

REDUCING THE HEALTH HARMS OF INCARCERATION

A Report of the Aspen Health Strategy Group



Foreword by Kathleen Sebelius and William Frist

Edited by Alan R. Weil, Alexandra J. Reichert, and Karyn Feiden



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The mission of the **Aspen Health Strategy Group (AHSB)**, part of the Health, Medicine & Society Program at the Aspen Institute, is to promote improvements in policy and practice by providing leadership on complex health issues. AHSB brings together some two dozen senior leaders representing a mix of influential sectors, including health, business, philanthropy, and technology, to tackle a single health issue annually through year-long, in-depth study. Co-chairs are Kathleen Sebelius, 21st U.S. Secretary of Health and Human Services and former Governor of the State of Kansas, and William Frist, former U.S. Senator from Tennessee and former Senate Majority Leader.

The topic of AHSB's sixth annual report is the health harms of incarceration. This compilation opens with a consensus report based on the group's in-depth learning process, followed by a set of background papers. These papers explore the disconnect between correctional health and community-based structures of care, the intertwined relationship between incarceration and behavioral health, the influence of structural racism, and the community health impacts of incarceration.

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CO-CHAIRS

Kathleen Sebelius, 21st U.S. Secretary of Health and Human Services (2009-2014); former Governor, State of Kansas (2003-2009)

William Frist, former U.S. Senator (TN) (1994-2006); former U.S. Senate Majority Leader (2003-2007)

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Richard Baron, President and CEO, American Board of Internal Medicine

Richard Besser, President and CEO, Robert Wood Johnson Foundation

Gail K. Boudreaux, President and CEO, Anthem, Inc.

Dena Bravata, Healthcare Entrepreneur

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Victor Dzau, President, National Academy of Medicine

Judy Faulkner, Founder and CEO, Epic Systems

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Harvey Fineberg, President, Gordon and Betty Moore Foundation

Helene Gayle, President and CEO, The Chicago Community Trust

Ai-Jen Poo, Co-founder and Executive Director, National Domestic Workers Alliance; Co-founder and Director, Caring Across Generations

David J. Skorton, President and CEO, Association of American Medical Colleges

Jeff Thompson, Executive Advisor and CEO Emeritus, Gundersen Health System

Antonia Villarruel, Dean, University of Pennsylvania School of Nursing

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Donna Shalala, 18th U.S. Secretary of Health and Human Services (1993-2001)

Louis W. Sullivan, Chair, Sullivan Alliance to Transform America's Health Professions, Association of Academic Health Centers; 17th U.S. Secretary of Health and Human Services (1989-1993)

David Mathews, President and CEO, Kettering Foundation; 11th U.S. Secretary of Health, Education and Welfare (1975-1977)

STAFF

Alan R. Weil, Editor-in-Chief, *Health Affairs*

Alexandra Reichert, Ph.D. Student, Vanderbilt University; former Coordinator, *Health Affairs*

Ruth J. Katz, Vice President and Executive Director, Health, Medicine & Society Program, Aspen Institute

Katya Wanzer, Manager of Operations, Health, Medicine & Society Program, Aspen Institute

Raven Tucker, Project Coordinator, Health, Medicine & Society Program, Aspen Institute



March 2022

I'm pleased to introduce the sixth annual report of the Aspen Health Strategy Group (AHSG).

Established in 2015, AHSG explores some of America's most pressing health challenges and advances actionable solutions to address them. Previous reports have covered end-of-life care, the opioid epidemic, chronic disease, antimicrobial resistance, and maternal mortality. The focus of this report is one of equal importance to our society: the health harms of incarceration.

While it is widely recognized that the United States has the highest incarceration rate in the world, the health of the population in our jails and prisons, and the care that incarcerated individuals receive, has drawn far less attention. These realities demand a careful look, not only because there is a moral imperative to treat all people humanely, but also because the health effects of incarceration reverberate widely across families and communities.

The Aspen Health Strategy Group is housed within the Aspen Institute's Health, Medicine & Society Program and co-chaired by Kathleen Sebelius and William Frist, both long-time partners to the Aspen Institute. Kathleen Sebelius, who has held positions as both U.S. Secretary of Health and Human Services and as Governor of the State of Kansas, has helped to lead AHSG since its launch. William Frist, former U.S. Senator from Tennessee and former Senate Majority Leader, assumed the position as co-chair in 2020. AHSG's diverse membership includes the leaders of major corporations, health systems, professional organizations, and philanthropies, as well as academic experts. My thanks to each of them for taking time from their many other responsibilities to contribute to the important work of moving us closer to the creation of a free, just, and equitable society.

The Aspen Health Strategy Group embodies the Aspen Institute's mission to drive change through dialogue, leadership, and action to help solve society's greatest challenges. It is this commitment that has allowed AHSG to reach policymakers and

other influencers positioned to act on the recommendations presented here. I am confident that this effort will be successful, and am grateful for the efforts of this group to improve the lives of some of America's most vulnerable citizens.

Thank you for reading and for your support.

A handwritten signature in black ink that reads "Dan Porterfield". The signature is written in a cursive style with a long horizontal line extending to the right from the end of the name.

Dan Porterfield
President and CEO
Aspen Institute

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Foreword

Kathleen Sebelius
AHSG Co-Chair

William Frist
AHSG Co-Chair

In this, the sixth report of the Aspen Health Strategy Group (AHSG), we confront the health harms of incarceration. In doing so, we are taking on an issue that has never received the attention it merits—even though more than 10 million people are incarcerated every year in the United States and an astonishing 45 percent of Americans have a family member who has been jailed or imprisoned.

Health in carceral settings is as knotty a topic as any we have confronted to date. In our capacity as cochairs of AHSG, we feel truly privileged to bring together some of the best and brightest minds to take it on. The diversity of their backgrounds and their connections and commitment give them unique authority to drive forward policies and practices that can strengthen systems intended to serve people who are incarcerated.

The health challenges facing that population, their families, and their communities are encyclopedic. Well before being incarcerated, many people have undiagnosed or untreated behavioral health issues and chronic illnesses. A fractured health system means they lose whatever insurance coverage they had before entering jail or prison and struggle to reclaim it upon release. The therapeutics, counseling, and other support they have been prescribed in one setting is often unavailable in another. Their children are at greater risk of mental health and substance use disorders and their communities have invariably endured the consequences of trauma and structural racism.



2 Reducing the Health Harms of Incarceration

The 2021 AHSG report offers five big ideas for addressing these and many other harms. The work was informed by subject matter experts who developed four white papers to ground members in the complex issues surrounding carceral health and then joined the convening to explore them further. Their findings are presented in this report.

To inform and ground its deliberations, AHSG gives a voice to those most affected by the issues it studies. At the convening, Robert Day, a formerly incarcerated man, described his deteriorating health and captured the staggering indifference of the carceral system by saying, simply: “You are not treated as a human being.” Lisa Puglisi, an assistant professor of medicine at Yale University, who sees Day in clinical practice, served as moderator for his presentation.

For the second year, the Aspen Health Strategy Group met virtually to take its deep dive. It would not have been our choice to substitute online conversation for the rewards of in-person interaction, and we hope that the pandemic will release its grip enough in 2022 to allow us to come together in one locale. Nonetheless, we are gratified to discover how much is possible when thoughtful innovators dedicate their time and energy to meet in whatever format is possible.

The work of the Aspen Health Strategy Group could not move forward without our generous funders. The Robert Wood Johnson Foundation and the Laurie M. Tisch Illumination Fund have provided financial support since its launch and were joined this year by Arnold Ventures. As always, we note that the perspectives expressed in this report are those of the authors and do not necessarily reflect the views of these funders.

On behalf of the Aspen Health Strategy Group, we thank everyone who helped make possible our 2021 convening and this timely report, which has so much potential for impact.



AHSG Co-Chairs

ASPEN HEALTH STRATEGY GROUP REPORT

**Five Big Ideas on Reducing
the Health Harms of Incarceration**

Part 1



*“Incarceration is a primary source of poor health for individuals,
families, communities, and our nation as a whole.”*

– THE ASPEN HEALTH STRATEGY GROUP

Five Big Ideas on Reducing the Health Harms of Incarceration

Introduction

Despite having the highest incarceration rate in the world,¹ the United States pays little attention to the health of the millions of people directly touched by the criminal justice system. People enter jail and prison with significant unmet health needs, often experience harm and deteriorating health while incarcerated, and face elevated mortality and morbidity rates when they return to the community. The poor health of this population harms their families and communities and saps the strength of the nation as a whole.



Describing his care while incarcerated, Robert Day told the Aspen Health Strategy Group, “You are not treated as a human being.” There is no justification for the punitive aspects of the criminal justice system to include harming the health of the people involved.

¹ Unless noted otherwise, the data in this report all come from the background papers prepared by subject matter experts and published in conjunction with this report.

The Aspen Health Strategy Group selected incarceration and health as its topic for 2021, its sixth year. Due to the COVID-19 pandemic, the multisectoral group of leaders met virtually, discussing the topic with the assistance of subject matter experts who prepared background papers to inform the discussion. The group emerged with five big ideas to tackle systemic issues at the intersection of incarceration and health.

The Aspen Health Strategy Group’s goal is to promote improvements in health policy and practice by providing leadership, ideas, and direction on important and complex health issues. Cochaired by Kathleen Sebelius, former governor of Kansas and former U.S. secretary of health and human services and William Frist, a physician and former U.S. Senate majority leader, the group comprises 24 senior leaders across sectors including health, business, media, and technology. More information about the Aspen Health Strategy Group can be found on the Aspen Institute website (<http://www.aspeninstitute.org/aspen-health-strategy-group>).

This report captures the conversations of the group, but no specific section or statement in the report should be considered to represent the opinion of any individual group member.

Background

Our work builds upon four papers prepared by subject-matter experts in advance of our meeting. These papers are published in conjunction with our report. Data and conclusions that appear in our report without citation are drawn from these papers.

“The world of correctional health—meaning the health care and outcomes of people who enter America’s 3,000 jails, 2,000 prisons, 150 immigration detention centers, and 2,000 juvenile detention settings—is poorly understood,” states Homer Venters in “The Hidden World of Correctional Health.” Describing the structure, history, and harms of the incarceration system’s approach to health care, he points out, “Mass incarceration in the United States has led thousands of jails, prisons, and immigration detention settings to deliver health services to people who are disproportionately of color and whose serious health needs are often ignored or inadequately addressed.”

While the U.S. Supreme Court established a legal right to health care for people in jail and prison, the Social Security Act precludes the use of federal funds for that care. With a proliferation of state and local jurisdictions, each individual carceral system allocates its own funding to health-care services with little oversight. The result, states Venters, is that “Crucial decisions about the scope of services, quality measurement, and reporting of health outcomes are often left to jail and prison administrators whose expertise lies elsewhere.”

Jails, generally utilized for pretrial detention and short sentences, primarily focus on urgent issues, such as detoxification or mental health crises. Prisons, on the other hand, care for incarcerated people over longer periods of time and must manage a broad range of acute and chronic conditions.

No overarching structure ties the far-flung carceral system together. Two bodies, the National Commission on Correctional Health Care, and the American Correctional Association, have standards and accrediting programs, but accreditation is not required or even rewarded. Ultimately, collecting and analyzing data on process and outcomes, and modifying practices, are the responsibility of law enforcement agencies, with occasional intervention by the courts through litigation or pressure generated by media reports.



In “Caring Less: Treatment of Mental Health and Addiction in Carceral Settings,” Tracie Gardner and Dan Mistak point out that the large number of people in the carceral system with behavioral health needs results from decades of policy decisions that criminalized health conditions. A turning point was President Richard Nixon’s launch of the “war on drugs” in the 1960s alongside the deinstitutionalization of people with mental health disorders.

According to Bureau of Justice Statistics data from 2005, over half of prison and jail inmates needed mental health services. Incarcerated people are three to five times more likely to meet the threshold for serious psychological stress than non-incarcerated U.S. adults. Correctional facilities have become the largest providers of mental health services in the country. Yet, state Gardner and Mistak, they are “ill equipped to provide support for those living with substance use disorders and mental health needs.”

What, ask Gardner and Mistak, does provision of mental health and substance use treatment look like in jails and prisons? Their answer: “Confinement conditions run counter to good behavioral health support. Correctional needs often trump therapeutic needs, leading to missed medications. Jails may process people through their systems too quickly to understand whether they have unmet behavioral health needs. Individuals with mental health needs may find themselves in solitary confinement so that they can be more easily managed.” Among the many tragic results of poor care is that suicide is the leading cause of death in U.S. jails.

Like Venters, Gardner and Mistak point to the lack of standards in the correctional system, stating, “Because jails are run by local jurisdictions and prisons are run by state correctional systems, there are no uniform policies for their mental health systems.”

In “Community Health Impacts of Mass Incarceration,” Emily Wang and Hedwig Lee describe how incarceration impacts individual, family, and community health. The returning population is large, with 10.6 million people released from correctional systems back into their communities each year (600,000 from prisons and



10 million from local jails). A history of incarceration is associated with elevated risk for nearly all diseases, communicable and non-communicable. Much research demonstrates the negative impact of incarceration on mental health, including increases in depression, with particular harms associated with solitary confinement even following release.

The cycling of people into and out of correctional systems makes it essential to focus on continuity and transitions. Wang and Lee note, “Individuals who are incarcerated are likely to spend far more time out of correctional systems than in them. For instance, Black males who have ever been in prison spend 13.4% of their adult lives incarcerated. In other words, the average incarcerated individual is exposed to the consequences of past incarceration six times as long as to incarceration itself.”

Inadequate health insurance coverage is a primary barrier to accessing care among people returning to the community. Disruption of Medicaid coverage—the primary source of coverage among people who are incarcerated—is common, although recent policies and efforts have shown some promise. Still, due to lack of coordination and linkages to the community health system, even having coverage does not assure adequate care. For example, many people with prescriptions do not fill them after release, and those with chronic conditions often leave prison without follow-up appointments.

The effects of incarceration reach well beyond the individual. Forty-five percent of adult Americans have had an immediate family member incarcerated. The rates are disproportionate by race: 63% for Black Americans, 48% for Latino/Latina Americans, and 42% for White Americans. Effects on children, romantic partners, and other family members of an incarcerated person range from psychological stress related to stigma,

grief related to loss, relationship strain, and economic, food, and housing insecurity. Entire communities where residents have high incarceration rates face distinct health disadvantages, including the chronic stress associated with population turnover and increased police presence. These communities are the same ones harmed by redlining, public divestment, and other racially disparate policies.

In “Mass Incarceration as a Manifestation of Structural Racism: History, Impact, and Potential Remedies,” Monik Jiménez and Mary Bassett argue that “reducing the negative health consequences of incarceration ... must include dismantling inherently race-biased policies and reducing the sheer size and scope of the existing system.” They provide a historical account of the laws that form the basis for mass incarceration targeting Black Americans: the “Black codes” after the Reconstruction era limited Black Americans’ right to serve on juries, change employment, and vote, which in turn gave rise to vagrancy laws and the Jim Crow era. These legal mechanisms for social control through incarceration, fines, and fees remained in place until the 1960s, only to be replaced by the war on drugs and the war on crime, which continued the racially disparate policies of the past. The cumulative effects of more than 100 years of racialized policies are reflected in current incarceration rates.

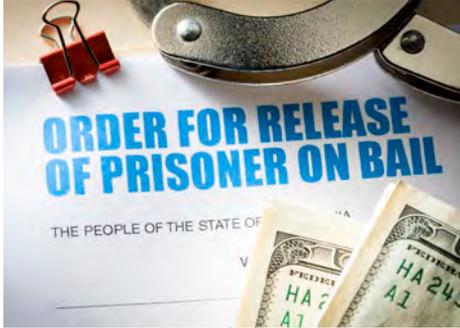


Jiménez and Bassett report incarceration rates per 100,000 by race and ethnicity in 2010: 2,306 for Black people; 1,291 for American Indian or Alaska Native people; 1,017 for Native Hawaiian or Pacific Islander people; 831 for Latino/Latina people; 450 for non-Hispanic White people; and 115 for Asian people. Black, Latino, and Indigenous



people are charged with more serious crimes that have more punitive sentences than their White counterparts. Black Americans in particular are represented disproportionately at all touchpoints of the criminal legal system, facing more encounters with law enforcement, higher use of threats and force during interactions with law enforcement, higher likelihood of conviction, harsher sentencing, and more stringent postrelease conditions.

The cash bail system in the United States further deepens the burden on communities in poverty and communities of color, and incarcerates those who have not been convicted of a crime. and Jiménez and Bassett note, “Nearly three-quarters of people incarcerated in jails by local authorities have not been convicted of any crime and are largely those who cannot afford cash bail.” Bail is routinely set higher for Black and



Latino defendants than for their White counterparts, sometimes almost \$10,000 higher. Similarly, 3.6 million people are estimated to be on probation, a status that enables probation officers to exercise discretion, with technical violations the leading reason for reincarceration.

While incarceration rates have recently started to decline, the prison population remains nearly five times what it was in 1980. Jiménez and Bassett conclude, “By fundamentally redefining our notion of public safety to one centered on providing resources needed to thrive, we can collectively shift our societal priority from carceral control to community empowerment.”

