Challenging the Health Impacts of Incarceration: The Role for Community Health Workers

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Abstract

With 2.1 million Americans behind bars, the United States incarcerates more people per capita than any other country in the world. This article examines the ways mass incarceration contributes to poor health, particularly within poor communities and communities of color, which already bear a disproportionate burden of ill-health and disease. We explore the multiple health impacts of incarceration and the ways current criminal justice policies contribute to health disparities. We discuss the role of Community Health Workers in mitigating the effects of incarceration by fostering social support, linking formerly incarcerated individuals with existing community services and acting as agents for social change.

Keywords: incarceration, community health workers, reentry, health disparities

Imprisonment was once mainly a matter of concern for the individual being incarcerated, but the scale of incarceration today is such that its impact is far broader– first, on the growing number of family members affected financially and emotionally by the imprisonment of a loved one; beyond that, by the way incarceration is now experienced by entire communities in the form of broad-scale economic hardships, increased risk of fatal disease, and marked economic and social risk for the most vulnerable children. And ultimately, a society in which mass imprisonment has become the norm is one in which questions of justice, fairness, and access to resources are being altered in ways hitherto unknown (Mauer & Chesney-Lind, 2002, p. 3).

Introduction

For the past 30 years, the U.S. has relied on increasingly harsh criminal justice policies that have resulted in mass imprisonment. At mid-year 2004, 2.1 million people were held in jails or prisons (Harrison & Beck, 2005) and over four million were on probation or parole (Glaze & Palla, 2004). Long seen as primarily an issue of crime control and public safety, mass incarceration is increasingly recognized as a public health issue. Policies that were ostensibly developed to ensure public safety are in fact creating increased risks for ill-health and diminished well-being for those already suffering from the divestment of health and human services in low-income communities. In this way, incarceration itself becomes another social determinant of health – one that increases the existing disparities based on race, socio-economic status, and gender.

Disproportionate Impact on Communities of Color

Soaring incarceration rates have been fueled by the War on Drugs, "tough on crime" policies such as mandatory minimum sentencing laws, "three strikes" legislation, and the reduced use of parole. While support for these measures was garnered based on concerns about violent crime, these policies have in fact led to high rates of confinement for nonviolent offenders (Dyer, 2000). Nearly three quarters of new admissions to state prison have been convicted of non-violent crimes (Human Rights Watch, 2003).

The War on Drugs has been the single greatest force contributing to the racial disparities in incarceration; African American and Latino communities bear a vastly disproportionate burden of these policies. Approximately 64 percent of prisoners in the U.S. are people of

color (Harrison & Beck, 2005). Although African Americans made up about 12 percent of the nation's population in 1997, they represent half of the nation's prison population, and are imprisoned at nearly seven times the rate of Whites (Justice Policy Institute, 2000). Despite the fact that drug use rates do not differ significantly by race, African Americans and Latinos are arrested, prosecuted, and imprisoned at far higher rates than whites (Drug Policy Alliance, 2005; Dyer, 2000). In fact, it has been estimated that if incarceration rates are unchanged, one in three African-American males are expected to go to prison in their lifetime (Bonczar, 2003).

The War on Drugs has taken a particularly harsh toll on women. The number of imprisoned women has increased more than six fold between 1980 and 1999 (Chesney-Lind, 2002). Profound racial disparities are evident in rates of female incarceration: a Black woman is seven times as likely to spend time behind bars as a White woman (Freudenberg, 2002a). Spiraling incarceration rates have left more than two million children with a parent in prison (Child Welfare League of America, 2004). One out of every fourteen African-American children has a parent in prison (Mauer & Chesney-Lind, 2002). The human cost – in fractured families, wasted human potential, and permanent marginalization of poor communities and communities of color – is beyond calculation.

