CENTER FOR Science IN THE Public Interest

Strategies to Optimize Food and Nutrition in Correctional Facilities

Findings and Recommendations of an Expert Workgroup

Background:

Achieving health equity has never been more urgent as in the era of COVID-19 and renewed commitments to racial justice in public health and other sectors. Increasingly, public health experts recognize that the disproportionate incarceration of Black, Indigenous, Latinx, and other socially at-risk individuals in the United States is both a manifestation of structural racism and a driver of health inequity.[1] Outside of confinement, the same historically marginalized communities experience disparities in access to healthy food and burden of chronic diseases.[2] While reducing the number of people incarcerated is an important goal, it is also critical to minimize harm to people already in the system and facilitate their healthy return to the community. In this way, there is an opportunity to advance health equity through the correctional food environment. Furthermore, as this report will describe, there is an urgent need to raise standards, and then meet them, for health, palatability, and dignity in much of correctional facility food service.

This report is based on the insights of an expert Workgroup that convened throughout 2020. It summarizes key findings from our efforts to synthesize information about the correctional food landscape and makes recommendations for advocates, policymakers, and funders seeking to optimize food and nutrition in adult and youth correctional facilities.

About the Correctional Facility Food Service Guidelines Special Project Workgroup:

From March to December 2020, the Center for Science in the Public Interest (CSPI) convened the Correctional Facility Food Service Guidelines Special Project Workgroup ("the Workgroup") to fill a knowledge gap among food service guidelines (FSG) advocates regarding food and nutrition in youth and adult correctional facilities. FSG are standards for healthier foods and beverages that can improve the food environment in public facilities (*e.g.*, hospitals, universities, office buildings, parks, senior centers); however, correctional facilities have often been left out of state and local efforts to adopt FSG. The Workgroup consisted of public health advocates,

---

[1] Bowleg L. Reframing Mass Incarceration as a Social-Structural Driver of Health Inequity. *Am J Public Health*. 2020;110(S1):S11-S12;Acker J, et al. *Mass Incarceration Threatens Health Equity in America*. Robert Wood Johnson Foundation. December 1, 2018. https://www.rwjf.org/en/library/research/2019/01/mass-incarceration-threatens-health-equity-in- america.html;American Public Health Association. New Public Health Policy Statements Adopted at APHA 2020. October 25, 2020. https://www.apha.org/news-and-media/news-releases/apha-news-releases/2020/2020-apha-policy-statements.

[2] Centers for Disease Control and Prevention. *National Diabetes Statistics Report 2020*. https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf;Centers for Disease Control and Prevention. Estimated Hypertension Prevalence, Treatment and Control Estimates Among US Adults Tables. 21 Jan. 2020. https://millionhearts.hhs.gov/data-reports/hypertension-prevalence-tables.html#Table1; US Department of Health and Human Services Office of Minority Health. Heart Disease and American Indians/Alaskan Natives. February 14, 2020. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=34;Benjamin EJ, et al. Heart Disease and Stroke Statistics—2019 Update: A Report from the American Heart Association. *Circulation*. 2019;139(10):e56-e528;Odoms-Young A. Examining the Impact of Structural Racism on Food Insecurity: Implications for Addressing Racial/Ethnic Disparities. *Fam Community Health*. 2018;41 Suppl 2 Suppl, Food Insecurity and Obesity(Suppl 2 FOOD INSECURITY AND OBESITY):S3-S6;Jernigan VBB, et al. Food Insecurity among American Indians and Alaska Natives: A National Profile using the Current Population Survey-Food Security Supplement. *J Hunger Environ Nutr*. 2017;12(1):1-10.

criminal justice reform advocates, researchers, and officials from public health and correctional agencies at the federal, state, and local level. Additionally, a formerly incarcerated individual and a family member of an incarcerated person participated periodically.

