

On Life Support: Public Health in the Age of Mass Incarceration

NOVEMBER 2014

David Cloud

FROM THE PRESIDENT

Vera's Justice Reform for Healthy Communities initiative aims to improve the health and well-being of communities that have been most impacted by decades of mass incarceration. Guided by a national advisory board comprised of public health and criminal justice policymakers, practitioners, researchers, and advocates, the initiative advances its mission through public education, coalition building, briefings, and publications. It will examine the role of mass incarceration as a driver of health disparities—both behind bars and in communities—and it will look at opportunities to apply a public health framework to address aspects of the criminal justice system that deepen social inequalities and exacerbate health disparities.

This work is a logical next step for Vera, as we have long explored the intersection of justice and health systems for the betterment of disadvantaged communities. National healthcare reform efforts under the Affordable Care Act, combined with national, state, - and local leaders seeking ways to reduce incarceration, provide an ideal opportunity for Vera to build on that body of work.

This report is the first in a series of publications Vera will release to inform policymakers on opportunities created by the ACA to enhance public safety and reform sentencing and corrections practices by advancing public health. By fostering new ideas and more effective solutions, we can reduce costs, strengthen and expand services, and improve public health outcomes for families and communities.

A handwritten signature in black ink, appearing to read 'N. Turner', with a stylized flourish at the end.

Nicholas Turner
President and Director
Vera Institute of Justice

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Introduction

Health disparities persist deeply in American society.

Over the past century, the U.S. population as a whole has benefited from continuous gains in health and longevity, such as longer life expectancy and lower infant mortality rates, but these gains have not been distributed evenly across the nation's populace. For example, between 1980 and 2000, people in higher socioeconomic groups experienced larger gains in life expectancy than those in poorer groups, and the gaps in health between poor and wealthy Americans widened. Research in epidemiology shows that growing inequalities in health outcomes parallel rising trends in U.S. income inequality.¹

Health disparities persist deeply in American society. For all of U.S. history, racial and ethnic minorities and other historically marginalized groups, especially those living in poverty, have faced more barriers in accessing care, received poorer quality care, and experienced worse health outcomes than the rest of the population.²

In society, the social determinants of health (SDH)—defined by the World Health Organization as “the circumstances in which people are born, grow up, live, work, and age, as well as systems designed to deal with illness”—are major contributors to health disparities. Thus, major social, political, and economic changes and social safety net policies impacting living conditions in communities shape health disparities.³ For example, the gap in health outcomes between black and white Americans narrowed in the years following historic advances in equality achieved by the Civil Rights Movement in the 1960s.⁴ Conversely, disparities widened between 1980 and 1991 amidst deep cuts to social safety net programs and publicly-funded health services that benefit low-income minority populations.⁵

The large-scale expansion of incarceration has become one such factor in the constellation of social determinants of health.⁶ Over the last 40 years the criminal justice system has expanded to such a degree that, today, mass incarceration is one of the major contributors to poor health in communities.⁷ Since the 1970s, the correctional population in the U.S. has grown by 700 percent and, from 1982 to 2001, state expenditures on corrections increased each year, outpacing overall budget growth, and swelling from \$15 billion to \$53.5 billion, adjusted for inflation. Since then, expenditures on incarceration have hovered around \$50 billion.⁸

Mass incarceration is one of a series of interrelated factors that has stretched the social and economic fabric of communities, contributing to diminished educational opportunities, fractured family structures, stagnated economic mobility, limited housing options, restricted access to essential social entitlements, and reduced neighborhood cohesiveness.⁹ In turn, these collateral consequences have widened the gap in health outcomes along racial and socioeconomic gradients in significant ways. For example, research in epidemiology indicates that had the U.S. incarceration rate remained at its 1973 level, then the infant mortality rate would have been 7.8 percent lower than it was in 2003, and disparity between black and white infant deaths nearly 15 percent lower.¹⁰

The millions of people who cycle through the nation's courts, jails, and prisons experience chronic health conditions, infectious diseases, substance use, and mental illness at much higher rates than the general population. The conditions of confinement inside jails and prisons, such as overcrowding, violence, sexual victimization, use of solitary confinement, and lower standards of medical care are harmful to the physical and mental health of incarcerated individuals.

There is, however, growing interest among health and justice system leaders to work together in the pursuit of health equity, public safety, and social justice. In many states and localities, health and justice agencies are already working collaboratively to enroll eligible people into health plans in different justice settings, bolster diversion programs at the front door of the criminal justice system that aim to steer people away from incarceration and into community-based services, and build the information-sharing frameworks that are needed to promote continuity in care and improve health and public safety outcomes.

This report describes the public health implications of mass incarceration. It summarizes what is known about the burden of disease among people who experience incarceration, identifies the conditions of confinement that are deleterious for health, and discusses the various ways in which the continuous expansion of the criminal justice system has contributed to health disparities over the past 40 years. It then explains why now is an opportune moment to support and expand bipartisan efforts to implement a public health approach to reducing mass incarceration.

The Burden of Disease Behind Bars

While people in correctional facilities are mostly excluded from national health surveys, an extensive literature review reveals that this population has dramatically higher rates of disease than the general population, and that correctional facilities too often serve as ill-equipped treatment providers of last resort for medically underserved, marginalized people.¹¹

MENTAL HEALTH

For nearly a century, state psychiatric hospitals were the primary institutions for treating people with mental health problems. These state asylums were established as the result of a 19th-century national crusade to decrease the extent that people with mental illness were being housed and abused in jails and poorhouses. Unfortunately, these institutions created further problems, often warehousing patients in deplorable living conditions against their will. In the late 1950s, states began closing their asylums in large numbers with the promise that they would be replaced with a robust network of behavioral health care

Infectious diseases

are more prevalent among people who are incarcerated than in the general population.



HIV/AIDS
is **2 to 7 times**
more prevalent and an
estimated 17 percent of all
people with HIV living in the
U.S. pass through a correctional
facility each year.

Hepatitis C
occurs at rates
8 to 21 times
higher among incarcerated
people, and accounts for more
deaths in the community
than HIV/AIDS.

Tuberculosis
is more than
4 times
as prevalent.



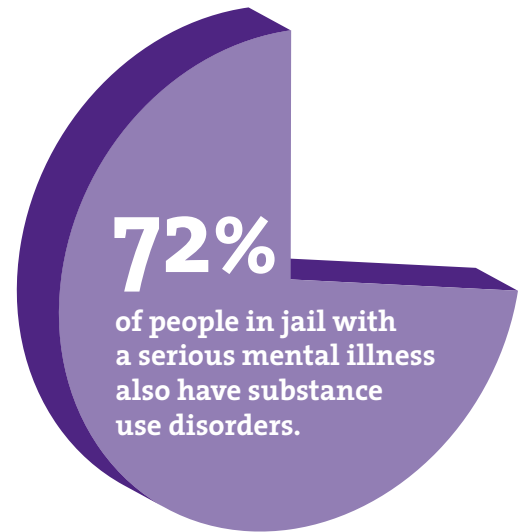
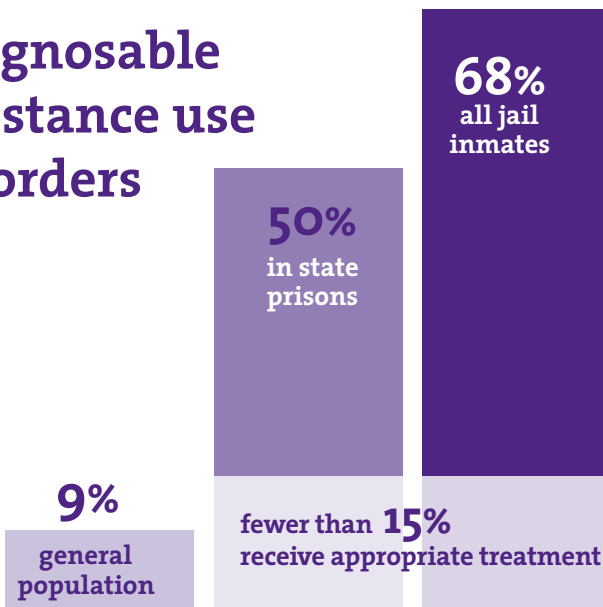
Common STDs
(sexually transmitted diseases),
such as chlamydia and
gonorrhea, are more prevalent,
especially among incarcerated
women who have significant
histories of sexual trauma
and/or engage in sex work.