Incarceration Exacerbates Existing Health Disparities

People entering prison tend to have significantly higher rates of chronic health, substance abuse, and mental health problems than the general population (National Commission on Correctional Health Care [NCCHC], 2002). The prevalence of AIDS among prisoners is estimated to be five times greater than the prevalence among the U.S population and the Hepatitis C Virus (HCV) among U.S. prisoners is at least 10 times higher than the estimated prevalence in the general population (NCCHC, 2002). Reuse of needles among those incarcerated is a major factor in the spread of HIV and HCV in prisons. Even though European prisons have demonstrated the effectiveness of providing prisoners with condoms, clean needles and syringes, such harm reduction remains nonexistent in most U.S. correctional systems (Haggerty, 2000).

Additionally, overcrowded and unsanitary conditions, as well as improper ventilation can increase a prisoner's risk of exposure to other infectious diseases. Several of the worst outbreaks of tuberculosis (TB) in the U.S. originated in prisons and jails. In the largest outbreak of multidrugresistant tuberculosis in New York City in 1989, fully 80 percent of all index cases could be traced to jails and prisons. In the New York state correctional system, for instance, the average annual TB incidence went from 15.4 cases per 100,000 prison inmates in 1976-78 to 105.5 in 1986 (Farmer, 2003).

Jail and prison medical care is far below community standards of care and compromises the health and safety of prisoners and the communities to which they will return. Those who enter jails and prisons with a disproportionate burden of illness receive limited or inadequate treatment behind bars, putting them at increased risk for deteriorating health (Freudenberg, 2002a). The NCCHC's 2002 report to Congress describes how prevention, screening, and treatment programs in corrections are woefully inadequate, citing the failure of a significant proportion of prisons to implement HIV prevention programs and adhere to Centers for Disease Control and Prevention (CDC) standards regarding TB (NCCHC, 2002). In most cases, the correctional system recognizes the high rates of disease among those incarcerated, but provides very little treatment, prevention, discharge planning or aftercare unless there is a legal threat or humanitarian influence (Davis, 2002). In fact, a recent national study highlights that issues of medical care are the foremost subject of jail or prison litigation (Schlanger, 2003).

Many forces have converged to entangle the mentally ill in the criminal justice system at an increasing rate over the last 30 years, and jails and prisons have essentially become the largest psychiatric facilities in the United States (Kupers, 1999). The dismantling of the public

mental health system, the failure to provide adequate community mental health resources, the criminalization of homelessness and dramatic cuts in social services have left the mentally ill vulnerable to incarceration (Gilligan, 2001; Kupers, 1999). Results from past studies show that up to 20 percent of the current prison population nationally suffers from either some sort of significant mental or psychiatric disorder or a developmental disability (Haney, 2003). The regimented and rule-bound nature of institutional life can be challenging for those who have difficulty controlling their emotions and behavior and they often end up in a vicious cycle of more punishment and further isolation (Haney, 2003). In 1998, it was estimated that 283,000 mentally ill adults were incarcerated in the nation's jails and prisons, and another 547,800 adults with histories of mental illness or treatment were being supervised on probation (Ditton, 1999).

A recent NCCHC report (2002) states that "few jails provide a comprehensive range of mental health services … and most prisons and jails fail to conform to nationally accepted health care guidelines for mental health screening and treatment." One study found that nearly 80 percent of incarcerated women had a history of some type of abuse prior to incarceration (Covington, 2003), yet very few jails or prisons offer support services for women suffering from such trauma. The experience of incarceration, which may include sexual exploitation from male guards (Smith, 2001) constitutes further anguish for a large number of female prisoners. The failure to treat, coupled with the heightened stress of incarceration, means that the communities to which prisoners return will be expected to absorb and address the high level of psychological trauma and untreated disorders that many will bring with them (Haney, 2003).

Poor health-care in correctional settings means that people often leave jail or prison sicker -both physically and mentally- than when they entered. In some cases, inmates die in custody from acute conditions or chronic illness – their incarceration has become a death sentence (Murphy, 2003). Deteriorated health, either in the form of contagious diseases or the increased burden of coping with a chronic illness, directly affects their families and friends to whom they return (CDC, 2001). The communities to which most prisoners return are already struggling with disproportionately high rates of poor health, substandard housing, unemployment and drug use. Without extensive systems of support for prisoner reentry, the formerly incarcerated are set up to fail.

