

CRM

January 7 & 9: Introduction to course / Prison as a Determinant of Health

1. **Bryant, T., Dennis, R., Shrecker, T., & Labonte, R. (2011). Canada: A Land of Missed Opportunity for Addressing the Social Determinants of Health.** Health Policy 101, 44-58.

Introduction

Canada's track record since the 1980s in five respects related to social determinants of health:

- (a) the overall redistributive impact of tax and transfer policies;
- (b) reduction of family and child poverty;
- (c) housing policy; , in a context of declining housing affordability
- (d) early childhood education and care; and
- (e) urban/metropolitan health policy

Have reduced Canada's capacity to reduce existing health inequalities

The past three decades have seen a weakening of Canada's capacity to address health inequalities by way of reducing the inequitable distribution of the social determinants of health.

two stylized explanations of how these policy directions came about:

- (a) inadequate or ineffective knowledge generation, dissemination, and translation, and
- (b) changes in Canada's political and economic economy, partly related to increased integration into the world economy, and associated with shifting political allegiances and values

Health care, SDH, and health inequalities in Canada

- Canada introduced universal public health insurance in 1971.
- The problem seems to be shifts in the political economy of the nation that has led to welfare state retrenchment and governmental withdrawal from assuring an equitable distribution of the social determinants of health across the population.

A brief review of the SDH concept in Canada

- a distinction has been made between social determinants of health and the distribution of the social determinants of health.
 - In the latter case, focus is on how the inequitable distribution of these determinants comes to cause health inequalities

SDH (verify with notes) 12 key determinants of health

- Physical environments;
- Employment and working conditions;
- Social environments;
- Social support networks;
- Health services;
- Culture;

- Income and social status;
- Education and literacy;
- Personal health practices and coping skills;
- Healthy child development;
- Biology and genetic endowment;
- Gender.

An overview of the Canadian population health scene & SDH scene

- Except for life expectancy – and even here, Canada’s ranking has been slipping in recent years – Canada’s health indicators are far from #1
- Income major determinant of health
 - For some, its distribution – primarily its skewed distribution – is the direct cause of health-related inequalities.
 - For others, it is the material and social deprivation associated with lack of income that has health consequences
 - Housing too... has lead too housing crisis and homelessness disaster
- income inequality in Canada has increased since 1980 with the increase being especially great for market income
- Canada is one of the few nations where child poverty rates were higher than overall poverty rates over the past two decades
- Housing affordability
 - the federal and some provincial governments withdrew from social housing provision during the 1990s

Canadian public policy in broader perspective

- **Esping-Andersen’s** three-type approach of the welfare state
 - liberal (Canada, UK and USA)
 - less attention to citizen security and provision which translates into lower quality and greater commodification of resources associated with the SDH
 - conservative (France and Germany)
 - contributory , social insurance based programs
 - social democratic ((Sweden and Norway)
 - gender equity issues and tax-supported
- Canadian spending on families and old age is unchanged from 1980 to 2005, and it is very low in comparison to the OECD average and the six selected nations.
- The Canadian increase in income inequality (and poverty) has been especially great over the last 10 years

Canadian public policy and the SDH

- Canada was never a welfare state to the extent of many European nations and this continues to be the case.
- There has been, however, a profound shift in the federal influence on public policy which has led to a deterioration in the quality of the SDH for many Canadians
- Striking increases in income inequality and poverty rates since the mid-1990s.

