



Using Research to Improve Health and Health Care in US Correctional Facilities

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Correctional health care systems in the United States are responsible for the care of the more than 1.4 million people incarcerated in prisons, with more than 800,000 incarcerated people experiencing at least one chronic health condition (Carson 2020; Wilper et al. 2009). As 95 percent of people confined in prisons are eventually released, their health has implications for community health and community-based health care systems.¹ To implement policies and practices that foster positive health outcomes and fulfill the US government’s constitutional obligation to provide adequate health care to people who are incarcerated, researchers and practitioners must understand their health needs and the nature and quality of the care they receive.

Much on this subject remains unknown, from the extent to which facilities comply with agreed-upon standards of health care to the ways that individual-level factors (such as mental health) interact with the conditions of confinement to produce negative health outcomes. This brief gives an overview of what is known about health and health care in correctional settings and what must be investigated to improve treatment and health outcomes in correctional settings.

Literature Review

The right of incarcerated people to health care is enshrined in American and international laws and standards. In 1976, the Supreme Court ruled that incarcerated people are constitutionally entitled to health care, and that depriving them of necessary medical treatment violates the Eighth Amendment;² the court upheld this right as recently as 2011.³ Title II of the Americans with Disabilities Act mandates

that prisons provide equal access to benefits and services—including health care—to all people who are incarcerated, including those with disabilities and/or chronic illnesses.⁴ The American Bar Association’s standards for the treatment of prisoners and the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) declare that incarcerated people are entitled to “adequate” physical and mental health care that is universally accessible, delivered in a timely and individualized manner, of a quality consistent with community standards, and respectful of patient confidentiality and informed consent (ABA 2012; UNODC 2016).

Despite these laws and guidelines, the opaque and fragmented nature of the American prison system means there is much we do not know about the extent and quality of health care behind bars. The next sections explore what is known and what should be investigated in order to ascertain whether prisons provide health care that meets the above standards, develop metrics that foster transparency and accountability, and improve the quality of correctional health care services.

Mechanisms for Accountability and Oversight

Many prisons lack sufficient mechanisms to ensure that incarcerated people receive adequate health care. In fact, what constitutes “adequate” health care is somewhat controversial (Rich, Allen, and Williams 2014). The measures and data systems used to track health outcomes and health care quality in correctional facilities vary between and within states, perhaps unsurprising given the nature of America’s prison system, which is fractured into federal, state, public, and private facilities (Ahalt et al. 2013; Damberg et al. 2011). In addition, few of the leading national public-health datasets track individuals’ incarceration statuses and histories in a manner sufficient for assessing incarcerated people’s health or evaluating the impact of incarceration on health (Ahalt et al. 2012). To promote effective oversight of prison health care services, set reasonable standards, and improve health outcomes for incarcerated people, consistent data collection and more widespread, transparent reporting are necessary.

Another challenge is the lack of accountability mechanisms to ensure that facilities and providers meet basic standards of care. Organizations including the [American Public Health Association](#), the [National Commission on Correctional Health Care](#), and the [American Correctional Association](#) produce standards for health care in correctional settings and bestow accreditations upon correctional facilities. However, a majority of US correctional facilities are not accredited (Rich, Allen, and Williams 2014). For accredited facilities, no data exist regarding the effectiveness of these accreditation procedures in improving quality of care, and anecdotal evidence from corrections experts suggests that less-than-adequate health care exists even at accredited facilities (Stern, Greifinger, and Mellow 2010). Furthermore, when examining health care accreditations, accreditors’ business models merit further consideration. For example, the National Commission on Correctional Health Care contracts to help correctional systems meet its standards, giving it a potential financial incentive for accrediting systems that purchase its services.⁵

Research intended to change mechanisms for accountability and oversight in prison health care might ask the following questions:

- What new metrics must be developed and tested to accurately measure health care quality in the correctional environment?
- What innovative methods and strategies can be implemented to increase consistency in the measures and data systems used to track quality of care, outcomes, and value in correctional health?
- What is the role of patient feedback in quality-of-care assessments in prison health care systems?
- To what extent does accreditation ensure that correctional institutions comply with minimum standards of care?
- What policies and procedures for prison oversight would improve care and health outcomes for incarcerated people?
- How might Black people, Indigenous people, people of color, and other disproportionately incarcerated populations be empowered to oversee and hold facilities accountable for the quality of correctional health care in their communities?

