Out of sight, out of mind: Investing in prison primary healthcare to target vulnerable groups

Stephen Hampton, Penelope Abbott

THE VALUE OF INVESTING in primary healthcare for people in prisons should not be underestimated. People who reside in prison are drawn from the most vulnerable groups in society and have disproportionately poor physical, mental and social wellbeing.[1] Yet, people in prison are often forgotten.

The characteristics of people who reside in prison demonstrate the social determinants of health, including poverty, disrupted education, disability, homelessness and unemployment.[1] Adverse childhood events are predictive of incarceration, being positively associated in a dose-response fashion. Aboriginal and Torres Strait Islander people make up 32% of the prison population, but only 3.2% of the Australian population. Incarceration makes disadvantage and poor health even worse, and subsequently, is itself a social determinant of health. It has significant negative effects on families and communities, particularly on the children of incarcerated individuals.[2]

Half of prison entrants report a chronic health condition (52%) and a previous diagnosis of a mental health condition (51%). There is high substance use, including smoking (71% of prison entrants), hazardous alcohol use (31%) and illicit drug use (73%).[1] Cognitive disability and developmental disorders are common, becoming as prevalent as 90% in incarcerated youth.[3]

These statistics are tragic and mandate a response from the healthcare system. Given limited healthcare resources, it makes sense to target groups where investments will make the biggest difference. The process of 'risk stratification' refers to identifying individuals who are most at risk of poorer health outcomes and targeting health interventions to this group of people as a way of maximising the value of money spent in the health system.[4] When risk stratification is undertaken, it generates a list of people facing social disadvantage and correlates with the population of people in prison.

The high concentrations of people with poor health in prisons allow efficient targeting of investment. For example, there is good evidence that opioid agonist programs in prisons reduce mortality after people are released from prision and that this is cost-effective.[5] In other examples, reduction in the prevalence of hepatitis C in New South Wales prison entrants has been attributed to hepatitis C treatment in prisons,[6] and early intervention for young people in custody who have psychosis has been shown to improve health outcomes and decrease recidivism.[7]

Many people are overdue for much needed healthcare when they enter prison, having neglected their health due to competing demands and mental health and substance use problems.[1] However, the delivery of primary care in the prison setting is difficult and the prison health system is under-resourced. Compared to the community setting, patients in prison face substantial wait times for routine primary healthcare[8] and constrained access to allied health and specialised medical services. Healthcare plays a secondary role to security, except in emergency care. Patients are only able to be seen for short windows of time through the day, move between correctional centres, and cycle in and out of prison, impeding and fragmenting their healthcare.[2] Patients are commonly released from prison before planned care is delivered, but continuity of care arrangements can be poor.[9] The siloing of healthcare might be exacerbated by people choosing to not want to reveal their incarceration to community healthcare providers in anticipation of stigma.[2]

To improve the health of this population and to achieve healthcare efficiencies, there needs to be more visibility, resourcing and professionalisation of this area of medicine. The Royal Australian College of General Practitioners (RACGP) formed the Specific Interest Group in Custodial Health in 2009, with its work including the development of educational resources and advocacy. The RACGP introduced enhanced learning objectives and teaching materials for justice-involved people into its curriculum in 2022. Updated RACGP accreditation standards for prison health services were released in 2023. Universities are increasingly providing clinical placements in prisons, which assist to overcome fears and stereotypes.[10] The RACGP and other stakeholders continue to lobby for a post release Medicare item number to support quality primary care for people within the first three months after release from prison. More research into the comparative investment in prison health services across jurisdictions and the relationship between investment in prison health services and health outcomes would assist policy making.

Conclusion

People in prison are drawn from the most vulnerable in society, coming from backgrounds of social disadvantage, poor health and trauma. Their incarceration creates a moral imperative to improve their

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health, which is also an opportunity to generate a health and financial benefit for society.

General practitioners are in an ideal place to assist in the stabilising of the health of those in custody and maintenance of the health of those released from prison. Not investing in primary care for justice-involved people is an unused opportunity.

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