporarily residing in Canadian institutions.

1.1.1 Objective

Participants and Peer Health Mentors in the “Supporting the Achievement of Health Goals with 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 health care experiences. The guidelines aim to increase awareness of this patient population and ultimately improve the experiences of formerly incarcerated people with the health care system.

1.1.2 Issue

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, 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 and intergenerational trauma. 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 transferring medical records from prison to the community.

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 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.

1.2 DEVELOPMENT PROCESS

1.2.1 Advisory Group

An advisory group comprised of physicians working with currently and formerly incarcerated people participated in the collaborative development of the guidelines. The advisory group's role was to critically analyze the draft guidelines.

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

1.2.2 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

1.2.3 Timeline of Development

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).

1.3 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 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).

2 An Epidemiological Overview

2.1 DEMOGRAPHIC PROFILE

The formerly incarcerated population is diverse; however, formerly incarcerated people are overrepresented among those living below the poverty line, receiving social and disability assistance, and working in precarious employment arrangements.^{1,2} People who have experienced incarceration in Canada are overwhelmingly more likely to be Indigenous peoples or from racialized groups.^{3,4} Their overrepresentation within the Canadian prison system is underpinned by systemic racism, the effects of intergenerational trauma, and policy changes such as mandatory minimum sentencing regulations. Historical and ongoing colonization, land dispossession, child apprehension, and the Sixties Scoop are all related to the overrepresentation of Indigenous peoples within the prison system.³ Similarly, the legacy of slavery, redlining (the practice of directly or indirectly denying services to residents of certain areas based on race or ethnicity), and police brutality are all related to the overrepresentation of Black Canadians in the prison system.⁴

Formerly incarcerated people are much more likely to have experienced childhood trauma, including abuse, neglect, and household dysfunction, than the general population.⁵ Among formerly incarcerated women, experiences of intimate partner violence, rape, and sexual assault are significantly higher than among people who have not been incarcerated.⁶ These life experiences impact relationships and behaviours across the life course.⁷

While formerly incarcerated people are accountable for their actions, understanding common early life experiences can provide context for these actions. Adverse life circumstances can impact trust, interpersonal relationships, decision making, and the ability for social participation. Structural factors, such as poverty, lack of educational opportunities, and discrimination, can reinforce adverse life circumstances and create barriers to employment, social support, and community building. Together, adverse life circumstances and structural barriers multiply disadvantage, which limits the array of options available to resolve challenges, constrains choices, and results in the disproportionate representation of marginalized people in prisons.⁸

Informal economies, such as sex work, drug trafficking and gangs, are often criminalized. Involvement in informal economies are some of the only options for people who do not complete formal education, are precariously employed, or are homeless or marginally housed. Rather than addressing the structures that lead people to make these constrained 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 education.⁹ The reduction in options available to formerly incarcerated people often results in their return to informal economies and recidivism.¹⁰

Lastly, everyone has experiences of both oppression and privilege, which influence their own protective and risk factors for incarceration. Marginalized identities (e.g. being a woman, racialized person, 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. 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 with marginalized identities while advantaging those with dominant identities.

2.2 PRIORITY HEALTH ISSUES

Formerly incarcerated people are overrepresented among those living with chronic conditions, developmental disabilities, chronic pain, mental health, and substance use issues.⁵ 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 race.¹¹ More details will be covered on Indigenous health in the guidelines.

2.3 ROLE OF FAMILY PHYSICIAN DURING REINTEGRATION

Utilize an inclusive, patient-centered, trauma-informed, culturally safe, and harm reduction approach to care. Support patients 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 formerly incarcerated individuals, leading case management within an interprofessional team of allied health and social service providers.

2.4 RISK AND PROTECTIVE FACTORS

Concerning reintegration into the community, a variety of risk and protective factors have been outlined that either contribute to overall health and reintegration or 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 to make a difference in the individual lives of patients and support the achievement of health goals while recognizing the systemic factors that impact health status.