- increase in tax for bottom 10% part of the cause ^
 - 30.7% in 2005
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2. **De Viggiani, N. (2006). Surviving Prison: Exploring Prison Social Life as a Determinant of Health.** International Journal of Prisoner Health 2(2)

- Too much focus on biomedical problems, This trend is particularly evident with the management of drug misuse, suicide and self-harm, where energy is directed at containment and treatment rather than prevention
 - Deprivation perspectives
 - imprisonment is synonymous with deprivation and
 - prison deprivations have significant physical, psychological, emotional & social repercussions for individuals.
 - ‘**prisonisation**’ to describe the regimented, habitual and institutionalised behaviour of prisoners as they became progressively socialised into the prison community.
 - ‘**Prison code**’ The code is commonly described as a normative value system to which some prisoners subscribe, evident within their attitudes and behaviours. Ex. Acting tough
 - poverty, social exclusion and health
 - **Prisoner Social Relations**
 - Tension and Transience
 - atmosphere across the prison was described as tense
 - suspicion and paranoia due to rapid turnover
 - Front Management
 - tension between presenting a true reflection of themselves and projecting a false facade
 - Prison Talk
 - superficial and public mode of communication
 - sometimes offensive
 - One-upmanship
 - Macho Image
 - essential survival strategy
 - Emotional Repression
 - Reputation
 - Use bad criminal reputation to earn respect from others
 - Heterosexism
 - Homophobic banter that lead to forced heterosexism to conform and not appear weak
 - Sexist, misogynist and homophobic banter was perceived as harmless
 - Racism
 - Exploitation
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3. **Reyes, H. (2007). Pitfalls of TB Management in Prison, revisited. International Journal of Prisoner Health 3(1), 43-67.**
- prisons are reservoirs of TB and multi-drug resistant (MDR)-TB
 - Until very recently, prisons were not taken into consideration in national health strategies
 - Contracting tuberculosis is not part of a prisoner's sentence
 - Overcrowded prisons facilitate the spread of TB as bad ventilation often accompanies overcrowding, adding to the risk of contagious airborne disease
 - high levels of stress affect the immune system
 - Bad ventilation nor sunlight to enter for security reasons
 - An adequate diet is essential for TB treatment.
 - TB specialists who have never worked in prisons simply do not realize the many specific difficulties involved
 - 'bridge populations spread from prisoners through visitors outside world
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4. **Robert, D. (2008). Prison and/as Public Health. Prison and Inmates as Vectors of Health in the New Public Health Era. The Case of Canadian Penitentiaries (pp. 359-370). In Tagg, Brigitte & Hillenkamp, Thomas(eds)**

The following table is indicative of the situation most specific to the prisoners.

Table 1. Partial health profile of inmates in Canadian penitentiaries

HIV/Aids	From 2% to 12% of inmates (known cases)/ 6 to 70x higher than general population.
Hep C	33% of male inmates and 40% of female inmates.
Tuberculosis	21% of inmates/ 10x higher than general population.
Emotional distress	44 % of male inmates have anxiety disorders and 22% of female inmates suffer from depression.
Drug/alcohol	41% have a drug dependency and 47% have an alcohol dependency.
Aging	9% are more than 50 and this age group is growing the fastest.

Research also shows that Canadian prisoners make very intensive use of healthcare services (Hutchings et al., 1999; Sheps, Schechter, & Prefontaine, 1987).

Table 2. Partial yearly health services utilization profile for inmates in Canadian penitentiaries

Nurses	99% of all prisoners visited the nurses. An average of 20 annual visits.
General practitioners	91% of the all prisoners made at least one visit to the G.P. An average of 6 annual visits.
Specialized services	29% of prisoners used specialized services in the community and 3% used community hospitals.

