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Chapter

Patient Safety and People Who Are Incarcerated

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Abstract

We explore a number of key relationships between patient safety and the health status of imprisoned people. This is a conceptual study drawing connections between a number of literatures including the field of patient safety, the work done on health and illness amongst imprisoned people, their social characteristics, and the carceral environment itself. We show that this is an underexplored and under-theorised field of inquiry. It also sets the scene for further investigation of not only individual and systemic factors in the health and illness experienced by such people but the role of the carceral environment. It seems clear that the risk of ill-health rises for many people who are incarcerated. Errors of both omission and commission are common in carceral environments. Risks rise for patients in such environments due to delays in diagnosis, referral and treatment. Understanding the complex and inter-related factors that increase ill-health in individuals, groups and communities provides a starting point for understanding why, when and how imprisoned people need to access and utilise healthcare, how will they are when they do so, and how. It also opens up the question of how these factors might affect their susceptibility to medical errors and adverse events.

Keywords: iatrogenesis, patient safety, carcerality, prisoners, incarceration, social determinants of health

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1. Introduction

An exploration of patient safety in this chapter is based on the premise that, just as they contribute to the health status of individuals and populations, social determinants of health contribute to the quality, safety and outcomes of health care. In this chapter we will explore patient safety in this context by exploring the dynamics of the intersection between the carceral environment and the social determinants of health experienced by people who become incarcerated, who are disproportionately from socially marginalised populations vulnerable to poor health outcomes. This chapter examines the intersection between carcerality and patient safety through the complex and inter-related factors that can affect susceptibility to medical error and associated harm(s) for those who are imprisoned. There are broader implications of this work for patient safety in other carceral spaces and places including institutions such as acute psychiatric units and 'locked' dementia wards and for people 'incarcerated' by public health orders.

2. Methodology

This chapter is offered as a conceptual discussion of the issues affecting the quality and safety of care, rather than either an empirical study or a systematic review. The material draws on our research into the quality and safety of care for vulnerable individuals and groups [1] as well as a consideration of the literature we have considered over time. Readers interested in exploring this literature may consider using a range of patient safety terms, such as patient safety, medical or medication error, iatrogenic harm, adverse event, preventable injury, healthcare/hospital acquired infection, nosocomial infection, and or medical harm, as well as terms for incarceration, including for example: prison, incarceration, correctional, jail or gaol, inmate, detention and or parole.

Table 1 provides definitions of some of the key terms relating to incarceration that have been used in this chapter. It must be noted that these terms (their use and definition, including in the specific legal context) may differ from country to country.

3. The health of incarcerated persons

Even prior to their incarceration, people who are incarcerated tend to have worse health than the general population. This can be explained through the lens of the social determinants of health (SDoH), which the World Health Organization explains as the '*the conditions in which people are born, grow, live, work, and age, including the health system. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries*' [6: n.p.].

Term	Definition
Detention	*Detaining or holding a person charged with a crime following the person's arrest on that charge* [2:61] or *the confinement of a person in custody* [3:199]. Please note that while the first definition appears in the legal and criminology literature, individuals who have not been charged with a crime are also detained by governments, including for example asylum seekers, and people involuntarily admitted to psychiatric hospitals.
Incarceration/carcerality	*Imprisonment in a jail, prison or any penal institution for a period of time ranging from one day to a life-term imprisonment* [2:103].
Jail or gaol or prison	*Prisons are places that house individuals who have been sentenced for violating the criminal law. In some jurisdictions, remand or pre-trial detainees are also incarcerated in prison. Elsewhere, pre-trial detainees are held in jail as opposed to prison. The vast majority of inmates are eventually released from prison; however, prisons provide few rehabilitative opportunities, making re-entry into the wider community very difficult*. [4:171]. There is no consistent agreement in the use of jail/gaol or prison, although jails seem to be associated with shorter term incarcerations, whereas prisons are more often associated with longer term incarcerations.
Parole	*Selective early release from prison followed by supervision.* [5:154]

Table 1.
Terms relating to incarceration.

People who are incarcerated are more likely to have low-income status [7], to be homeless, unemployed, had poor quality education and have poorer health [8, 9]. They are also more likely to be First Nations peoples and/or people with a disability, both groups with worse health than the general population – quite apart from their potential incarceration [9–13] – but these factors act as multipliers of disadvantage [14].