	Protective Factors	Risk Factors
Individual	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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

3 Recommended Approaches to Care

3.1 SOCIAL INCLUSION AND STIGMA REDUCTION

It is common for formerly incarcerated people to feel isolated, ostracized, and excluded from their communities during reintegration. This 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.

3.2 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

You Might Ask:

"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.

You Might Ask:

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?

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.

Additional Resources

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

3.3 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.⁷ Further, emerging epigenetic evidence indicates that childhood trauma can alter the expression of genes, which can be passed down to children, increasing the likelihood that children whose parents have experienced trauma exhibit behaviours such as heightened awareness and hypervigilance.¹²

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.

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 trauma.¹³ 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 (BCCEWH)
<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

3.4 CULTURAL SAFETY FOR INDIGENOUS PEOPLES

For Indigenous peoples, there is a need for culturally safe approaches to health care due to Aboriginal determinants of health, including racism, social exclusion, and trauma.¹⁴

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 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 effects.¹⁴

You Might Ask:

“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.

Beyond doing no harm, there is a need to engage effectively with cultural practices and recognize cultural practices as an option for the individual within their treatment plan. To be culturally effective, physicians need to create space and opportunity for people to connect with traditional approaches to health care within family practice if they so choose.¹⁶ The impacts of colonization on Indigenous people varies as does the 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
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

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.

3.5 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.”¹⁷ Harm reduction principles apply to both prescribed and illicit substances.

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.

You Might Ask:

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

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://www.bccdc.ca/resource-gallery/Documents/respectful-language-and-stigma-final_244.pdf

4 Recommendations for Population Health

4.1 INDIGENOUS HEALTH

Indigenous people are significantly overrepresented among those with incarceration experience. In 2015, Indigenous people represented 24.4% of the total federal incarcerated population while comprising only 4.3% of the overall Canadian population.¹⁸

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. To engage meaningfully with Indigenous peoples, the most effective health care providers are self-reflective of their own heritage, privileges, and experiences. They work alongside Indigenous patients as partners, respecting autonomy and placing choice and control in patients' hands.

Recommendations

1. Family physicians engage in cultural safety training with the intention that this is the beginning of a lifelong course of learning on how to work in partnership and collaboration with Indigenous peoples, including additional trainings and learning opportunities.
2. Family physicians review the Calls to Action from the Truth and Reconciliation Commission of Canada Report, especially those that relate to health care.
3. 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

4.2 WOMEN'S HEALTH

4.2.1 Women's Population Health Needs

Compared to incarcerated men, women in federal prisons are twice as likely to have a serious mental health diagnosis and also have high rates of self-reported experiences of physical abuse (86%) and sexual abuse (68%).¹⁹

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 an out-of-home placement is another reason that Indigenous women may have well-warranted mistrust and concern when interacting with service providers.²⁰ Refer to section 4.1 on Indigenous health in the guidelines.

Lesbian, bisexual, and other women who have sex with women, are significantly overrepresented among

incarcerated women.²¹

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 people.²² Refer to section 4.4 on transgender health in the guidelines.

Recommendations

1. Family physicians familiarize themselves with supports and approaches to care that are specific to Indigenous women.
2. 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

4.2.2 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 federal custody 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 services workers then determine whether or not the child will remain with the mother.

Despite mother-child programs being in place in women's prisons, a lack of understanding of 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 routinely having their children removed by child protective services and placed in care.

Apprehending children can be devastating for the mothers, resulting in decompensated mental health status and self-harm, as well as a lost opportunity for building strong 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

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

RECOMMENDATIONS FOR POPULATION HEALTH

2. 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

4.3 MEN'S HEALTH

Over 90% of the federal and provincial incarcerated populations are male. 23.2% of federally incarcerated men are Indigenous.²³

Men experience a higher prevalence and incidence of physical health issues, mental illness, suicide, and substance use. Care-seeking is much less common among men due to gender norms, which dictate that men who seek care are weak.²⁴ 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.

Many men lose connection with family and friends and restoring these relationships can better support their reintegration into the community.

