Mass Incarceration Threatens Health Equity in America

UCSF
University of California
San Francisco

Robert Wood Johnson
Foundation

Authors

Julia Acker, University of California, San Francisco
Paula Braveman, University of California, San Francisco
Elaine Arkin, Independent Consultant
Laura Leviton, Robert Wood Johnson Foundation
Jim Parsons, Vera Institute of Justice
George Hobor, Robert Wood Johnson Foundation

Acknowledgments

We thank the following individuals who provided insightful and substantive comments on drafts:

Dwayne Proctor, Robert Wood Johnson Foundation
Tracy Orleans, Robert Wood Johnson Foundation
Susan Egerter, University of California, San Francisco
Maisha Simmons, Robert Wood Johnson Foundation
Margaret diZerega, Vera Institute of Justice

Suggested Citation

Content from this publication may be reproduced without permission provided the following citation is referenced:
Acker J, Braveman P, Arkin E, Leviton L, Parsons J, Hobor G. *Mass Incarceration Threatens Health Equity in America*. Executive Summary. Princeton, NJ: Robert Wood Johnson Foundation, 2019.

The goal of this report is to raise awareness that mass incarceration is a major threat to health equity in our nation. While awareness of detrimental effects of mass incarceration has been growing, its impact on health and health disparities has not received much attention. This report discusses how incarceration and health are related, not only for those who experience incarceration, but also for their families, their communities, and the nation as a whole. This report also reviews promising programs, policies, and justice reform proposals to help end mass incarceration and its devastating health and social consequences in America.

Foreword

This report also offers an Executive Summary. Other reports on health equity from the Robert Wood Johnson Foundation (RWJF) include What Is Health Equity? And What Difference Does a Definition Make?, Early Childhood Is Critical for Health Equity, and Wealth Matters for Health Equity. The first report defines health equity (below) and takes a deeper look at what it means and implications for action. These reports aim to assist those working in public health, health care, and other sectors that powerfully shape health—such as law enforcement, courts, education, child development, employment, housing, and community development—to build a world in which everyone has the opportunity to be as healthy as possible.

> **Health equity** means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay; quality education and housing; safe environments; and health care. For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.

According to this definition, **health inequities** are produced by inequities in the resources and opportunities available to different groups of people based on their racial/ethnic group; socioeconomic, disability, or LGBTQ status; gender; and other characteristics closely tied to a history of being marginalized or excluded.

Contents

Introduction	2
Mass Incarceration Harms the Health of Inmates, Families, Communities, and the Nation	6
Marginalized Groups are Disproportionately Incarcerated	14
Inequitable Policies and Practices Drive Dramatic Disparities in Incarceration	18
What Can Be Done to End the Vicious Cycle?	21
Mass Incarceration—We Know Enough to Act	29
Resources	30
References	31

Introduction

An estimated 2.2 million American adults are currently serving time in prison or jail,[1,2] and more than 45,000 American youth are confined in juvenile detention facilities, adult prisons, and jails.[5] The number of people incarcerated in the United States increased every year from 1980 to 2008. Despite subsequent decreases to a two-decade low in 2016, both the number of people incarcerated and the incarceration rate in the United States still exceed those of every other nation in the world, including totalitarian regimes.[3,4] This unacceptable level of incarceration—often referred to as mass incarceration—appears to be the result of policies enacted from the 1970s through the 1990s that imposed tougher penalties for crimes, including more severe sentencing and compulsory incarceration for minor repeat offenses.[3] The First Step Act, which was enacted on December 21, 2018, will affect those incarcerated in federal prisons—nearly 181,000 people of the 2.2 million people in prison or jail in America—but does not address the primary drivers of mass incarceration in the United States. This punitive approach has been applied since the early 1970s, particularly in relation to the War on Drugs. The continuing War on Drugs has targeted drug users who could benefit more from treatment than punishment. It has been accompanied by the rise of aggressive over-policing of communities of color, which has in turn contributed to dramatic racial inequities in incarceration. The stated rationale behind these practices is that harsher sentencing and tougher responses to crime will strongly deter and, thus, reduce crime overall. During the nearly five decades of increasing incarceration rates, however, rates of crime have fluctuated and are today similar to those in the 1960s, when the incarcerated population was less than one-seventh of its current size.[6,7]

