Submission to the PAHO Commission on Equity and Health Inequalities in the Americas

The role of prisons, jails and youth detention centres in addressing health inequalities in the Americas

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Synopsis and Recommendations

Each year millions of people cycle through prisons and youth detention settings in the PAHO region. People who experience incarceration are distinguished by a high prevalence of co-occurring health problems, typically set against a backdrop of entrenched disadvantage. Health outcomes after release from custody are typically poor, and rates of preventable mortality are markedly elevated. Incarceration profoundly impacts the children and families of those incarcerated, and the health of the wider community: 'prisoner health is public health'. Given the concentration of ill health and disadvantage among people who experience incarceration, responding to the health needs of these vulnerable individuals is important to addressing health inequalities at the population level.

Effective responses are contingent on appropriate prison healthcare governance, good data to inform policy and practice, and regional coordination to support monitoring and data collection, and build regional capacity. The WHO European Region Health in Prisons Programme (HIPP), established in 1995, recently implemented a regional prison health survey that has now been completed by 39 countries in the European region. The data, available online in the Health in Prisons European Database (HIPED), provide an overview of health in prisons in Europe according to key public health indicators. These data are the first step towards establishment of a global minimum dataset on prison and youth detention health.

Policies intended to address health inequalities at the population level must be inclusive of the health needs of people who experience incarceration. The lack of data on prisoner health status and prison health systems hampers both informed policy-making and accurate surveillance and reporting, at both country and regional level. A coordinated regional approach to policy and research would provide much-needed support to PAHO countries to commence the work needed to develop evidence-based policies about prison and youth detention health. This work is well aligned with the Strategic Plan of the Pan American Health Organization 2014-2019.

Establishing a Health in Prisons Programme in the PAHO region would provide a policy and research focus for this work, and enable PAHO's existing program areas to incorporate prison and youth detention health into their work. Expansion and adaptation of the WHO European Region prison health survey to the PAHO Region would provide new and critical evidence to inform efforts to reduce health inequalities through evidence-based, equitable healthcare for the millions of people who experience incarceration in the Region.

Recommendations

1. That the Commission recognise prisons and youth detention centres as healthcare delivery sites of critical importance for identifying health needs at the individual level and addressing health inequalities at the population level.
2. That the Commission identify the high rates of incarceration in many countries in the Americas as a pressing public health concern, not only for the individuals incarcerated, but also for their children, their families, and the wider community.
3. That the Commission recognise that effective, sustainable responses to the health needs of people who experience incarceration are contingent on continuity of care, which in turn requires close coordination of prison and community health services.
4. That the Commission recommend the establishment of a Health in Prisons Programme within PAHO, including establishment of at least one corresponding WHO Collaborating Centre in the Region.

5. That the Commission express support for the adaptation and administration of the WHO European Region prison health survey in the PAHO region.
6. That the Commission recommend that PAHO Member States:
    a. Implement an evidence-informed approach to decision making about health systems and services in prison and youth detention settings, including with respect to coordination and continuity of care between prison/detention and community.
    b. Ensure that prisons and youth detention settings are included in all public health strategies, policies and planning: that is, an approach of 'prison health in all policies'.
    c. Prioritise continuity of care and effective flow of health information between prison/detention and community health services.
    d. Ensure that prisons and youth detention centres remain in scope for national data collections and other routine monitoring regarding population health, health systems and services.

Incarceration in the Americas

The global prison[i] population exceeds 11 million people and is growing at a rate in excess of population growth.[1] Countries in the Pan American Health Organization (PAHO) region account for approximately 40% of the global prison population (3.8 million people) and, across the region, the incarceration rate (387 per 100,000) is around two and a half times the global average (144 per 100,000).

Country-specific data reveal that trends in incarceration and rates of incarceration vary greatly across the PAHO region. There have been sharp upward trends in incarceration across much of the Americas since 2000. Excluding the United States (US), the prison population in the Americas has increased by 108% since 2000, with an increase of 80% in Central America and 145% in South America. Trends in North America are more varied with comparatively modest increases in the US and Greenland, and decreases in Canada (by 8%) and Bermuda (by 25%). The US incarceration rate is among the highest in the world at 698 per 100,000[2] and there are more than 2.3 million people in US prisons at any one time, including 615,000 in local jails.[2] The US accounts for 4.3% of the global population[1] but more than 20% of the world's prisoners.[1] In 2016, Brazil emerged as the third largest prison population in the world and the largest in South America, with an average of 726,700 people incarcerated on any one day; this figure has risen by 707% since the early 90's.[3] In the Americas, the median incarceration rate is higher in Caribbean countries (347 per 100,000) than in South American countries (242 per 100,000), but rates vary markedly between countries. Incarceration rates and static prison population sizes in the Americas are shown in Figure 1.