After agreeing on our objectives for gathering information and developing recommendations, the Workgroup met monthly via Zoom, with each meeting being devoted to one or more of the following topics: demographic characteristics of the incarcerated population; key nutrition-related health concerns for incarcerated people; operational characteristics of correctional food service; correctional facility food and nutrition policies and compliance; food-related experiences of incarcerated people; and barriers, facilitators and best practices for improving nutrition in correctional facilities. Prior to each meeting, members reviewed documents such as policies, research findings, and investigative reports that addressed the topic of interest. During the meetings, presentations and facilitated discussions deepened our understanding of the issues. Following the information-gathering phase of the work, CSPI drafted a summary of the Workgroup's key findings and recommendations that was refined based on two rounds of feedback from members.

Summary of the Key Findings:

Black, Latinx, and Indigenous individuals are disproportionately incarcerated in the United States.

The United States has the largest incarcerated population in the world, at more than 2.1 million individuals,[3] with year-end 2019 data indicating that 1.4 million individuals are confined in state or federal prisons; the remainder are in local jails.[4] Following a stable rate of incarceration for most of the 20th Century, the incarceration rate began to dramatically increase starting in 1975,[5] reaching an all-time high in 2008 (1,000 incarcerated per 100,000 adults).[6] This trend (often referred to as "mass incarceration") has historically and continues to disproportionately burden historically marginalized groups:

- While the general adult population in the United States is approximately 63.7 percent white, 12.6 percent Black, and 16.3 percent Latinx,[7] these racial/ethnic groups constitute 31 percent, 33 percent, and 23 percent of the prison population, respectively.[8]
- The greatest racial disparities in imprisonment rates are between Black and white males: overall, the imprisonment rate of Black males is 5.7 times greater than that of White males, and Black males aged 18 to 19 years are 12 times as likely to be imprisoned as White males of the same age.[9]

---

[3] Maruschak LM, Minton TD. *Correctional Populations in the United States, 2017-2018*. Bureau of Justice Statistics. August 27, 2020. https://www.bjs.gov/index.cfm?ty=pbdetail&iid=7026
[4] Carson, EA. *Prisoners in 2019*. Department of Justice, Bureau of Justice Statistics. October 2020. https://www.bjs.gov/content/pub/pdf/p19.pdf
[5] Langan PA, et al. *Historical Statistics on Prisoners in State and Federal Institutions, Yearend 1925-86*. Bureau of Justice Statistics. May 1988. https://www.ojp.gov/pdffiles1/Digitization/111098NCJRS.pdf; U.S. Bureau of the Census. Projections of the Population of the United States: 1975 to 2050. *Current Population Reports.* 1975; P-25(601). https://www.census.gov/content/dam/Census/library/publications/1975/demo/p25-601.pdf.
[6] Maruschak, 2020.
[7] Racial/ethnic terminology taken from source material. Humes KR, Jones NA, Ramirez RR. *Overview of Race and Hispanic Origin: 2010*. United States Census Bureau. March 2011. https://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf.
[8] Carson, 2020.
[9] Carson, 2020.

- Indigenous individuals are incarcerated at more than twice the rate of white Americans.[10]
- In one survey, 16 percent of transgender adults reported having been incarcerated, and 47 percent of Black transgender people reported having been incarcerated at some point during their lives.[11]

The most recently available data (late 2018) estimate that approximately 37,500 youths were detained (combined correctional and residential facilities),[12] with the most recently available stratified data (2017) showing that 28,000 youths were detained in juvenile correctional facilities and 4,500 in adult jails and prisons.[13] When compared to white youth in 2017, Black, Indigenous, and Latinx youth were 4.6, 2.9, and 1.4 times more likely to be incarcerated, respectively.[14]

Currently and formerly incarcerated people are more likely to have certain nutrition-related chronic diseases and risk factors compared to the general population.