At the same time, considerable evidence shows that mass incarceration has produced enormous negative effects on society overall, particularly for individuals in the most disadvantaged groups. The men and women behind bars in this country have been largely among the poorest members of society, with a pre-incarceration median income that is 41 percent lower than that of currently non-incarcerated people of similar ages.[8] While members of racial or ethnic minority groups represent 39 percent of the population nationally,[9] they make up 60 percent of incarcerated persons.[10] Black Americans are the most affected, representing 33 and 34 percent of the prison and jail populations,[1,2] respectively, but only 13 percent of the population overall.[9] Black men bear an especially high burden, with research indicating that 1 in 3 will experience incarceration during his lifetime. [10]

With approximately 2.2 million American adults and youths behind bars, the United States incarcerates many more persons—both in absolute numbers and as a percentage of the population—than any other nation in the world.

Among individuals who are incarcerated, future prospects for employment,[11] economic stability,[12] affordable housing,[13] and education[3] are curtailed and in many cases eliminated, with dire consequences for their families' health and well-being as well: An estimated 2.7 million children nationwide are growing up with one or both parents behind bars,[12] while "approximately 10 million children have experienced parental incarceration at some point in their lives."[14] Within communities, high rates of incarceration disrupt social and family networks, reduce potential economic development, and generate distrust and resentment toward law enforcement, which may ultimately increase neighborhood crime rates.[7] Each of these factors contributes to wider gaps in incarceration and health between socially advantaged and disadvantaged groups. For the nation as a whole, mass incarceration diminishes productivity and prosperity, wastes immense levels of resources,[15] and appears to have a negligible impact on crime rates.[7] It creates cycles of repeat offending and repeat incarceration and contributes to the entrenchment of intergenerational poverty.[16]

Definitions of Terms Used in This Report

Health refers to health status or outcomes rather than health care (which is only one of many important influences on health).

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay; quality education and housing; safe environments; and health care. For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.

Health disparities are differences in health that adversely affect groups of people who historically have been excluded or marginalized (for example, people of color, people living in poverty, people with disabilities, LGBTQ persons, and girls/women). Health disparities are used to measure progress toward achieving health equity.

Discrimination is a broad term that includes, but is not limited to, racism. Prejudicial treatment has been based on a wide range of characteristics, including not only racial or ethnic group, but also low income, disability, religion, LGBTQ status, gender, and other characteristics that have been associated with social exclusion or marginalization.

Racism refers to prejudicial treatment based on racial or ethnic group and the societal institutions or structures that perpetuate this unfair treatment. Racism can be expressed on interpersonal, structural/institutional, or internalized levels.

Excluded or marginalized groups are those who have often suffered discrimination or been excluded or marginalized from society and the health-promoting resources it has to offer. They have been pushed to society's margins, with inadequate access to key opportunities. They are economically and/or socially disadvantaged. Examples of historically excluded/marginalized or disadvantaged groups include—but are not limited to—people of color; people living in poverty, particularly across generations; religious minorities; people with physical or mental disabilities; LGBTQ persons; and girls/women.

Incarceration means confinement in prison, jail, or a detention center.

Mass incarceration refers to extremely high rates of incarceration and the disproportionate incarceration of specific groups of the population. In the United States, the group most affected by mass incarceration is young black men from large urban centers.[17]

Juvenile incarceration refers to court-mandated placement of individuals under age 18 in out-of-home correctional facilities including youth detention centers, group homes, long-term secure facilities, and adult prisons and jails.

The justice system is the set of government agencies, policies, and practices responsible for prosecution and punishment, including law enforcement, courts and accompanying prosecution and defense lawyers, correctional facilities, and community reentry and post-release supervision. In this report, the term "justice system" rather than "criminal justice system" is used deliberately to avoid stigmatizing individuals involved with the justice system, including offenders and those who may not have committed crimes.