Impact on the Health and Well-being of the Family and Community

The sheer number of people swept up by the criminal justice system means that its effects are felt not only by the individuals incarcerated, but also by their families and communities who suffer the collateral consequences in the form of broad-scale economic hardship, increased risk of fatal disease, dislocated families, and marked economic and social risk for their children (Mauer & Chesney-Lind, 2002). While conditions in jail or prison may represent a temporary improvement from life on the streets for some, many come home traumatized, ill, and alienated from their families and friends. The experience of incarceration often contributes to a downward cycle of economic dependence, social isolation, substance abuse, and other physical and mental health problems (Freudenberg, 2002a).

Children with incarcerated parents suffer the loss of social support and often experience feelings of abandonment, loss, and extreme anxiety, all of which are compounded by the social stigma attached to having a family member incarcerated. Weaver (2003) observed that over half of incarcerated parents had not seen their children during their sentence. Children whose relationships with their parents are fractured by prison often suffer severe emotional consequences from the trauma of separation. Weaver (2003) reports that preschool-aged children separated from imprisoned mothers demonstrated stressful behaviors, including "constant crying, little response to stimulation, little effort to crawl, and incidents of self-punishment." Children of incarcerated parents are approximately six times more likely than other children to be incarcerated themselves, and half of the

incarcerated juveniles have a parent who has been to jail or prison (Weaver, 2003). Federal "fast-track adoption" laws (such as the Adoption and Safe Families Act of 1997) allows states to file for termination of parental rights once a child has been in foster care for 15 or more of 22 consecutive months. This shortened deadline has particularly severe consequences for incarcerated mothers, who serve an average of 18 months (Covington, 2003).

Barriers to Reintegration

The fact that punishment does not end when a prisoner is released, but extends for the rest of their life because of post-conviction penalties, further increases risk of health and social problems. In the "tough on crime" environment of the last two decades, local, state and federal policies have constructed a series of barriers to successful reintegration that can be nearly insurmountable for people leaving jails and prisons. The majority of this population faces loss of public benefits, inability to live in public housing, and reduced employability.

The federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) imposes a lifetime ban on receiving welfare benefits and food stamps for people with certain drug and felony convictions. The lifetime welfare ban seriously compromises women's ability to overcome addiction, to raise their children, find work or access drug treatment. As a result of such policies, families experience more economic strain, which, in turn, has negative consequences for the entire family. Caregivers become overextended and stress ridden, which will significantly affect the well-being of their children (Allard, 2002).

The federal "One Strike You're Out" law that evicts an entire household from public housing based on drug-related or criminal activity of a household member or guest results in many of those returning home from jail or prison losing their housing or being turned away by family or friends who fear eviction (U.S. Department of Housing and Urban Development, 2001). In a landmark case, Department of Housing and Urban Development v. Rucker et al., the Supreme Court upheld the right of the housing authority to evict a tenant without specific proof that the tenant knew about or possessed the ability to control the criminal activity. The failure to secure housing reduces one's chances for success post-release. It makes it nearly impossible for parents to reunite with their children, further contributes to stressors experienced by parents and their children, and increases their risk of homelessness, drug use and criminal activity. Such policies also may put women at increased risk of abuse -given they may be forced to return to an abusive situation (Allard, 2002).

Many state and local governments exclude people with criminal records from employment, and most job applications ask if the applicant has ever been convicted of a felony. Several studies have indicated that a criminal record is a serious impediment to finding a job, as employers are reluctant to hire someone with a criminal record (Allard, 2002; Harrison & Keller, 2005). Even in a strong job market, formerly incarcerated people usually end up in the least desirable jobs that fail to pay a living wage (Bushway, 2003). Failure to find a job also translates into being uninsured, further increasing the risk of ill health for the former prisoner and their family. Given the limited opportunities for legitimate employment in communities most affected by incarceration, many newly released prisoners find themselves returning to the illegal activities that led to their imprisonment in the first place.

