

Optimizing continuity of care throughout incarceration

Case and opportunities

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In Canada, there are approximately 250 000 adult and 1500 youth admissions to correctional facilities each year, and an average of about 40 000 people are in correctional facilities on any given day.¹⁻³ The length of stay in correctional facilities for most adults and youth is days to weeks,^{3,4} and many people have multiple incarcerations each year. International data reveal that the health of the incarcerated population is poor compared with that of the nonincarcerated population, with a disproportionate burden of mental illness, infectious diseases, chronic diseases, and premature mortality.⁵ In this context of a large population with poor health transitioning in and out of correctional facilities, there are many opportunities to improve health and health care.

The World Health Organization (WHO) has identified the need for coordinated health care and service delivery for incarcerated people. Recognizing the overrepresentation of marginalized populations in prisons, the risks of communicable diseases transmission at the time of release, and the unhealthy living conditions in most correctional facilities, the WHO has called for “close links or integration between public health services and prison health.”⁶ The WHO has also noted the need for “partnerships between corrections-based and external service providers”⁷ in order to provide “effective and continuous services for prisoners.”⁷

The period of transition between the community and correctional facilities might be associated in particular with health risks,⁸ including alcohol withdrawal on admission⁹; disruptions in essential treatment during admission or release, such as methadone therapy,¹⁰ anti-retroviral therapy,¹¹ and psychotropic medications¹²; and death¹³ or hospitalization¹⁴ on release. However, these transitions also present opportunities to improve health and health care, such as the initiation of contraception before release^{15,16} and providing linkages with primary care services at the time of release.^{17,18}

There are multiple barriers to achieving continuity of health care during incarceration and at the time

of release. Inmates are frequently transferred between facilities, which complicates ongoing medical management. The length of stay is often short and there might be uncertainty regarding the date of release, which might preclude effective discharge planning.¹⁹ Planning for release might not be a priority within institutions, which might reflect a lack of executive-level champions, limited financial resources, and poor data resources such as electronic medical records.²⁰ Recently released persons might face multiple competing priorities, including the demands of parole and the need to arrange for reinstatement of income supports.^{14,17,19} Finally, high rates of mental illness, including addictions, and poverty in this population might contribute to low rates of follow-up for care.^{5,21}

These substantial challenges notwithstanding, primary care physicians and other health care providers can take basic steps to improve health and health care during incarceration and at the time of release. As an example, the following case illustrates efforts to optimize care for a woman through 2 incarcerations.

Case

A woman in her 20s with hepatitis C who was receiving methadone maintenance treatment was admitted to a correctional facility in Ontario during the first trimester of a pregnancy. She was released to the community during her first trimester, then incarcerated again during the second trimester. Her community-based family physician initiated contact with the family physician working in the jail during the second incarceration. With the patient's permission, the community- and jail-based physicians communicated about several issues relevant to her health.

Admission to the facility and release date. The community physician contacted the jail physician to ask whether the patient had been admitted to the jail, which the patient had anticipated and discussed with the community physician. As this patient was being seen frequently during her pregnancy and for methadone maintenance treatment, it was important for the community physician to know where the patient was and to know the date of her release. Continuity of methadone treatment is needed to decrease the risk of withdrawal, which might cause fetal distress and miscarriage, and

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to prevent relapse to illicit opioid use.²² Therefore, the community physician arranged for methadone prescriptions as soon as the patient was released from jail.

Prenatal testing. The community physician and jail physician communicated about which tests had been performed in the community and in the jail, respectively, and about indicated plans for follow-up. This correspondence decreased unnecessary tests and ensured that information was communicated that could affect the health of the patient and fetus.

Housing and social situation. The community physician told the jail physician that the patient did not have anywhere to stay upon release. Physician visits in correctional facilities are often limited in time owing to the large volume of patients who need to be seen, so having key social and medical information conveyed is helpful. The jail physician referred the patient to see the social worker in the jail to discuss housing options on release. The community physician arranged for a community-based social worker to meet with the patient while incarcerated, which was helpful for building rapport, gathering information, and identifying priorities for the time of release. The information that the community-based social worker collected was subsequently used by the community physician to complete an application for social assistance for the patient at the time of release. The social worker and the patient continued to work together subsequent to the patient's release, which the patient found very helpful.

Referrals. The jail physician referred the patient to see an obstetrician, as was routine practice in the correctional facility. Information regarding the referral was provided to the community physician. In this way, the community physician could follow up directly with the patient at the time of release to discuss whether further follow-up with the obstetrician was desired, along with other options for prenatal and intrapartum care.

Discussion

Primary care physicians can play an important role in achieving continuity of care through incarceration, as shown by this case. We advocate for increased communication between health care providers in the community and in correctional facilities, which could improve health.

There is also an urgent need for systemic changes to improve care for this population, especially at the time of release, and any program or policy changes should be evaluated with respect to acceptability, costs, effectiveness, and equity. Potential changes include routine sharing of information between correctional health care staff and community physicians (eg, through shared electronic health records²⁰); linkage of persons who do not have regular care providers with tailored local primary care services¹⁷; and

discharge planning for medical and social issues.¹⁸ As per the Canada Health Act,²³ incarcerated persons should have access to similar standards of care in correctional facilities as in the community, including medical services such as methadone maintenance treatment, contraception, hepatitis C treatment, and opioids, as well as other publicly available services such as smoking cessation.

By framing incarceration as a chance to improve health and access to care, it is possible to identify and anticipate challenges and opportunities across periods of incarceration. Other jurisdictions have articulated a "throughcare" framework^{24,25} that provides "services to prisoners and their families from the point of sentence or remand, during the period of imprisonment and following release into the community."²⁴ Such an approach in correctional facilities in Canada could benefit the incarcerated population, as well as the rest of society.