Prisons (also called "penitentiaries") are state- or federally-administered facilities that house inmates convicted of felony offenses and are serving sentences of (typically) one year or more. State and federal prisons housed approximately 1.3 million and 189,000 individuals, respectively, in 2016.[1]

Copyright 2019 Robert Wood Johnson Foundation

Private for-profit prisons (often referred to simply as "private prisons") are private for-profit, third-party-owned confinement facilities contracted by a government agency. Private prisons currently operate in 28 states and house 8 percent of the total state and federal prison population.[18]

Jails are county- or city-run facilities that house inmates convicted of misdemeanor offenses who typically serve sentences of less than one year. Jails also house people who have been arrested and are awaiting trial or sentencing, as well as inmates who have been sentenced to prison and are waiting to be transferred to another facility. In 2016, approximately 741,000 individuals were incarcerated in U.S. jails.[2]

Probation refers to a period of supervision of an offender who has been conditionally released from prison on parole; probation is sometimes imposed instead of incarceration. Approximately 3.8 million U.S. persons were on probation at the end of 2015.[19]

Parole refers to the conditional release of prisoners before completing their maximum sentence period. At the end of 2015, an estimated 870,500 individuals were on parole.[19] Parolees may be re-incarcerated if they violate the conditions of their parole. Examples of conditions of parole include obeying the law, keeping mandatory appointments with a parole officer, abstaining from drug and alcohol use, obtaining employment, and not voting in elections.

Recidivism is repeat offending.

Mass Incarceration Harms The Health of Inmates, Families, Communities, and the Nation

Substantial evidence links incarceration with poor health outcomes. In the United States, incarceration not only punishes through confinement, but is also associated with a range of adverse health effects that last far beyond the period of confinement. Longitudinal studies have documented strong, pervasive links between incarceration and multiple adverse health indicators across the lifespan, even after considering health before incarceration.[13,20,21] Compared with individuals who have never been incarcerated, current and former inmates have significantly higher rates of communicable diseases (including sexually transmitted infections, HIV, hepatitis C, and tuberculosis); chronic health conditions (such as hypertension, diabetes, arthritis, and asthma); and psychiatric and substance use disorders.[20] Most adult inmates are released from correctional facilities with more chronic medical problems than they had before admission.[13] According to the U.S. Department of Justice, one-third of illness-related deaths in state prisons from 2001 to 2004 (the latest years for which this statistic was reported) resulted from conditions not present at the time of admission.[22] The five leading causes of death in state prisons during these years were heart disease, cancer, liver disease, AIDS, and suicide.[22] Juvenile incarceration also predicts a range of adverse health outcomes in adulthood, including worse general health; suicidal thoughts, intentions, and behavior; substance abuse; greater physical and psychological limitations; and premature death.[23-27]

Longitudinal studies have documented strong, pervasive links between incarceration and multiple adverse health indicators across the lifespan, even after considering health before incarceration.[13,20,21]

Examining mortality among New York state adult parolees over a 10-year period, a 2015 study found that each year spent in prison corresponded with a two-year reduction in life expectancy.[28] In the two weeks following release from prison, the mortality rate of former inmates is approximately 13 times higher than that of the general population, primarily due to drug overdose.[29] Rates of suicide among those who are incarcerated are 60 percent higher than rates in the national population.[30]

Although incarceration has repeatedly been correlated with poor health outcomes, researchers face the challenge of distinguishing the effects of incarceration from the effects of cumulative health-damaging life experiences before incarceration. Adult and juvenile offenders—who are largely from marginalized communities that suffer high rates of disease and premature death[3]—enter correctional facilities with multiple health problems.[31,32] Few studies, moreover, have examined the direct health effects of the experience of incarceration itself and of conditions in different types of facilities (public prison, private prison, jail, or juvenile facilities). Despite these limitations, current scientific evidence documents profoundly harmful effects of both juvenile and adult incarceration on the health of inmates throughout their lives.[21,32]

 Copyright 2019 Robert Wood Johnson Foundation

Prison and jail conditions directly compromise inmate health in many ways.

