# Optimising patients' medical care after prison in Luxembourg

**J. R. Batista[1]**

**R. Stein[1,2], M. Baumann[3], E. Andres[4], P. Tabouring[1], A. Even[1], F. Raphaël[1]**

*[1]Formation Spécifique en Médecine Générale – Université du Luxembourg (L)*
*[2]Service de Médecine Pénitentiaire du Centre Pénitentiaire de Luxembourg – Centre Hospitalier de Luxembourg (L)*
*[3]Integrative Research Unit on Social and Individual Development - Université du Luxembourg (L)*
*[4]Service de Médecine interne, Diabète et Maladie Métaboliques - Hôpitaux Universitaires de Strasbourg (F)*

# Conflict of Interest Disclosure Form

Name: Dr Jorge R. BATISTA
Affiliation: University of Luxembourg and University of Strasbourg

## DISCLOSURE

**I have no potential conflict of interest to report**

# Presentation plan

1. Introduction
2. Methods
3. Results
4. Discussion
5. Take home messages

# 1. Introduction

*" Prison health is part of public health and prisons are part of our society. One third of prisoners leave prison every year and the interaction between prisons and society is huge. We have to ensure that prisons are not becoming breeding places for communicable and noncommunicable diseases, and we must also seek to use the experience of imprisonment for the benefit of prisoners and society. "*

Dr Jakab Zsuzsanna, WHO Europe Regional Director since 2010

prison release = period of vulnerability

# 1. Introduction

## Main actors in post-prison care

- CPL (main prison) and CPG (semi-detention)
  - Somatic medicine prison service (CHL)
  - Mental health prison service (CHNP)
- Psychosocial services (SPSE and SCAS)
- Institutions or organisations treating drug addicts
- Medical doctors, including general practitioners

# 1. Introduction

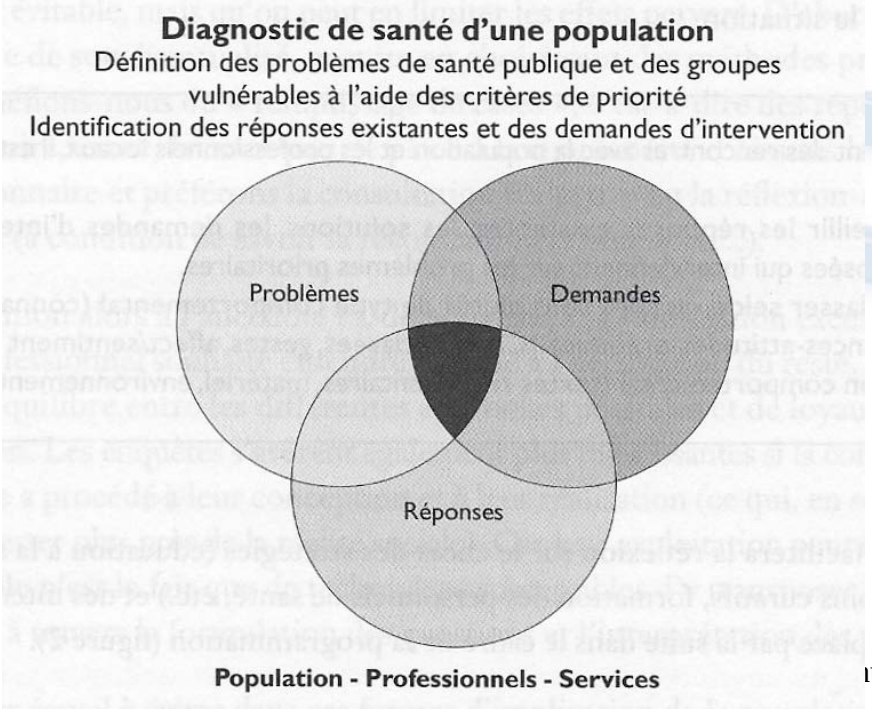
## Main objective

identification and analysis of the factors that favour and oppose the practice of primary care for patients leaving prison in Luxembourg

## Secondary objective

development of recommendations depending on the main results based on a literature review

# 1. Introduction




From the health diagnosis of a population to evaluations of health actions according to Pr Baumann

Baumann M, Cannet D, Châlons S. communautaire et action umanitaire: le diagnostic de d'une population. Rennes: Ed. ENSP; 2001.