Defining the population

In most countries in the PAHO region, the majority of prison sentences are relatively short and a large proportion of people in custody are unsentenced (pre-trial), such that the annual 'churn' through prisons far exceeds the daily number. There are no reliable global or regional estimates of annual prison throughput, however the United Nations (UN) estimated in 2008 that more than 30 million adults pass through prisons globally each year.[4] This crucial distinction between the daily number of people incarcerated and the number of people exposed to incarceration each year is often ignored by policy-makers. The difference between the cross-sectional population and number of persons incarcerated each year is particularly striking in the US, where 615,000 people are held in jails on any one day, but the annual 'churn' through jails in the US is around 10.6 million.[2] The lack of routine reporting on annual prison throughput arguably perpetuates the misconception that prison 'populations' are small and static, and masks the fact that almost all of these individuals return to the community eventually, usually after a relatively short period of time in custody.[5] Thus, prison is best conceived of as a setting that members of the community come into contact with, often repeatedly; from a public health perspective, it is unhelpful to characterise people in prison as a separate 'population'.

[i] Because most countries do not make a distinction between prisons and jails (as the US does), throughout this document the term 'prison' is used to refer to both prisons and jails.

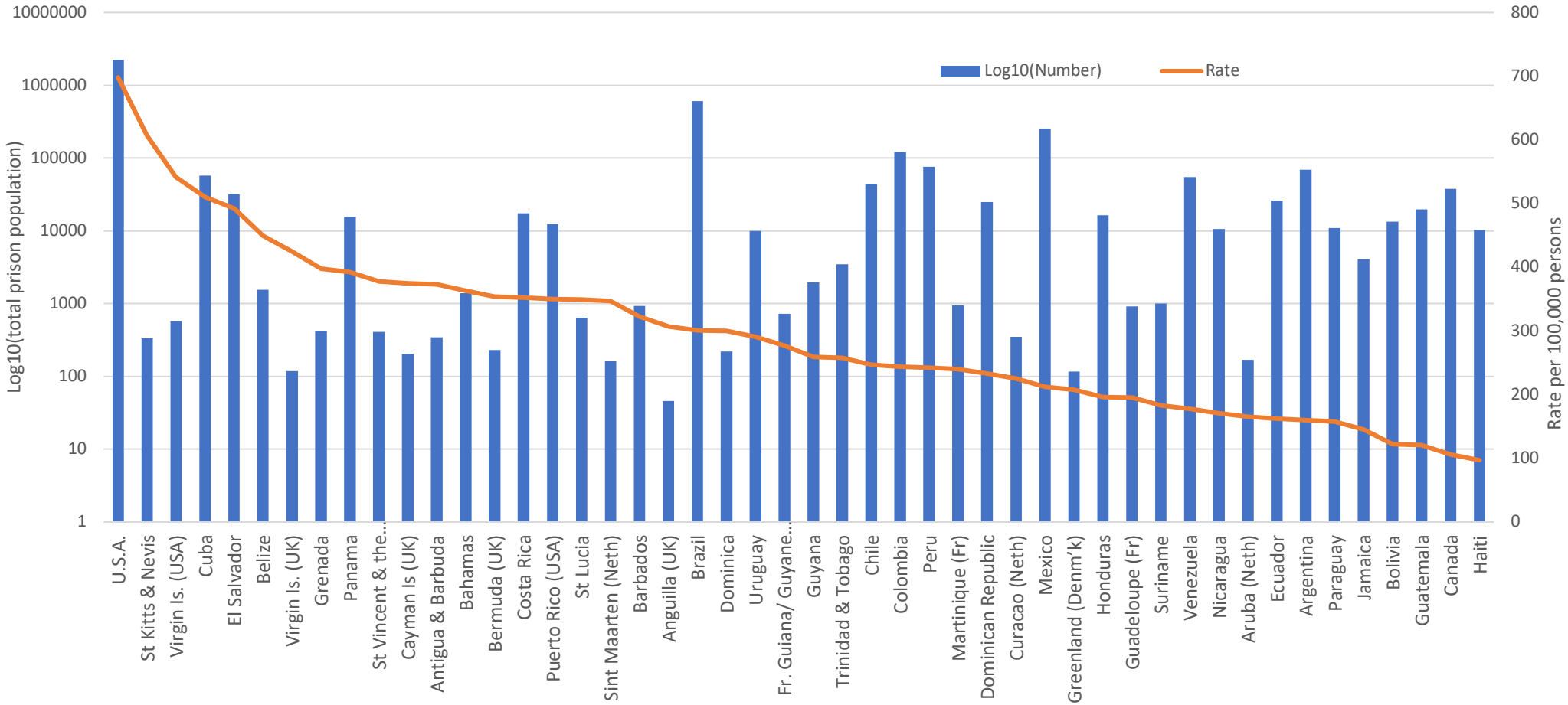

Figure 1. Incarceration rates and prison population sizes in the Americas.[86]

Many countries incarcerate adolescents separately from adults, but there are no robust global or regional estimates of the number of young people held in youth detention on any one day, much less the number exposed to youth detention each year. In 2009 UNICEF estimated that around 1.1 million children were held in detention on any given day;[6] updating this estimate is one goal of the current UN Global Study on Children Deprived of Liberty, although this study does not currently include measurement of any health indicators.[7] It has been reported that rates of youth detention are far higher in the US than anywhere else in the developed world, with a rate of 336 per 100,000 young people in the population reported in 2008.[8] By comparison, in 2012 the rate of youth detention in Brazil was 100 per 100.000.[9]

The health of people who experience incarceration

