Custodial dermatology for First Nations peoples: a niche service caring for incarcerated communities

Positionality statement

Our group comprises an Aboriginal dermatologist, a general practice clinical researcher and an Aboriginal otolaryngologist. As clinicians and advocates, we have an enduring dedication to the health and wellbeing of First Nations adults and children, particularly as it relates to our work in custodial health due to the overwhelming and racialised hyperincarceration of our communities. It is through this lens that we strive to deliver health care services that meet and exceed our duties under the United Nations obligations. Our position is that our collective human rights focused health care duty extends beyond emergency and primary care needs for incarcerated communities and aspires to ensure equitable and timely accessibility to medical and surgical subspecialty disciplines. Given the complex health needs of those experiencing the intersectional marginalisation of incarceration, chronically ill health, disability and barriers to culturally safe care, health care should be of the same standard or better, to meet the complex needs for incarcerated individuals with the goal of returning healthier people to our communities.

Introduction

It is within the walls of prisons that Australia's inescapable history as a penal colony and the current relationship with our First Nations peoples collides. There is international acknowledgement of the overincarceration of marginalised communities with an already higher burden of disease, and the inherently unhealthy environment of prisons.[1] The effectiveness of diversion and decarceration strategies are not evident for First Nations children and adults who continue to be incarcerated at rates substantially above the national average.[2]

Alongside the increasing incarceration rates and decreasing accessibility to care, the accumulation of poor health and disadvantage can be particularly insidious in specialties such as dermatology, where illnesses are often deprioritised despite their high risk of harm.[3] Infectious, inflammatory and malignant dermatological conditions[4,5] can lead to serious life-limiting consequences, impose a high symptom burden, and cause significant stigmatising visible differences, ostracism and shame. In providing contemporary custodial health care to an overincarcerated priority population, we must go beyond addressing acute health conditions reactively. It is imperative that prison-based health services are inclusive of subacute, recurrent and chronic diseases, such as skin diseases.

To deliver comprehensive care, it is essential to address not only illnesses but also to ensure the overall wellbeing of the patient. This involves offering wrap-around services that enhance a holistic care model. By integrating these services, we can better identify and treat a broad range of health needs, leading to improved outcomes for both patients and the community.

First Nations clinician-led custodial dermatology clinics have been implemented across two jurisdictions and are effectively addressing the need for care equivalence where needs are high and access is challenging.

Health impacts of incarceration for First Nations peoples

The chronic overincarceration and institutionalisation of First Nations peoples has been demonstrated in recent data with a trend towards reduced rates of incarceration for the non-Indigenous community and increased rates in First Nations peoples (204 persons per 100 000 adult population compared with 2500 persons per 100 000).[2] Just under one-third (30%) of all incarcerated Australians are First Nations peoples.

Overincarceration of African American men is well recognised, and studies show reduced life expectancy in factors of years as a direct consequence of incarceration[6,7], with the harm extended to siblings, children or parents of incarcerated individuals.[8] Australia imprisons its First Nations peoples at about two and a half times the rate of African Americans.[9] One-third of incarcerated Aboriginal adults and two-thirds of detained Aboriginal young people have experienced transgenerational incarceration.[10] Transgenerational incarceration affects individual and community wellbeing, and amplifies racialised overinvolvement with the legal system. We must consider if the collective "tough on crime" legal framework undermines the health and wellbeing of First Nations people and the broader community.[11] The prevailing sentiments within the legal system and the wider community, favouring punitive measures rather than rehabilitation, hinder incarcerated peoples' access to equitable and equivalent health care.[11]

Health care for people experiencing incarceration

The right to freedom from discrimination based on legal status or Indigenous status, and the equivalence of health care for people living in custodial care, are internationally accepted principles. However, disproportionate rates of chronic and communicable diseases are the norm and health care access can be elusive for First Nations people in custody.[12] In our experience as clinicians who work in custodial health, services in prisons struggle to meet the demand for dermatology and other subspecialty services, and

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care that is equivalent to what the broader community receives, is not yet being achieved.

There are substantial barriers to incarcerated communities accessing specialty health care.[13] Notwithstanding the best intentions of clinicians to provide care to those living in custody, the system for subspecialty services, such as dermatology, relies on already overburdened public hospitals providing care to those housed in nearby custodial facilities. Other factors contribute to the shortfall, including workforce challenges, a punitive community lens on the priority of incarcerated people accessing health services, stretched care continuity and facilitating systems, and tensions between state and federal government commitments. Visiting medical and surgical subspecialty clinicians and services that are committed, timely, regular, culturally connected and clinically safe are well placed to prioritise the health and wellbeing of individuals and communities who are experiencing incarceration by lifting logistical barriers.