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Competing interests

None declared

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References

1. Statistics Canada [website]. *Adult correctional services, admissions to provincial, territorial and federal programs (Canada)*. Ottawa, ON: Statistics Canada; 2012. Available from: www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/legal30a-eng.htm. Accessed 2013 Nov 4.
2. Walmesley R. *World prison population list*. 8th ed. London, UK: International Centre for Prison Studies, King's College London; 2009.
3. Munch C. *Youth correctional statistics in Canada, 2010/2011*. Ottawa, ON: Statistics Canada; 2012. Available from: www.statcan.gc.ca/pub/85-002-x/2012001/article/11716-eng.htm. Accessed 2013 Nov 4.
4. Dauvergne M. *Adult correctional statistics in Canada, 2010/2011*. Ottawa, ON: Statistics Canada; 2012. Available from: www.statcan.gc.ca/pub/85-002-x/2012001/article/11715-eng.htm. Accessed 2013 Nov 4.
5. Fazel S, Baillargeon J. The health of prisoners. *Lancet* 2011;377(9769):956-65. Epub 2010 Nov 18.
6. World Health Organization Europe. *Prison health as part of public health. Declaration. Moscow, 24 October 2003*. Copenhagen, Denmark: World Health Organization Europe; 2003.
7. World Health Organization Europe. *Prevention of acute drug-related mortality in prison populations during the immediate post-release period*. Copenhagen, Denmark: World Health Organization Regional Office for Europe; 2010.
8. Binswanger IA, Nowels C, Corsi KF, Long J, Booth RE, Kutner J, et al. "From the prison door right to the sidewalk, everything went downhill," a qualitative study of the health experiences of recently released inmates. *Int J Law Psychiatry* 2011;34(4):249-55. Epub 2011 Jul 29.
9. Fiscella K, Pless N, Meldrum S, Fiscella P. Alcohol and opiate withdrawal in US jails. *Am J Public Health* 2004;94(9):1522-4.
10. Fu JJ, Zaller ND, Yokell MA, Bazazi AR, Rich JD. Forced withdrawal from methadone maintenance therapy in criminal justice settings: a critical treatment barrier in the United States. *J Subst Abuse Treat* 2013;44(5):502-5. Epub 2013 Feb 22.
11. Springer SA, Spaulding AC, Meyer JP, Altice FL. Public health implications for adequate transitional care for HIV-infected prisoners: five essential components. *Clin Infect Dis* 2011;53(5):469-79.
12. Baillargeon J, Hoge SK, Penn JV. Addressing the challenge of community reentry among released inmates with serious mental illness. *Am J Community Psychol* 2010;46(3-4):361-75.

13. Binswanger IA, Blatchford PJ, Mueller SR, Stern MF. Mortality after prison release: opioid overdose and other causes of death, risk factors, and time trends from 1999 to 2009. *Ann Intern Med* 2013;159(9):592-600.
14. Wang EA, Wang Y, Krumholz HM. A high risk of hospitalization following release from correctional facilities in Medicare beneficiaries: a retrospective matched cohort study, 2002 to 2010. *JAMA Intern Med* 2013;173(17):1621-8.
15. Clarke JG, Rosengard C, Rose JS, Hebert MR, Peipert J, Stein MD. Improving birth control service utilization by offering services prerelease vs postincarceration. *Am J Public Health* 2006;96(5):840-5. Epub 2006 Mar 29.
16. Hedrich D, Alves P, Farrell M, Stöver H, Møller L, Mayet S. The effectiveness of opioid maintenance treatment in prison settings: a systematic review. *Addiction* 2012;107(3):501-17.
17. Wang EA, Hong CS, Shavit S, Sanders R, Kessell E, Kushel MB. Engaging individuals recently released from prison into primary care: a randomized trial. *Am J Public Health* 2012;102(9):e22-9. Epub 2012 Jul 19.
18. Kinner SA, Lennox N, Williams GM, Carroll M, Quinn B, Boyle FM, et al. Randomised controlled trial of a service brokerage intervention for ex-prisoners in Australia. *Contemp Clin Trials* 2013;36(1):198-206. Epub 2013 Jul 10.
19. Booker CA, Flygare CT, Solomon L, Ball SW, Pustell MR, Bazerman LB, et al. Linkage to HIV care for jail detainees: findings from detention to the first 30 days after release. *AIDS Behav* 2013;17(Suppl 2):S128-36.
20. Mellow J, Greifinger RB. Successful reentry: the perspective of private correctional health care providers. *J Urban Health* 2007;84(1):85-98.
21. Lincoln T, Kennedy S, Tuthill R, Roberts C, Conklin TJ, Hammett TM. Facilitators and barriers to continuing healthcare after jail: a community-integrated program. *J Ambul Care Manage* 2006;29(1):2-16.
22. Jones HE, Deppen K, Hudak ML, Leffert L, McClelland C, Sahin L, et al. Clinical care for opioid-using pregnant and postpartum women: the role of obstetric providers. *Am J Obstet Gynecol* 2014;210(4):302-10. Epub 2013 Oct 10.
23. *Canada Health Act*. Ottawa, ON: Government of Canada; 1985.
24. Glasgow City Council [website]. *Throughcare*. Glasgow, UK: Glasgow City Council. Available from: www.glasgow.gov.uk/index.aspx?articleid=4038. Accessed 2013 Nov 5.
25. Stevens K. *The challenges of implementing throughcare*. Paper presented at: Probation and Community Corrections: Making the Community Safer Conference of the Australian Institute of Criminology and the Probation and Community Corrections Officers' Association; Perth, Australia; 2002 Sep 23-24.

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