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 people.²² See section 4.4 for more information on the transgender health.

Recommendations

1. Family physicians validate men who are seeking care by recognizing their strength and seizing the opportunity to engage them in a meaningful way.
2. 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/>

4.4 TRANSGENDER HEALTH

Transgender people are overrepresented among incarcerated people.²¹ 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 people.²²

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.

Life-saving hormone therapy is often disrupted or discontinued for many incarcerated transgender people.

Recommendations

1. 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>

5 Recommendations for Systems Navigation

5.1 TRANSFERRING MEDICAL RECORDS FROM PRISON TO THE COMMUNITY

To acquire a patient's medical records from prison, 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

1. 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

5.2 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. People with low socio-economic status are more likely to be hospitalized for conditions that could have been avoided with earlier disease management and reducing barriers to access.

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.

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 (see Section 5.2 Additional Resources) is one approach to addressing this gap in care.

You Might Ask:

"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

1. Family physicians familiarize themselves with the Poverty Screening Tool, which asks family physicians to:
 - a) Inquire about poverty when screening all patients²⁵
 - b) Include poverty as a health risk factor
 - c) Inquire about family status, including asking if children live in the home to be inclusive of family poverty
 - d) 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>

5.3 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

1. Family physicians inquire with formerly incarcerated patients regarding dental pain and dental hygiene.
2. Family physicians refer formerly incarcerated patients to low-cost and free dental care as needed.
3. Provide information on how dental problems, if left unattended, can lead to physical health problems.
4. 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/fnih-spnia/fnih-spni/nihbr-ssnar-eng.php>

5.4 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

1. Family physicians familiarize themselves with vision care services available to those on low or fixed incomes, social assistance, and disability assistance.
2. 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>

5.5 MEDICATION COVERAGE

If available in your area, PharmaNet or a similar service can be used to verify a patient's medications. 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. A patient's medication list should also be included in their medical record from prison. This can be requested from the prison by mail.

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

1. 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/ndvds/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>

6 Recommendations for Managing Issues Surrounding Recidivism

6.1 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

1. 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.
2. 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.
3. 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>

6.2 CONTINUITY OF CARE DURING RE-INCARCERATION

If your patient becomes re-incarcerated, you can reach out by sending a letter to the prison marked "ATTN: Health Care" offering support. If your patient is not there, the letters will be returned. You can also phone the facility. If your patient is not there, the booking clerk will inform you. Contact your provincial or territorial correctional branch for a list of provincial or territorial prisons.

Recommendations

1. 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>

7 Recommendations for Clinical Practice

7.1 COMMUNICABLE DISEASE

7.1.1 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 prevalence.²⁶

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 greatly reduce the risk of HIV transmission.²⁷

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.

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

1. Family physicians caring for formerly incarcerated patients inquire about HIV risk factors to assess the need for HIV testing.
2. 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

7.1.2 Hepatitis B

Rates of contraction of hepatitis B have increased since the 1990s in prisons in Canada.²⁸ Patients may have initiated hepatitis B vaccination while in prison.

Recommendations

1. Family physicians inquire about risk and protective factors for hepatitis B for formerly incarcerated patients.
2. 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
https://www.liver.ca/wp-content/uploads/2017/09/HBV-QR-EN-_FINAL_Web.pdf

- Management of chronic hepatitis B: Canadian Association for the Study of the Liver consensus guidelines
https://www.liver.ca/wp-content/uploads/2017/09/2007_CASL_Consensus_Guidelines_-Hepatitis_B.pdf

7.1.3 Hepatitis C (HCV)

A peer-led study of the prevalence of injection drug use inside one federal prison found that 35% of men reported current injection drug use²⁹ and 21% of provincially incarcerated women reported current injection drug use.³⁰

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 HCV transmission.

