Statement on Mass Incarceration

Student National Medical Association

Health Policy and Legislative Affairs Committee

Statement on Mass Incarceration

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INTRODUCTION

Founded in 1964 by medical students from Howard University College of Medicine and Meharry Medical College, the Student National Medical Association (SNMA) is the nation's oldest and largest, independent, student-governed organization focused on the needs and concerns of medical students of color. The SNMA is dedicated to practices leading to better healthcare for minority and underrepresented communities. As these communities are disproportionately subject to the consequences of discriminatory practices, the SNMA strongly opposes legislation and actions that maintain these barriers, particularly the continued practice of mass incarceration. The purpose of this statement is to illustrate the impact mass incarceration has on the health of individuals and communities and to elucidate the cost the penal system places on United States (US) taxpayers. Further, this statement will present an argument for reform and abolition (as defined in our "Statement of Position and Recommendations" below) within the US criminal justice system. We will illustrate the need for sentencing reform, bail reform, and prosecutorial reform, and the continued development of reentry programs. Additionally, we will demonstrate how wrap-around support systems that promote improved education, equity, and health equity are necessary in ameliorating the harmful effects of incarceration on individuals and communities.

For the purposes of this policy statement and by definition of the Bureau of Justice Statistics, incarceration refers to the practice of imprisoning an individual within a city, county, state or federal house of corrections. Prisons house individuals held on felony charges for $\geq$1 year while jails hold individuals that are either awaiting trial or serving less than a one-year sentence.[1]

BACKGROUND

The American Civil Liberties Union (ACLU) defines mass incarceration using two key statistics:

1. Despite the fact that the US population makes up roughly 5% of the global population, the US holds 25% of the world's incarcerated population, and
2. The incarcerated population since 1970 has far outpaced population growth and crime.[2]

According to the Robert Wood Johnson Foundation (RWJF), the number of individuals incarcerated in the US surpasses that of any other nation in the world.[3] An estimated 2.3 million

people are serving time in a US prison or jail, a number that has steadily increased since the 1980s.[4,5] These individuals occupy 1,833 state prisons, 110 federal prisons, 1,772 juvenile correctional facilities, 3,134 local jails, 218 immigration detention facilities, 80 Indian Country jails, military prisons, and prisons in the US territories.[6] An estimated 70% of people in jails have yet to be convicted of a crime and remain behind bars because of an inability to afford the cost of bail.[6]

Black/African-American and Latinx individuals are strikingly overrepresented amongst the incarcerated population in the US. In 2017, Black/African-American and Latinx individuals represented 12% and 16% of the US adult population, yet 33% and 23% of the sentenced prison population, respectively, while Whites accounted for 64% of the US adult population, yet 30% of prisoners.[7] Additionally, women of color make up the fastest growing incarcerated population in the US.[4] This leaves an estimated 2.7 million children in America with at least one parent incarcerated.[3] These statistics can in part be explained by disparate policing and sentencing practices across varied ethnic and racial groups. For example, for comparable offenses leading to an arrest, Black/African-American men are more likely to convicted and subsequently to receive prison sentences that are 70% longer than White men.[8,9] These practices are intricately related and supported by the prison-industrial complex.

Prison-Industrial Complex

The prison-industrial complex can be defined as the overlapping interests of government and industry that use surveillance, policing, and imprisonment as solutions to economic, social, and political problems. As defined by national grassroots organization, Critical Resistance, the prison-industrial complex helps and maintains the authority of people who get their power through racial, economic and other privileges.[10] This power is held primarily over communities of color, people living in poverty, queer people, and immigrants. The prison-industrial complex is a symptom of a larger system of capitalism and acts to continuously incarcerate the very patient populations the SNMA aims to support and protect. It is impossible to describe and understand the larger ramifications and health-focused consequences of mass incarceration without acknowledging the rooted structures that support and promote its existence.

Incarceration and Health

Within a health context, incarceration can put entire communities at elevated risk for poor physical and mental health outcomes.[11] In 1976, the US Supreme Court ruled in *Estelle vs Gamble* that failure to provide basic healthcare in correctional facilities violated the constitutional prohibition against cruel and unusual punishment. This ruling mandated that jails and prisons provide acute care services to prisoners.[11] However, the quality and accessibility of medical care for chronic disorders in correctional settings is highly variable. In fact, overcrowding of correctional facilities, especially prisons, has prompted judges to mandate the release of prisoners because their level of overcrowding renders incarcerated individuals without basic resources such as food, recreation, and health care, and therefore constitutes cruel and unusual punishment.[12] These findings only begin to describe the breadth of the problem, but they do elucidate how incarceration affects overwhelming underrepresented communities in the US.