Framing the Issue

Five themes emerged in the group’s discussion that helped guide the development of this year’s big ideas. The themes are as follows:

- **Incarceration leads to poor health**

Incarceration is a primary source of poor health for individuals, families, communities, and our nation as a whole. The most visible harm is the direct and immediate effect on those who are incarcerated. The period of incarceration is associated with the onset and exacerbation of acute and chronic conditions. Some harm arises from the high rates of physical and sexual assault that occurs behind bars. Other harm is due to poor medical treatment in jails and prisons. Little attention is given to assuring continuity of treatment plans and care as people return to the community. The consequences of these various sources of harm continue long after release, with those returning to the community facing higher rates of mortality and morbidity.

While less visible, the harms to families arising from incarceration are profound. Entire families suffer from lost family connections, lost income, and

lasting barriers to employment and social benefits. Children's behavioral issues increase, which generally leads to punishment, not support. The statistics are stark. Among the estimated 45% of Americans who have a family member who has been incarcerated, life expectancy is two years less than those without a family member who has been incarcerated.



Individual and family harm spreads to communities and the nation as a whole. Communities bear the brunt of missing family members and wage earners, with these burdens multiplied by the excessive policing that often follows. Correctional staff experience elevated levels of stress and bring the consequences of that stress home to their families and communities. The nation loses the productivity of a large share of people in their prime working years and devotes inordinate resources to a system that ultimately causes great harm.

The physical consequences of these harms are borne by individuals while the economic harm spreads far and wide. The economic harm begins with the struggles of individuals and families coping with poor physical and mental health and reduced opportunities to work. Taxpayer-financed programs, initially primarily Medicaid and later Medicare, must then cover the costs of addressing long-term health needs that could have been avoided with timely, appropriate care. As people who were incarcerated enter private sector jobs, private health insurance premiums must cover these elevated costs. Safety net programs, such as community mental health systems and programs for the homeless, are strained due to costs imposed on them that arise from serving people who were incarcerated.

- **Carceral health operates outside the norms of the health sector**

Despite providing health-care services to a highly vulnerable population, prisons and jails operate completely outside the many systems designed to assure access and quality in the civilian health-care system.

What is most striking about carceral health is its lack of data, standards, quality reporting, and systems of quality improvement. While the health-care sector as a whole has made tremendous strides and investments in all of these areas over the past few decades, carceral health systems have been completely left behind.

Myriad examples of this disconnect exist, some of which are as follows:

- Electronic health records that facilitate provider communication, continuity of care across settings, and quality measurement in the civilian sector are almost unheard of in carceral settings.
- Surveillance of chronic conditions such as HIV and hepatitis C, which is essential to disease control and prevention, is limited in carceral settings.
- Infection control, through antibiotic stewardship, surveillance, improved hygiene, and other mechanisms, does not have the priority in carceral settings that it has in civilian health-care settings.
- Monitoring of adverse events, such as medication errors, which facilitates system improvement, does not typically occur in carceral settings.
- An infrastructure for quality improvement designed around root cause analyses of adverse events generally does not exist in carceral settings.
- Despite the high prevalence of chronic conditions ranging from substance use disorders to diabetes and hypertension, planning for care transitions that facilitate continuity is almost entirely absent as people move from jail to prison or return to the community.
- Basic quality measurement and transparent reporting of quality metrics, which has been a top priority of the health-care sector over the past two decades, is completely absent in the carceral sector.



• **Incarceration is a counterproductive response to mental health needs**

Prisons, jails, and the criminal justice system as a whole (including police, courts, and probation) have become the primary societal mechanism for responding to what are actually health conditions, most notably mental health and substance use disorders. Yet this system is not clinically or patient oriented, yielding predictably poor health outcomes. Examples include:

- The continued use of solitary confinement, which causes significant and lasting harms to mental health, runs directly counter to the health needs of the population.
 - One reason suicide is the leading cause of death in jail: suicide watch focuses on removing immediate opportunities for self-harm rather than treating the underlying mental health conditions that can lead to suicide.
 - Detoxification carries with it substantial risk of death, but many carceral settings are ill-prepared to handle it in a medically appropriate manner and may be unable to respond in a timely way to emergencies that arise.
 - Mental health issues are often interpreted by untrained security staff as noncompliance, which leads to punishment instead of treatment.
 - As Homer Venters points out, “Only a handful of jails and prisons offer access to methadone and suboxone to people who meet clinical criteria for treatment, despite decades of programs operating safely in both jails and prisons.”
 - All of these harms arise from standard community practices of sending police as first responders to mental health crises, with the attendant escalation of violence and the funneling of people with substantial health care needs into a system that is not designed to handle them.
- **Security needs trump health needs**

A defining feature of carceral health is that it is subservient to the imperative of security, as defined by those who run the prisons and jails. With security as the overarching goal, practices that are harmful to health continue unabated. In addition to solitary confinement and suicide watch, described above, the following are examples of this phenomenon:

- People who are incarcerated have no expectation of privacy with respect to their medical conditions, which undermines the trust necessary for effective medical treatment.
- Schedules for sleep, meals, exercise, and the like are established around the needs of the carceral setting, which may conflict with what is most effective for administering medication and other activities to better manage acute and chronic conditions.

- Untrained correctional staff continually make judgments as to whether to bring in clinical staff. In doing so, they lean on biases and assumptions about behavior that are not rooted in evidence and that can have life-or-death consequences.
- The criminal justice system requires that defendants are “competent” to stand trial, which can lead to mental health treatment to restore competency followed by conviction and incarceration in a setting that provides little or no mental health treatment.



Overall, incarcerated people are fully aware that clinical staff members are first and foremost aligned with the jail or prison, and all interactions are tainted by an appropriate lack of confidence that clinicians are placing the needs of the incarcerated first.

- **Incarceration typifies a structurally racist system**

Incarceration is merely the tip of the iceberg of a system that exemplifies “structural racism,” which the Aspen Institute defines as “a system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity.”²

The systems of criminal justice and policing, of which incarceration is a part, dehumanize people of color and subject them to arbitrary exercises of power based on social and cultural norms that perpetuate long-standing inequities. They are the latest in a long, historical series of policies that convert the majority’s legitimate desire for safety into practices that consistently and reliably disadvantage racial and ethnic minorities.

The system is self-reinforcing. Excessive rates of incarceration and aggressive policing feed into cultural narratives of race-based deviance and sustain the economic disadvantage of communities of color. The criminalization of mental

² Keith Lawrence, Stacey Sutton, Anne Kubisch, Gretchen Susi and Karen Fulbright-Anderson, *Structural Racism and Community Building*, Aspen Institute Roundtable on Community Change (Washington, DC: The Aspen Institute, 2004).

health needs in certain communities (while those same needs are met through the health-care system in others) perpetuates the cycle of disadvantage. These structural elements yield the constant re-creation of racially disparate outcomes even as societal views toward race evolve and increasingly recognize that disparate outcomes can only be eliminated through intentional structural change, not by changing individual attitudes and behaviors.

Five Big Ideas to Reduce the Health Harms of Incarceration

We must take concrete steps to reduce the health harms associated with incarceration. The Aspen Health Strategy Group offers five big ideas to do so.

1. Eliminate the Medicaid exclusion

The single step most likely to effect positive change in carceral health is to repeal Medicaid's inmate exclusion. Medicaid coverage of people in jails and prisons would bring with it myriad changes that are the precursors to improved health:

- Medicaid coverage would provide a funding stream that would reduce (though not eliminate) the competition for resources within correctional budgets that lead to underinvestment in health.
- Particularly in states that have adopted the Medicaid expansion under the Affordable Care Act, coverage during incarceration would facilitate care transitions as people enter and exit jails and prisons. Stable, continuous coverage provides the foundation for effective management of acute and chronic conditions.
- Medicaid coverage would bring with it the requirement that those who provide care to people who are incarcerated meet credentialing and certification standards.
- Medicaid programs process claims and collect and report data. Bringing these steps into carceral settings would quickly and dramatically increase the amount of information available to understand and improve correctional health.



- Medicaid programs are required to have quality improvement plans. Linking carceral health systems to Medicaid would enable their inclusion in quality improvement efforts.
- Medicaid programs are administered by states with federal government oversight. Repealing the Medicaid inmate exclusion would provide a level of state and national oversight of carceral health that is now completely absent.

We acknowledge that the origin of the inmate exclusion is the historical goal of preventing states from shifting correctional health costs to the federal government. Without endorsing a specific mechanism, we note that there are examples of federal recapture of state funds when the federal government has expanded coverage into an area previously funded by states. The most notable example is Medicare Part D, which relieved states of financial responsibility for the prescription drug costs of people dually eligible for Medicare and Medicaid. States' Medicaid savings were "clawed back" through a formula designed to offset the fiscal relief states received.

2. Make health a priority in correctional systems

Correctional systems cannot treat health as an afterthought or as a goal always subservient to safety. Correctional systems should demonstrate this priority through steps such as the following:

- The use of solitary confinement should be eliminated.
- Individual adjustments in food, sleep, and activity schedules should be permitted when necessary for appropriate disease management and medication effectiveness.
- Jail intake procedures should be revised to account for the high frequency of mental health and substance use-related crises upon entry, with more rapid assessment and immediate deployment of evidence-based interventions.
- Jails and prisons should increase health-related training of correctional staff and quickly shift responsibility from correctional officers to clinical staff whenever an incarcerated person requests or shows evidence of needing care.



- Jails and prisons should become routine settings for clinician training.
- All possible steps should be taken to minimize stigma and interference with clinical care when people who are incarcerated receive care in community hospitals.
- Correctional systems should plan for inmate release around the health needs of incarcerated people. Release plans should include confirming that the person has health insurance, which may involve restoring Medicaid coverage or applying for that coverage prior to release. Release plans should also include medication management, self-management of chronic conditions, and assessment of the living circumstances the person will enter to determine if particular supports are needed to meet the person's health needs. Some of these items are referenced in the recently introduced Medicaid Reentry Act of 2021 (H.R. 955).

To those who question the appropriateness of a health-oriented group making recommendations to correctional systems, we offer this response: If people discharged from hospitals were likely to end up in jail, it would be only natural for those in corrections to query what was going on in hospitals to yield this result, and to seek action to alter it. We find ourselves in a symmetrical position. A system seemingly independent from health care is placing tremendous burdens on the health-care sector and population health.

As experts in health, we call upon the health sector to engage more closely with the corrections sector to explore the relationship between the two. The ultimate goal is to reduce the negative effects of the criminal justice system on the health of people who are incarcerated and on the public's health more broadly.

3. Bring population health and quality standards to carceral health

The Centers for Disease Control and Prevention (CDC) and state and local departments of health should conduct a top-to-bottom review of the degree to which their work considers the health of people who are incarcerated. Among the questions to be asked are:

- To what degree do disease surveillance efforts include people who are incarcerated?
- Are communicable diseases addressed as effectively in carceral settings as they are in the community?
- What are the rates of community spread of diseases that occur within carceral settings?

- Do population health improvement efforts reach people who are incarcerated?
- Are clinical initiatives, such as infection control and antibiotic stewardship, adopted in carceral settings?
- Are workforce initiatives addressing shortages that affect access to needed care among people who are incarcerated?

Based upon this review, the CDC and state and local departments of health should modify their activities and programs to assure that their work addresses the needs of people who are incarcerated.

Similarly, payers, quality improvement organizations, and standards-setting organizations should examine whether they have an adequate focus on the health of people who are incarcerated. For example:

- Medicaid agencies, Medicaid managed care organizations, private payers, and health plans should work together and with formerly incarcerated people to determine what data can and should be shared to help support the needs of individuals who have been incarcerated and develop goals for achieving specific quality outcomes for this population.
- Quality measurement organizations should develop metrics specific to the health burdens and needs of people who have been incarcerated and establish goals for achieving the same health outcomes as other populations.
- Quality measurement organizations should consider mechanisms to assure that the churn of people in and out of carceral settings does not, during their period of incarceration, remove them from the population measured.
- The Agency for Healthcare Research and Quality should examine its core adult and child measure sets for Medicaid and the Children's Health Insurance Program (CHIP) and assure that they capture the health needs of people who have been incarcerated and their family members.

4. Coordinate care inside and outside carceral settings

The disconnect between health care inside and outside carceral settings is a core source of avoidable harm. These steps would reduce that harm:

- The Center for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare and Medicaid Services (CMS) should design a set of initiatives focused directly on improving outcomes for people who transition between jails and prisons and the community.

- The Office of the National Coordinator for Health Information Technology within CMS should establish goals for adopting interoperable electronic health records within jails and prisons, and among the service providers most used by people prior to and after incarceration.
- Quality improvement organizations, standards-setting organizations, and CMS should develop care coordination metrics focused specifically on people transitioning to and from carceral settings.



5. Dramatically reduce the level and consequences of incarceration

Ultimately, the most clear-cut way to reduce the harm associated with incarceration is to dramatically reduce the number of people who are incarcerated. This will require policy changes at the federal, state, and local levels, including reorienting our treatment of people with mental health and substance use disorders toward health and away from punishment. Some mechanisms for doing so include:

- Having mental health professionals, rather than police, respond to emergency calls involving people in crisis;
- Expanding the use of diversion courts that focus on providing needed services to people with substance use disorders and/or mental health conditions; and
- Developing monitoring centers as an alternative to jail to hold people who are intoxicated or experiencing a mental health episode.

We must also reduce the negative sequelae associated with incarceration. With almost twice as many people on probation as in jail and prison, the extensive use of probation and the discretion inherent in its use warrants reconsideration.

Similarly, employers should eliminate practices that disadvantage people who have interacted with the criminal justice system—practices often rooted in biases and assumptions that have no basis in evidence. The health-care sector, commanding one-seventh of the economy, should take a lead role in this policy change by reviewing hiring practices, policies related to workforce education and training, and supply chain sources in order to eliminate this form of discrimination.

Moving Forward

High rates of COVID-19 in communities burdened by incarceration have raised awareness and brought attention to the health harms created by the carceral system. While infectious diseases are one source of harm, this report documents a broader population along many health dimensions. The COVID-19 pandemic only adds urgency to the need to change policies and reduce the health consequences of incarceration, which are experienced both by the incarcerated and those in the community.

The Aspen Health Strategy Group, with its multisector membership, has developed these ideas to motivate improvements in policy and practice. With this report, we call on the Biden administration, Congress, states, and localities to recognize the avoidable health burdens among incarcerated communities and take action to remove them.

BACKGROUND PAPERS

**The Hidden World of
Correctional Health**

Homer Venters, M.D.

**Caring Less: Treatment of Mental Health
and Addiction in Carceral Settings**

Tracie M. Gardner, B.A. and
Dan Mistak, J.D., M.A., M.S.

**Mass Incarceration as a Manifestation
of Structural Racism: History, Impact
and Potential Remedies**

Monik C. Jiménez, Sc.D. and
Mary T. Bassett, M.D., M.P.H.

**Community Health Impacts of
Mass Incarceration**

Emily Wang, M.D. and Hedwig Lee, Ph.D.

Part 2





“While there are many areas that must be addressed, transparency must come first. The lack of data or agreement on the actual conditions of care and health access and outcomes behind bars require that our public health organizations take on a clear role in this domain.”

– HOMER VENTERS, M.D.

The Hidden World of Correctional Health

Homer Venters, M.D.

Introduction

With over 10 million incarcerations per year, the United States has established itself as the world's most prolific jailer (Wagner 2020). The war on drugs and other criminal justice policies of the past several decades have resulted in the mass incarceration of people of color and those with behavioral health problems in a way that has profoundly impacted health disparities. While criminal justice reform has become a topic of considerable policy discussion, the world of correctional health—meaning the health care and outcomes of people who enter America's 3,000 jails, 2,000 prisons, 150 immigration detention centers, and 2,000 juvenile detention settings—is poorly understood.



By design, correctional health is largely separate from community-based structures of health care and oversight (Pew Charitable Trusts 2017). Elements we take for granted in the broader health-care system are largely absent in correctional health: infection control, population health, medical ethics, transparency, and quality assurance and improvement. Applying standard features of the health-care and public health systems to correctional health would go a long way toward addressing its myriad flaws, but would require structural, funding, and oversight changes.

To understand correctional health, we need to recognize the power imbalances that characterize jails and prisons. Carceral settings are places of common violence where physical and sexual assault are routinely experienced and witnessed (Widra 2020b; Ford 2019; Widra 2020a). The only national mandate for health-related training of staff and reporting in U.S. carceral settings revolves around sexual abuse. The

Prison Rape Elimination Act was passed by Congress in 2003, but almost 20 years later sexual abuse remains a common problem, and ineffective investigations, retaliation, and stigma continue to lead to underreporting (Smith 2021).

Structure

Health care behind bars occurs in many different forms, but one common feature is that most American correctional health services are not independent from the security service. For example, the health staff in most state prisons is employed either by the Department of Corrections or by a for-profit vendor. Similarly, in county jails the health staff may work for the county sheriff or a for-profit vendor. In a handful of mostly large, urban jail settings like in New York City and Chicago, the health service is part of the local Department of Health or public hospital system, but that model is rare.

While incarcerated people have had a legal right to health care since it was established by the U.S. Supreme Court in 1967, the Social Security Act passed in 1965 precluded the use of Medicare or Medicaid dollars to pay for it (Fiscella, Beletsky, & Wakeman 2017). As a result, there is no federal provision to fund health care for the only group of people in the United States who are constitutionally guaranteed access to it. Each carceral system instead allocates funding with little transparency



or oversight of the care it provides or the clinical needs of the patients. Crucial decisions about the scope of services, quality measurement, and reporting of health outcomes are often left to jail and prison administrators whose expertise lies elsewhere.

