CASE STATEMENT

PUBLIC HEALTH & THE CRIMINAL JUSTICE SYSTEM

The reality of mass incarceration translates into a reality of mass reentry.[1]

NATIONAL CONTEXT

Virtually, every incarcerated person in jail – and 97% of those incarcerated in prison – will eventually be released. This results in nearly 650,000 people being released from prisons and over 7 million different individuals being released from jails in the United States each year. Federal and state prisoners are released on average at a rate of 1,780 per day, with many more coming out of juvenile facilities[2]. Unfortunately, the vast majority of these prisoners (2 out of 3) will be rearrested within 3 years of their release[3].

As of June 2004, one in every 138 Americans was incarcerated in prison or jail – growing at a rate of 932 inmates a day[4]. Between 1970 and 2000, the number of people incarcerated in state and federal prisons grew from just under 200,000 to over 1.3 million (plus an estimated 600,000 in local jails, and over 100,000 in youth detention facilities)[5]. The rate of incarceration and the number of people leaving prison each year has quadrupled. These are increases that have far-reaching consequences for public health and safety.

Parole & Probation: Nearly 80% of all state prisoners will be released to parole supervision[6]. By 2003, over 4.8 million adult men and women were under federal, state, or local probation or parole jurisdiction. Many prisoners (36%) are released for the second time on the same sentence. In fact, returnees are the fastest growing category of prison admissions[7]. Prisoners are now less likely to succeed on parole: in 1980, 70 percent of parolees completed their parole terms, but by 1998, only 45% were successful[8].

CRISIS IN CALIFORNIA

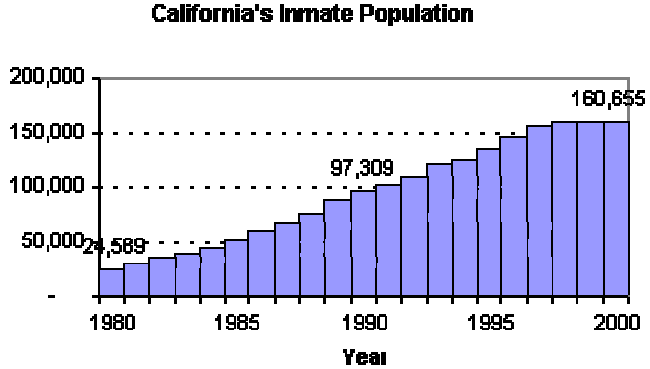
The State of California operates the third largest penal system in the world[9]. California's inmate population ranks behind only the national correctional systems of China and the United States. California has experienced a dramatic rise over the past twenty-five years in both the rate of incarceration and the absolute number of individuals in jails, prisons and youth detention facilities. Between 1980 and 2000, the state prison population increased nearly seven-fold from 23,000 to 160,000[10]. In the same time span, the number of correctional facilities has nearly tripled, growing from 12 to 33. Currently, the California Department of Corrections manages a $4.8 billion enterprise, with over 47,000 employees.

The proportion of male inmates incarcerated for drug offenses rose from 7% to 28% between 1983 and 1999. During the same period, the proportion of women inmates incarcerated for drug offenses rose from 13% to 44%[11]. Due to the steady decline in resources and changes in sentencing, most of those incarcerated will return to their communities having served, on average, longer sentences with minimal rehabilitative programming. This has resulted in new challenges for local jurisdictions.

State Trends in Parole: The number of parolees in California has increased 10-fold over the last 20 years compared to three-fold nationally. This has resulted in a disproportionate share of U. S. parolees residing in California. Today, nearly one in five parolees lives in California; more than 125,000 adult parolees are returned each year. California is also the national leader in returning these parolees back to prison; especially for technical violations. The state return rate has increased 30 times between 1980 and 2000. If current parole revocation trends continue, three out of four people entering California prisons each year will have failed the terms of their parole[12].

Local Jurisdictions: Criminal justice and correctional policies have created disproportionate incarceration rates in communities that face other serious social problems, including inadequate education, high unemployment, and limited health care. In low-income neighborhoods, these obstacles are considerable.