Incarcerated peoples and detainees also have "*… higher rates of mental health conditions, chronic physical disease, communicable disease, tobacco smoking, high-risk alcohol consumption, illicit drug use, and injecting drug use than the general population … This means that people in prison often have complex, long-term health needs.* [This means that] *the health of people in prison is much poorer compared with the general community, and people in prison are often considered to be elderly at the age of 50–55 (compared with 65 and over in the general community). This is known as 'accelerated ageing'*" [8: 4]. It is important to note that while this quotation is from an Australian publication, the detainees and incarcerated people demonstrate similar patterns of ill health around the globe [14–19], although it should also be noted that knowledge about the health of prisoners demonstrates "*… critical evidence gaps, notably the lack of evidence from low- and middle-income countries*" and in relation to the health of detained adolescents [4, 20].

It is also important to note that while for some incarcerated individuals, prison offers access to healthcare services that were not available prior to incarceration [see for example 21] for most people, incarceration is associated with a worsening of both their mental and physical health [22, 23], including significantly higher "*Rates of infectious diseases, such as tuberculosis, HIV, hepatitis B and C, and sexually transmitted diseases, are higher among the incarcerated population than among the general … population*" [14: 4S]. This has also been highlighted during the COVID epidemic where factors such as close proximity and delayed or limited prevention strategies [24] mean that "*Carceral facilities are epicenters of the COVID-19 pandemic*" [25: 1].

3.1 Mental health and patient safety of incarcerated person

The mental health of incarcerated individuals is of particular concern, both prior and subsequent to incarceration. The compounding nature of ill-health and incarceration is particularly evident in relation to mental health. As David Satcher argues "*Far too many people enter our criminal justice system due to an untreated or under-treated mental illness. Too often, we find our prison system substituting for the mental health care once provided in mental hospitals and other medical settings. It is estimated that one in six people in the correctional system lives with a serious mental illness. Compounding the problem is the co-occurrence of mental illness and substance abuse*" [26: vi]. Rekrut-Lapa & Lapa [15: 69] speak to a similar conclusion, but also noted that such conditions "*… require both emergency and routine care.*" They also found evidence that about a third of medications possessed by detainees at arrest were for the management of psychiatric illnesses.

Even for people without a prior mental illness, the experience of incarceration can act to facilitate these conditions. One high profile example of this is the rapid mental deterioration of many asylum seekers incarcerated while they await a review of their situation, in detention centres around the world [27, 28]. Commonly reported mental health issues experienced by long term detainees included "*Depression and demoralisation, concentration and memory disturbances, and persistent anxiety … Standardised measures found high rates of depression, anxiety, PTSD and low quality of life scores*" [29: 2070].

Suicide is also a recurrent risk for incarcerated persons, accounting for about a half of prison deaths worldwide [30] and is 13 times higher in released prisoners

than in the general population [31]. Rekrut-Lapa & Lapa [15: 70] quoted a UK report which showed that 46% of near misses (defined as *any incident which resulted in, or could have resulted in, serious illness or self-harm of a detainee*) in police custody were attempted suicides and self-harming behaviour, in contrast to medical emergencies which only made up 14% of such incidents.

4. Carcerality

There is a growing interdisciplinary literature on studies of the process of incarceration itself, on carceral spaces and places, and their consequences for those incarcerated [32]. Such spaces are increasingly seen to include not only places of formal imprisonment but various institutional spaces that may have 'secure' facilities and associated features [e.g. 33, 34]. These may be both formalised and informal (e.g. informal and formal refugee camps) and cover the control and 'management' of various groups in the population e.g. secure youth facilities, mental health facilities, disability care facilities, orphanages and so on. In other words, there is a growing understanding of the similarities between the types of carceral spaces societies produce and the systemic problems that can occur in them.

One of the issues associated with such spaces is that, historically at least, some have been the sites of abusive practices including, for example, Parramatta Girls Home in New South Wales, Australia where young, often Aboriginal, girls were subject to significant physical, psychological and sexual abuses over many decades [see 35, 36]. These types of institutions and their practices effectively manufacture places of abuse and ill-health. And this is far from unique, as many inquiries into patient safety, child abuse and other domains have shown across various jurisdictions [e.g. 37, 38]

This nexus of institutional, carceral spaces has clearly produced a variety of negative outcomes for many of those incarcerated including both physical and mental health consequences as illustrated throughout this chapter. Such outcomes can be long-term, even lifelong, in their impacts making such sites the producers of ill-health for those detained within them. In the criminological literature these forms of often sustained abuses of the rights of individuals have even been characterised as the consequences of harmful societies [39]. This emphasis suggests that our societies have the capacity to generate systemic institutional harms that, ultimately, must reflect back on that society. In effect, the abuses enacted, and tolerated, in carceral spaces reflect the 'true' values of our societies because they represent enacted values in contrast to espoused values [e.g. 40].

