14 Health Promotion in Jails and Prisons: An Alternative Paradigm for Correctional Health Services

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According to the Bureau of Justice Statistics, each year 10.6 million people pass through a jail in the United States. About 1.5 million individuals are in prison on any given day (Zeng, 2019). It is worth noting that although the United States makes up 5% of the world's population, it incarcerates 25% of the world's prisoners (Lee, 2015). Individuals who become incarcerated include some of the most vulnerable populations, those suffering from or at higher risk of infectious and chronic diseases, addiction and mental illness, and victims and perpetrators of violence (Dolan et al., 2016; Kelly et al., 2014; Stürup-Toft et al., 2018). Not only are incarcerated populations themselves often unhealthy, but untreated they can also worsen the well-being and impose additional costs on their families and communities (Nowotny & Kuptsevych-Timmer, 2018; Uggen et al., 2012). Unfortunately, the majority of people leave prison or jail without having their most serious health problems addressed, and many correctional health systems in the United States, in particular, see their main responsibility as providing only the most essential medical care to those in their custody. In this chapter, we consider whether the paradigm of health promotion can provide an alternative framework for correctional health in the United States and examine the scientific evidence, benefits, and opportunities for this perspective.

For the last 35 years, the World Health Organization (WHO) has made health promotion a priority. The Ottawa Charter for Health Promotion, adopted in 1986, defined health promotion as the "process of enabling people to increase control over and to improve their health." The 2016 Shanghai Declaration recast the transformative potential of health promotion for sustainable development in the contemporary world, with emphasis on multisectoral action, not just individuals (WHO, 2017). In this vision, health promotion addresses the interconnected reality of people's lives; that well-being and health may be outside of individual and traditional health sector control; and that multisectoral collaboration and advocacy are needed to sustain health-promoting efforts (WHO, 2017).

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R. B. Greifinger (ed.), *Public Health Behind Bars*, https://doi.org/10.1007/978-1-0716-1807-3_14

This declaration was in the context of global Sustainable Development Goals, which are a roadmap for global development. For corrections, this lens offers a broader view of the role of corrections in society and as a place that can contribute to communities. *Interconnectedness* recognizes that correctional facilities are part of communities, and incarcerated people have multiple interactions with others, meaning that correctional health issues are also public, community, family, and individual health issues. The idea that major influences on *well-being and health may be outside of individual and traditional healthcare system control* acknowledges inequities in access to health care and preventive services, healthy food, a safe environment, adequate housing, and other necessities of life.

In the United States, the reality is that over the past decades, often by default rather than by design, incarceration has become a de facto solution to mental illness, addiction, poverty, and inequality. For those who seek more effective and humane solutions to these and other social problems, improving correctional health services and integrating health promotion within these services may become a system change strategy that can enlist other sectors in defining more appropriate, achievable, and limited roles for jails and prisons.

WHO initiatives on health promotion provide one influence on reconsidering the scope of correctional health services. Another source is the recent movements to end mass incarceration, the war on drugs, and the inequitable impact of criminal justice policies on low-income communities and people of color (Chettiar & Raghavan, 2019). These movements have sought to interrupt the school-to-prison pipeline; end racially biased criminal justice practices; divert inmates out of correctional facilities to the mental health, substance abuse, and other services better prepared to treat them; and ensure successful community and civic reintegration after release. Thoughtfully designed health promotion programs can contribute to each of these goals.

Just as *multisectoral collaboration and advocacy* are needed to sustain global health promotion and to support criminal justice reform movements, correctional institutions cannot transform their mission and strategies on their own. As jails and prisons play more complex roles in the lives of individuals and communities, they will need partners to negotiate this transition—partners within the criminal justice, public health, social service, economic development, workforce preparation, social justice, and other sectors.

At first sight, this expansive conception of health promotion may seem too naïve or idealistic to serve as a useful framework for transforming the practice of correctional health. However, as society reconsiders the role of the criminal justice system in promoting public safety, social justice, and core American values, we make the case in this chapter that a transformative and forward thinking definition and practice of health promotion can serve as a bridge to bring together correctional and public health professionals, incarcerated people and their families and communities, and elected officials who must define an approach to incarceration and justice that engages public trust and support. The challenges that the recent opioid and coronavirus epidemics posed to the correctional system illustrate the potential societal contributions that a health promotion perspective could bring to this system.

In Table 14.1, we summarize the broad vision, how it applies to corrections, and our recommendations from the literature about tangible health promotion activities that could occur in jails and prisons.