One third
of women
admitted into jails
who receive a screen for STDs
test positive for syphilis.

Syphilis rates
among women incarcerated
in New York City are
1,000 times
that of the general population.

Disease Behind Bars

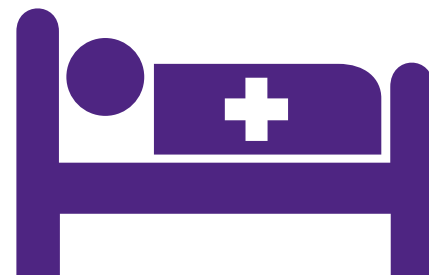
Diagnosable substance use disorders



Serious mental illnesses in jails

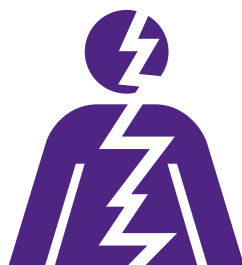


In state prisons, prevalence of serious mental illness is 2 to 4 times higher than in the community.



Chronic Disease

Between 39 and 43 percent of people in custody have at least one chronic condition.

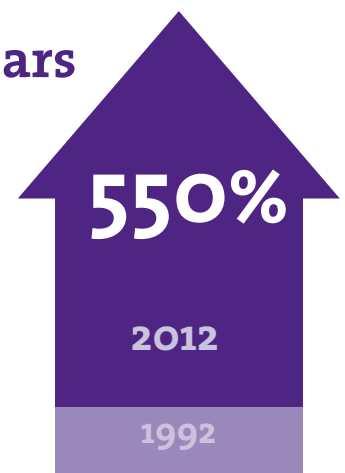


Suicide and Violence

Suicide accounts for one-third of deaths in jails. 15 percent of state prisoners reported violence-related injuries and 22 percent reported accidental injuries.

Graying Behind Bars

People aged 55 years and older are among the fastest growing segments of the incarcerated population. Older adults have higher rates of chronic conditions and mental and physical disabilities.

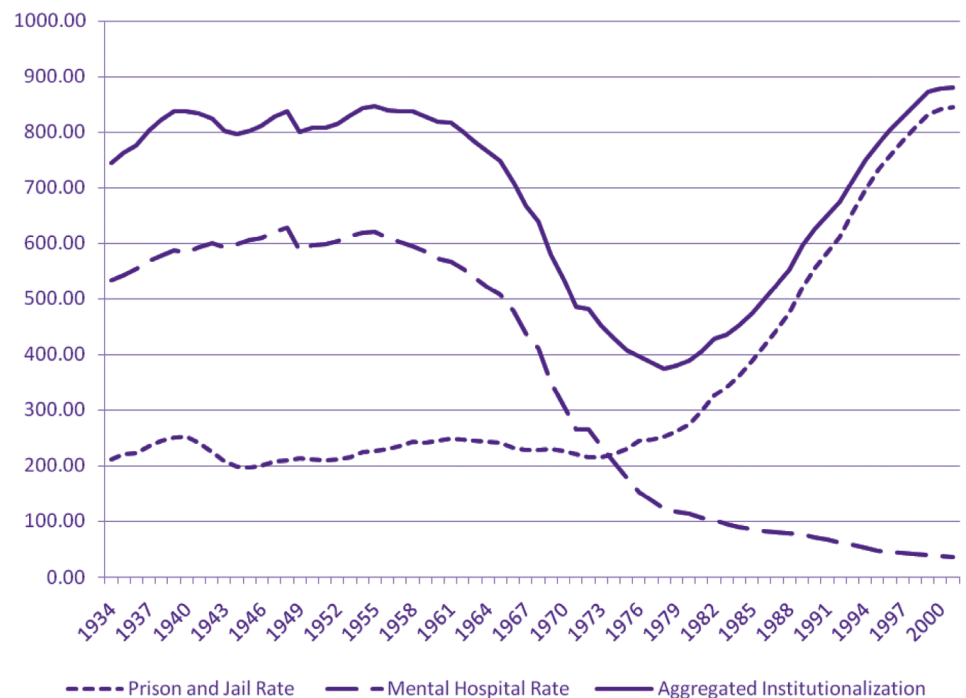


centers where people could receive the services they needed, while continuing to live in the community—a movement known as *deinstitutionalization*.

Deinstitutionalization was the result of advances in psychotropic medication, stronger due process protections against civil commitment, the growing influence of community psychiatry, and the enactment of Medicaid in 1965. The newly created community centers were envisioned to offer a range of services: inpatient, outpatient, emergency, partial hospitalization, and consultation and education on mental health.¹²

Unfortunately, the promise of the community mental health movement fell short of its ambitions due to underfunding at the federal and state levels, preventing many people from accessing the services they needed. Dramatic cuts to a variety of social safety net programs in the 1980s—which led to increases in homelessness and the number of people with untreated mental illness on the street—coincided with massive government spending on the War on Drugs and prison construction.¹³ Figure 1 illustrates how continued declines in state asylum populations coincided with the rise of mass incarceration.¹⁴

Figure 1: State Asylum and Incarcerated Populations, 1934–2001



Rates of institutionalization, including jails, in the United States (per 100,000 adults), 1934–2001.

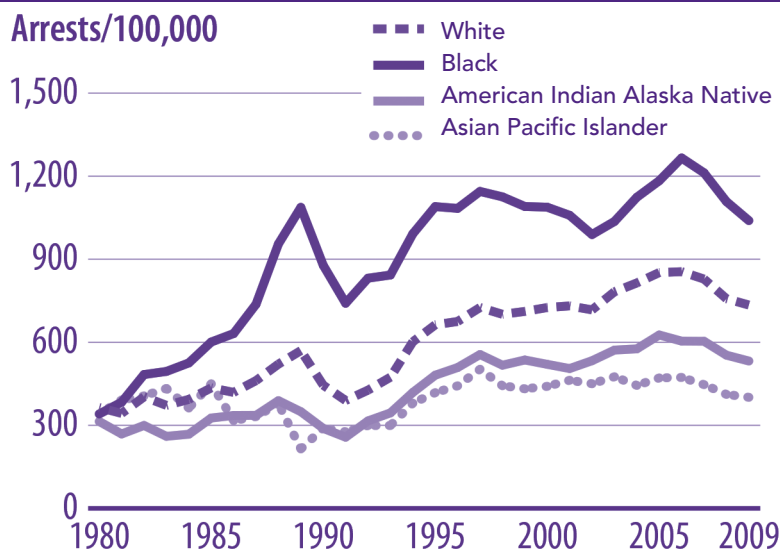
Harcourt, Bernard E. "Reducing mass incarceration: Lessons from the deinstitutionalization of mental hospitals in the 1960s." *Ohio St. J. Crim. L.* 9 (2011): 53.

