SOCIETAL OBLIGATIONS FOR MENTAL HEALTHCARE PROVISION IN CORRECTIONAL FACILITIES: AN ETHICAL APPROACH

Grace Anne Holladay

Washington and Lee University

Course Instructor: Professor Art Goldsmith

Second Reader: Professor Melina Bell

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I. Introduction

Since the founding of our country, Americans have been promised access to three unalienable rights: life, liberty, and the pursuit of happiness. Incarcerated individuals lose this right to liberty. Should they also lose their right to life? For every year that an individual spends behind bars, that individual's life expectancy is shortened by two years (Patterson). Indeed, considering the millions of individuals in the carceral system, estimates suggest that the U.S. population life expectancy would have increased 51% more from 1981-2007 than it actually did (Wildeman 374-375). Such dramatic statistics are no surprise when considering the existing state of healthcare in correctional facilities and the size of the prison population. Despite the higher rates of chronic illness, infectious disease, and mental illness among incarcerated individuals, treatment can be low-quality and hard to access (Maruschak et al.). Mental healthcare in correctional facilities is a particular point of concern due to the high rates of mental illness among incarcerated individuals and the scarcity of treatment and preventative resources currently available to this population (Bronson and Berzofsky).

Are these healthcare inequalities just? Consideration of such a question is essential at this point in history. The prison system has increasingly come under scrutiny due to poor conditions, racial inequalities, privatization, and overcrowding. Moreover, increasing numbers of incarcerated individuals are being released in response to the COVID-19 pandemic. We may be on the precipice of restructuring our prison system. Many prison systems have decreased their populations over the past year due to the pandemic through mild decarceration and fewer arrests and admissions (Macmadu et al.). An Arizona report found that their state prison system could save $1.4 billion over the next ten years by enacting an expanded release policy that could decrease prison populations by over 20% (Forslund). As such, investigating better ways to

provide mental healthcare to incarcerated individuals could provide needed structure as changes to the criminal justice system begin to occur. With the pressing nature of future changes in mind, this essay investigates the essential question that must be answered when structuring a correctional healthcare system: What ethical and moral obligations does society hold to provide incarcerated individuals with healthcare access and resources, especially in the realm of mental healthcare? This essay conducts a systematic literature review to evaluate the existing state of mental healthcare in correctional facilities in terms of health outcomes, legal precedents, and current policy. Using theories of justice described by John Rawls and Martha Nussbaum, this essay analyzes the medical, legal, and economic dimensions of existing correctional medicine. Thereafter, these ethical frameworks are applied to investigate the merits of the principle of equivalence, the theory underpinning correctional healthcare in many European countries. Ultimately, this ethical analysis supports the conclusion that a system based on equivalence could serve as an alternative to current practices in correctional medicine that addresses some of the existing ethical shortcomings.

II. Literature Review

In order to address the question regarding the ethical and moral obligations that society holds towards the provision of resources for mental health treatment and prevention in the correctional setting, a thorough literature review was conducted. This review establishes the significance of health and healthcare, discusses the existing state of mental health resources in the correctional setting, and describes the ethical lenses of healthcare distribution that will be used to critically evaluate existing systems.

Moral Importance of Health and Healthcare

For the sake of this essay, "good" health is characterized as the full and normal functioning of an individual that enables equality of opportunity (Boorse; Daniels). Without good health, a person is unable to function normally, thus reducing the set of opportunities given to a person (Daniels 17-21). Health in this way is both intrinsically valuable, as a person's well-being has inherent value, and instrumentally valuable, as it increases a person's functioning and benefit to society (Venkatapuram 270). Healthcare strives to promote this good health through traditional medical treatment and preventative services as well as public health initiatives, which are widespread efforts to educate the public and facilitate healthy living. These services and initiatives help society keep its citizens functioning normally. Indeed, healthcare carries a special moral significance as a means through which individuals can access other rights and opportunities. Therefore, healthcare bears the important responsibility of equitably preventing and responding to the consequences of illness. Due to the impact of health on basic functioning and the opportunities available to a person, healthcare is a social institution of unique moral importance entitled to equitable distribution.

Healthcare in Correctional Facilities

Given the moral significance of health and healthcare provision for the general population, the structure of healthcare systems and the equity of health outcomes in the prison system should be critically evaluated. Incarcerated individuals have disproportionately high rates of illness relative to the general population. A special report from the Bureau of Justice Statistics (BJS) indicated that 40% of prisoners and jail inmates have a chronic health condition. Moreover, about half of the prison and jail population have had a chronic health condition at some point. However, only 66% of prisoners and 40% of jail inmates with a chronic health

condition are taking prescription medication, indicative of poor medical treatment. Moreover, for every specific condition and infectious disease considered in the report, incarcerated individuals reported higher rates than the general population controlling for age (Maruschak et al.). This inequality of health outcomes gives rise to concern.[1] Since health serves as an avenue for equality of opportunity, the disproportionately high rates of illness among incarcerated individuals need to be addressed.