In this expanded view, correctional health services (CHS) seek to improve population health both by treating the conditions that inmates present to facility providers and by offering the knowledge, skills, and referrals that incarcerated people need to protect their health inside the prison or jail and after release. CHS can also serve as referral sites for both facility-based (during incarceration) and community-based (after release) health education, health care, mental health, substance use, and social services, and also as resource on health for inmates' partners and children in the free world. In this model, the outcome of incarceration is assessed in part on the extent to which the facility has

Table 14.1 Vision for health promotion as it applies to corrections

Health promotion concept	Utility for corrections	Key activities
Interconnected reality of people's lives	Changing view of role of corrections in society and as a place that can contribute to communities; people in corrections have community contact—meaning health issues corrections deals with are community, family, and individual health issues	Provide inmates, correctional officers, and families with education and information Prepare individuals for release Enable individuals to act on behalf of their health
Well-being and health outside of individual and traditional health sector control	Reality of corrections as a United States' mental health solution, poverty solution, and addiction solution; corrections in the business of serving people and communities; responsibility for access to health care and prevention, healthy environments, and safety	Ensure access to appropriate health care Create healthy environments in correctional facilities (sanitation, infection control, unpolluted air, water) Provide basic necessities like healthy food, safe housing, and protection from violence
Multisectoral collaboration needed to sustain health promotion	Gains in public health, reduction of recidivism and safety of communities may need to include partners outside corrections	Facilitate collaboration to conduct health promotion activities
Advocacy for criminal justice reform	Recognizes need for ongoing advocacy to win changes in criminal justice reform, policies, and budgets that support enhanced role for health promotion in correctional systems	Training of CHS staff and inmates to serve as advocates for health promotion inside and outside correctional facilities

prepared those in its custody for healthier living after release. Since correctional systems tend to select populations at highest risk of health problems, an added benefit of this expanded conception of the role of CHS is that it can contribute to reducing the stark inequities in health that now characterize the United States and many other nations.

Finally, from a criminal justice perspective, health problems such as substance use, perpetration of or victimization by violence, mental illness, or chronic or infectious diseases can increase recidivism, encourage dependency, or endanger the well-being of people connected to the returning individual. Health promotion activities that prevent or reduce these problems can help to encourage healthier and safer post-release behaviors and lifestyles, thus serving a rehabilitative and public safety function.

In this chapter, we consider health promotion using the broad framework set out by the WHO and including enhancements suggested by the recent criminal justice reform movements as a mindset that views CHS as an integral element of public health that is judged by its contribution to improved population health. We distinguish this perspective from the more traditional view that CHS simply provide care that meets minimal legal standards for those in custody.

Rationale and Mandate for Health Promotion in Correctional Facilities

For the last 25 years, the United States and the European Union have set standards for correctional health care. In the United States, the National Commission on Correctional Health Care (NCCHC) first introduced a clinical guidelines document in 2001, with the most recent standards updated in 2018 (NCCHC, 2001, 2018a, b, c). The purpose of the NCCHC guidelines was to assist healthcare workers with the management of illness in correctional settings and improve incarcerated patient

outcomes. The NCCHC also developed a document that specifically addressed health education within correctional facilities (Task Force on Correctional Care Standards, 2003). The Health in Prisons Project (HIPP) was started in Europe in 1995 by the WHO with the goal of improving health in European prisons in order to improve public health (Gatherer et al., 2005). Member countries (there are currently 38) have pledged the resources necessary to build a public health infrastructure in prisons and participate actively in the collaboration (Whitehead, 2006; WHO, 2019).

On the public health sector side, both Healthy People 2020 and its successor Healthy People 2030, the primary national health planning process of the United States, and the "Public Health 3.0" vision, which sets the tone for how local public health in the United States addresses local challenges, have also called either for comprehensive responses to incarceration as a social determinant of health and multisector collaboration as a solution for addressing complex community health problems (Healthy People 2020, 2017; Centers for Disease Control and Prevention, 2017; DeSalvo et al., 2017).

Together, these mandates demonstrate that a wide variety of correctional health and public health professionals and organizations support the inclusion of a health promotion perspective within CHS. In our review of these calls to action, the literature, and our experience offering health promotion programming in jails, we identified eight key program activities that can provide an operational definition of health promotion within correctional facilities. These were: (1) providing inmates, correctional officers, and families with education and information; (2) preparing individuals for release; (3) enabling individuals to act on behalf of their health; (4) ensuring access to appropriate health care and preventive services; (5) creating healthy environments in correctional facilities (sanitation, infection control, unpolluted air, water, etc.); (6) providing basic necessities like healthy food, safe housing, and protection from violence; (7) facilitating collaborations to conduct health promotion activities; and (8) training of CHS staff and inmates to be advocates for health promotion inside and outside correctional facilities. These activities are not mutually exclusive, but each activity has distinct characteristics, as defined in Box 14.1.