The strength of a person's relationship to their community has long been understood to shape health and well-being. Social capital and collective efficacy – the capability of groups to achieve desired outcomes based on exchange relationships – are the direct by-products of the vitality of local social networks (Kawachi & Berkman, 1999; Rose & Clear, 2003; Sampson, Raudenbush, & Earls, 1997). Incarceration is associated with stigma, fractured relationships, financial stress, and reduced self-esteem, all of which may reduce social capital or collective efficacy. This has a significant impact on neighborhoods with a high population of returning prisoners.

Mass incarceration is counterproductive social policy as it ultimately fails to ensure public

safety by weakening social structures (such as strong family ties, work force participation, and civic engagement) that are capable of mitigating illegal activity. Research suggests that high incarceration rates in a community may actually increase crime rates (Sampson et al., 1997). Alternately, evidence suggests that programs that offer prerelease as well as post-release services, and integration of drug treatment, health care, employment and vocational training, social services, mental health and housing are able to reduce the negative impact of incarceration and address the health and social needs of the formerly incarcerated (Conklin, Lincoln, & Flanigan et al., 1998; Freudenberg, 2001a; Hammett, Roberts, & Kennedy, 2001; Richie, Freudenberg, & Page, 2001; Travis, Solomon, & Waul, 2001).

The Role of Community Health Workers in Challenging Health Impacts of Incarceration

Community health workers (CHWs) may be broadly defined as community members who work almost exclusively in community settings and who assume many different roles including; providing culturally appropriate health education and information, ensuring that community residents receive health and social services, providing counseling and social support, advocating for individual and community needs, building individual and community capacity, and serving as bridges between communities and health and social service systems (Rosenthal, Wiggins, Brownstein, Johnson, Borbon, & Rael, 1998; Witmer, Seifer, Finocchio, Leslie, & O'Neil, 1995). CHWs are known by various names: lay health worker, village health worker, lay health advisor, community health advocate, promotora de salud, community health promoter, community outreach worker, and indigenous health worker (Nemcek & Sabatier, 2003; Swider, 2002). They come from the communities where they work and act as advocates for those communities. Although definitions may vary in practice, there is agreement that CHWs are "insiders" -- they are rooted in the community being served, and it is precisely their familiarity and identification with the community that is the great strength of the CHW model. Because they share cultural values, language, and life experiences with community members, they have a qualitatively different ability to enter people's lives. The CHW approach is potentially the single most effective method of health education and health promotion for a disadvantaged community (Becker, Kovacj, & Gronseth, 2004).

Community health workers can play a significant role in mitigating the health impacts of incarceration. National and state surveys indicate that 3/4 of community health workers are from communities of color (Love, Gardner, & Legion, 1996) -the same communities most affected by the high rates of incarceration. Because many CHWs already serve the health needs of the formerly incarcerated and their families, and because they are trusted members of the communities, they are especially well-poised to help with the transition from prison or jail to their home. Some of the critical roles CHWs may assume as facilitators of community reintegration include; offering guidance and support, linking former prisoners to health and social services, countering the stigma and discrimination experienced by ex-inmates and their families, and empowering their communities to advocate for changes in policies that serve as barriers to successful community reintegration.

The Contribution of CHWs in Eliminating Health Disparities

The fact that eliminating health disparities is becoming a national priority means that the role of community health workers is becoming more critical. Research during the last two decades has highlighted the importance of social and environmental factors (such as income, education, housing, discrimination, institutionalization/ incarceration, social support) in shaping health (Link & Phelan, 2002). As a result, there is increasing recognition that interventions to reduce health disparities must address factors in the social environment in order to be effective. Because of their unique positions within their communities and society, CHWs are instrumental to efforts to reduce health disparities. CHWs are culturally competent and are well versed in the ethnic, cultural, social and environmental forces that shape their communities. They are able to see

how health is determined by social place, educational achievement, economic opportunities, or quality of housing. By offering advice and linking individuals with social services, they work toward an agenda that will change individual circumstances, emphasize prevention efforts, and improve access to care (Ro, Treadwell, & Northridge, 2003).

