Prison health: Interview with Dr. Ruth Martin

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Ruth Elwood Martin (pictured here) is a Clinical Professor with the UBC School of Population and Public Health, and an Associate Faculty with the UBC Department of Family Practice. Ruth worked as a Vancouver family physician for over 25 years, and part-time as a prison physician for 17 of these years. She is the Chair of the Prison Health Program Committee, College of Family Physicians of Canada; and, the Inaugural Director of the Collaborating Centre for Prison Health and Education (CCPHE). Her current research includes community-based, participatory health research and preventive health projects that engage both individuals who are in custody and also individuals with incarceration experience who are now living in the community. She is a Site Lead faculty with the FLEX Foundations of Scholarship, UBC Undergraduate Medical Program. She was Lead Research Faculty for the UBC family medicine residency program (1999-2015) and a Course Director for Doctor Patient and Society 410 (2011-2015).

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Every year from 2006 to 2009, approximately 37,000 individuals were admitted to federal and provincial correctional systems in British Columbia.[1] Ten percent of those admitted were women, many of whom are incarcerated for crimes associated with substance abuse. In addition to a higher prevalence of blood–borne diseases, the estimates for comorbid psychiatric illnesses were as high as 80% in this population.[2] These numbers reflect significant difficulties for healthcare within a prison setting. Although an in–depth discussion of this topic would take years of study, I was fortunate to interview Dr. Ruth Martin of UBC's Faculty of Medicine for a brief overview of prison health.

What is your background and how did you come to specialize in prison health?

Dr. Martin worked as a GP in Vancouver in a thriving private practice. Prison health is not a formal "specialty" and she came upon it by chance: "I had been looking for something different and I got the opportunity to work a shift at the Burnaby Corrections Facility for Women, and I was hooked: it was compelling, meaningful work." Dr. Martin practiced in BC prisons for 17 years, where she provided much–needed access to quality care: "The women are motivated to get healthy, have deep gratitude for the care given, and the medicine in a prison setting is inherently challenging, with a variety of diagnoses and circumstances."

What are the biggest health impacts of institutionalization on incarcerated individuals?

"There are differences in health impacts depending on the length of the sentence," Dr. Martin says. "With shorter sentences, you see more acute, life–threatening medical issues like substance withdrawal. In longer sentences—that is, greater than 2 years—the issues escalate […] they become more complicated and chronic." These issues tie into a multifaceted, complex diagnosis that is both medical and social. "There are fascinating diseases you would rarely see anywhere else, like tertiary syphilis or invasive cervical cancer. What also emerge are the social determinants of health and circumstantiality behind each medical condition. There is a higher prevalence of, for example, traumatic childhoods and lower socioeconomic status [in the incarcerated population]."

Dr. Martin also highlights the dual effects of incarceration. "It's yin–and–yang," she says. "In a way, prison saved them by lifting them out of their life situation... providing clothing, a roof over their heads, a routine. However, the ethos of prison is the restriction of freedom and personal choice…and this reinforces a pattern of increasing institutionalization." It becomes a vicious cycle of re–traumatization and isolation.

"Incarcerated individuals begin as individuals at–risk, and as stresses and insults accumulate, substance use becomes a coping mechanism. Once incarcerated over a longer period of time, the combination of a lack of substances and coping mechanisms breeds a constellation of repeated nightmares, flashbacks, and insomnia," explains Dr. Martin. This 'new' post–traumatic stress disorder, against a backdrop of possible pre–existing developmental, interpersonal, and other undiagnosed psychiatric symptoms, eventually leads to altercations with correctional officers and other incarcerated individuals. [3, paraphrasing from Dr. Martin] This leads to Dr. Martin's next major point:

segregation and its misuse. "The biggest mantra in prison is that security is the focus," she says. "Isolation is used as a form of control." The adverse effects of seclusion on individuals, such as suicide and worsening of mental health, have been well documented.[4] Solitary confinement in individuals with mental illness perpetuates this cycle. As Dr. Martin puts it, "Rather than building on their strengths and giving them new coping skills, this type of punishment has the greatest health impact of all."

What are the resources available to them, and how are they distributed?

The short answer, not surprisingly, is that resources are scarce. B.C. prisons are either provincially or federally funded; however, the distribution of available resources depends on the management team, which is headed by the prison warden. "It depends on the warden," Dr. Martin says, "to bring down the walls of the prison [so that] the community comes in." Support from the community comes in many forms: "Public health nurses, education, training for future employment, counselors, religious services […] all sorts of things—things that rehabilitate [the women], as opposed to locking them up in a cell. These resources help build self–esteem." Unfortunately, connecting with the community is not easy.

What are some structural and systemic barriers that you have faced to ensure optimal care as a physician working in a prison? How did you overcome those barriers?

As discussed, management itself can be a barrier. "The wardens themselves need to have a vision," Dr. Martin says. Furthermore, the healthcare in B.C. prisons is contracted to a private company under the Ministry of Justice; this places restrictions on the system and leaves little room for optimal healthcare. "There are never two doctors in the prison at the same time," says Dr. Martin, "so you can imagine continuity of care is a challenge and communication is key." For an incarcerated individual to see a doctor, she would have to convince the head nurse, who would then find room in the schedule, but it would often be with a different doctor. What about if a patient needed a referral to see a specialist? "I would have to convince the head nurse, who then convinces security, who then convinces the CO [Corrections Officer], who then has to set up an escort and a ride."

How did you overcome those barriers?

Dr. Martin reiterates her dedication to prison health and her passion for research in the field. "You have to ask questions," she says. "[First] describe the situation and then look for ways to improve it." This is exactly what Dr. Martin did. Besides journal articles, some of her findings have been published, together with anecdotes from former incarcerated individuals, in her book Arresting Hope. She also finds teaching helpful: "By promoting prison health among students and getting students involved… [it's] a way of creating that symbiotic relationship between academia and prison health." She also uses the WHO Health in Prisons project as inspiration. Here, a network of prison representatives from 30 European countries exchanged their experiences for more than a decade and created a guide to help make prisons a healthier place for the incarcerated, as well as the staff.[5] In a similar fashion, Dr. Martin organizes monthly telephone conferences to connect with BC physicians as a way of enhancing awareness and sharing evidence to effect change.

What are some potential strategies to mitigate and/or remove those barriers, and what can medical professionals do to change things for the future?

"Organize and network," Dr. Martin says. She calls for the creation of a "tool kit of best practice, while improving the profile of prison health by increasing interest." She references prison healthcare in Alberta as a feasible way forward. The Ministry of Justice runs the prison system in Alberta, but the Ministry of Health runs healthcare in prison. "That is something very interesting and promising in terms of what we could see happen in BC."

Incarcerated individuals are marginalized in every sense—physically, socially, culturally, financially, and even in terms of their self and identity. Dr. Martin emphasized to me the importance of words as labels in prison health: for example, the use of the word "inmate" in the provincial system, and "offender" in the federal system. In her practice, she chooses to use "incarcerated individual." The different nuances of these words emphasize the depersonalization that incarceration imposes.

"Prison health is population health," Dr. Martin says. "By giving the best possible care, and achieving [healthcare] equity, we are really helping the population at large because incarcerated individuals will rejoin the community." By providing the right opportunities to change prison from a punitive measure to a therapeutic environment, we are helping not only the marginalized incarcerated, but pushing for a better future for everyone.

disclosures

The author and Dr. Martin do not have any conflicts of interest.

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Interview with Dr. Ruth Martin over telephone, conducted on October 11, 2015.