

## Putting the Patient Before the Prisoner

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Last week in clinic, we saw a 57-year-old-homeless man, Abe, with hepatitis C and a rapidly growing liver mass. At face value, this patient seems fairly typical. But he had a unique experience—Abe was returning home from prison.

Criminal justice exposure is an experience that is common in the United States yet entirely hidden from view. Close to 13 million patients return home from correctional facilities in the United States each year, and most primary care providers and trainees are not equipped to understand the challenges that these patients face. Only 22 US primary care residency programs offer training in how to care for prisoners or people who have been through the correctional system.<sup>1</sup>

This lack of training contributes to knowledge deficits that undermine providers' capacity to assess the risks associated with criminal justice exposure and to take action to mitigate those risks. Patients returning home from prison experience exceptionally high rates of psychiatric illness and substance use disorders. Engagement in care upon release is critical yet rarely happens. Few patients have a primary care provider prior to going to prison, and many states systematically strip prisoners of their Medicaid coverage while in prison.<sup>2</sup> Upon release, patients must re-apply for their insurance, delaying needed access to care for these chronic conditions. Most of these patients will not have seen a primary care provider even one year after release.<sup>3</sup>

While these issues are commonplace in the US health care system, the consequences of these structural barriers and health risks are striking.

Patients returning home from prison are 2.5 times more likely to be hospitalized within the first seven days of release compared with matched controls.<sup>4</sup> Within the first two weeks of release from prison, these patients face a mortality risk that is 12 times greater than the general population even after controlling for patient age, race, and sex.<sup>5</sup>

Primary care providers may not be able to alter the conditions of the criminal justice system that predispose our patients to these risks, but they can mitigate these risks in the critical post-release period. At Transitions Clinic-New Haven, where we practice primary care, our goal is to build long-term relationships with patients who have recently returned home from prison. We teach providers and trainees how to tactfully and empathically discuss exposure to the criminal justice system in the context of their patients' health.

A conversation with Abe revealed that he was diagnosed with hepatocellular carcinoma (HCC) prior to his last incarceration. His frequent yet brief prison stays created breaks in health care, insurance, and community plans for housing. Without routine monitoring, his HCC had metastasized to his colon, causing a life-threatening GI bleed. Without insurance, he often would go months and weeks without medications and never could make the list for housing.

Unfortunately, most primary care providers will overlook their patients' incarceration history for the simple reason that they were not trained to ask. However, asking about incarceration history, focusing on transitions of care, and framing medical histories in relation to correctional experiences provides criti-

cal information in developing effective plans of care. Notably, we are able to address individual and structural factors in the post-incarceration period. These complex factors critically influence illness management, disease course, and even the risk of re-incarceration for our patients. And as Abe demonstrates, the cycle of incarceration may gravely worsen one's health prospects.

How can we train providers and trainees to delve into these tough issues while remaining sensitive to the ways in which these stories may make our patients feel more vulnerable and us more fearful?

First, we must acknowledge the scope of mass incarceration. One in 31 adults in the United States is currently in the prison system; one in 17 white men, one in six Hispanic men, and one in three black men in the United States will have been incarcerated at some point during his lifetime. You don't have to be a physician in prison to take care of patients who have been to prison.

Second, providers should be aware of the health risks associated with incarceration so that they understand the importance of asking. Rates of substance use and mental health disorders in correctional populations are estimated to be at least two to four times that of nonincarcerated populations.<sup>6</sup> These conditions not only compound the impacts of incarceration—suicide accounts for 50% of prison deaths worldwide—but also place patients at greater risk for reincarceration in the future.<sup>7</sup> Prisoners additionally experience higher rates of chronic conditions like asthma, hypertension, and arthritis as well as many infectious diseases. Seventeen percent

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of prisoners are estimated to have hepatitis C. Understanding a patient's history of incarceration will prompt providers to screen for hepatitis C and HIV and ask about health risks including time in solitary confinement or post-traumatic stress disorder following incarceration.

Third, providers should reflect on their personal biases in caring for patients with a history of incarceration. Implicit bias can directly impact the care that we provide to our patients. An incarceration history, in particular, reinforces stereotypes of criminality—black, dangerous, and deserving of punishment.<sup>8</sup> In a survey of patients recently released from prison, 42% perceived discrimination by health care providers related to their criminal records.<sup>9</sup>

Medical residency programs like the one at Yale train their residents in correctional health care by visiting prisons. Our residents often are surprised to learn that prisoners are the only group in the United States who are constitutionally guaranteed access to health care. Many prisoners see a medical provider for the first time in their adult lives and as a result are diagnosed with a chronic condition while incarcerated. Routine access to care, housing, and food contribute to decreased mortality and decreased racial health disparities while in prison.<sup>10</sup> However these gains are far outstripped by the loss of services and rights on release, including bans on food stamps, public housing, educational grants, and voting. Even as the Affordable Care Act promises to expand Medicaid coverage for patients returning home from prison, patients can face persistent discrimination at the systems and provider level, eroding access to routine care and basic needs.

Primary care providers and trainees can be more attentive to these issues, simply by taking a thorough, yet thoughtful incarceration history. Rather than asking about criminal activity, directed questions about release date, length of incarceration, and probation or parole status can foster collaborative discussions to reduce recidivism risk. Questions about new diagnoses or medications and about the challenges returning home from prison contextualize our patients' disease processes and management without further stigmatizing or stereotyping them.

When patients are released from correctional facilities, their health care support systems often vanish, leaving many of our sickest and most vulnerable patients without essential resources. Our lack of awareness about the specific needs of the prison population and about our own biases may cause patients to avoid primary care and mental health and substance use treatment. When we do not effectively engage these patients in care, we are left with what the statistics suggest and Abe's story illuminates—patients who disproportionately end up in emergency departments and inpatient wards almost surely are subject to iterative cycles of incarceration.

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