The same socially disadvantaged groups that are disproportionately incarcerated in the United States (*i.e.*, Black, Latinx, and Indigenous individuals) are also more likely to develop nutrition-related chronic health conditions, including diabetes, hypertension, and cardiovascular disease, as well as obesity, which increases the risk of developing the aforementioned conditions.[15] The median time served by individuals released from state prisons in 2016 was 1.3 years, which equates to more than 1400 meals eaten while incarcerated; as diet is a key modifier of several preventable diseases, the quality of food served in correctional facilities may have long-term health ramifications.[16]

According to nationally representative data from 2011 to 2012, the prevalence of overweight (BMI≥25) and obesity (BMI≥30) among adults is similar in the incarcerated and non-

---

[10] Daniel, R. Since You Asked: What Data Exists About Native American People in the Criminal Justice System? Prison Policy Initiative. April 22, 2020. https://www.prisonpolicy.org/blog/2020/04/22/native/

[11] Grant JM, et al. *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. National Center for Transgender Equality & National Gay and Lesbian Task Force. 2011:163. https://www.transequality.org/sites/default/files/docs/resources/NTDS_Report.pdf

[12] Hockenberry S, Sladky A. Juvenile Justice Statistics: National Report Series Bulletin. U.S. Department of Justice. December 2020. https://ojjdp.ojp.gov/publications/jrfc-2018-selected-findings.pdf

[13] The Prison Policy Initiative has classified the nine categories from the Census of Juveniles in Residential Placement into either correctional facilities (these are more restrictive, *i.e.*, detention center, long-term secure facility, reception/diagnostic center) or residential facilities, in which youths can still participate in community life and which may offer tailored programs/services (i.e., residential treatment center, group home, ranch/wilderness camp, shelter, boot camp, etc.). Sawyer W. Youth Confinement: The Whole Pie 2019. Prison Policy Initiative. December 19, 2019. https://www.prisonpolicy.org/reports/youth2019.html

[14] The W. Haywood Burns Institute. United States of Disparities. 2021. https://usdata.burnsinstitute.org/#comparison=2&placement=1&races=2,3,4,5,6&offenses=5,2,8,1,9,11,10&year=2017&view=map

[15] Centers for Disease Control and Prevention, National Center for Health Statistics. Prevalence of Obesity and Severe Obesity Among Adults: United States, 2017-2018. Data Brief No. 360. February 2020. https://www.cdc.gov/nchs/products/databriefs/db360.htm#:~:text=The%20age%2Dadjusted%20prevalence%20of%20obesity%20among%20U.S.%20adults%20was,age%20group%20(Figure%201);U.S. Departments of Health and Human Services Office of Minority Health. Obesity and American Indians/Alaska Natives. March 26, 2020. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=40;Centers for Disease Control and Prevention. National Diabetes Statistics Report 2020. https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf;Centers for Disease Control and Prevention. Estimated Hypertension Prevalence, Treatment and Control Estimates Among US Adults Tables. January 21, 2020. https://millionhearts.hhs.gov/data-reports/hypertension-prevalence-tables.html#Table1; US Department of Health and Human Services Office of Minority Health. Heart Disease and American Indians/Alaskan Natives. February 14, 2020. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=34 ;
Benjamin EJ, et al. Heart Disease and Stroke Statistics—2019 Update: A Report from the American Heart Association. *Circulation.* 2019;139(10):e56-e528.

[16] Kaeble D. Time Served in State Prison, 2016. U.S. Department of Justice, Bureau of Justice Statistics. November 2018. https://www.bjs.gov/content/pub/pdf/tssp16.pdf

institutionalized populations.[17] However, while there is some inconsistency in the literature, several studies reported an association between incarceration and weight gain, with a 2020 systematic review and meta-regression reporting that weight increased steeply at the beginning of incarceration and appeared to level off after two years. The mean weight gain was 11.7 lbs. at 2 years, which is up to five times the rate in the middle-aged US population.[18]