Box 14.1 Defining Key Activities for Health Promotion in Jails and Prisons

Provide inmates, correctional officers, and families with education and information *for health promotion, but do so using multilevel models that address institutional, peer, family, and community influences on health outcomes.*

Prepare individuals for release *with programming that helps people avoid the health risks of release (drug overdose, homicide, suicide, HIV health risk, for example). Provide multifaceted wraparound care that acknowledges comorbidities and social needs after release from jail or prison.*

Enable individuals to act on behalf of their health *by facilitating critical reflection of circumstances, solutions, and engaging the broader community in building structures that support change. This can also include preparing individuals, families, and communities to advocate for policies that protect their well-being.*

Ensure access to appropriate health care *with a reorientation of services to focus on disease screening, chronic disease management, and preventive care. This reorientation takes the long view that investing in prevention saves costs and lives down the road.*

Create healthy environments in correctional facilities *with a focus not only on jail and prison conditions, but also on policies that encourage social support, family interaction, and better preparation for release. This also includes policies that prevent correctional facilities from amplifying epidemics.*

Provide basic necessities like healthy food, safe housing, and protection from violence to all inmates *both to fulfill basic human rights obligations and to ensure that released inmates do not return to their communities with unmet health needs or higher burdens of trauma.*

Facilitate collaboration to conduct health promotion activities *through linkages among correctional entities, community organizations, and local public health departments to expand the scope of population health activities provided by CHS.*

Train advocates for health promotion *by drawing on the experience of criminal justice reform movements. Examine policies across sectors to see which policies harm communities; change CHS procedures; and when necessary, use litigation to effect change.*

The structure of US jails and prisons offers multiple opportunities as well as daunting obstacles to health promotion. Jails incarcerate individuals who are awaiting adjudication, those sentenced to terms of a year or less, and parole and probation violators (James, 2004). Because of the high volume, short lengths of stay, and rapid turnover, jails provide unique opportunities to reach many vulnerable individuals within low-income communities and to link them to community health promotion efforts after release. Unlike prisons, jails are usually located within high-incarceration communities, enabling activities to engage family members in health promotion activities (Begun et al., 2017; Freudenberg, 2001; Maschi et al., 2018). On the other hand, the high turnover, security concerns, dynamic environment, and external demands from elected officials, the media, and the public on jails make them a difficult environment for health promotion. This setting requires health staff to have patience, modest goals, and a willingness to balance their desires to address health issues with the custody and control priorities of correctional officials.

Prisons typically house people sentenced to more than a year and include individuals who will never be released from the facility. Longer lengths of stay and a more secure and stable environment sometimes enable prisons to have more opportunities for planned health activities and to have the intensity and duration of contact needed to achieve health goals. However, prisons have more limited interactions with families and communities, reducing their potential to have an impact on population health (Austin & Hardyman, 2004).

Correctional systems also vary in their support for and commitment to health services. Some jurisdictions have established model programs and CHS, and wardens, sheriffs, or commissioners/directors are forceful advocates for health (Lincoln et al., 2006; Sinclair & Porter-Williamson, 2004; White et al., 2003). Others, however, view health as a distraction from more traditional custody and control issues and take on health issues mainly in response to litigation (Nathan, 2004). Obviously, health professionals in a supportive environment will have an easier time adding a health promotion perspective into existing CHS, while those in more traditional settings face greater obstacles. Even in challenging environments, however, litigation, new state or federal mandates, or forceful advocacy can stimulate interest in more comprehensive approaches to health, including health promotion.

Another external influence is the growing trend of assigning responsibility for correctional health services to external contractors. While the quality and scope of such privatized services vary widely, a recent review identified problems related to quality of care, accountability of professionals, and timely access to care in privatized services (Weiss, 2015). Whether contacted out services provide more or less health promotion has not, to our knowledge, been studied. Since privatized services are generally not accountable for population health, their role in health promotion may be limited.

A fourth contextual variable of interest is the extent to which existing officials in local or state correctional or health departments or in local or state government as a whole support intersectoral, multilevel approaches to reentry and improved health. The approach to health promotion described here works best if officials, providers, and advocates from multiple systems and agencies are willing to come together to articulate a shared vision, identify and solve problems, exchange resources, and plan comprehensively. Having a high-level official who supports and is willing to lead such an effort significantly increases the likelihood of success.

Operationalizing a Vision for Health Promotion: A Review of Evidence and Opportunities

While to our knowledge no correctional system has yet implemented a comprehensive and integrated health promotion initiative, in fact all elements of such a program have been implemented in some correctional facilities. In Table 14.2, we provide an overview of the components of a comprehensive health promotion program for correctional facilities. In a subsequent section, we provide practitioners with a practical list for health promotion opportunities in correctional and post-release settings.