Alameda County (San Francisco Bay Area): Home to 30,000 parolees, re-entry is increasingly being identified as a major contributor to violence and health risks in Alameda County. Ranking 9th in the nation in 2001, Alameda County received 6,453 releases of which 1,469 were violent offenders[13]. Inmates



Center on Juvenile and Criminal Justice, May 2005

return after years of incarceration without adequate services, job training, or economic opportunities.

Because state law requires that parolees be released in the area of their most recent residence, the City of Oakland maintains a large concentration of parolees. According to Oakland's Department of Human Services, the California Department of Corrections paroled 2,989 adult ex-offenders into Oakland during the 2000 fiscal year and averages over 2000 from San Quentin State Prison annually. An article in the Los Angeles Times estimated that one out of every 14 adult males in the City of Oakland is on parole or probation[14]. The article also estimated that approximately 11,400 parolees and probationers currently reside within the city limits. The National Organization of Black Law Enforcement Executives (NOBLE) found that on a daily basis, "approximately 700 parolees in Oakland are wanted for some type of [parole] violation and that over 50% of reported crime in Oakland is committed by persons on probation or parole[15]."

Los Angeles County: Ranking highest in the nation, Los Angeles County had the largest number of releases from prison (37,080), followed by Cook County, IL, (17,480), and San Bernardino, CA, (10,183) in 2001. Of these, 9,480 were violent releases[16]. Sixty percent of all parolees in the state return to Southern California. In 1998, Los Angeles County alone received 30% of all state felons paroled, even though its residents comprise only 12% of the state population[17].

Meanwhile, public and private health services in Los Angeles County have faced devastation under the weight of financial deficits; resulting in the closure of numerous clinics and hospitals[18]. With a population of 9.5 million, about 2.5 million (26%) have no medical insurance, and this number is rapidly rising.

The circumstances in Los Angeles are by no means unique. The social safety net across the State of California has come under increasing attack. Once the envy of the country, California's healthcare system is struggling to adjust to serious under-funding of all services and provide care to more than 7 million uninsured Californians. In 1998-99 alone, emergency departments reported financial losses of over $315 million while serving 9.3 million patients. Physicians working in these same emergency departments experienced losses exceeding $100 million[19]. In Alameda County, emergency rooms alone operated at an annual loss of $24 million (1999/00), up $4 million from the previous year[20].

IMPLICATIONS FOR PUBLIC HEALTH

"We estimate in California that 85 percent of prisoners who have HIV also have HCV,"
- Judy Greenspan, California Prison Works HIV/HCV Coordinator.

Prisoners and soon-to-be-released inmates are disproportionately afflicted with illness and tend to be sicker, on average, than the U.S. population. The Congressional report, *The Health Status of Soon-to-be Released Inmates—A Report to Congress*, documents significantly higher rates of communicable disease, mental illness, and chronic disease among releasees as compared to the general population. The prevalence of infectious disease is on the average 4 to 10 times greater among prisoners than among the general population. People passing through prisons and jails account for a significant share of the total population who are infected with HIV or AIDS, hepatitis C, and tuberculosis.

CONDITION	PREVALENCE COMPARED TO US POPULATION
INFECTIOUS DISEASE	
Active Tuberculosis	4 times greater
Hepatitis C	9-10 times greater
AIDS	5 times greater
HIV Infection	8-9 times greater
CHRONIC DISEASE	
Asthma	Higher
Diabetes/hypertension	Lower
MENTAL ILLNESS	
Schizophrenia or other psychotic disorder	3-5 times greater
Bipolar (depression) disorder	1.5-3 times greater
Major depression	Roughly equivalent
SUBSTANCE ABUSE AND DEPENDENCE	
Alcohol dependence	25% fit CAGE profile
Drug Use	83% prior to offense; 33% at time of offense

SOURCES: NCCHC, "Prevalence of Communicable Disease, Chronic Disease, and Mental Illness Among the Inmate Population," The Health Status of Soon-To-Be Released Prisoners, A Report to Congress, 2002; BJS Special Report: Substance Abuse and Treatment, State and Federal Prisoners, NCJ 1999.

HIV/AIDS: In 1997, state prisoners tested positive for HIV at a rate eight to nine times greater than the general public. Nearly 25% of all people living with HIV or AIDS, nearly 33% of people with hepatitis C, and more than one-third of those with tuberculosis were released from a prison or jail that year[21].

