

Health-Focused Arguments for Eliminating Overcrowding in Prisons, Jails, and Other Detention Facilities

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 **See also Adler and Chen, p. 936.**

Living incarcerated in a prison, jail, or detention facility is certainly not intended to be easy, but living in such facilities when they are overcrowded is truly horrific. In this issue of *AJPH*, Adler and Chen (p. 936) report on their analysis of the relationship between the extent of prison overcrowding—prisons with incarcerated populations larger than the designed occupancy—and five health care and health outcomes. They do so by using prison-month level data for 30 California state prisons primarily from 2013 to 2019, generally a period of reduced overcrowding.

The negative health implications of overcrowding are applicable far beyond California's prisons, and hence the potential for decarceration to prevent and mitigate these harms also has broader scope for the more than two million people incarcerated or detained in the United States and the 11 million incarcerated or detained globally.¹ Although there are numerous health-related and non-health-related arguments for eliminating carceral overcrowding, here I focus on those connected to individual and public health.

Crowding in carceral settings is linked to worsened health outcomes via multiple causal mechanisms. These mechanisms include (1) more likely and more rapid spread of infectious diseases for which transmission is density dependent²; (2) increased individual stress from crowded conditions, leading to the onset of or worsening of a variety of chronic physical and mental health conditions^{3,4}; (3) increased demand for limited health care appointments, reducing access and leading to delays in diagnosis and treatment as well as potentially shorter or lower quality health care visits; and (4) increases in interpersonal conflict, anger, aggression, and violence, leading to increased risks of nonfatal and fatal outcomes.

In their study, Adler and Chen primarily focused on health care access and quality and mortality during incarceration. In the case of health care access and quality, they found that increases in overcrowding generally reduce health care access and that even when access improves at lower levels of overcrowding, healthcare grievances (forms filed by incarcerated people not in agreement

with the health care treatment they are receiving) are not significantly diminished. With respect to mortality, they did not find a significant relationship between reductions in overcrowding and reductions in mortality, but their study was not necessarily powered to do so. They did not examine nonfatal health outcomes such as disease incidence or cause-specific mortality for causes more plausibly linked to crowding, nor did they analyze the relationship between overcrowding and infectious disease incidence or mortality during the COVID-19 pandemic period.

From a public health perspective, reducing carceral overcrowding is most important in terms of preventing, mitigating, and controlling infectious disease outbreaks. Although the Adler and Chen study reasonably excluded the COVID-19 pandemic period, numerous studies have documented the greatly increased risk to the health of incarcerated people during this period.⁵ In fact, this was the rationale for California decarcerating thousands of people from the state prison system during first six months of the pandemic.⁶ Notably, such dynamics are by no means particular to COVID-19.² Tuberculosis incidence in both incarcerated populations and the community at large has become much higher with rising prison population sizes and resultant overcrowding.^{7,8} Within prisons, jails, and other detention facilities, the size of seasonal spikes in respiratory viruses and the impact of emerging infectious diseases depend on the extent of overcrowding and are amenable to decarceration.

The health effects of overcrowding likely depend on both the intensity of overcrowding, the focus of Adler and Chen's study, and the duration of exposure to overcrowding. For example,

risks may be moderately elevated for someone incarcerated for a day in an overcrowded jail, but the extent of risks and harms may be much greater if that same person is incarcerated for several years in a facility at the same level of overcrowding. Such differential effects could arise because it is unlikely that one day of exposure to overcrowded conditions meaningfully alters an individual's ability to access timely and appropriate medical care, whereas residing in a chronically overcrowded situation likely implies backlogs and consequent delays in receipt of care. Long durations of incarceration in overcrowded conditions can also greatly compound the risk of acquiring a transmissible infection.

Furthermore, the chronic stress of being confined in overcrowded conditions for a long period of time may itself be sufficient to harm health or worsen an array of preexisting conditions.^{4,5} Thus, when carceral systems formulate and implement decarceration plans, attention should be given to both dimensions of overcrowding.

The size of health benefits achieved through decarceration depends on how decarceration is operationalized. Decarcerating frail or vulnerable people from overcrowded institutions (e.g., older people, those with existing health conditions, young children held in immigration facilities) may result in greater absolute reductions in risk.⁹ Unfortunately, older people incarcerated in prisons often are still there because of long sentences for convictions related to more serious criminal offenses. Thus, despite evidence suggesting that recidivism among frail, vulnerable, and elderly people is extremely low, it may be more challenging for systems to release them; moving them to lower density settings may be more feasible. Furthermore, the extent to which overcrowding harms

health through increased stress leading to violence or mental health issues elevates the priority of decarcerating additional at-risk groups.

Across the incarcerated population, many people who receive health care for a variety of chronic conditions lack insurance or connections to clinics and providers outside.^{10,11} Thus, for those who are decarcerated, redirecting a portion of the expenditures that would have been used to incarcerate them toward transition programs that ensure there are no gaps in care is essential given the evidence that release in the presence of such gaps can carry substantial health risks.^{10,11} Better and more timely health care, mental health services, and infection control measures during incarceration, along with linkages to appropriate care upon release, can also address public health concerns about how released individuals might transmit infections acquired while they were incarcerated.^{2,7}

The harmful effects of overcrowding and the health benefits of decarceration are generalizable far beyond the prisons of California. They apply to prisons and jails in other states and countries. But they also apply to populations that are increasingly incarcerated before being charged with or convicted of a crime, including people—adults and children alike—whose immigration status is in question. It may soon be the case that many more such individuals, per shifts in Trump administration policy, will be held for longer periods in Immigration and Customs Enforcement detention facilities with consequent increases in health risks, as was witnessed during the COVID-19 pandemic.¹²

Eliminating overcrowding is not the only measure required to ensure reasonable access to health care and

improve health outcomes among incarcerated people. Yet, regardless of one's view of incarceration, the body of evidence shows that incarcerating people in overcrowded facilities impedes their access to health care, exposes them to increased risks, and harms their health in numerous ways; it is simply cruel and unjustifiable. *AJPH*

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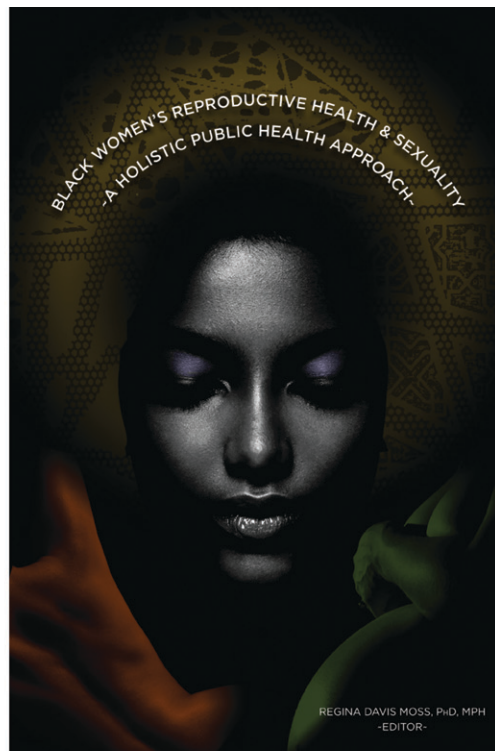
CONFLICTS OF INTEREST

The author notes no conflicts of interest.

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