HCV treatments are changing and there are new anti-viral drugs that have been approved by Health Canada with cure rates of more than 90%, which 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

1. Family physicians caring for formerly incarcerated people inquire about risk factors for HCV 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://demo.liver.ca/wp-content/uploads/2017/09/CASL_Hep_C_Consensus_Guidelines_Update_-Jan_2015.pdf

7.1.4 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 infection.³¹ Many formerly incarcerated people are interested in knowing if they have active or latent TB. Active TB diagnoses are reportable.

TB is often co-morbid with HIV and/or HCV. Continuity of care between the community and prisons remains a challenge. Specific to Indigenous peoples, there is a need to better coordinate care with Indigenous communities' on-reserve health care.

Recommendations

1. 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>

RECOMMENDATIONS FOR CLINICAL PRACTICE

- Health Canada – First Nations Inuit Health
<http://www.hc-sc.gc.ca/fniah-spnia/index-eng.php>

7.1.5 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.).³²

STIs are more common among those with incarceration experience than the general population.³³ STIs are more common among those who have engaged in substance use and sex work, especially among formerly incarcerated women and Aboriginal men.³⁴

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 released.³⁵

Recommendations

1. 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>

7.2 MENTAL HEALTH

7.2.1 Mental health

Mental health disorders are 2-3 times more prevalent in the prison population than in the general population.¹⁹ 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-medication with substances.³⁶ People with incarceration 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.^{37 38} You may receive questions about prescribed marijuana for anxiety.

Recommendations

1. Family physicians screen formerly incarcerated patients' mental health during primary care visits as part of regular intake for all patients.
2. 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

7.2.2 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.^{39 40 41} 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

1. 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>

7.2.3 Social Support and Relationships

Social support is a protective factor against depression, suicide, and self-harm. 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.

You Might Ask:

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

Meeting with peers, people who also have incarceration 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.

Recommendations

1. 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/>

7.3 SUBSTANCE USE

7.3.1 Harm Reduction

Harm reduction is an approach that minimizes the harms associated with drug use and respects the lives of people who use drugs. Harm reduction engages people in care and meets people where they are at.

A physician-patient relationship founded on respect, compassion, and acceptance is essential to a harm reduction approach. It promotes social inclusion and lessens the patient's experience of stigma and shame.

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

1. 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>

7.3.2 Substance Use Disorders

Many people are incarcerated for crimes committed while under the influence of substances. 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

1. Family physicians familiarize themselves with current clinical practice guidelines for the diagnosis and treatment of substance use disorders in primary care settings.
2. 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/>

7.3.3 Opioid Overdose Prevention

Multiple studies show increased overdose deaths among individuals recently released from prison, especially within the first 2 weeks.^{42 43}

In response to the fentanyl crisis, access to harm reduction tools has been expanded, including naloxone. Naloxone restores breathing in those having an opioid overdose. Coverage and accessibility for naloxone kits varies across provinces and territories.

Recommendations

1. 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.
2. 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>

7.3.4 Opioid Substitution Therapy (methadone and suboxone)

Opioid Substitution Therapy is offered in provincial and federal prisons, requiring continuity of care after release. Methadone and suboxone 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

1. 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>

7.4 INJURY/DISABILITY

7.4.1 Injury and Rehabilitation

Injuries requiring rehabilitation are prevalent 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 towards people with incarceration experience (please see section 7.6.1).

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

1. Family physicians become familiar with the application process for disability assistance if available.
2. Family physicians become familiar with public and low-cost rehabilitative services available in their region.
3. 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>

7.4.2 Disability

People living with disabilities are overrepresented among people with incarceration experience. 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 undiagnosed.⁴⁴

Systems navigation, especially access to disability assistance or social assistance, is a major concern.

Recommendations

1. Family physicians:
 - a) Utilize person-first language (e.g. people living with disabilities)
 - b) Focus on the strengths of the patient (e.g. what the patient can do)
 - c) Avoid deficit-based and pathologizing language (e.g. instead of “decreased anterior pelvic tilt,” you can say “you lean forward when you walk”)
 - d) Recognize that success is defined differently by each patient
 - e) Support patients in meeting and maintaining their activities of daily living
2. 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>

7.5 CHRONIC PAIN

7.5.1 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 men.⁴⁵ People of colour are more likely to be undertreated for pain than white people.⁴⁶

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

1. 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

RECOMMENDATIONS FOR CLINICAL PRACTICE

health issue.