# 2. Methods

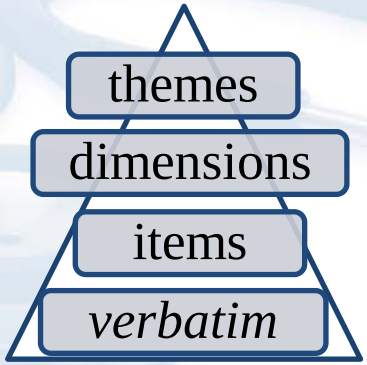
- semi-structured individual interviews following an interview guide approved by Pr Baumann (medical sociologist)

**general practitioners**

GPs enrolled in the opioid substitution program in Luxembourg

14 contacted, 10 consenting

*M (EA to EJ)*




**patient-detainees**

Prisoners at the CPL having left prison at least once

11 contacted, 10 consenting

*D (E1 to E10)*

- transcription of interviews, then categorical thematic content analysis

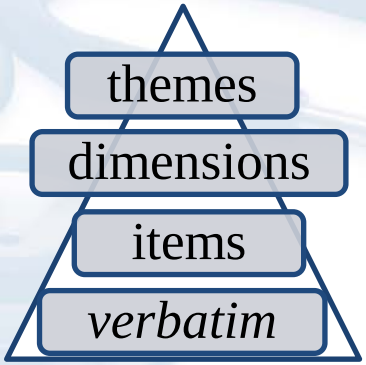
# 3. Results

**general practitioners**

7 themes

25 dimensions

148 items




**patient-detainees**

7 themes

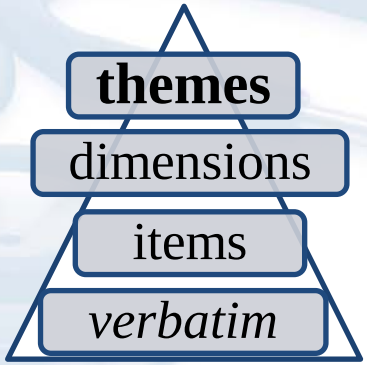
26 dimensions

145 items

# 3. Results

**general practitioners**

A. The prisoners' state of health
B. What doctors know about the penitentiary system.
C. The link between care inside and outside of prison.
D. Institutions or organisations dealing with drug addicts.
E. Prison release - aids in place and to put in place.
F. The detainee seen by the doctor.
G. The doctor's role in the life of a former prisoner - from care to the prevention of reincarceration.




**patient-detainees**

A. The prisoners' state of health
B. The care provided in prison.
C. The link between care inside and outside of prison.
D. Institutions or organisations dealing with drug addicts.
E. Prison release - aids in place and to put in place.
F. The detainee - life in prison and life in freedom.
G. The doctor's role in the life of a former prisoner - from care to the prevention of reincarceration.

# 3. Results

## The prisoners' state of health

- infectious diseases like *E6 (3): "(...) hepatitis C, HIV." (M6/D6)*
- psychiatric / psychological diseases *(M7)* were not mentioned by the patient-detainees
- addictions *(M4/D2)* -> patients with addiction did not consider their condition as a disease, except for the *detainee 9*

# 3. Results

## What doctors know about the penitentiary system

- *EB (2): "Not much"* or *ED (2): "Very little (...)" (M9)*
- 2 distinct services: psychiatric care *(M3)* and general / somatic medicine *(M9)*
- cooperation with the CHL *(M7)*

## The care provided in prison

- satisfied with the care delivered in prison *E8 (6): "They are (...) good anyway" (D8)*
- several administrative points criticised