These changes contributed to a disproportionate number of underserved people with mental health problems becoming entangled in the criminal justice system and correctional facilities becoming their default treatment providers.¹⁵ Today, about 14.5 percent of men and 31 percent of women in jails have a serious mental illness, such as schizophrenia, major depression, or bipolar disorder, compared to 3.2 and 4.9 percent respectively in the general population.¹⁶ While estimates vary, the prevalence of serious mental illnesses is at least two to four times higher among state prisoners than in community populations.¹⁷

SUBSTANCE USE AND ADDICTION

The punitive sentencing laws and aggressive policing practices that emerged out of the national War on Drugs were perhaps the single greatest factor responsible for surging prison populations. Starting in the early 1970s, and accelerating over the following decades, a series of new punitive state and federal policies led to unprecedented numbers of people being sent to prison to serve long custodial sentences for drug offenses. The concentration of drug arrests in urban communities of color is a primary driver of pervasive racial disparities in the criminal justice system (see Figure 2). African Americans are significantly more likely to be arrested, 13 times more likely than whites to go to prison for a drug conviction, and comprise 62 percent of people imprisoned for a drug conviction, despite negligible differences in reported drug use. The increase in incarceration following arrest on drug charges accounted for about two-thirds of the increase in the federal prison population and one-half of the increase in the state prison populations between 1985 and 2000.¹⁸

Figure 2: Drug Possession/Use Arrest Rates by Race, 1980-2009



Source: Snyder, Howard N. *Arrest in the United States, 1980-2009*. US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2011

Today, nearly 68 percent of people in jail overall and more than 50 percent of those in state prisons have a diagnosable substance use disorder, compared to 9 percent of the general population.¹⁹ Moreover, most people who have a serious mental illness also have a co-occurring substance use diagnosis. For instance, in jails an estimated 72 percent of people with a serious mental illness also have a substance use disorder.²⁰

Despite this high need, less than 15 percent of people who are incarcerated receive appropriate treatment.²¹ For instance, although a significant body of research shows that pharmacological treatments such as methadone and buprenorphine effectively treat opioid addictions, most correctional facilities choose not to offer them, subjecting people with chronic addictions to higher risk of withdrawal while in custody and of overdose when released to the community.²²

INFECTIOUS DISEASE

Infectious diseases are also more prevalent among incarcerated populations than in the general population. For instance:

- > **HIV/AIDS** is 2 to 7 times more prevalent among people in correctional facilities than in the community, and an estimated 17 percent of all people with HIV living in the U.S. pass through a correctional facility each year.²³
- > **The Hepatitis C virus (HCV)**—which accounts for more deaths in the community than HIV/AIDS—occurs at rates between 8 to 21 times higher among incarcerated people than in the general population.²⁴
- > **Tuberculosis (TB)** studies have found 29.4 cases of tuberculosis per 100,000 prisoners compared to 6.7 cases per 100,000 people in the general population.²⁵
- > **Common sexually transmitted diseases (STDs)**, such as chlamydia and gonorrhea, are more prevalent in correctional environments than any other setting, especially among women.²⁶ For instance, in 2011, the Centers for Disease Control and Prevention reported that one-third of women admitted into jails who receive a screen for STDs test seropositive for syphilis. One study found the rates of syphilis among women incarcerated in New York City to be 1,000 times that seen in the general population.²⁷

CHRONIC DISEASE

In the U.S. and other industrialized nations, chronic diseases, such as cardiovascular diseases and diabetes, are amongst the primary causes of death and disability.²⁸ While more research is needed, existing studies reveal disproportionately high rates of chronic physical conditions among correctional populations. One nationally representative survey found higher rates of hypertension, asthma, arthritis, cancer, and cervical cancer among correctional populations compared to the general population, even after controlling for a range of socioeconomic factors.²⁹

VIOLENCE AND SELF-HARM

Violence and injuries are among the most common health problem in correctional environments.³⁰ Suicide remains a leading cause of death, accounting for one-third of deaths in jails between 2000 and 2009.³¹ Intentional and accidental injuries to prisoners, corrections officers, and staff are rampant. In a Bureau of Justice Statistics (BJS) survey, 15 percent of state prisoners reported violence-related injuries.³² The incidence of self-harm, injuries inflicted on correctional staff, and suicide tend to be significantly higher in solitary confinement units than in the rest of correctional environments.³³ Additionally, there is growing concern over high rates of a history of traumatic brain injuries (TBIs) among justice-involved populations. The neurological, emotional, and cognitive deficits associated with TBIs can have considerable implications for both quality of life and recidivism.³⁴

GREATER HEALTH DISPARITIES FOR WOMEN

The number of women imprisoned in the U.S. increased nearly 6.5-fold from 1980 to 2010. Today, women comprise about 7 percent of all prisoners and 13 percent of all local jail populations, and face a greater burden of disease than incarcerated men, which is partly explained by disturbingly high rates of sexual victimization, substance use, and trauma.³⁵ An estimated 6 percent are pregnant, with the majority having conceived within 3 months of release from a prior incarceration.³⁶ A significant percentage of these women have not seen an obstetrician on a regular basis prior to incarceration and are in unhealthy states due to substance use and malnutrition prior to entering custody. While a structured environment, regular meals, and access to care can improve birth outcomes, according to a recent survey, state prisons often fail to use best practices and established standards when caring for pregnant women.³⁷

GERIATRIC HEALTH

Finally, geriatric health behind bars is a growing public health problem. From 1990 to 2012, the number of people behind bars aged 55 years and older soared by 550 percent.³⁸ Older adults have higher rates of chronic conditions and experience more physically and mentally debilitating conditions, including neurodegenerative diseases associated with aging, such as mild-cognitive impairment (MCI), Alzheimer's disease, and dementias. Cognitive impairments and physical disabilities make older prisoners extremely vulnerable in correctional environments, putting them at an increased risk of injury, victimization, and cognitive and emotional decompensation. Prisons and jails are generally ill-equipped to meet the needs of elderly patients who may require intensive services for these conditions.³⁹

Conditions of Confinement and Health

People held in correctional facilities are the only group in the U.S. with a constitutional right to healthcare.⁴⁰ Yet, the overcrowded, unsanitary conditions inside many correctional facilities combined with poor nutrition, lack of ventilation, enforced idleness, and the impact of violence, trauma, and solitary confinement can have long-term negative effects on health that infringe on the constitutional and human rights of prisoners and detainees.

OVERCROWDING

Overcrowding underpins many of the poor living conditions in jails and prisons. Decades of sustained prison growth has resulted in severely overpopulated correctional facilities, which creates significant risks to the health and safety of people living and working in these institutions.⁴¹ At the end of 2013, 17 states had more people in their prisons than their facilities were designed to house. For example, Alabama's prisons were originally designed for 13,318 people and currently house around 32,000 people.⁴² In a 2012 report, the federal Government Accountability Office (GAO) described how overcrowding in federal prisons has led to increased use of double and triple bunking, expanded waiting lists for education and drug treatment, reduced access to meaningful work opportunities, and increased use of solitary confinement in response to disciplinary infractions.⁴³ In the early 1990s, severe overcrowding contributed to spikes in the incidence of multidrug-resistant forms of TB in correctional systems. NYC's jail on Rikers Island had one of the highest rates of TB in the country, which was largely attributable to severe overcrowding, poor ventilation, and inadequate medical protocols to control the spread of the disease.⁴⁴

THE U.S. SUPREME COURT ON HEALTH AND PRISON OVERCROWDING: *PLATA v. BROWN* (2011)

The 2011 landmark Supreme Court case *Plata v. Brown* is emblematic of the severe consequences that prison overcrowding can have on human health. *Plata* uncovered pernicious impacts of overcrowding throughout California's prisons, including: increased violence and suicide, unsanitary living conditions, spread of communicable diseases, psychiatric deterioration, and medical neglect resulting in injury, illness, and death.