How can the links between incarceration and poor health be explained, independent of the health damage that inmates are likely to have experienced before being incarcerated? U.S. prisons, jails, and juvenile correctional facilities are unhealthy environments, where inmates are exposed to a wide range of conditions that are detrimental to physical and mental health.[33,34] When inmates are released, their health can be further compromised by societal stigmatization and denial of opportunities for gainful employment, stable housing, education, and other conditions that promote good health.[23]

A 2015 study found that each year spent in prison corresponded with a two-year reduction in life expectancy.[28]

Because prisoners are more likely than never-incarcerated individuals to have experienced unhealthful living conditions prior to confinement, incarceration could, at least in theory, improve health for those confined. For example, correctional facilities can provide respite from toxic home and neighborhood environments, regular and healthy meals, reduced access to drugs and alcohol, and increased access to medical care and treatment for substance dependence.[3,21] Correctional facilities are the only places in the United States where health care is constitutionally mandated, thus presenting a unique opportunity for individuals to receive medical care that they might not receive otherwise. Quality of care varies considerably across facilities, however, and often fails—sometimes dramatically—to meet community standards of care.[33,35]

The increase in the size of the incarcerated population has resulted in a scarcity of medical staff and resources; substance abuse treatment in particular has consistently failed to meet demand.[33] In at least 35 states, inmates in state or county correctional facilities must make copayments—some as high as $100[36]—to access medical treatment. This can be a major deterrent to seeking care for inmates who typically earn $0–$4.90 per hour if they are actually able to secure employment while incarcerated.[37] In a 2017 survey of inmates across 83 prisons in 21 states, 63 percent of prisoners reported being denied needed health care and nearly 40 percent reported having to wait weeks or months to receive needed care.[38] For female prisoners, poor access to feminine hygiene products and pregnancy-related care can be significant threats to health equity, as can lack of staff who are trained to provide women-specific trauma treatment.[39]

Correctional environments are often so inherently unhealthy that even the most well-intended efforts to provide adequate health care are ineffective.[33] Factors contributing to unhealthy conditions include substandard meals; overcrowding; violence and sexual assault; and solitary confinement.

Within prisons, jails, and juvenile correctional facilities, living conditions are often inhumane and degrading. Prison meals often are unsanitary and nutritionally inadequate,[33] putting inmates at greater risk of food-borne illness,[40] unhealthy weight gain, and chronic diseases such as hypertension

and heart disease.[41] Many U.S. prisoners report having been denied meals or given too little food, being served food in containers labeled "not for human consumption," and/or being served moldy, spoiled, or insect-infested foods.[38]

High incarceration rates make overcrowding a pervasive problem that can affect every aspect of an inmate's life, greatly amplifying the stresses of confinement.[33] In 2016, the Federal Bureau of Prisons reported operating federal prisons at 114 percent of capacity overall.[1] That same year, 14 state prison systems and 17 percent of U.S. jails were operating at or over capacity.[1,2] Twenty percent of juvenile facilities were operating at or over capacity in 2014.[42] Many inmates are double- or triple-bunked in cells originally intended for one or in rooms designed to be common spaces. Overcrowding jeopardizes cleanliness and standards of hygiene, often compromising air quality and sanitation levels. The growing number of inmates has corresponded with longer waiting lists for educational, vocational, and drug abuse treatment programs and reduced recreational and work opportunities, contributing to greater inmate idleness and subsequent tension and violence.[43]

Correctional officers and guards are also at risk

The health and well-being of correctional officers and guards have been largely neglected in scientific circles and policy debates about mass incarceration. A new landmark report by researchers at the University of California, Berkeley confirms that correctional officers and guards are exposed frequently to violence and trauma that increase their risks of serious injury, post-traumatic stress disorder (PTSD), depression, and suicide.[55] Among a sample of over 8,000 guards and parole officers, half reported that they often feel in danger at work. Such work-related stress is accompanied by significant adverse health consequences, including headaches, digestive issues, high blood pressure, diabetes, and heart disease.[55] State-sponsored programs exist that are intended to improve the well-being of officers and guards, but are seldom used. Many correctional facility staff are concerned about negative repercussions from seeking such assistance.[55]

Violence and sexual assault are pervasive features of incarceration. In 2011 and 2012, 4 percent of all prison inmates and 3.2 percent of all jail inmates (totaling approximately 80,600 inmates nationwide) reported experiencing sexual victimization by either another inmate, staff, or both during the prior year.[44] Nearly 10 percent of youth in state juvenile correctional facilities in 2012 reported being sexually assaulted in the facility.[34] Female inmates and inmates with mental disorders are at particularly high risk of sexual assault.[45] Although there are no nationwide surveys measuring rates of physical violence in correctional facilities, research suggests it is common.[46] Examining the prevalence of inmate-on-inmate and staff-on-inmate physical victimization in 14 adult prisons over a six-month period, one study found that male and