Prevalence of Mental Illness in Correctional Facilities

Though increased recognition of the high rates of chronic illnesses and infectious diseases within the prison system have led to improved rates of treatment and screening, the inequalities of mental healthcare treatment and outcomes are still poorly addressed. Indeed, mental illness is now two to four times higher among incarcerated individuals compared to the general population (Faiver 210-211). Consideration of the historical prevalence of mental illness in prisons as well as the increasing rates of mental illness highlight the importance of improving mental healthcare in correctional facilities.

Rise of Mental Illness in Prisons. There are far more individuals with mental illness in correctional facilities than in community mental health facilities. This distribution is due in large part to the deinstitutionalization of psychiatric treatment facilities in the mid-1940s following complaints of maltreatment, poor healthcare, and cost ineffectiveness. As state mental hospitals became increasingly rare, prisons became the principal institution for housing the mentally ill (Faiver 206-208, 215). Housing the mentally ill in prisons is especially prevalent for

[1] It is also worth noting here that there is a selection bias among individuals who are incarcerated. Demographic factors such as race and socioeconomic status are correlated both with high rates of incarceration and poor health outcomes. In order to fully address health inequity, these correlations will have to be addressed as well. However, this essay focuses primarily on the healthcare offered within prisons rather than the external factors that lead to a discrepancy of care.

impoverished individuals. Faiver writes, “The jail is now the poor person's mental health facility. Although the mental health system can say 'no' to a patient, the criminal justice system cannot” (Faiver 210). This declining availability of state mental health care has been compounded by increasing criminalization of mental illness. The Hinkley Effect in the 1980s led to an uptick in incarceration of mentally ill patients as states began to pass laws that made the criteria of “guilty but mentally ill” harder to achieve. Such laws were driven by the desire to protect society rather than to treat mental illness following John Hinkley’s attempted assassination of Ronald Reagan in 1981 (Faiver 209). Such trends led to a dramatic uptick of admissions of individuals with mental illness into the carceral system.

Rates of Mental Illness in Prisons. In its special report on mental illness in prisons and jails, the BJS provides an immense amount of data on the prevalence of serious psychological distress (SPD) and history of mental illness among prison populations. Researchers found that one in seven prisoners met the criteria for SPD and approximately 37% had a prior history of mental illness. Moreover, the percentage of prisoners who met the criteria for SPD was over three times higher than the percentage of the standardized US population with no criminal history. Only a third of prisoners with an indicator for mental illness were receiving mental health services at the time of the report (Bronson and Berzofsky). Another study indicates that though an estimated 45% of incarcerated individuals suffer from mental health and behavioral problems, two-thirds of individuals had not received any mental health or behavioral treatment while incarcerated. Of the group that had received treatment, less than half indicated that the treatment was helpful, with some prisoners describing the counselors as seemingly inexperienced or difficult to trust (Ring and Gill).

Mental Health Treatment in Correctional Facilities

The high rates of mental illness in prisons and jails necessitate the development of a robust treatment system. Assessment of existing mental healthcare in correctional facilities includes consideration not only of tangible medical resources such as medication and counseling services, but also of the prison environment, which is often isolating and fear-inducing and can foster poor mental health.

Treatment Resources and Accessibility. Survey data from 18,185 prisoners indicated that there is poor availability of mental health treatment in U.S. state and federal prisons. The study found that that less than half of prisoners who were taking medication for mental illness prior to entry have continued their pharmacotherapy. Higher rates of intake screening for mental illness are associated with higher rates of seeing a healthcare professional while in prison and thus higher rates of medication continuity. As such, the lack of treatment continuity is more likely to occur if mental health screenings upon prison entry are not enforced. In addition to poor pharmacotherapy continuity, the study states that counseling services are not heavily utilized in correctional facilities. Moreover, the high cost and the lack of medical personnel may contribute to lack of adequate mental illness treatment (Reingle Gonzalez and Connell).

In addition to insufficient resources, the health records kept by correctional facilities are often inadequate. Though the records contain notes about mental status, medication, and current symptoms, they rarely include prior treatment and history. The records also rarely consider life circumstances and stressors that may affect mental illness (Faiver). Without a full understanding of the factors affecting mental health, meeting the specific needs of patients becomes challenging. These results indicate that the existing structures for providing mental health resources are not adequately meeting the needs of incarcerated individuals.