People who experience incarceration are distinguished by remarkably poor health status,[10] including elevated rates of mental illness[11], substance use disorders[12], communicable[13] and non-communicable diseases[14], brain injury[15] and intellectual disabilities,[16] and elevated rates of self-harm and suicide.[17-21] These co-occurring health problems often interact in a syndemic fashion,[ii] whereby multiple epidemic conditions interact synergistically,[22 23] and are typically set against a backdrop of entrenched and intergenerational social disadvantage.[24] Additionally, in many countries in the PAHO region and elsewhere, Indigenous peoples and other racial and ethnic minorities are over-represented at all levels of the criminal justice system, and often experience particularly poor health outcomes.[25] The health profile of detained adolescents appears similar, although much less is known about their health status and needs outside of the US.[26-30]

Places of detention are a critical site for addressing health inequalities. Incarceration provides access to health services for people with significant health needs, who may face substantial barriers to accessing healthcare in the community. Incarceration therefore represents a regrettable yet critical public health opportunity to identify and commence treatment for unmet health needs. Illustrating the scale of this opportunity, Hammett and colleagues estimated that in 1997 20.1-26.2% of all people with HIV/AIDS, 29.4-43.2% of all people with hepatitis C, and 39.6% of all people with TB infection, were released from a prison or jail in the US.[31] Estimates from 2006 suggest that the proportion of people with HIV in the US released from prisons and jails each year has fallen to around one in seven (14%), largely due to improved discharge planning for people with HIV. However, large increases in the number of people cycling through prisons and jails over this period (from 7.3 million in 1997 to 9.1 million in 2006) mean that the absolute number of people with HIV released from custody in the US each year has remained about the same.[32]

Most people who are incarcerated spend a relatively short time in custody before returning to the community. The benefits of health services delivered (and the consequences of inadequate health service delivery) in prison are often only realised after these individuals return to their communities, thus the truism that 'prisoner health is public health'.[33] Given the number of people who experience imprisonment or youth detention each year globally, improving the health of people who experience incarceration is therefore important to global health, to public health, and to reducing health inequalities.[34]

Incarceration does not only affect those held in custody. While the precise number of children and family members indirectly affected by the incarceration of people close to them is unknown, evidence suggests that the impact is substantial. The intergenerational impacts of incarceration are well-