Table 14.2 Elements of a comprehensive correctional health promotion program

Health promotion activity	Selected activities/ approaches in jails or prisons	Selected health and social outcomes: inmates	Selected health and social outcomes: correctional facilities	Selected health and social outcomes: society as a whole	Selected references
Provide education and information	Health education and other health promotion programming; family planning, parenting, violence prevention, and other health programs	Improved HIV outcomes; better chances for successful reentry; lowered rates of violent recidivism; improved relationships with children; less jail transmission of infectious diseases	Improved HIV management and delivery; lowered healthcare costs; lowered violent reoffenses	Improved HIV testing, prevention, and treatment policies and practices; improved outcomes for children of inmates; decreased violent reoffenses	Polaschek (2011), Belenko et al. (2013), Bronson and Sufrin (2019), Miller et al. (2014)
Prepare individuals for release	Reentry programming (chronic, infectious, mental health, substance abuse, housing, employment, education planning); case management services; integrated treatment programs for trauma	Improved HIV care retention; fewer drug overdoses; improvement in mental health	Greater linkage of care for HIV and other health conditions; fewer drug overdose deaths; increased delivery of trauma-informed care	Better HIV care delivery systems; decreased drug deaths; improved mental health outcomes	Althoff et al. (2013), Wallace et al. (2011)

Table 14.2 (continued)

Health promotion activity	Selected activities/ approaches in jails or prisons	Selected health and social outcomes: inmates	Selected health and social outcomes: correctional facilities	Selected health and social outcomes: society as a whole	Selected references
Enable individuals to act on behalf of their health	Health literacy programming; empowerment; civic engagement approach	Increased knowledge on positive living strategies; increased community engagement	Reduced imprisonment-related HIV vulnerability; greater civic engagement	Improved social structures and reentry for incarcerated populations; increased representation of groups in civic processes	Daniels et al. (2011), Draine et al. (2011), Emerson et al. (2019)
Ensure access to health care	Move from disease treatment to disease management, health promotion, and prevention; develop continuity of care inside and after release; train providers to promote health	Improved control of chronic conditions; lowered healthcare costs after release	Greater infrastructure for providing health care and promotion; lowered healthcare costs; greater efficiency through health promotion & prevention; more linkages to community-based organizations	Better community health outcomes; reliance on healthcare system for emergency care; more seamless medical care inside and on release	Institute of Medicine (2002), Gopalappa et al. (2013), Ramsey et al. (2019)
Create healthy environments	Sanitation, infection control, clean air, water; encourage positive social support; improve mental and physical outcomes; encourage healthy family relationships; training health providers and peers	Reduced transmission of infectious diseases; reduced mental health burden; greater substance abuse care; better family functioning post-release	No overcrowding; greater healthcare provider knowledge on how to deliver care; better linkages to care	Reduced transmission of infectious diseases; better relationships for spouses and children of inmates	Roux (2011), Newman and Scott (2012), Thomas et al. (2019), Wohl et al. (2010)
Provide basic necessities	Advocate policies that provide substance abuse, mental health, HIV support, and other services during incarceration and after release; reduce stigma against people returning; provide job training and education inside and after release	Increased access to and use of housing assistance, substance abuse treatment services, mental health services; increased ability to find employment and reduce dependency after release	Greater infrastructure for substance abuse and mental health treatment and promotion	Lowered unemployment, homelessness and illegal activity rates, better HIV linkage to care	Kerr and Jackson (2016), Freudenberg et al. (2005), Schmitt and Warner (2011)

(continued)

Table 14.2 (continued)

Health promotion activity	Selected activities/ approaches in jails or prisons	Selected health and social outcomes: inmates	Selected health and social outcomes: correctional facilities	Selected health and social outcomes: society as a whole	Selected references
Facilitate collaboration	Needed to sustain health promotion activities; establish linkages with community organizations, local public health departments to encourage cross-sectoral collaboration to meet complex population health needs	Increased access to health care and promotion; creation of community environments that reduce recidivism; increased knowledge on risk reduction	Greater infrastructure and resources for providing health care and health promotion; less reliance on funding from corrections departments and time from staff to provide services	Increased linkage to care; improved health outcomes of vulnerable populations	Harawa et al. (2018), Senkowski et al. (2016), Nunn et al. (2010)
Advocate for health-enhancing policies and programs	Organize community coalitions to advocate for policies listed above	Inmates better equipped to advocate for jail and community policies that will enhance their well-being	Correctional leaders will have additional community, staff, and inmates' support for health-promoting policies	Cities and states will have greater capacity to enact and implement health-promoting correctional policies	Hatton & Fisher, (2018), Jeffrey, (2018), Freudenberg & Heller, (2016)

