



## Commentary

# Improving Health Equity for Women Involved in the Criminal Legal System



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More than 1,000,000 women in the United States are currently under supervision of the criminal legal system (CLS), with the majority on probation or parole.<sup>1</sup> Since 1980, the number of women in prison has increased by more than 800%, which is twice the rate of growth for men, whose rates are falling (Bronson & Carson, 2019). Similarly, the male jail population decreased by 9% from 2008 to 2018, whereas the female jail population experienced a 15% increase (Zeng, 2020). Women involved in the CLS (WICLS) have high rates of mental and physical health conditions, socioeconomic challenges, and trauma and violence histories (Meyer et al., 2014; McDaniels-

Wilson & Belknap, 2008; Fedock & Covington, 2017; Sufirin, 2017).<sup>2</sup> These high rates are consequences of pre-incarceration factors, including poverty, structural racism, and inadequate health care access; limited jail and prison health care; and the health impacts of carceral systems themselves (Binswanger et al., 2012; Cloud, Bassett, Graves, Fullilove, & Brinkley-Rubinstein, 2020; Venters, 2019). Broader efforts to address women's health equity should include WICLS, who are often otherwise excluded from public health programs, policies, and initiatives.

The health and well-being of WICLS may also be adversely shaped by intersecting forms of oppression, including racism, poverty, ageism, ableism, homophobia, and sexism. Social determinants of health and CLS involvement include aspects of the social environment, such as discrimination and income, the physical environment, and health services. Furthermore, parenting and reproduction, health care needs as they age, and reentry challenges of WICLS are underrepresented in current policy, research, and clinical contexts (Aday & Forney, 2014; Fedock & Covington, 2017; Sufirin, 2017). These intersectional forces bear on women and their families before, during, and after incarceration and may lead to poor health across the lifespan

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<sup>1</sup> Jails are typically short-term holding facilities under local jurisdiction for the newly arrested, those awaiting trial or sentencing, and those serving short sentences. State or federal prisons are institutional facilities where those who are convicted serve longer sentences.

<sup>2</sup> Women and men involved in the CLS include adults serving sentences in prisons and jails, awaiting trial or sentencing, and those under community supervision. We try to use person-first and nonstigmatizing or pejorative language (Broyles et al., 2014; Tran et al., 2018).

(Hayes et al., 2020; Meyer, 2019a). CLS involvement increases risk of physical and sexual violence, with direct or indirect health and health care effects, which impact families and communities (Brinkley-Rubinstein, 2013; Hatzenbuehler, Keyes, Hamilton, Uddin, & Galea, 2015; Kajeepeta et al., 2020; Venters, 2019).

We delineate reproductive health and motherhood, aging in prison, and reentry as critical areas exemplifying women's complex health-related needs, which may be best addressed via gender-responsive and trauma-informed care.<sup>3</sup> WICLS have different experiences and needs in comparison with men involved in the CLS as well as other women living in the community without CLS involvement. These complex medical, psychiatric, and social conditions may require dedicated high-quality, comprehensive, and evidence-based health care in prisons and jails, which link women to care and support in the community on release (Meyer, 2019b; Rich et al. 2013). Patient-centered care is well-suited to address the heterogeneity of experiences, identities, and health conditions and to support developing well-tailored, structurally competent interventions and programs for WICLS (Metzl & Hansen, 2014; Meyer, 2019b).<sup>4</sup> Paradoxically, some jails and prisons have become spaces where women can find health care, which reflects the withering health and social safety net that fails to advance equity in many of our communities (Sufrin, 2017).

### CLS Involvement and Health Among Women

CLS involvement among women closely affects a broad range of health outcomes. Women have similar or lower prevalence of chronic conditions compared to men in the general population, yet rates of chronic illness and comorbid conditions of WICLS are higher than those of other women in the community and men involved in the CLS (Binswanger, Krueger, & Steiner, 2009). An analysis of Bureau of Justice Statistics data and nationally representative cross-sectional data from the early 2000s finds nearly 65% of women in prison and jail reported having a chronic condition, in comparison to approximately 50% of men in prison and jail reporting a chronic condition (Harzke & Pruitt, 2018). Women's pathways to being enmeshed in the CLS are often associated with their relationships, including substance use in dyads, conscription or coercion to engage in illicit activity, and intimate partner violence exposure (Meyer et al., 2014, 2017; Jiwatram-Negrón & El-Bassel, 2015).