Access to dermatology care in the community and prison

Despite the well recognised burden of skin disease across the broader Australian community, access to dermatologist care is suboptimal in community settings. Privately funded outpatient care in metropolitan areas of major coastal cities is where dermatology care is easiest to access;[14] however, access can still be cumbersome and erratic due to the relatively small workforce, subacute nature of many presentations, cost and the restricted capacity of the limited public clinics. In addition, despite a significant burden of skin diseases in urban[5,15,16] and regional/remote[4] First Nations communities, accessibility to dermatology care is further impeded by normalisation of skin sores by the medical community,[3] a collective sense of futility about care accessibility, and dermatological illnesses being deprioritised in the context of more pressing acute illness. This leads to undertreatment and the risk of serious sequelae for First Nations people with skin disease.

Even when accounting for the general access difficulties in rural and regional communities, the gradient of care is steeper for those in prisons, which are often outside metropolitan areas, and steeper again for First Nations peoples in prisons.[13] Australian custodial facilities house communities who are ten-fold disproportionately First Nations.[17] There are no reasonable grounds to assume that people living in prisons, who are generally sicker, are experiencing higher rates of skin health and wellbeing compared with those who are not incarcerated, given the life circumstances by which they enter custody.

There has been support and resource allocation to commence and maintain an in-reach custodial dermatology service in New South Wales to address the inaccessibility of timely and culturally safe specialist dermatological care, to reduce the high symptom burden, the risk of significant systemic sequelae, and the stigmatisation and shame of visible difference.[18] An in-prison dermatology service can provide an example of a model of care for health provision for highly symptomatic but subacute, chronic and recurrent health conditions. Novel services are required if we are to ensure equitable clinically and culturally safe care to patients who have previously been excluded. If the dermatology workforce invests in care delivery for custodial communities, a specialty where diversity is considered an area of opportunity,[19] there will be countless ways in which further improvements can be made and extended to other intersectionally marginalised communities where health care has previously had less visibility and presence.

First Nations-led specialty care in prison

During the coronavirus disease 2019 pandemic, when pre-existing care access barriers were exacerbated in a highly visual and hands-on specialty, a First Nations dermatology workforce emerged and proposed a custodial dermatology service. This was unanimously supported. Similar to a hospital-based specialty service in its mode of care, primary care clinicians refer complex medical and surgical cases, which are triaged according to clinical urgency. This novel approach in the custodial health sector is improving dermatological health and wellbeing for people living in NSW prisons and has extended to the Northern Territory.

For many First Nations doctors, gaining specialist qualifications confers a humble responsibility to commit to service provision for First Nations communities, particularly where care access is challenging. Even when calibrating for variables in lived experiences, numerous studies have shown that those doctors from under-represented communities provide incommensurately higher rates of care for priority communities.[20,21] First Nations doctors are often uniquely equipped with the cultural lens to relate with patients about matters of health, wellbeing, resilience and the medical journey. Medical qualifications do not insulate medical staff from the experiences of discrimination and these experiences may be one of many factors that attract First Nations doctors to serve in their communities to address unacceptable health outcomes.

It may be ambitious for a dermatologist to seek to address incarcerated individuals' and communities' chronic and recurrent inflammatory and infectious dermatological conditions in the same way that it may be aspirational to aim for carceral reform and address structural inequities. However, health care providers are well placed for systemic advocacy as well as responsible and duty-bound to promote humanised care.[20,22-24]

The first First Nations custodial dermatology service

Despite available resources, a focus on culturally safe models of care, and increased First Nations' workforce, health and wellbeing remains elusive for many First Nations children and adults who experience

preventable or treatable medical conditions.[25] This is particularly so when faced with the cumulative and intersectional othering of living in custodial settings with dermatological ill-health. However, within the confines of strict cross-institutional security protocols, fewer resources and patients living with competing physical and psychiatric polymorbidity, qualified and well intentioned clinicians choose to work in this inherently challenging but extremely rewarding environment with a community of patients who are grateful to have their rights to equitable health care honoured. The First Nations custodial dermatology service exemplifies a First Nations-led dedicated approach to overcoming systematic and racialised inaccessibility to timely and high quality health care and reflects a commitment to ethical and socially responsible health care services with a focus on bridging care gaps for the under-served, particularly our First Nations peoples.

In the face of a dearth of translational cross-disciplinary and patient-focused health research, centring and prioritising First Nations' voices is essential to how we create, deliver, sustain and support novel and equity-focused services in areas of great need to improve health and wellbeing. We are ethically responsible for ensuring our duty of care is met for First Nations peoples living in incarceration, committing to a rehabilitation focus and ensuring specialist health care is adequately considered and accessible.