From 2011 to 2012, 44 percent of people in prison custody and 45 percent of people in jails reported ever having a chronic medical condition, compared to just 31 percent and 27 percent of their non-incarcerated counterparts, respectively.[19] Incarcerated individuals in prisons and jails are respectively 1.5 and 2 times more likely to have high blood pressure, diabetes, or asthma compared to a standardized general population.[20]

Increased risk of chronic disease may persist after individuals are released from correctional facilities. A prospective study found that formerly incarcerated individuals experienced 60 percent higher odds of developing hypertension in young adulthood compared to those who had never been incarcerated when adjusting for smoking, alcohol and illicit drug use, and family income.[21] A prospective study of veterans showed that incarceration within the last year was associated with uncontrolled hypertension compared to those who had never been incarcerated, after adjusting for confounding factors.[22]

Formerly incarcerated individuals face several social and economic barriers to meeting basic needs.[23] Specifically, there is an association between history of incarceration and increased risk of food insecurity, the latter of which is linked to a range of negative health outcomes.[24]

Correctional food service operations vary widely across and within federal, state, and local jurisdictions.

The Workgroup's experiences indicated that there is no one uniform approach to food service in corrections; federal, state, and local governments usually set their own policies and procedures for the facilities in their jurisdiction, often with different agencies overseeing adult and youth detention.

Some of the more variable characteristics of correctional food service have significant implications for making improvements. For example, some correctional agencies outsource food service for some or all facilities to companies like Aramark and Trinity, while others use self-operated food service. Additionally, in some jurisdictions each facility does its own food

---

[17] Centers for Disease Control and Prevention. Obesity and Overweight. National Center for Health Statistics. January 11, 2021. https://www.cdc.gov/nchs/fastats/obesity-overweight.htm; Maruschak LM, Berzofsky M, Unangst J. Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-12 (NCJ 248491). Bureau of Justice Statistics. 2015. https://www.bjs.gov/content/pub/pdf/mpsfpji1112.pdf.
[18] Bondolfi C, et al. Impact of Incarceration on Cardiovascular Disease Risk Factors: A Systematic Review and Meta-Regression on Weight and BMI Change. *BMJ Open*. 2020;10(10):e039278.
[19] Maruschak, 2015.
[20] Maruschak, 2015.
[21] Wang EA, et al. Incarceration, Incident Hypertension, and Access to Health Care: Findings From the Coronary Artery Risk Development in Young Adults (CARDIA) Study. *Arch Intern Med*. 2009;169(7):687–693.
[22] Howell BA, et al. Incarceration History and Uncontrolled Blood Pressure in a Multi-Site Cohort. *J Gen Intern Med*. 2016;31(12):1496-1502.
[23] Harding DJ, et al. Making Ends Meet After Prison. *J Policy Anal Manage*. 2014;33(2):440-470;Western B, et al. Stress and Hardship after Prison. *AJS*. 2015;120(5):1512-47.
[24] Testa A, Jackson DB. Food Insecurity Among Formerly Incarcerated Individuals. *Crim Justice Behav*. 2019; 46(10): 1493-1511.

production, but other jurisdictions centralize food production and distribute ready-to-eat meals to each correctional facility, which influences the types and quality of foods that are served.

Despite this variation in policy and practice, the Workgroup found several consistent characteristics across jurisdictions. Typically, correctional agency officials above the facility level prescribe and oversee planning of standardized menus and at least some procurement and contracting activities. Limited budget also appears to be a consistent feature: among adult correctional facilities, the food budget per person per day (including all food costs and sometimes additional costs of labor and utensils) typically ranges from $1-$4.50.[25] Food service is typically a very small percentage of the agency's total budget and in many states, the food expenditures per person have decreased markedly over the past 20 years.[26]

There is substantial variation in the robustness of food and nutrition policies for correctional settings, as well as inconsistent accountability to put policy into practice.

Ideally, all correctional food service operations would provide balanced, nutritious, safe, appealing, culturally relevant meals that promote health, well-being, and dignity for incarcerated people. The Workgroup's experiences indicated that reality often deviates from this ideal due to complex factors along the continuum from policy to practice.