Even a brief discussion with incarcerated people illuminates how health care is a distant second priority in institutions

built for punishment and control. The care environment may compromise confidentiality, and health providers may be limited in how they can deliver care, which can directly impact quality and patient trust. For example, when the security service decides to place someone in solitary confinement, health staff decides who is fit for punishment and who should be excused, effectively making the health provider part of the punishment apparatus (Glowa-Kollisch, Kaba, Waters, Leung, et al. 2016). Health providers may be told to limit or alter their care in ways that harm

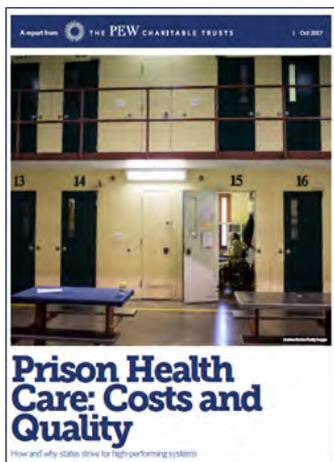
the effectiveness or participation of patients. One common example is health staff being forced to administer insulin to diabetic patients or take vital signs through a narrow, waist-level food slot in the cell door. This is extremely uncomfortable and unsettling for patients who may simply refuse care rather than stoop down or get on their knees for this type of encounter (Mualimm-Ak 2013).



The problem of dual loyalty—the erosion of the health mission by the priorities of the security setting—is an ever-present issue. Patients are keenly aware of this when a doctor clears them to be punished via solitary confinement, turns a blind eye to abuse, or otherwise tacks toward security priorities and away from providing ethical and evidence-based health care (Glowa-Kollisch, Kaba, Waters, Leung, et al. 2016). These and other power imbalances of health care behind bars not only increase the risk of morbidity and mortality, they also damage the engagement of patients with their care after release.

The nature of care in jails and prisons differs significantly. Because jail settings usually hold people shortly after arrest, their health services often focus on caring for people who are acutely intoxicated, in the midst of withdrawal, experiencing a mental health crisis, or suffering from new injuries or exacerbation of chronic health conditions (Subramanian, Delaney, Roberts, Fishman, & McGarry 2015). Immigration

detention facilities also tend to hold people for shorter periods of time, as do juvenile detention settings. By contrast, most people going to prisons have already spent some time in a local jail and thus may have fewer acute complaints. The long-term nature of prison sentences means that the correctional health services have an extended view of diagnosis and treatment (Pew Charitable Trusts 2017). In general, prison settings have more resources dedicated to rehabilitation programs and education than jails and other short-term settings.



Because the scope of correctional health services is not standardized, costs vary tremendously. A review of the Virginia prison system in 2017 found the cost

of health services to be approximately \$6,500 per person per year (Joint Legislative Audit & Review Committee 2018). A report by the Pew Charitable Trusts found a similar range for per-person health expenditures in state prisons, with a top cost of almost \$20,000 in California (Pew Charitable Trusts 2017). In order to reduce costs, many systems have turned to for-profit vendors to provide correctional health services (McLeod 2019; Healy & Willmsen 2020).

Unlike community health settings, state departments of health and accrediting organizations do little to assess access to, or quality of, care. Because mass incarceration in the United States has disproportionately impacted people of color, correctional health represents one of the most significant settings for health disparities in U.S. health-care delivery. Black Americans are approximately five times more likely than Whites to receive health care there (Nellis 2016).

Health Services Behind Bars

The basic structures of correctional health are built along the path of the criminal justice pipeline, with the various types of services matching a process that stretches from arrest and arraignment to incarceration and release.

Jail Intake

In general, the churn of people in and out of local jails, which are primarily utilized for pretrial detention and short sentences, involves brief assessments by security or nursing staff at the time of entry to detect imminent emergencies or urgent issues

(National Commission on Correctional Health Care n.d.). The scope and staff level of this initial encounter are crucial, especially in smaller jails or where jails are used to hold people who are acutely intoxicated or in mental health crisis. In some settings, every person entering jail may be assessed by a physician or mid-level provider not only for urgent health issues but also to conduct public health interventions including testing for hepatitis C, HIV, gonorrhea, and chlamydia. An initial encounter may be with on-site

nursing staff, but before a person is officially admitted to the jail, and if the staff cannot obtain vital signs or otherwise establish that the person is medically stable, the escorting law enforcement staff will take the person to a hospital emergency de-



partment for clearance. This approach creates a safeguard against admitting people who cannot be assessed and who may have multiple medical and behavioral health issues that could become medical emergencies in the following hours.

A more thorough assessment is often completed sometime in the following two weeks. This delay reduces the need for more thorough assessments, and thus the amount of care provided and costs of staffing and other resources, since up to half of people leave jail in the initial week. Because many people arrive in jail in the midst of acute intoxication, withdrawal, and/or a mental health crisis, it is common for jails to simply place people into a “sobering cell” to wait several hours or more before their intake assessment. For people in jail who are identified as having urgent issues, there is normally a referral process that includes higher-level care and/or hospital transfer. People identified as having chronic health issues are generally scheduled for an encounter with a physician or mid-level provider in the following two weeks. Access to specialty care generally requires a referral from a facility provider and approval from the medical director or, in the case of many larger prison systems, a utilization committee.

Prison Intake

In a prison setting, much of the chaos of the early stages of jail admission are absent. Most prisons take several weeks to complete a health classification process at an intake prison designed to assess the physical and behavioral health status of each person before deciding to which prison they should be sent (Federal Bureau of Prisons 2019). This attention to the physical and behavioral health status of each person allows prisons to match their needs to the available resources and to categorize their ability to work within the prison system (Leung 2018; North Carolina Department of Public Safety 2012).

Behavioral Health

Mental health services in jails are generally very limited and often respond to acute mental health crises with isolation and rudimentary suicide prevention interventions. For example, a person who is thought to be at risk of suicide, or is engaging in self-harm, is often placed into a locked jail cell called a “safety cell”—that is, a cell with no toilet, sink, or other potential anchor points for ligatures. Their clothes are taken away and they are given a safety smock to wear. They also are often placed under a constant watch, which means that a correctional officer stands outside their cell and observes them through the vision panel. These practices are aimed at the physical disarming of people from the means of suicide, and not at the underly-

ing mental health crisis, and as a result, they often fail (Pohl & Gabrielson 2019). One of the most alarming data points in correctional health is that suicide is the leading cause of death in U.S. jails (Prison Policy Initiative 2020).



Despite a high prevalence of substance use among incarcerated people, evidence-based treatment has been largely unavailable. Only a handful of prisons and jails offer access to methadone and suboxone to people who meet clinical criteria for treatment, despite decades of operating such programs safely in both jails and prisons. As courts increasingly recognize this as an unconsti-

tutional denial of care, most settings are at least designing or starting to implement some sort of substance use disorder treatment (Pew Charitable Trusts 2020). However, access to methadone and buprenorphine is an example of the structural and funding challenges that exist within correctional health. The data on increased overdose deaths among people leaving prisons and jails is clear, yet the focus of administrators is limited to the outcomes inside the walls of their facilities. The same can be said of funding for hepatitis C treatment, which is extremely cost-effective, but whose benefits may not be apparent to the correctional services that take on the costs.

Acute Needs

In both jail and prison settings, a process called “sick call” exists whereby people can report a medical issue and be seen by health staff. This process, like most of the others in correctional health, often relies on paper forms submitted by patients and may not become part of the patient’s medical records. The discarding of sick call requests is a crucial failing, because if the health service only documents the care they provide, which is a numerator, they omit the true denominator, which is requests for care. This failure undermines basic efforts to assess timeliness and adequacy of care (Runyeon 2020).

Absence of Standards

While each prison and jail health service has its own set of policies and clinical guidelines, some common standards have been developed. Both the National Commission on Correctional Health Care and the American Correctional Association

have standards and offer accrediting programs, but these programs are voluntary and they are not reviewed by state health departments. While some individual systems may require one of these accreditation certificates for new health vendors, the absence or loss of accreditation does not interrupt the ability of a carceral setting to operate. One of the most widely disseminated sets of polices is that of the Federal Bureau of Prisons, which is often utilized as a standard of comparison for other prison settings because it is publicly available and comprehensive in scope (Federal Bureau of Prisons n.d.).



Because correctional health care is largely ignored by community-facing public health entities such as state health departments and the Centers for Disease Control and Prevention (CDC), problems are often identified through litigation, with improvements flowing from consent decrees and other outcomes of adversarial legal processes. This is in stark contrast to community health settings, where hospitals, ambulatory care clinics, long-term care settings, and other health entities operate and report outcomes rooted in evidence-based standards of quality. In correctional health, tracking outcomes falls to law enforcement agencies, and the focus is often on meeting minimal compliance standards, rather than continuous improvement. A compelling example is that the U.S. Department of Justice, which tracks deaths during incarceration, only recently released data from 2016—its latest (Prison Policy Initiative 2020).

Health Harms of Incarceration

Most discussion of correctional health revolves around the provision of care to patients with significant levels of physical and behavioral health problems. The nature of mass incarceration results in a disproportionate share of people of color and people with health issues being incarcerated. But this frame misses another basic truth: incarceration itself harms health. Carceral settings confer new health risks—immense trauma and suffering, risks of physical and sexual abuse, and risks of illness and death. These systematic experiences can impact health during and after incarceration, but are rarely acknowledged, let alone measured.

One of the most common health risks of incarceration is physical injury. Despite sophisticated injury surveillance systems in the CDC, state departments of health, and many community health systems, very little is known or reported about injuries

in jails, prisons, or other carceral settings. In New York City, one of the only places to establish injury surveillance within correctional health services, rates of overall injury, intentional injury from violence, and blows to the head were reported at rates far in excess of community rates (Ludwig 2012; Siegler, Rosner, MacDonald, Ford, & Venters 2017). As the share of older people increases in carceral settings, injuries are an increasing health concern. Other measurable health risks include death from homicide, suicide, or medical neglect. The metric of “jail-attributable death” refers to deaths in custody that are caused, or significantly impacted, by conditions in confinement. Tracking the origins of poor health outcomes is a basic principle of epidemiology, but this approach is not utilized in most carceral settings.

One of the most dramatic weaknesses in correctional health is the response to a death. Most deaths behind bars result in an internal investigation to assess whether



any criminal activity was involved, and an autopsy by a medical examiner or coroner. These reports also consider whether the death was accidental or due to natural causes or some other event. Very often, neither the internal review nor the coroner’s report will address two critical questions: Did the patient receive the standard of care? Was the patient’s death significantly impacted by the conditions of their incarceration?

The lack of oversight and basic health administration, combined with litigation concerns within many correctional health services, often leaves these questions unanswered. As a result, no report identifies errors or opportunities for improvement after a person dies because they, for example, were denied insulin, had a seizure disorder, or committed suicide after being placed into solitary confinement.

Integrating Correctional and Community Health

The lack of adequate care for incarcerated people represents one of the starkest examples of health disparities in the United States. The lack of transparency and access to basic care, alarming rates of suicide, and the abuse and neglect endured by people who are disproportionately Black, brown, and poor, and who often suffer from behavioral health problems, is perhaps the most significant unaddressed failure in U.S. health care.

Transparency

While many areas of carceral health must be addressed, transparency is the first priority. The lack of data or agreement on access to care, the conditions in which it is provided, and the outcomes that result require that our public health organizations take on a clear role in this domain. One of the consistent themes identified by the Presidential COVID-19 Health Equity Task Force has been the lack of data integration from jails and prisons to the rest of the nation's health information infrastructure (Presidential COVID-19 Health Equity Task Force 2021). Implementing electronic medical records, and connecting community and carceral health data systems, are essential to sustaining most health-related innovations behind bars, as well as to promoting basic human rights for people involved in justice systems (Glowa-Kollisch, Andrade, Stazesky, Teixeira, et al. 2014). Similar gaps have been identified in surveillance and tracking deaths relating to substance use and hepatitis C. Prior work on improving access to HIV care in carceral settings can serve as an example for improving data systems and reporting.

Surveillance

Once a commitment is made to implement health surveillance systems in carceral settings, new programs, policies, and resources can be measured for efficacy. One example is the use of Medicaid Section 1135 waivers, designed for national emergencies, to fund some services behind bars (Guyer & Serafi 2016).

Treating substance use disorders, and preventing subsequent overdose deaths in the community, is often cited as the

use case for this approach. This represents a potential improvement, allowing access by patients who currently do not receive care, at least in their final days of incarceration. But, recalling the dramatic power imbalance in carceral settings, it is essential to establish who receives the funds for these programs and whether they are used in a clinically relevant manner. For example, sheriffs and other administrators may impose barriers to the use of methadone or suboxone and force an interpretation of medication-assisted treatment that favors vivitrol, which has less rigorous evidence behind it (Lee, Nunes, Novo, Bachrach, ... & Rotrosen 2018), or even a purely abstinence-only approach (Schwartzapfel 2019). Fears about diversion of medications, or the potential for overdose among people who are being treated, may serve as a pretext



for limiting access to evidence-based care. In these situations, the power imbalance between the health providers and the security setting in which they work becomes very clear, with security concerns predominating over clinical ones, even when the security concerns are eminently addressable. These issues, and the use of federal funds for substance use treatment, require transparency and common understanding before they are implemented.

Many of the data-driven innovations that are sorely needed in correctional health already exist in some communities, and only require that they be adopted elsewhere.

Including Correctional Health within Standard-Setting Agencies

Given the CDC's mission to protect public health, identifying morbidity and mortality among incarcerated people and working to promote their health should be pressing priorities. The CDC's recent declaration that racism is a public health concern creates an opportunity to bring the agency's resources and attention to bear on the structural challenges within correctional health (CDC 2021b). The CDC and



state health departments can launch correctional health programs that connect to community-based efforts on diabetes, hypertension, suicide, substance use disorder, traumatic brain injury, and other public health issues.

This move is more possible today than ever because of the response to COVID-19. During the pandemic, the CDC promulgated guidelines on responding within carceral settings (CDC 2021a), an approach that is crucial now because of demographic changes that have kept more elderly people and women behind bars. State health departments have also been drawn in, providing counsel and sometimes direct assistance with testing and vaccination. Such involvement can continue by leveraging these agencies to track data and determine how and whether guidelines are being followed, and then to expand the scope of their support and involvement.

Avoiding the Carceral System

One of the most promising sets of reforms involves directing people with clear health-related issues into treatment settings instead of local jails. These measures can start with having mental health professionals, instead of police, respond to 911 calls about people in crisis (Alonso-Zaldivar 2021). When police do become involved, we need to create centers where people in mental health crisis or who are acutely intoxicated can be taken for monitoring and treatment, rather than to jail. Examples of these mod-

els abound (Jarvis, Kincaid, Weltge, Lee, & Basinger 2019).

Inside carceral spaces there are also examples of correctional health systems that have turned away from isolation as a response to mental health crisis, instead using an engagement response that mirrors community standards and results in better health and security outcomes (Ford, Silverman, Solimo, Leung, et al. 2020).



A central tension in these settings is that provision of adequate and ethical behavioral health care behind bars is more costly and difficult than in community settings; thus, while an evidence-based and ethical standard of care should be established in carceral settings, treatment is best provided in community settings.

Conclusion

As this paper has documented, mass incarceration in the United States has led thousands of jails, prisons, and immigration detention settings to deliver health services to people who are disproportionately of color and whose serious health needs are often ignored or inadequately addressed. The incarcerated population faces many new health risks, including serious illness or injury, as well as a heightened danger of dying. The structural drivers of these disparities include the way in which correctional health services are organized, funded, and monitored, and the lack of involvement in the evidence-based structures that promote equity and quality elsewhere in the U.S. health care system. An important first step in addressing these problems is to create clear and official roles for the CDC and state health departments so that they track health needs, assure the quality of health-care delivery, and play a central role in promoting the health of people in carceral settings.

Homer Venters, M.D., is a physician and epidemiologist working at the intersection of incarceration, health and human rights and has served on the Biden-Harris COVID-19 Health Equity Task Force. Since April 2020, Venters has focused on addressing COVID-19 responses in jails, prisons and immigration detention facilities. He is the former chief medical officer of the New York City Correctional Health Services and author of *Life and Death in Rikers Island*. Venters has also worked in the nonprofit sector as the director of programs of Physicians for Human Rights and president of Community Oriented Correctional Health Service. Venters is an adjunct clinical associate professor of the New York University College of Global Public Health.

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“By default correctional institutions are the largest providers of behavioral health support at people’s most vulnerable times... The failure to identify the central role that these institutions play leads to the continued re-traumatization and entrenchment of the criminal-legal systems, especially amongst BIPOC communities.”

– TRACIE M. GARDNER, B.A. and DAN MISTAK, J.D., M.A., M.S.

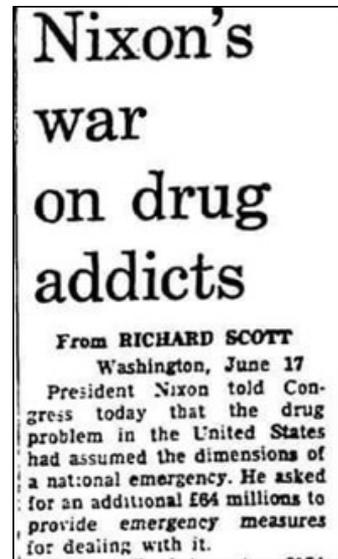
Caring Less: Treatment of Mental Health and Addiction in Carceral Settings

Tracie M. Gardner, B.A. and Dan Mistak, J.D., M.A., M.S.