To address these types of societal and systemic drivers of abuse in these sorts of bounded carceral environments, we need to consider the voices of those harmed and not simply the official responses or inevitable list of formal recommendations that often result. In other words, we need to disrupt the conventional discourses that present such spaces/places and the abuses that occur within them as exceptions to some general benevolent rule. As various writers have commented, including feminist theorists, this process of exceptionalising often widespread, even repetitive, systemic abuses, adds an additional harm to those injured in them [see 41]. Their experiential truths are often either minimised or dismissed in systemic responses and thus there is a diminution of the harms perpetrated on people who are often amongst the most vulnerable in our societies.

This approach has an additional benefit for both theory and research because it extends the scope of inquiry beyond the individual carceral site and seeks to identify

and unpack patterns of health-related harms and their connection to the environments, or places, within which they occur. We would further suggest that there is an issue of *generativity* to be examined here in that some institutions can acquire such reputations but not all do, or at least not to the same degree. If the pattern is not uniform, then clearly some mix of institutional governance and perhaps individual factors combine to enable carceral environments that produce these types of harmful outcomes. This in turn can assist us in developing a body of theory to examine past, present and potentially future scenarios where such problems have emerged and might yet emerge. Potentially, at least, if such understanding can be used to influence policy, practices and professional values then future harms may be averted.

We can look for and potentially predict the consequential outcomes for human health and wellbeing in carceral environments that have the capacity for, or may have even already produced, harms to vulnerable people in them (we note this may include staff too). And we can seek to understand these factors better by looking for similarities and differences across multiple carceral domains – prisons, youth detention, mental health, aged care and so on. By disrupting the systemic distinctions between these often quite similar environments, we can better theorise why such things emerge in this first place and why they persist. In addition, because some causes are obvious to a degree, we can readily identify the repetition of factors that lead to harms.

The current reporting on deaths at the New York Riker's Island facility illustrates how contemporary these issues are and yet how sustained they can be across time to the serious detriment of those incarcerated within them. Examining such facilities on a case-by-case basis runs the serious risk of making each one seems unique when clearly a variety of overt and covert factors are in play.

5. The safety of incarcerated patients

The provision of healthcare to prisoners is a complex task, because as discussed earlier in this chapter, prisoners are often at the intersection of multiple vulnerabilities and multifaceted mental and physical conditions affecting their health [14], with treatments undertaken in an environment which is often not under either the patients' or clinicians' control [42, 43].

The irony of prison health is that in some cases treatment within prisons may be the best opportunity an individual has to receive the care they require [21]. This is 'balanced,' however, by the difficulties and barriers which impede such care and which include everything from societal attitudes to prisoners, to clinicians' knowledge and experience of specific conditions and treatments [44]. In between these two extremes are the difficulties faced in both providing and receiving care when the patient frequently has multiple co-morbidities, including mental health issues [45].

Patient safety is defined as the "*... avoidance, prevention and amelioration of adverse outcomes or injuries stemming from the process of healthcare*" [46: 31], which in turn are defined as injuries caused "*... by medical management (rather than the underlying disease) and that prolonged the hospitalization, produced a disability at the time of discharge, or both*' [47: 370]. There are two broad categories of errors – that is errors of commission (where something wrong was done) and errors of omission (where the right thing was not done) [48: n.p.] and three categories of adverse events: *'Preventable adverse events: those that occurred due to error or failure to apply an accepted strategy for prevention; Ameliorable adverse events: events that, while not preventable, could have been less harmful if care had been different;* [and] *adverse events due to negligence: those*

that occurred due to care that falls below the standards expected of clinicians in the community' [49: n.p.].

While the available literature is limited, what is available shows clear patterns of errors of omission and commission for incarcerated people. In terms of errors of commission (where the wrong thing was done) the literature shows that the safety of care for incarcerated people is lessened by factors such as: mis-diagnosis [50–52], medication errors/issues [53, 54] including under-prescribing/ceasing medications before indicated by evidence based practice [55: 506] or over-prescribing particularly in the case of women, as a mechanism for control [56–58] and/or polypharmacy [59].

The list of errors of omission are even longer. Studies show that the quality and safety of care for incarcerated individuals is lessened by: failure to diagnose treatable conditions [60, 61]; failure to treat latent infection [62]; fear/lack of confidence in clinicians inhibiting uptake of treatments [63, 64]; and routine failures to identify and mitigate risk factors (particularly in mental health) [65].

A recurrent theme in the literature on errors of omission in prisons is the effects of delays on patient outcomes, including: delays in testing or diagnosis [62, 66, 67]; delays in treatment [56, 61]; and delayed responses to request for medical appointments issues [54].