SCOPE OF THE PROBLEM

1. Health of Individuals

Incarceration within jails, prisons, detention centers, and other houses of corrections can be detrimental to an individual's short-term and long-term health status.[13] Exposure to various communicable diseases and untreated or unaddressed chronic illnesses contribute to and exacerbate morbidity and mortality amongst individuals who are or have been incarcerated. The US Bureau of Justice Statistics (BJS) reports that the most common infectious diseases reported by incarcerated populations include hepatitis B, hepatitis C, HIV/AIDS, tuberculosis, methicillin-resistant staphylococcus aureus (MRSA), and sexually transmitted infections.[14] The Centers for Disease Control and Prevention (CDC) also reports disparities in testing and prevalence of cardiovascular disease and behavioral and mental illness.[15]

1.1. Chronic Diseases

For the purposes of this section, we refer to the BJS National Inmate Survey definition of chronic medical disease as persistent health problems that have long-lasting effects.[16] The CDC published its first national survey of prison health systems in 2016. In this report, the CDC found that among the 45 participating states, delivery of on-site testing, screening or treatment resources for major chronic health conditions varied considerably between states. Thirty-one of the 45 states

delivered on-site screening for chronic diseases and 35 offered long-term/nursing home care and hospice care. When on-site resources lacked to address chronic health concerns, telemedicine was occasionally utilized to meet the healthcare needs of incarcerated individuals in 30 of the participating states. The BJS survey data demonstrated that an estimated 50% of prisoners and jail inmates had ever had a chronic condition and 40% had a chronic condition at the time of survey administration. Interestingly, among those reporting a history of a medical condition, only 80% of prisoners and 47% of jail inmates reported seeing a health care professional for a medical reason since being incarcerated. This variability may be attributed to financial constraints, lack of political will to institute large reform or adequately invest to meet the need, overcrowding in jails and an aging prison population.[17] It also demonstrates severe inequities within the criminal justice system for identification and treatment of chronic disease.

1.2. Communicable Disease Prevalence and Bloodborne Pathogens

Rates of communicable diseases within incarcerated individuals, though difficult to accurately count, are among the most prevalent and alarming. HIV prevalence is roughly 5 times higher among those who are incarcerated than in the general population.[11] Statistics show that between 8% to 43% of the US prison population have a current hepatitis B infection and between 23% and 33% are infected with hepatitis C.[18–20] Due to the sharing and reusing of needles for intravenous drug use, dispensing of medications, and tattooing in prisons and jails, the incarcerated individuals are at 9-10 times higher risk of contracting hepatitis C via infected needles.[11] Along with increased prevalence of viral hepatitis is the increased transmission rate of tuberculosis among incarcerated individuals. Rates of each of these conditions are between 5-30 times higher than in the general population, and in some cases, rates amount to epidemic proportion.[11,18–21]

1.3. Behavioral and Mental Health

In 2016, chronic mental health disorders as defined in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* (DSM-IV), were prevalent among 56% of state prisoners, 45% of federal prisoners, and 64% of jailed individuals. Between 2007-2009, the prevalence of substance use disorder (SUD) was 58% among state prisoners and 63% among sentenced jailed inmates. These numbers are astonishing when compared to 9% prevalence of substance use disorder in the general population in 2009.[22,23]

Poor mental health both causes and is caused by incarceration. For example, those with SUD are more likely to be incarcerated than those who do not have SUD. Similarly, individuals with both SUD and a history of incarceration had 3.1 times the odds of utilizing alcohol use disorder treatment and 1.6 times the odds of using drug use disorder treatment compared to their counterparts with SUDs and no history of incarceration.[24] Practices within correctional facilities, such as solitary confinement, are shown to have short- and long-term repercussions on mental health. A study conducted in the New York City jail system demonstrated a 6.27 greater odds of inflicting potentially fatal self-harm in inmates subjected to solitary confinement.[13] The negative health outcomes experienced by the imprisoned population demonstrates imminent and disproportionate harm to the numerous prisoners subjected to the correctional system.

2. Health of Communities

The impacts of mass incarceration stretch far beyond the individual. These impacts are multidimensional, intergenerational, and dynamic. Systemic change and reform not only affect the life trajectory of individuals, but also the communities these individuals belong to, many of which are low income communities of color.