Among the many appalling conditions detailed in the Court's decision: more than 200 prisoners living in a gymnasium space under the supervision of only two correctional officers; people with acute medical conditions on interminable waiting lists to see a doctor; an average of one suicide per week and reports of suicidal prisoners being left in cages the size of a telephone booth, soaking in pools of their own urine, with no access to mental health treatment; doctors prescribing the wrong medications to patients, causing harmful side effects and death; forced closure of medical spaces due to unsanitary conditions; and spates of inmate-on-inmate violence without accountability.

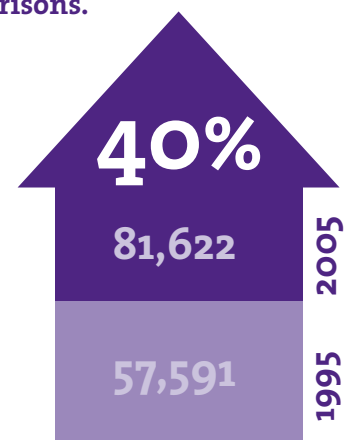
The Court upheld a federal mandate that required California to reduce its prison population by at least 38,000 people to remedy multiple 8th Amendment violations stemming from endemic overcrowding.

SOLITARY CONFINEMENT

The U.S. exposes more people to punitive and administrative segregation (i.e. solitary confinement) than any other country. From 1995 to 2005, the number of people in solitary confinement nationally increased by 40 percent, from 57,591 to 81,622 people, and the most recent estimates suggest at least 84,000 individuals live in conditions of isolation, sensory deprivation, and idleness in U.S. jails and prisons.⁴⁵ Prisoners housed in segregation units are held in a tiny cell—with minimal access to natural sunlight, long periods of silence but also at times continuous noise from things like clattering metal doors and loud, startling outbursts and distressed voices—for 23 hours each day, and are allowed out for only one hour for exercise or a shower. They are mostly deprived of human interaction and rarely receive opportunities for counseling, job training, and educational programming to help them adapt after returning to society. Many people live in these conditions for years or even decades and are often released directly from isolation to the community. The harmful effects of solitary confinement on physical and mental health have been extensively document-

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ed, and are especially pronounced for young people and those with a serious mental illness. Nearly every scientific study on the effects of solitary confinement over the past 150 years has found that subjecting a person to more than ten days of solitary confinement results in a distinct set of emotional, cognitive, social, and physical pathologies. The incidences of self-harm and suicide among prisoners, and injuries to correctional staff, are significantly higher in solitary confinement units than in the general prison or jail population.⁴⁶

SEXUAL VICTIMIZATION

Even following the passage of the Prison Rape Elimination Act (PREA) in 2003, sexual victimization remains a serious problem inside jails and prisons. Sexual assault and harassment expose victims to physical injury, psychological trauma, STDs, and can lead to self-harm and suicide.⁴⁷ A 2012 BJS survey found that 10 percent of former state prisoners reported being sexually victimized while incarcerated.⁴⁸ A separate survey found that 4 percent of people in state and federal prison and 3.2 percent of those in jail reported experiencing one or more incidents of sexual victimization by another inmate or facility staff in the preceding year or since admission to the facility. Women experience higher rates of sexual victimization than men. A 2008 survey found three times as many females (13.7 percent) reported being sexually victimized by another prisoner than males (4.2 percent); and that twice as many women reported being sexually victimized by staff.⁴⁹

QUALITY OF CARE

The quality, availability, and organization of correctional health services influences health outcomes among incarcerated populations, but have not been well studied. However, the standard of care lags far behind community health standards.⁵⁰ Several organizations, including the National Commission on Correctional Health Care, set standards and offer accreditation to correctional facilities for healthcare services. Yet, only about 17 percent (500 of 3,000 correctional facilities) have been accredited by these bodies.⁵¹ In effect, there is minimal oversight and a lack of uniform quality standards governing correctional health services. Moreover, correctional health providers are culturally and organizationally detached from mainstream healthcare systems. Physicians and medical professionals working behind bars rarely coordinate care with community health providers. The lack of connectivity undermines continuity of care for people transitioning from correctional facilities into community settings, as the first few days and weeks in the community following a period of incarceration are associated with a much higher risk of serious injury or death.⁵² Poor communication also poses risks for people entering correctional systems. Clinicians performing medical intake rarely have protocols to obtain access to important diagnostic or clinical history from community providers, which increases the risk of clinical error or discontinuation of medications, and can result in psychiatric deterioration for people with serious mental illnesses.

The Health of Communities

The negative consequences of incarceration are not limited to those who experience the system firsthand. The vast majority of incarcerated people will be released, and the continuous cycling of people with high rates of disease between corrections and communities poses risks to the health of people living where incarceration is most endemic. Each year, the nation's jails process more than 11 million admissions, and prisons release nearly 700,000 people to the community. While progress is being made in some jurisdictions, coordination of healthcare services between correctional and community health providers is often absent. At the point of release, most corrections agencies do little more than make a medical referral or provide a temporary supply of medication. For people with chronic physical conditions or a serious psychiatric condition requiring regular care management, this service gap increases the chance that they will discontinue treatment regimens they started while incarcerated, greatly endangering the health of these individuals. For people with a history of injection drug use, failure to promote care continuity upon release increases risk of relapse, overdose, and risky behaviors that spread HIV/AIDS and HCV disease in communities.⁵³

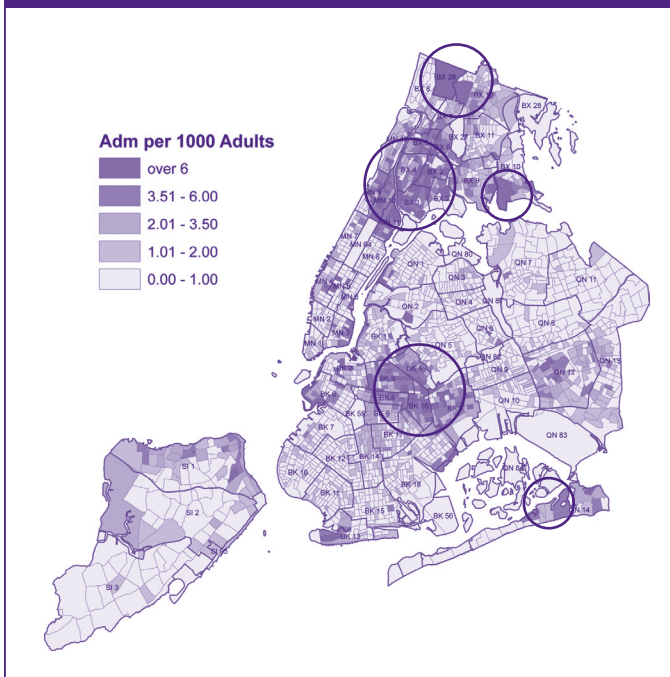
According to a widely-accepted public health model called the social determinants of health (SDH), human health is profoundly influenced by a range of social, economic, and political forces beyond the control of the individual.⁵⁴ Forty years of mass incarceration has had crippling, intergenerational effects on SDH including:

- > Altering the demographic composition of communities in ways that fracture family structures and trap young children in poverty;
- > Diminishing the educational opportunities of youth;
- > Stagnating economic mobility and widening income inequality;
- > Exacerbating homelessness;
- > Restricting access to essential social benefits; and
- > Siphoning political capital from inner city communities through “prison gerrymandering” and disenfranchisement.⁵⁵



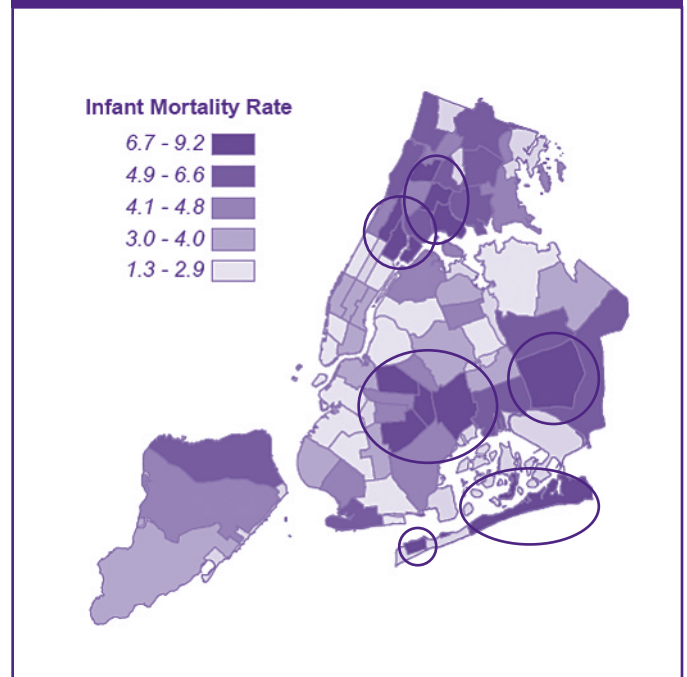
These are the communities that the majority of people exiting correctional facilities return to. For example, researchers from the Justice Mapping Center have plotted rates of incarceration by census tract for a number of cities using a geo-spatial visualization technology that allows us to see the neighborhoods where incarceration is most concentrated. When JMC’s map of New York City is viewed along with health statistics collected by the NYC Department of Health and Mental Hygiene (DOHMH), it is too plain to see that the highest rates of incarceration and the greatest rates of disease are concentrated in the same neighborhoods. Central Brooklyn, the South Bronx, and Upper Manhattan—where incarceration is most prevalent—also have disproportionately high infant mortality rates, HIV incidence, STD prevalence, asthma rates, and hospitalizations due to assault.⁵⁶ (See Figures 3 and 4.).

Figure 3: NYC People Admitted to Prison per 1000 Adults by Census Tract of Residence



Data Source: Justice Mapping Center (JMC), Rutgers University
Analysis of NYC DOCCS data. DOCCS not responsible for JMC findings.

Figure 4: NYC Average Infant Mortality by Community District, 2009-2011



Source: New York City Department of Health and Mental Hygiene.
SUMMARY OF VITAL STATISTICS 2012: THE CITY OF NEW YORK INFANT MORTALITY

FAMILY STRUCTURE

Strong family ties and social bonds are essential for good health. Mass incarceration has deeply changed the structure of families in many communities, resulting in intergenerational effects that may only be beginning to manifest. Most people who go to prison have children: 52 percent of people in state prison and 63 percent in federal prison, leaving about 2.7 million children under the age of 18 living in the U.S. with at least one parent in prison.⁵⁷ Parental and familial incarceration impacts so many lives that Sesame Street aired episodes

to educate children on the issue of familial incarceration and maintains information on its website.⁵⁸

In certain situations, removing a parent from a household can benefit a family, especially when the incarcerated parent is responsible for domestic or child abuse. More commonly, however, parental incarceration perpetuates disadvantage for children and families. For example, studies have shown that the growth in paternal incarceration has contributed to elevated rates of homelessness among black children by thinning family finances and placing additional strains on mothers.⁵⁹ Furthermore, imprisonment of a mother is less likely to result in homelessness than incarceration of a father, but often results in foster care placement. One study concluded that recent increases in female imprisonment rates explain 30 percent of the doubling of foster care caseloads between 1985 and 2000.⁶⁰

Having a parent behind bars deepens financial hardships for fragile families already on the brink of poverty by removing a primary source of income. Sociological research has shown that the concentrated removal of young men through incarceration has significantly altered the demographic composition of communities of color, contributing to lower marriage rates among African American women and spurring an uptick in single-mother families living in poverty.⁶¹ While some incarcerated parents are afforded opportunities to work while in custody, the average hourly wage for state prisoners is about \$0.89, wholly insufficient to fulfill child support and other financial obligations.⁶²

Additional financial burdens for the families of incarcerated individuals include:

- > Depositing money into prison commissary accounts for use by their incarcerated family members.
- > Traveling costs and wages lost related to visiting correctional facilities that are often located in rural locations several hours outside metropolitan centers.
- > The high cost of staying in touch by phone or video visitation, which can force families to choose between paying to stay in touch and other basic living expenses.
- > The emotional stress and financial commitment that comes with staying in touch over time can foster familial conflict that is damaging to marriages and parental-child bonds.⁶³

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EDUCATION AND EMPLOYMENT OPPORTUNITIES

It has been estimated that imprisonment penalizes an individual's annual wages by 40 percent.

In the modern U.S. economy, educational attainment—and increasingly a college degree—is critical to the economic stability of individuals and families. It is the surest path to steady employment, which is paramount to having adequate access to comprehensive health services and living conditions that promote good health.⁶⁴ For youth, an arrest or period of incarceration can interrupt schooling and greatly hinder completing high school or getting into college, and—with few exceptions—correctional institutions offer little in the way of rigorous educational programs or vocational training that can help individuals obtain employment on release. Most states impose legal restrictions that prohibit people with felony records from working in specified industries, and nearly all employers require job applicants to provide details on history of arrest or conviction, which often automatically exclude otherwise qualified applicants.⁶⁵ It has been estimated that imprisonment penalizes an individual's annual wages by 40 percent, and that it results in a nearly four times greater loss in aggregate lifetime earnings for black males than white males.⁶⁶

HOUSING STABILITY AND SOCIAL ENTITLEMENTS

Incarceration is strongly associated with housing instability and homelessness. Research shows that paternal incarceration has played “a silent but vital role in the increasing risk of homelessness for American children even when the economy was healthy.”⁶⁷ Children with an incarcerated father are at a significantly higher risk of experiencing child homelessness during their lives.⁶⁸

Policies such as banning people with a drug felony conviction from receiving cash welfare, food stamps, and subsidized housing lead to housing instability for justice-involved individuals and their families.⁶⁹

- > Though the length of exclusions is shifting or being reduced in some jurisdictions, in the majority of cities, parolees are routinely barred from living in public housing upon reentry as federal regulations allow local public housing authorities to deny admission to any individual who is convicted of a felony.
- > Chronic health issues, such as HIV/AIDS and serious mental illness, can compound the hardship of finding affordable housing post-release.⁷⁰
- > The accumulation of legal debts during incarceration that people are unable to pay can further diminish prospects of securing stable housing. Delinquency on debt damages credit scores that serve as the basis for obtaining home purchasing loans. In some jurisdictions, state law permits government seizure of joint assets and property to relieve these unpaid debts.⁷¹