Patient safety for incarcerated individuals is also notable for the evidence of two factors associated with the particular experience of incarceration itself. These are prisoners' experience of the negative attitudes of clinical staff [68–71], including failures of privacy and lack of dignity/incivility [53, 54, 72] and the way in which treatment is (or is not) provided including: treatment interruption [73, 74]; lack of continuity of care [75]; and the discontinuation of treatment on release from prison [62, 76–80].

6. Improving the quality and safety of care for prisoners

Health providers and services have a legal and moral obligation to provide safe care to people who are incarcerated. The United Nations Mandela minimum rules for the treatment of prisoners includes specific medical and health care requirements. Under the category of vulnerable groups of people, the United Nations state that governments have the responsibility to *"Ensure that prisoners with physical, mental or other disabilities have full and effective access to prison life on an equitable basis, and are treated in line with their health conditions"* [81: 7]. The section on medical and health services underscores that clinicians'*"… relationship with prisoners is governed by the same ethical and professional standards as those applicable to patients in the community"* including: *"ensuring the same standards of health care that are available in the community and providing access to necessary health-care services to prisoners free of charge without discrimination; evaluating, promoting, protecting and improving the physical and mental health of prisoners, including prisoners with special healthcare needs; adhering to the principles of clinical independence, medical confidentiality, informed consent in the doctor-patient relationship and continuity of treatment and care (including for HIV, tuberculosis, other infectious diseases and drug dependence);* [and] *an absolute prohibition of health-care professionals to engage in torture or other forms of ill-treatment, and an obligation to document and report cases of which they may become aware"* [81: 8].

The literature on the quality and safety of care for incarcerated persons also provides insights into potential ways of improving this care. These fall into three broad categories of improved treatment, improved education and training for both

health professionals and prisoners, and improved coordination of care. The literature specifically suggests the need to improve the: diagnosis, screening and triage for those entering correctional facilities [51, 52, 64]; medical assessment and care in police custody [54, 82, 83]; therapeutic relationships between inmates and correctional healthcare staff [73, 84]. It also identifies the need to reduce polypharmacy [57], provide alternative mental health treatment other than medication [56], introduce short-course treatment for latent TB infection [74, 77] and the provision of care consistent with TB treatment guidelines [62], and finally allowing the self-administration of treatment by inmates [72, 84].

Other improvement strategies are based on the education of health professionals and or incarcerated persons. These include the need to improve training for healthcare professionals working in correctional facilities [60], including training to improve knowledge and attitudes among custodial staff [e.g. 64, 68, 69, 71, 73] and, on the other hand, the provision of health literacy education programs for incarcerated persons, especially understanding of the importance of adherence to treatment [e.g. 63, 64, 66, 71, 73]. One organisational strategy which has been suggested by numerous studies is the need to improve the co-ordination and communication between correctional and community-based health services to improve health care and continuity of treatment [e.g. 62, 75, 76, 78–80].

Finally, the John Jay College of Criminal Justice in New York proposed a set of patient safety standards for prisons, entitled "Patient Safety Behind Bars". These address most of the requirement of the Mandela rules, and specifically address: access to and the availability of care (including access to prenatal and postpartum care); establishing a culture of safety within the incarcerating organisations (including active safety leadership and a shift to a systems approach to the safety of care); addressing the needs of health care personnel (including training, addressing staff fatigue and burnout, ensuring adequate staffing and competency); medication management (including the use of computerized medication systems); management of transitions and communication (including ensuring timely access to specialists, tests and consultations); addressing specific conditions (ranging from chronic diseases and the provision of access to care after acute mental health problem); and finally the involvement of patients in their care and treatment (including informed consent, informed refusal, the provision of interpreters, patient notification of results, patient tailored decisions and the choice of advanced directives) [85].

7. Conclusion

In this chapter we bring together some of the core issues affecting the safety of care for incarcerated persons. These issues typically begin far earlier than the person's incarceration, in the social determinants of health which affect their communities, families and themselves disproportionately. On entering incarceration, the risk of ill health increases. The provision of safe, quality health care therefore is not just a question of addressing the existing health conditions of inmates, but also of ensuring that they are not exposed to additional iatrogenic harm, as has been the case during the COVID pandemic.

While the literature is somewhat limited, the studies and frameworks which are available provide a clear direction in terms of improving the existing quality of care for people who are incarcerated. Most importantly they point to the need to understand the unique history, context and health risks faced by incarcerated people, both prior and subsequent to their incarceration. Finally, the growing literature on

carcerality itself points to new ways of examining and theorising the health effects, both short and long term, of the incarceration experience. This in turn suggests the opportunity for an expanding cross-disciplinary research and knowledge development base as key concepts and tools are applied to a growing variety of carceral environments.

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