Environment in the Prison. The second most powerful factor influencing mental illness, followed only by the impact of medication, is the environment. Mental illness treatment facilities are ideally characterized by nurturing and supportive environments. Correctional facilities, however, are not designed to meet such expectations. In his book, Faiver argues that jails and prisons enforce harsh rules in order to compel individuals who have broken the law to better comply with regulations. However, such a structure hinges on the assumption that people can understand rules and punishes people who violate expectations. Individuals suffering from mental illness may have a different level of understanding and are thus disproportionately punished by this environment (Faiver).

The environment itself also contributes stressors that may exacerbate mental health problems. Confinement, trials, separation from loved ones, fear of inter-prisoner violence, sanctions, and sentencing may add stress to incarcerated individuals throughout their imprisonment. Moreover, the structure of the correctional facility may also lead to fear and uncertainty, lack of control over one's life, anxiety, and feelings of general mistrust (Ibid.). The counterproductive environment of the prison may validate claims of attempting to shift mental healthcare back out of the prison system and into treatment centers. Such a technique has been suggested by the Bland Act in Texas, which asks county jails to make a good faith effort to send people with potential mental health issues to healthcare institutions when arrested (Coll). Other suggestions have included creating a special housing unit within the prison to counteract the negative environmental aspects, as well as to establish long-term care plans that include safe housing when individuals are released (Faiver).

Though initiatives to push mental health treatment out of the prisons and into healthcare institutions may be preferable for the treatment of the majority of individuals suffering from

mental illness, the justice system will inevitably still house some individuals with mental illness. As such, the structure of mental healthcare provision within correctional facilities deserves attention, critique, and revision.

Legal Precedent for Correctional Healthcare Provision

Evaluation of healthcare provided in correctional facilities must also consider the legal mandates that guide the implementation of healthcare services. These legal implications establish a bare minimum threshold of care that is expected across the U.S. prison system.

Estelle v. Gamble (1976) and the Eighth Amendment. The landmark case of *Estelle v. Gamble* investigated the poor healthcare received by Gamble, an inmate in the Texas prison system who was injured during his work assignment. The U.S. Supreme Court determined that Gamble's treatment was unconstitutional under the cruel and unusual punishment clause of the Eighth Amendment. The standard of care required by this judgment only guaranteed the "absence of deliberate indifference" to a prisoner's injury or illness, but it led to a series of cases that eventually entitled prisoners to "adequate care at a level reasonably commensurate with modern medical science" (Coll). Now, prisoners are entitled to "the right to access to care, the right to the care that is ordered, and the right to a professional medical judgment" according to the guidelines published by the U.S. Department of Justice (Anno 70). This entitlement makes incarcerated individuals the only population in the U.S. with a constitutional right to healthcare.

Mental Healthcare. A year after the *Estelle* ruling, the courts extended the right to healthcare in prisons to include psychiatric treatment in *Newman v. Alabama* (Teasdale et al.). Moreover, a decade later, *Langley v. Coughlin* ruled that medication for mental illness should not be implemented alone, but rather as part of a treatment plan that includes interventional methods such as therapy (Ibid). The extent to which correctional facilities abide by the *Langley* decision

varies, as interventional methods appear to be more sparsely practiced. The varied adherence to established standards may be due to inadequate or inconsistent reporting and measuring tools to hold correctional facilities accountable.

Cost of Healthcare in Correctional Facilities

Though incarcerated individuals have a right to healthcare as established by *Estelle v. Gamble* and subsequent court decisions, many have to pay high medical copays relative to their wages in order to receive care. In fact, according to a 2017 article from the Prison Policy Initiative, inmates earn between 14 and 63 cents per hour on average, with seven states paying inmates nothing for their work. Yet states charge between two and five dollars in medical copayment fees on average. In fourteen states, the price of copays is equivalent to charging nonincarcerated minimum wage workers over $200 (Sawyer). As specified by the Federal Bureau of Prisons, copays come out of inmates' commissary accounts, which are furnished by inmate income and family contribution. When unable to pay, a debt is created that will follow inmates after release. Moreover, the Medicaid Inmate Exclusion Policy as defined by Social Security Act (Sec. 1905(a)(A)) denies inmates Medicaid coverage while incarcerated (U.S. Congress). These policies and practices disincentivize inmates from seeking healthcare, despite their relatively high rates of chronic illness and infectious diseases.

A Global Approach to Correctional Medicine – the Principle of Equivalence.

An understanding of existing practices in other countries will allow for a comparison of approaches to correctional medicine. Such comparison can guide recommendations for new practices in the revision of the US correctional medicine system.