Male and female prisoners are 18 and 27 times more likely to experience physical assault than males and females in the general population.[47]

Copyright 2019 Robert Wood Johnson Foundation

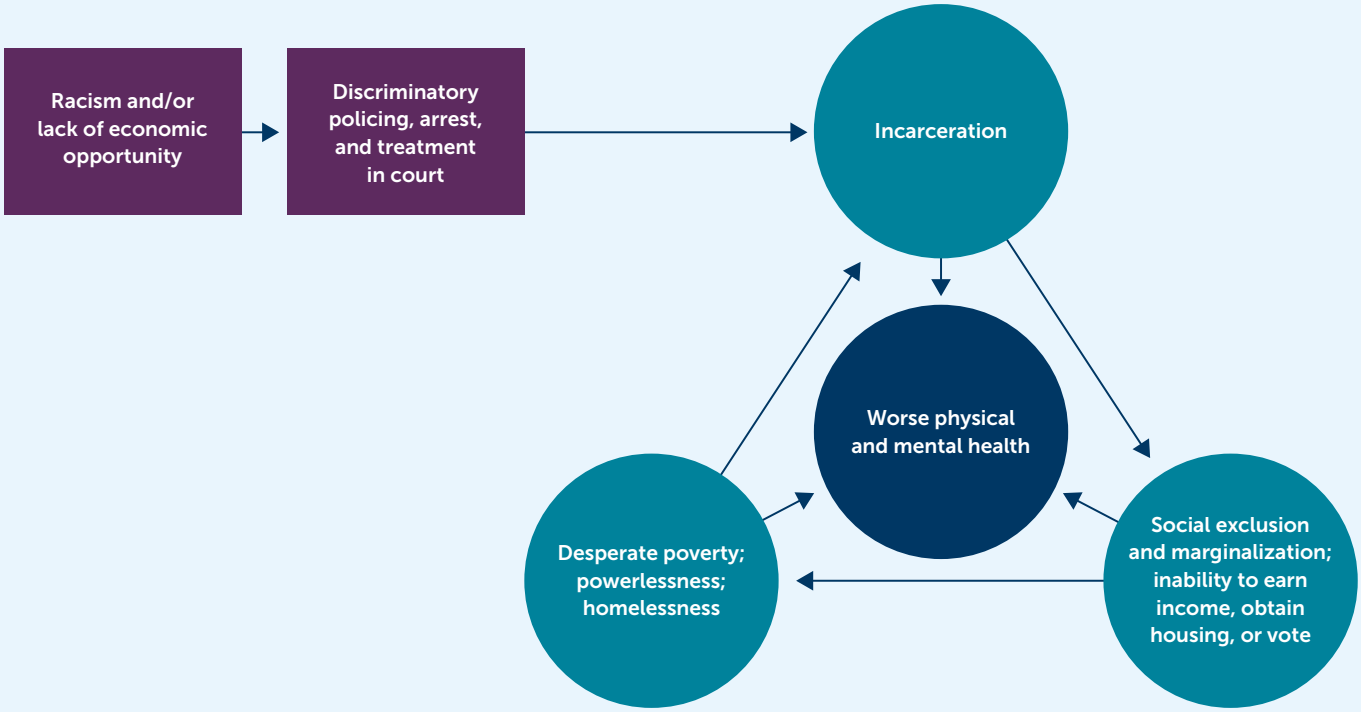
female prisoners are 18 and 27 times more likely to experience physical assault than males and females in the general population.[47] In a nationally representative survey of incarcerated youth, 43 percent of children in juvenile correctional facilities or camp programs "said they were somewhat or very afraid of being physically attacked, while 45 percent reported that staff use force when they don't need to."[34] Both violence and sexual assault are likely to be underreported. Fear of retaliation by other inmates and/or staff often discourages inmates from reporting instances of sexual and physical victimization to authorities.[46] By one estimate, only 8 percent of all prisoners who experience sexual assault report their victimization.[48]