Health Effects of Incarceration

Researchers seeking to better understand correctional health care must first understand that prisons themselves are often detrimental to incarcerated people's health. The COVID-19 pandemic has underscored that incarcerated people are particularly vulnerable to respiratory pathogens because of prison conditions and policies, including chronic and widespread overcrowding, inadequate ventilation, and limited access to personal hygiene items (e.g., toilet paper, tissues, soap, hand sanitizer, cleaning products).⁶ Lawsuits filed on behalf of incarcerated people allege unsafe structural prison conditions—such as the presence of mold, asbestos, and lead—that can lead to adverse health outcomes.⁷ For example, a statewide study in Texas found that incarcerated people were particularly vulnerable to MRSA infection, likely owing to poor sanitation and lack of access to hygiene products (Baillargeon et al. 2004). Evidence also shows that prison conditions make incarcerated people more likely to experience insomnia (Dewa et al. 2015), which has a range of adverse effects on health and longevity (Colten et al. 2006). Furthermore, dietary programs in American prisons are woefully underregulated, which in some facilities has led to obesity and malnutrition, both of which contribute to heightened rates of related chronic illnesses including diabetes (Firth et al. 2015; McKirgan 2013). Despite these concerns, data on the extent of unhealthy conditions in US prisons and the impact of incarceration on health are scarce. Systemwide data on the health of incarcerated people are needed so researchers can recommend ways to improve health outcomes in prisons through policy and practice.

Prison overcrowding and solitary confinement are particularly unhealthy for incarcerated people. Prison overcrowding, which is still widespread despite having been ruled unconstitutional, facilitates the spread of infectious diseases and increases the risk of suicide among people incarcerated in minimum-security facilities (Huey and McNulty 2005; Warmesley 2005). Solitary confinement leads to higher rates of mental illnesses, cardiovascular disease, hypertension, diabetes, and arthritis, and,

particularly in older adults, to confusion and memory loss (Lobel and Smith 2019; Williams 2016; Williams et al. 2019). Given recent US policies and international standards mandating reductions in overcrowding and in the use of solitary confinement, researchers should seek to better understand the nature and extent of the harm that these practices have caused. Future research should explore how individual-level characteristics interact with institutional conditions to produce negative health outcomes.

Researchers and practitioners must also reckon with the legacy of American health care—especially prison health care—as a means of oppressing marginalized people (Ahalt et al. 2018). The Tuskegee syphilis experiment is perhaps the most notorious example of US government researchers deliberately causing the deaths of low-income people of color in the service of medical research.⁸ Other examples of deliberately fatal research conducted on uninformed and nonconsenting incarcerated people of color include the Stateville Penitentiary malaria experiments and the sexually transmitted disease experiments conducted in Guatemala and Terre Haute, Indiana (Bioethics Commission 2011, 220; Miller 2013; Rodriguez and García 2013).

Although the US government has implemented rigorous human-subjects protections for research involving incarcerated people, contemporary accounts demonstrate that medical treatment can still be an instrument of oppression in prisons. From 2006 to 2010, more than 100 women incarcerated in the California prison system were sterilized without (and in some cases, against) their informed consent via procedures that served no medical purpose, were explicitly banned by the state government, and allegedly targeted pregnant women who had given birth to two or more children (Roth and Ainsworth 2015). Moreover, from May to July 2017, a Tennessee judge permitted incarcerated people to elect to be sterilized in exchange for reduced jail sentences of 30 days, with the explicit aim of reducing the numbers of children being born with drug-related health problems and entering the foster care system (Adams 2018). The United States has long abused sterilization to practice eugenics against poor people, people of color, and others deemed a burden on public resources and/or unfit to parent, and these occurrences must be contextualized within the country's legacy of intersecting racist, misogynistic, and classist oppression.