2. 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

7.6 CHRONIC DISEASE

7.6.1 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 age.⁴⁷ Overall, in recent years the Canadian incarcerated population has seen a dramatic increase in individuals aged 50 years and older.

Approximately 80% of incarcerated people smoke and 93% of incarcerated smokers report tobacco use inside prison despite smoking bans in federal and provincial prisons.⁴⁷

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.cahs-acss.ca/wp-content/uploads/2011/09/cdm-final-English.pdf>

7.7 CANCER

7.7.1 Cancer

Cancer is the leading natural cause of death among federally incarcerated people in Canada.¹⁸ Cancer screening is less common inside prisons where the focus is often on immediate health needs rather than preventive care. Invasive screenings can be triggering for formerly incarcerated people with experiences of trauma; therefore, a trauma-informed practice approach is needed (See section 3.3).

Overall, in recent years the Canadian incarcerated population has seen a dramatic increase in individuals aged 50 years and older. Approximately 80% of incarcerated people smoke and 93% of incarcerated smokers reporting tobacco use inside prison despite smoking bans in federal and provincial prisons.⁴⁸ The quality of nutrition varies across prisons and there is limited access to physical activity, especially at medium and high security prisons.

Recommendations

1. Family physicians follow current cancer screening, diagnosis, and treatment protocols.
2. 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.cfp.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/>

8 References

1. Visher C, Debus-Sherrill S, Yahner J. Employment After Prison: A Longitudinal Study of Former Prisoners. *Justice Quarterly*. 2011;28(5):698-718.
2. Sapers, H. Annual Report of the Office of the Correctional Investigator 2012-2013. Ottawa, ON: The Correctional Investigator Canada; 2013.
3. Office of the Provincial Health Officer. Health, Crime, and Doing Time: Potential Impacts of the Safe Streets and Communities Act (Former Bill C-10) on the Health and Well-being of Aboriginal People in BC. Canada: Her Majesty the Queen in Right of Canada; 2013.
4. Office of the Correctional Investigator. A case study of diversity in corrections: the black inmate experience in federal penitentiaries, final report. Ottawa, ON: The Correctional Investigator Canada; 2013.
5. Schuler, A, Matheson, FI, Hwang, SW, Kouyoumdjian, F. Health Status of Prisoners in Canada. *Health Status of Prisoners in Canada. Canadian Family Physician*. 2016;62(3): 215-222.
6. Martin, RE, Buxton, JA, Smith, M, Hislop, TG. The Scope of the Problem: The Health of Incarcerated Women in BC. *BC Medical Journal*. 2016.
7. Felitti V, Anda R, Nordenberg D, Williamson D, Spitz A, Edwards V et al. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. *American Journal of Preventive Medicine*. 1998;14(4):245-258.
8. World Health Organization, Regional Office for Europe. Causes and consequences: what determines our sexual and reproductive health? Copenhagen, Denmark: Division of Noncommunicable Diseases and Health Promotion Sexual and Reproductive Health; 2011.
9. Correctional Service Canada. Barriers to Reintegration: Rethinking Corrections: Rehabilitation, Reentry, and Reintegration. Canada: Her Majesty the Queen in Right of Canada; 2014.
10. Stafford, C. Finding Work: How to Approach the Intersection of Prisoner Reentry, Employment, and Recidivism. *Georgetown Journal on Poverty Law & Policy*. 2006;12: 261-81.
11. Allan, B and Smylie, J. First Peoples, second class treatment: The role of racism in the health and well-being of Indigenous peoples in Canada. Toronto, ON: the Wellesley Institute.
12. Stein MB, Jang KL, Taylor S, Vernon PA, Livesley WJ. Genetic and environmental influences on trauma exposure and posttraumatic stress disorder symptoms: a twin study. *American Journal of Psychiatry*. 2002 Oct 1;159(10):1675-81.
13. Bonanno G, Galea S, Bucciarelli A, Vlahov D. What predicts psychological resilience after disaster? The role of demographics, resources, and life stress. *Journal of Consulting and Clinical Psychology*. 2007;75(5):671-682.
14. Reading, C, Wien, F. Health Inequalities and Social Determinants of Aboriginal Peoples' Health. Prince George, BC. National Collaborating Centre for Aboriginal Health; 2009.
15. First Nations Health Authority. Creating a Climate for Change: Cultural Humility Resource Booklet.