Among Adult Facilities:

Federal, state, and local jurisdictions vary in specificity and strength of their written food and nutrition guidelines, which are typically part of the internal policy of the correctional agency. If nutrition standards are included, they are often nutrient adequacy goals (*i.e.,* the Dietary Reference Intakes), since these are mandated by the American Correctional Association (ACA), which accredits most facilities.[27] Nutrient adequacy goals are necessary to prevent deficiencies but are not sufficient to ensure that the meals provided are generally consistent with the *Dietary Guidelines for Americans* (DGA), which provide food-based recommendations that consider health promotion and chronic disease prevention in addition to nutrient adequacy.

Written policy guides menu planning in correctional agencies; however, lack of specificity allows for inconsistent interpretation at the facility level and diminishes the policy's value in holding facilities accountable. Enforcement mechanisms vary across facilities: periodic audits, which may be announced or unannounced, may be conducted by the correctional agency, the jurisdiction's health department, the ACA, or a combination. When violations are identified, the facility might need to submit a correction plan to the government auditor or ACA, though the latter has no legal power to enforce its standards. Incarcerated individuals can also submit a grievance through internal agency mechanisms or (depending on the nature of the complaint) sue under the Eighth Amendment, which prohibits governments from imposing cruel and unusual punishment. In practice, it is very difficult to resolve complaints in these manners.

---

[25]Soble L, Stroud K, Weinstein M. *Eating Behind the Bars: Ending the Hidden Punishment of Food in Prison*. Impact Justice. 2020. https://impactjustice.org/wp-content/uploads/IJ-Eating-Behind-Bars.pdf

[26] For example, Impact Justice calculated that only 4 percent of the Texas Department of Correction's FY 2019 operating budget was allocated to food services. Soble, 2020.

[27] Morgan R. Developing Prison Standards Compared. July 1, 2000; 2(3):325-342; American Correctional Association. Seeking Accreditation. August 15, 2008. https://www.prearesourcecenter.org/sites/default/files/library/overviewoftheprocess_0.pdf

Among Youth Facilities:

Many juvenile detention facilities participate in the National School Lunch Program (NSLP) and School Breakfast Program (SBP). In these programs, federal reimbursement for meals is contingent on compliance with U.S. Department of Agriculture (USDA) meal pattern guidelines based on the 2010 DGA and adherence to "Smart Snacks" standards for other foods available during the weekday.[28]

The Workgroup identified several opportunities for improvement concerning the meal standards for facilities participating in the NSLP and SBP, including implementation of an added sugar limit and improving palatability of meals by requiring some amount of fruit and vegetable servings to be fresh. Participating facilities are not subject to the USDA nutrition standards for the dinner meal or for snacks and beverages sold and served outside of school hours, which leaves a gap in policy that may result in lower expectations for healthfulness.

In Workgroup member investigations of food conditions in state prisons, incarcerated individuals consistently reported low-quality and unappetizing food, limited access to fresh fruits and vegetables, rushed and hostile eating environments, and staff neglect of food safety and quality control measures.

The Workgroup reviewed findings from Impact Justice and the Farm to Prison Project, based on surveys and focus groups with approximately 300 individuals who were formerly or currently incarcerated in state prisons. Additionally, one formerly incarcerated individual generously shared her experiences with us in a question-and-answer session. Consistent across reports were assertions of low-quality meals that looked, smelled, and tasted unappetizing, or were served at an inappropriate temperature; reports of rare or no access to fresh produce; consistent feelings of physical hunger; rushed and hostile eating environments that perpetuated sentiments of dehumanization related to food; and lack of oversight of facility staff permitting neglect of policies and procedures at the expense of food quality and safety.[29]

Limited resources, security concerns, and lack of political will are consistent barriers to improving food quality and nutrition in correctional facilities. Progress requires patience, buy-in from leadership, and robust accountability measures.