Introduction

The relationship between mental health and substance use (collectively, behavioral health) and incarceration is defined by two important, related phenomena. First, the large number of people in the carceral system with behavioral health needs is the result of a decades-long sequence of policy choices in the United States that criminalized what are fundamentally health conditions. Second, when the goals of the criminal-legal system conflict with the goals of health care, the criminal-legal system's goals take precedence. This manifests as a combination of direct harm to the mental health of people who are incarcerated and inadequate treatment of people with behavioral health needs.

The evolution of incarceration in America is described more fully by Jiménez and Bassett in this volume. As incarceration relates specifically to behavioral health, a key turning point was the combination of deinstitutionalizing those with mental health disorders in the 1960s and the “war on drugs” launched by President Richard Nixon in 1971. As the country grappled with deinstitutionalization and its failure to live up to the promises of community behavioral health support, this blossoming war shifted institutionalization from the hospital to the criminal-legal system. This shift placed substance use and co-occurring mental health needs into correctional settings, where therapeutic supports did not exist and had not even been contemplated. Although they are ill equipped to provide support for those living with substance use disorders and mental health needs, correctional facilities have become the largest providers of mental health services in the US.



The war on drugs has been central to a shift in language, policies, and politics. One can draw a direct line from the language used to launch this war to the criminalization of substance use disorders and co-occurring mental health disorders. The racial component of the war on drugs, tied to President Nixon’s “southern strategy” to win the support of White voters, had long-term consequences that remain today: mass incarceration focused primarily on people of color. The consequences of this shift is borne most heavily by Black, Indigenous, and People of Color (BIPOC), who have been and continue to be targeted for surveillance, arrest, and prosecution. The fact that discussion of how to respond to the tremendous behavioral health needs in this country centers around the topic of criminal justice is an indication of how distorted our system has become.

Theories of incarceration generally describe the aims of carceral settings as disincentivizing crime through specific deterrence (stopping a particular individual from committing another crime) or general deterrence (punishing an individual as an example to other would-be offenders), retribution (harming those who harmed others), or rehabilitation (reintegrating offenders back into the broader social fold) (Meyer 1968). These abstract goals are quickly lost in jails and prisons that largely function as warehouses for people with critical, unmet behavioral health needs. Rather than organizing institutions to counter crime and address its root causes, centuries of policy choices, the failures of a behavioral health safety net, and the disparate impact of these policies and failures on communities of color have organized the present criminal-legal systems and the quality of services provided there.

Profile of the Incarcerated



At year-end 2018, the most recent year for which Bureau of Justice Statistics (BJS) data are available, there were 1,465,158 prisoners under state or federal jurisdiction. Ninety-three percent were male and 7% female (Carson 2020). The number of people incarcerated in state and federal prisons pales in comparison to the number of people who regularly move through the jail system (see the next section for a

description of how the criminal-legal system is structured). While just over 600,000 people enter prison each year, there are 10.6 million admissions into local jails (Sawyer & Wagner 2020). For most people, being jailed is not a single event. There is enor-

mous churn of people in and out of short-term detention, moving from community to jail and back again. Indeed, in 2018 the weekly inmate turnover rate was 55%, and the average inmate spent approximately 25 days in jail (Zeng 2020). This churn is a key differentiator between the jail and prison systems.

People who enter jails are disproportionately poor and people of color. In 2018, 226 per 100,000 U.S. residents had been to jail (Zeng 2020). Black people, however, were jailed at more than three times the rate of Whites and Hispanics: 592 per 100,000 Black residents, compared to a rate of 187 per 100,000 for Whites and 182 per 100,000 for Hispanics.



Incarcerated individuals are far poorer than those on the outside, with a median annual income of \$19,185 prior to their incarceration (2014 dollars) (Rabuy & Kopf 2015). Stints in jail can lead to unemployment, loss of children through protective services, loss of housing, and a variety of collateral consequences, including for those who have not been convicted of the crime for which they are being jailed.

People in jails and prisons are also disproportionately sicker than those on the outside. Fifty-eight percent of state prisoners and 63% of sentenced jail inmates met the criteria for drug dependence or abuse (compared to just 5% of the general population above the age of 18) (Bronson, Stroop, Zimmer, & Berzofsky 2020). The short duration of most jail stays makes it difficult to obtain good data on the number of individuals who are dependent on drugs.

According to BJS data from 2005, over half of prison and jail inmates needed mental health services. This included 705,600 inmates in state prisons, 78,800 in federal prisons, and 479,900 in local jails (James & Glaze 2006). Prison and jail inmates are three to five times more likely to meet the threshold for serious psychological distress than adults in the nonincarcerated U.S. population (Bronson & Berzofsky 2017).

Criminal-legal systems are incredibly costly. BJS estimates the annual total cost of corrections to taxpayers at just over \$80 billion, and many experts believe that to be an underestimate (Department of Justice 2013). Hidden within these budgets, often with little accountability or clarity, is spending on health care services for some of

the highest-need populations. For example, New York's Department of Corrections and Community Supervision is the biggest purchaser of psychiatric medications in the state.

A Nonsystem of Systems

Before looking at how health care is delivered in the criminal-legal system, it is important to highlight some of the central features of that system and how they relate to the quality of data and opportunities for intervention.

There is no single description of how behavioral health issues are handled in the criminal-legal system because multiple fragmented systems are involved. The federal Bureau of Prisons handles federal crimes and offenders, state prisons handle those convicted of breaking state criminal laws, and county jail systems process individuals who have not yet been to trial, who are pending a disposition, or who are sentenced to less than a year. These three systems rarely communicate with one another, and each operates with different financing structures, regulations, and oversight. With each system facing its own challenges and responding to different types of political and managerial pressure, finding a single point of leverage for addressing problems is elusive.

The criminal-legal system extends beyond prisons and jails. There are probation systems, which may be officers of the court or a separate agency; parole systems that can release a person from incarceration or return them there; police; sheriffs; highway patrols; drug courts; and the judiciary. Incarceration can result from a conviction, of course, but it can also result from a missed court date, unpaid fines, or little more than the ire of an overworked probation officer.

These disparate systems all have to grapple with the behavioral health needs of those who pass through their custody. In such a deeply stratified and fragmented structure, it should not be a surprise that good data are hard to come by. There are no consistent hierarchies across states, and few data reporting requirements. The criminal-legal system enjoys an opacity that is unique among most public systems, which only increases the challenges of improving community connections and behavioral health supports. In the absence of good data, news articles are often the primary source of insight the public has into the failures of these systems.

Correctional Settings as Locations of Treatment

Anyone interested in correctional health care should go to jail. A visit may offer some insight, but the experience of actually entering these facilities puts the challenges of adequate treatment into true perspective. It is impossible to describe the architecture in a way that appropriately captures its effect on the human spirit. The monochrome walls, artificial lighting, and ubiquitous bars and security doors all send the same message: this is not a therapeutic setting.

Direct harm to prisoners is frequent and substantial. For example, while solitary confinement was originally an attempt by Quaker reformers to meet rehabilitative goals by inspiring self-examination, this common practice is now better understood as a form of torture (Haney & Lynch 1997).



Good mental health requires social contact and support, while solitary confinement can exacerbate decompensation (worsening of psychological symptoms) (Gregg & Lieberman 2021).

Regardless of on which side of the bars a person resides, correctional settings worsen mental health outcomes. In California, for example, more than one-third of correctional officers reported that someone in their lives has told them they have become more anxious or depressed since they started working in corrections. Twenty-eight percent reported often or sometimes feeling down, depressed, or hopeless, and 38% have little interest or pleasure in doing things. One in three have experienced at least one symptom of PTSD, and 10% have thought about suicide (Lerman 2017). Such is the toll on the individuals who can clock out at the end of the day.

How Care Is Provided

Due to the disparate mechanisms governing acquisition and quality of care, the quality and breadth of services available in correctional settings varies greatly. Jurisdictions provide health care through public health systems, contracting with proprietary correctional health companies or nonprofits, or a mix of all of these. Many jurisdictions contract out separately for behavioral health support, while others in-

tegrate medical services into these contracts. Staffing levels and licensure requirements in these facilities are set through a mix of contracting, local budget limitations, and often receivership agreements with the Department of Justice. Most fiscal responsibility for care in jails falls to counties and for care in prisons to states.



As in community settings, correctional settings are challenged to find qualified staff such as psychiatrists (Coll, 2019). This challenge is exacerbated by the fact that RFP-driven health service contracts often lower costs by paying staff less than market rates despite the challenging and stressful settings in which they work.

Treating Behavioral Health Conditions

What, then, does provision of mental health and substance use treatment look like in jails and prisons? Confinement conditions run counter to good behavioral health support. Correctional needs often trump therapeutic needs, leading to missed medications. Jails may process people through their systems too quickly to understand whether they have unmet behavioral health needs. Individuals with mental health needs may find themselves placed in solitary confinement so that they can be more easily managed.

Correctional settings are high-stress places in which to deal with the many ways behavioral health needs present themselves. When behavioral health conditions, dementias, or intellectual or developmental disabilities are perceived as lack of compliance, they can engender punishment and harsher treatment. For example, correctional staff in California deliberately burned a man's hands with boiling water as punishment for his refusal to cooperate (Aspergren 2021).



Reports from Miami-Dade County, Florida, indicate that individuals with mental health needs remain incarcerated eight times longer, on average, than individuals who do not report mental health needs, at seven times the cost (Office of the Mayor 2007). Knowing this, detainees may fail to report their own mental health needs when they enter jail. Indiana is setting this disparity into statute. This year, the state's governor, Eric Holcomb, signed a bill that prevents detainees who need mental health support from being released from the Department of Corrections unless there is a spot for them in a "treatment facility" or with a family member. In effect, Indiana has decided to make up for a shortage of community settings by holding people in jails and prisons for no other reason than their mental health needs.

In order to deal with the large number of individuals with serious mental health needs, many jurisdictions create specialized units that house these people together. While this does not improve the therapeutic environment, removing these individuals from the general population does make it easier to administer the facility. However, some community members oppose the use of dedicated mental health units out of concern that functionally re-create mental health institutions in a carceral setting (Pohl & Finch 2021). The Department of Justice recently found that using isolation and mental health wings at the Alameda County, California, jail violated the constitutional ban on cruel and unusual punishment (Fernandez 2021).

Responding to Emergencies

Jails in both rural and urban environments face extreme challenges in identifying and appropriately responding to emergency substance-use-related medical crises. Mortality rates are higher in jails with fewer than 50 people, which may reflect their



limited capacity to handle emergencies and identify health crises (Rose Quandt 2021). For example, the inability to identify an individual who is withdrawing from substances such as benzodiazepines or suffering from an acute mental health crisis can lead to preventable deaths. Recently, Bernalillo County, New Mexico, terminated its contract with a proprietary health provider after nine people died

while incarcerated—six of whom died while detoxing from drugs (Kaplan 2021). Jails are asked to operate as critical triage sites with little oversight from the clinical and human service systems that are supposed to provide such services.

Substance Use Treatment

Substance use treatment is increasingly being brought into correctional settings that are challenged to comply with confidentiality and clinical standards. When substance use treatment begins in the community, it may be discontinued behind bars because of funding limitations or loss of follow-through with the client. Conversely, when treatment begins in jail, there is no guarantee it will be available outside. Many community programs have specific criteria for participation that conflict with probation requirements; others simply lack the necessary providers to continue treatment.

Suicide

Suicide is an ever-present risk in jails and prisons. In California, the incidence of suicide is 80% higher in jails than in the community. Reports of suicidal ideation may not be taken seriously by health or correctional staff and or seen as an attempt to “get to medical,” where confinement conditions may be less restrictive. A recent tragic example was the New York City Correction Department captain who was charged with criminally negligent homicide after refusing to help an inmate who then hanged himself. The guard told others present that the detainee was “faking it” (Fears 2021).

An individual on suicide watch is typically not provided with behavioral health support but rather isolated in units where it is harder to commit suicide. A suicide watch es-



essentially involves placing an individual in an empty cell, dressed in special tear-away clothes that minimize hanging risk, and then having correctional or health staff check on that person every 15 minutes. Even with a diligent watcher, however, suicides sometimes happen in plain view. The Bureau of Justice Statistics reported that in 2016 more than 1,000 suicides occurred in local jails (Carson & Cowhig 2020).

Misuse of Clinical Language

Even if these environmental and operational concerns were resolved, these systems would still exacerbate mental health needs, given their reliance on legal standards that are often decoupled from clinical standards. For example, an individual may be held in jail pending a competency hearing to determine their fitness for trial. A legal finding that an individual is not competent to stand trial can result in being committed to a state hospital for treatments designed to restore legal competency. Once that competency is established, the individual will be taken back to jail, where they then decompensate and are again found incompetent to stand trial. This ping-ponging can allow detainees to languish between institutions for decades without ever receiving a trial (Tullis 2019).



A similar tension is evident in the use of clinical language in criminal-legal systems that does not always align with its meaning in medical environments. For example, “innocent by reason of insanity” is a criminal defense that relies on legal, not clinical, definitions of a particular mental state to determine culpability, and so conclusions about a defendant’s mental state are reached by judges rather than clinicians.

A number of strategies are in place to address clinical needs outside prison and jail settings. Probation and parole officers may have special “mental health dockets” that are created primarily to manage probationers and parolees with mental health needs that may have led to their initial entanglement with the criminal-legal system. Specialty courts have been developed to divert some individuals into special programs to help “manage” their needs outside the normal criminal-legal system. However, the degree to which any of these criminal-legal functions are coordinated with community and health care providers varies significantly.

Lack of Standards

Because jails are run by local jurisdictions and prisons are run by state correctional systems, there are no uniform policies for their mental health systems. To the extent that standards do exist, few mechanisms are in place to enforce them. The National Commission on Correctional Health Care and the American Correctional Association have established voluntary accrediting standards, but these are mainly focused on policies and procedures and have not been widely accepted. Even worse, the percentage of facilities that have pursued and received accreditation is in the “single digits” (Bozelko 2021).

The vacuum created by a lack of meaningful standards has been filled by policy created through litigation. The 1976 U.S. Supreme Court case *Estelle v. Gamble* set the constitutional standard for a detainee’s guaranteed level of care. In this case, the Supreme Court ruled that “deliberate indifference” by prison personnel to an inmate’s “serious illness” constitutes cruel and unusual punishment, contravening the Eighth Amendment (*Estelle v. Gamble* 1976). The Court went on to rule, however, that the failure of the prison staff to perform an X-ray or use appropriate diagnostic techniques did not constitute “deliberate indifference,” but would be considered, at worst, medical malpractice. Thus, although incarcerated individuals are one of the few populations with a constitutional right to health care, that care often falls far below community standards.



In the last decade, the inability to provide adequate mental health services due to overcrowding has been a central driver of policy change. The 2011 U.S. Supreme Court case *Brown v. Plata* resulted in an order to reduce California’s prison population to 137.5% of the intended capacity (*Brown v. Plata* 2011). The Court found that overcrowding and lack of medical treatment created “needless suffering and death,” and constituted “serious constitutional violations.”

Justice Anthony Kennedy ruled that the overcrowding in California prisons was so bad that adequate mental health services could not be offered, describing conditions in which inmates were held in “telephone-booth-sized cages without toilets.” Experts in the case testified that they had observed an inmate held in one of these

cages for almost twenty-four hours, standing in his own urine, “unresponsive and nearly catatonic.”

Plata did not have any precedential value—it did not determine that overcrowding in itself violates federal constitutional standards. That was no doubt a relief to every facility across the country, as nearly every state’s prisons are vastly over capacity (Widra, 2020). *Plata* also did not wade into definitions of adequate care, but simply stated that whatever would be considered adequate could not be accomplished in such a tightly packed carceral setting.

What Happens When People Leave?

Other authors discuss the connection with health care outside the walls of correctional facilities, but it is worth noting that the effects of incarceration and correctional mental health systems are felt in surrounding communities. In the first two weeks after leaving jail or prison, an individual’s mortality rate is twelve times higher than that of the general public (Binswanger, Stern, Deyo, Hergerty, et al. 2007). And the damage endures, as Kalief Browder’s particularly salient story reveals. Browder was a 15-year-old accused by the

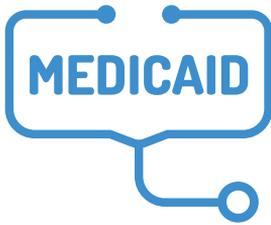


New York Police Department of stealing a backpack. He refused to accept the prosecutor’s plea deal because he did not want a permanent record for something he said he did not do. He was held in Rikers Island without trial for three years, including two in solitary confinement, until prosecutors ultimately dropped the charges against him. A vibrant young man, Browder was broken by his time in jail and committed suicide two years after his release (Gonnerman, 2014).

Family members of incarcerated people receive little support while their partners or parents are incarcerated. The result is often behavior in children that becomes criminalized at school, which subsequently drives youth into the criminal-legal systems (Martin 2017). This cycle makes it six times more likely that children of incarcerated parents will eventually be incarcerated themselves, compared to a child whose parents have not been incarcerated.

The fractured healthcare system does further damage. Long-standing federal policies restrict otherwise-eligible Medicaid beneficiaries from receiving Medicaid services while incarcerated. Discontinuities in coverage make reentry more difficult and impede care transitions that can lead to decompensation and death.