Hepatitis: The prisoner population also has a high rate of hepatitis C virus (HCV) infection. Estimates range from 17 to 19 percent of the national prison population as infected with HCV (NCCHC 2002). Hepatitis C, unlike the A and B types, can be treated, but has no vaccine or cure. Conditions in prison that involve the sharing of personal items lead to a high rate of in-prison transmission. Few prison systems test for or treat HCV, so prisoners may be released while still unaware they are infected. More than 300,000 inmates were estimated to have HCV in 1997.

Hepatitis in California Prisons: In California, an estimated 40% of inmates are HCV+. However, prison health authorities are reluctant to test or treat them, either due to costs or risks of legal redress. When they do test, prison officials face insurmountable

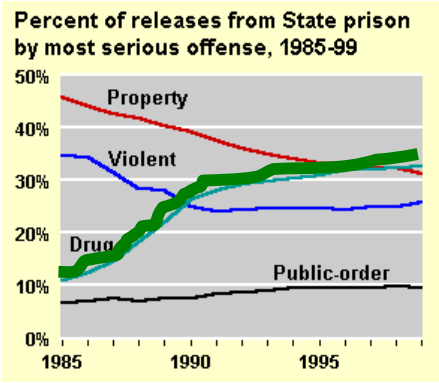
obstacles for treatment. Although adequate research has not been pursued, many experts suspect that prisons may serve as incubators for the HCV epidemic, in much the same way they did for multi-drug-resistant strains of tuberculosis in New York and Russia over the past two decades[22].

Tuberculosis: While the incidence of tuberculosis disease has declined in the U.S. population, the incidence rates continue to be 4 to 17 times higher among inmates than the general population. An estimated 131,000 prison and jail inmates tested positive for latent tuberculosis infection in 1997. Inmates who return to their communities must continue to follow treatment regimens in order to reduce the spread of the disease.

Chronic Diseases: In terms of chronic diseases, the prevalence of asthma among jail and prison inmates was estimated to be higher than among the general population (8.5 percent versus 7.8 percent). Although the prevalence of diabetes (5%) and hypertension (18%) were lower among the prison population, the prevalence is still fairly high given that these conditions are typically associated with older populations. These conditions may increase as the state prison population ages (Davis 2002). Inmates with untreated chronic diseases can create substantial burdens on both the correctional healthcare system and the community healthcare system. Asthma, diabetes, and hypertension can be managed in ways that would result in improved health outcomes for returning inmates and reduce the demand for costly acute care and hospitalization services.

Mental Illness: Prisons house more mentally ill people than all other public institutions in American society. Serious mental health disorders such as schizophrenia/psychosis, major depression, and bipolar disorder are more common among prisoners (two to five times higher) than among the general population. An estimated 8 to 16 percent of the prison population has at least one serious mental disorder and is in need of treatment[23]. According to the Sentencing Project, the Los Angeles County Jail is the world's largest mental hospital, with about 3,300 ill inmates on any given night[24]. Further, of California's 116,000 parolees, the 40,000 who are mentally ill reside in Los Angeles County[25]. Often, little assistance is available for inmates in making linkages to community-based mental health treatment upon release.

Substance Abuse: There is a clear relationship between substance abuse, crime, mental health problems and communicable diseases[26]. Substance abuse is the most common health issue among the prison population, which has important implications for both public health and public safety.



U.S. Department of Justice · Bureau of Justice Statistics

The National Center on Addiction and Substance Abuse at Columbia University reports that alcohol abuse is linked to 80% of crimes committed by incarcerated prisoners in the United States (Belenko 1998). More than half of state prisoners reported that they were using drugs or alcohol when they committed the offense that led to their incarceration. Nearly one in five prisoners said they committed their most recent crime to obtain money for drugs (Mumola 1999). In California, "drug use" is the largest single category of Criminal Returns (20 percent in 2000)[27].