[ii] Syndemics is a conceptual framework for understanding diseases or health conditions that are exacerbated by the social, economic, environmental, and economic landscape in which a population lives. "The hallmark of a syndemic is the presence of two or more diseases that adversely interact with each other, negatively affecting the mutual course of each disease trajectory… which are made more deleterious by experienced inequities" (*The Lancet*, 2017, p. 881).

established. Children of incarcerated parents are more likely than their counterparts without incarcerated parents to exhibit behavioural problems[35] and low self-esteem[36], and experience traumatic separation, unstable childcare arrangements[37], reduced income/employment opportunitites[38 39], and increased rates of premature mortality[40]. Despite the deleterious effects of parental incarceration, the needs of the families of incarcerated individuals typically receive insufficient support from the criminal justice, social welfare or healthcare systems. Interrupting the profound intergenerational effect of incarceration is likely a critical component of a global health response to the health inequalities experienced by disadvantaged children and adolescents.

The risk factors for incarceration overlap strongly with determinants of health inequalities. Markers of poor health and health inequity, including a lack of health insurance, are associated with an increased risk of reincarceration.[41-43] Incarceration is disproportionately experienced by minority racial and ethnic groups, by those concentrated in impoverished neighbourhoods, and by individuals with substance use disorders, developmental disability and poorly controlled mental illness, poor educational attainment, experiences of neglect and trauma, family breakdown, unstable housing, parental incarceration, and previous incarceration.[10 25 44 45] Although the purported function of prisons and youth detention centres is to detain and (to varying degrees) rehabilitate people who have committed crimes, prisons in reality function as a filter for poor health and disadvantage in the community, a process that has been described as the 'sedimentation of disease'.[46]

Health systems and health data 'behind bars'

The *United Nations Standard Minimum Rules for the Treatment of Prisoners* (the Mandela Rules)[47] require member states to provide healthcare in prison and youth detention that is equivalent to that available in the community (Rule 24.1), and to maximise coordination of care between prison and community health systems (Rule 24.2). Given the concentrated health burden in custodial settings, the so-called 'principle of equivalence' is typically understood to require disproportionate investment in custodial healthcare to achieve equivalence of outcomes, rather than 'the same services'.[48] Despite this, and although the Sustainable Development Goals (SDGs) call for expansion of universal health coverage for all,[iii] people in prison and youth detention are uniquely excluded from such coverage in some countries, including the United States[49] and Australia.[50 51] This is just one striking illustration of the mismatch between healthcare demand in custodial settings, and healthcare services in these settings. Funding mechanisms and governance arrangements for custodial healthcare in most countries have never been publicly documented or explicitly compared, although a recent survey in the WHO European region has, for the first time, provided data on prison healthcare funding across that region.[iv]

Although it is clear that people in custody have poor health, not enough is known about the epidemiology or natural history of health problems in people who experience incarceraton. Critical evidence gaps are particularly pronounced in low- and middle-income countries (LMICs), because the vast majority of the scientific literature on health and health systems in custodial settings has emerged from a handful of high-income, mostly western countries.[45] Sound, publicly available and directly comparable epidemiological data on the prevalence and co-occurrence of health problems in custodial settings in all PAHO countries are needed to inform appropriate scaling and coordination of health services.

To focus on prison health services in isolation would be to perpetuate the historic error of creating administrative, financial, and legal silos around correctional institutions. Many people transition

[iii] SDG target 3.8 calls for "universal health coverage (UHC), including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all".

[iv] http://apps.who.int/gho/data/node.prisons.Prison_Health_Care_Oversight?lang=en

rapidly in and out of prison settings, often with lengths of stay less than 30 days. Given that the period "behind bars" is often short, effective and sustainable responses to the health needs of these individuals, and by extension to health inequalities at the population level, require improved coordination of care with community services. Data on health systems in prisons and youth detention centres, and information on how these systems interact with community health systems, are even more limited,[45] as is research funding directed towards answering these questions.[52-54]

The case for continuity of care

People released from prison and youth detention often experience homelessness or unstable housing[55] and typically face enormous challenges in accessing education and training, and securing employment or other legal income.[56] They are at high risk of poor acute health outcomes including injury from all causes,[57] self-harm[19 58-60], and non-fatal drug overdose;[61 62] they access expensive, acute and tertiary health services at higher rates than their community peers.[63-66] Relapse to risky alcohol, tobacco, and illicit drug use after release from custody appears to be normative,[67-70] such that incarceration is most accurately conceived of as an interruption in patterns of harmful substance use. Rates of preventable mortality after release from prison and youth detention are dramatically elevated; drug overdose, suicide, injury, and violence are among the leading causes,[71-76] however rates of mortality due to communicable and non-communicable diseases are also markedly elevated.[77 78]