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1 Franco-Paredes C, Ghandnoosh N, Latif H, et al. Decarceration and community re-entry in the COVID-19 era. *Lancet Infect Dis* 2021; 21: e11-e16.

2 Australian Bureau of Statistics. Corrective services, Australia. Canberra: ABS, Jun-quarter-2024. https://www.abs.gov.au/statistics/people/crime-and-justice/corrective-services-australia/latest-release (viewed Jan 2023).

3 Yeoh DK, Anderson A, Cleland G, Bowen AC. Are scabies and impetigo "normalised"? A cross-sectional comparative study of hospitalised children in northern Australia assessing clinical recognition and treatment of skin infections. *PLoS Negl Trop Dis* 2017; 11: e0005726.

4 Haggett MG, Tait CP. Five years of dermatological disease requiring specialist care in the Kimberley region of Western Australia. *Australas J Dermatol* 2021; 62: 157-161.

5 Slape DR, Saunderson RB, Tatian AH, et al. Cutaneous malignancies in Indigenous Peoples of urban Sydney. *J Med Imaging Radiat Oncol* 2019; 63: 244-249.

6 Daza S, Palloni A, Jones J. The consequences of incarceration for mortality in the United States. *Demography* 2020; 57: 577-598.

7 Patterson EJ. The dose–response of time served in prison on mortality: New York State, 1989–2003. *Am J Public Health* 2013; 103: 523-528.

8 Sundaresh R, Yi Y, Harvey TD, et al. Exposure to family member incarceration and adult well-being in the United States. *JAMA Netw Open* 2021; 4: e2111821.

9 United States of America Department of Justice, Bureau of Justice Statistics. Prisoners in 2021 – statistical tables. Washington: BJS, 2022. https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/p21st.pdf (viewed Jan 2023).

10 Remond MZ, Austin R, Bowman K, et al. Intergenerational incarceration in New South Wales: characteristics of people in prison experiencing parental imprisonment. Canberra: Australian Institute of Criminology, 2023. https://www.aic.gov.au/publications/tandi/tandi663 (viewed Feb 2023).

11 Reinhart E. Reconstructive justice - public health policy to end mass incarceration. *N Engl J Med* 2023; 388: 559-564.

12 Australian Institute of Health and Welfare. Health of people in prison. Canberra: AIHW, 2022. https://www.aihw.gov.au/reports/australias-health/health-of-people-in-prison (viewed Jan 2023).

13 Kendall S, Lighton S, Sherwood J, et al. Incarcerated aboriginal women's experiences of accessing healthcare and the limitations of the 'equal treatment' principle. *Int J Equity Health* 2020; 19: 48.

14 The Australasian College of Dermatologists. Accessible and quality dermatology care for all Australians. St Leonards: ACD, 2022. https://www.dermcoll.edu.au/wp-content/uploads/2022/12/ACD_Accessible-and-quality-dermatology-care-for-all-Australians_White-Paper_Nov-2022.pdf (viewed Jan 2023).

15 Ricciardo BM, Kessaris H-L, Kumarasinghe SP, et al. The burden of bacterial skin infection, scabies and atopic dermatitis among urban-living Indigenous children in high-income countries: a protocol for a systematic review. *Syst Rev* 2022; 11: 159.

16 Williams C, Hunt J, Kern JS, et al. A casemix study of patients seen within an urban Aboriginal Health Service dermatology clinic over a five-year period. *Australas J Dermatol* 2021; 62: 331-335.

17 Australian Bureau of Statistics. Prisoners in Australia. Canberra: ABS, 2022. https://www.abs.gov.au/statistics/people/crime-and-justice/prisoners-australia/latest-release (viewed Jan 2023).

18 Flohr C, Hay R. Putting the burden of skin diseases on the global map. *Br J Dermatol* 2021; 184: 189-190.

19 Akhiyat S, Cardwell L, Sokumbi O. Why dermatology is the second least diverse specialty in medicine: how did we get here? *Clin Dermatol* 2020; 38: 310-315.

20 Saha S. After affirmative action - working toward equitable representation in medicine. *N Engl J Med* 2023; 389: 1817-1821.

21 Venkataramani AS. Affirmative action, population health, and the importance of opportunity and hope. *N Engl J Med* 2023; 389: 1157-1159.

22 Salhi BA, Osborne AD. Incarceration and social death - restoring humanity in the clinical encounter. *N Engl J Med* 2021; 384: 201-203.

23 Morris N. Injustice disorder. *N Engl J Med* 2022; 387: 2017-2019.

24 Vanjani R. On incarceration and health - reframing the discussion. *N Engl J Med* 2017; 376: 2411-2413.

25 O'Brien G. Racial profiling, surveillance and over-policing: the over-incarceration of young First Nations males in Australia. *Social Sciences* 2021; 10: 68. ■