Solitary confinement also presents a threat to inmate health. With overcrowding, correctional facilities have become increasingly reliant on solitary confinement as a form of inmate control and punishment. Solitary confinement refers to imprisonment in an isolated cell, often for 23 hours a day, with varying restrictions on exercise, showers, reading materials, food and toiletry purchases, visitation, interpersonal contact, and participation in educational and vocational activities offered to inmates.[49] Sometimes, solitary confinement is not a part of the sentencing of an offender sanctioned by a judge, but is applied as an administrative measure by prison officials in response to inmate infractions.[50] In Illinois, 85 percent of inmates who had been held in solitary confinement over a one-year period had been sent there for minor infractions such as using abusive language.[51] Inmates often are placed in solitary confinement for months or even years, with many county jurisdictions allowing prisoners to be confined in isolation indefinitely.[50]

Decades of research on solitary confinement have consistently documented its adverse psychological effects, including anxiety, insomnia, paranoia, hallucinations, cognitive dysfunction, aggression, loss of impulse and emotional control, self-harm, and suicide.[52] While no federal reporting system tracks how many inmates are isolated at a given time, one study estimated that, in the fall of 2014, between 80,000 and 100,000 prisoners were being held in isolation, not including persons confined in jails, juvenile facilities, or military and immigration detention centers.[49] Reports on individual facilities also reveal egregious overuse of juvenile solitary confinement, often without constitutionally-mandated due process protections.[34] In the Rikers Island correctional facility in New York City, for example, three-fourths of the 140 adolescents held in solitary confinement in July 2013 were mentally ill.[53] Along with extremely high rates of incarceration, the overuse and lack of regulation of solitary confinement makes the U.S. incarceration system particularly brutal and inhumane by international standards.[50] The United Nations Human Rights Committee, the Committee Against Torture, and the United Nations Special Rapporteur on Torture all have condemned solitary confinement practices in the United States, stating that "they may amount to cruel, inhumane or degrading treatment in violation of international human rights law."[54]

Along with extremely high rates of incarceration, the overuse and lack of regulation of solitary confinement makes the U.S. incarceration system particularly brutal and inhumane by international standards.[50]

Discrimination and Incarceration Trigger a Vicious Cycle that Threatens Health Equity



The diagram above demonstrates how racism and/or lack of economic opportunity can lead to prejudicial treatment in the justice system, which can trigger a vicious cycle that increases a person's risks of poor health in many ways. Discriminatory treatment by both the police and courts markedly heightens the likelihood of incarceration among people of color and poor people in all racial groups. Incarceration then leads to worse health through exposure to an array of unhealthy conditions both during incarceration (including overcrowding, violence, and poor sanitation) and after release (including social exclusion and marginalization, as reflected in barriers to employment and therefore earnings). Social exclusion and marginalization in turn lead to greater poverty, powerlessness, and homelessness, further exacerbating the risks of poor health.

This diagram is a simplified representation of a complex process. For example, racism, lack of economic opportunity, and prejudicial treatment by police in themselves can each lead to ill health—independent of whether incarceration occurs—such as when a person's ability to afford decent housing or healthy food is limited, or when use of excessive force by the police results in injury.

The health consequences of incarceration persist long after release.

The most serious health consequences of incarceration may not manifest until after release. Individuals treated for chronic health conditions while incarcerated often face obstacles to accessing care after leaving the justice system. Many are released without medications or scheduled follow-up appointments in the community, and many suffer from mental health or substance abuse problems that can prevent them from keeping up with treatment.[13] Only 19 percent of correctional facilities provide HIV-infected inmates with CDC-recommended discharge services, which include making an appointment with a community health provider, assisting with enrollment in Medicaid or the AIDS Drug Assistance Program, and providing a copy of the medical record and a supply of HIV medications.[56] During the first two weeks after release, former prisoners experience exceptionally high mortality rates, particularly from drug overdose, cardiovascular disease, homicide, and suicide.[57,58]