Despite this, the transition from prison or youth detention back to the community is often poorly planned, poorly coordinated, poorly managed and under-resourced, such that medical problems continue to go unaddressed and are exacerbated in the community, even when such needs have been identified and treated in prison.[79-82] Addressing this inequity requires a whole-system approach and targeted investment in maximising continuity of care. Emerging evidence from a handful of randomised trials and other rigorous evaluation studies confirms the long-held view that, although improving health in prison is essential, uninterrupted access to appropriate healthcare is required upon release to the community, if long-term public health benefits are to be realised.[83-87]

Excluding prison and youth detention settings from public health and safety planning undermines a country's capacity to systematically address health inequalities.[88] Lack of early health interventions in prisons and youth detention centres may result in community health services and hospitals intervening, at considerable cost, when a released person's physical or mental health problems become acute. Initiating a long-term health plan in custody, in consultation with the individual, that is continued into the community, is likely to strengthen the capacity of formerly incarcerated people to achieve the best possible health status, with consequent benefits for the health of their families, for public health, and for efforts to reduce health inequalities.

What challenges need to be overcome?

To address persistent health inequalities among people who experience incarceration in the PAHO region, we have identified three primary challenges that need to be overcome: (1) suboptimal prison and youth detention healthcare governance arrangements; (2) a lack of data on health and health systems in places of detention; and (3) a lack of regional coordination. In this section we briefly describe these challenges, and offer some partial solutions.

There is a tendency to consider prisons and youth detention centres as separate healthcare systems that are beyond the responsibility of public health data collection, planning, funding, and decision-making. This perspective is further reinforced through the typical separation in governing bodies, with prison and youth detention health systems often governed by ministries of justice (or equivalents) rather than ministries of health. Informed by the extant evidence and relevant human rights instruments, the WHO Health in Prisons Programme (HIPP), established by the WHO Regional Office

for Europe in 1995, recommended in 2013 that ministries of health (rather than ministries of justice) deliver health services in prison.[89]

People in prison and youth detention experience stigma[90 91] that can be reflected in political and administrative unease at providing and adequately resourcing health services in prison and detention settings, and in difficulties in attracting qualified healthcare staff to work in these settings. By contrast, in recognition of the importance of including prisons in wider efforts to reduce health inequalities, the WHO *Moscow Declaration on Prison Health as part of Public Health*[88] states that prison health "must be an integral part of the public health system of any country" (p.2). In concrete terms this means systematically including prison and detention health within all public health planning, policy, financing, and data collection.

There are substantial evidence gaps relating to the health of people in prisons and youth detention centres, and to health systems and services in these settings, particularly in LMICs.[92] While this is a global issue, substantial progress has been made in the European Region through the leadership of the WHO HIPP. For example, with the support of the HIPP Steering Group[v], other partners and donors' funding, the HIPP developed the WHO European Region prison health survey; a national questionnaire designed to generate a minimum public health dataset for prisons, which 39 countries completed in 2016/2017. The data, available online in the Health in Prisons European Database (HIPED)[vi] provide an overview of health in prisons according to key public health indicators covering seven main domains: (1) prison population statistics, (2) prisoner mortality statistics, (3) prison health care systems, (4) prison environment and risk factors, (5) disease screening, (6) prevention of communicable and non-communicable diseases, and (7) treatment of communicable and non-communicable diseases.

The data in HIPED for the first time permit meaningful comparison of prison health services and systems across countries, contribute to an increased understanding of health needs, and provide an opportunity to contextualise the strengths and weaknesses of different prison healthcare systems to inform the development of evidence-based policies.

Expansion of the WHO HIPP and prison health survey to the PAHO region

The WHO European Region prison health survey is an excellent starting point to create a global minimum public health dataset for prisons and youth detention settings, supporting regional and international comparisons. A global project is currently underway, involving many of the contributors to this submission, to adapt and apply the survey across the remaining WHO regions, including PAHO. The scope of the survey project involves:

- Expansion of the survey to encompass youth detention settings as well as adult prisons;
- The inclusion of indicators relating to coordination of care, and information flow between prison/detention and community health systems; and
- Adaptation for use in non-European settings (including translation and accommodating different administrative arrangements and cultural factors).

