

Asserting Prisoners' Right to Health: Progressing Beyond Equivalence

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The concept of the “right to health,” regardless of a person’s legal status, is a guiding force in establishing adequate standards of health care for all, including prisoners with mental illness. Prison health care in the United States, however, often falls below acceptable minimum standards. In the United Kingdom, the notion of equivalence has been the main driving force in improving prison mental health care. Although improvements have been made over the past ten years, demand for services continues to outstrip supply, as in the U.S. prison system. In both prison systems, prisoners often present with complex and multiple needs, much greater than those found in community samples. Even mental health care equivalent to that provided in the community falls significantly short of what is required. Further improvements to prison health care, therefore, remain a priority, and a more suitable model needs to be established and implemented. The authors propose an assertive application of a person’s right to health with a well-defined framework for health care that is available, accessible, acceptable, and of good quality (AAAQ). The authors explore how the AAAQ framework can move beyond minimal or equivalent standards to deal with complex prison structures, meet health care needs, and measure progress more effectively. The AAAQ framework could lead to more equitable standards of health care that can be applied to international settings. (*Psychiatric Services* 63:270–275, 2012; doi: 10.1176/appi.ps.201100256)

In the United Kingdom, the policy landscape for mental health care for people in contact with the criminal justice system is rapidly changing. The high proportion of prisoners with mental disorders has long been recognized (1) and has prompted a radical reconsideration of policy. A review of offender health care and other influential government policy documents (2,3) emphasized the need to divert those with

mental health problems away from custody. Despite these recommendations, and despite significant national service developments over the past decade, including the advent of prison mental health “inreach” teams, many prisoners still lack adequate mental health care while in custody. Demand for inreach services has significantly outstripped supply; for example, referrals to inreach services has increased by 57% from 2005 to

2007, with 87% of inreach teams being inadequately staffed to accommodate the high demand (4).

By contrast, the United States has one of the highest incarceration rates in the world, with a national average of 756 people in penal institutions per population of 100,000, more than six times higher than the U.K. average of 152 per population of 100,000, which is itself higher than the European average of 120 per population of 100,000 (5,6).

As in the United Kingdom, the U.S. prison system is significantly overcrowded, although the U.S. situation is more dramatic, with a 500% increase over the past 30 years, compared with a 200% increase in the United Kingdom (7,8). This is attributed largely to a tougher U.S. sentencing policy, leading to more frequent and longer incarceration of nonviolent drug users (9). The excessive increase of the U.S. and U.K. prison populations brings rising health care costs for large numbers of prisoners with significant health problems.

The rates of mental illness within U.S. and U.K. prisons are especially high; more than 70% of the prison populations of England and Wales have two or more psychiatric disorders (10). In the United States, 56% of state and 45% of federal prisoners have either a current or a recent history of mental health problems (11).

The treatment and management of prisoners with mental illness in both countries is concerning, particularly in California, raising both ethical and human rights issues. Some reports have revealed that the lack of prison

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mental health care means that prisoners with mental illness are punished rather than treated and that they are more likely to be housed in harsh conditions (for example, “supermaximum” prisons) and kept in isolation (or segregation) for prolonged periods to manage difficult or disturbed behavior (12–14). Mental health professionals are limited in what they can provide because of the prison regimes, often just administering psychotropic medication and stopping in front of cells to ask how a person is doing (15). The nature of the environment, the regime, the role of punishment, and the effect of segregation all amount to an impoverished and narrow view of what mental health professionals have to offer—a situation compounded by an apparent lack of central guidance regarding minimum standards of mental health care for those incarcerated, with an absence of apparent incentives (for providing agreed minimal standards) or penalties (for inadequate provision) at a corporate provider level.

Needless to say, mental health care in both countries—particularly the United States—needs urgent reform. The U.S. prison system in particular has not kept up with international standards for moving toward improving prison health care. Instead, a great gulf exists between rhetoric and reality: the United States is a signatory of the 2009 Convention on the Rights of Persons With Disabilities and the Universal Declaration of Human Rights in 1948, which does not appear to have affected the provision of mental health care in prison.