The stigma associated with having a criminal record can permanently diminish a person's employment and housing opportunities. Only 55 percent of former prisoners have any earnings during the first year after release, and those who find employment often are relegated to low-wage jobs with poor benefits and no health insurance.[11] Precarious employment or low income hinders an individual's ability to afford rent, health insurance, medical care, healthy food, and basic utilities such as heat and electricity—all of which can adversely affect health. Individuals facing housing instability or outright homelessness are at increased risk of adverse health consequences including illnesses due to, or aggravated by, exposure to inclement weather and/or violence. Exposures to health-harming conditions are further exacerbated in many states where former inmates are denied educational loans, government-subsidized housing, food stamps, and other social services.[13,23]

For juveniles, even short periods of incarceration can have severe long-term consequences. Youths who have experienced confinement are less likely to return to school in the future; many who do resume their schooling are classified as having a disability due to a behavioral or social disorder, which reduces the likelihood that they will graduate.[59] Holding other variables constant, being arrested between ages 13 and 15 lowers a person's chances of enrolling in college by 35 percent and increases his or her chances of being on welfare at ages 18 to 20 by 14 percent.[60]

The limits and barriers faced by individuals following incarceration can create cycles of offending and reoffending, in which former inmates too often become career offenders with limited opportunities outside of crime. In three national studies examining recidivism during the 1980s to 2000s, nearly two-thirds of ex-prisoners were rearrested within three years after release.[61] Among youth who have been released from detention centers, approximately 70 to 80 percent are rearrested within two or three years.[62]

The limits and barriers faced by individuals following incarceration can create cycles of offending and reoffending, in which former inmates too often become career offenders with limited opportunities outside of crime.

Mass incarceration harms the health of families, communities, and the nation.

A household member's incarceration can have drastic consequences for a family's health and well-being. The majority of incarcerated parents were their households' primary earners prior to sentencing but are unable to provide economic support to their children and partners while serving time in prison or jail.[12] Incarceration of a family member thus reduces a household's economic resources while at the same time increasing household expenses due, for example, to legal fees and the costs of phone calls and visits to correctional facilities.[63] As a result, families with an incarcerated family member are significantly more likely to live in poverty[64] and experience homelessness[65] than other families, diminishing their chances for economic mobility and good health. Additionally, among women the stress of having an incarcerated partner is associated with a higher risk of mental disorders and physical health problems.[63,66] The high incarceration-related likelihood of relationship dissolution or divorce can further increase the risks of family instability and child neglect.[63,66]

A rich body of longitudinal and other studies has documented numerous adverse effects of parental incarceration on children, independent of many other factors known to influence outcomes.

The relationship between a parent and child can suffer significantly as a result of parental incarceration. The loss of care, companionship, nurturance, and stability can create chronic stress for the child.[i] A rich body of longitudinal and other studies has documented numerous adverse effects of parental incarceration on children, independent of many other factors known to influence outcomes. For example, paternal incarceration is associated with significant increases in aggressive behaviors and attention deficits in early childhood.[67] Having an incarcerated father predicts poorer educational outcomes and lower likelihood of college enrollment, while research on the effect of maternal incarceration on children's educational outcomes is inconclusive.[12,68] When mothers are incarcerated, children often are placed in the foster-care system,[69] creating significant disruption that may adversely affect children's development and lifelong health.[70] Parental incarceration in childhood increases children's risk of drug abuse, criminality, and delinquency as they mature[68] and predicts a wide range of health problems—including poor self-rated health, HIV/AIDS, asthma, high cholesterol, migraines, depression, PTSD, and anxiety—during young adulthood.[71] Children of incarcerated parents are also far more likely than other children to be incarcerated themselves as juveniles and later in life.[72]

Not only are families affected, but whole communities can suffer when rates of incarceration are high. For example, the perpetual cycling of people with high rates of communicable diseases between correctional facilities and the community poses significant public health risks. The justice system's failure to

[1] The effects of chronic stress in childhood on lifelong health are discussed in another RWJF report, Early Childhood is Critical for Health Equity.