There have been some promising efforts to address some of these challenges. Recent efforts to suspend, rather than terminate, Medicaid coverage during periods of incarceration, often pursued in conjunction with the Affordable Care Act's Medicaid expansion to low-income adults, have significantly closed coverage gaps. With enrollees covered continuously for longer periods, Medicaid agencies have a financial incentive to focus on the longer-term needs of justice-involved



people. Medicaid expansion has also improved the use of medications for opioid use disorder by justice-involved individuals (Khatri & Winkelman 2021).

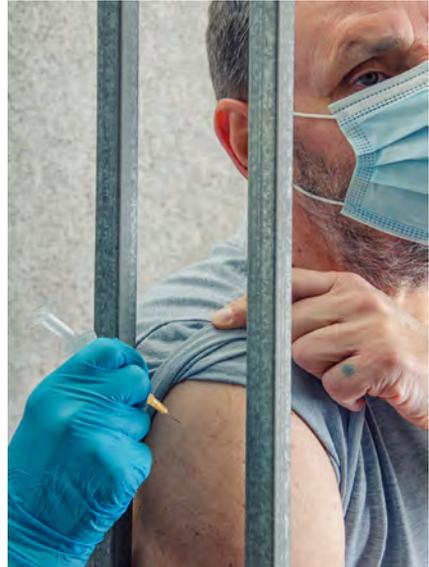
Many jurisdictions are now scrambling to connect community health systems with health systems behind bars. However, jails and prisons often lack access to community formularies and therapies. An individual who is stabilized on a particular medication in the community is not guaranteed access to that medication if they are jailed; likewise, a medication prescribed to an incarcerated individual may not be available once that person is released. Colorado has created a unitary formulary to ensure medication continuity, but this approach has not been widely adopted.

The burdens of unmet mental health needs also drive entanglements with the criminal-legal system, burdening homeless service providers and communities struggling with the crushing homelessness crisis. Local jurisdictions arrest people who have nowhere else to go, as evidenced in a meta-analysis that found that lifetime arrest rates among unhoused individuals range from 62.9% to 90.0% (Roy, Crocker, Nicholls, Latimer, & Reyes Ayllon 2014). A recent report from the Vera Institute of Justice showed that people without housing are 11 times more likely to be arrested than housed people (Bailey, Crew, & Reeve 2020).

People leaving incarceration also face hurdles connecting with social supports. Due to the inmate exclusion, individuals may have their Social Security and Medicaid benefits suspended or terminated upon incarceration, complicating their care and links to community support at a critical time. They may have lost their jobs and connections to family and friends. The failure at the back door of the criminal-legal system cycles back into safety-net failures in the community. The behaviors flowing from these unmet needs then recycles back into corrections through the variety of front doors entering into criminal-legal systems.

Mental Health Effects of COVID-19

COVID-19 has made the critical situation in jails and prisons even more dire. To stop the spread of SARS-CoV-2 in overcrowded correctional facilities, many jails and prisons enacted draconian lockdowns. In Washington, D.C., individuals were kept in their cells 23 hours a day (Jamison 2021). Vermont locked prisoners into 8.5- x 10-foot cells with as little as 10 minutes a day dedicated to time outside the cell. Vermont is the only state that has not lost a single detained individual to COVID-19, but that came at the cost of at least one suicide (Issawi & Norman 2021). In Sonoma County, California, similar policies led to a hunger strike after more than a year of having no contact with loved ones (Chavez 2021). While the isolation and desperation suffered by the population during the pandemic was very real, it pales in comparison to the suffering endured by those who were incarcerated during this time.



Conclusion

By default, correctional institutions have become the largest providers of behavioral health support at one of the most vulnerable times in a person's life. The failure to identify the central role that these institutions play in providing essential care outside the broader health system has helped to entrench criminal-legal systems and contributed to ongoing traumatization, especially among BIPOC communities.

While healthcare policymakers have sought to identify medically complex patients and create payment structures and delivery systems that respond to them, jails and prisons have escaped review and integration. The movement for Black lives and the bipartisan scrutiny of the entire criminal-legal system are hopefully sounding the alarm for policymakers who have long overlooked a healthcare delivery site that touches millions of people with complex needs each year. Failing to identify jails and prisons as part of the health system, for better or worse, only strengthens the criminal-legal system to the detriment of management of complex populations.

Policymakers have a choice: Will we recognize that justice involvement is a critical social determinant of health, or will jails and prisons continue to render long-neglected populations invisible? Advocates working in the criminal-legal arena find it incomprehensible that jails and prisons have been left out of the picture. Hopefully, the dawning recognition that they are a constant presence in the lives of many impacted communities will drive reforms in both the health and criminal-legal systems.

Tracie Gardner, B.A., is Legal Action Center's Senior Vice President of Policy Advocacy, overseeing both the New York and federal policy advocacy work on LAC's core issues related to substance use, harm reduction, and criminal legal system reform. She has worked more than 30 years in the health and social services policy arena as a policy advocate, trainer, and lobbyist. From 2015-2017, Gardner served as the Assistant Secretary of Mental Hygiene for New York State, where she oversaw the state's addiction, mental health, and developmental disabilities agencies.

Dan Mistak, J.D., M.A., M.S., is acting president and director of Health Care Initiatives for Justice-Involved Populations. At Community Oriented Correctional Health Services (COCHS), Mistak has provided support to federal lawmakers and regulators as they sought to understand correctional health care. He has provided technical assistance to state and local governments as they aim to improve coordination between community and correctional health systems and has been a monitor in jails across the country. He provides consultation on improving the behavioral health safety net to provide alternatives to incarceration. He rejoined COCHS after a two-year leave with the Legal Aid Society of Hawai'i where he provided support to map Hawai'i County's behavioral health safety net and its interface with the criminal-legal system.

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“The premise of this paper is that reducing the negative health implications of incarceration requires uprooting the structural violence embodied in the current carceral system. The primary remedy must include dismantling inherently race-biased policies and reducing the sheer size and scope of the existing system.”

– MONIK C. JIMÉNEZ, Sc.D. and MARY T. BASSETT, M.D., M.P.H.

Mass Incarceration as a Manifestation of Structural Racism: History, Impact and Potential Remedies

Monik C. Jiménez, Sc.D. and Mary T. Bassett, M.D., M.P.H.

Introduction

The U.S. incarceration rate, 655 per 100,000 people, is the highest in the world (Walmsley 2018). The United States holds over 2.3 million people in a decentralized network of prisons, jails, detention centers, Indian Country jails, civil and state psychiatric commitment centers, and other facilities. Including community supervision, nearly 7 million people are directly affected by incarceration (Sawyer & Wagner 2020). Moreover, these numbers do not account for lifelong exposure, the impact on families, or egregious inequities by race, ethnicity, sexual and gender identity, mental health status, or disability.

Paul Farmer, a physician and anthropologist, has described “structural violence” as a consequence of arrangements that are structural because they are “embedded in the political and economic organization of our social world; they are violent because they cause injury to people” (Farmer, Nizeye, Stulac, & Keshavjee 2006). The carceral system, which includes police, jails, courts, and prisons, is a form of structural violence, one with deep roots in U.S. history. This system relies on widely held cultural tropes of Black criminality and involves multiple institutions, features of structural racism (Bailey, Feldman, & Bassett 2021). A better understanding of the history of mass incarceration and the inequities it reflects and perpetuates can, we hope, enable action and produce remedy.



The premise of this paper is that reducing the negative health consequences of incarceration requires uprooting the structural violence embodied in the current carceral system. The primary remedy must include dismantling inherently race-biased policies and reducing the sheer size and scope of the existing system.

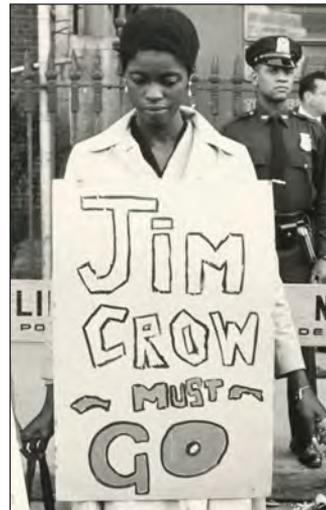
The Historical Framework: Inequity by Design

Many date the end of U.S. slavery to the Emancipation Proclamation, but the Thirteenth Amendment ended the centuries-long practice. That amendment included a critical exception:

*“Neither slavery nor involuntary servitude, **except as a punishment for crime whereof the party shall have been duly convicted**, shall exist within the United States, or any place subject to their jurisdiction.”* (emphasis added)

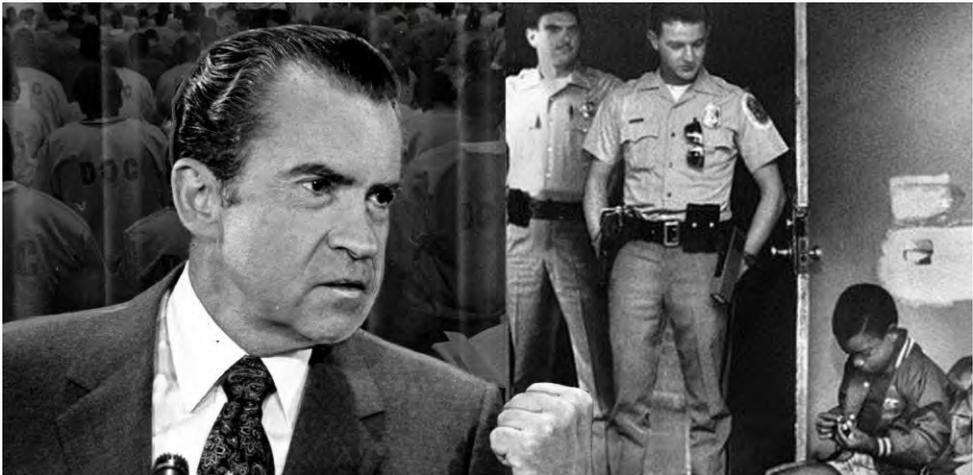
The post-Civil War nation rapidly adopted incarceration as a way to limit the freedom of the newly emancipated population. During the short-lived Reconstruction era (1865–1877), federal oversight and funding supported efforts to rebuild with racial equity. Nonetheless, Georgia increased the incarceration of Black men threefold from 1868 to 1878 (from about 10 per 100,000 males to 31 per 100,000 males), with no change among White men (Myers & Massey 1991). By the 1870s, 95% of the prison population in Georgia was Black men. Racially skewed practices were upheld in courts across the nation. In *Pervear v. Massachusetts* (1866) the U.S. Supreme Court ruled that incarcerated people did not have constitutional rights, and the Virginia Supreme Court case *Ruffin v. Commonwealth* (1871) set the precedent for incarcerated people to be considered “slaves of the state.”

With the end of Reconstruction came the “Black codes,” which limited the rights of Black Americans to serve on juries, change employment, and vote. These codes laid the foundation for vagrancy laws, giving law enforcement discretion to consider activities ranging from insulting gestures to walking without purpose as criminal. Jim Crow revived legalized social control through incarceration, fines, fees, and resulting cycles of debt. These legal mechanisms remained in place for nearly 100 years, until finally being overturned in the 1960s.



Fleeing racial terror in the South for more opportunity in the North and later the West, millions of Blacks left southern states between 1910 and 1970 in what came to be known as the Great Migration (US Census Bureau 2012). However, vagrancy laws accompanied Black Americans, extending this effective method of social control and contributing to the racial inequities in incarceration in the North that came to exceed those in the South. The first Great Migration (1910–1940) coincided with waves of European immigration to U.S. cities. These immigrants, while mainly not Anglo-Saxon, would be absorbed under a broader White identity, clearly distinguishing immigrants from Black Americans and assuring them greater access to resources (Muller 2012).

The Civil Rights Act of 1964 outlawed racial discrimination in public places and employment. But the early 1960s also saw an increase in crime (Cooper & Smith 2011) and urban uprisings, beginning with New York’s City’s Harlem in 1964 and the Los Angeles neighborhood of Watts in 1965. In response to mass violence, Lyndon B. Johnson paired the war on poverty, barely a year old, with a new war on crime (Hinton 2021). As Hinton relays in her recent book, *America on Fire*, from 1965 to 1970, the federal government pumped up its annual allocation to local police departments from \$10 million to \$300 million, an unprecedented federal action (Hinton 2021). In 1964, there had been no such federal funding. With greatly militarized policing, the front door to the criminal-legal system was flung open.



Under the Nixon administration, a war on drugs followed the war on crime, with federal laws leading to state and local action. First came the DC Court Reorganization Act of 1970, which instituted various sentencing reforms in the powerful DC circuit,



including mandatory minimum sentences, expanded placement of youth in the adult system, and authorization for wiretapping and no-knock raids by law enforcement (Hinton 2016). There was a slow rise in the rate of incarceration between 1970 and 1980 (Cahalan & Parsons 1986), followed by exponential increases during the

1990s. Incarceration then continued more gradually through the mid-2000s, when modest declines began (Beck, Karberg, & Harrison 2002; Glaze & Parks 2012).

Through the 1990s, mandatory minimum sentencing reforms proliferated across the country. These laws locked judges into sentencing lengths, limiting their discretion. Inequity in sentencing for cocaine powder relative to crack cocaine is an example of racialized sentencing (Anti-Drug Abuse Act of 1986). The Fair Sentencing Act of 2010 reduced the disparity in sentencing duration from 500:1 to 18:1, but inequity persists.

In the mid-1990s, three-strikes laws also swept the country, providing for life sentences without parole, typically for people convicted of a serious violent felony who had prior convictions. The California “Three Strikes and You’re Out” law (1994) was one of most severe in the nation. The law mandated a doubling of sentences for a second felony among those with a prior strike and sentences of 25 years to life for a felony conviction for a defendant with two or more strikes. California did not require that the third felony conviction be serious or violent.

In data from over 170,000 people incarcerated in California prisons, Black people were overrepresented among second and third strikers, and Latinos were overrepresented among second strikers compared to White people (Chen & Chung 2020). Importantly, Chen et al. describe how, despite supposed race neutrality, racial bias affected prosecutors’ discretion to dismiss prior convictions that would contribute toward a third strike and district attorneys’ decisions to permit a petition to dismiss prior convictions. The result was that Black defendants experienced the harshest convictions under the three-strikes legislation. In 2012, California Proposition 36 allowed for the resentencing for nonserious, nonviolent third-strike convictions that would otherwise lead to life sentences. Up to 18 months postrelease, the rate of reincarceration for a new offense was well be-



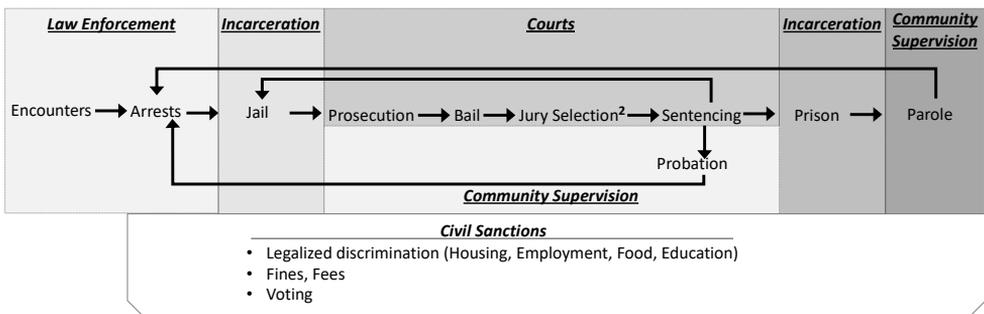
low the state and national averages (1.3% compared to 27% and 30%, respectively) (Stanford Law Three Strikes Project & NAACP Legal Defense and Education Fund 2014), suggesting that the three-strikes law kept people incarcerated despite a low recidivism risk.

Other policies contributed to inequities in sentencing and the long-term impact of incarceration following release. Examples include truth-in-sentencing reforms, which require individuals to serve at least 85% of their sentence; allowing nonunanimous jury convictions in state courts; and laws that prohibited people with convictions from receiving certain public benefits (e.g., the 1996 Personal Responsibility and Work Opportunity Reconciliation Act and the Housing Opportunity Program Extension Act of 1996). Taken collectively, such policies and prosecutorial and judiciary decisions will continue to shape the face of the U.S. incarcerated population for decades to come.

Criminal-Legal System Touchpoints

Black Americans are disproportionately represented in all aspects of the criminal-legal system and face greater consequences from their interactions. This includes encounters with law enforcement, likelihood of conviction, harsher sentencing, incarceration rates, and postrelease discrimination. By tracing the path through the criminal-legal system (Figure 1), we can examine the scope of carceral control and the role and cumulative impact of key actors and agencies (e.g., law enforcement, prosecution, courts, and state, federal and civil policies).

Figure 1. Criminal-Legal System Touchpoints¹



¹ Figure provides a simplified pathway through the criminal legal system and is not meant to be exhaustive, but rather to illustrate key junctures through the system at which racial/ethnic inequities are amplified.

² For those cases which go to trial.

Encounters and Arrests

Encounters with law enforcement are the typical entrance to the criminal-legal system. These encounters on their own are not benign; police intrusion into daily life contributes to individual-level mental health distress and loss of community trust (Fratello, Rengifo, Trone, & Velazquez 2013; Geller, Fagan, Tyler, & Link 2014). Community surveillance, disproportionately directed at communities of color and the poor, ensures high levels of interaction between law enforcement and community members. Law enforcement presence is widespread, including in schools, areas of recreation, residence, and business.