Substance use, psychiatric disorders, and prior exposure to violence are prevalent among WICLS. According to the Bureau of Justice Statistics, 69% of women in state prison and 72% of women sentenced in jail in 2012 met criteria for severe substance use disorders, which require specialized approaches to management (Bronson, Stroop, Zimmer, & Berzofsky, 2017). Similarly, infectious diseases related to injection drug use and high-risk sex networks, such as HIV and hepatitis C, were more prevalent than in the general population (Binswanger et al., 2010; Williams et al., 2013; Meyer, 2019a). Furthermore,

<sup>3</sup> This article focuses primarily on people whose biological sex is female and who identify as women (also known as cis-gendered women); however, we recognize transgender individuals' disproportionate contact with the criminal legal system and that people who may not identify as "women" (i.e., trans men) might have pregnancy and other reproductive health care needs.

<sup>4</sup> Metzl and Hansen (2014) introduce "structural competency": 1) recognizing the structures that shape clinical interactions, 2) developing an extra-clinical language of structure, 3) rearticulating "cultural" formulations in structural terms, 4) observing and imagining structural interventions, and 5) developing structural humility.

sexually transmitted infection rates were recorded as 10 to 20 times greater relative to women in the community without CLS experience and, if left untreated, these infections can negatively impact women's health (Knittel & Lorvick, 2019; Linder, 2018; Meyer, 2019b). Thus, the Centers for Disease Control and Prevention issued recommendations to expand sexually transmitted infection screening and treatment in prisons and jails in 2015 (Centers for Disease Control and Prevention, 2015).

The prevalence of co-occurring psychiatric disorders and substance use disorders, often associated with trauma, frequently exceed 75% among WICLS (Meyer et al., 2013; Prins, 2014; Staton-Tindall, Duvall, Leukefeld, & Oser, 2007; Winkelman, Chang, & Binswanger, 2018). People with severe psychiatric disorders have high rates of repeated contact with the CLS, where evidence-based treatment may be lacking, further contributing to negative psychiatric outcomes (Baillargeon, Binswanger, Penn, Williams, & Murray, 2009; Glied & Frank, 2009).

Girls and young women of color are disproportionately vulnerable to "the sexual abuse to prison pipeline" (Marquardt, 2020). Girls only constitute 20% to 25% of the juvenile CLS population, yet 50% to 66% of those dually involved in juvenile criminal legal and child welfare systems are girls (Saar et al., 2015). WICLS contend with violence and trauma history as prevalent as 95%, including sexual assault and intimate partner violence (Meyer et al., 2014; McDaniels-Wilson & Belknap, 2008; Richie, 2012). Nearly 40% of WICLS meet criteria for post-traumatic stress disorder, and research shows that untreated posttraumatic stress contributes to women's distinct incarceration and recidivism pathways (Baranyi, Cassidy, Fazel, Priebe, & Mundt, 2018; Fuentes, 2014; Harner, Budescu, Gillihan, Riley, & Foa, 2015).

Exposure to degradation, body searches, shackles, cell shakedown, restraints, and seclusion during incarceration further compound trauma; in addition, trauma-related symptoms may be mistaken for acts of aggression or defiance (Center for Substance Abuse Treatment, 2014; Kramer & Comfort, 2011; Fedock & Covington, 2017; Kraft-Stolar, Brundige, Kalantry, & Getgen, 2011). Prison discipline policies punish women more harshly than men, including disproportionate isolation for minor, nonviolent infractions (LaChance, 2018; U.S. Commission on Civil Rights (USCCR), 2020). Disciplinary record, charges, and punishment can be associated with gendered charges. Women with psychiatric conditions are overrepresented in segregation environments (LaChance, 2018). Staff sexual misconduct, lack of respect, and potential control of women's bodies may be conducive to a lack of safety, abuse, exploitation, and violence (Owen, Wells, & Pollock, 2017; Rantala, 2018). Violence targeting transgender women is particularly perilous, given disproportionate incarceration and victimization risks (Bačák et al., 2018).

People who are incarcerated are the only population in the United States with a constitutional guarantee to health care, including protection from serious physical and psychological harm, yet health care standards and practices widely vary (Dolovich, 2009; Venters, 2019). *Estelle v. Gamble* established the constitutional mandate that institutions of incarceration address "serious medical needs" (Dolovich, 2009). However, there are no mandatory standards as to what services have to be provided or what conditions count as serious medical needs. Health care spending, quality, and organizational structures vary across facilities where services and practices also vary, particularly for women's health within prison and jail contexts designed primarily for men (Pew Charitable Trusts, 2017). Overall, health delivery systems within prisons and jails are associated with various levels of expertise in evaluation, quality improvement,

evidence-based practice, and implementation science (Pew Charitable Trusts, 2017).

### Reproductive Health and Parenting

Approximately 75% of women in state and federal prisons are younger than 45, so health care needs must address reproductive health, including family planning care; comprehensive pregnancy, birth, and postpartum care; and abortion access (Carson, 2020). Addressing incarcerated women's health care within a reproductive justice framework prioritizes health care inequities, alongside material resources—such as safe neighborhoods, good schools, clean water, and just court systems—needed to parent (Hoff et al., 2020; Strickler & Simpson, 2017). Reproductive justice is an intersectional theory and platform for action that emerged from and centers the experiences of women of color and draws on the knowledge of historical legacies in which their reproduction has been systematically devalued (Ross & Solinger, 2017; Price, 2011). Three rights are central to achieving reproductive justice: the right not to have children, the right to have children, and the right to parent children in dignity and safety. Incarceration disrupts core reproductive justice tenets, denying contraception and abortion access and implementing coercive contraceptive practices, and providing substandard maternity and postpartum care (Hayes et al., 2020). Currently, there is over-investment in systems to confine people and under-investment in safety net systems.

Menstrual dysfunction is three times higher among incarcerated women, of whom 50% lack access to basic menstrual supplies (Allsworth et al., 2007; Linder, 2018). Only four states offer free access to menstrual products in prison (Johnson, 2019). WICLS, in custody and upon release, experience unmet family planning service needs, including contraceptive access and counseling (Allsworth et al., 2007; Clarke et al., 2006; Larochelle et al., 2012). Unlawful sterilization in California prisons as recently as 2010 runs counter to necessary noncoercive, patient-centered, reversible contraceptive methods access (Hayes et al., 2020; Sufirin et al., 2009a). Although incarcerated women retain their legal right to abortion, many facilities disallow access (Bronson & Sufirin, 2019; Hayes et al., 2020; Sufirin, Creinin, & Chang, 2009b).

Nearly 4,000 admissions of pregnant people to prisons and 55,000 to jails occur annually (Bronson & Sufirin, 2019; Sufirin et al., 2020a). Until 2019, there was limited systematic data reporting on incarcerated pregnant people and related outcomes, including births, miscarriages, and abortions. This lack of data collection and reporting reflects a potential disregard for incarcerated women's gender and reproductive specific needs and the slow pace at which the growing female jail and prison populations have been addressed. Shackling women in labor in federal prisons is banned, yet only 29 states have similar laws for state prisons, which are frequently violated (Goshin, Sissoko, Stringer, Sufirin, & Byrnes, 2020; Sufirin, 2019; Kuhlik & Sufirin, *in press*). Pregnant people with opioid use disorder may experience withdrawal, despite this being contrary to standards of care (Sufirin et al., 2020b). Prenatal care availability and quality vary considerably, as do policies promoting breastfeeding and infant bonding for birth while in custody.

Approximately 60% to 80% of incarcerated women have minor children and most are single parents (Fedock & Covington, 2017; De Claire, K., & Dixon, L., 2017). Compared with incarcerated men, women in prisons and jails are five times more likely to have children placed in foster care (Swavola, Riley, & Subramanian,

2016; De Claire & Dixon, 2017). Many barriers prevent children's visits, including inconvenient visiting hours, related costs, lack of child-friendly visiting space, caregivers' desire to keep child from carceral environments, and distance from home (Boudin, 2011; Fedock & Covington, 2017; Swavola et al., 2016; OCRE, 2020). Incarcerated parents' children, who may struggle with this separation, are more than six times more likely to experience incarceration themselves (Boudin, 2011; Wakefield & Wildeman, 2013). Notably, women's removal and return to communities associated with incarceration can have effects on families and communities (Boudin, 2011; Fedock & Covington, 2017).

Policy reforms should standardize and expand reproductive health care scope and quality for incarcerated women, including comprehensive prenatal, birth, and postpartum care; abortion and noncoercive contraception access; menstruation management; cervical and breast cancer screening, diagnosis, and management; and pregnancy data collection. Further, training and oversight will bolster policies in supporting the right to parent in safety and dignity, alongside alternatives to incarceration, community health, and economic infrastructure (Hayes et al., 2020). Lastly, supporting parenting skills along with contact and reunification with loved ones is critical to rehabilitation and reducing recidivism (De Claire & Dixon, 2017; Fedock & Covington, 2017; Meyer, 2019b).

### Aging

Disproportionate incarceration rates and longer sentences than men for similar offenses often combine with histories of violence, trauma, and poverty to compromise the health of older WICLS. Incarcerated older women experience higher rates of chronic disease and disability, victimization, and mental illness in comparison with men involved in the CLS and non-incarcerated women (Aday & Farney, 2014; Barry, Adams, Zaugg, & Noujaim, 2020). The proportion of aging women in prison is growing faster in comparison with men, which is associated with greater health demands and costs largely owing to increased comorbidity burden and physical and cognitive disabilities (Skarupski, Gross, Schrack, Deal, & Eber, 2018). In 2018, nearly 25% of women in state and federal prisons were over the age of 45 (Carson, 2020). Between 1993 and 2013, the number of women in state prisons age 40 and older increased by more than 300% (Carson & Sabol, 2016).

Geriatric syndromes, including cognitive and functional impairment, dementia, falls, and incontinence, are present at higher rates and at younger ages in incarcerated populations than for nonincarcerated women (Bedard, Metzger, & Williams, 2016; Williams et al., 2006). Jail and prisons' environmental conditions "designed to restrict the liberty of young people," poor lighting and ventilation, inadequate climate control, overcrowding, and service barriers exacerbate older women's physical challenges (Bedard et al., 2016; Aday & Farney, 2014). Physically demanding work activities lacking modifications for functional impairments persist and vary across states (Williams et al., 2006). Additionally, daily living activities while incarcerated are also more challenging for women than men (Skarupski et al., 2018; Williams et al., 2006). Consequently, many older women who would be independent in the community are not in prison (Williams, Goodwin, Baillargeon, Ahalt, & Walter, 2012).

Clinicians working with patients who are incarcerated oftentimes lack training in palliative care, which is the community standard of care for patients with life-limiting or serious illnesses (Bedard et al., 2016). Additionally, while medical or

“compassionate” release policies exist to allow people of advanced age or with serious illness to leave prison before they die, in practice few are released through these mechanisms (Mitchell & Williams, 2017; Prost & Williams, 2020). As a result, ideal medical release candidates frequently lack appropriate assessments and remain unnecessarily confined (Prost & Williams, 2020). Many older women also experience difficulties and unmet needs around grief and loss as part of traumas of incarceration, which also include personal, social, and environmental deprivations (Aday & Farney, 2014; Aday & Krabill, 2016).

Gender-sensitive, trauma-informed, patient-centered, and evidence-based geriatric and palliative care standards appropriate to carceral environments should be designed to minimize victimization and injury. Relatedly, improving disability trajectories by mitigating environmental risk factors and reducing avoidable suffering for women with serious and life-limiting illness while in prison is key if older women must remain incarcerated (Rich, Allen, & Williams, 2015). Older women, in comparison with older men in prison and women in the community, are prone to fewer disciplinary infractions and lower recidivism rates upon release (Bedard et al., 2016). Reentry supports for aging women should facilitate securing health care continuity, housing, employment, and social services. WICLS returning to the community may experience bias and discrimination associated with their age, gender, class, race, and criminal records.

States continue to grapple with how to handle the aging prison population growth. The Centers for Medicare and Medicaid Services funds a privately owned nursing home facility contracted by the state of Connecticut, which houses ailing people in custody. Experts urge repeal of mandatory minimum, “habitual offender,” and truth-in-sentencing laws and support interim reform efforts, such as conditional release for aging men and women in custody who pose little security risk, compassionate release, parole board transparency, and federal aging prisoner release reauthorization (Mitchell & Williams, 2017; Williams et al., 2012). Moreover, further research in this area is needed to improve survey methods, tools, and research to optimally assess the health of older WICLS (Barry et al., 2020; Bedard et al., 2016; Skarupski et al., 2018; Williams et al., 2012).

## Reentry

Nearly 95% of those incarcerated will return to communities (Hughes & Wilson, 2002). This reentry period is associated with numerous health challenges, including increased mortality, psychiatric symptoms, and victimization (Binswanger et al., 2007, 2011; 2013, 2016; Meyer et al., 2014). During reentry, women’s high rates of co-occurring conditions can be exacerbated by care discontinuities, medication disruption, and inadequate insurance (Binswanger et al., 2011; Johnson et al., 2015; Woods et al., 2019). Common health care barriers include experienced or anticipated stigma and discrimination, low health literacy, and difficulties navigating health care systems (Johnson et al., 2015; Kramer & Comfort, 2011; Winkelman et al., 2016). Many women return to under-resourced neighborhoods amidst prevalent poverty, violence, and substance use (Fedock & Covington, 2017; Golembeski & Fullilove, 2008). Women’s reentry challenges include greater parental responsibilities, income disparities, housing insecurity, and dependency on partners for subsistence needs (Fedock & Covington, 2017; Johnson et al., 2015; Western, 2018).

Custody revocation laws and child welfare oversight may compromise family reunification (Sufirin, 2017). Reentry-related stressors may lead women to deploy survival strategies, including transactional sex, associated with recidivism (Kramer & Comfort, 2011; Richie, 2012). Difficulties securing housing and employment, plus exposure to potential violence, drug use, and high-risk survival behavior, can compound trauma (Binswanger et al., 2014; Jiwatram-Negrón & El-Bassel, 2015; Meyer et al., 2014). Women often shoulder greater financial burdens and family responsibilities than men (Hersch & Meyers, 2018; Richie, 2012). Plus, collateral consequences of incarceration for women involving health, employment, housing, debt, civic involvement, families, and communities can reduce opportunities to sustain healthy relationships and financial security (Fedock & Covington, 2017; Hersch & Meyers, 2018; Kirk & Wakefield, 2018).

Transitions to care outside of jails or prisons have improved through the establishment of community-based clinics providing transitional care, including primary care and case management, as well as peer patient navigators (Binswanger et al., 2015; Fox et al., 2014; Wang et al., 2010). For instance, New York’s Women’s Initiative Supporting Health-Transitions Clinic involves peer health workers in providing treatment and support to recently released women (Bedell, Wilson, White, & Morse, 2015; Morse et al., 2017). Cross-agency collaboration, which incorporates psychological and emotional components that women need to heal and recover, can facilitate and sustain integrative continuity of care models that address structural racism, poverty and trauma histories, and mental and physical health conditions.

## Conclusions

Adverse life events are prevalent among WICLS, who contend with structural barriers that compromise health and well-being and facilitate contact with the CLS. Disproportionate health burdens and barriers to care are associated with syndemic effects of substance use disorders, plus chronic medical and psychiatric conditions within the context of racism and gender inequities (Meyer et al., 2013; Williams et al., 2013). Sexual and physical violence within the CLS is a serious concern (McDaniels-Wilson & Belknap, 2008; Venters, 2019). Relatedly, the forced migration, also known as coercive mobility, of incarceration disrupts social, family, and sexual networks with secondary effects on communities (Binswanger et al., 2012; Hatzenbuehler et al., 2015).

Most national health surveys exclude WICLS, so much is unknown to researchers and providers about their gender and reproductive health specific needs. This problem can be remedied: experts have developed ethical data collection for public health surveillance in jails and prisons and for individuals under community supervision (Ahalt, Haney, Kinner, & Williams, 2018; Binswanger et al., 2019; Sufirin et al., 2019b; Wang, Macmadu, & Rich, 2019).<sup>5</sup> Additional research, clinical, and policy efforts to address intimate partner violence, trauma, and comorbid health conditions are needed to improve health equity for WICLS (Bowen & Murshid, 2016).

The transformative role of WICLS in peer support, research, service delivery, and policy addressing inequities associated with

<sup>5</sup> Data collection purposes include surveillance, health promotion and disease prevention, healthcare performance and patient value, policy relevance, health equity, and human rights and legal considerations (Binswanger et al., 2019).

the CLS is widely acknowledged (Bedell et al., 2015; Binswanger et al., 2015; Epperson & Pettus-Davis, 2017; Kraft-Stolar et al., 2011; Sturm & Tae, 2017). Moreover, the Share Project, a health justice initiative, trains patients with incarceration histories, community health workers, policymakers, and researchers in participatory research involving a data-sharing platform (Elum Madera et al., 2019). Health care providers are uniquely qualified to improve the health of WICLS via care that is patient-centered, structurally competent, and sensitive to the complex interplay of trauma, violence, and co-occurring mental and physical health conditions (Goshin et al., 2019; Hayes et al., 2020; Metzl & Hansen, 2014; Morse et al., 2017; Sufirin, 2017).

Decarceration, drug policy reform, and alternatives to incarceration are necessary criminal justice reform efforts, which may improve health outcomes further upstream and aid women in addressing underlying challenges while maintaining and strengthening positive ties to families and communities. From a systems perspective, it is less costly and disruptive to avoid incarceration altogether and deliver continuous care in the community for chronic health conditions including substance use and psychiatric disorders (Meyer, 2019b). Women have strengths, needs, risks, and pathways into the justice system that often differ from men's (Binswanger et al., 2013; Richie, 2012; Machtinger, Cuca, Khanna, Rose, & Kimberg, 2015). Gender-responsive, trauma-informed, strength-based care supports women's reintegration and recovery. Relevant clinical training, capacity building, material resources, and structural support in communities are also necessary to sustain such efforts (Machtinger et al., 2015; Meyer et al., 2017; Binswanger et al., 2014).

Bipartisan criminal justice reform legislation, which includes improving the health of WICLS, is gaining support. The Second Chance Act, the Fair Sentencing Act, and the First Step Act of 2018 have been enacted. The Dignity for Incarcerated Women Act, which focuses on health, visitation, programming, oversight, and telecommunications, was reintroduced by Senators Elizabeth Warren and Cory Booker in April 2019. The First Step Act, which only applies to federal contexts, contains some of the Dignity Act's clauses: menstrual product provision, shackling bans, and incarceration closer to home. Moreover, the proposed 2018 Pregnant Women in Custody Act supports data collection and reporting on pregnant women, prohibiting restrictive housing and restraints, and addressing health care needs in federal prisons. Relatedly, Senators Ann McLane Kuster and Booker's proposed Humane Correctional Health Care Act seeks to improve health care delivery and treatment behind bars (Kuster & Booker, 2019). As a public health community committed to advancing equity, we must evaluate and support legal and legislative reform that seeks to improve health care quality and access for this often overlooked population.

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