HEALTH INSURANCE

Lack of insurance is the most significant contributing factor to limited access to adequate health care. Among adults, people of color are nearly twice as likely to be uninsured than whites.⁷² The federal government prohibits use of Medicaid dollars to pay for healthcare services delivered to people in correctional facilities and the ACA does not change this longstanding rule (also known as “the inmate exclusion”).⁷³ While the federal government encourages states and local systems to suspend Medicaid during extended periods of incarceration and reinstate benefits at release, all but 12 states still terminate Medicaid following a period of incarceration, typically longer than 30 days. The termination of Medicaid without reinstating it prior to release creates a perilous service gap for people as they reenter the community from jail or prison, a transition when there is a significantly elevated risk of death and disability.⁷⁴ Recent research shows that for people with a serious psychiatric disease, having Medicaid at the point of release increases utilization of community-based behavioral health services and reduces recidivism.⁷⁵

POLITICAL CAPITAL

When residents from urban neighborhoods are incarcerated in rural areas, they are counted in the national census as residents of those communities. This reallocates political and economic capital from inner city communities of color to rural communities. Not being counted as members of the communities they are from in the census starves inner city communities of critical federal support while making the small towns where many prisons are based eligible for additional federal subsidies. The manipulated census figures are further used to gerrymander political boundaries in ways that boost the political power of rural and suburban towns, while further depriving impoverished, inner city communities of political influence.⁷⁶ The siphoning of political capital from these communities limits their ability to elect government representatives at the federal, state, and local levels that serve their best interests.

A Political Landscape Ripe for Reform

After more than 30 years of unrelenting growth, the U.S. incarcerated population modestly declined each year from 2009 through 2012. In 2013, while there was a modest uptick in state prison populations, the number of people in federal prison dropped for the first time since 1980.⁷⁷ Since 2006, a handful of states (Michigan, Rhode Island, South Carolina, Wisconsin, and Virginia) have significantly reduced spending on corrections and reduced their prison populations.⁷⁸ The downward trend has prompted some leading scholars to suggest that the

nation's unrelenting reliance on incarceration and satiation with "tough on crime" politics is waning.⁷⁹

Indeed, there is growing bipartisan support for reforming and scaling back the severity of sentencing regimes (e.g. mandatory minimum drug crimes, three strikes laws) that fueled continuous prison growth for decades. For example, a recent Vera study found that more than 29 states have amended, scaled down, or repealed mandatory minimum sentencing laws that statutorily imposed lengthy prison sentences for drug and other crimes.⁸⁰ Similarly, in 2011, the Sentencing Project reported that six states (Iowa, California, Connecticut, Missouri, Ohio, and South Carolina) have taken steps toward abating disparities in sentences for crack versus powder cocaine—emblematic laws passed during the acceleration of punitive drug laws that imprisoned large numbers of racial minorities.⁸¹

In the November 2014 elections, California voters passed Proposition 47 (The Safe Neighborhoods and Schools Act), a ballot measure that downgrades minor drug and property felonies to misdemeanors, permits people convicted of these crimes to petition for release, and reinvests savings in education and behavioral health services. The reforms are projected to reduce 40,000 felony convictions to misdemeanors, permit 10,000 state prisoners to petition courts for immediate release, and generate hundreds of millions of dollars in correctional savings to be reinvested in addiction treatment, education, and mental health.⁸² New York and New Jersey have markedly decreased their jail and prison populations by reducing felony drug arrests, changing sentencing practices, and investing in community-based alternatives to incarceration, alongside significant decreases in all major crimes.⁸³

At the federal level, a 2013 speech by Attorney General Eric Holder to the American Bar Association emphasized the need for state and local systems to expand community-based alternatives to incarceration as a more humane and effective response to drug crimes. In Congress, Senators Rand Paul (R-KY) and Cory Booker (D-NJ) have co-authored the REDEEM Act, legislation intended to reduce the stigma that people convicted of nonviolent drug crimes commonly face by limiting the lifespan of criminal records that are huge impediments to securing employment and public benefits.⁸⁴ The passage and reauthorization of the Second Chance Act (SCA) has provided substantial funding to states and localities to assist people returning to society from incarceration seek employment, secure housing, and enroll in social entitlement programs that are shown to protect against recidivism and improve reintegration into the community.⁸⁵ While such legislation is not targeted to health *per se*, from a SDH perspective, it holds great promise for the health of communities.

The U.S. Supreme Court's landmark decision in *Plata v Brown* upholding a mandate requiring California to reduce its prison population to redress constitutional infringements on prisoners' right to basic medical and mental health-care set a legal precedent for addressing prison overcrowding.⁸⁶ In 2011, the United Nations decried the use of solitary confinement in U.S. correctional facil-

ities as excessive and tantamount to torture under international norms.⁸⁷ Since, two Congressional hearings on the need to curb this practice in the Bureau of Prisons and in the states have taken place. Additionally, audits for PREA, which “creates policies and practices to ensure a zero tolerance for sexual assault in prisons and corrections facilities by preventing, detecting, and responding to sexual abuse,” are underway. Fiscal year of 2014 is the first year that states and territories will have a percentage of federal grant funds withheld unless they demonstrate an intention to comply with the law. Two states, New Hampshire and New Jersey, have certified that they are in full compliance with PREA, and 46 jurisdictions have submitted an assurance that they are spending the required amount of resources to achieve and certify full compliance with the standards in future years.⁸⁸

The departure from policies predicated on severe punishment and retributive justice is further evident in the proliferation of policing models such as crisis intervention teams (CITs), jail and prison diversion programs, and specialized courts founded on the idea of “therapeutic jurisprudence,” all of which involve interdisciplinary collaborations between justice agencies and health and social services providers to promote engagement in community services as an alternative to incarceration. For instance, as recently as 2003, there were fewer than 75 adult mental health courts (MHCs). A decade later, there are 346 adult and 51 juvenile MHCs and more than 2,700 adult and juvenile drug courts currently operating in the United States.⁸⁹ The effectiveness of these specialized courts is still being debated, but their proliferation signifies a greater commitment to providing community-based alternatives to incarceration.

The Potential of the Affordable Care Act

The passage of the ACA in 2010 was a watershed moment in U.S. history. State and local governments are increasingly realizing the opportunities created by the ACA to develop partnerships between health and justice systems that simultaneously abate health disparities and enhance public safety. A number of the legislation’s key provisions—the expansion of Medicaid, increased coverage and parity for mental health and substance use services, and incentives for creating innovative service delivery models for populations with complex health needs—provide new funding streams and tools for policymakers to strengthen existing programs and develop solutions to reduce mass incarceration.⁹⁰ The ACA creates critical opportunities for states, local governments, and healthcare stakeholders to greatly expand the capacity of their community health systems to better meet the needs of underserved populations, curb the flow of medically-underserved populations into jails and prisons, pursue collaborative pro-

sive healthcare coverage to an estimated additional 10.5 million low-income Americans. Under the new rules, a substantial percent of justice-involved individuals living in expansion states are now able to enroll in Medicaid.⁹³