New York City's stop-and-frisk program, for example, reached a peak of nearly 700,000 annual stops in 2011. That year, 52% of the encounters were among Blacks, 31% were among Latinos, and 10% were among Whites. Some neighborhoods averaged one stop per resident per day. Weapons were identified in less than 2% of frisks, with lower rates of weapons recovery among Blacks and Latinos, compared to Whites. In fact, no further action (either arrest or summons) was taken in 88% of encounters. Despite a dramatic drop in the volume of encounters, racial inequities persist in stop-and-frisk encounters (Dunn, Shames, & Lee 2019).



National data from the Bureau of Justice Statistics' 2018 Police-Public Contact Survey show no statistical differences between police-initiated encounters for Black (11%) and White people (12%); the data do not specify the nature of the encounters (Harrell & Davis 2020). Among those who reported any interaction with law enforcement, Black and Latino people were twice as likely to report experiencing threats or use of force (3.8% and 3.4%, respectively) as White people (1.5%). Among adolescents, police stops were associated with symptoms of depression, especially among girls (Jahn, Agenor, Chen, & Krieger 2021).

In addition to more police encounters, arrest rates are higher for Black people across all ages, irrespective of the suspected offense. Other people of color share this experience, although it varies by geographic region. In a meta-analysis of 27 data sources collected from 1977 to 2004, people classified as non-White had a 45% increased probability of arrest, irrespective of the offense ($p < 0.05$) (Kochel, Wilson, & Mastrofski 2011). In one southwestern U.S. county, American Indian / Alaska Native (odds ratio

[OR] = 3.60, 95% CI: 3.32–3.90), Latino (OR = 1.53; 95% CI: 1.35–1.73), and Black people (OR = 1.28; 95% CI: 1.05–1.55) experienced significantly greater odds of arrest for misdemeanor drug- or alcohol-related charges than their White counterparts (Camplain et al. 2020).



Further, in a national longitudinal survey of adolescents conducted between 1994 and 2009, Black youth had a 47% significantly greater chance of arrest, even after adjusting for delinquent and criminal behavior, education, and home characteristics (OR = 1.47, 95% CI: 1.17–1.85) (Gase, Glenn, Gomez, Kuo, et al. 2016). The same study showed behavior (alcohol and drug use, delinquency and prior arrest) and contextual factors (neighborhood deprivation, exposure to violence, and child-parent bond) were associated with an increased risk of arrest in young adulthood for White but not Black adolescents, consistent with racial bias in arrests (Schleiden, Soloski, Milstead, & Rhynhart 2020). Inequities are amplified for people with intersectional marginalized identities, illustrated by especially high rates of arrest experienced by young Black males with disability (McCauley 2017) and transgender people of color (Reisner, Bailey, & Sevelius 2014).

Jail

Once arrested, the next step is typically confinement in a jail system. These are dynamic environments with up to 10 million arrests processed yearly (Zeng & Minton 2021). Individuals are generally confined in jails before trial, so they have not been convicted. Misdemeanor convictions, which generally carry a sentence of less than one year, are also served in jails, although thresholds vary across states. In Massachusetts, individuals are held in jail for sentences of up to two and a half years (*Advisory Sentencing Guidelines* 2017).

In 2019, U.S. jails were incarcerating 746,000 individuals at any one time in 2019 (Sawyer & Wagner 2020). Based on data from 2005 to 2019 from the Bureau of Justice Statistics, stark inequities exist in jail incarceration rates for Black, Latino, and Indigenous populations (Zeng & Minton 2021). In 2019, jail incarceration was highest among Black adults (600 per 100,000 people), followed by American Indian / Alaska Native adults (420 per 100,000 people), White adults (184 per 100,000 people), and Hispanic/Latino adults (176 per 100,000 people) The lowest rate was reported for Asian adults (25 per 100,000 people). Over the past decade, incarceration rates decreased for Black and

Hispanic/Latino adults, bringing jail incarceration rates for Hispanic/Latinos similar to those of Whites for the first time in 2017, while rates increased for American Indian / Alaska Native adults. Importantly, between 1990 and 2013 the Black:White racial gap in adult jail incarceration decreased as the result of an 88% increase in jail incarceration among White adults (Subramanian, Riley, & Mai 2018).

Although the rate of incarceration among women is lower than that of men overall, rates of jail incarceration among women have increased marginally since 2005 (Zeng & Minton 2021). The underlying causes of that increase is not fully understood but is likely due to a combination of arrest rates, pretrial detention policies, probation or parole violations, and misdemeanor policies that disproportionately incarcerate poor women.



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Nearly three-quarters of people incarcerated in jails by local authorities have not been convicted of any crime and are largely those who cannot afford cash bail (median cash bail for a felony offense is approximately \$10,000). Jail populations soared in the past 20 years, but the increase is principally in

those held pretrial; the numbers serving sentences have remained relatively stable (Sawyer & Wagner 2020). Judicial racial bias in bail-setting is widespread (Arnold, Dobbie, & Yang 2018), with bail set higher for Black and Hispanic/Latino defendants than for their White counterparts (Hinton, Henderson, & Reed 2018). For example, data from Miami and Philadelphia show bail may be up to \$9,923 higher (Arnold, Dobbie, & Yang 2018) for Blacks and Hispanic/Latinos than for Whites.

Even short incarcerations can have long-lasting negative implications for housing stability, employment, family stability, medical care continuity, and medical, mental, and reproductive health, all consequences experienced mainly by people of color and the poor.

Prosecution and Sentencing

On average, Black, Latino, and Indigenous people are charged with more serious crimes that carry more punitive sentences than their White counterparts (Hinton, Henderson, & Reed 2018). This disadvantage becomes self-replicating, as past conviction increase the likelihood of subsequent arrest and conviction. Studies have sought to explain racial and ethnic differences as based on socioeconomic status or other personal factors rather than race per se. But statistical adjustments show-

ing that racial and ethnic inequities are attenuated, eliminated, or reversed when other factors, such as prior convictions or employment status, are introduced into the equation should be considered critically (Mitchell 2005). The number and type of prior convictions and the present conditions of employment and housing stability are themselves consequences of systemic racial bias.

Lack of available data hampers understanding of racial inequities in prosecutorial decisions. For example, we cannot document by race or ethnicity decisions to proceed with prosecution rather than dismiss low-level misdemeanor offenses, the loading up of more severe charges that carry longer sentences, or decisions about the court circuit within which to prosecute. Prosecutorial discretion can determine the severity and length of sentencing. More than 90% of criminal cases never go to trial (Devers 2011), and serious charges may effectively coerce acceptance of plea bargains. Long jail stays while awaiting trial add further incentive to accept a plea bargain, as time served can be counted against a defined prison sentence, avoiding the uncertain outcome of a trial. For cases that do reach trial, prosecutors may further influence outcomes by the disproportionate dismissal of Black, Latino, and Indigenous jurors (Bagnato 2010; Gross 2016; Hinton, Henderson, & Reed 2018).

Approximately 80% of all criminal cases filed between 2007 and 2016 were misdemeanors (13.2 million cases per year) (Stevenson & Mayson 2018). Because discretion plays a large role in misdemeanor offenses, Stevenson & Mayson (2018) argue that misdemeanor charges reflect patterns of surveillance, rather than actual crime. Data from the National Center for State Courts in 2014 show that arrests



occur more commonly among Black compared to White people across all major categories of misdemeanor charges, excluding driving under the influence and liquor law violations (racial inequity ratios ranged from 1.14 for drunkenness to 9.63 for gambling) (Stevenson & Mayson 2018). Cases against law enforcement agencies in Baltimore, Maryland, and Ferguson, Missouri, cited data showing that disproportionate misdemeanor arrests among Black people were intended to generate revenue (Investigation of Baltimore City Police Department 2016; Investigation of the Ferguson Police Department 2015). Despite a decline in the total number of misdemeanors filed nationally, racial inequities in misdemeanor arrests have remained relatively stable since 1980.

Misdemeanor penalties range from fines and fees to incarceration and may mark the beginning of a cycle of carceral involvement. Data from Suffolk County, Massachusetts, between 2004 and 2018 show that not prosecuting nonviolent misdemeanor offenses significantly lowered the probability of further criminal complaints over the next two years (Agan, Doleac, & Harvey 2021). In contrast, the decision to prosecute carries long-term impacts. Misdemeanor convictions become part of a permanent criminal record that can become a barrier to future employment, housing, and economic advancement.

Prison

State and federal prisons confine 68% of the total incarcerated population (1,430,800 people), the majority (88%) in state prisons. Six states (Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont) have integrated jail and prison systems (Bureau of Justice Statistics 2021). Fifty-five percent of people incarcerated in state prisons hold violent convictions, more of them among Black (62%) and Latino (62%) people compared to Whites (48%). In contrast, among those incarcerated in federal prisons, drug convictions are the most prevalent (46%), with the highest proportion among Latinos (60%), followed by Blacks (43%) and then Whites (38%) (Carson 2020).

Overall, the adult prison population has decreased by 11% since 2009, largely reflecting a decrease in the male prison population (-12%); the female population dropped by only 5% (Carson 2020). Still, the prison population remains nearly 500% higher than it was in 1980. The racial disparity in prison incarceration exceeds that in jails. For Black adults the prison incarceration rate is 5.5 times higher (1,446 per 100,000 people) and for Latinos it is 2.9 times higher (757 per 100,000 persons) than for White people (263 per 100,000 persons), despite a 32% and 29% decrease, respectively, in the number of incarcerated Black and Latino people over the past decade. When disaggregated by age, the inequities were greatest for both Black and Latino males and females ages 18 to 24 years.

An aging prison population is a consequence of decades of draconian sentencing. The largest proportional increase was among those 55 and older, who constituted 4.6% of the state prison population in 2003 and 9.9% in 2013 (Carson & Sabol 2016). Nearly 30% of these older adults were sentenced to life in prison or to death, and 50%



had been incarcerated for more than 10 years. Among people over 55, those sentences increased most from 2003 to 2013 for Blacks (164%), followed by Latinos (125%) and then Whites (109%).

Community Supervision

Community supervision, through probation and parole, is one example of the carceral system's reach into the community. Probation may be imposed in lieu of an incarceration sentence, while parole is a conditional release back to the community to complete the length of a sentence (Kaeble & Alper 2020). Although decreasing, an estimated 3.6 million people are on probation, nearly twice the number of those incarcerated



in prisons and jails (Kaeble & Alper 2020). Details regarding the average length of probation sentences and required conditions are largely lacking (Corbett 2015). Probation sentences may include monthly administrative fees; other fines or fees levied by the court; legal fees; regular meetings with a probation officer; court hearings and other conditions, such as repeated drug screening, curfews, and supplying DNA samples; and so on. Technical violations of supervision terms, not reoffending, are the primary reasons for a loss of probation that leads to incarceration.

Every year, about one million people are released on parole to complete their sentences, a number that has increased only gradually since 1990 (Kaeble & Alper 2020). Like probation, the conditions of parole and fees can create a substantial burden, and technical violations are the leading causes of reincarceration. Unlike probation, parole is granted to eligible individuals by a parole board, not by a judge or jury. As with other aspects of the carceral system, parole board composition, requirements, and procedural transparency vary dramatically. For example, in many states parole boards do not meet face-to-face with the incarcerated person, do not define the requirements for parole eligibility, and do not use objective guidelines to determine eligibility (Ruhland, Robey, Rhine, & Mitchell 2016). Despite limited data, we believe it is reasonable to speculate that access to and retention in these community supervision systems is likely lower for Blacks, Latinos, and Indigenous people. They are instead more likely to be incarcerated rather than placed on probation at sentencing, to serve longer sentences without parole, and to be more challenged to avoid technical violations.

Civil Sanctions

The number of people currently in the carceral system is only a subset of the population that has had carceral contact. Nearly 5 million people have been incarcerated in a state or federal prison, and a further 19 million people hold a felony conviction; 77 million people have a criminal record, with either felony or misdemeanor convictions (Sawyer & Wagner 2020). Moreover, 45% of adults from a nationally representative survey of U.S. households reported having an immediate family member who had been incarcerated.

Discrimination based on criminal record is substantial and has included denied access to food stamps, cash assistance, employment, and housing. For example, the Personal Responsibility and Work Opportunity Reconciliation Act (1996) allowed for a lifetime ban on receiving food assistance (Supplemental Nutrition Assistance Program, formerly food stamps) and cash assistance (Temporary Assistance for Needy



Families) for people with a felony drug conviction and legalized discrimination in housing due to prior convictions (Evans, Blount-Hill, & Cubellis 2019). Although full bans on food assistance based on felony convictions have been reversed in all states, 22 states still have partial bans, with access contingent on the type of felony conviction or court-mandated programming (Thompson & Burnside 2021). Seven states prohibit access to

cash assistance based on drug felony conviction, and 21 states impose partial bans (Thompson & Burnside 2021). Other long-term sanctions include loss of voting rights for people incarcerated with a felony conviction, either indefinitely, while incarcerated, or while on probation or parole (National Conference of State Legislatures 2021); termination of Medicaid and Medicare while incarcerated, with barriers to enrollment upon release (Beck 2020); potential discrimination in access to higher education due to a criminal record (American Association of Collegiate Registrars and Admissions Officers 2019); and discrimination in access to federal education grants (which was recently revised to allow access to incarcerated people effective in 2023) (Martinez-Hill & Delany 2021).

Opportunities for Change and Possible Remedies

As explored, the United States incarcerates people at a prodigious rate and has the distinction of unmatched disproportionality in incarceration among people in minority groups. Mass incarceration, a consequence of today's sprawling carceral system, reflects the legacies of African enslavement, as well as specific policies adopted more than five decades ago.

The process of dismantling mass incarceration must acknowledge both the historical context that has stamped multiple generations and communities and current policy failures. It will not be simple. The rationale of “public safety” has enabled enactment of laws and policies that have continued racial subjugation. In this frame, the carceral system does not simply have unexpected and arguably unwanted consequences due to a few excesses or “bad” people among police or even judges and juries. A starting point in identifying the need for change is acknowledging that the carceral system is working as it is intended to work and that addressing mass incarceration is part of the larger project of dismantling structural racism.

All aspects of carceral control have a demonstrably negative impact on physical and mental health (Figure 2). Moreover, these health-related consequences occur not only at the individual level but also on communities at large (Wildeman & Wang 2017). From the impact of trauma inflicted by the carceral system; through disruptions in routine medical, mental, and reproductive health care; to community-level maternal and child mortality, carceral systems and the U.S. criminal legal system initiate and perpetuate harm, immediately and long-term, over the life course and across generations.

Figure 2. Health Implications of Exposure to the Criminal-Legal System

Criminal Legal System Exposure				
Encounters	Arrests	Incarceration	Community Supervision	Community
<p>Health Impact:</p> <ul style="list-style-type: none"> • Psychological distress • Trauma (physical and mental) • Death 	<p>Health Impact:</p> <ul style="list-style-type: none"> • Disruption in: <ul style="list-style-type: none"> - Medical care - Medication adherence - Oral contraception use - Hormone therapy - Substance use - treatment • Potential loss of housing, employment, family, financial burden • Trauma (physical and mental) 	<p>Health Impact:</p> <ul style="list-style-type: none"> • Trauma (physical and mental) • Infectious disease (respiratory illness including COVID-19, hepatitis C, sexually transmitted infection, HIV) • Environmental risk factors and carcinogens • Solitary confinement • Poor diet (high sodium, high sugar processed foods) • Limited physical activity • Cardiovascular disease and cancer • Access to regular and specialized medical care • Tooth loss and other oral disease • Increased risk of death post release 	<p>Health Impact:</p> <ul style="list-style-type: none"> • Psychological distress • Housing and food insecurity • Barrier to receipt of substance use treatment during relapse • Increased risk of incarceration 	<p>Health Impact:</p> <ul style="list-style-type: none"> • Family and child wellness <ul style="list-style-type: none"> - Psychological distress - Substance use disorder - Educational attainment - Family disruption and separation • Family food insecurity • Family housing insecurity or homelessness • Family economic burden • Community level maternal mortality • Community level infectious disease transmission (ex. COVID-19 and sexually transmitted infection)

Still, mitigation of harms is possible and should be pursued. Health care professionals can play a critical role in shaping mitigation efforts and ending mass incarceration through both policy and individual-level action (Barsky, Kung, & Jiménez 2021). Current movements within the medical community are aimed at acknowledging and addressing social determinants of health and utilizing trauma-informed approaches to treatment. However, these initiatives have often ignored exposure to the criminal-legal system. The junctures that trace a pathway to incarceration provide a useful framework for identifying the many opportunities to redirect those pathways and minimize harm, as Figure 3 shows. We offer examples in policy, prosecution and sentencing, and community supervision.

Federal, state, and local policies can have a critical impact on shaping entry into and movement through the carceral system. For example, policies that decriminalize or legalize low-level drug offenses can reduce arrests and incarceration. As of April 2021, 17 states and the District of Columbia had legalized the possession of small amounts of marijuana for recreational use (State Medical Marijuana Laws 2021); some have also provided paths to expunge criminal records for previous marijuana possession convictions or resentencing (Ahren 2020). In addition, divesting funds from policing and carceral systems can free up resources to invest in communities and support the ability of all to thrive. For example, in 2021 the Los Angeles County Board of Education approved the diversion of funds from the Los Angeles School Police Department to investments in the educational needs of Black students (Gomez 2021).