Providing Education and Information

While helping people to learn about health and develop skills in order to improve their own health is central to the concept of health promotion (WHO, 1986), more recent scholarship emphasizes the importance of integrating education and counseling into a continuum of services operating at multiple levels (Golden et al., 2015). By recognizing that people incarcerated in jails and prisons are part of a community of people and organizations—from the inmates themselves, to correctional staff, and family members in communities, CHS staff can ensure that educational programs are embedded in multilevel health promotion programs. The challenge remains to integrate the many tested models of counseling, health education, and disease management established in correctional facilities for such problems as HIV and other sexually transmitted infections (STIs) (Spaulding et al., 2013; Harawa et al., 2018; Belenko et al., 2013), tuberculosis (Parvez et al., 2010), violence prevention (Polaschek, 2011; Cooley, 2019; Opsal et al., 2019), prenatal care and reproductive health (Bronson & Sufrin, 2019; Knittel et al., 2017; Ramaswamy et al., 2015), and parenting (Barr et al., 2014; Miller et al., 2014; Troy et al., 2018) into multilevel models that address institutional, peer, family, and community influences on these outcomes. The recent COVID-19 epidemic further illustrates the role correctional facilities can play in providing information that can help protect inmates, staff, and families.

These educational programs often demonstrate increases in knowledge and motivation to change; sometimes in health behavior and health beliefs; and less frequently in health status. Program characteristics that have been identified with more successful outcomes include use of multiple methods, materials and communications that are culturally and linguistically appropriate, sufficient program intensity and duration, opportunities for practice of skills, and reinforcement of messages (Freudenberg,

2001; Freudenberg & Heller, 2016; Lowenkamp et al., 2006; Palmer, 1995). The focus on infectious diseases, violence prevention, reproductive health, and parenting in these interventions also suggests that researchers and practitioners are looking beyond only the inmates to sex partners, families, and communities.

Though interventions to increase access to education and information are a vital component of correctional health promotion programs, their value is significantly enhanced by interventions at other levels of organization (e.g., family, correctional facility, community, public policy) that help to create a context in which individuals have the opportunity to use the skills they have acquired. For example, several HIPP prisons now make condoms and sterile injection equipment available to people in prison (Gatherer et al., 2005). But while harm reduction initiatives have been successful at providing increased access to clean needles in nonincarcerated populations in the United States (Crawford et al., 2013; Dasgupta et al., 2019), no US correctional system distributes clean needles and only a few make condoms available inside the facility (McCuller & Harawa, 2014; Leibowitz et al., 2012).

A less common trend is health promotion programming that focuses on providing health education and information to correctional officers. Though significantly less vulnerable than inmates when it comes to health, correctional officers also face high levels of stress, burnout, violence, depression, and chronic conditions associated with stress like high blood pressure (Bezerra et al., 2016; Ferdick & Smith, 2017; Lerman & Harney, 2019). The few interventions that do exist to address these problems have been mental health counseling, referral, and peer support programs (Powell & Gayman, 2019). The health risks that correctional officers face have been well established, but the resources available for correctional officers have been much slower to develop. Taken together, most health promotion programming focuses on one segment of the affected population, and less so on the total world of interconnected people affected by corrections. In the future, including correctional and CHS staff in health promotion programs may increase support for this approach and highlight shared needs of all those who spend time behind bars.

Preparation for Release

There are many health dangers associated with release from jails or prisons—death, overdose, psychosis, for example (Binswanger et al., 2016; Zlodre & Fazel, 2012). Most of the evidence-based interventions have focused specifically on HIV, substance use, and mental illness (Freudenberg & Heller, 2016). These take the form of discharge planning programs, linkages to health care, and housing, with programs showing promise when they are multifaceted (for example, addressing mental health and substance abuse problems at the same time), gender-specific (particularly important for women), and offer wraparound health and social services (Freudenberg & Heller, 2016). A new trend of "transitional healthcare" programs has also cropped up in several cities across the United States. Their model is noteworthy because it focuses on primary care linkages as a way to reduce acute care use and ultimately reduce recidivism (Wang et al., 2012). Early evidence shows this model is effective, but the effects on recidivism are mixed (Shavit et al., 2017; Wang et al., 2012, 2019). Programs that address the transition from corrections to communities are also often better positioned to address the relationship between individuals who become incarcerated and their contacts in the community. Models include programs that address HIV prevention among couples, where one partner has criminal justice involvement (Reznick et al., 2011). But on the whole, these programs are rare, and thus represent a missed opportunity for addressing some of the most pressing causes of poor health during the transition from corrections to communities.