> **Expands coverage and parity for behavioral health treatment:** The ACA provides one of the largest expansions of mental health and substance use disorder coverage in U.S. history. Prior to the ACA, 47.5 million Americans lacked health insurance coverage and 25 percent of adults without health insurance had a mental health condition or substance use disorder or both. For Medicaid and private insurance beneficiaries, the ACA requires insurers to cover a range of health benefits, including mental health and substance use disorder services, greatly improving access to behavioral healthcare for large volumes of people who come into contact with the criminal justice system due to an unmet health need. Additionally, the ACA mandates health plans to provide parity between behavioral health and other medical services. Parity means that health plans cannot impose treatment limits or financial coverage requirements that are more restrictive than what they cover for physical health. The ACA goes a step further and prohibits insurance providers from imposing annual or lifetime dollar limits for mental health and substance use services, such as counseling, psychotherapy, and prescription drugs. The U.S. Department of Health and Human Services estimated that the ACA will extend behavioral health coverage to 27 million people who previously lacked health insurance, and provide federal parity protections to 62 million U.S. citizens overall.⁹⁴

> **Reducing health disparities:** The ACA has the capacity to abate health disparities by providing new federal funds to expand community-based health initiatives, requiring enhanced monitoring of disparities, creating incentives for diversifying the healthcare workforce and offering financial incentives for medical professionals to work in underserved areas—all which stand to benefit the communities most impacted by mass incarceration. The federal government should include criminal justice populations into the larger mission to abate health disparities. For example, including jails and prisons in population health surveys and data collection efforts to monitor health disparities would increase transparency inside correctional settings and potentially improve the quality of care available there. Furthermore, conducting analyses that examined the relationship between conditions of confinement and community health would provide impetus for programming that bridges community and correctional health systems.⁹⁵

STRENGTHENING FRONT-END ALTERNATIVES TO ARREST, PROSECUTION, AND INCARCERATION

There are huge opportunities for police agencies, prosecutors, and community-based service providers to work together to develop new responses to low-level crimes.

Increasingly, police, correctional facilities, courts, and community corrections are forming collaborative partnerships with community health providers and social services systems to develop solutions that steer people with treatment needs away from jail and prison. Many of these diversionary programs (e.g., CITs, alternatives to arrest, alternatives to incarceration, and problem-solving courts) are showing promise for improving utilization of health services in the community, reducing the number of people sent to jail or prison, and saving money. However, in many jurisdictions the capacity of diversion programs is insufficient to serve everyone who may benefit from participating, due to their reliance on local funding streams and/or individual grants to support the provision of treatment.

Through Medicaid expansions and improved coverage for mental health and substance use services, the ACA creates a critical funding stream that can be used to support and expand these front-end diversion programs. As long as people who are referred to these programs are enrolled in a health plan, then the mental health and addiction services that they are diverted to as part of these programs can likely be reimbursed by Medicaid or private insurance. Thus, there are huge opportunities for police agencies, prosecutors, and community-based service providers to work together to develop new responses to low-level crimes that do not result in arrest, prosecution, or incarceration and instead serve as a vehicle for referral to behavioral health and other social services.⁹⁶

BRIDGING HEALTH AND JUSTICE SYSTEMS

Historically, community health and corrections systems have operated in silos with different cultures, funding streams, and priorities. The ongoing cultural and organizational divide between these systems undermines continuity in care, leads to inefficiency, and results in preventable morbidity and mortality. Even though many large metropolitan jails deliver a quantity of health services comparable to a medium-sized hospital, correctional health providers are detached from services, standards, technologies, and ethics of mainstream health systems. As discussed previously, the lack of connectivity and coordination between correctional and community health systems poses considerable risks to the health of justice-involved individuals and the communities where they live.

The ACA provides the following important tools to help bridge this divide and rethink the points along the criminal justice continuum as opportune moments for outreach, enrollment in health insurance, and care coordination.

ENABLING OUTREACH AND CARE COORDINATION

The ACA requires states to develop strategies for enrolling vulnerable populations—defined as “children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS”—into health insurance plans and coordinated care.⁹⁷ Care coordination—the conscious effort to gather and organize a patient’s medical information from multiple care providers—is essential for promoting continuity of care planning and preventing adverse events, especially for patients with multiple chronic medical conditions, who receive care from several health professionals, take multiple medications, and frequently transition from one care setting to another.⁹⁸

Within this frame, the ACA creates opportunities to improve outreach and care coordination and enhance connectivity between community and correctional health systems in several ways:

> **Establishing Medicaid Health Homes:** The ACA provides incentives for states to establish Medicaid Health Homes, which are entities designed to coordinate services for Medicaid beneficiaries with one or more chronic conditions, including serious mental illnesses and substance abuse conditions, asthma, diabetes, and heart disease that require coordinated care between multiple providers.⁹⁹ Health homes employ “care managers” to help their patients access health and social services from multiple providers needed to live healthy lifestyles and reduce emergency room visits. These care managers should work in partnership with justice agencies to also prevent unnecessary episodes of incarceration.

Enrolling eligible justice-involved individuals into health homes can open new doors for diversion and improve outcomes at reentry. By working together, health homes, community treatment providers, police agencies, public defenders, and courts can devise policies and legal mechanisms for redirecting health home participants who come into contact with law enforcement away from incarceration and into community-based services. For example, if pretrial service agencies and prosecutors are able to determine that a person arrested on a low-level quality-of-life crime is a health home member, then they may be willing to decline prosecution and hand the individual off to a community case worker.

> **Providing funding for navigators:** The ACA requires states to establish a Navigator Program to conduct outreach and education to raise public awareness about Health Insurance Marketplaces where individuals, families, and small businesses learn about their health coverage options, choose a plan, and enroll in coverage.¹⁰⁰ Navigators can be trained and deployed to

While incarceration has clear negative impacts on community health, it is important to acknowledge that there are many important opportunities to implement health interventions in justice settings that can close service gaps and increase access to treatment.

conduct Medicaid enrollment, plan selection, and care coordination in criminal justice settings. For example, the Illinois Health Exchange is currently utilizing navigators to enroll justice-involved populations into Medicaid or other health plans and connect them to community services.

> **Providing opportunities to increase the role of peers and community health workers (CHWs):** CHWs are defined as community members or peer-specialists who work in community settings and perform many different roles including: delivering culturally competent health education, engaging community residents in health and social services, providing counseling and social support, advocating on behalf of individuals and communities for better health services, and working across different community health and social service systems.¹⁰¹

- Research shows that CHWs offer a valuable addition to healthcare workforces, because they are rooted in the same communities as their patients, and are better equipped to empathize with all of their patients' needs and establish rapport. Research also shows that formerly incarcerated CHWs are highly effective in engaging patients who are transitioning from correctional environments to the community in healthcare services.¹⁰²
- More states should emulate the state Medicaid policies of Maine, New York, Oregon, South Dakota, Washington, and Wisconsin, which allow CHWs to deliver services for Medicaid beneficiaries with complex health needs.¹⁰³ Jurisdictions should also continue exploring how to employ CHWs in community courts, probation offices, diversion programs, and other settings to identify and engage people in community services.

ENROLLING ACROSS THE CRIMINAL JUSTICE CONTINUUM

With more people eligible to enroll in Medicaid and subsidized health plans, there is a huge opportunity to redefine jails, courts, and community corrections settings as points of access to care for justice-involved individuals and their families. Community Oriented Correctional Health Services, Treatment Alternatives For Safe Communities, and other entities across the country are working diligently to help correctional systems establish Medicaid enrollment protocols in jails, courts, and probation offices. While incarceration has clear negative impacts on community health, it is important to acknowledge that there are many important opportunities to implement health interventions in justice settings that can close service gaps and increase access to treatment. Because they admit and release large numbers of people every day and are located close to communities, courts, and pretrial service agencies, jails in particular are opportune settings where community health systems can work with criminal justice agencies to bolster screening for infectious, behavioral, and chronic medical conditions; identify people who can be diverted to community services and those eligible for other alternatives to incar-

ceration; and conduct outreach and care engagement to help people with complex health needs who may also have a high risk of recidivism connect to appropriate medical and social services in the community.