Substance abuse problems that are not addressed during the period of incarceration or upon release can severely hinder the reintegration process. This is particularly problematic because only 10% of state inmates in 1997 reported receiving substance abuse treatment, down from 25% in 1991[28]. In the absence of treatment, the risk of relapse following release from prison is high. For example, between 60 and 75 percent of parolees who have histories of cocaine or heroin use are reported to return to those drugs within three months after release, if untreated[29]. Despite the clear need and cost efficiency of addressing this issue, treatment resources are lacking.

Characteristics & Demographics: The changing characteristics of the reentry population and their demographics also have a direct impact on the prevalence of disease. The size of the release population is growing and concentrated in five states: California, Florida, Illinois, New York, and Texas. The length of time served by prisoners has also increased. Today, there are more returnees (individuals who have multiple periods of incarceration) and more unconditional releases than in the past. Further, fewer prisons are offering and fewer inmates are participating in educational, vocational, and prerelease programs[30]. From a public health perspective, these factors have negative implications for successful reentry.

Demographic trends also have implications for reentry and public health. Releasees from state prisons tend to be older, introducing complex health issues associated with age. Inmates in their 50s are considered geriatric cases, due to their poor health and shorter life expectancy. As the number of older prisoners increases, the cost of healthcare rises because they require more medical services, including costly long-term care. In 1997, 48 percent of state prison inmates age 45 and older reported a physical or mental impairment[31].

Gender-Specific Risk Factors: Ninety-four percent (94%) of inmates are men. This factor poses additional challenges due to the increasing crisis in the health and well-being of American men[32]. Alarming statistics demonstrate that the health of males at every age is at great risk. Men have higher death rates from pneumonia, influenza, strokes, cancer, and diabetes than women. Men ages 55-74 are twice as likely as women to die of heart disease. In the United States, male deaths outnumber females in the top 10 causes of death[33]. All of these top 10 causes are in the domain of primary care – one of the most serious health problems in America today.

Men have a higher death rate for every one of the top 10 leading causes of death[i]:

Cause of Death	Men	Women
Heart Disease	166.9	93.3
Cancer	141.1	105.5
Injuries	43.0	17.0
Stroke	26.6	23.6
COPD*	25.9	18.1
Diabetes	15.2	12.3
Pneumonia/flu	16.3	11.0
HIV Infection	9.2	2.2
Suicide	12.2	4.0
Homicide	11.3	3.2

* Chronic Obstructive Pulmonary Disease

New data has documented that a gender-based approach to male health is necessary in order to address different reproductive health needs, different risks for specific diseases and disabilities, and gender differences in health-related beliefs and behaviors. This presents exceptional challenges to providers because men do not fall within the cohort of the maternal-child health structure and they are seldom targeted for program specific funding. When men do receive services, programs are seldom comprehensive enough to manage their male-specific risk factors. Many men, especially poor men, obtain health services at three points of entry – the military, emergency wards, or the correctional system. Because counties lack the financial means to provide coordinated health opportunities for males, when they obtain services at these or other entry points, it is usually during a crisis, thereby increasing their vulnerability.

Institutional Challenges: Health providers face multiple institutional obstacles at all levels. The difficulties faced in dual and triple diagnoses (for substance abuse, mental illness, and HIV infection, for example) are particularly acute, and the associated service needs are even more complex and challenging. Most support programs have been disease specific, which do not address factors of co-morbidity or integrated services for multiple diagnoses. The period of incarceration offers the opportunity to provide needed health services for offenders. However, such opportunities are not fully realized due to few broad disease prevention programs within correctional facilities.

There is also a great need for better data management and tracking systems. State prisons do not collect data on a regular basis to allow for estimates of disease prevalence. As a result, it is impossible to assess the true profile of prisoner health. This is exasperated by challenges in cross-agency information sharing, confidentiality, and cooperation: resulting in extensive duplication of services specifically encountered with the formerly incarcerated. Currently, there is not an adequate system to access previous records of care provided. As a result, tests and exams are often repeated three to five times.

IMPACT ON COMMUNITY

Regrettably, in the national debate over America's punishment policies, the impact of returning prisoners on families and communities has been largely overlooked.