- West Vancouver: First Nations Health Authority; 2016.
16. Ruben, BD. Guidelines for Cross-Cultural Communication Effectiveness. *Journal of Strategic Contracting and Negotiation*. 1994;2(4): 470-79.
 17. Harm Reduction Coalition. Principles of Harm Reduction; 2016 Retrieved from: <http://harmreduction.org/about-us/principles-of-harm-reduction/>
 18. Sapers, H. Annual Report of the Office of the Correctional Investigator 2013-2014. Ottawa, ON: The Correctional Investigator Canada; 2014.
 19. Sapers, H. Annual Report of the Office of the Correctional Investigator 2014-2015. Ottawa, ON: The Correctional Investigator Canada; 2015.
 20. Fallon B, Chabot M, Fluke J, Blackstock C, MacLaurin B, Tonmyr L. Placement decisions and disparities among Aboriginal children: Further analysis of the Canadian incidence study of reported child abuse and neglect part A: Comparisons of the 1998 and 2003 surveys. *Child Abuse & Neglect*. 2013;37(1):47-60.
 21. Meyer I, Flores A, Stemple L, Romero A, Wilson B, Herman J. Incarceration Rates and Traits of Sexual Minorities in the United States: National Inmate Survey, 2011–2012. *American Journal of Public Health*. 2017;107(2):267-273.
 22. Peek, C. Breaking out of the Prison Hierarchy: Transgender Prisoners, Rape, and the Eighth Amendment. *Santa Clara Law Review*. 2004; 44(4): 1211, 1248.
 23. Office of the Correctional Investigator. Backgrounder - Aboriginal Offenders - A Critical Situation. Ottaway, ON: The Correctional Investigator; 2013.
 24. Johnson J, Oliffe J, Kelly M, Galdas P, Ogorodniczuk J. Men's discourses of help-seeking in the context of depression. *Sociology of Health & Illness*. 2011;34(3):345-361.
 25. Brcic V, Eberdt C, Kaczorowski J. Development of a Tool to Identify Poverty in a Family Practice Setting: A Pilot Study. *International Journal of Family Medicine*. 2011;2011:1-7.
 26. Lines, R, Jurgens, R, Betteridge, G, Stover, H, Laticevschi, D, Nelles, J. Prison needle exchange: Lessons from a comprehensive review of international evidence and experience. Montreal, Canada: Canadian HIV/AIDS Legal Network; 2004.
 27. Montaner J, Lima V, Harrigan P, Lourenço L, Yip B, Nosyk B et al. Expansion of HAART Coverage Is Associated with Sustained Decreases in HIV/AIDS Morbidity, Mortality and HIV Transmission: The "HIV Treatment as Prevention" Experience in a Canadian Setting. *PLoS ONE*. 2014;9(2):e87872.
 28. Correctional Service Canada. Infectious Diseases in Canadian Federal Penitentiaries, 2000–2001. Canada: Her Majesty the Queen in Right of Canada; 2014.
 29. Bonnycastle K, Villebrun C. Injecting Risk Into Prison Sentences: A Quantitative Analysis of a Prisoner-Driven Survey to Measure HCV/HIV Seroprevalence, Risk Practices, and Viral Testing at One Canadian Male Federal Prison. *The Prison Journal*. 2011;91(3):325-346.
 30. Martin RE, Gold F, Murphy W, Remple V, Berkowitz J, Money D. Drug use and risk of bloodborne infections: a survey of female prisoners in British Columbia. *Canadian Journal of Public Health*. 2005; 96: 97–101.