The Workgroup heard accounts from members who have been involved in efforts to adopt FSG policies or other strategies to improve the food environment in correctional facilities. These include individuals representing the jurisdictions and organizations of New York City, Philadelphia, Multnomah County, OR, Washington, Oregon, Maryland (via the Farm to Prison Project), Alliance for a Healthier Generation, and the Federal Bureau of Prisons. These members shared the details of each intervention including policies and standards, facilitators of and barriers to progress, and any best practices identified.

Factors that facilitated FSG implementation include:

- Incorporation of standards into policies and contracts to allow for accountability;

[28] However, the USDA has not published the exact number of juvenile detention facilities that participate; rather, they are included in the broader count of residential childcare institutions.
[29] Soble, 2020.

- Buy-in from all levels of administration;
- Input from incarcerated individuals to evaluate acceptability of food;
- Patience for incremental change; and
- Monitoring and evaluation to hold facilities accountable and to track outcomes.

Common barriers to progress include:

- Insufficient funds to incorporate fresh produce and cook from scratch;
- Insufficient compensation to attract and minimize turnover of skilled food service staff;
- Limited capacity of existing food production systems and equipment to make menu changes;
- Security concerns (*e.g.*, that fresh fruit can be fermented to alcohol);
- Meal timing restrictions, which limit the number of menu choices (*e.g.*, salad bars); and
- Cultural stigmatization of incarcerated people, leading to lack of political support for change.

Recommendations for Optimizing Food and Nutrition in Correctional Facilities:

While it is impossible to make universally applicable generalizations in such a heterogeneous system, the Workgroup's discussions tended to reveal that there is an urgent need to raise standards (and then meet them) for health, palatability, and dignity in correctional facility food service overall, particularly when centering the perspective of people who have been incarcerated. The Workgroup's recommendations below are not exhaustive, but serve to provide a minimum set of benchmarks for policymakers, advocates, and funders to pursue immediately.

Policy Recommendations:

We recommend that all governments with authority over correctional facilities adopt or amend their written policies, such as legislation, executive order, administrative policy, and all applicable contracts, to include:

- FSG concerning nutrition for all foods and beverages served and sold in the facility that meet or exceed the most recent *Dietary Guidelines for Americans*.
    - Selected FSG should be met through minimally processed foods and beverages and preclude the need to provide essential nutrients through a fortified beverage.
- Food safety standards that are at least as strong as those included in the Food Service Guidelines for Federal Facilities and, if needed, a timeline for phasing them in.
- Requirement that potable, palatable drinking water be accessible to incarcerated individuals at mealtimes and as much as possible throughout the rest of the day.
    - Appropriate agencies should assure that drinking water access points (fountains, sinks, etc.) are maintained and that water at the tap is tested annually for compliance with both the National Primary Drinking Water Regulations and National Secondary Drinking Water Regulations, or state limits if more stringent.[30] Results should be posted near water access points.

[30]The U.S. Environmental Protection Agency establishes both National Primary Drinking Water Regulations, which are legally enforceable and limit the levels of unsafe contaminants in drinking water, and National Secondary Drinking Water Regulations, which set non-mandatory limits for contaminants that negatively affect taste, color, and odor.

- Measures that uphold the humanity and dignity of incarcerated people in relation to food provision, including but not limited to:
    - Requirement that all facility staff who are involved in food service or oversee dining should be trained on the importance to an individual's physical and mental wellbeing of healthy food and a dignified eating experience.
    - Requirement that the incarcerated population be consulted about the menu, commissary selection, and other aspects of the food environment on an ongoing basis and that their feedback be used to guide changes. This can be done with periodic surveys and focus groups, perpetual mechanisms for submitting written feedback, taste tests of new items under consideration, and other methods.
    - Requirement that each incarcerated individual be given at least 20 minutes of seated time to consume each meal, not counting time spent waiting to be served.[31]
    - Prohibiting all food-related punishments.
    - Requirement that the same selection of food and beverages be available to employees and people in custody.