Several European nations have adopted the principle of equivalence for correctional healthcare. The equivalence principle suggests that incarcerated individuals should receive the

equivalent amount of healthcare as the general population (Charles and Draper 1). There are two main kinds of equivalence – equivalence of process and equivalence of outcome. Most attempts to achieve equivalence have occurred through the process route, which essentially grants equivalent healthcare resources to the prison population as to the general population. For example, NHS doctors provide care for prisoners and for the general population. However, a process-oriented approach may fail to appropriately identify and correct for existing health inequities (Charles and Draper 2-3). Equivalence of outcomes, on the other hand, focuses more on equality of health outcomes, which may require more resources to be distributed to a needier population. The outcome-oriented approach to equivalence in healthcare distribution is preferable in that it considers the unique challenges to receiving adequate care that are faced by incarcerated individuals. As previously discussed, there are higher rates of infectious disease, chronic illness, and mental illness in prisons relative to the general population that would be more effectively addressed by an outcome-oriented approach (Maruschak et al.). However, an outcomes-based approach is often difficult to implement due to the increased administrative burden of evaluating individual conditions as well as justifying the increase of resource allocation to a stigmatized population (Charles and Draper 3).

Over the past twenty years, various countries have begun to formally implement the principle of equivalence. England and Wales disbanded their Prison Medical Service in 2002, and now instead operate both prison health and national health through the National Health Service (Charles and Draper 2). Other European countries such as Hungary and Italy have split responsibility between the prison administration and the national health administration. Most nations, however, still delegate prison healthcare to the prison administration (Ibid). A unified system would be harder to establish in America due to the lack of national healthcare coverage.

Unlike many other nations, the US does not have an established right to healthcare, making the prison population unique in the right they have been granted under the eighth amendment. Therefore, establishment of equivalence is less clearly defined.

Ethical Approaches to Healthcare Distribution

In order to evaluate the existing structure of correctional healthcare provision as well as to provide guidance for potential changes to these systems, this essay will engage in an ethical analysis. A multitude of ethical approaches have been proposed to analyze allocation of healthcare resources. Two key approaches are outlined below. These approaches are based in social justice, human dignity, and equality. Though they are not comprehensive, they serve as the primary lens through which this essay analyzes the ethical dimension of correctional medicine.

The Rawlsian Approach. A liberal egalitarian theory of distributive justice that has been widely discussed in modern philosophy comes from John Rawls. In his theory, Rawls argues in favor of two principles of justice. The first states that everyone is entitled to essential basic rights and liberties, and the second states that inequality is permissible insofar as it is to the greatest benefit of the least advantaged group and is attached to positions accessible to all (Ikkos et al. 204). Rawls does not apply his ethical framework to healthcare allocation, saying that health is a natural primary good due to lottery of birth, and thus not needed to be redistributed by social institutions. However, social factors indeed do affect health, as Rawls later acknowledges, and healthcare is a social good entitled to distribution (Ekmekci and Arda 3). As such, Rawls would advocate in favor of a fair healthcare system rather than equal health outcomes, provided that the healthcare system is characterized by processes that restrict inequalities that do not benefit everyone.

Norman Daniels extends this framework to apply it to healthcare allocation. Daniels suggests that health, or lack thereof, can affect someone's ability to function and thus can impact their life opportunities (Daniels). Under Rawls's framework, society has an obligation to protect the opportunities of all individuals, especially those in disadvantaged circumstances such as individuals with poor health, individuals living in poverty, or incarcerated individuals. As such, society is obligated to provide individuals with healthcare. Daniels specifically highlights the importance of addressing social determinants of health under this ethical framework (Ibid.). This framework supports both positive and negative components of healthcare. Society is obligated to provide services that enable full functioning required for freedom of opportunity, a positive component, as well as to protect individuals from poor health outcomes that restrict freedom of opportunity, a negative component (Ikkos et al. 205).

A boundary of the Rawlsian approach is the assumption that the parties in the original position who determine the principles of justice have sufficient levels of health and intellectual capacity to create and satisfy their life perception of the "good" (Ekmekci and Arda 7). Rawls himself acknowledges the idealization of the parameters, understanding that human beings will never be able to actually operate according to the original position that he proposes. Rawls idealized away illness because he instead focused upon addressing poverty and socioeconomic inequality rather than focusing on concepts such as illness, crime, war, and other evils. That said, Rawls's line of thinking does not directly provide the resources to address health and crime but can be used as a springboard to think about distributive justice and equality in these spheres.

The Capabilities Approach. Another important ethical framework originates with Amartya Sen and Martha Nussbaum's concept of capabilities. Nussbaum proposes ten essential capabilities for individuals' well-being: normal life span, bodily health, bodily integrity, senses,

imagination and thought, emotions, practical reason, affiliation, other species, play, and control over one's environment (Nussbaum). Indeed, the choice of a restrictive ten can seem arbitrary. Moreover, the importance of different capabilities may vary with age, culture, and individual (Anand 300). Nevertheless, lists of capabilities have been constructed by multiple scholars, many of which contain similarities to Nussbaum's selection (Ibid.). As such, striving to guarantee access for these essential capabilities provides a compelling ethical framework for resource allocation, as they emphasize an individual's opportunity, autonomy, and freedom rather than dictating an individual's actions in pursuit of a good life.