REFERENCES

31. Correctional Service Canada. Infectious Disease Surveillance In Canadian Federal Penitentiaries 2007-2008. Canada: Her Majesty the Queen in Right of Canada 2008.
32. Zakaria D, Thompson JM, Borgatta F. Rates of Reported Sexually Transmitted Infections since Admission to Canadian Federal Prison and Associated Incarceration Characteristics and Sexual Risk-Behaviours. Correctional Service Canada; 2016.
33. Wiehe S, Rosenman M, Aalsma M, Scanlon M, Fortenberry J. Epidemiology of Sexually Transmitted Infections Among Offenders Following Arrest or Incarceration. *American Journal of Public Health*. 2015;105(12):e26-e32.
34. Caviness C, Anderson B, Stein M. Prevalence and Predictors of Sexually Transmitted Infections in Hazardously-Drinking Incarcerated Women. *Women & Health*. 2012;52(2):119-134.
35. Thomas J, Levandowski B, Isler M, Torrone E, Wilson G. Incarceration and Sexually Transmitted Infections: A Neighborhood Perspective. *Journal of Urban Health*. 2007;85(1):90-99.
36. Smith P. The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature. *Crime and Justice*. 2006;34(1):441-528.
37. Saxon A, Davis T, Sloan K, McKnight K, McFall M, Kivlahan D. Trauma, Symptoms of Posttraumatic Stress Disorder, and Associated Problems Among Incarcerated Veterans. *Psychiatric Services*. 2001;52(7):959-964.
38. Harlow, CW. Prior Abuse Reported by Inmates and Probationers. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics; 1999.
39. Byng R, Howerton A, Owens C, Campbell J. Pathways to suicide attempts among male offenders: the role of agency. *Sociology of Health & Illness*. 2015;37(6):936-951.
40. Haglund A, Tidemalm D, Jokinen J, Långström N, Lichtenstein P, Fazel S et al. Suicide After Release From Prison. *The Journal of Clinical Psychiatry*. 2014;75(10):1047-1053.
41. Binswanger IA et al. Release from Prison — A High Risk of Death for Former Inmates. *New England Journal of Medicine*. 2007;356(5): 157-165.
42. Winter RJ et al. Incidence and predictors of non-fatal drug overdose after release from prison among people who inject drugs in Queensland, Australia. *Drug and Alcohol Dependence*. 2015;153:43-9.
43. Groot E et al. Drug Toxicity Deaths after Release from Incarceration in Ontario, 2006-2013: Review of Coroner's Cases. *PLoS One*; 2016.
44. Ospina M, Dennett L. Systematic Review On The Prevalence Of Fetal Alcohol Spectrum Disorders. Institute of Health Economics; 2013.
45. Hoffmann D, Tarzian A. The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain. *The Journal of Law, Medicine & Ethics*. 2001;28(s4):13-27.
46. Streitzer J, Wade T. The Influence of Cultural Group on the Undertreatment of Postoperative Pain. *Psychosomatic Medicine*. 1981;43(5):397-403.

REFERENCES

47. Williams B, Stern M, Mellow J, Safer M, Greifinger R. Aging in Correctional Custody: Setting a Policy Agenda for Older Prisoner Health Care. *American Journal of Public Health*. 2012;102(8):1475-1481.
48. Collier R. Prison smoking bans: clearing the air. *Canadian Medical Association Journal*. 2013;185(10):E474-E474.



The Collaborating Centre for Prison Health and Education

The University of British Columbia
2206 East Mall, Vancouver, BC, Canada, V6T 1Z3

www ccphe ubc ca
Email: ccphe@spph.ubc.ca
Toll free: 1-855-999-4976
Facebook: facebook.com/CCPHE.UBC