GRANTING MEDICAID WAIVERS AND INNOVATION FUNDING

Medicaid waivers are one avenue for states to extend coverage to new populations, cover additional services, and pursue experimental pilots and demonstration projects, beyond what is in federal rules.¹⁰⁴ State policymakers and advocates should work together to pursue novel Medicaid waivers that explicitly permit reimbursement for a range of services provided in the community that are designed to divert people with behavioral health needs from arrest, detention, and incarceration.

The ACA also created the Center for Medicare and Medicaid Innovation to allocate \$10 billion in federal funds to states and local reformers pursuing new payment and service delivery models. For example, states and local jurisdictions may apply for these funds to support programs dedicated to diverting people with chronic health needs away from arrest and incarceration and towards community healthcare, housing, and other social services. If new models yield measurable gains in health outcomes and lead to cost savings, then a strong case can be made to sustain them.

USING CMS INNOVATION FUNDING TO BRIDGE THE DIVIDE: THE TRANSITIONS CLINIC NETWORK

Center for Medicare and Medicaid Services (CMS) innovation funding was used to launch the Transitions Clinic Network (TCN), a network of community clinics that partner with correctional agencies to engage people preparing to leave prison in primary care and other services following release.* TCN clinics employ formerly incarcerated CHWs, who complete a specially-designed certification program at local community colleges, to deliver culturally competent care coordination for prisoners. In a randomized trial, the TCN model has proved to be highly effective in increasing utilization of primary care services and reducing use of hospital emergency rooms among recently released prisoners.

* Emily A. Wang et al., "Transitions clinic: creating a community-based model of health care for recently released California prisoners," *Public Health Reports* 125, no. 2 (2010): 171.

ADVANCING HEALTH INFORMATION TECHNOLOGY

Advancing health information technology is a key component of national healthcare reform efforts to improve the ability for clinical information to flow seamlessly between treatment providers working in different settings, inform

If all states expanded Medicaid, the number of uninsured in the U.S. would fall by another 10 million.

clinical decision making by supplying timely access to accurate information, and empower patients by giving them more control over their own health information. A sister legislation to the ACA, the HITECH Act of 2009, provides financial reimbursements for healthcare providers—including qualifying correctional institutions—to adopt electronic health records (EHRs). The Bureau of Correctional Health Services (CHS) within the NYC DOHMH, which oversees the care of all people in the NYC jail system, is the first correctional health agency to successfully obtain these financial reimbursements.

Data from EHRs can be used to verify a person's health needs before or immediately upon entering the justice system, thereby increasing opportunities for diversion and alternatives to incarceration by providing timely access to accurate information on mental health or substance use needs. More reliable and timely transmission of health information from correctional to community settings also allows community-based providers to improve health outcomes and continuity of care for people returning from incarceration. For people with mental health and substance use problems, this can significantly reduce the risk of recidivism.¹⁰⁵

REGIONAL CHALLENGES WITH THE ACA

The ACA's potential for justice system reform varies considerably by state, with those not adopting the Medicaid expansion continuing to experience large inequities in coverage. Nearly two-thirds of people who were originally intended to receive coverage under Medicaid expansion reside in these states, and while other provisions of the ACA are reducing the number of uninsured residents (including subsidies in health insurance exchanges, the requirement to purchase insurance, and increased participation among those currently eligible for Medicaid), millions of low-income individuals remain without access to health insurance—a significant percentage of whom are racial and ethnic minorities.

A recent study in the *New England Journal of Medicine* compared mortality rate, coverage, access to care, and self-reported health outcomes between three states that substantially expanded Medicaid eligibility since 2000 with neighboring states that did not. This study found significant mortality reductions and improved health equity in expansion states, especially among adults between the ages of 35 and 64 years, racial and ethnic minorities, and people living in poor counties. This research demonstrates the enormous potential for Medicaid expansions under the ACA to address health disparities among poor and underserved populations.¹⁰⁶

According to the Kaiser Family Foundation, if all states expanded Medicaid, the number of uninsured in the U.S. would fall by another 10 million, and in conjunction with other provisions of the ACA, the number of people without health insurance would be 47.6 percent lower nationally than before the ACA was enacted.¹⁰⁷

Correctional systems in states where justice-involved individuals remain ineligible for Medicaid will have more difficulty capitalizing on the benefits of the ACA for justice system reform. A 2014 GAO report found that between 72 percent and 90 percent of inmates were Medicaid eligible in three expansion

states (New York, Colorado, and California), compared with just two percent in non-expansion North Carolina.¹⁰⁸

Conclusion

Mass incarceration is one of the great public health challenges of our times. Going forward, it is essential to continue acknowledging that many of the laws, policies, and practices set into motion during the acceleration of the prison boom have exacerbated structural inequalities in communities where the majority of residents are from historically oppressed groups.¹⁰⁹ It is also important to continue examining how these inequalities manifest in population health disparities. Doing so is important not only to understand the impact of the past 40 years of criminal justice policy on population health, but also as a tool to energize intersectoral commitment to design, implement, and evaluate reforms to meaningfully reduce mass incarceration and improve the social environments and health of the communities that have been most affected.

The burden of disease behind bars is unacceptably high and largely invisible to the health system, and the negative impacts of incarceration on the health of communities is a serious issue. Some states and local governments are making progress in reducing their prison populations and implementing legal reforms and programmatic interventions that help sustain lower rates of incarceration and, across the political divide, the appetite among governments to drive down prison populations and invest in community solutions is growing. Health reform through the ACA creates momentous opportunities to improve access to health services in communities most impacted by mass incarceration in a number of ways. It creates opportunities at the state and local level for leadership and innovation—which involves strategically using the funding streams of the ACA to bolster diversion initiatives.

While the ACA offers unprecedented opportunities to advance a new wave of criminal justice reform, it is not a panacea for abating the public health consequences of mass incarceration. Much more is needed to undo the now intergenerational damage done to whole communities by our overly punitive criminal justice system.

The social determinants of health or SDH framework—whose central idea is that human health is, in large part, determined by a range of social, economic, and political forces beyond the control of the individual—offers a model for states to dissect the current laws, policies, and practices that sustain overcrowded jails and prisons, undermining the prospects for economic security and causing families and communities an unwarranted degree of suffering. It also provides a platform for designing comprehensive plans to overhaul the justice system and develop intersectoral solutions to put the nation on the path of exiting the era of mass incarceration and restoring the health and sense of justice in communities that have felt its heavy hand.

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About *Justice Reform for Healthy Communities*

Mass incarceration has become one of the major public health challenges of our time. The millions of people who cycle through our nation's courts, jails, and prisons every year experience far higher rates of chronic health problems, infectious diseases, substance use, and serious mental illness than the general population. *Justice Reform for Healthy Communities* is a year-long initiative of the Vera Institute of Justice that aims to improve the health and well-being of individuals and communities most affected by mass incarceration. Guided by a national advisory board comprised of public health and criminal justice policymakers, practitioners, researchers, and advocates, the initiative advances its mission through public education, coalition building, briefings, and publications.

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