Nussbaum's capabilities have direct ties to healthcare allocation. For example, normal life span, bodily health, and bodily integrity all directly apply to one's physical health, while senses, imagination and thought, emotions, and practical reason apply to an individual's mental health. Moreover, in the same line of thinking as Daniels, good health indirectly supports the other capabilities, especially affiliation, play, and control over one's environment. As such, healthcare allocation should be designed to support not only the physical health of a person, but the comprehensive ability to function in mind, body, and interactions with others. Such an approach also carries both positive and negative duties for society in order to promote well-being of its individuals (Anand). This approach leads to the prioritization not only of direct treatment, but also of long-term care and prevention efforts necessary to ensure the actualization of these capabilities later in life.

III. Methodology

This essay utilizes Rawlsian and capabilities-based frameworks as a guidepost to assess the ethical acceptability of correctional mental healthcare. Such analysis establishes societal

obligations for healthcare provision in prisons and jails and shapes recommendations for the revision of existing systems.

A systematic literature review serves as the primary method of this analysis. The review focuses around three key components. First, it establishes the existing state of mental healthcare in correctional facilities from a medical, legal, and economic perspective. The medical perspective details inequalities in health outcomes as well as treatment and preventative measures. The legal perspective analyzes existing precedents for providing healthcare in prisons through investigation of court decisions, constitutional precedents, and existing policies. The economic perspective discusses the cost burden that falls upon incarcerated individuals due to differential coverage policies. Secondly, the review evaluates the principle of equivalence as a potential alternative to the existing American system. Thirdly, the review explains the Rawlsian and capabilities-based frameworks that will be used to guide the analysis.

Ultimately, this essay addresses the components of the literature review through the lens of our two key justice-based approaches in order to analyze the existing state of mental healthcare and to analyze the potential effectiveness of alternative healthcare allocation schemes. Such methodology enables an interdisciplinary examination of healthcare allocation in correctional facilities. This interdisciplinary discussion, though not entirely comprehensive, begins a crucial evaluation of the multi-faceted impacts of healthcare allocation.

IV. Analysis

After considering the systematic literature review and establishing key justice-based frameworks for analysis, this section applies the logic of Rawls and Nussbaum to the existing state of mental healthcare in the carceral system and derives the equivalence principle from each

perspective. Neither Rawls nor Nussbaum directly address correctional healthcare in their frameworks of distributive justice; however, both theories offer insights that can guide ethical considerations for correctional healthcare. Therefore, this analysis takes a three-part approach: (1) Applying Rawls, (2) Applying Nussbaum, and (3) Applications of the Equivalence Principle.

Part I – Applying Rawls

IA – Rawlsian Approach to Existing Mental Healthcare Outcomes and Treatment Resources in Correctional Facilities

Since Rawls is operating in ideal theory, he removes from consideration nonideal circumstances such as poor health and crime in his construction of the original position. This intentional omission enables him to speculate upon the principles guiding a perfectly just society. That said, he does not address criminal wrongdoing at all. However, as his difference principle states, Rawls stresses that any inequality should benefit the individuals from the least advantaged group.[2] Thus we should critically evaluate the inequality in the correctional healthcare system from a Rawlsian perspective.

First, consider the inequality of mental healthcare between the general population and incarcerated individuals. The percentage of prisoners who meet the criteria for serious psychological distress is over three times higher than the percentage of the standardized US population with no criminal history (Bronson and Berzofsky).[3] Moreover, studies have shown

[2] Rawls gives an example of this principle as an entrepreneurial business owner and unskilled laborers who work under him, saying that this inequality is only justifiable if the lack of inequality would make these laborers worse off (Rawls 67-68). For example, suppose this relationship enables the business owner to create household appliances that improve the lives of the laborers, and without the relationship, the laborers would not have access to such appliances. Thus, this inequality is justifiable.

[3] These data come from the Department of Justice's 2011-12 special report on mental health in prisons and jails. However, it is worth noting that mental illness has risen greatly in the last ten years. In 2012-2014 data from the National Surveys on Drug Use and Health, an estimated 42.5 million adults experienced any mental illness (SAMHSA 2014). This number increased to 51.5 million individuals in according to 2019 NSDUH data – over a

that a 50-year-old incarcerated individual has an equivalent disease burden of a 60-year-old in the general population (Jotterand and Wangmo). Not only are health outcomes unequal, but the treatment itself is inequal. Only a third of individuals showing indications of mental illness were receiving treatment at the time of the last BJS report on mental health (Bronson and Berzofsky). Moreover, less than half of prisoners who were taking medication prior to entry have continued their pharmacotherapy (Reingle Gonzalez and Connell). As such, the majority of incarcerated individuals are not receiving adequate mental health treatment, despite a high need relative to the general population.