Figure 3. Strategies to Dismantle Mass Incarceration

Policy: Legalize all drugs in defined personal use quantities. Review convictions based on highly punitive sentences, or from nonunanimous juries. Reduce use of community supervision and excessive fines and fees. Eliminate three strikes laws, minimum sentences, and truth in sentencing. Eliminate custodial sentences for misdemeanors.			
Encounters and Arrests: <i>Fewer arrests and increased police accountability</i>			
<ul style="list-style-type: none"> - 9-1-1 diversion for mental health or crisis response triage - Community accountability in place of or in partnership with law enforcement - End stop-and-frisk - Universal adoption of body cameras - Data transparency and individual-level tracking of stop-and-arrest rates by encounter-related characteristics and by race/ethnicity - Reform law enforcement integration into schools - Independent oversight of law enforcement with impacted community members - Inventory activities that need an armed response, rather than a default armed response 	Prosecution and Sentencing: <i>Decrease/eliminate prosecution of low-level offenses with increased data transparency</i>		Community Impact: <i>Support successful homecoming</i> <ul style="list-style-type: none"> - Ban discrimination in housing, employment, education, licensure, social services - Community education and legal aid to expunge or seal criminal record - Eliminate/revise conditions of community supervision - Eliminate punitive technical violations for reincarceration - Expand housing options for returning community members without addiction or mental health concerns
	<ul style="list-style-type: none"> - Bail reform (eliminate cash bail, or charitable bail fund) - Prosecutorial reform with increased data transparency regarding decision making - District attorney use of discretion to not prosecute low-level nonviolent offenses (e.g., marijuana charges) - Data transparency and tracking court outcomes for prosecutors and judges by race/ethnicity - Increase access to diversion courts (e.g., drug, mental health, or community restorative justice courts) - End racial/ethnic discrimination in jury selection - Revise nonunanimous jury convictions 	Incarceration in Jails and Prisons: <i>Population decompression and conditions of confinement</i> <ul style="list-style-type: none"> - Decarcerate facilities - Moratorium on construction of prisons, jails, and detention centers - Independent oversight, including impacted community members - Parole board protocol transparency - Increase access to medical parole/compassionate release - End solitary confinement - Robust rehabilitative programming irrespective of conviction - Mandate activation of health insurance and receipt identification documents upon release 	

Prosecutors have discretion as to which charges they will pursue. The Brennan Center for Justice (2018) has outlined 10 recommendations to ensure prosecutorial due process. For example, they call upon prosecutors to avoid filing the maximum possible charge as the default course of action, or to coerce guilty pleas by using threats of death penalty, life without parole, or transfer from juvenile to adult court. The degree of adherence to such recommendations can only be critically examined with robust data transparency to facilitate public accountability.

Community supervision alternatives and reforms have not been as widely discussed, presumably because community supervision has been considered preferable to incarceration (Pew Charitable Trusts 2016). However, as noted above, community supervision may actually lead to incarceration along with increased civil sanctions (Frankel & Neier 2020). To help break the cycle of probation and arrest, Michigan enacted sweeping legal system reforms in January 2021 that focused on

misdeemeanor classification and probation (Michigan Joint Task Force on Jail and Pretrial Incarceration 2020, Michigan Joint Task Force on Jail and Pretrial Incarceration 2022). The state reduced probation terms, defined new thresholds for the maximum jail time imposed for technical violations, and updated the processes for early dismissal from probation.

These examples highlight both the appetite for change and the opportunity for further work. By fundamentally redefining our notion of public safety to one centered on providing resources needed to thrive, we can collectively shift our societal priority from carceral control to community empowerment. This shift is essential to reduce the health harms associated with incarceration and the many other elements of the carceral system that disproportionately burden Black, Latino, and Indigenous communities.

Monik Jiménez, Sc.D., is an epidemiologist and assistant professor at Harvard Medical School and Harvard T.H. Chan School of Public Health. Her work is centrally focused on the role of intersectional domains of marginalization on racialized inequities in health. It aims to center the voices of directly impacted community members and she works with community advocacy groups to design, disseminate and conduct research focused on community identified needs. Broadly her work is focused on racial, ethnic and sex inequities in stroke and the role of incarceration in creating and perpetuating racialized inequities in health.

Mary T. Bassett, M.D., M.P.H., is Health Commissioner for the state of New York. Bassett has dedicated her career to advancing health equity. She served as the director of the François-Xavier Bagnoud (FXB) Center for Health and Human Rights at Harvard University and the FXB professor of the Practice of Health and Human Rights at the Harvard T.H. Chan School of Public Health before taking public service leave. Prior to joining the FXB Center, Bassett served as New York City's Commissioner of Health from 2014 to 2018.

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**STATE
PRISONER**

“The health impacts of mass incarceration are felt throughout communities in multiple ways: by individuals when they are removed from and return home from correctional systems, by family members and support systems of those incarcerated, and by communities which are overpoliced and oversurveilled.”

– EMILY WANG, M.D. and HEDWIG LEE, Ph.D.

Community Health Impacts of Mass Incarceration

Emily Wang, M.D. and Hedwig Lee, Ph.D.

Introduction

The health impacts of mass incarceration are felt throughout communities in multiple ways: by individuals when they are removed from and return home from correctional systems, by family members and support systems of those incarcerated, and by communities that are overpoliced and oversurveilled.

Some 10.6 million people are released from correctional systems back to the community each year (600,000 from prisons and 10 million from local jails) (Sawyer & Wagner 2020). Upon release, these individuals are at inordinately high risk of largely preventable hospitalization and death (Binswanger, Stern, Deyo, Heagerty, et al. 2007; Wang, Wang, & Krumholz 2013). Each of these people is connected to family and social networks,



whose health is also impacted by their incarceration and return from incarceration. An estimated 45% of Americans have a family member who has been incarcerated, and their life expectancy is two years less than those without such a family member (Sundaresh, Yi, Harvey, Roy, et al. 2021).

The experience of incarceration concentrates predictably within certain neighborhoods, usually ones where more racial, ethnic, and impoverished minorities live. The structures and systems of social control and punishment that accompany incarceration (policing, racial profiling, parole, and probation) are associated with chronic stress and worse health outcomes. Living in these neighborhoods, whether one has experienced incarceration or not, is also associ-

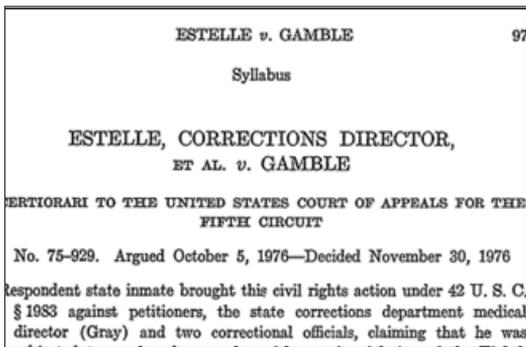
ated with lower life expectancy (Holaday, Howell, Thompson, Cramer, & Wang, 2021; Kajeepeeta, Mauro, Keyes, El-Sayes, et al., 2021).

This paper describes how incarceration affects individual, family, and community health and explores approaches that can mitigate the harms.

Individual Health

Health of Incarcerated People

Numerous studies have examined how current and past incarceration influence individual health. Paradoxically, research suggests that being incarcerated may actually lower mortality and physical morbidity *in the short term*. Incarcerated individuals have lower mortality rates than individuals of the same age, race, and sex in the general population (Spaulding, Seals, McCallum, Perez, et al. 2011; Wildeman, Carson, Golinelli, Noonan, & Emanuel 2016). Black men—especially young Black men who have high mortality rates in the community—experience the largest “mortality advantage” while incarcerated (Patterson 2010). The age-standardized mortality rate for Black men in state prisons was 42% of the rate for Black men in the community (Wildeman, Carson, Golinelli, Noonan, & Emanuel, 2016). This lower risk may be driven by decreased exposure to violence or accident, less access to drugs and alcohol, and increased access to health-care services, although such mechanisms are debated (Patterson 2010; Rosen, Schoenbach, & Wohl 2008; Spaulding, Seals, McCallum, Perez, et al. 2011).



Sadly, many people gain their first access to health care as adults in correctional facilities. Prisons and jails are some of the only places in the United States where health care is guaranteed by law. In 1976, the Supreme Court ruled in *Estelle v. Gamble* that failure to provide basic health care in correctional facilities violated the constitutional prohibition against “cruel and unusual

punishment” (*Estelle v. Gamble* 1976). That ruling mandated that prisons and jails provide acute care services. As the prison population has grown and aged, prisons have also had to provide more care for chronic diseases and mental health.

An estimated 40% of incarcerated individuals are first diagnosed with a chronic health condition while incarcerated, and 80% report seeing a medical provider while incarcerated (Wilper, Woolhandler, Boyd, Lasser, et al. 2009). Unfortunately, the quality of health care in correctional settings is highly variable, often compromised by low funding and, in the many privatized prisons, profit motives. In several states, including Alabama, Arizona, and California, abysmal medical care of incarcerated individuals has led judges to order increased funding and oversight.

Compared with the community population, incarcerated individuals have high rates of chronic medical conditions such as hypertension and asthma; infectious disease, including HIV, hepatitis C, and COVID-19; substance use disorders; and mental health disorders (Wilper et al., 2009). A few studies suggest that incarceration improves the management of chronic physical conditions, relative to time spent outside of correctional facilities, but that health worsens incrementally with repeated incarceration.

This is especially so with HIV, where repeated incarceration weakens viral load suppression (Hawks, McGinnis, Howell, Khan et al. 2020; Khan et al. 2019; Schnittker & John 2007; Springer, Chen, & Altice 2010).



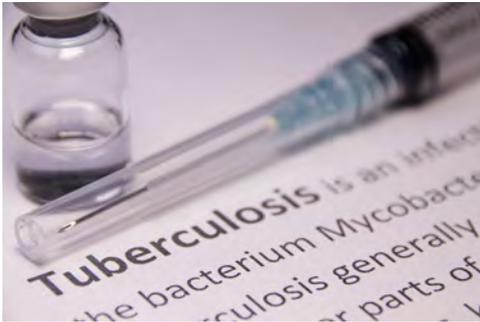
Much research also suggests that being incarcerated worsens mental health. For example, a few studies have shown increases in self-reported measures of depression and decreases in life satisfaction (see, for example, Turney, Wildeman, and Schnittker 2012; Wildeman, Turney, and Schnittker 2014). Solitary confinement, in particular, has myriad negative long-term repercussions, including higher risks of self-harm and death, not only while incarceration but also following release (Brinkley-Rubinstein, Sivaraman, Rosen, Cloud, et al. 2019; Kaba, Lewis, Glowka-Kollisch, Hadler, et al. 2014). An estimated 55,000 to 62,500 people were placed in solitary confinement in 2019 (Correctional Leaders Association & the Arthur Liman Center for Public Interest Law at Yale Law School 2020).

Health Effects of Past Incarceration

Despite apparent short-term physical health benefits, the preponderance of evidence suggests incarceration has strong deleterious health effects over the life course. Individuals who are incarcerated are likely to spend far more time out of correctional systems than in them. For instance, Black men who have ever been in prison spend

13.4% of their adult lives incarcerated (Patterson & Wildeman 2015). In other words, the average incarcerated individual is exposed to incarceration roughly one-sixth as long as the time they spend bearing the consequences of past incarceration. Hence, in considering the lifelong health effects of incarceration, the postrelease period is critical.

Studies using administrative data have consistently found increased mortality among formerly incarcerated people, although the magnitude of this association varies across studies (Binswanger, Stern, Deyom Heagerty, et al. 2007; Spaulding, Seals, McCallum, Perez, et al. 2011). One study that used a quasi-experimental design found that incarceration elevates the risk of premature mortality for women, but not for men, after adjusting for confounders (such as a history of drug use, low



educational attainment, and preexisting health problems) (Massoglia, Pare, Schnittker, & Gagnon 2014).

The evidence that a history of incarceration increases morbidity is more consistent, showing an association with virtually all communicable and non-communicable diseases, even after adjusting for a host of confounders. In a sample matched on common sociode-

mographics (e.g., sex, age, race/ethnicity), a history of incarceration was associated with 1.8 times the odds of having hepatitis or tuberculosis (Massoglia 2008). Research has also found that formerly incarcerated people suffer high rates of psychiatric morbidity and that the experience of incarceration is at least partially to blame (Massoglia 2008; Schnittker, Massoglia, & Uggen 2012).

Many studies rely on self-reported data. Two exceptions are the Coronary Artery Risk Development in Young Adults (CARDIA) Study and the Veterans Aging Cohort Study (VACS), which include measures of exposure to incarceration and objective data on health status (Wang, McGinnis, Long, Akgün, et al. 2015; Wang, Pletcher, Lin, Vittinghoff, et al. 2009). In the CARDIA study, the adjusted odds of developing hypertension among the ever-incarcerated were 1.6, compared to the never-incarcerated (Wang, Pletcher, Lin, Vittinghoff, et al. 2009). In the VACS study, the adjusted odds of having poorly managed hypertension among those recently released were 1.57 times higher than the never-incarcerated (Howell, Long, Edelman, McGinnis, et al. 2016). New studies using statewide cancer tumor registries have shown that people exposed to incarceration have higher incidence of late-stage diagnosis compared with those who have never been incarcerated.

Incarcerated individuals must learn to manage new diagnoses within the context of correctional institution health care, where they rely on correctional officers and health professionals to administer care and medications as well as to monitor daily adherence (Shavit, Aminawung, Birnbaum, Greenberg, et al. 2017). This highly structured care approach occurs among a population with generally low levels of health literacy and in a setting with little focus on self-efficacy or fostering the ability to engage in various healthful behaviors (Hadden, Puglisi, Prince, Aminawung, et al. 2018). Indeed, self-efficacy often runs counter to the notions of safety and security that are prioritized in carceral environments. For instance, given safety concerns surrounding needles, incarcerated people typically cannot draw up their own insulin or use glucometers, which may contribute to limited diabetes self-management after release. Similar practices impede their ability to manage other chronic diseases once they are back in the community.

Transitions Upon Return to the Community

Formerly incarcerated individuals face a range of barriers in navigating their health post-release. Patients with chronic conditions are often released without medications or a follow-up appointment to community care (Visher & Mallik-Kane 2007). Most prisons have some basic form of discharge planning services, which may include a limited supply of medications (e.g., fewer than 30 days). A few prison systems also provide referrals to primary and specialty care, such as substance use treatment in the community. Jails less commonly have a formalized discharge planning system focused on health concerns, given the shorter periods of incarceration they provide. Unpredictable dates and times of release also contribute to poor health. Individuals can be released in the middle of the night without their belongings, medications, or any referral to community health care. Whether they are released from prison or jail, people are rarely provided their medical records, and often must pay to get them (Puglisi, Calderon, & Wang 2017).

Even when people are prescribed medications upon release, many do not obtain them. Using data from the Texas Department of Corrections, a study found that only 5.4% of individuals filled an initial prescription for antiretroviral medications within 10 days (95% confidence interval [CI] = 4.5%–6.5%). Fewer than one-third (30.0%) had done so within 60 days (95% CI = 28.1%–32.0%) (Baillargeon, Giordano, Rich, Wu, et al. 2009). Absent intentional coordination and linkages to the community health system, providing prescriptions alone did not ensure that formerly incarcerated individuals could engage with and access needed care upon release.

People with health problems are challenged not only to manage their health, but also to meet other basic needs (Western 2018). People returning from incarceration

often lack housing, employment, and family support, and face substantial discrimination in finding jobs and housing (Geller & Curtis 2011; Pager 2003). If they have



been convicted of drug felonies, they may also be prohibited from accessing certain safety net services, including food stamps, public housing, and federal grants for education (Wang, Zhu, Evans, Carroll-Scott, et al. 2013; Western 2018). Those who have been incarcerated earn 30% less than comparable never-incarcerated persons (Western 2002; Western 2006).

Further, community health systems are not designed or prepared to provide care for those returning home from incarceration. There is often a months-long wait for a new patient appointment with a primary care provider, so people visit emergency departments for medication refills. Most primary care visits require personal identification and proof of insurance and are typically 15 minutes in length, which is insufficient time to address urgent health needs. Not surprisingly, recently released incarcerated individuals are less likely to have a primary care physician, disproportionately use emergency departments for health care, and have high rates of preventable hospitalizations (Frank, Linder, Becker, Fiellin, & Wang 2014; McConville, Mooney, Williams, & Hsia 2018; Wang, Wang, & Krumholz 2013). A recent audit study conducted in Ontario, Canada, found that having a criminal record was associated with decreased odds of obtaining a primary care appointment.