Consequences of Concentration: Returning prisoners are concentrated in a few states, a few core urban counties within those states, and a few neighborhoods within those counties. In 1998, for example, five states accounted for half of all releases in the United States. Within these states, prisoners typically return to relatively few neighborhoods which are already experiencing significant disadvantages. For Los Angeles and Alameda counties, parolees cluster disproportionately in high poverty census tracts. This high concentration of people represents an unprecedented public health challenge. Unfortunately, these are also communities that are least capable of facilitating the successful reintegration of former prisoners. For example, these areas are likely to contain a high percentage of people on public assistance, immigrants, refugees, and other low-wage workers competing for the same entry-level jobs as released prisoners.

Some researchers have found that high concentrations of prisoner removal and return can further destabilize these communities[34]. Recent research by Todd Clear and Dina Rose indicates that high incarceration rates may disrupt a community's social network, affecting family formation, reducing informal control of children and income to families, and weakening ties among residents. The researchers posit that when removal and return rates hit a certain tipping point, they may actually result in higher crime rates, as the neighborhood becomes increasingly unstable and less coercive means of social control are undermined[35].

Community Health Risks: Since each prisoner is tied to a community and a family, the detrimental affect of their physical and mental health while in prison inexorably increases health risks for others upon their return home. For example, if an individual

unknowingly is infected (and not screened or treated during incarceration) with HIV, hepatitis C (through needle sharing or unprotected sex) or tuberculosis in prison, upon release that individual may put his/her family, friends and community at risk for infection. The health of prison staff and their families are also at risk for contracting and transmitting diseases that are prevalent within institutional walls. Community risk is best demonstrated by a statistic from the National Commission on Correctional Health Care. During 1996, up to 35% of the total number of people with selected communicable diseases passed through a correctional facility that year.

Limited Health Services: The type of health services that is available in the areas from which prisoners originate is also an important factor. The health profile of the prisoner population is quite possibly a reflection of the inadequate healthcare that is administered in these neighborhoods. For example, surveys conducted by the Los Angeles County Department of Health Services reveal that residents in these regions already experience high levels of medical stress (see Key Health Indicators for Service Provision Areas SPAs). Inmates enter jails and prisons with a disproportionate burden of illness, receive limited or inadequate treatment while behind bars, and then return to regions that face significant challenges in providing the health services that may prevent disease.

Key Health Indicators for Service Provision Areas (SPAs) 4, 6, 7, and LA County

Residents Surveyed	*SPA 4*	*SPA 6*	*SPA 7*	*County*
% Uninsured adults (18-64 yrs)	**37.6**	**36.4**	**28.7**	**26.2**
% Reporting no regular source of health care	**27.5**	**21.1**	**18.6**	**19.3**
% Reporting health as "fair to poor"	**24.9**	**30.1**	**24.6**	**21.6**

Children: One and a half million children have a parent currently in prison in the United States. Of the soon-to-be-released prisoner population, about two-thirds had children in 1997[36]. Currently, fifty-five percent have children under 18[37]. In California, 195,000 children have a parent in state prison and another 97,000 children have parents in county jails. The parents of 564,000 other children were on parole and probation, bringing the total number of California children with parents involved in the adult criminal justice system to 856,000 in 2000[38].

Research confirms that children whose parents have been incarcerated experience a range of negative consequences. The extent to which these negative health consequences are a direct result of a parent being incarcerated have not yet been fully determined[39].

The direct costs to provide support services to these children have not been fully comprehended. For example, forty percent of kids in Foster Care have a parent that was at one time criminal justice involved[40]. For the African American community, the costs of incarceration have had unprecedented impacts for children. One in 14 African American children has a parent in state or federal prison[41].

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In light of the size, severity and cost of these problems, concerns about the effects of incarceration and the success or failure of prisoners reentering the community can no longer be considered solely a criminal justice policy issue. Recognizing the prevalence of public health issues as 4-10 times greater in prison populations, the status of prisoner health is a major public health concern. The health of the reentry population is so inextricably linked to the health of the general public that efforts to develop reentry strategies must include appropriate health care and disease prevention strategies. There are numerous public health benefits of improved care for returning inmates. These include reduced use of emergency rooms and hospitalization, less family disruption, improved social cohesion in the community; improved public safety; reduced transmission of infectious disease, reduced substance use, reduced recidivism, improved management of mental illness and other chronic conditions; and lower costs for medical care.

ENDNOTES

CHART

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NARRATIVE

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