In the United Kingdom, one model used to raise the standard of prison health care is underpinned by the concept of equivalence—that prisoners are entitled to the same standard of health care as that provided outside prison—and this has proved useful in highlighting problems with prison health care and the shortfall in health provision and in instigating improvements (16). However, the principle of equivalence is rather blunt, and an exact translation of its meaning between the community and a prison setting has limitations. Additionally, it does not address the excess morbidity in prison, given the com-

plexity of prison structures and rules, serious problems in providing adequate and timely hospital care for those with acute mental illness, and the exclusion of the Mental Health Act (and therefore compulsory treatment) from prison settings (17).

Further improvements to prison health care remain a priority in the United Kingdom but are even more relevant to the U.S. context. A suitable model or framework to achieve these improvements needs to be established and implemented. A strong contender is the application of a person’s right to health using the well-defined AAAQ framework for health care that is available, accessible, acceptable, and of good quality (17). In this article, we explore the potential of the AAAQ framework to set a standard to help prison health care go beyond mere equivalence to a model of care that is appropriate for the complex prison structures, to better enable care to meet prisoners’ needs, and to provide a more effective measure of the progress of prison health care.

Evolution of the right to health

It is worth restating that the right to health represents a fundamental human right (18). Adopted in 1948, the Universal Declaration of Human Rights endorsed the right to the highest attainable standard of health. Article 25 stated that “Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services.” Almost 20 years later, the 1966 International Covenant on Economic, Social and Cultural Rights established the state’s obligations to respect, protect, and fulfill “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (Article 12) but acknowledged that although the state’s obligations were limited by its resources, they could be progressively realized over time. This right included freedom from discrimination and from nonconsensual medical treatment and experimentation, as well as entitlements to a system of health protection on an equal basis for all, including essentials such as

water and sanitation, prevention and treatment of illness, and access to essential medicines, information, and education about health (18,19). However, the right to health is not the same as the right to be healthy.

The Declaration of Alma-Ata (20) was another milestone, identifying primary health care as central to attaining health for all. The declaration acknowledged the economic and social imperative of promoting and protecting the health of the country’s population.

In 2000, the United Nations adopted the General Comment 14, a comment on Article 12 of the International Covenant of Economic, Social and Cultural Rights (21). This statement outlines that, in practice, a right to health refers to the availability, accessibility, acceptability, and quality of health care (22).

The protection and promotion of the right to health at an international level were underpinned by the creation of an independent U.N. Special Rapporteur in 2002 (23). In this important role, Paul Hunt identified three objectives: promote the right to health as a fundamental human right, clarify the content of the right to health, and find practical ways to operationalize the right to health.

The General Comment 14 shaped much of the Special Rapporteur’s work and marked another important milestone in understanding the right to the highest attainable standard of health (24). The Rapporteur’s work included a series of reports to “unpack” the right to health, making it more specific and accessible to interested groups, policy makers, and so forth (25). Part of this work included an analytical framework that comprises ten key elements and is applicable to all aspects of the right to health, including the basic determinants of health (such as access to clean water and sanitation).

In one report, the Special Rapporteur highlighted the high rates of mental illness in prisons, poor prison conditions that exacerbated mental health problems, and limited access to even basic mental health and support services (26). In one example, the Rapporteur noted that women with mental health problems are especially

Key Criteria for Transforming Prison Mental Health Care

1. A clear acceptance that penal institutions are seldom, if ever, able to treat and care for seriously and acutely mentally ill prisoners is needed.
2. The vulnerability of newly admitted prisoners must be understood and assessed.
3. A personal sentence and care plan should be prepared for each prisoner.
4. Promoting mental health and well-being should be central to a prison's health care policy. This criterion is aimed at the prison's environment and procedures, as well as the types of activities offered to prisoners.
5. Prisons should be resourced to take the steps listed above, with effective leadership by the governor or director and adequate resources to provide a sufficient level of staff with proper initial and continuing training.
6. Health care is very important for the general rehabilitation of prisoners, with mental health treatment for those with mental illness and mental health promotion for all prisoners being crucial parts of health care in prison. The level of health care should be based on assessed need and be as equivalent as possible to that available in the community.

vulnerable to violence and also noted the incidence of sexual abuse in custody and the imperative to provide adequate services to meet these needs and ensure women's protection (26).

Subsequent evidence continues to demonstrate that prisoners' health needs are not being met around the world (27). This is largely because prisoners have higher morbidity levels (with HIV, tuberculosis, and mental disorders) than the community from which they originate. Poor prison conditions, such as overcrowding and lack of sanitation and hygiene, raise concerns about the state's ability to provide health services that can fulfill the obligation to deliver the right to health in prisons as a whole (27)—hence, the need to go beyond equivalence. Although the AAAQ framework has been developed to examine the health care system of the state, it has potential value in being linked explicitly with the health care system provided to those held in prisons by the state.