A key enabling factor for this survey in the PAHO region will be the establishment of a health in prisons programme within the PAHO region, supported by one or more collaborating centres. As a global prison and youth detention health database expands over time, it will show trends over time that will improve understanding of the health needs of people who experience incarceration, and permit objective assessment of the impact of different custodial health service delivery models. Collection of

[v] Public Health England/WHO Collaborating Centre, European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), United Nations Office on Drugs and Crime (UNODC), AIDS Foundation East-West (AFEW), and representatives from Switzerland, Netherlands, Spain and Slovenia, European Centre for Disease Prevention and Control (ECDC), Council of Europe, European Commission

[vi] HIPED; http://apps.who.int/gho/data/node.prisons

these data will permit countries to consider the adequacy of their own custodial healthcare arrangements and to learn from models adopted in other countries in and beyond the PAHO region.

Conclusions

Policies intended to address health inequalities at the population level must be inclusive of the health needs of people who experience incarceration. Given the extreme health inequalities experienced by these individuals, their disproportionate contribution to the burden of disease, particularly in countries and regions with a high incarceration rate, and the rapid 'churn' between community and custodial settings, prisoner health is indeed an important part of public health. Countries that choose to exclude custodial settings from their public health planning are ignoring a key mechanism for improving the health of their population, and reducing health inequalities. The lack of data on prisoner health status and prison health systems hampers both informed policy-making and accurate surveillance and reporting, at country and regional level.

A coordinated regional approach to policy and research would provide much-needed support to PAHO countries to commence the work needed to develop evidence-based policies about prison and youth detention health. Fortunately, this approach aligns perfectly with the core functions of PAHO, as listed on p.28 of the *Strategic Plan of the Pan American Health Organization 2014-2019*:[87]

1. Providing leadership on matters critical to health and engaging in partnerships where joint action is needed.
2. Shaping the research agenda and stimulating the generation, dissemination, and application of valuable knowledge.
3. Setting norms and standards, and promoting and monitoring their implementation.
4. Articulating ethical and evidence-based policy options.
5. Establishing technical cooperation, catalyzing change, and building sustainable institutional capacity.
6. Monitoring the health situation and assessing health trends.

Establishing a PAHO Health in Prisons Programme would provide a policy and research focus for this work, and enable PAHO's program areas to incorporate prison and detention health into their existing work. In addition, expansion and adaptation of the WHO European Region prison health survey to the PAHO Region will provide new evidence to inform efforts to reduce health inequalities through evidence-based, equitable healthcare for the millions of people who experience incarceration in the Region.

Recommendations

1. Noting the high prevalence of complex, co-occurring health problems among people who experience incarceration that the Commission recognise prisons and youth detention centres as healthcare delivery sites of critical importance for identifying health needs at the individual level and addressing health inequalities at the population level.
2. That the Commission identify the high rates of incarceration in many countries in the Americas as a pressing public health concern, not only for the individuals incarcerated, but also for their children, their families, and the wider community.
3. Noting the rapid 'churn' of vulnerable individuals between custodial and community settings, that the Commission recognise that effective, sustainable responses to the health needs of people who experience incarceration are contingent on continuity of care, which in turn requires close coordination of prison and community health services.
4. That the Commission recommend the establishment of a Health in Prisons Programme within PAHO, including establishment of at least one corresponding WHO Collaborating Centre in the Region.
5. That the Commission express support for the adaptation and administration of the WHO European Region prison health survey in the PAHO region.
6. That the Commission recommend that PAHO Member States:
    a. Implement an evidence-informed approach to decision making about health systems and services in prison and youth detention settings, including with respect to coordination and continuity of care between prison/detention and community.
    b. Ensure that prisons and youth detention settings are included in all public health strategies, policies and planning: that is, an approach of 'prison health in all policies'.
    c. Prioritise continuity of care and effective flow of health information between prison/detention and community health services.
    d. Ensure that prisons and youth detention centres remain in scope for national data collections and other routine monitoring regarding population health, health systems and services.

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