- **“less eligibility principle”** How do we offer basic conditions of hygiene and care that prevent inmates’ health from deteriorating while making sure that prison doesn’t offer conditions better than those endured by the poorest segment of the free population.
- “less eligibility principle” was fundamental to the modern prison as it emerged in the 18th century.
- **Modern prison**
 - (18th/19th century)
 - environment that was healthy and antiseptic was necessary for reform
 - **Now**
 - introduce harm-reduction programs like condom distribution and safe tattooing equipment
- **The old public health model**
 - the State as the central authority
 - took control over health measures especially when there were epidemics
 - Acted when problems were already occurring
 - authorities did not hesitate to use constraints in order to maximize the health of populations
 - replaced in the middle of the 20th century
 - Replaced by focusing on individuals (rather than the community) and on the treatment of disease (curative) rather than health promotion (preventive)
- **The new public health model**
 - Starting in the middle of the 1970
 - **“healthism”** the right to health is transformed into a duty to maximise one’s health
 - a duty for both individuals and collectivities
 - prevention campaigns are directed not only towards sick people but also towards the population as a whole
 - self-care, risk management and prevention of diseases
 - self-regulation
 - This model proposes norms to which they have to comply “voluntarily”
- **Prison, prisoners and the new public health**
 - prison seems to be the ideal place and opportunity to educate, train and re-orient those hard-to-reach portions of the population towards healthy behaviours.
- **Healthization of actuarial justice**
 - Actuaries evaluate future risks such as unemployment, illness, and death
 - a change where the goal is not to transform or rehabilitate inmates but rather to manage the risks they represent.
 - One popular way to do this is through the use of standardized correctional paths and risk management tools and scales.
 - Following this model, a prisoner having a low criminogenic risk but presenting a high health related economic risk, would be transferred to the community more quickly.
 - On the other hand, this model also allows for the punishment of risky health-related behaviours

- Rather than reintegrating offenders into the community, the «medicalization» of supervision will allow the State to maintain control and oversee heretofore-closed aspects of offender's lives
- To our knowledge, this «healthization» of actuarial justice is not formally in use in the correctional system

The production-punishment of healthcare consumers inside the walls

- The main reasons are people who want to use prison to get themselves back on track and second group, people with serious health problems who only realize it while in prison.

5. Godderis, R. (2006). Dining In: The Symbolic Power of Food in Prison. The Howard Journal 45(3), 255–267.

Prisoners' narratives revealed that the inability to make decisions about their daily routine was a great source of frustration and anxiety for them.

- Lack of control
 - everyday choices about when they would eat
 - where they consumed their food
 - what they could wear during meal times
 - prisoners fed cow's tongue without being informed them what kind of meat
 - inability to access ethnic dishes
 - baking versus deep-frying
- **Consumptive Resistance**
- Individual Adaptations and Adjustments
 - prisoners developed adaptations and adjustments that helped them cope with their loss of freedom
 - 'cognitive tricks' that individual prisoners played on themselves to prevent the distress that was created by the memory of foods and food-related rituals that they used to engage in.
 - involved the avoidance of cues, such as coupon books and television commercials that reminded participants of food choices
- individual displays of opposition
 - involved the avoidance of cues, such as coupon books and television commercials that reminded participants of food choices
 - treat to guards contamination of food
- legitimate group activities
 - ethnic culture groups
- illegitimate group activities
 - kitchen employees stealing
 - food commodity to barter

6. Boisaubin, E., Duarte, A., Blair, P., & Stone, H. (2005). Well Enough to Execute: The Health Professional's Responsibility of the Death Row Inmate. Journal of Correctional Health Care 11, 31-43

- The difficulty recruiting healthcare professionals to work behind bars

- The antisocial population these healthcare professionals are catering to

7. **Llewellyn, J, & Downie, J. (2011). Restorative Justice, Euthanasia, and Assisted Suicide: A New Arena for Restorative Justice and a New Path for End of Life Law and Policy in Canada.** Alberta Law Review, 48 (4) 965-986.