The Trenčín Statement: a plan of action

In 2007, delegates at the International Meeting on Prisons and Health in Trenčín, Slovakia, shone a spotlight on the issue of people in custody with mental health problems. Delegates noted previous statements and instruments adopted by the United Nations and the Council of Europe (described above), together with findings from international research, to draw up a

comprehensive plan in the form of the Trenčín Statement (28). They developed key criteria for success, which are summarized in the box on this page.

These criteria indicate a need for more integration between health and custodial arrangements, for example, to better understand vulnerability and personal sentence and care plans. However, because of their regimes, prisons are challenged to provide individualized health care to the extent found in hospitals.

The principle of equivalence

Improvements in prison health care have been driven for some time by the idea that health care should be, wherever possible, equivalent to that already available in the community. In England, government policy adopted the principle of equivalence during reforms to prison health care over a decade ago (29). Equivalence in prison health care was intended to cover policy, standards, and delivery (30). Prisons were conceptualized as a community that required equivalent standards at a primary care level, including some specialist outpatient services. However, cracks in the equivalence model soon appeared, such as the lack of treatment facilities, lack of a clear legal framework for treating prisoners with severe mental illness, inadequately designed prison health care wings, and considerable delays in hospital transfers (17).

Other critics have questioned the

validity of the equivalence model for improving prison health care. Lines, for example, pointed to the excess of health problems in the prison population, which exceed levels found outside of prison (27). As Lines stated, "Given the scope and urgency of the issues involved, Governments have a legal and ethical obligation to provide a standard of healthcare greater than that available in the community. Equivalence is only a minimum acceptable standard, rather than an ideal one."

Because of the greater need in prison, achieving standards that are only equivalent to those found in the community, as Lines argued, would, in some cases, fall short of human rights obligations and public health needs. Instead of equivalent standards as a key goal, Lines promoted standards that meet equivalence of objectives (27). Achieving this standard implies that the scope and accessibility of prison health care services should be greater than those in the community.

Niveau (31), arguing from a clinical perspective, reached a similar conclusion: "The principle of equivalence is often insufficient to take account of the adaptations necessary for the organisation of care in a correctional setting. The principle of equivalence is cost-effective in general, but has to be overstepped to ensure the humane management of certain special cases."

To some extent, U.K. prison mental health care is now temporally beyond equivalence; its limitations are based on a decade's worth of service provision in custodial environments. Moving well beyond equivalence and finding a robust alternative remains a key priority in addressing and preventing the continued shortfall in prison health care provision. What would a suitable model of prison health care look like? How could it promote better integration between health and custody personnel? How can we measure its progress?

Why the AAAQ framework?

The AAAQ framework provides an important foundation on which to build a more appropriate standard-setting approach and model of prison health care. This framework has the

potential to be applied internationally in the pursuit of the highest attainable standard of health through four essential components:

Availability

Availability pertains to functioning public health facilities, goods, services, and programs in sufficient quantity throughout a state. Here, the duty falls on the state to promote the highest attainable health of the population. When imprisoning people, the state simultaneously increases its responsibility for providing health care because it removes prisoners' ability to access it for themselves. However, this sets up a tension between these responsibilities because sufficient availability of health care services is also dependent on the overall resources of the state.

Accessibility

Accessibility emphasizes access to health services to all and seeks to eliminate health-related discrimination, particularly among the marginalized and vulnerable.

Prisoners with mental health problems represent such a group. Access to health care is difficult for prisoners, partly because of stigma, the lack of trust of people in authority (32), the design of prison services, and the level of resources allocated to health care in prisons. The services need to be available and designed in such a way that prisoners can reach them.

Acceptability

The principle of acceptability emphasizes the need for services to be appropriate for all groups in a diverse society and that specific needs and services may be required to accommodate gender, religion, age, disability, ethnicity, and sexual orientation.

Good quality

The provision of high-quality health care facilities is dependent on the use of medical and scientific research and a highly skilled workforce that is sustained through investment in science and training.

The AAAQ framework holds within it the principle of equivalence but has the advantage of offering a more sophisticated measure for identifying

the limitations in prison health care and the opportunity for more focused change (17).