Enabling Individuals to Act on Behalf of Their Health

A new set of health promotion programs designed for people with criminal justice involvement utilize civic engagement, community building, and critical health literacy approaches to engage people with a history of criminal justice involvement (Daniels et al., 2011; Draine, McTighe, & Bourgois, 2011; Emerson, Allison, and Ramaswamy, 2019). These programs are centered on engaging the target population in critical reflection of their circumstances, solutions, and then for some, engaging the broader community in building structures that support change. On a practical level, these programs have been associated with reductions in substance dependence, days spent reincarcerated, gains in voter registration, and community activism to address HIV and mass incarceration (Daniels et al., 2011; Draine, McTighe, & Bourgois, 2011; Emerson, Allison, and Ramaswamy, 2019). They are also challenging to fund, design, implement, and evaluate, yet serve as a model for what comprehensive, participant-engaged health promotion programming can look like.

Ensuring Access to Appropriate Health Care

When Congress authorized the creation of Medicare and Medicaid in 1965, it prohibited Medicare or Medicaid from paying for health care in the nation's jails and prisons. This exclusion, known as the "inmate exception," has diminished the capacity of the correctional healthcare system to meet inmate needs and isolated CHS from mainstream medicine. This exclusion has inadvertently contributed to the opioid crisis by leaving a large vulnerable population with limited access to care. As Fiscella et al. observed, "repeal of the inmate exception can improve correctional health care, boost community health and safety, and reduce wasteful public spending" (Fiscella et al., 2017).

Before passage of the Affordable Care Act (ACA) in 2010, most adults leaving prison or jail were not eligible for Medicaid because coverage generally did not extend to most childless low-income adults. By 2018, however, 33 states and the District of Columbia had expanded Medicaid to all adults with incomes below 138% of the federal poverty level (FPL), creating the potential to expand coverage to people after their release from jail or prison (Guyer et al., 2019). Some states have initiated the enrollment process before inmates are released, expanding the pool of those who return to their communities with access to health care. Such coverage can help to reduce recidivism and related costs as well as and unnecessary emergency department visits and hospitalizations—a benefit to inmates and their families, the healthcare system as a whole, and taxpayers (Guyer et al., 2019).

Most health services in the United States focus on treatment of acute and chronic conditions rather than on primary care and prevention, despite evidence that a shift in emphasis could improve population health and reduce costs (Institute of Medicine, 2002). This is certainly reflected in correctional settings, where the vast proportion of healthcare resources is devoted to providing acute care for inmates who present medical problems to correctional health services staff; and relatively few resources are devoted to prevention. In jails, correctional health resources are often consumed by performing mandated services such as intake physical examinations, often repeatedly on the same people who reenter the system frequently.

Two recent epidemics illustrate the challenges and potential of using correctional facility healthcare programs to promote inmate, community, and population health. During the opioid epidemic, many correctional facilities have had high proportions of inmates with opioid addiction. By proving onsite treatment within jails and prisons, ensuring that released inmates were connected to community care, and coordinating services with community-based providers that served people before and after incarceration, CHS programs can help to reduce the impact and prevalence of opioid addiction (Fiscella et al., 2018; Wakeman & Rich, 2015). More recently, the COVID-19 epidemic showed both

the potential for correctional facilities to serve as amplifiers of epidemics and also their capacity to use widespread screening, prompt treatment, and early release to prevent infections and transmission (Gibson, 2020).

Broader changes in medical practice require CHS programs to reassess their practices and policies. In the free world, for example, extensive routine physical examinations are no longer recommended for young adults. In correctional settings, however, more effective and economical alternatives to this outdated approach have yet to be developed. In this context, reorienting health services might include: expanding prevention and health promotion initiatives; providing routine screening for appropriate conditions and ensuring that those testing positive receive appropriate follow-up before or after release; devoting more resources to chronic disease management; and increasing opportunities for healthier behavior and use of preventive services after release.

Such a reorientation faces significant obstacles in part because many correctional officials believe that their legal mandate is limited to providing acute care to those in their custody. Additionally, meeting the complex health needs of inmates can break the budgets of for-profit CHS corporations. It is estimated that 70% of medical care is provided by an outside source, with most contracts run by for-profit corporations with an eye toward their financial bottom line (Coll, 2019). Thus, CHS often fail to provide *preventive* health services to inmates. Although the previously cited standards provide a rationale for prevention and health promotion, these activities are usually perceived as a lower priority, even though their potential for improving the health of individuals and populations and reducing the cost of CHS may be greater. Moreover, since most correctional systems do not see health promotion as part of their core mission, these entities do not claim leadership in bringing about the reallocation of resources that such a reorientation requires.

To what extent have CHS begun a reorientation of priorities? Examples include the addition of routine chlamydia screening to CHS protocols (Gopalappa et al., 2013), partnerships between CHS and community-based health centers (Ramsey et al., 2019), and stronger linkages between CHS and community-based substance abuse and mental health services (Lorenzen & Bracy, 2011; Wohl et al., 2010; Finfgeld-Connett & Johnson, 2011; McKenzie et al., 2012; Wolff et al., 2013). These examples illustrate the potential for moving on a variety of fronts to shift healthcare resources from acute care and facility-based services only to a balance of treatment and prevention and facility and community-based care.