In recent years, CHWs have strengthened intervention approaches to preventing disease and promoting health. The East Side Village Health Worker Partnership is a community-based participatory research partnership (CBPR) that brings CHWs together with a number of community partners to address social determinants of health in Detroit (Parker, Schulz, Israel & Hollis, 1998). The CHWs (or village health workers, as they are known in this project) assume critical roles in this project, building and providing social support, bringing together community members committed to their neighborhoods, linking community members to resources in the community, mobilizing community resources to address the needs of residents, strengthening social networks, and becoming agents of change in Detroit (Schulz et al., 2003).

Another CBPR project, Poder es Salud (Power for Health), based in two Portland communities, uses community health workers to enhance community social capital by reducing language and cultural barriers. CHWs increase communication and collaboration between the community and local health or social organizations and works towards increasing resources, programs and infrastructure to support healthy environments, policies, and behaviors (Farquhar, Michael, & Wiggins, 2005). While the number of health promotion programs using CHWs has increased substantially in the last decade, they have not gained formal recognition for facilitating community reintegration from jails and prisons.

Community-based CHW interventions hold the most promise for mitigating the negative effects of incarceration on individuals, families, and communities. The role of incarceration in producing and exacerbating health disparities has been recognized (Freudenberg, 2002a) and CHWs have firsthand knowledge of the impacts of incarceration on community health. Community health workers can assist prisoners (or persons released from jail or prison) and their families in obtaining benefits, link them with support services, and facilitate their access to medical and mental health care. They can play a pivotal role in establishing community partnerships that bring the voice of historically marginalized communities to the decision-making table. Because ex-inmates experience discrimination, marginalization and alienation, CHWs can play an invaluable role in bringing their experiences to the fore.

Building Community Capacity: Community Health Workers as Change Agents

Social support is at the heart of CHW interventions; it is the primary mechanism to mediate conditions associated with poor health (Roman, Lindsay, Moore, & Shoemaker, 1999). The common features of lay health advisor interventions are to enlist indigenous members of a population in channeling health-enhancing social support to individuals and groups (Eng & Parker, 2002). Becker et al. (2004) note how one CHW, describes her role:

The most help is the listening and the dignity. Sometimes we work with clients who've been in the system so long that they're not treated with respect, and all they need is somebody to recognize that they're human beings and they have value and listen to them. Once you give them that, they can take it from there. That first step is self-esteem.

Prisoners are one of the most stigmatized groups within our society. The sense of shame associated with incarceration can be extremely damaging for ex-inmates and their families. Thus, these first steps at acceptance and understanding are important for an individual's community re-entry.

The collateral consequences of punitive justice policies make it difficult for ex-inmates to successfully reintegrate into the community (Mauer & Chesney-Lind, 2002). Community health workers are in a particularly strong

position to help challenge that stigma and support returning prisoners seeking to re-enter the community and rebuild their lives. Traditional health care models often fail to acknowledge or build on the strengths that already exist in low-income communities (Roman et al, 1999). Community members who overcome difficult life circumstances can become powerful positive role models for change. CHW interventions, particularly those that are situated within partnerships that bring community stakeholders together, may be more appropriate than professional-driven approaches for affirming and strengthening a community's existing assets to improve health (Bishop, Earp, Eng, & Lynch, 2002).

One of the most devastating effects of mass incarceration is the way communities most affected by it experience a deep sense of powerlessness. Community health workers are in a particularly strong position to promote empowerment on both individual and community levels. Because they operate through a community's political dynamics, CHWs have the potential to bring people together to work towards transforming environmental factors that impede community health and well being (Eng & Parker, 2002). They can do much more than counsel and assist individuals in behavioral change by promoting community empowerment. CHWs can also build partnerships with formal service delivery systems and work towards structural change in the health system and social change in their communities (Eng & Parker, 2002).