Resource Allocation:

Correctional facilities need more resources or reallocation of existing resources to provide consistently safe, healthful, and appealing food service. Limited budgets for food and labor appear to be consistent barriers to improving food conditions throughout the system.

- The federal school meal program reimbursement rates of approximately $2 to $3.50 per meal provide a starting point for rethinking the correctional food budget, considering that costs will be greater to feed adults than youth.[32]
- Investments in updates to kitchens, dining facilities, equipment, and storage may be needed to make menu changes desired to meet higher standards for health, quality, and dignity.
- Compensation for food service workers should reflect the need to attract and retain skilled personnel.
- Governments, especially at the state level, are well-positioned to incentivize farm-to-institution sourcing of fresh produce and other healthy foods to co-benefit local economies and food quality.

Practice Recommendations:

The following are additional strategies we recommend for correctional agencies and facilities to achieve a healthy, appetizing, and dignified eating experience for incarcerated people:

- Secure appropriate resources and equipment to maximize the use of fresh foods and cooking from scratch.

[31]This the same amount of time advocates recommend for school meals.
[32] Federal Register. National School Lunch, Special Milk, and School Breakfast Programs, National Average Payments/Maximum Reimbursement Rates. July 19, 2018. https://www.federalregister.gov/documents/2018/07/19/2018-15465/national-school-lunch-special-milk-and-school-breakfast-programs-national-average-paymentsmaximum

- Minimize the time between food preparation and service to maximize control of temperature and quality. Recipe development should incorporate taste testing after the dish has been held, transported, reheated, etc. as it would be in practice.
- Incorporate choice of multiple options at each meal to the extent possible to uphold autonomy for incarcerated individuals.
- Offer a variety of healthy items at affordable prices in the commissary.
- Identify and implement needed improvements in the physical space and facility culture to make the eating environment hospitable.
- Consider developing nutrition education, gardening, and culinary programming to support health and rehabilitation.

Acknowledgements

This report was funded by a grant from Voices for Healthy Kids, an initiative of the American Heart Association (AHA). The AHA has not reviewed the data or science in this report. We are grateful for the support from NaDa Shoemaker, Christine Compton, and the rest of the Voices team over the course of the project.

Jessi Silverman, Policy Associate, and Madeline Holt, Intern, of the Center for Science in the Public Interest, led the drafting of this report. We thank the following individuals for attending Workgroup meetings and contributing content and feedback for this report:[33] Katie Bishop Kendrick, American Heart Association; Meghan Maroney, Center for Science in the Public Interest; Nessia Berner Wong, ChangeLab Solutions; Phil Miller, formerly of the Correctional Association of New York; Kanav Kathuria, The Farm to Prison Project; Mitchel Holliday, Federal Bureau of Prisons; Leslie Soble, Impact Justice; Charlene McGee, Kimberly Pidcoke, Helen Kidane, and Susan Van't Hof, Multnomah County REACH; Michael Garcia, New York City Department of Health and Mental Hygiene; Glenn O'Connor and Moreen Frankson-James, New York City Department of Corrections; Elena Guevara, Oregon Department of Corrections; Catherine Bartoli, formerly of the Philadelphia Department of Public Health; Kristen Giombi, RTI International; Chris Mornick, Washington State Department of Health; and Jo Saint-George.

We also acknowledge the following individuals for providing information for the benefit of the Workgroup: Heidi Hunn, GD Correctional Services; Terah Lawyer, Impact Justice; Angela Odoms-Young, University of Illinois at Chicago; and Lori Golden, formerly of Alliance for a Healthier Generation.

For more information, please contact the Center for Science in the Public Interest at policy@cspinet.org.

March 2021

[33] The individuals listed provided subject matter expertise and input to this project. The content of this document does not necessarily reflect the official position of the Workgroup member's organizations and their participation does not constitute an endorsement of all the content of this report.