Better measures of prison health care are needed. One European study on the concepts, models, and routine practices in prison mental health care found a significant lack of data on the prevalence of mental disorders in prisoners (33). This was due to the lack of trained staff to carry out assessment and screening, which increased the risk of undetected mental illness and psychiatric needs. Pathways to care for an acute psychotic episode differed considerably among European Union countries, with referrals to prison hospitals, prison wards, forensic hospitals, or general psychiatric hospitals varying depending on national legal regulations, the availability of services, and other regional circumstances. Many experts involved in the study questioned the equivalence of care and recommended the implementation of basic indicators (34).

The four components of the AAAQ framework also provide a good set of possible indicators which, in the United Kingdom, could complement tests carried out by Her Majesty's Inspectorate of Prisons (35) to determine a prison's health: safety, respect, purposeful activity, and resettlement.

Implementing AAAQ in Prison Health Care

Resource and security constraints are two of the biggest barriers to major improvements in prison health care. However, the international right to health and the AAAQ framework impose some immediate obligations that may be addressed without resource implications (36); for example, the requirement of nondiscrimination, as prisoners with mental health problems often suffer stigma both within and outside of prison. Hunt and Mesquita (36) argued that the recognition of this stigma, an emphasis on care and treatment of mental illness in training material for health professionals, promotion of antistigma and discrimination campaigns, support for service user and caregiver groups, extension of community care services, and so forth are important goals, regardless of resource constraints.

However, this is not universally accepted, because activities such as staff training and antistigma campaigns cannot always be delivered within existing resources.

Many elements of the right to health are dependent on "progressive realization" and resource constraints. Put simply, all states, especially in developed countries, are expected to strive to deliver continuous improvement in standards of living and health to ensure that, for example, public health is better in five years than it is currently. Progressive realization therefore requires indicators and benchmarks to monitor progress (36)—in this case, prison mental health care in relation to the right to health (37).

The limits of the AAAQ framework perhaps lie in the potential difficulty in translating its idealism, conceptual complexity, and legal language into practice. Various stages are needed to ensure that the AAAQ principles are applied and implemented in everyday practice in prisons. First, a campaign is needed to persuade policy makers and the public that inadequate access to health care should not be part of custodial punishment. This is particularly relevant where the needs of prisoners will be competing with the needs of other populations for resources.

There is a need to achieve a consensus between different services to recognize the principles of universal health care along with sentencing of offenders—that access to health care should be independent of punishment. This is particularly important for multidisciplinary services where these principles may not be embedded at every level and, in some cases, may require a long-term program of culture change.

On a more practical level, practitioners need clear guidelines that link to the underlying principles of equivalence of outcomes. For example, Coyle (38) produced a handbook for prison staff that outlines the essentials of delivering appropriate health care and putting them into practice.

There is also a need for a more standardized system for quantifying differing levels of need across populations to help compare them more ef-

fectively and prioritize care in areas of greater need.

Last, there needs to be a realization that meeting AAAQ principles will require the financial and practical resources necessary to facilitate culture change. This includes an awareness of the resource implications of training health professionals and raising awareness among the general public about rights to health and the benefits that are available from this approach. Even in the midst of fiscal restraint and increasing public deficits, developing the AAAQ model of prison health care remains an important endeavor to, among other things, reduce unnecessary deaths and maltreatment. Combining this model with components of a service known to be effective and efficient could also yield long-term cost savings and reduce reoffending.

Conclusions

The AAAQ ideal has been discussed within the U.K. policy context as a point of departure for improving prison health care; however, the general principle is applicable in international settings, including the United States, where the prison system is in great need of reform. The AAAQ framework has evolved out of the concept of equivalence, through ten years of service delivery in the United Kingdom and heuristically “finding out what works” to something more sophisticated with a potential for wider application that can provide a more equitable approach to rationing health resources for prisoners and nonprisoners alike. In addition, the AAAQ framework can be used as a guiding principle for delivering equitable standards of care in international settings, with a potential to affect the health care of the worldwide prison population of 9.25 million.

Although levels of attention to prison health care vary across different countries (with serious human rights concerns in many states), the AAAQ ideal provides a framework through which relatively resource-rich countries can lead the debate. We have suggested a way in which policy and service delivery can now step beyond some of the constrictions of equivalence into a welcome new

space in which creative measurement and progressive realization might be emboldened.

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