There are some examples of evidence-based interventions to engage recently released individuals in primary care, one of which is the Transitions Clinic Network (Shavit, Aminawung, Birnbaum, Greenberg, et al. 2017).*TCN is a national consortium of more than 45 primary care centers that serve the primary health-care needs of individuals returning from incarceration. TCN programs include interdisciplinary primary care teams with community health workers who have personal histories of incarceration. In a randomized controlled trial, participants in the TCN program in San Francisco had 51% fewer visits to the emergency department in the year following their release, compared with those who were assigned to receive expedited primary care in a safety



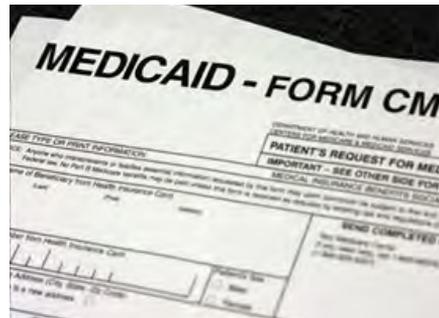
* Emily Wang, a co-author of this paper, is a primary care provider and co-founder of the Transitions Clinic Network.

net system (Wang, Hong, Shavit, Sanders, et al. 2012). TCN participation also impacts future criminal justice contact and is specifically associated with lower rates of recidivism for technical parole or probation violations and fewer days of incarceration, compared with the control group (Wang, Lin, Aminawung, Busch, et al. 2019).

Insurance Gaps

Health insurance coverage remains a barrier to obtaining primary care or treatment for substance use and mental health conditions immediately following release. Medicaid is the primary source of insurance for those impacted by incarceration. A state-federal health-care program for low-income people, Medicaid covers mental health and substance use treatment and services, intensive case management, rehabilitation, and support services used by formerly incarcerated individuals. Medicaid enrollment prior to release is associated with increased engagement in treatment among people with serious mental illnesses (Morrissey, Domino, & Cuddeback 2016).

Prior to the Affordable Care Act (ACA), roughly 80% of formerly incarcerated individuals were uninsured at the time of their release. Even those who did have insurance typically lacked the financial resources to pay for their medical care (Cuellar & Cheema 2012). In 2014, the ACA provided states with substantial funding to expand Medicaid to low-income adults without dependent children, who had been largely excluded from the program in the past. This created an opportunity to provide insurance to criminal justice-involved populations, engage them in care, and possibly reduce recidivism.



The Department of Justice has estimated that roughly 35% of people newly eligible for Medicaid had a history of incarceration. However, while enrollment in Medicaid increased substantially as a result of the ACA, subsequent engagement in substance use and mental health treatment did not, according to two studies that drew on data from the National Survey of Drug Use and Health (Howell, Wang, & Winkelman 2019; Saloner, Bandara, McGinty, & Barry 2016). Such findings demonstrate that simply having insurance does not overcome additional barriers to engaging with the health system or addressing mistrust of the health-care system.

Beyond increasing access to health care, Medicaid coverage may also affect crime, rearrest, and costly reincarceration. A recent study found that Medicaid expansion

under the ACA was negatively associated with numerous types of crime, including homicide (He & Barkowski 2020). Evidence also suggests that Medicaid expansion reduces recidivism for certain violent and public-order crimes (Aslim, Mungan, Navarro, & Yu 2021). Together, these findings suggest that lack of Medicaid coverage harms not only individuals involved in the criminal justice system, but also the communities in which they live.

Yet disruption of Medicaid benefits remains a challenge. The Medicaid Inmate Exclusion Policy, which under Social Security Act Section 1905(a) prohibits use of federal funds and services, including Medicaid, for medical care provided to “inmates of a public institution,” remains a central determinant of health insurance loss among those who have been incarcerated. Nearly two-thirds of the local jail population



being held prior to trial, who have not been convicted of a crime, lose their Medicaid health benefits or are ineligible for Medicaid coverage because of this policy (Pew Charitable Trusts 2016).

However, Medicaid administrative rules allow states to suspend, rather than terminate, an incarcerated individual’s Medicaid benefits, which has been shown to facilitate

prompt reactivation of Medicaid following release (Rosen, Schoenbach, & Wohl 2014). Suspension also has been shown to have financial benefits, as states can be reimbursed for the inpatient medical services they have provided to incarcerated individuals enrolled in Medicaid. Numerous states, including Arkansas, Colorado, and Michigan, have reported cost savings ranging from \$3 million to \$19 million per year through this mechanism (Bachrach, Boozang, Herring, & Reyneri 2016).

While the Medicaid Inmate Exclusion Policy prevents federal Medicaid funds from being used to cover care for individuals who are incarcerated, it does not explicitly limit individuals from being enrolled in Medicaid during incarceration (MACPAC 2018). Some correctional systems have implemented programs to ease the transition for newly released individuals by allowing them to apply for Medicaid and Medicare prior to their release (Bandara, Huskamp, Riedel, McGinty, et al. 2015). These programs offer insights on best practices for the enrollment process, including training correctional staff to serve as navigators to help incarcerated people complete applications, creating plans for direct handoffs from correctional health-care providers to community health-care providers following release, and providing individuals with

information about Medicaid and community-based systems of care prior to their release (Ryan, Pagel, Smali, Artiga, et al. 2016).

A range of other social policies influence and dictate the ability of recently released individuals to address their basic health and social needs. Many individuals with criminal records face the collateral consequences of incarceration, namely legal and regulatory restrictions that limit or prohibit people convicted of crimes from accessing employment, business and occupational licensing, housing, voting, education, and other rights, benefits, and opportunities. For instance, eligibility guidelines for public housing subsidies, local regulations for the use of Section 8 housing, and one-strike housing policies (i.e., policies that allow for eviction and denial of housing applications for household with criminal activities or felony convictions) have long made housing a serious challenge for people returning home from correctional facilities (Curtis, Garlington, & Schottenfeld 2013; Geller & Curtis 2011; Lundgren, Curtis, & Oettinger 2010).

Many states still ban access to the Supplemental Nutrition Assistance Program (SNAP) by those with a criminal conviction or require individuals to work to receive such benefits, exacerbating food insecurity following release from incarceration (Golembeski, Irfan, & Dong 2020; Testa & Jackson 2019). As well, those with felony convictions are often unable to obtain licenses to work in the health-care and beauty sectors, and may face other barriers to specific jobs (Nerbovig 2018; Warner, Kaiser, & Houle 2020). For example, states that suspend a person's driver's license for certain criminal convictions prevent them from working as taxi or truck drivers (Eaglin 2015). Such bans come against a backdrop of other employment-related processes and policies that make it difficult for individuals with criminal convictions to find employment. Taken together, existing health and social policies create and maintain a stigma for those with histories of incarceration histories that have long-term impacts on individual and family health. In response, some federal and state agencies have taken action to mitigate the effects of such discriminatory policies through ban-the-box policies that eliminate the question about incarceration on job applications; clean-slate initiatives, which clear convictions from the records of those who stay crime free; and fair-chance hiring (Hanks 2017).



Community Health

Family Health

As noted earlier, an estimated 45% of adult Americans have had an immediate family member incarcerated. The racial disparity is evident in data showing the greatest prevalence among Blacks (63%), followed by Latinx (48%) and white populations (42%) (Enns, Yi, Comfort, Goldman, et al. 2019). One in 14 children have had a parent incarcerated in jail or prison (Annie E. Casey Foundation 2016). Black children experience the highest rate of parental incarceration (11.4%), followed by Latinx children (3.5%) and white children (1.8%) (Pew Charitable Trusts 2010). A Black child born in 1990 had a 25.1% chance of having their father sent to prison; among those whose father did not finish high school, the risk was 50.5%.



Having a family member incarcerated reduces life expectancy by an estimated 2.6 years (Sundaresh, Yi, Harvey, Roy, et al. 2021). Research indicates that romantic partners, especially women, as well as other adult family members of those in jail or prison experience higher rates of multiple physical and mental health conditions, including cardiovascular disease and related risk

factors, asthma, substance use disorder, and depressive symptoms. (Lee, Wildeman, Wang, Matusko, & Jackson 2014; Lee & Wildeman 2021; Wildeman, Schnittker, & Turney 2012; Bruns & Lee 2020). Children of incarcerated parents also experience higher rates of poor mental health (e.g., attention deficit disorder and attention deficit hyperactivity disorder) and are at increased risk of substance use disorder (Turney 2014). Moreover, new research suggests that mothers of incarcerated persons, especially those caring for grandchildren, also have higher rates of mental distress (Sirois 2020).

Many mechanisms link incarceration to the health of a family member or loved one. They include chronic psychological stress related to the stigma of having a family member incarcerated (Connors, Flores-Torres, Stern, Valdimarsdóttir, et al. 2020); the grief related to loss of a parent, child, or partner; relationship and caregiving strain; and economic, food, and housing insecurity (Braman 2004; Comfort 2008). Other influences are discrimination in health-care settings, failure to acknowledge incarceration-related stressors during health-care visits, limited time or resources to access health care or engage in self-care and preventive health behaviors, and the

tendency to avoid care due to fear of surveillance or stigma in health-care settings (Brayne 2014). Because of the disproportionality in exposure to incarceration, populations of color are excessively impacted, contributing to significant racial and ethnic disparities in health.



The Broader Community

Beyond the impacts of incarceration on individuals and their families lies damage to the communities in which they reside and leave, and to which they return. A robust body of literature finds strong associations between community-level incarceration rates and a host of population-level health outcomes, including higher rates of premature mortality, infant mortality, mortality due to substance use and suicide, infant preterm birth and low birthweight, sexually transmitted infections, and, more recently, COVID-19 infections (Holaday, Howell, Thompson, Cramer, & Wang 2021; Jahn, Chen, Agénor, & Krieger 2020; Kajeepeta, Rutherford, Keyes, El-Sayed, & Prins 2020; Massoglia, Pare, Schnittker, & Gagnon 2014).

The mechanisms that link incarceration to community health are similar to those that impact the health of family members. These include chronic stress due to reduced social capital, population turnover and reduced social networks, and increased police presence. These stressors are compounded by long-standing structural racism rooted in housing, education, and health-care policies that intersect with incarceration, such as regulations that prevent individuals with a criminal record from living in public housing or receiving Pell grants for schooling (Alexander 2012). Communities negatively impacted by incarceration are also impacted by redlining, public disinvestment, and other policies and practices (Sampson & Loeffler 2010). For example, Massoglia and colleagues found that while whites return to worse neighborhoods after their release, Black individuals do not because the neighborhoods in which they lived prior to entering prison or jail were already greatly disadvantaged, leaving no room for further downward neighborhood mobility (Massoglia, Firebaugh, & Warner 2013).

Location of Correctional Facilities

Today, there are over 7,000 correctional and detention facilities across the United States, including state prisons, federal prisons, local jails, and other facilities (Sawyer & Wagner 2020). While most people who become incarcerated hail from urban



areas, correctional facilities are more likely to be located in rural areas (Porter, Voorheis, & Sabol 2017), especially in the South. Since 1970, the use of jails for pretrial detention has declined in urban areas but increased by 436% in rural areas (Kang-Brown & Subramanian 2017). For many rural areas with limited economic opportunities, correctional facilities represent one of the few “growth industries” (Huling, 1999). Rural areas can derive a significant stream of revenue by holding people from other jurisdictions or agencies who are awaiting trial in local correctional facilities (Mai, Belaine, Subramanian, & Kang-Brown 2019).

An emerging area of research suggests that there are health consequences for those who are employed, or live, in a community with a prison or large incarcerated population. A study on the consequences of job stress among correctional officers found

that the life expectancy of a correctional officer was 59 years, compared to the national average at the time of 75 years. On-the-job stress leads to higher rates of cardiovascular disease and substance use disorder (Cheek & Miller 1982).



In facilities that administer lethal injection, correctional officers experience psychosocial and mental health consequences, including perpetration-induced traumatic stress (PITS), a specific form of posttraumatic stress disorder (PTSD) (MacNair 2002; Muller 2018). In addition, it is well established that infectious diseases spread more efficiently under the conditions that are common in correctional facilities (e.g., group quarters, overcrowding), placing both incarcerated people and correctional officers at risk (Na-

tional Academies of Sciences, Engineering, & Medicine 2020; Ndeffo-Mbah, Vigliotti, Skrip, Dolan, & Galvani 2018). Recent research suggests that communities adjacent to prisons and jails are experiencing higher rates of COVID-19 infection due to the movement of jail and prison staff (National Academies of Sciences, Engineering, & Medicine 2020). This suggests that incarceration has health impacts not only on the communities directly connected to incarcerated populations, but also on the ones in which correctional facilities are sited and where correctional officers live and work.

Conclusion

Soaring incarceration rates over the past four decades have profoundly impacted health in the United States, especially in poor and minority communities. Incarceration may improve some physical health outcomes during imprisonment, but after release, and over the life course more broadly, incarceration worsens both physical and mental health across nearly every domain. Given the uneven distribution of incarceration, these ill effects may be a significant contributor to racial and class disparities in community health in the United States. The criminal justice system has become an institution that both reflects the history of systematic and institutionalized racism and exacerbates existing inequities.

Beyond the urgent necessity of decarceration, some important practice and policy levers can improve the health of currently and formerly incarcerated populations, as well as the communities that are connected to them. We highlight a few of these in this paper and they include lowering the threshold for recently released individuals to access primary care, expanding the Transitions Clinic Network and funding mechanisms that allow community health workers with histories of incarceration to work in primary care, extending Medicaid benefits into correctional facilities and ensuring continuous insurance coverage, and advocacy and legislative efforts to eliminate the collateral consequences of incarceration. The advocacy and legislative efforts include responding to Ban the Box and Clean Slate campaigns with policies that enable people to find jobs, housing, and food assistance following release. Other innovative strategies promoted by health systems and hospitals can be employed to further promote the health of populations impacted by incarceration and repair the harm suffered.



Health systems that either provide care within jails and prisons, or inpatient care to incarcerated people, could standardize and humanize their care. That includes reconsidering whether or when to permit shackling in a hospital room and allowing a correctional officer to be present. Further, as the primary employers and largest industries in many communities, hospital systems could redirect capital toward local communities to address the individual, family, and community effects of mass incarceration.

For example, the Healthcare Anchor Network is a national collaboration of 60 health-care systems focused on supporting the neighborhoods that surround them. Their strategies include directing spending in construction, laundry, catering, and the like to local companies, providing loans to families who have been impacted by incarceration, and hiring formerly incarcerated individuals. Kaiser Permanente



recently reserved one-third of its construction jobs for people who lived nearby, including 70 formerly incarcerated people who are employed as plumbers, carpenters, and elec-

tricians (Goodman 2019). Within the Healthcare Anchor Network, or more broadly through the community benefits program required by all nonprofit hospitals, health systems can explicitly address the health harms of mass incarceration through their investments.

Given the wide reach of the criminal justice system and the multilevel, multifaceted ways that incarceration impacts health, health equity cannot be achieved until health-care providers, systems, and payers attend to the injustices of mass incarceration.

Emily Wang, M.D., is a professor in the Yale Schools of Medicine and Public Health and directs the SEICHE Center for Health and Justice. The SEICHE Center is a collaboration between the Yale School of Medicine and Yale Law School working to stimulate community transformation by identifying the legal, policy, and practice levers that can improve the health of individuals and communities impacted by mass incarceration. She also leads the Health Justice Lab research program, which receives National Institutes of Health funding to investigate how incarceration influences chronic health conditions, and uses a participatory approach to study interventions which mitigate the impacts of incarceration. As an internist, she has cared for thousands of individuals with a history of incarceration and is co-founder of the Transitions Clinic Network, a consortium of 45 community health centers nationwide dedicated to caring for individuals recently released from correctional facilities by employing community health workers with histories of incarceration. Wang co-chaired the National Academy of Sciences consensus report, *Decarcerating Correctional Facilities During COVID-19*, the Steering Committee on Improving Collection of Indicators of Criminal Justice System Involvement in Population Health Data Programs, and workshops on Health and Incarceration and Means of Violence.

Hedwig (Hedy) Lee, Ph.D., is a professor of sociology at Washington University in St. Louis and holds a courtesy joint appointment at the George Warren Brown School of Social Work. She is also co-director of the university's Center on the Study of Race, Ethnicity, and Equity. Prior to joining Washington University, Lee was a professor at the University of Washington Department of Sociology in Seattle. As an interdisciplinary scholar, she has written articles spanning a range of topics and disciplines including demography, medicine, political science, public health, social work, and sociology. Her recent work examines the impact of mass incarceration on health and health disparities.

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P.30: <https://www.northcarolinahealthnews.org/2020/02/25/for-some-opioid-users-in-nc-jail-doesnt-mean-detox/>



P.41: Photo by Peter Macdiarmid, www.gettyimages.com/detail/news-photo/year-old-inmate-james-looks-out-of-the-window-of-the-young-news-photo/53460365?adppopup=true



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P.48: Photo courtesy of Scott Ball, www.sanantonioreport.org/crossroads-program-keeps-girls-with-mental-health-issues-out-of-jail



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REDUCING THE HEALTH HARMS OF INCARCERATION

A Report of the Aspen Health Strategy Group

The mission of the Aspen Health Strategy Group (AHSG), part of the Health, Medicine & Society Program at the Aspen Institute, is to promote improvements in policy and practice by providing leadership on complex health issues. AHSG brings together some two dozen senior leaders representing a mix of influential sectors, including health, business, philanthropy, and technology, to tackle a single health issue annually through year-long, in-depth study. Co-chairs are Kathleen Sebelius, 21st U.S. Secretary of Health and Human Services and former Governor of the State of Kansas, and William Frist, former U.S. Senator from Tennessee and former Senate Majority Leader.

The topic of AHSG's sixth annual report is the health harms of incarceration. This compilation opens with a consensus report based on the group's in-depth learning process, followed by a set of background papers. These papers explore the disconnect between correctional health and community-based structures of care, the intertwined relationship between incarceration and behavioral health, the influence of structural racism, and the community health impacts of incarceration.



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