Creating Healthy Environments

Healthy physical and social environments can make important contributions to individual and population health (Tsai & Papachristos, 2015; Bunnell et al., 2012; Roux, 2011; National Research Council, 2013). In correctional facilities, physical environmental factors that have been associated with poor health include overcrowding; lack of privacy; pests; lack of access to showers, hot water, and soap; and exposure to infectious agents (Ruderman et al., 2015; Lambert et al., 2016; Newman & Scott, 2012). Social environmental conditions associated with poor health in correctional facilities include exposure to physical and sexual violence, isolation from family and friends, and stigma (Perry & Bright, 2012; Harner et al., 2017; Cloud et al., 2015).

Creating healthier correctional environments requires making changes in physical conditions, for example, improving ventilation, reducing overcrowding, or reducing exposure to pests without increasing exposure to harmful pesticides. Often, such changes have been achieved through litigation (Chanin, 2014).

Strategies to improve social environments and increase the positive support that incarcerated people experience include correctional staff training to improve positive interactions with inmates;

changes in policies related to visits from partners, family, and children; more vigorous enforcement of laws on sexual violence and inmate bullying, and campaigns against stigma and isolation both inside the facility and after release (Galanek, 2014; Moore et al., 2015; Massoglia and Pridemore, 2015). For the most part, such interventions have not been described or evaluated in the literature. After release, a variety of reentry programs seek to connect people returning from jail to prosocial networks and individuals, strengthen family functions and parenting, and prepare individuals for work and self-sufficiency (McKenna et al., 2014; Wikoff et al., 2012; Thomas et al., 2019). Often, these programs serve only people with mental illness or HIV infection, rather than the general population. Few of these programs have been systematically evaluated; those that have been evaluated often show positive but modest results (Senkowski et al., 2016; Lorenzen & Bracy, 2011; Wohl et al., 2010).

Providing Basic Necessities

As noted in previous sections, ensuring that inmates have access to the basic necessities of life during their incarceration and in the post-release phase can help to prevent problems that can burden individuals, the inmate population as a whole, families, communities, and taxpayers. These basic needs include safe housing, healthy food, access to medical care, protection from inmate and correctional staff's sexual and physical violence and discrimination (Hoke & Demory, 2014). Every inmate returning to the community with an untreated health condition or new traumatic experiences behind bars or returning to unsafe or unhealthy living conditions poses a risk to individual and community health. Preventing such occurrences both ensures recognition of the basic human rights of inmates and the public mandate to protect public health.

Collaboration

A central tenet of the health promotion literature is that health professionals alone can achieve only limited improvements in health, but in partnership with a variety of community-based organizations, more significant gains are possible (Corbin et al., 2016). In correctional settings, community organizations have played a variety of health roles including providing health education and counseling, especially on HIV; seeking referrals for post-release health care, mental health, and social services; and providing post-release case management and other services (Harawa et al., 2018; Lichtenstein & Malow, 2010; Senkowski et al., 2016; Draine et al., 2011; Nunn et al., 2010).

A small but growing evidence base shows that effective collaborations with local public health departments and local correctional facilities can, for example, provide contraception to women leaving jails and HPV vaccine for inmates (McNeely et al., 2019; Ramaswamy et al., 2019). Local public health departments can also play an important role in vaccination for other conditions inside correctional facilities, for example, influenza and hepatitis B (Farrell et al., 2010; Lee et al., 2014). These partnerships between public local entities could be cost-effective, in line with local health departments' mission to serve the public's health, and meet the new goals of cross-sectional partnership of Public Health 3.0 models (DeSalvo et al., 2017).

Negotiating effective partnerships between correctional agencies, health departments, academic institutions, and community organizations presents many challenges, including finding common ground among differing missions, locating the resources that can sustain the collaboration, and choosing priorities among the multiple needs that incarcerated and returning populations face (Barta et al., 2016; Freudenberg et al., 2005; Robillard et al., 2003).

Advocacy

In recent years, the public health community has called attention to the importance to population health of public policies in a variety of sectors, including housing, education, the environment, work, taxation, and criminal justice (Daniel et al., 2018; Golden et al., 2015; Basu et al., 2017). In fact, this is the explicit mission of the Public Health 3.0 mandate of local health departments (DeSalvo et al., 2017). Recent research on the health of incarcerated populations demonstrates that policies on substance abuse, crime, housing, employment, health care, and other issues can adversely affect their well-being (Kerr & Jackson, 2016; Nyamathi et al., 2018; Freudenberg & Heller, 2016; Schmitt & Warner, 2011; Cramer et al., 2019; Edwards & Collins Jr., 2014; Thomas et al., 2019). Often these policies impose disproportionate burdens on vulnerable and disenfranchised groups—people of color, women, transgender people, and drug users, and may thus contribute to growing disparities in health (Mignon, 2016; Wang & Green, 2010; Weidner & Schultz, 2019).