According to a Rawlsian ethical framework, inequality itself is not inherently unjust. Inequality is permissible as long as the least advantaged group is also served by this inequality, such that individuals would be worse off if the inequality were eradicated. Incarcerated individuals are deemed the least advantaged group in our consideration of mental healthcare provision – they lack the basic right of freedom, they have poor health outcomes, and they have worse life prospects even to the point of a shortened lifespan. Therefore, we must ask the question under the Rawlsian framework: is society benefiting this population with the way correctional mental healthcare is structured?

No, incarcerated individuals are not served by this inequality. Rather, they experience shorter life spans and worse health outcomes than the general population. The better health of the general population does not positively impact incarcerated individuals, who are spatially isolated from broader society. This inequity not only fails to benefit incarcerated individuals but also enables the propagation of harm to their physical and mental well-being. It is difficult to imagine that the rational parties behind the veil of ignorance would permit this level of inequitable mental

20% increase (SAMHA 2020). As such, it is likely that the rates of mental illness among incarcerated individuals have experienced similar increases.

health outcomes or the poor mental health treatment services that have permeated our justice system. As such, the Rawlsian framework supports principles that prevent the development of our correctional healthcare system as it currently stands.

IB – Rawlsian Analysis of the Equivalence Principle: a Process-Oriented Approach

Having proposed that the current state of correctional healthcare is inadequate under a Rawlsian framework, we next consider what other form of correctional healthcare the parties in the original position would support. This section considers the Rawlsian analysis of the equivalence principle, a proposed approach to mitigate the inequities of the prison system that has been particularly utilized in the United Kingdom, Switzerland, France, Norway, and a few other European countries (Jotterand and Wangmo; Charles and Draper). As previously discussed, this principle specifies that incarcerated individuals should be entitled to the same level of care as the general population (Ibid.).

Effectively implementing a system that grants incarcerated individuals the same level of care as the general population addresses the concerns regarding inequality of treatment access that originate from a Rawlsian perspective. Rawls's original position allows for unequal outcomes provided that the inequality is attached to positions accessible to all individuals. As such, Rawlsian theory supports procedural justice, requiring that society offers a just allocation of resources rather than ensuring that these resources are equally distributed.[4] An equivalence of process supports this procedural justice, entitling incarcerated and non-incarcerated individuals alike to the same level of healthcare. Since the Rawlsian position endorses just allocation rather

[4] As an example, consider a monk who chooses to fast. This monk could still be offered the same access to food as another individual. As such, this is a just allocation of resources and acceptable under a Rawlsian framework, even though this monk experiences hunger more than another individual who chooses to accept available food.

than equal outcomes, Rawls would support the process-oriented principle of equivalence as a response to societal obligations for mental healthcare provision in correctional facilities.

Part II: Applying Nussbaum

IA – Capabilities-Based Approach to the Existing Mental Healthcare Outcomes and Treatment Resources in Correctional Facilities

Nussbaum's theory focuses on a list of ten capabilities that society should ensure are accessible to all individuals. She does not specifically address correctional healthcare or the criminal justice system in her work; however, as discussed, some capabilities are directly applicable to health, while others are indirectly made accessible through good health. Nussbaum advocates that these capabilities should be accessible to everyone, which would include incarcerated individuals. Therefore, the extent of societal obligations to provide healthcare for incarcerated individuals should also be considered under Nussbaum's framework.

First, consider the impact of imprisonment upon Nussbaum's first capability: normal life span. For every year that an individual spends behind bars, that individual's life expectancy is shortened by two years (Patterson). This shortening directly infringes upon the right to a normal life span. The capability of bodily health is also violated in correctional health outcomes. As discussed, a 50-year-old incarcerated individual has an equivalent disease burden of a 60-year-old in the general population (Jotterand and Wangmo). Moreover, the literature discusses poor access to treatment services due to cost barriers and expensive copays (Sawyer). Even when mental health treatment services are offered, they can be suboptimal, with less than half of prisoners in one study finding counseling services helpful, even to the extent of describing the counselors as seemingly inexperienced or difficult to trust (Ring and Gill). When evaluating this

barrier through Nussbaum's capabilities approach, the suboptimal healthcare implies that incarcerated individuals are not offered the essential capabilities of normal life span, bodily health, and bodily integrity. Furthermore, failing to adequately treat mental illness restricts an individual's full access to the capabilities of senses, imagination and thought, emotions, and practical reason. Such restrictions upon capabilities in the current correctional healthcare system are not permissible under a capabilities-based approach. Society is therefore obligated to provide increased access to these capabilities to incarcerated individuals.