In addition to the egregious violations of the rights and dignity of incarcerated people described above, prisons frequently negate the agency of incarcerated queer and transgender people through health care policies and procedures. In many cases, prison administrators, not health care providers, decide whether transgender people receive medical care such as hormone therapy (Anafi et al. 2018). Furthermore, in some facilities, correctional staff violate queer and trans people's constitutional right to privacy by disclosing confidential information, such as LGBTQ status, HIV status, and medical history of gender dysphoria (Anafi et al. 2018).⁹ Researchers seeking to transform the way that incarcerated people are treated must therefore rigorously study the systemic harms perpetrated via the prison health care system, asking to what extent incarcerated people experience medical treatment that is nonconsensual, coercive, punitive, and/or in service of racist, misogynistic, transphobic, classist, ableist, or ageist oppression.

Lastly, the position and power of health care providers and researchers seeking to transform correctional health care merit further consideration. In most states, physicians have the power to recommend compassionate release for incarcerated patients who are seriously ill or disabled, though these releases occur infrequently in practice (Mitchell and Williams 2017). Furthermore, correctional health care providers are uniquely positioned to witness the deleterious effects of solitary confinement on patient health and longevity, presenting them with conflicting ethical and professional obligations (Ahalt, Rothman, and Williams 2017). Researchers should continue to explore the ways that health care providers who work in correctional settings can advocate for the health and well-being of their incarcerated patients, and they should continue developing and evaluating medical-ethics trainings designed for the correctional environment. In addition to examining the roles of health care providers, researchers must also reflect on their role and the manner in which they conduct research. For example, given incarcerated people have disproportionately low levels of educational attainment and literacy and disproportionately high rates of health conditions that adversely impact cognition (Ahalt et al. 2017), correctional health care researchers must pay particular attention to ensuring that participants understand and consent to any research.

A transformative research agenda should investigate and ameliorate the ways in which prison conditions and the prison health care system harm incarcerated people. Potentially fruitful lines of inquiry include the following:

- How widespread are unsafe prison conditions, such as poor nutrition, a lack of hygiene and sanitation, and the presence of harmful environmental substances? To what extent do these conditions contribute to negative health outcomes?
- What policies and procedures can increase transparency and accountability regarding the above conditions?
- In what ways other than those mentioned in this brief do overcrowding and solitary confinement impact health outcomes, and how do individual-level factors (e.g., mental health) interact with conditions of confinement to produce negative health outcomes?
- Do incarcerated people, particularly those living at the intersections of marginalized identities, feel that correctional health care providers respect their agency and dignity?
- To what extent do incarcerated people experience medical treatment that is nonconsensual, coercive, punitive, and/or in service of racist, misogynistic, transphobic, classist, ableist, or ageist oppression?
- To what extent do health care professionals in correctional settings advocate for the health and dignity of their patients?
- How can medical-ethics trainings be better applied to health care provision in correctional settings, and how might these trainings, when implemented effectively, impact how health care providers engage with incarcerated patients?

- How can correctional health care researchers ensure that incarcerated research participants understand and consent to research?

Mental Health Care

People who are incarcerated experience mental illness at disproportionately higher rates than people who are not (Al-Rousan et al. 2017; Fazel et al. 2016; James and Glaze 2006; Prins 2014). Although precise estimates vary, studies have found that approximately half of all incarcerated people have been diagnosed with or report experiencing symptoms of at least one mental illness (Al-Rousan et al. 2017; James and Glaze 2006), and that incarcerated women, people of color, and young people experience mental illness at disproportionately high rates (Al-Rousan et al. 2017; Freudenberg 2001; Hatcher et al. 2009; James and Glaze 2006). More people with serious mental illnesses are confined in prisons and jails than are housed in hospitals, by a factor of 10 in some states (Torrey et al. 2010). In communities with insufficient behavioral and mental health care resources, prisons become the de facto—and, in some cases, the only—way that community members can access the behavioral and mental health treatment they need.¹⁰ Because of this phenomenon, research must explore the experiences of incarcerated people with mental illnesses and the state of mental health care behind bars.

