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.

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)

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.

Recommendations

1. Family physicians familiarize themselves with the Poverty Screening Tool, which asks family physicians to:
    a) Inquire about poverty when screening all patients[25]
    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/fniah-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 incarcerate 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/ndvdls/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 use[29] 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

- 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-medicating 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

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.cfpc.ca/Cancer_care/

- CCPHE Cancer Walks Free Documentary
  https://www.youtube.com/watch?v=vJKloTHFAko&list=PLwTqMyAQ47SYqi2dHi4oXdXgiPwlpMKan

- Trauma-Informed Practice Guide (BCCEWH)
  https://bccewh.bc.ca/2014/02/trauma-informed-practice-guide/

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, Ogrodniczuk 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. Streltzer J, Wade T. The Influence of Cultural Group on the Undertreatment of Postoperative Pain. Psychosomatic Medicine. 1981;43(5):397-403.

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.

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