2.1. Disproportional Impact of Incarceration on Black and Latinx Communities

The BJS reports that in 2017, county and city jails held 745,200 inmates while federal prisons held 1,489,400 inmates.[25,26] At the time of this survey, 12% of the US population identified as Black/African American, yet this racial group made up a significant percent of individuals incarcerated: 37.0% of the federal prison population, 33.8% of state prison population, and 34.4% of jail population.[22] Likewise, those who identified as Hispanic/Latino in 2016 represented 17.3% of the US population, yet 32.0% of the federal prison population, 20.8% of state prison population, and 15.2% of jail population.[22,27]

According to the BJS, 52% of state and 63% of federal inmates reported being parents to an estimated 1.7 million children.[12] The rate of incarceration among Black/African American families is greater than that of other racial/ethnic groups. Hedwig Lee's 2006 General Social Survey investigated the social and familial impacts of incarceration among White and Black/African-American communities. Analyzed data demonstrates 44% of Black/African-American women and 32% of Black/African-American men have a family member in prison,

compared to 12% of White women and 6% of White men. Additionally, Black/African-American women are far more likely to have an acquaintance (35% vs. 15%), family member (44% vs. 12%), neighbor (22% vs. 4%) or someone they trust (17% vs. 5%) in prison than are White women. Approximately 25% of Black/African American children will have a father imprisoned, compared to roughly 5% of White children.[12] These data illuminate alarming disparities in representation of Black and Latinx people within the criminal justice system.

2.2. Impact of Incarceration on Women's Health

Incarceration of women has increased more than six-fold since the 1980's.[28–30] For context, an overwhelming amount of incarcerated women were raised in poorer, economically depressed communities of color deficient in socioeconomic resources.[31] There are also racial/ethnic disparities among incarcerated women. The lifetime risk of a incarceration by race per 1000-women is 36 for Black/African Americans, 15 for Hispanic/Latinos, and 5 for Whites.[32]

Between 2000 and 2013, there was a 30% increase in the number of incarcerated women, while incarceration of men increased by 13%.[33] This drastic increase in the number of women being incarcerated has contributed to unsafe sentencing practices. Women requiring varied levels of security based on their offenses and varied healthcare needs have been grouped into the same correctional facilities as the current prison infrastructure cannot reasonably accommodate this increase. Women who are incarcerated also face the challenge of "forced migration" as a result of lower number of correctional institutions for women, which results in separating inmates from their support system and families.[28,34]

A majority of incarcerated women have a history of sexual abuse, domestic abuse, mental health challenges, and/or chronic medical conditions.[32,35] As demonstrated above, correctional facilities lack the infrastructure to address these issues. Incarceration during pregnancy is a notable example of the issues with healthcare delivery in US correctional facilities. Access to prenatal and perinatal care, and the quality of care varies significantly across facilities.[36,37] Access to obstetric exams during pregnancy also varies by type of institution, with 94% of women in prison receiving obstetric exams compared to only 48% of women in jail while pregnant. Pregnant women in custody face the risk of delayed medical attention as symptoms of labor must be acknowledged by an untrained facility guard who is then responsible for contacting appropriate providers at a local hospital, and arranging the transport of the inmate to the local hospital for delivery.[33]

Policies regarding shackling, or forced physical restraint, during labor, delivery, and the recovery period following delivery continue to be debated, though they have been demonstrated to be harmful for both the mother and baby.[36] Specifically, shackling of women in pregnancy is associated with increased risk of falls, hemorrhage, and stillbirths.[33] Only 21 states and Washington, DC have instituted anti-shacking law, prohibiting the shackling of incarcerated women in pregnancy and during labor. [33,38,39] Additionally, many facilities require a guard to be present in the room during labor. This guard is not mandated to have any medical training, sensitivity to the plight of a mother in labor or concerned for her wellbeing before during or after birth.[36] Women who give birth while incarcerated are also at risk of early separation from their children. Most facilities require separation of the mother and baby within the first 24-48 hours of birth, increasing the stress for mom and reducing the opportunity for maternal and infant secure bond development.[37] Separation immediately after birth reduces the likelihood of adequate breastfeeding, which has been proven to have protective effects for both mom and the baby. Incarcerated women also report a feeling of "loss and abuse" as a result of separation from their newborns.[37,40] Not surprisingly, a majority of incarcerated women also have a history of insecure and even pathologic attachment as a result of abuse or separation secondary to incarceration.[37]

Another contributor to poorer maternal-child health outcomes among incarcerated women of color is the uncertainty of whether or not they will be able to keep custody of the child after delivery. Separation is more common among women serving longer sentences. Incarcerated women who are scheduled for induced delivery are rarely informed of the details of their delivery, i.e., place, date and time, which reduces the possibility of having a familiar face present during labor. It also makes it more challenging for family members to arrange to take custody of the child once born – thus, another loophole that leads to increases rates of children of incarcerated children entering the foster care system.[41–43] The lack of standard requirements and variation concerning family separation, birthing practices, sentencing and the provision of women's healthcare services create demonstrably damaging health disparities among incarcerated women of color and their families.