Numerous barriers prevent incarcerated people from receiving effective mental health care while in prison. A cross-sectional study of everyone incarcerated in the Iowa prison system found that 99 percent of mental illness diagnoses were first made during incarceration and that diagnoses of mental illness and substance use disorders often occur long after people enter prison (Al-Rousan et al. 2017). For people who enter the prison system with a mental illness diagnosis and medication, fewer than half receive medication while incarcerated (Reingle Gonzalez and Connell 2014). Furthermore, though studies of the prevalence of mental illness among incarcerated people are numerous, the field lacks a robust body of prison-specific evidence from randomized control trials to support the use of particular treatments or interventions for people experiencing mental illness behind bars (Fazel et al. 2016; Prins 2014). Lastly, few longitudinal studies of the mental health of incarcerated people exist, making it difficult to know how much the correctional environment contributes to mental illness and which treatment strategies may be most effective (Al-Rousan et al. 2017; Fazel et al. 2016).

Transformative research seeking to improve mental health care in US correctional facilities must shed light on the experiences of incarcerated people with mental illness and examine the root causes of the barriers described above. Researchers taking this approach might ask the following questions:

- Is the stigma around mental health issues greater in the correctional environment? If so, does that deter incarcerated people from disclosing information that might lead to a mental illness diagnosis?
- How frequently do people enter the criminal justice system with preexisting, undiagnosed mental illnesses? To what extent is mental illness caused or exacerbated by adverse experiences in the criminal justice system?

- What factors account for delayed mental illness diagnoses among incarcerated people, and what policies and procedures best ensure prompt diagnosis and linkage to treatment?
- Given gender, race, ethnicity, and age are correlated with heightened rates of mental illness, to what extent are processes for diagnosing and treating mental illness in correctional facilities culturally competent, gender responsive, and trauma informed?
- What programs or regimens are most effective for addressing mental illness in prison?
- How might harnessing underused research methods, particularly randomized control trials and longitudinal studies, shed light on which strategies for treating mental illness behind bars are most effective?

Notes

- ¹ "Reentry Trends in the U.S.: Releases from State Prison," Bureau of Justice Statistics, last revised November 26, 2020, <https://www.bjs.gov/content/reentry/releases.cfm#top>.
- ² *Estelle v. Gamble*, 429 U.S. 97 (1976).
- ³ *Brown v. Plata*, 563 U.S. 493 (2011).
- ⁴ Americans With Disabilities Act of 1990, 42 USC § 26 (1990).
- ⁵ "Consulting Services," National Commission on Correctional Health Care, accessed October 22, 2020, <https://www.ncchc.org/NCCHC-Resources>.
- ⁶ Keri Blakinger and Beth Schwartzapfel, "Coronavirus and Prisons," The Marshall Project, March 6, 2020, <https://www.themarshallproject.org/2020/03/06/when-purell-is-contraband-how-do-you-contain-coronavirus>; "Lawsuits Filed on Behalf of Terminal Island and Lompoc Prisoners," ACLU of Southern California, May 15, 2020, <https://www.aclusocal.org/en/press-releases/lawsuits-filed-behalf-terminal-island-and-lompoc-prisoners>.
- ⁷ Jesse Garza, "Lawsuit Says Prairie Du Chien Inmates Were Exposed to Asbestos, Black Mold, Contaminated Water," *Milwaukee Journal Sentinel*, August 8, 2019, <https://www.jsonline.com/story/news/2019/08/08/lawsuit-says-prairie-du-chien-inmates-exposed-asbestos-black-mold-contaminated-water/1960070001/>.
- ⁸ "U.S. Public Health Service Syphilis Study at Tuskegee," Centers for Disease Control and Prevention, last updated March 2, 2020, <https://www.cdc.gov/tuskegee/index.html>.
- ⁹ "Prisons and Jails," Center for HIV Law and Policy, accessed October 12, 2020, <https://www.hivlawandpolicy.org/issues/prisons-and-jails?page=0%2C0%2C0%2C0%2C0%2C1>.
- ¹⁰ Constance Hull and Colette Marcellin, "Community-Based Supports Are Essential to Better Address Behavioral Health Needs and Reduce Incarceration," *Urban Wire* (blog), Urban Institute, October 29, 2020, <https://www.urban.org/urban-wire/community-based-supports-are-essential-better-address-behavioral-health-needs-and-reduce-incarceration>.

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