# 3. Results

## The link between care inside and outside of prison

- transmission of information between the prison and the outside = advantage *(M7/D7)*

  *EE (30): "I think it could only have advantages, neh?"*

  *E10 (38): "(...) the benefits are (...) first-hand information from the doctor who probably has been following you for (...) a little while"*

# 3. Results

## Prison release - aids in place and to put in place

- *ED (51): "(...) the patients are otherwise a little neglected (…)" (M5)*
- medical help = *EB (53): "(...) Once they are released from prison, they are free, so they have to get by" (M6)*
- lack of social security, lack of help in general *E6 (42): "(...) you leave here without anything, you stay without anything! (...) I would say the problems, it is especially that (...) when you are abounded on yourself (...)" (D4)*
- *E7 (31): "On the other hand, when you leave Givenich, that's great! We are well supervised, they really help us to find a job, to find a home. (...)" (M1/D5)*

# 3. Results

## Prison release - aids in place and to put in place

- unprepared prison release *EI (35): "(...) there is a big problem and it does not depend on the medical staff, it is especially that there are disasters releases (... ) overnight there are people coming out (...)" (M4)*
- loss of follow-up = relapse *EI (82): "(...) then they go out and they find themselves in fact in what was before and they relapse very (...) quickly and there is very little supervision afterwards, especially for drug users" (M5)*
- *EI (57): "(...) a report (...) medical (...) what happened, because often it happened a lot! (...)" (M5/D5)*

# 3. Results

## The detainee - life in prison and life in freedom

- *E1 (81): "For life outside it is more difficult because here we can rest (...) until freedom. Outside, (...) must pay the rent (…) work" (D3)*
- incarceration = gain for their health *E7 (18): "(...) I think this time I have a chance that it works the operation, so for me it's a gain to be there (...) Yes, thanks to the prison. (...) here at least every day I am treated" (D3)*
- stigmatisation of drug addicts *E4 (200): "A tox 'is (…) an evil to love (...) the person (...) looks at us as (...) a person who killed, an assassin, even looks at us as for example a paedophile or what, more serious! Even a person who has been to prison for killing someone, an addict is how you say: trash! Know trash? We are trash (...)" (D3)*

# 3. Results

## The doctor's role in the life of a former prisoner - from care to the prevention of reincarceration

- general practitioner on the front line *E5 (39): "After I left the therapy, I made direct contact with my GP that I go to since my childhood (...)" (D8)*
- mental health services *(D3)*, NGOs *(D3)* and drug addiction organisations *(D2)*, emergency department *(D3)*
- network of general practitioners taking charge directly after prison release = in favour *(M9/D7)* and would be interested in participating *(M6)* or benefiting from it *(D9)*
- multidisciplinary care management *(M3/D1)*

# 3. Results

## The doctor's role in the life of a former prisoner - from care to the prevention of reincarceration

*"To what extent does general medicine have a place in the prevention of reincarceration?"*

- differing opinions: *EG (85): "Yes of course (...)" (M9/D4) + E2 (121): "No. Everyone is himself, huh. If I had not done the shit, I wouldn't be here! The doctor couldn't do anything!" (M3/D2)*
- psychological/psychiatric care *(M3/D2)* and management of addictions *(M6/D2)* with withdrawal

# 4. Discussion

## Medical care in prison

- *"Know your epidemic, know your response"*[1] = a national database to monitor the health status of patient-detainees in order to define their needs -> behaviour change = decrease in criminal recidivism and improvement of their health *in fine* => cooperation between the prison medical service and psychosocial services
- Audit report on penitentiary medicine in the Grand-Duchy of Luxembourg *(Professors Gravier and Elchardus, 2017)* -> single prison health service with a electronic patient record

[1] Plan d'action national VIH - . Ministère de la du Grand-Duché de Luxembourg; 2017

# 4. Discussion

## Medical care in prison

- *E6 (14): "(...) I might say that from time to time we are short of doctors here (...) as I said, there may be a lack of doctors precisely (...)"*