- **THE CURRENT APPROACH TO EUTHANASIA AND ASSISTED SUICIDE**
- carries a mandatory minimum life sentence with no possibility of parole for ten (for second degree murder) or 25 years (for first degree murder)
- **Morton's fork** —
 - either acquit even though guilt has been proven (and suffer the distress of disrespecting the law), or
 - convict (and suffer the distress of knowing that a person who is no threat to anyone and who acted out of compassion in the face of intractable suffering will be sent to jail for a minimum of 25 years).
- Equality is denied as those individuals who are physically capable of ending their own lives are free to do so, but those who have a disability that makes them physically incapable of ending their own lives without assistance are not
- Some family members or friends of those who die as a result of assisted suicide or euthanasia suffer an extraordinarily high level of stress and distress as they help a loved one to die
- **WHAT KIND OF JUSTICE IS RESTORATIVE JUSTICE?**
- Restorative justice is a relational theory of justice.
 - This means that it starts from an understanding of people and the world where relationship — connection rather than separation or independence — is foundational.
- Relational theory pays serious attention to relationships and how they are structured
- the effects they have on those involved,
- and what is needed from our relationships with one another to assure our well-being and flourishing.
- a system of criminal justice which focuses on the rehabilitation of offenders through reconciliation with victims and the community at large.
- **THE DIFFERENCE THAT RESTORATIVE JUSTICE MIGHT MAKE**
 - **A BROADER UNDERSTANDING OF HARM**
- The current criminal justice approach equates wrong (which warrants a justice response) with lawbreaking, and will see wrong in all cases of euthanasia and assisted suicide simply because there has been a breach of the law.
- Restorative justice, on the other hand, determines wrong on the basis of resulting and related harm.
 - It is thereby capable of seeing that a wanted death may not have been harmful,
 - and therefore would not constitute a wrong despite the fact that a law has been broken
- **ENHANCED ACCOUNTABILITY AND RESPONSIBILITY**

- Restorative justice not only broadens the view and categories of those involved, but also treats them as fluid and complicated
 - It does forgo punishment, but it ensures meaningful response to harm in the form of active participation in reparation of harm.
 - in this way, restorative justice challenges the identification of punishment with accountability.
 - more likely to assure a response to cases of euthanasia and assisted suicide
 - leaves little choice if they feel public interest not served by prosecution
 - **A PROACTIVE AND PREVENTATIVE FOCUS**
 - traditional approach is concerned with ensuring that offenders pay for their past deed
 - rj does not rely on negative incentives to avoid future behaviour
 - **A MORE INCLUSIVE, PARTICIPATORY, AND DEMOCRATIC PROCESS**
 - **BUILDING A RESTORATIVE RESPONSE TO EUTHANASIA AND ASSISTED SUICIDE**
 - Robert Latimer
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8. **Maschi, T., & Richter, M. (2017). Human Rights and Dignity Behind Bars: A Reflection on Death and Dying in World Prisons.** *Journal of Correctional Health Care*, 23(1), 76-82.

- **Death and Dying in Prison**

9. **Osborne, G. (2006). Scientific Experimentation on Canadian Inmates: 1955-75.** *The Howard Journal* 45(3), 284-306.

- Correctional Services Canada (CSC)
- Nuremberg tribunals judged Nazi doctors who had conducted research on prisoners as criminal
- the Nuremberg Code, the first internationally recognised code of ethics for research
- World Medical Association in 1961 and formally adopted under the Declaration of Helsinki in 1964 CODE OF ETHICS

subject to experiments

3 key forces

(1) ethical standards

2 medical industrial complex

3 correctional philosophy

- 3 key forces
 - ethical standards of the time were far from entrenched in the scientific community.
 - the pharmaceutical advances had created a social and medical climate in which testing for new drugs and products was deemed necessary, regardless of who volunteered for the experiments.

- a correctionalist perspective pervaded criminology and the criminal justice system, which encouraged prisoner participation as it would contribute to their psychological well-being and ongoing rehabilitation.
 - Presentism encourages a kind of moral complacency and selfcongratulation whereby we find ourselves morally superior and our forebears constantly failing to measure up to our present day standards
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10. **Pont, J. (2006). Medical Ethics in Prisons: Rules, standards and challenges. International Journal of Prisoner Health 2(4), 259-267.**

- Prison inmates
 - who cannot choose their doctor may find it difficult to trust a physician who is employed by the opposing prison administration.
 - They may question the doctor's confidentiality, professional independence and qualification.
- Prison physicians likewise are challenged by the unique peculiarities of providing health care in prison:
 - How to manage confidentiality, privacy and true consent of the patient in the totalitarian prison environment?
- Prison governors and custodial staff may have different perspectives of the physician's role regarding safety and security and of health care expenses: