



Inadequate Healthcare in the American Prison System

Susan E. Mathias

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APPROVED BY

Committee Chair:

Dr. Brittani McNeal, Associate Professor & Program Director of Doctor of Science in
Public Safety at Middle Georgia State University

Committee members:

Christopher C. Tsavatewa, DSc

John P. Hall, Ph.D. Associate Professor of History and Political Science

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Abstract

Inadequate prison healthcare is a result of insufficient legislation and varying policies within a single agency. This study analyzed court cases based on their advancement to the district, appellate, and Supreme Courts. The cases selected included those directly related to prison healthcare. The purpose of this methodology is to assess how rulings from Supreme Court cases have shaped the delivery of healthcare to incarcerated populations, and to evaluate the extent to which these rulings have succeeded or failed in ensuring access to adequate medical care. It was discovered that inadequate healthcare in the prison system is a result of both insufficient legislation and varying policies.

Dedication

Stephen C. Svonavec Ph.D. and Kara S. Svonavec Ph. D:

My academic parents. I would not be as successful as I am today without their guidance and dedication to higher learning.

Bulloch County Department of Family and Children Services: Where I have grown both personally and professionally.

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Introduction

Prison healthcare serves as a critical measure of a society's commitment to human rights, justice, and public health. Yet, it remains one of the most underexamined and underfunded areas of the correctional system. Basic healthcare is an essential human right that most Americans have access to in some form when living in the community. Insurance to cover essential care can be obtained through one's employer, a private network, or government assistance programs such as Medicaid or Medicare. When incarcerated, one's ability to access and afford adequate healthcare is ultimately in the hands of the administration running the prison where they are incarcerated. The Eighth Amendment entails protections against cruel and unusual punishment, which includes the right to healthcare while incarcerated.

Evaluating the American carceral system is a complex effort that requires further research. The American carceral system consists of approximately 98 federal prisons, 1,566 state prisons, and 3,116 local jails. In 2023, the federal prison system served approximately 155,972 incarcerated individuals (Sawyer and Wagner, 2025). The Bureau of Justice Statistics (2024) reported that in 2022 and 2023, 21% of medical and healthcare positions were vacant throughout the federal prison system. Such a high inmate-to-healthcare staff ratio warrants the necessity of evaluating the effectiveness of prison healthcare.

Since *Estelle v. Gamble* (1976), the concept of deliberate indifference has set the standard for legal recourse against inadequate healthcare. This requires that an inmate prove what factors lead the facility to deliberately treat their access to healthcare differently from that of other incarcerated individuals. By proving deliberate indifference,

one has shown direct unethical practices that constitute cruel and unusual punishments that violate one's Eighth Amendment rights.

There are incarcerated individuals across the country who are fighting for access to basic healthcare and are claiming a violation of their Eighth Amendment rights. These violations of incarcerated individuals' rights can be a result of inadequate protocols, overpopulation, and/or lack of funding and resources. If any protocol related to medical care within the prison system changes, this should be communicated clearly so that incarcerated individuals know what to expect when seeking care.

The COVID-19 pandemic is one of the most recent examples of how quickly a single disease can affect an inmate population. By January of 2024, 1.1 million individuals had died in the United States as a result of COVID-19. Incarcerated individuals have little ability to execute proper precautions, such as social distancing, personal protective equipment, and proper sanitation, as they are at the mercy of their institution. Social distancing was near impossible as 1,215,800 individuals were incarcerated in state and federal prisons as of December 2020. By June of 2021, it was documented that there were half a million cases of COVID-19 among prison staff and incarcerated individuals, as well as 3,000 deaths. The need for medical care during the pandemic far exceeded the resources available to prisons, resulting in such statistics (Mei et al., 2024).

Prison healthcare is shaped by a history of neglect and uneven reform and continues to suffer from systemic failures that restrict access to quality care. By evaluating its historical context, inmate health challenges, existing policies, and institutional limitations, one can see that improving prison healthcare is both a constitutional obligation and a vital step toward advancing justice, public health, and

successful inmate reintegration. Thus, the current study examines how prison healthcare has evolved historically, and what reforms have shaped current practices.

This paper analyzes case law to determine what constitutional and ethical principles are upheld by the courts regarding inmate healthcare policy. Current research outlined in the literature review shows challenges and barriers but does not connect how legislation has influenced these issues. This study seeks answers to several concerns.

- How do existing policies support or fail to support adequate healthcare delivery in prisons?
- What are the most pressing healthcare issues faced by inmates, and how effectively are they being addressed?
- What systemic and institutional barriers prevent prison facilities from meeting healthcare standards?
- What reforms could most effectively improve prison healthcare outcomes?

This study is crucial to ongoing public safety efforts as it directly addresses the critical healthcare needs of individuals classified as a direct threat to their own communities. Prison leadership must consider the overall well-being of its clientele. This is especially important when placing correction officers in direct contact with individuals who cannot walk freely in their own communities.

Literature Review

The literature on prison healthcare highlights a troubled history, persistent gaps in service delivery, and ongoing policy debates that shape the experiences of incarcerated individuals. *Estelle v. Gamble* (1976) set the constitutional standard for deliberate indifference and is still used today to defend claims of inadequate medical care for incarcerated individuals. While legislation outlines the minimum standards for healthcare, it falls on the institution itself to ensure incarcerated individuals have access to adequate medical care. Claims by incarcerated individuals have been filed on local, state, and federal levels for grievances related to delayed or denied medical care, a lack of specialized care, or inadequate housing contributing to insufficient care. This study shows that even when procedure is followed, accessing appropriate healthcare remains a challenge for incarcerated individuals across the country.

Estelle v. Gamble (1976)

The case of *Estelle v. Gamble* (1976) was a pivotal case that set the standard for all future legal cases regarding prison healthcare. J.W. Gamble worked at the prison textile mill in Huntsville, Texas, during his incarceration. W. J. Estelle Jr., Director of the Texas Department of Corrections, was identified in the case as the defendant. In November 1973, Mr. Gamble sustained a back injury and reported that the injury was a result of being understaffed. He cited that he was denied proper medical care after working for hours after sustaining the injury before requesting medical care. Gamble was seen on multiple occasions and given medication to address the pain, as well as specific housing and bedding accommodations to address the injury. In December

1973, he was medically cleared for light work and removed from the previously awarded special accommodations.

Gamble maintained that his injury was just as severe as the day he was injured and vocalized that he was unable to work. Gamble was taken before a disciplinary board and stated that the injury was still prominent, in addition to high blood pressure that was not being addressed. Gamble was returned to solitary confinement for December and January and treated for his back injury and blood pressure issues. Gamble was threatened with a work detail, and medical care became more challenging to obtain. He was brought before the disciplinary committee again on January 31, 1974, for refusing to work. He was returned to solitary confinement and later told that incarcerated individuals in solitary confinement must have approval from the warden's office for medical care. After delayed care, it was later discovered that Gamble had heart trouble and was seen at the hospital. He returned to solitary confinement despite still reporting chest pain and filed a complaint that his Eighth Amendment right had been violated on February 11, 1974 (*Estelle v. Gamble*, 1976).

Gamble took the necessary steps to file a complaint against various individuals in the prison system who were responsible for his medical care. The basis for this claim was that a lack of proper medical care is considered cruel and unusual punishment. Originally, the district court denied his claim, but the Court of Appeals passed the case to the Supreme Court. The Supreme Court ruled that Gamble's Eighth Amendment rights had been violated as he was not given proper medical care, which led to preventable pain and suffering (*Estelle v. Gamble*, 1976). From this point forward,

constitutional rights to healthcare were addressed on new levels, allowing for improvements in prison medical care across the country.

Constitutional and Ethical Expectations

The Supreme Court has established constitutional expectations for prison health care. In *Rhodes v. Chapman* (1981), the Supreme Court analyzed how inadequate healthcare access could violate an incarcerated individual's Eighth Amendment right. The Supreme Court ruled that overpopulation alone does not constitute cruel and unusual punishment. The inmate must connect how overpopulation is affecting their ability to access necessities. The protocol to file a violation of rights must be followed, including the steps outlined in the Prison Litigation Reform Act (PLRA). This process can be complex and is often difficult for incarcerated individuals to manage due to varying criteria that constitute a legitimate grievance. Once the PLRA process has been exhausted, the inmate is responsible for providing sufficient evidence to support that inadequate healthcare has caused them to suffer from cruel and unusual punishment (Arias, 2025).

The prison healthcare system follows the same code of ethics as healthcare providers in the community. Cromer (2025) explains that the AMA Code requires prison medical staff to treat incarcerated individuals with the same quality of care they would provide to someone in the community without a criminal offense. According to Engstrom and van Ginneken (2022), humane treatment, autonomy, and stimuli are the primary ethical components of the architecture of prison healthcare. The facility should implement principles of justice for the distribution of resources, and medical providers' beneficence should be evident in their practice. Informed consent allows the inmate to

be fully aware of their diagnosis, treatment options, and treatment plan. The absence of these components constitutes when an inmate may begin the process of filing a violation of rights claim.

In some cases, constitutional rulings shape the ethical obligations of healthcare for incarcerated individuals. *Taylor v. Barnett* (2000) concluded with a ruling that cost cannot be the sole factor in medical decisions, and a medical rationale must be provided for an individual's treatment plan. In *Owens v. O'Dea* (1998), the courts upheld that medical care must be provided to incarcerated individuals, but the course of action must be determined by a medical provider. While an inmate may have preferences in medication and treatment, the facility is only required to provide what the providers deem medically and ethically necessary.

Inmate Experience with Prison Healthcare

Experiences with inadequate healthcare can vary for incarcerated individuals across the prison system. Studies conducted by Scaggs (2025) and Sonntag (2017) have analyzed legislation regarding inmate healthcare and how it shapes constitutional minimums for incarceration facilities. Little is known about how these facilities advance beyond the constitutional minimum, as few comparative evaluations exist. Even when care is medically necessary, it can be delayed or denied by prison staff. This can result in a decline of physical and mental health or untreated substance abuse. There are policies in place for incarcerated individuals to request care and file a grievance when care is delayed; however, legislation does not provide a universal protocol that maintains a chain of command for incarcerated individuals to follow across the board.

Delayed or Denied Medical Treatment

Despite being under the care and control of the prison system, many incarcerated individuals still have a small portion of responsibility regarding their healthcare. Copays are established so that the prison can recoup the partial cost of providing care for the inmate, as well as holding them responsible for their own healthcare. While a copay deters incarcerated individuals from seeking unnecessary medical services, studies have found a pattern between copays and delayed medical care across prison systems (Howell et al. 2024; Lupez et al, 2024). Incarcerated individuals are paid pennies to the dollar compared to minimum wage, and copays force incarcerated individuals to choose between medical care and commissary items, and phone calls. Low wages in conjunction with necessary day-to-day purchases can delay timely medical care, as it may take weeks to months for the individual to work and save to pay the copay. (Wiggins, 2021).

While copays are required outside of prisons for sick visits, annual well checks are covered for free by most public and private insurance companies. Medicaid does not cover individuals during periods of incarceration, often terminating coverage on the day of entry. This results in a gap of adequate health care coverage as prisons do not provide well checks for incarcerated individuals. Prisons mostly offer as-needed medical care despite preventive screenings for diabetes, high blood pressure, and the like, preventing more costly diagnoses later in their incarceration. Disparities in care are created when routine bloodwork and annual testing are not completed, resulting in a delay in addressing physical health needs early in their onset (Armstrong, 2022; Haber et al., 2024).

The case of Elliot Earl Williams demonstrates the ultimate cost of denying medical care to incarcerated individuals. Mr. Williams was a veteran who was arrested in 2011 during a mental health crisis. Mr. Williams was taken by force to his cell after he refused to cooperate during his intake. He banged his head against the cell door and collapsed. Nurses left him on the ground as he complained of neck pain and vocalized that he was unable to move. The psychiatrist eventually placed Mr. Williams in an observation cell with camera surveillance. Staff documented his ongoing condition, but treatment was not offered until days into his incarceration. Because of the delayed medical care, Mr. Williams was found unresponsive and later pronounced dead. An autopsy revealed that Mr. Williams was dehydrated in addition to a hematoma that traveled and attacked his spinal cord, resulting in the cessation of his respiratory system. Had medical staff not denied him medical care, Mr. Williams could have survived his injuries. (Spence et. al, 2025).

Chronic Illness and Infectious Diseases

Carrying the diagnosis of a chronic illness as an inmate can bring many challenges. Incarcerated individuals who require more intensive medical care often face difficulty accessing specialized providers. This is often tied to funding and the cost associated with paying for the specialized care the inmate requires. A trend commonly found in prison healthcare is the use of physical exercise and diet as preventive factors for noncommunicable diseases to potentially lower the risk of a decline in physical health. Studies have shown that when given a choice, incarcerated individuals did not always take advantage of the options presented to them (Papa et. al, 2021; Pimentel Cabral et al., 2023).

Contagious diseases such as COVID-19, HIV, and Hepatitis can be passed between individuals quickly if proper medical measures are not implemented efficiently. A common pattern found among prisons is the creation of an infection prevention plan. This plan outlines necessary measures that will need to be implemented should an infectious disease be detected (Bancroft, 2009; Kendig, 2024). With incarcerated individuals in such proximity to one another, especially in overpopulated prisons, a new inmate could carry the disease into the prison undetected and pass it to fellow incarcerated individuals. Should the disease spread rapidly among the incarcerated individuals, a large portion of the population could require medical care at the same time.

One of the more vulnerable populations that battle chronic illness and infectious diseases is the elderly. 83% of elderly incarcerated individuals reported a long-standing illness or disability (Papa et. al, 2019). One study from 2022 found that of the 1.2 million individuals who were incarcerated in a state or federal prison, 24% were considered elderly due to being 50 years of age or older. In addition to preexisting conditions, they are also susceptible to accelerated aging and premature biological aging during their incarceration. The rate of aging for an elderly inmate was found to be approximately a two-year reduction in life expectancy for each year the individual remains incarcerated (Arias, 2025).

Substance Abuse and Rehabilitation Needs

While prisons are designed to reduce recidivism, prison staff can also be the ones who bring contraband into the prison. This makes access to illegal substances as easy as accessing the commissary. Prisons select incarcerated individuals of a certain status

to become informants so that first-hand knowledge of such transactions can be brought to light. Giving the responsibility of being an informant is a measure used to hold the inmate accountable and encourage them to maintain sobriety while costing the prison nothing to implement (Dittmann, 2019). There is little research or legislation that outlines the criteria or success of utilizing the title of informant to deter incarcerated individuals from using substances within a carceral setting.

For those actively seeking treatment instead of their net fix, Medicated Assisted Treatment (MAT) is a regulated way of addressing substance abuse within the prison system. Methadone and Buprenorphine are utilized in the prison systems as a treatment for substance use disorder. Bandara et al. (2021) conducted a study that spanned from August 2019 to January 2020, interviewing 35 individuals representing 19 carceral systems that use Methadone and Buprenorphine treatment. Challenges with a program of this nature were identified as licensing requirements, prescription limitations, adequate staffing, and appropriate space within the prison. Doses were found to be limited to low levels and required the individual to participate in other support services such as detox and counseling. (Bandara et al., 2021). There is little research that tracks inmates' use of MAT and the benefits such treatment brings to those with a substance abuse disorder.

Residential Substance Abuse Treatment (RSAT) programs are a division of the prison system designed for those who need ongoing substance abuse treatment. These programs tend to have more medical and mental health staff on site due to the specific needs of this population within the prison system. The program is anywhere from 6 to 12 months long and focuses on preparing the individual to be self-sustaining upon

release. Participants receive substance abuse treatment, mental health services, vocational training, and transitional services. (Gonzales et. al, 2005)

Mental Health Concerns

In addition to substance abuse treatment, mental health treatment is also imperative to the success and safety of not just the inmate but also for the incarcerated individuals and staff around them. Edwards et al. (2024) studied a sample of 314 individuals with personality disorders who were also enrolled in prison-based substance abuse treatment. This study found that males diagnosed with personality disorders were more likely to become involved in the criminal justice system at an early age, whereas women are more likely to have longer histories with mental health treatment in addition to internalizing symptoms.

A lack of mental health care can affect an inmate both mentally and physically. Santiago et al. (2025) analyzed the case of Mr. A, a fifty-year-old white male committed to the attorney general. Mr. A required intense mental health treatment and was placed in one of the Federal Bureau of Prisons' administrative facilities. Mr. A's refusal of medication and social decline led to physical health challenges that created a complex case for the prison's medical team to tackle. Mr. A required surgery; however, his mental health affected his ability to understand the need for surgical intervention. Mr. A ultimately passed away due to his physical health complications, which were exacerbated by his mental health. This example is one of many that prove the importance of proper mental health treatment for incarcerated individuals. While research exists related to cases of this nature, legislation regarding mental health

treatment does not offer specifics, but rather general guidance in how to address the immediate needs of the individual.

Research such as that of Gonderman (2025) and Máximo-Bocanegra et al. (2025) has shown both a lack of adequate mental health services for incarcerated individuals as well as a distrust of the available providers. These studies have found a pattern in inmate beliefs towards mental health services to include a mistrust of providers and being perceived as weak by fellow incarcerated individuals. An alternative to traditional mental health services has been the use of animal-assisted intervention, which capitalizes on the bond between a human and animal to reduce symptoms of anxiety and depression (Gonderman, 2025; Máximo-Bocanegra et al., 2025).

Gender-Specific Healthcare Challenges

Physical and mental trauma are tied to obstetrician care in the prison system. One study by Kirubarajan et. al (2022) consisted of 645 female incarcerated individuals, 69 healthcare providers, and 70 prison staff revealed a sense of dehumanization of prenatal care and delivery in the prison system. This group reported the use of shackles throughout their pregnancy, which creates challenges with mobility. In addition to difficulty in accessing medical care, these incarcerated individuals lacked sufficient mental health resources. While many had privacy concerns during their care, some also faced challenges with being able to access female staff members. (Kirubarajan et. al, 2022). Qualitative studies on such needs are readily available, yet quantitative data are more challenging to find. Legislation also lacks constitutional minimums for varying aspects of gender specific care.

Difficulty obtaining menstrual products affects the daily lives of female incarcerated individuals. Darivemula et. al (2023) analyzed a sample of 156 females with a history of incarceration. 62.6% of these women had to trade food or personal favors for basic hygiene products, while 29.5% had to trade for menstrual hygiene products. 53.8% were given fewer than five menstrual products during their initial processing, leading to 23.1% sustaining health problems from prolonged use of menstrual products (Darivemula et. al, 2023).

When incarcerated individuals are not able to receive gender affirming care, detrimental consequences can occur. The story of Ophelia De'lonta is one of many examples of challenges with gender affirming care for incarcerated individuals. De'Leonta is a trans woman who was serving her sentence in a male prison based on her biological genitalia. Ophelia was diagnosed with gender identity disorder and requested many accommodations during her incarceration. Starting in 1999, Ophelia would bring her concerns for inadequate healthcare to the courts many times. She was granted access to hormones and allowed to dress as a female in an all-men's prison. Ophelia attempted to self-castrate many times during her incarceration and was not able to access Sex Reassignment Surgery until she was released on parole. Ophelia spent her sentence across eight different prisons during her incarceration, in which many she was sexually abused by other incarcerated individuals (Francisco, 2021). The story of Ophelia De'Leonta shows how multiple aspects of inadequate healthcare (mental health, specialized care, and living conditions) come together to show the disparities within the prison healthcare system.

Policies in Prisons

Medical care for federal prisons is regulated through the Federal Bureau of Prisons. When an individual enters a federal prison, they are classified with a Care Level of one through four. Level one is generally the younger population who require minimal medical care every six to twelve months for diagnosis, such as asthma or diet-controlled diabetes. Level two requires a bit more care with monthly to semiannual clinic visits. This can be for medication-controlled diabetes or epilepsy. Level three requires ongoing care for disorders such as cancer and end-stage organ failure to prevent the need for hospitalization. Level four requires inpatient care at a Medical Referral Center for diagnosis, such as active cancer treatment or dialysis (Godfrey, 2024). This process allows all incarcerated individuals to be assessed for medical concerns upon entry, and a care plan is created and documented for those who require consistent medical intervention.

Federal legislation outlines oversight designed to regulate prison healthcare. In July of 2024, President Biden signed the Federal Prison Oversight Act. The act mandates that access to physical and mental healthcare is available to all incarcerated individuals and prison staff (Federal Prison Oversight Act, 2024). Additionally, public reports on prison conditions and any necessary correction plans are a requirement of this act. This act created a position for an Inspector General to oversee the requirements of the new legislation. It also creates a position for an Ombudsman who is responsible for investigating concerns raised by those both inside and outside the prison. This act not only seeks to improve the conditions of prison healthcare but also branches out to receive input on such decisions from former incarcerated individuals,

their loved ones, and area service providers (Federal Prison Oversight Act, 2024; Haber et. al, 2025).

While the Federal Prison Oversight Act mandates that medical care be available, it does not specify whether that care is associated with a cost to the inmate (Federal Prison Oversight Act, 2024). Each state has its own Department of Corrections that regulates the prisons in its state. The State of Georgia's Rules and Regulations state that medical and hospital care will be provided for all incarcerated individuals in the State of Georgia prisons. Unless identified in other legislation, medical care will be provided to the inmate at no cost to them or their loved ones (GA R&R - GAC - Rule 125-4-4-.01. responsibility). The State of Florida requires incarcerated individuals to pay a \$5 co-pay for non-emergency visits (The Florida Senate). If they do not have the full \$5 in their account when their care is requested, half of all future deposits will be held until the balance is paid. Once all federal-mandated requirements are implemented, each state may regulate remaining aspects as its governing body sees fit.

Accreditation

The National Commission on Correctional Health Care (NCCHC) offers optional accreditation to institutions based on the quality of the healthcare services they provide. They oversee accredited facilities in 48 states as well as Puerto Rico. NCCHC works to provide prisons with the necessary tools and resources to improve how incarcerated individuals request, receive, and follow up with medical care. NCCHC reports that in 2024, there was an 86% decrease in deaths per month among accredited prisons (NCCHC, 2024). In the five years before 2024, they saw a 264% increase in opioid treatment programs and a 1,100% increase in mental health services. (NCCHC, 2024).

The American Correctional Association (ACA) offers optional accreditation for the prison's overall operation. Their mission focuses on improving the overall conditions of correctional facilities, including an evaluation of the prison's healthcare services (American Correctional Association and Commission on Accreditation for Corrections, 2021). The process of accreditation assesses seven aspects within the prison, including living conditions and access to basic needs. The ACA works to ensure that incarcerated individuals receive proper care during their incarceration and know how to exercise their rights if necessary. (American Correctional Association and Commission on Accreditation for Corrections, 2021).

While the American Correctional Association is considered prestigious to some, whistleblowers in the United States Senate have brought an end to their unity with the Federal Bureau of Prisons. In April of 2024, the Federal Bureau of Prisons did not renew its contract with the ACA after Senators Elizabeth Warren, Ed Markey, and Jeff Merkley brought concerns to light about the ACA's misleading efforts and financial incentives to provide accreditation when ACA standards were not met (Sobie et al., 2025). This has resulted in ACA accreditation only being available to correctional facilities at the state level or lower. This is little research on how this legislative change has directly affected healthcare services within the federal prison system.

Issues Prisons Facilities Face

Burton (2017) analyzed data from 2010 and 2015 and found little change in the average cost of healthcare per inmate. The average cost to provide physical, dental, mental, and substance abuse care was \$5,720. California, New Mexico, Vermont, and Wyoming were found to have spent over \$10,000 per inmate, while Alabama, Indiana,

Louisiana, Nevada, and South Carolina only spent \$3,500 per inmate (Burton, 2017). This study assessed the incarcerated individuals as equals across the country; however, state budgets affect the availability of resources, indicating that smaller budgets of \$3,500 are significantly more restricted than those of \$5,720 and \$10,000 (Burton, 2017). While a budget analysis can be conducted from one fiscal year to the other, there is a lack of legislation that requires explanation for the financial decisions made by carceral facilities.

Private healthcare in the prison system is less effective at providing care for the overall health and well-being of incarcerated individuals. Private healthcare consists of single-provider options, eliminating a competitive healthcare market. There are few private healthcare providers for prison systems, even fewer after lawsuits find probable cause against a private company (Gelman, 2020). Prisons have discretion to contract with another private provider if their current one is terminated due to legal recourse. Private contracts are implemented in two forms. The cost-plus model allows the prison to reimburse the provider for exact expenses in addition to a fee for overseeing the services (Gelman, 2020). This often results in poor service quality as less expensive methods of care are used to keep the prison's financial responsibility low. Managed-care contracts define a flat rate for the care of each inmate. With this model, prisons can pocket the money not used on healthcare as profit (Gelman, 2020).

The Bureau of Prisons (BOP) faces a difficulty with staff employment and retention. In 2019, BOP utilized 6.7 million hours of overtime, with 4.7 million being worked by correctional officers (Trautman, 2022). By the 2022 fiscal year, the BOP had 37,834 staff members responsible for 155,826 incarcerated individuals (Trautman, 2022). When

required to work overtime at this rate, employees are at a higher risk for burnout and health risks. This can result in a direct effect on inmate care (Trautman, 2022).

Overpopulation can also directly affect an inmate's access to medical care. In the event of overpopulation, if an individual does not have a concern that requires immediate attention, it can take longer for them to see a medical provider (Spycher et al., 2021). Even with overpopulation, the prison's budget may not allow the funds to bring in additional medical providers. This leaves resources for a fixed number of incarcerated individuals to be stretched further than originally planned.

While individually critical, the factors of overpopulation, understaffing, and budget constraints together create detriment for the prison system. Privatized care has been criticized as a negative alternative due to poor quality of care, resulting in ongoing lawsuits (Gelman, 2020). Transferring incarcerated individuals to a private prison only temporarily addresses overpopulation while lightening the financial burden (Asif, 2025). Prisons are allowed to hire medical providers who may be on disciplinary restriction and cannot practice in the community (Song, 2024). This is allowed under a specific licensing standard and allows the growing inmate population to have more frequent access to providers. While this addresses the issue of understaffing, it can have negative implications compared to privatized healthcare, as there is no upholding of ethical standards. If a provider is unable to ethically work within the community, issuing a limited license only allows unethical practitioners access to a vulnerable population (Song, 2024).

Practices Used to Address Inadequate Healthcare in Prison

When access to healthcare resources is limited, prisons will utilize alternative practices to alleviate the burden. Compassionate release is considered for individuals who may require extensive medical care that can become costly for the prison. Alternatively, telehealth is utilized for consultation with the doctor when a full physical exam may not be necessary or available. By utilizing practices such as these, prisons can better meet the needs of incarcerated individuals in ways budgets and resources cannot.

As an alternative to in-person appointments, many institutions have begun to offer medical services via telehealth to quickly meet the medical needs of incarcerated individuals. One study analyzed the use of telehealth services in prison systems and found that most incarcerated individuals felt that telehealth services were sufficient or comparable to in-person appointments (Tian et al., 2021). Alternatively, Hewson et al. (2024) analyzed the continuity of care after the initial telehealth appointment and found that telemedicine is not always appropriate. Issues with technology and the need for face-to-face assessment in order to treat appropriately can blur the effectiveness of telemedicine. Additionally, follow-up appointments only occurred between 37.4% and 72% of the time due to factors such as prison transfer, release, and financial constraints (Hewson et al., 2024).

For those with medical conditions that require end-of-life care, certain criteria may allow them to apply for and be considered for compassionate release. This practice is used as a measure to address overpopulation and reduce the overall cost of long-term medical care (Holland et al., 2021). An inmate can become eligible for compassionate

release at a certain age or if they suffer from a terminal illness (Cooney, 2024). One must apply for compassionate release and be able to support their request with valid medical documentation. If approved, the inmate is released from their incarceration and becomes responsible for their own medical care. In 2013, the Bureau of Prisons was investigated when concerns arose that eligible incarcerated individuals were not being considered for compassionate release (Cooney, 2024). Incarcerated individuals with terminal illnesses were also dying before decisions could be made on the request. The compassionate release policy was revised in 2023 by the Sentencing Commission. An extraordinary and compelling reasons exist, and the inmate cannot be a danger to society. (Cooney, 2024; Holland et al., 2021).

Despite a growing body of scholarship on correctional healthcare, significant gaps remain in the evaluation of prison healthcare for incarcerated individuals. Much of the existing research focuses narrowly on specific health issues such as infectious diseases, mental illness, or substance use disorders, without fully addressing how systemic factors—such as policy implementation, funding structures, and privatization—shape overall healthcare delivery in prisons (Bancroft, 2009; Burton, 2017; Kendig, 2024; Santiago et al., 2025).

Additionally, while landmark court cases like *Estelle v. Gamble* (1976) established a constitutional right to healthcare, relatively few studies have examined how subsequent litigation and policy reforms have been enforced across diverse state and federal systems (Scaggs, 2025; Sonntag, 2017). Comparative evaluations that integrate legal rulings, administrative policies, and on-the-ground health outcomes remain scarce,

leaving an incomplete understanding of how prison healthcare both succeeds and fails in practice.

Research gaps underscore the need for a methodological approach that combines policy analysis, comparative literature review, and case law evaluation to provide a more comprehensive assessment of prison healthcare. This study will complete a case law analysis to identify key themes in past legislation as well as identify potential improvements to future legislation.

METHODOLOGY

This evaluation employs a case law analysis framework to examine the state of prison healthcare in the United States. Accessibility and timeliness of care, equity, and compliance with legislation were considered with each case. The purpose of this methodology is to assess how rulings from Supreme Court cases have shaped the delivery of healthcare to incarcerated populations, and to evaluate the extent to which these rulings have succeeded or failed in ensuring access to adequate medical care. Case law forms a critical component of the focus of this paper, as judicial decisions have historically shaped the legal obligations of correctional institutions. Landmark cases such as *Estelle v. Gamble* (1976), which established that “deliberate indifference to serious medical needs” constitutes cruel and unusual punishment under the Eighth Amendment, provide a legal baseline for evaluating prison healthcare. Additional cases, such as those addressing mental health care, disability rights, and class-action suits against private providers, are analyzed to determine how courts have influenced both policy development and enforcement.

Research Design and Approach

Thirty-four court cases related to prison and jail healthcare were analyzed to determine if they were successful in having a positive change on inmate healthcare. This analysis did not provide numerical data, but rather overarching themes from various aspects of prison healthcare. Case law forms a critical component of the focus of this paper, as judicial decisions have historically shaped the legal obligations of correctional institutions. Cases as recent as 2022 have shaped the nature and presentation of available healthcare resources for incarcerated populations.

A case law analysis is most appropriate for this study as it identifies the core issue, the court's ruling, and how that ruling has a direct effect on prison healthcare. These rulings vary in outlining the constitutional minimum for accessibility, timeliness, and equity of care. Similar studies conducted by Scaggs (2025) and Sonntag (2017) utilized a case law analysis to analyze state legislatures regarding inmate healthcare.

Data Sources

Thirty-four published court cases were selected from the district, appellate, and Supreme Courts. As *Estelle v. Gamble* (1976) set the standard for deliberate indifference in prison healthcare, all selected cases were after 1976. Both the initial complaint and rulings were analyzed. Data for this study were obtained from published legal cases and did not use human subjects. Sensitive information regarding the incarcerated population was not used. No information in this study portrays healthcare neglect within prison facilities. As a result, an IRB exception applied to this study.

Case Selection Criteria

Table 1 details the thirty-four cases analyzed in this study to create a cross-case synthesis. This is the table that outlines the case, the year it was heard, the court's ruling, and its effect on prison healthcare. These cases direct prison administrators on how to handle cases related to various healthcare needs. They do not specify a uniform protocol and procedure for all prisons to follow when providing healthcare to incarcerated populations. It leaves much room for interpretation on when, how, and why prison administrators should provide healthcare access and resources. As a result, this creates a variety of implications for prison healthcare.

Case	Year	Issue	Ruling	Contribution to Prison Healthcare Standards
Estelle v. Gamble	1976	Deliberate indifference to medical needs	Established that neglect of serious medical needs violated the 8 th Amendment	Set constitutional baseline for prison healthcare
Bell v. Wolfish	1979	Security practices like body cavity searches	Established that such practices do not meet criteria for deliberate indifference when upholding safety and security standards	Provide further clarification to deliberate indifference
Vitek v. Jones	1980	Transfer to a mental hospital was based on a physician's recommendation, potentially based on mental health stigma	Established procedural requirements for consideration of mental health hospitalization outside of the prison	Notice of a hearing where evidence can be presented by legal counsel before transfer to a mental health hospital
Rhodes v. Chapman	1981	Incarcerated individuals felt that a double ceiling was considered cruel and unusual punishment	Established that overpopulation is not cruel and unusual punishment if all basic needs are met	All incarcerated individuals, regardless of population size, must have access to necessary medical care
Whitley v. Abers	1986	Excessive force used to restore order during a riot	Established when excessive force is necessary and when it is considered a violation of the Eighth Amendment	Separated deliberate indifference and good faith efforts during riots.
Turner v. Safley	1987	Marriage required prison superintendents' approval and was limited to pregnancy and illegitimate children	Establish a four-part test for determining if a prison regulation is unconstitutional.	Marriage no longer needed the approval of the prison's superintendent and had no limitation for necessity.
West v. Akins	1988	Private medical care was inadequate and	A private provider contracted with the state is obligated to	Prison is held liable for inadequate care regardless of using a

		violated 8 th amendment protections	meet prison healthcare standards	public or private medical provider
Washington v. Harper	1990	Requiring incarcerated individuals to take antipsychotic medication.	Established that the safety of the inmate and those around them outweigh the right to refuse the medication.	Set standards for when antipsychotic medication can be administered without consent
Inmates of NY State with HIV v. Cuomo	1991	Inadequate HIV care	This case was settled and dismissed.	Created a quality improvement plan for HIV care and mandates all prison healthcare officials' complete HIV specific trainings each year.
McIlwain v. Prince William Hosp.	1991	Failure to inform inmate of HIV positive blood test resulted in his infecting his wife after release	Case against hospital was dismissed due to providing emergency care. Deliberate indifference by the doctor was proven.	Upheld the deliberate indifference standard for specialized care.
Nolley v. County of Erie	1991	Isolation and labeling the files of HIV positive incarcerated individuals	Sherriff was ordered to pay \$68,401 in damages to Louise Nolley for violating their rights.	Isolation of incarcerated individuals due to medical diagnosis is unconstitutional.
Wilson V. Seiter	1991	Overpopulation and housing with physically and mentally ill incarcerated individuals.	Established that proof of deliberate indifference by the prison must be provided by the plaintiff.	An inmate must prove a culpable state of mind by prison officials.
Hudson v. McMillian	1992	Excessive force by prison officials	Established that excessive force can be a violation of the Eighth Amendment even without injury.	Considers malicious and sadistic intent of prison official
Moore v. Mabus	1992	Isolation of HIV positive incarcerated individuals and inadequate healthcare	Appellate Court reversed the lower court's dismissal and required court appointed counsel be provided to properly addresses allegations	Allowed the incarcerated individuals access to counsel for proceedings they could not completed

			of deliberate indifference.	with their own knowledge.
Casey v. Lewis	1993	Allegations of inadequate medical, dental, and mental health care for incarcerated individuals: specifically, females lacking access to mental health care	Established criteria that the prison must uphold to include sufficient staff, mental health housing facilities, medication management, and equal care regardless of gender.	Required the prison to report to the courts every 6 months with a status update
Helling v. McKinney	1993	Involuntary exposure to environmental tobacco smoke by fellow incarcerated individuals	Established that cruel and unusual punishment can consist of exposure and not current need.	Expanded deliberate indifference to include both current and future health risk
Doe v. Wigginton	1994	Alleged violation of the Fourteenth Amendment when HIV status of inmate was shared with a corrections officer	Established that disclosure of a current incarcerated individuals HIV status to prison staff is not a constitutional violation of the Fourteenth Amendment	Distinguishes between the disclosure of HIV status to prison staff from disclosure to another inmate
Farmer v. Brennan	1994	Transgender female inmate was sexually assaulted after being forced into general population with male incarcerated individuals	Established that prisons should take reasonable measures to protect incarcerated individuals' health and safety	Holds prisons accountable for ignoring known serious risk to an incarcerated individual's health and safety
Edginton v. Missouri DOC	1995	Edginton claimed he was denied care for mental health and aids related issues	Dismissed by the Appellate Court due to a lack of details	Edginton could revise his claim and file an amended complaint
Williams v. Dehay	1996	HIV positive inmate was given alternatives to	Deliberate indifference was not proven, and ruling was in favor of	Williams later filed another claim for a different issue.

		narcotics and sleep aids due to jail policy requiring a court order for such medications	Cathy Dehay, Warden. Williams was not prescribed the medications he requested.	
Owens v. O'Dea	1998	HIV positive inmate alleged he received inadequate medical care.	Claim was denied as he was provided medical care but disagreed with the course of action.	Upheld that medical care must be provided and a course of action must be determined by a medical provider.
McNally v. Prison Health Services	1999	HIV positive inmate alleged he was denied HIV medication which violates ADA and constitutes deliberate indifference	McNally was found to have proven deliberate indifference and motions to dismiss by PHS were denied.	Case was settled before a jury trial occurred.
Perkins v. Kansas DOC	1999	HIV positive inmate claims that he was required to wear a mask outside of his cell and was denied medical care and outdoor exercise.	Dismissed due to insufficient evidence. Prison was able to prove medical care, and he disagreed with his treatment plan.	Upheld that medical care must be provided and a course of action must be determined by a medical provider.
Sullivan v. County of Pierce	2000	HIV positive inmate was accepted into a jail but not given his medication due to the jail pharmacy not having it.	Deliberate indifference was found and the case was sent to a jury.	Maintained that facilities must be able to accommodate the medical needs of those they accept.
Hallett v. NY State Dept. of Correctional Services	2000	Hallett claimed he was denied medical care and access to special programs due to him being an HIV positive amputee.	Upheld a violation of ADA but dismissed claims of inadequate medical care	Differentiated between denial of medical care and ADA violation

Taylor v. Barnett	2000	Taylor claimed his AIDS medication was changed without his knowledge, and the change was motivated by cost	Taylor was granted access to his medical records and a plan and rationale for his medical care was to be turned into the courts.	Cost cannot be the sole factor in medical decisions, and a medical rationale must be provided
McKune v. Lile	2002	Treatment program for sex offenders required admission of guilt	Consequences of not participating did not compel self-incrimination	Programs requirement of admission of guilt serves a purpose
Overton v. Bazzetta	2003	Limits visitation to attorneys and clergy after two substance abuse violations	Upheld limitations on visitation does not affect the health and safety of the offender	Limits exposure to outside sources for those with a history of substance abuse violations
Beard v. Banks	2006	Restricted reading material to religious and legal text when conduct is an issue	Upheld the use of limiting reading material as a deterrent from negative behaviors	Enforces restrictions as a punishment for negative behavior
Brown v. Plata	2011	Overcrowding affecting access to medical care	Established that court-mandated population limits must be followed by prisons.	Enforced how many incarcerated individuals can be housed to ensure access to health care for all.
Minnecci v. Pollard	2012	Alleged inadequate medical care in a private prison	Established when a Bivens claim is necessary	Defined how incarcerated individuals in a private prison proceed when claiming their Eighth Amendment rights are violated
Valentine v. Collier	2020	Texas geriatric prison failed to implement COVID-19 safety measures	Established that when a PLRA remedy is not accessible for a violation of the 8 th amendment exhaustion is not required (<i>Ross v. Blake</i>)	Bypass “unavailable” components of PLRA for 8 th amendment violations related to imminent harm.

Concepcion v. United States	2022	Resentencing request under First Step Act was denied based on original record and not rehabilitation and conduct since sentencing.	Established that rehabilitation and conduct can be considered in resentencing under the Fair Sentencing and First Step Acts.	Incentivizes participation in accessible substance abuse treatment programs and other rehabilitative efforts
Dobbs v. Jackson Women's Health Organization	2022	Eliminated the constitutional right to abortion	Established that lawsuits regarding abortion access and 14 th amendment violations are no longer valid	Limits access to abortions resulting in women giving birth while incarcerated.

Initially, internet searches using platforms such as Galileo and Google Scholar were conducted to find court cases regarding prison healthcare. The search was further refined by looking for cases that made it to the level of the Supreme Court. This limited the results greatly, so the search was expanded to include cases that made it to district or appellate courts. Key phrases used to identify appropriate cases for this study included prison healthcare, deliberate indifference, Eighth Amendment, and violation of rights.

Given that *Estelle v. Gamble* set the standard for deliberate indifference in prison healthcare, all selected cases were after 1976. Selected cases required the plaintiff to address one or more areas of health care for incarcerated individuals; however, they did not have to result in the plaintiff winning the case. The initial complaint of each case was assessed for its relation to inmate healthcare to be selected. For coding, the initial complaint and the case's outcome determined the classification of the case into its respective theme.

When the courts do not want to prescribe a specific healthcare standard, they defer to the corrections administrators to make decisions that meet a constitutional minimum. Several cases were found that cited deliberate indifference in their claim, but they did not correlate directly with complaints of inadequate healthcare and were thus excluded. Once identified, cases were analyzed for their core issue and coded based on the theme to which they were seeking recourse. Factors considered included the ruling made by the court and the case's final contribution to prison healthcare standards overall. No coding software was utilized.

Analytical Framework

This study found several key themes within prison healthcare. After cases were selected, themes emerged organically throughout the analysis. Cases were grouped in the same theme if they brought similar concerns or issues to the courts. Cases that established and continued the precedent of deliberate indifference were categorized together. The standard of deliberate indifference was set in *Estelle v. Gamble* (1976). This case has been used throughout the years to determine if violations of the Eighth Amendment met the standard of deliberate indifference or if the inmate was not getting the preferred care they expected from the prison system. This case is considered a pivotal movement within the American prison system, thus defining the theme of deliberate indifference.

Prison safety is paramount, considering the clientele consists of people deemed too dangerous to live freely in their own communities. *Nolley v. County of Erie* (1991) brought isolation tactics to the attention of the courts. As a result of isolating an HIV positive inmate, it was made known to the general population that he was ill in some

way. This was ruled by the courts as unconstitutional, and the inmate was awarded restitution. This case supported future claims regarding prison safety affecting an inmate's access to healthcare, defining the theme of prison safety as a result.

Another theme identified was concerns for adequate mental health treatment. *Vitek v. Jones* (1980) was a defining case for the future mental health care of incarcerated individuals. This case created a requirement that notice of a hearing must be provided to the individual in question. This hearing allows evidence to be presented by legal counsel before one is transferred to a mental health hospital. This fundamental right within the realm of mental health was written into legislation and shaped future efforts to include what services should be available to incarcerated individuals and when medication is required to be given to an inmate against their will.

Specialized care was also found to be a prominent issue among the incarcerated population. In addition to basic physical and mental health needs, there are a variety of specialized health care services that must be offered to ensure the overall safety and well-being of the incarcerated individuals. *Inmates of New York State with HIV v. Cuomo* (1991) was one of the first cases to hold the prison system accountable for their errors in care. This case laid the groundwork for the theme of specialized care as the legislation mandates that all prison healthcare officials complete HIV specific training each year. This case was also crucial, as many cases under this theme were related to HIV care and improving how the course of treatment remains appropriate despite cost or necessary housing.

Lastly, living conditions were found to be a factor that negatively affected the health and well-being of incarcerated individuals. *Rhodes v. Chapman* (1981) set a precedent that a double ceiling does not violate the Eighth Amendment if all individuals

can continue to access healthcare when needed. As a result, future cases challenged factors beyond population size to include poor living conditions, creating health issues that were not properly addressed, to being separated from the general population due to one's physical or mental illnesses.

Limitations

This study held a self-bias due to no coding software being used and all cases being selected by hand. Three limitations affect the results of this study. The judicial opinions of the court often reflect the *minimum standards* and not the best medical practice. Judges do not have any licensed medical credentials, making their rulings based on law and not medical fact. Secondly, not all healthcare issues within the prison system rise to the level of court intervention, especially at the level of the Supreme Court. This can result in issues not being addressed in litigation. Lastly, the court can defer to prison administrators, giving them the autonomy to interpret and uphold the court ruling; thus, limiting the scope of judicial oversight. This can create ethical concerns as those who hold the decision-making power regarding prison healthcare have no medical credentials or background.

RESULTS

This chapter examines cases regarding various aspects of prison and jail healthcare. These cases include aspects of mental health, substance abuse, women's rights, and legal process. Table 2 outlines the five emergent themes identified through a case law analysis. While a legislative standard outlined in *Estelle v. Gamble* (1976), deliberate indifference was a theme of its own. Cases like *Bell v. Wolfish* (1979) and *Helling v. McKinney* (1993) cited prison practices that instilled deliberate indifference towards incarcerated individuals. *Minneci v. Pollard* (2012) and *Valentine v. Collier* (2020) focused more on the administrative procedure an inmate must follow. These concerns all hint towards a much larger systemic issue of how incarcerated individuals request, receive, and continue with appropriate health care.

Theme	Case(s)	Key Legal Standard	Implication for Prison Healthcare
Deliberate Indifference	<i>Estelle v. Gamble</i> (1976) <i>Bell v. Wolfish</i> (1979) <i>West v. Akins</i> (1988) <i>Mcllwain v. Prince William Hosp.</i> (1991) <i>Helling v. McKinney</i> (1993) <i>Williams v. Dehay</i> (1996) <i>Minneci v. Pollard</i> (2012) <i>Valentine v. Collier</i> (2020)	Officials must not ignore serious medical needs	Baseline constitutional protection, but minimal
Prison Safety	<i>Whitley v. Abers</i> (1986) <i>Nolley v. County of Erie</i> (1991) <i>Hudson v. McMillian</i> (1992) <i>Doe v. Wigginton</i> (1994) <i>Taylor v. Barnett</i> (2000) <i>Overton v. Bazzetta</i> (2003)	Prison protocol must aim to protect the health and safety of all incarcerated individuals	Identifies when prison policy and procedure puts incarcerated individuals' health and safety at risk
Mental Health	<i>Vitek v. Jones</i> (1980) <i>Washington v. Harper</i> (1990) <i>Casey v. Lewis</i> (1993) <i>Edgington v. Missouri DOC</i> (1995)	Mental health must be considered when assessing	Identifies when an individual has a say in their mental health treatment and when prison officials can

	McKune v. Lile (2002) Beard v. Banks (2006)	overall health and safety	make the decision for them
Specialized Care (Substance Abuse, HIV, Reproductive Care)	Turner v. Safley (1987) Incarcerated individuals of NY State with HIV v. Cuomo (1991) Owens v. O'Dea (1998) Dobbs v. Jackson Women's Health Organization (2022) Concepcion v. United States (2022) McNally v. Prison Health Services (1999) Perkins v. Kansas DOC (1999) Hallett v. NY State Dept. of Correctional Services (2000)	Adequate healthcare consists of more than being physically well	Identifies the pros and cons of specialized healthcare programs, how they are offered, and its effect on incarcerated individuals' daily life
Living Conditions	Rhodes v. Chapman (1981) Nolley v. County of Erie (1991) Wilson v. Seiter (1991) Moore v. Mabus (1992) Farmer v. Brennan (1994) Brown v. Plata (2011)	Incorporates living conditions as a factor for overall health	Baseline housing standards necessary to protect the overall health and safety of incarcerated individuals

The first section of Table 2 shows how expansive the concept of deliberate indifference is and the many ways it can be applied to inadequate healthcare. *Estelle v. Gamble* (1976) is a landmark case for prison healthcare as it set the standard for deliberate indifference. *West v. Akins* (1988) upheld that the prison system is liable for inadequate healthcare regardless of whether it is a medical provider within the prison system or a private provider. *Minneeci v. Pollard* (2012) established that Eighth Amendment claims can be made from within a private prison and not just those in a public prison. Overall, legislation has maintained that all individuals in both public and private facilities are protected when treated by both public and private medical providers.

Systemic issues are found within each facility as well as within the prison system as a whole. This results in unclear policy and procedure. ACLU of North Carolina (2025)

is currently assisting an incarcerated individual named Pamela Chambers in fighting for cataract surgery that has been deemed medically necessary. Chambers was scheduled to have cataracts removed from both of her eyes in 2022, and the first eye was completed. Surgery for her second eye was denied due to a policy that only allows one cataract removal surgery during one's incarceration, regardless of medical necessity and the doctor's support. As a result of this policy, Ms. Chambers is now blind in one eye, has double vision, and poor depth perception. These factors increase her chances of fall-related injuries. This case shows that, despite all of the cases before it, deliberate indifference in the prison system is just as much a factor today as it was in 1976 with *Estelle v. Gamble*.

The second section in Table 2 displays the theme of prison safety. *Whitley v. Abers* (1986) and *Hudson v. McMillian* (1992) address how excessive force protocol distinguishes between good faith and deliberate indifference towards the incarcerated individuals involved. Good faith and the intent of the officer are left for interpretation and are not defined clearly in legislation. Alternatively, *Doe v. Wigginton* (1994) concretely defined the difference between disclosure of HIV status to staff versus other inmates. *Taylor v Barnett* (2000) concretely established that a medical rationale must be provided for medical care, and decisions cannot be made based on the cost of care alone. This analysis has shown that as time progressed, more definitive legislation was created regarding prison safety.

This section highlights systemic issues with how to day care of inmates has a direct effect on their physical and mental health. For example, the use of force on inmates whose behavior can be explained by untreated mental illness ultimately falls on

the prison, as proper medication management could reduce or resolve behaviors that lead to the necessity of excessive force. Additionally, isolation based on diagnosis can place unnecessary stigma on individuals who, when provided sufficient treatment and care, pose no direct threat to the safety of fellow inmates. With no current legislation providing clarity and criteria for facility practices, it is at the discretion of the individual themselves to seek legal recourse in hopes of change within the facility.

Konieczny (2025) details the ongoing case that Edwin Escobar-Salmeron brought before the courts. He alleges that two correctional officers at Eastern Correctional Institute in Maryland used excessive force despite his compliance with their request. Escobar-Salmeron first denied medical care but later sought care on multiple occasions for injuries he claimed were from the incident.

Eastern Correctional Institute is just one example of how prison safety affects the health of incarcerated individuals. According to Konieczny (2025), this is not the first claim made against the prison. In 2024, an officer from this same prison pleaded guilty to destroying video evidence of another correctional officer assaulting an inmate. The Prisoner Rights Information System of Maryland has inquired about staffing shortages at this facility. Staff shortages have resulted in ongoing lockdowns that deprive incarcerated individuals of their constitutional rights.

The third section of Table 2 addresses the theme of mental health. Inadequate mental healthcare and practices for incarcerated individuals have been a longstanding systemic issue that contributes to higher rates of recidivism. *Vitek v. Jones* (1980) and *Washington v. Harper* (1990) directly addressed and created mental healthcare practices for incarcerated individuals. This progress receded when *Casey v. Lewis*

(1993) required reports to be turned into the courts every six months, but only from one specific facility. Progress moved forward again when *Beard v. Banks* (2006) addressed direct practices of mental healthcare in terms of appropriate discipline within the prison. As is evident by the variation in case outcomes, it appears that progress with concrete policy and legislation has varied greatly over the past four decades.

This section highlights systemic issues with the treatment of the prison system's most vulnerable populations. Mental health diagnoses are critical in determining when and if an individual is sound enough to make their own decisions. Prison administration is tasked with taking an individual's diagnosis and deciding on the best course of action regarding the inmate's access to treatment, housing, and social interactions. As prison administration positions do not require a medical background, uneducated decisions can result in poor quality of care for incarcerated individuals who require mental health care.

Access to adequate mental health care remains a challenge for the incarcerated population. For example, a lawsuit was initiated in 2024 by incarcerated individuals at the U.S. Penitentiary in Lee due to inadequate mental health care. These individuals each held a serious diagnosis, ranging from PTSD, bipolar disorder, and schizophrenia, where they were able to obtain medication management at other facilities, but were taken off of those medications shortly after arriving. As a result, these individuals have suffered physically, mentally, and emotionally. A lack of medication management has created insomnia, anxiety, suicidal ideation, and mania. There is a history of USP Lee denying mental health care, even after repeated requests, in addition to officers retaliating with physical and emotional abuse (Washington Lawyers' Committee, 2024).

The fourth section of Table 2 addresses specialized care. Accessing healthcare in any capacity is an ongoing challenge for incarcerated individuals, but accessing specialized care to address certain issues can seem nearly impossible. Two key issues were highlighted within this theme. Many cases addressed pregnancy and women's healthcare: *Turner v. Safley* (1987) created legislation that allowed marriage without a reason for necessity, such as an illegitimate pregnancy. Progress regarding pregnancy during incarceration took a drastic change when *Dobbs v. Jackson Women's Health Organization* (2022) limited access to abortions.

Additionally, concerns were found with adequate care for those with HIV/AIDS. *Incarcerated individuals of NY State with HIV v. Cuomo* (1991) resulted in legislation that requires all prison healthcare officials to complete HIV-specific training annually. *Owens v. O'Dea* (1998) and *Perkins v. Kansas DOC* (1999) plateaued legislation by reiterating that medical care must be provided but supported by a medical provider. *Hallett v. NY State Dept. of Correctional Services* (2000) further clarified legislation by differentiating between a violation of the Americans with Disabilities Act and being denied medical care. While slight, positive progress seems to have been made regarding policy and legislation for specialized healthcare.

This section shows systemic issues similar to those with a mental health diagnosis. Individuals who suffer from diseases such as cancer, HIV/AIDS, or kidney failure require specialized care to maintain a sufficient quality of life. Additionally, reproductive and gender-affirming care fall into this category of healthcare. As previously mentioned, uneducated prison administration holds the power to deny critical life-saving measures that a hospital would provide instantaneously without question.

This denial of care can be the result of a provider who is unable to practice in the community due to ethical concerns, being allowed to practice within the prison system, and presenting the administration with a less costly alternative that meets the minimum requirements of care while costing significantly less.

Current President Donald Trump has recently prohibited gender-affirming care in federal prisons. As a result, medical care related to hormone replacement therapy has ceased. The ACLU filed an ongoing lawsuit in 2025 on behalf of three transgender individuals from New Jersey, Minnesota, and Florida. Each individual has been diagnosed with gender dysphoria by BOP medical providers and was prescribed hormone therapy. Access to hormone therapy will be directly affected by President Trump's new legislation. This legal recourse cites the change in care as a cruel and unusual punishment (American Civil Liberties Union, 2025).

The final section of Table 2 is living conditions. These cases proposed various issues with prison living conditions that resulted in the evolution of health issues among the incarcerated individuals. A constitutional minimum was created with *Rhodes v. Chapman* (1981) as legislation required all incarcerated individuals should have access to healthcare regardless of the population size in the facility where they are housed. This was further reiterated thirty years later in *Brown v. Plata* (2011). *Farmer v Brennan* (1994) created legislation that holds prison facilities accountable for ignoring serious risk to one's health and safety. Living conditions are a crucial component included in a facility's American Correctional Association accreditation but are not a criterion considered for accreditation through the National Commission on Correctional Healthcare. Although both accreditations are optional for incarceration facilities, living

conditions are a systemic issue that affects the overall health and safety of incarcerated individuals.

This section is unique as it goes beyond the systemic issues of healthcare and into the realm of daily living. When incarcerated individuals are forced to live in overpopulated units with minimal space for social distancing, it can contribute to the rampant spread of infectious diseases. Prison administration is then tasked with both addressing the housing crisis and an epidemic. Additionally, in cases such as *Wilson v. Seiter* (1991), housing those who are a danger to themselves or others in general population settings puts those around them at risk of imminent harm.

Haywood (2025) gives insight into an ongoing lawsuit against a New Mexico prison when five female inmates pursued legal action after *Helicobacter pylori* circulated through the population. Allegations are being made that this is the result of both unsanitary kitchen conditions and failure to treat and test for the disease. The kitchen was infested with pigeons, rodents, and cockroaches, and trays were served with pigeon feces on them. This lawsuit also asks that grievance protocols be addressed by the court, as those who have filed face retaliation, such as being threatened with disciplinary action or ignored by staff.

Overall, this case analysis reveals that there are several issues currently within the prison healthcare system that require improvement. There is a lack of legislation that mandates constitutional minimums for various aspects of adequate healthcare. As a result, policy outlining how incarcerated populations access various forms of healthcare varies across state and federal prison facilities.

Cases brought before the court as recent as 2024 and 2025 reinforce ongoing systemic issues. This is due to a lack of policy and legislation that clearly addresses these issues directly. The Prison Litigation Reform Act further complicates the matter, as it states that all administrative procedures must be followed before a lawsuit can begin. The creation of legislation that outlines constitutional minimums across the board for state and federal prison systems would, in turn, create a uniform procedure that would guide individuals through the legal processes they must follow.

DISCUSSION AND RECOMMENDATIONS

Interpretation of Findings

The concept of deliberate indifference has been tried from various angles, from *Estelle v. Gamble* (1976) to *Helling v McKinney* (1993) to *Valentine v. Collier* (2020). While incarcerated individuals of *NY State with HIV v. Cuomo* (1991) and two other cases from 1991 directly addressed HIV care for incarcerated individuals, policy and legislation continued to evolve through *Hallett v. NY State Department of Correctional Services* (2000), where it was determined there is a difference between a denial of medical care and an ADA violation. These cases support that taking proper legal action can result in improvements to adequate healthcare standards.

Systemic and Institutional Barriers

Systemic and institutional barriers prevent prison facilities from meeting healthcare standards. Living conditions can have a direct effect on how illnesses and diseases spread through a facility. Preventative measures such as physical exercise and diet are used to lower the risk of chronic illnesses and infectious diseases (Papa et. al, 2021; Pimentel Cabral et al., 2023). An infection prevention plan is also used to outline necessary measures if an infectious disease is detected (Bancroft, 2009; Kendig, 2024). Even with these efforts in place, overpopulation can counteract all the prevention these measures aim to achieve. *Brown v. Plata* (2011) brought about limits on housing in relation to accessible healthcare for all. This piece of legislation aims to ensure that all individuals housed within a facility are able to obtain adequate healthcare regardless of population size.

In addition to physical health, mental health and specialized care treatment also lack regulation. This creates a sense of mistrust among the incarcerated population. *Casey v. Lewis* (1993) brought concerns for inadequate mental health care to the courts, and

as a result, the facility had to provide a bi-annual status report to the courts. This was only for this facility and was not made a constitutional requirement for all facilities.

Edgington v. Missouri DOC (1995) shows the attempt made to claim a lack of adequate mental and specialized health care; however, the case was dismissed due to a lack of details.

One of the largest systemic barriers that directly affects prison healthcare is the budget allocated for prison healthcare. A deficit in the budget can negatively affect incarcerated individuals in a variety of ways. *Casey v Lewis* (1993) requires prisons to maintain sufficient staff, mental health facilities, and medication management. *Taylor v Barnett* (2000) then contributed the concept that cost alone cannot be the deciding factor in what medical care is offered to incarcerated individuals. Recently, *Valentine v Collier* (2020) ruled that an inmate is not required to exhaust elements of PLRA when a remedy is not made available to them. Together, these cases show a direct correlation between budget constraints and access to mental and specialized healthcare.

While there are policies in place to request care and file a grievance when care is delayed, legislation does not provide a standard protocol across the board for all facilities to follow. Many facilities implement copays to recoup the cost of providing care for the inmate; however, due to little to no income, studies have found a pattern between copays and delayed medical care across prison systems (Howell et al. 2024; Lupez et al, 2024). Low wages in conjunction with necessary day-to-day purchases can delay timely medical care, as it may take weeks to months for the individual to work and save to pay the copay (Wiggins, 2021). Despite requiring copays, a lack of healthcare

coverage eliminates routine health checks and annual testing, which can result in delayed care (Armstrong, 2022; Haber et al., 2024).

Pressing Issues

There are several pressing issues for those seeking adequate medical care with little improvement. Deliberate indifference can be found in cases defending an individual's right to specialized care. Substance abuse treatment, such as Medication-Assisted Treatment, can be especially difficult to access, whereas the substances themselves are easily accessible through prison staff (Bandara et al., 2021; Dittmann, 2019). Gender specific needs, such as obtaining menstrual products and gynecological care, affect the daily lives of incarcerated females. They are faced with making decisions that males do not such as what to trade for hygiene products (Darivemula et al., 2023).

One of the most pressing issues in prison healthcare is accessing specialized care. This can range from HIV treatment, pregnancy, and substance abuse treatment. *McNally v. Prison Health Services HIV* (1999) exemplifies how one HIV positive inmate was able to prove deliberate indifference when he was denied HIV medication, and this violated the Americans with Disabilities Act. HIV treatment is not standard and requires specialized care to ensure the form of treatment prescribed is effective. *Sullivan v. County of Pierce* (2000) addressed how an HIV positive inmate was accepted into a jail but was not given his medication due to the jail pharmacy not having it. It was ruled that correctional facilities must be able to accommodate the medical needs of those they accept. This legislation is important for those who require specialized care, as it stipulates that prisons must provide all necessary medical care for those accepted into their facility. This included their safety, living conditions, and ability to access care.

Implications for Public Safety Policy and Practice

The concept of deliberate indifference is used when an inmate feels that their Eighth Amendment rights have been violated. This can encompass various concerns for an inmate's overall access to healthcare. Prison safety is tied to prison healthcare when the measures used to keep incarcerated individuals and staff safe result in the administration of medical care. Safe living conditions are a basis for ensuring that both physical and mental healthcare are effective beyond the prison's medical clinics. Specialized care is also critical for populations such as women, those with substance abuse issues, and those with lifelong illnesses such as HIV/AIDS.

Recommendations for Policy or Program Improvement and Action

Cases related to specialized care, such as *Incarcerated individuals of NY State with HIV v. Cuomo* (1991) and *Owens v. O'Dea* (1998), allege inadequate healthcare. The creation of a healthcare plan upon entry to the facility would help to hold the facility accountable for timely meeting the healthcare needs of incarcerated individuals. This would go further than the current assessment for urgent needs completed upon entry and would include the incarcerated individuals' concerns and whether resources are available to accommodate their needs.

The creation and implementation of this plan would document the date and time of the inmate's concerns upon entry, would remain in their chart and be updated with each visit, and document either the timeliness of referrals and implementation of services or the legitimate reason why such a request is being denied. Additionally, part of this assessment would be to provide the inmate with a physical copy of the policy and procedure for how to request healthcare services within the facility. This will require the

implementation and continuation of clear policy and procedure so that equal and sufficient healthcare can be accessed by all.

An example of the utilization of this assessment would be an incarcerated individual's request for mental health services. If an inmate reports that they suffer from depression and passive thoughts of self-harm, this would be documented, and a referral to available mental health services would be completed. If resources are not readily available, this assessment would be routinely updated with all efforts made to provide care to the inmate. If the inmate reports having those same symptoms, but they are alleviated with access to certain medications, privileges, or goods, this allows the prison to document the request and that it is denied due to the inmate seeking an exception to prison policy without medical necessity. Currently, each contact with a provider is documented in chart notes, but the introduction of this assessment would provide an overall summary of complaints and remedies without having to search through each chart note. This assessment can be instrumental in lawsuits as it would provide a summary of efforts that either hold the prison accountable for implementing services timely manner or explanations of why an inmate's request was denied.

The primary challenge associated with this reform is the creation and implementation of such an assessment. Current intake assessments vary across the state and federal levels. Creating and implementing a long-term tracking system of this nature would require consistency from providers in asking direct questions, documenting factual answers, and referring individuals for services timely manner.

The feasibility of this plan would be contingent upon several factors. At the state level, it would require each state's Department of Corrections to create an assessment

based on the legal requirements for healthcare minimums in their state. Federally, legislation would need to require all public and private facilities to follow such an intake procedure to ensure this process is completed at intake. Additionally, the facility's budgets and financial records would have to be current and accurate to ensure that adequate medical staff are available to complete these assessments thoroughly.

Rhodes v. Chapman (1981) found a direct correlation between staff shortages and the concerns brought before the court. Incentive programs could be used to entice healthcare professionals to seek a career in a carceral setting. This could include the creation of scholarships like those that teachers receive. The TEACH grant is offered to college-level students who agree to teach for four years in a low-income school. If a grant of this nature were created by the federal government for those in the medical field, they would agree to work as a healthcare provider in the prison system for a predetermined number of years in exchange for money towards their college tuition. This could incentivize medical students to seek opportunities for employment in the prison system that they may not have previously considered. The hope of this grant would be to keep consistent amounts of healthcare workers in the prison system so that inmates are able to access proper healthcare when needed. Additionally, tracking staff retention with routine employee counseling as well as exit interviews can provide data on what policy modifications could increase staff retention.

Limitations of the Evaluation

This study was limited to concerns brought before the district, appellate, and the Supreme Court. In addition to the cases that made it this far, there are a multitude of other complaints that are not filed by incarcerated individuals, settled outside of court, or

dismissed by a lower court. This limits what issues come before the courts and creates a change in legislation.

Suggestions for Future Research and Evaluation

With each state having its own Department of Corrections, the standards for adequate healthcare vary greatly across the country. A state-by-state research analysis related to the cases brought before lower-level courts regarding inadequate healthcare would provide a better insight into emergent themes related to inmate healthcare for each state. This could show that not all states have the same issue when it comes to prison healthcare or that one theme is common across the country.

An example of this would be how infectious disease seems to be a common practice that varies across the country. *Perkins v. Kansas DOC* (1999) was brought about by an HIV positive inmate being forced to wear a mask outside of his cell. *Hallett v. NY State Dept. of Correctional Services* (2000) was the result of an HIV positive inmate being denied access to special programs altogether. A state-by-state analysis could prompt inquiry into what the federal government is able to offer to better support state prisons and bring unity to policy and procedure.

Additionally, an evaluation of the Federal Bureau of Prisons' operational criteria could be beneficial. Areas of improvement can be identified, and an action plan can be created to rectify these areas by a particular deadline. Such findings could also identify more cost-efficient ways to provide necessary healthcare services to incarcerated individuals. *Taylor v. Barnett* (2000) was brought about when medication changes were fueled by cost. This resulted in the court's ruling that a medical rationale is necessary, and cost cannot be the sole factor. Federal legislation that brings uniformity to policy

and procedure instead of constitutional minimums could result in the improvement of healthcare access to inmates across the board.

CONCLUSION

Inadequate healthcare in the American prison system continues to be an ongoing challenge. This study aimed to address how legislation has evolved over the past several decades to improve the quality of healthcare offered to incarcerated individuals.

With access to adequate healthcare being one of the most basic and essential human rights, it is important to consider that incarcerated individuals do not have insurance to cover essential care. The Bureau of Prisons is ultimately responsible for the individuals in their care and is often tasked with interpreting the grey areas of the law. Without clear legislation to outline distinct policy and procedure, the BOP can interpret and implement the law in ways that are beneficial for them and not the overall health and safety of those they serve.

While access to adequate healthcare is the responsibility of prison administration, responsibility is shifted to incarcerated individuals by establishing procedures to request care and implementing copays to recoup the cost associated with caring for the carceral population. When such policies and procedures begin to violate essential human rights, the Eighth Amendment provides protections against the utilization of and access to healthcare as cruel and unusual punishment. Violations of this nature often manifest into legal action against the facility.

This study found five key themes within legislation from 1976 to the present. Those relevant to the concept of deliberate indifference showed that there are minimal, baseline protections for incarcerated individuals. Those related to prison safety showed how policy and procedure can directly affect the health and safety of those within a carceral setting. In addition to cases regarding physical health, cases specific to mental health care show the extent to which individuals are involved in their own mental health treatment and when the prison system makes decisions on their behalf. This leads to other types of specialized care, such as substance abuse, HIV/AIDS, and pregnancy, and how these needs are addressed within the American prison system. Lastly, living

conditions such as overpopulation and isolation have a direct effect on the continuity of care for individuals with specialized needs.

This study contributes to the field of public safety as it analyzes critical components of how individuals classified as threats to their communities receive humane healthcare. Prison officials are to be knowledgeable of the overall health and well-being of the individuals within their facility, as they are placing correction officers in direct interaction with those who, at their healthiest, are unable to live and function safely within their communities. Systemic failures continue to limit access to adequate care, which makes this study crucial to the process of examining how prison healthcare has evolved and what legislation has influenced current policy and procedures. It is important to move forward with further analysis of each state's Department of Corrections to see what trends are working on an individual level before seeking to apply such practices to a federal realm.

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