

MEDICAL CAUSES AND CONSEQUENCES OF MASS INCARCERATION

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In 2008, one of every 100 adults in the United States was incarcerated and one in every 31 was under correctional control.<sup>1</sup> In Massachusetts, one in 24 was under correctional control while in 1982, that number was only one in 127.<sup>1</sup> Between 2004 and 2010, the Massachusetts state prison population increased 19%<sup>2,3</sup> and is projected to increase an additional 30% by the end of 2019<sup>4</sup> (for a cumulative increase of 55% over 15 years). The annual national and Massachusetts correctional budgets have soared to \$68 billion and \$1.2 billion, respectively. This amount continues to exceed the amount Massachusetts spends on Higher Education, Public Health and Social Services.<sup>2,5</sup> There is little or no evidence that this huge surge in incarceration has improved public safety. In fact, the states with the most dramatic reductions in incarceration have experienced the largest decreases in crime rates.<sup>1,2,6</sup>

Much of the increase in incarceration is attributable to the failure to treat addiction and mental illness as medical problems. Over the last 40 years, the "War on Drugs" and the deinstitutionalization of mental patients have shifted the

burden of health care for mental illness and addiction into prisons that now house the bulk of those so afflicted.<sup>7</sup> Nationally, in 2004, 69% of state prisoners were regular drug users and 32% had used drugs at the time of their offense.<sup>8</sup> Similarly, in 2005, 56% of state prisoners and 64% of county jail inmates suffered from mental health problems with 30-40% experiencing major depressive or mania symptoms.<sup>9</sup> An additional 20-30% had psychotic disorder symptoms such as hallucinations and delusions.<sup>9</sup> However, only 40% of state prisoners with substance abuse problems received drug treatment or programs in prison, of which only one-third were professionally provided while two-thirds consisted only of self-help/peer counseling.<sup>8</sup> Similarly, only 34% of state prisoners with mental problems received treatment after admission, mostly consisting of prescribed medication, often without ongoing psychiatric therapy.<sup>9</sup> Furthermore, the harsh and socially isolating conditions during incarceration, especially when inmates are placed in solitary confinement (a routine outcome for the mentally ill who often have great difficulty conforming to arbitrary institutional rules) typically trigger or exacerbate mental illness.<sup>2,9</sup>

Other studies establish that 70-80% of prisoners have at least one physical or mental health problem, with 40-60% afflicted by more than one problem.<sup>10</sup> The rates of most chronic medical conditions are higher among prisoners than the general public, including the rates of infectious diseases. Nationally, it is

estimated that one in four Americans infected with HIV and one in three of those infected with hepatitis C cycle through a correctional institution each year.<sup>7</sup> Among Massachusetts state prisoners, the rate of HIV/AIDS is four times the national average (2%) while 17% harbor hepatitis C, ten times the estimated national rate.<sup>7,11,12</sup> Since nearly all prisoners eventually return to their communities, these high rates of infectious diseases threaten those local communities. Additionally, recidivism is increased in those with physical and mental illness.<sup>10</sup>

Indeed, the impact of high levels of incarceration penetrates far beyond prison walls, especially into low-income, minority communities. These are disproportionately affected, with resulting economic devastation and destruction of family relationships, leading to low wages, high unemployment as well as risky sexual partnering, increased rates of hepatitis, STD, HIV transmission, and unplanned pregnancies, all of which exacerbate already marginal health conditions.<sup>7</sup> 50% of Massachusetts state prisoners originate from only three counties (of 14 total) while 54% of prisoners that are released will return to only ten towns or cities (of 341 total),<sup>2,13</sup> emphasizing the dramatic local community disruption brought about by incarceration.<sup>1,2,5,14,15</sup> In some of these communities as many as 20% of adult males may be in prison at any one time, severely weakening the family and social networks ex-offenders need to rely on for successful re-

entry.<sup>2,14,15</sup> Some states that have implemented community revitalization and resource enrichment projects have seen substantial reductions in recidivism and crime rates as a result.<sup>2,15</sup> Similarly, since improvements in neighborhood living environments have been shown to improve health outcomes in poor communities<sup>\*,16</sup> it is likely that similar benefits in drug addiction and crime rates could be achieved through community revitalization projects that lower poverty rates, provide employment and improve schools.

Massachusetts correctional health care expenditures are the highest in the nation (>\$7,000/state prisoner/year)<sup>12</sup> but prisoners continue to be released with unresolved medical, addiction and psychiatric problems, typically with only a few weeks of medication and no stable access to health care. While Massachusetts offers "universal" health insurance, ex-prisoners receive only limited access to subsidized public medical care and are released without any pre-established linkage to specific providers or resources. Consequently, many released prisoners will fail to successfully access community health care because such care is often poorly available to those without private insurance.<sup>17</sup>

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\* A 1994 Housing and Urban Development study randomized 4498 women with children into groups; one group was given vouchers enabling them to move from high poverty neighborhoods (>40% of residents below federal poverty level) to low poverty neighborhoods (<10% of residents below poverty level) while a second group remained in the original neighborhoods. After 10-15 years of follow-up, obesity and diabetes rates were statistically significantly lower in those given vouchers, an outcome interpreted to result from improvement in available community resources in the lower poverty neighborhoods.<sup>16</sup>

## CONCLUSION

A multi-faceted approach is needed to correct the dysfunctional criminal justice system. Courts must widely implement evidence-based alternatives to incarceration, e.g., diversion of non-violent drug offenders, and mental and addiction treatment instead of imprisonment. Correctional administrators must recognize the failure of current practices to deal with addicted and mentally and physically ill prisoners by providing evidence-based and quality-assured programs that lead to effective rehabilitation and re-entry. Institutional health care must address the haphazard and ineffective delivery of services to prisoners while guiding correctional policies towards healthier physical and mental outcomes. As some experts with both academic and practical experience in corrections have concluded, "locking up millions of people ... has failed as a public safety strategy and has harmed public health in the communities to which these men and women return. A new evidence-based approach is desperately needed ... in order to reduce mass incarceration and its collateral consequences"<sup>7</sup> on public health and safety. Massachusetts House Bill #3286, recently enacted along with this year's state budget, establishes a commission to study and identify evidence-based strategies to reform the Massachusetts justice system. It remains to be seen if this will actually lead to the practical implementation of the improvements needed to accomplish these goals.

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