However, there is an objection to this application of Nussbaum's capabilities. Some might point out that it is deemed acceptable to take away certain capabilities as a consequence of violating the law, thus limiting the capabilities of the incarcerated in order to protect the capabilities of others. There are certainly consequences to violating the law, and restriction of freedom as well as reduction of the capability of control over one's environment are implied in imprisonment through the criminal justice system. Whether or not this restriction is permissible is beyond the scope of this essay. However, as a counterargument, Nussbaum might suggest that the loss of one or two capabilities does not justify the removal of other capabilities. After all, the loss of control over one's environment is the only capability explicitly considered when sentencing an individual to imprisonment. As such, other capabilities including normal life span, bodily health, bodily integrity, senses, imagination and thought, emotions should be either protected or considered during sentencing. These capabilities are not currently considered in sentencing and are thus entitled to protection.

The current state of correctional healthcare infringes upon these "protectable" capabilities. Indeed, the existing reduction of essential capabilities through shortened life span, high rates of illness, and insufficient healthcare go beyond the permissible treatment of

incarcerated individuals. As such, a capabilities-based framework does not support the current state of mental healthcare treatment in correctional facilities.

IB – Capabilities-Based Analysis of the Equivalence Principle: an Outcomes-Oriented Approach

Having established that the existing state of correctional healthcare does not give incarcerated individuals access to Nussbaum's central capabilities, now consider whether implementing the principle of equivalence might satisfy the demands of the capabilities-based framework. Unlike Rawls, Nussbaum's capabilities approach involves a threshold that needs to be reached. An equivalence of process might guarantee incarcerated individuals procedural justice, but this procedural equality does not guarantee that incarcerated individuals will have enough healthcare resources to reach the sufficient threshold of central capabilities. As such, Nussbaum's framework would focus more upon health outcomes.

The general population has better health outcomes, thus leading to a higher likelihood of reaching the threshold of central capabilities proposed by Nussbaum. For example, a healthy, middle-class individual is more likely to live a long life while engaging in capabilities such as play or affiliation. An incarcerated individual, on the other hand, is more likely to have a shortened life span or to experience serious psychological distress that diminishes the accessibility of capabilities such as imagination and thought. As such, Nussbaum would be less likely than Rawls to support a process-oriented principle of equivalence, which may not equalize this access to capabilities. Rather, Nussbaum would support an equivalence of outcomes, which would provide additional healthcare resources to incarcerated individuals in order to achieve health equity and subsequently equal access to capabilities. Through equivalence of outcomes,

incarcerated individuals would have greater access to the central capabilities, enabling them to achieve capabilities at an equivalent level to the general population.

Thus far, the principle of equivalence has been implemented in European countries as an equivalence of process (Jotterand and Wangmo). However, when looking at healthcare outcomes using this equivalence of process, we do not see improvement relative to the American system. For example, in the UK, nearly two thirds of incarcerated individuals suffer from a personality disorder (Burki). Perhaps these high rates are due to a lack of focus upon equivalence of outcomes. Through the equivalence of process, the healthcare system may be unable to meet the heightened level of care needed in the carceral system. As such, there is still much work to be done in order to better achieve the equivalence of outcomes necessary for satisfying the capabilities-based demands of Nussbaum.

The equivalence approach is not a utopian answer to the mental healthcare crisis in the American prison system. Indeed, there are still inequities and problematic treatments in the countries in which equivalence is already practiced (Burki). However, the implementation of equivalence in these countries thus far has been an equivalence of process (Jotterand and Wangmo). As such, pursuing equivalence of outcomes may be a potential alternative that begins to address, albeit imperfectly, a few of the ethical critiques of our existing systems in line with Nussbaum's capabilities approach.

Part III – Applications of the Equivalence Principle

After evaluating the correctional healthcare system through Rawlsian theory and Nussbaum's capabilities approach, we conclude that the existing health inequities and approaches to treatment are insufficient to satisfy the demands of these ethical frameworks. As

such, there is a necessity for the re-evaluation of current systems. Rawls supports the use of a process-based equivalence principle, while Nussbaum supports an outcomes-based equivalence principle. An equivalence of process approach aims to provide the same level of services to individuals both inside and outside of prisons, while an equivalence of outcomes approach would adjust the amount of healthcare provided to the prison population in response to the unique challenges in receiving and accessing care faced by prisoners. While the nuances and minute contradictions between these two different methods will need to be addressed when deciding upon the structure of a revised correctional healthcare system, the underlying ideas behind the general principle of equivalence provide guidance for applications in the field of correctional healthcare.