- incarceration = gain of health for the individual + public health opportunity for the screening and eventual treatment of an aging underprivileged population -> an investment in the prison medical service = investment in public health

# 4. Discussion

## Coordination of medical care during prison release

- prison release = underestimated period of vulnerability -> hospitalisation rate of 8,3% in the first 3 months (mostly avoidable), mortality risk x12
- solutions = medical examination before release, treatment and discharge prescription, hand over the medical file to the patient-detainee
- organising outpatient appointments: *EE (85): "(...) we know that in addictology information is not enough (…) we have to organise (...) proactively appointments because (…) it is not enough to give a brochure. (...)"*
- *EC (58): "(...) the fact of receiving a small medical report for example at the release (...) as with the people who were in the hospital (...)"*

# 4. Discussion

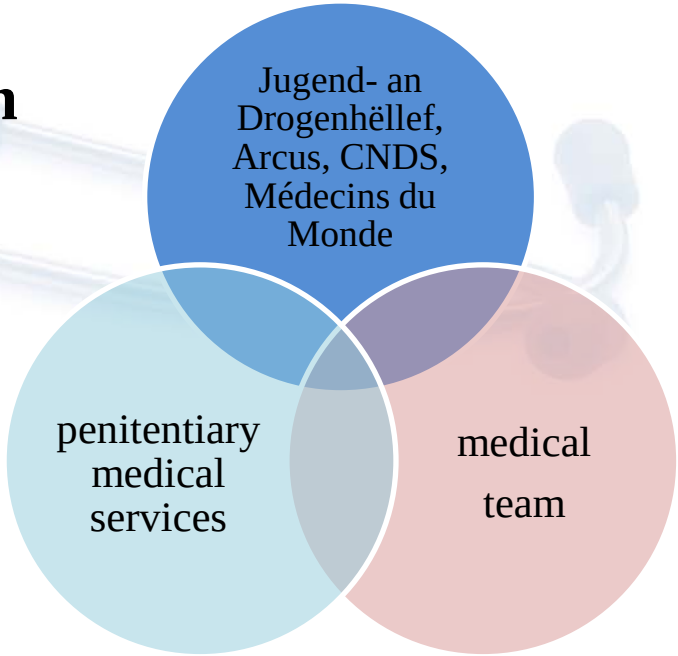
## Coordination of medical care during prison release

- *E9 (156): "For people who have heavy (...) treatments or substitution treatments, to work directly with generalists, I think it will be easier (...) than going out like this and ( ...) to be in nothingness, to see a doctor (...)"*
- *"continuity clinics"* or *"transitions clinics"* = specialised medical offices taking over the medical care provided in prison with *primary care-based complex care management programs*
- medical coordinator of care *(as proposed by the Ombudsman in 2010)* = contact interface between the medical team of prison, the outside and the penitentiary administration