Prevention-based models to improve health care for returning prisoners yield tremendous public health benefits: reduced transmission of infectious disease, decreased substance abuse, improved management of mental illness and chronic medical conditions, lower short- and long-term health costs, less family and community disruption, improved social cohesion, and improved public safety (Freudenberg, 2002b). Partnerships between corrections, community health providers and social service agencies are promising models, especially for prisoners who are serious communicable diseases or who have substance abuse and mental health issues (Freudenberg, 2002b; Health Link, 2004; Massachusetts Public Health Association, 2003). While community health workers are equipped to play an important role in assisting prisoners with reentry, helping them obtain benefits, linking them with support services, and facilitating their access to health care, it appears that few programs utilize CHWs in these roles.

Given the punitive nature of American justice systems and the trauma associated with incarceration, many ex-prisoners and their families may be reluctant to trust government agencies for assistance in their transition back to society. They may be more likely, by contrast, to turn to a member of their community for help and mentorship. Because CHWs are trusted members of their community and many of them have been directly affected by the prison system themselves, they play a vital role in the healing and restoration of their communities. Because they come from the community and share life experiences with many of its members, they are intimately aware of the community's needs and are able to mobilize its resources to address those needs (Eng & Parker, 2002). CHWs are community members who are well poised to use their experiences and position within their communities to shape re-entry programs that assist the previously incarcerated to navigate the transition from prison or jail back home more smoothly.

Additionally, community health workers, through their participation in broad community-based partnerships, can contribute to long-term efforts to address the injustices of wars on crime and drugs. By advocating for policy changes such as an end to the welfare ban for some offenders and one-strike housing policies, confronting policy makers about the need for sentencing reform and harm reduction, CHWs can bring the voices of those most affected by these policies to the arenas where decisions are made. Such upstream, preventative interventions are critical to breaking the cycle of incarceration.

Conclusion

The societal context weighs heavily, if not overwhelmingly, as a determinant of health status. Yet paradoxically, public health has avoided addressing directly the societal conditions which largely determine the burden of preventable disease, disability and premature death (Mann, 1998).

Jonathan Mann's (1998) call to public health professionals to take up the struggle for human rights and social justice as an integral part of public health work frames the essential arguments of this paper. Mass incarceration and post-conviction penalties shape the lives of millions of people in this country putting them at risk for remaining in poverty, living in substandard housing, and lacking medical care – deprived of the essential conditions requisite to health and well-being. Families are fractured, communities are weakened, and human dignity is decreased because of a collective failure to address systemic social inequalities. The public health commitment to ending racial and ethnic health disparities requires a critical examination of the ways incarceration reinforces those disparities, and a commitment to creating alternatives rooted in social justice.

There is growing recognition among key decision-makers of the crisis being generated by mass incarceration. We imprison more people than any country in the world (see Walmsley, 2003), yet U.S. crime rates have been decreasing for a decade (Catalano, 2004). Increasing use of incarceration during times of decreasing crime creates a significant public policy dilemma (Blumstein, 1998). Faced with severe budget crises and shifting public opinion about harsh criminal justice policies, state officials are beginning to close prisons, roll back mandatory sentences in favor of judicial discretion, and reform parole policies (Greene & Schiraldi, 2002).

Punishment alone will never guarantee public safety. The answers to the problems of crime and justice must be rooted in social justice and an egalitarian society. Policies that promote community-based alternatives to incarceration -- such as diversion programs, drug treatment, and victim-offender mediation -- will contribute to health promotion in communities that are staggering under the weight of poverty, unemployment; and cuts to health, education, and welfare.

One of the first obligations of health professionals is to do no harm. Challenging ill-conceived criminal justice policies that treat addictions or other long-standing social problems as crimes is certainly within the mandate of public health practitioners. Because of the many deleterious effects of imprisonment, public health practitioners have a particular stake in joining efforts for criminal justice reform. The crisis of mass incarceration presents an opportunity for major policy changes, increased prevention efforts, and partnerships that bring the voice and experience of community members to the fore.

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