1. *Services Provided: Treatment and Preventative.* United States policy granted incarcerated individuals the right to healthcare in *Estelle v. Gamble* and then extended the ruling the following year in *Newman v. Alabama* to include psychiatric treatment. A decade later, *Langley v. Coughlin* ruled that medication should not be implemented alone, but rather as part of a treatment plan that includes interventional methods such as therapy (Teasdale et al.). As such, existing policy covers for treatment rather than preventative measures. However, even with this policy, a BJS report indicated that only thirty percent of correctional facilities offer psychiatric assessment and only thirty five percent offer therapy (Ibid). Though it is fairly established that incarcerated individuals should have a right to healthcare treatment, better enforcement of treatment access should be employed, as is more expected among the general population.

In general, medical coverage decisions are based on medical necessity, which grants the practitioner the clinical judgment to evaluate whether the medical treatment is deemed necessary ("CorrectCare"). Though necessity for treatment is fairly straightforward, preventative efforts

remain more subjective. Moreover, prison doctors may hold a dual obligation to patient and prison administration, whereas doctors for the general public are primarily obliged to the patient. As such, prison doctors may have outside influences that impact whether a treatment is deemed medically necessary (Pont et al.). In the nature of the principle of equivalence, reducing this dual loyalty by creating a clear separation between administrative and healthcare tasks would create a more equitable healthcare delivery system.

Though the medical necessity of treatment is well-established, if not well-implemented, preventative efforts are less mainstream. Studies have shown that interventions such as group yoga and individual cognitive behavioral therapy increase rates of well-being within prisons. The CBT treatment group exhibited decreased rates of recidivism (Teasdale et al.). Preventative care that focuses on well-being support the capabilities of senses, imagination and thought, and emotions. In addition, better mental health in prison decreases recidivism (Wallace and Wang). Due to the impact of the harsh prison environment upon mental health, such preventative efforts may be able to counteract the stressors in a way that promotes overall well-being and prevents re-offense. Such an approach aligns with equivalence of outcomes rather than equivalence of process because the general population is not always covered for preventative mental health efforts. However, as mental healthcare becomes more integrated into insurance and health plans, such techniques may align with the equivalence of process in certain locations as well.

2. *Healthcare Coverage.* America is one of the only developed nations that does not provide its citizens with a right to healthcare. As such, insurance is crucial in order to pay for care. However, the Medicaid Inmate Exclusion Policy as defined by Social Security Act (Sec. 1905(a)(A)) denies inmates Medicaid coverage while incarcerated (Sawyer). Moreover, the debt accumulated on copayment fees can follow incarcerated individuals upon release,

disproportionately affecting individuals in poverty. This policy fails to uphold the principle of equivalence by denying incarcerated individuals the access to healthcare coverage that non-incarcerated individuals are able to access. Such restriction is not justified. As previously articulated, incarceration restricts certain freedoms such as free motion and the capability for certain choices. However, healthcare has long-term impacts that follow incarcerated individuals even after they have finished serving the consequences of their felony. Restricting the access to healthcare for incarcerated individuals is thus ethically impermissible according to Rawlsian and capabilities-based frameworks. Moreover, to restrict access to healthcare for incarcerated individuals through policy to a further extent than the general population violates the principle of equivalence. In order to better abide by a principle of equivalence as well as Rawlsian and capabilities-based ethics, this policy should be revisited and removed from the Social Security Act. Eligible incarcerated individuals should be able to access at least the same healthcare coverage as the general population.

V. Conclusion

Through applying Rawlsian and capabilities-based ethical arguments to the systematic literature review, this essay recognizes that the existing resources that we have for mental healthcare treatment and prevention in prisons are inadequate to meet the needs of a population with disproportionately high rates of mental illness. Moreover, the inequalities in health outcomes of incarcerated individuals relative to the general population is unacceptable by the ethical frameworks established by Rawls and Nussbaum. As such, the existing correctional healthcare system needs restructuring. Through an analysis of the equivalence principle as practiced in many European nations, an equivalence of process aligns with a Rawlsian

framework, while an equivalence of outcomes aligns with a capabilities-based approach. Both process and outcomes-based principles of equivalence have their limitations: the equivalence of process as implemented in the UK results in the same poor health outcomes among incarcerated individuals that currently persist in the UK. On the other hand, an equivalence of outcomes is limited by the potential public backlash and the administrative difficulties for its implementation.

Future research in this field would be well-served by evaluating small-scale programs that attempt to establish an equivalence of outcomes and to evaluate the scalability of such programs to the national correctional health system. Such research is crucial as we consider how to restructure our justice system. As a society, we are obligated to provide resources to address the health needs of all of our members, especially incarcerated individuals, in order to ensure access to equal opportunity. We are currently failing to adequately provide such care. Incarcerated individuals are humans. They are not statistics or stereotypes or second-class. Establishing a correctional healthcare system built upon equivalence can better provide the care to meet the needs of this population.

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