How have CHS staff taken on advocacy roles, given these realities? Some have chosen to become active in developing national standards of care that can serve to improve the quality of care in jails and prison (APHA, 2003; NCCHC, 2018b, c). Others have worked to change health insurance policies that barred coverage for people leaving correctional facilities, to provide immunizations for people in incarcerated populations, to advocate for laws that require discharge planning for people returning from incarceration, to reduce discrimination against inmates with HIV, and to improve housing options for those coming home from prison or jail (Beck et al., 2001; Freudenberg et al., 2005; Gondles, 2005; Restum, 2005). While the impact of these efforts has not been systematically evaluated, one review of litigation on correctional conditions concluded that these lawsuits had led to improvements in the past three decades (Nathan, 2004). An analysis of the role of litigation and legislation in California's successful effort to lower incarceration concluded that the "'dual sticks' of litigation and a ballot initiative …proved to be the driving forces in reducing California's use of mass incarceration" (Austin, 2016).

Another relevant body of experience is the legislative, legal, electoral, and other forms of advocacy by groups such as American Civil Liberties Union National Prisoner Project, Black Lives Matter, the Southern Center for Human Rights, the Equal Justice Initiative, the Center for Prisoner Health and Human Rights, Human Rights Watch, and others. These efforts have helped restore voting rights for ex-inmates, modified sentencing guidelines, changed policing practices that exacerbated racial inequities in incarceration, and educated the public about the health consequences of criminal justice policy. While few studies have evaluated the impact of these activities, they seem to have helped change the national conversation on criminal justice and public health and reduce the health-damaging social isolation that many ex-inmates face (Jansson, 2019; Hatton & Fisher, 2018; Jeffrey, 2018). Most of these groups have depended on evidence, testimony, and other forms of support from public health and correctional health professionals, examples of expanded roles for health professionals in improving CHS.

Recommendations

In this section, we suggest actions that could help to move CHS from an acute medical care perspective to a health promotion model (see Table 14.3). The recommendations are based on our review of the literature and our own experience working in jails and prisons. Once again, we use the activity categories proposed by the World Health Organization's definition of health promotion and practices of recent criminal justice reform movements.

Table 14.3 Menu of practical steps to strengthen health promotion in correctional settings

Task	Possible activities for CHS staff and partners
1. Provide inmates, correctional officers, and families with education and information	Develop, implement, and evaluate informational campaigns and educational programs Establish partnerships with public and nonprofit community agencies for education Train inmates to serve as peer educators and advocates
2. Prepare individuals for release	Ensure that all eligible inmates leave with prior enrollment for benefits that can support successful release (e.g., Medicaid, SNAP, job training, housing assistance) Facilitate community programs to meet and establish relationships with inmates prior to release Establish pick-up programs so that inmates who so desire can be released directly to housing, job training, substance use, or other programs
3. Enable individuals to act on behalf of their health	Provide training for peer advocates inside facility and after release Offer workshops in facility to prepare inmates to make informed health choices
4. Ensure access to appropriate health care	Advocate for repeal of Medicaid exemption Make strong referrals to community-based programs post-release Ensure that correctional facility healthcare programs meet standards and are monitored for quality of care
5. Create healthy environments	Establish ongoing monitoring systems for correctional facility environments Train staff to act to safeguards environmental conditions Engage staff, inmates, and management in ongoing activities to create healthful correctional environments
6. Provide basic necessities	Monitor food services, medical care, and housing conditions within facility and act to correct deficiencies Engage with community partners to make improvements in provision of necessities
7. Facilitate collaboration	Establish well-defined partnerships with universities, health departments, state and local governments, and community organizations as appropriate
8. Train advocates	Establish and evaluate programs to prepare inmates, correctional staff, and CHS staff to serve as advocates for healthier correctional programs and services

While few correctional systems will have the capacity or resources to adopt all these recommendations, every jail and prison has the potential to expand the repertoire of activities beyond treatment to health promotion. By viewing these two approaches as a continuum with a menu of options, CHS managers can begin to broaden their range of services within the realities of their political and financial constraints. At the same time, by articulating a vision of a correctional system whose mission has widened to include promoting the well-being of those who enter and exit its gates, we offer a more comprehensive view that can contribute more fully to the goals of improved public safety and community health.

Conclusion

The challenge ahead is to develop systematic approaches to making prisons and jails settings that improve rather than harm the well-being of the people who enter the front gate and the families and communities to which they return. At one level, this is as simple as recognizing the basic ethical principles that guide health professionals; at another, it will require a transformation of the US correctional system.

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