# 4. Discussion

## Coordination of medical care with institutions or organisations dealing with drug addicts in Luxembourg

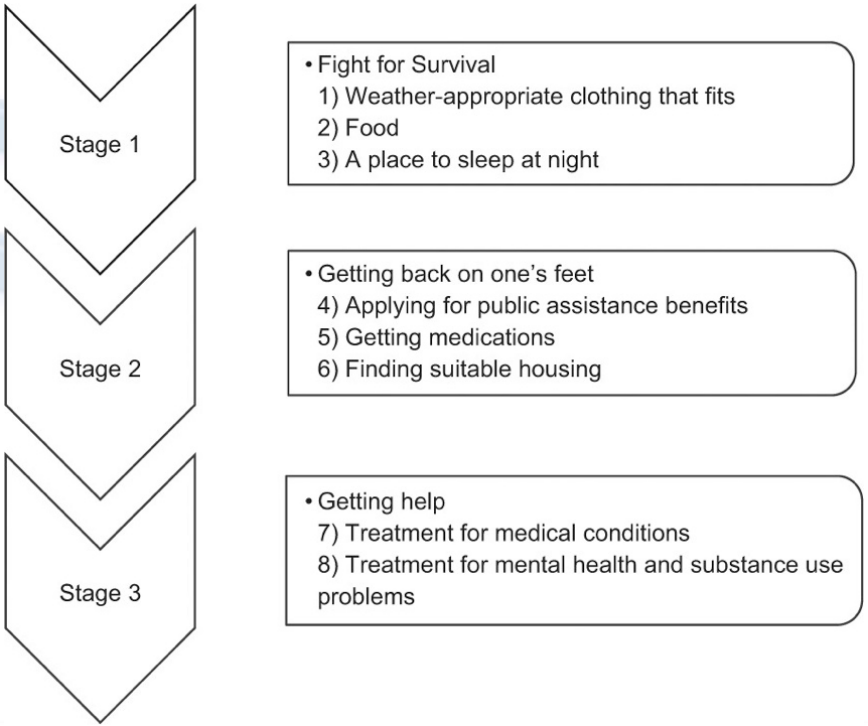
- cooperation between the prison medical service, outside doctors *(in the network if it is established)*, NGOs and organisations dealing with drug addicts



# 4. Discussion

## Transition phase between incarceration and freedom

- individualised and accompanied medico-psycho-social programs -> SCAS and SPSE = increases the use of primary care and thus the success rate of follow-up
- free and automatic affiliation to the social security + third party paying
- housing first




Blank Wilson A. How People With Serious Mental Illness Seek Help After Leaving Jail. Qual Health Res. c 2013;23(12):1575-90.

# 4. Discussion

## Transition phase between incarceration and freedom

- high demand for a transition period in resocialisation in semi-detention (Givenich) = favourable for access to care, work and housing
- social reintegration initiatives and services at the housing and employment level in cooperation with ex-offenders, collaborating with the health care system = decrease of readmission rate and increase of primary care follow-up
- stigmatisation of ex-prisoners = barrier to care -> training for this at-risk population in the medical curriculum

# 4. Discussion

## Harm reduction

- needle and syringe exchange program
- supervised drug consumption room
- opioid substitution program
- ***naloxone program***

## Relapse

- *E6 (49): "And the worst is that I've seen people go for good"*
- risk of death by overdose is up to 120 times greater compared to the general population for the 15-34 age group, even 270 times for the 35-54 age group

# 4. Discussion

## Remedicalisation of addictions

- *ED (104): "(...) drug addiction for me has become (...) a problem of prison, justice, court because of the ban on drugs! (...) Well, I think we have to talk about drug legislation again (...)"*
- for the less important and non-violent offenses = alternatives to imprisonment (e.g. the electronic bracelet) should be considered
- remedicalisation of addictive disorders would discharge the police and prisons in the first place -> put the focus on the medical care of a patient and not a criminal

# 4. Discussion

## Strengths

- original study
- inductive qualitative approach = in-depth analysis of the "why" of an untreated question in order to gather hypotheses, before a quantitative study can answer "how much" to one of the points found
- external and internal validations = triangulation (cross-referencing the data with the literature and recontextualising the results in relation to the specificities of the populations)

## Limits

- unrepresentative population = no generalisation
- no data saturation
- selection and analysis bias

# 5. Take home messages

- multidisciplinary care of a socially and medically at risk population
- internal reforms in prison
- crucial point = prison release has to be prepared in advance
- promote periods of transitions
- creation of a GP network taking over medical care after release
- investment in medical care in prison + effective transition during prison release = reductions in public health and legal costs due to lower rates of return to custody

# Optimising patients' medical care after prison in Luxembourg

**Jorge R. BATISTA, MD**

UNIVERSITÉ DU LUXEMBOURG

Faculté de médecine
Université de Strasbourg

**Thank you for your attention!**

+352 661 901 855

jorgerb1988@gmail.com

**Questions?**