Women can be trapped within a cycle of incarceration both as a result of socioeconomic oppression prior to incarceration and of incarceration itself. Factors known to increase the tendency to relapse into a previous condition or mode of criminal behavior or recidivism among women include a history of psychological disease secondary to childhood or domestic, being in a

dysfunctional relationship, unemployment, and lower educational attainment.[31] Housing, job, and food insecurity following release are also associated with a generally increased rate of recidivism.[22]

2.3. Impact of Incarceration on Children

Black and Brown children are more likely than their White counterparts to have a parent incarcerated and therefore be subject to the trauma associated with the carceral system. Beyond the aforementioned statistics on prevalence of likelihood of having incarcerated parents of family members, children born to mothers incarcerated are separated shortly after birth; a majority of them enter the foster care system. This practice is harmful as these infants have the potential to develop insecure attachment and other debilitating mental health conditions. Said conditions increase the risk of the child entering the judiciary system.[44]

Children of incarcerated parents often have a limited ability to develop a relationship with their parent. They must overcome financial difficulty for commuting and transportation to and from correctional facilities to visit their parent(s), costs to receive calls from correctional facilities, and commissary charges, to name a few. It is also important to note the child-friendliness. or lack thereof, within a given correctional facility.[45] Scholars have debated causation between the secondary trauma of incarceration and poorer health outcomes yet have demonstrated that children of incarcerated parents are more likely to use substances and engage in sexual activity earlier in life and experience teenage and unwanted pregnancy, behavioral issues, and juvenile incarceration.[46]

STATEMENT OF POSITION AND RECOMMENDATIONS

The Student National Medical Association (SNMA) acknowledges that health inequities are rampant within the criminal justice system, making it a growing public health concern. Mass incarceration of Black and Brown people both creates and perpetuates a number of concerning health disparities among patient communities that the SNMA holds dear. Members of the SNMA and our colleagues cannot be expected to be reasonable advocates or informed abolitionists if we are never exposed to the information presented in this document, at a minimum. We therefore recommend the following:

1. **Complete abolition of the criminal justice system as it stands today.**
    a. Prison abolition is a radical yet necessary stance to take incremental steps towards change and reform.[10] We believe that abolition is a utopian concept that society should strive toward because there is a true, demonstrated health and societal detriment for individuals or communities affected by incarceration. Taking an abolition stance does not negate the present need for current reform but rather seeks to inform reformist policies.
    b. As members of the SNMA and future healthcare providers, we have a responsibility to encourage systems and practices that enhance the health and well-being of communities of color. The criminal justice system historically and presently fails to do so and as such we cannot support the continuation of these practices.
2. **Adoption of equitable provision of healthcare services across correctional facilities.**
    a. It is required by law that correctional facilities must provide basic services to promote the health and wellbeing of inmates. Data presented in this statement demonstrate that is far from the case.
    b. All facilities must be required by federal law to provide inpatient and outpatient mental health care, care for chronic diseases, long-term and hospice care, inpatient and outpatient dental services, and emergency care sufficient to meet the demands of an expanding and aging incarcerated population. There is no existing federal legislation that both mandates the provision of these services and defines appropriate ratios of providers to patients or quality standards.
3. **Abolition of shackling practices during labor and birth at all correctional facilities.**
    a. Given the staggering rates of infant and maternal morbidity and mortality in the US, the aforementioned data presents a reasonable case for ending this practice as it is not in the health interest of the mother or baby.[47]
4. **In-house daycare and family visitation for newborns and children of incarcerated parents.**
    a. In New York State, development of prison nursery program led to reduced recidivism rates of the moms who participated, and high rates of secure attachment development among their children compared to moms and newborns who did not participate in the nursery program.[37,48] Across the US, eight states have developed

programs to allow newborns to remain with mom for several months following birth- the caveat here is that programs limited capacity, and the requirement of the mom having a minor offense, and short sentence in order to be considered.[37]

5. **Increased education for all health professionals and health profession students about the health inequities within correctional facilities and the systemic factors that drive them.**
    a. Instruction surrounding social determinants of health, and more specifically surrounding incarceration, varies considerably across institutions of higher learning.
    b. This policy statement aids in laying the foundation for larger understanding of the issue among SNMA members. It is the hope and goal of the SNMA to participate in this learning process through the creation of dedicated policy around issues important to our members communities and the communities they care for.

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