 Copyright 2019 Robert Wood Johnson Foundation

ensure continuity of medical care for released inmates encourages the spread of HIV, hepatitis C, tuberculosis, and other infectious diseases.[13] The removal of high numbers of men in their 20s, 30s, and 40s can cripple economic mobility in neighborhoods already fraught with concentrated poverty.[73] Taking into account individual- and other neighborhood-level risk factors, neighborhoods with high incarceration rates have been shown to have higher than predicted rates of psychiatric disorders; the association between neighborhood levels of incarceration and mental illness have been observed both for individuals who have been incarcerated and for those who have not.[74]

Incarceration rates in a neighborhood can have significant political implications. Inmates from urban neighborhoods who are incarcerated in rural areas are classified as residents of the county in which they are incarcerated[75]—a system that can significantly reduce the census in inner-city neighborhoods. By reallocating public investment and political representation from inner-city communities of color to small rural towns, this shift in population numbers can have the effect of depriving impoverished urban communities of federal subsidies and the ability to elect politicians that serve their best interests.

Local, state, and federal governments spend approximately $180 billion each year on corrections, policing, and criminal court systems.[15]

Mass incarceration consumes large portions of government budgets, with local, state, and federal governments spending approximately $180 billion each year on corrections, policing, and criminal court systems.[15] As discussed earlier, current and formerly incarcerated individuals, their families, and their communities generally are sicker and financially worse off than the rest of the population. This situation strains our nation's health care resources, diverting social and financial capital from investments in education and economic development to issues that could be prevented with a justice system focused less on excessive punishment and more on rehabilitation and providing healthful conditions. The massive growth in the number of incarcerated persons has significantly reduced the number of Americans who can actively participate in civic life by voting and serving on juries; approximately 1 in 40 adults currently is politically disenfranchised because of a criminal conviction—a statistic that includes individuals who have completed their sentences and those on probation or parole.[3] Furthermore, people under correctional supervision of any kind are excluded from most major population surveys of key social indicators—such as unemployment, educational attainment, income inequality, morbidity, and mortality—that governments routinely use to identify unmet need, allocate resources, and frame social policy. This means that population surveys for 2016 excluded more than 2.2 million individuals who were incarcerated[1,2] and approximately 4.7 million individuals who were on probation or parole.[19] Reported indicators therefore underestimate the true extent of racial and social inequality in this country.[76]

Marginalized Groups Are Disproportionately Incarcerated

Incarceration is strongly linked to social disadvantage.
Findings from a wide array of sources document the strong links between incarceration and many measures of social disadvantage. Research shows that before becoming incarcerated, incarcerated men and women, respectively, were 2.5 and 1.5 times as likely as non-incarcerated men and women of similar ages to have lived in poverty.[8] From 1999 to 2014, during the three years before becoming incarcerated, only 49 percent of male inmates ages 18 to 64 were employed and only 13 percent had incomes above $15,000.[11] In 2003, a Department of Justice report revealed the vast majority of prisoners had not completed high school.[77] There have been no nationwide studies on the educational backgrounds of prisoners since then, but recent state-level data show most prisoners in Georgia and Minnesota state-run facilities do not have a high school diploma.[78,79]

People of color make up the majority of the incarcerated population. Black and Latino adults, respectively, are 5.9 and 3.1 times more likely to be imprisoned than their white counterparts;[1] in some states, the black-white disparity is more than 10 to 1.[80] Young black men, especially those with little education, are the most affected: Among black men born between 1965 and 1969 who did not complete high school, 57 percent experienced incarceration by their 30s.[81] In 2015, 10 percent of black children, 3.6 percent of Latino children, and 1.7 percent of white children had a parent behind bars.[82]

Among black men born between 1965 and 1969 who did not complete high school, 57 percent experienced incarceration by their 30s.[81]

American Indian persons also are strikingly overrepresented in the justice system, especially in states with large American Indian populations. In 2010, American Indians represented 22 and 29 percent of the incarcerated populations in Montana and North Dakota, respectively, though they only accounted for 6 and 5 percent of the overall populations in those states that year.[83,84]

While rates of juvenile incarceration have declined in the United States (by 54% overall from 2001 to 2015),[5] greater declines in incarceration rates among white youths relative to youths of color have led to racial and ethnic disparities that are wider today than two decades ago. Black, American Indian, and Latino youth, respectively, are approximately 5,[85] 3,[86] and 1.65[87] times as likely as white youth to be incarcerated.

The dramatic increase in the incarcerated population from 1980 to 2008 was accompanied by an upward shift in the age composition of incarcerated persons. From 1974 to 2013, the percentage of state prison inmates age 40 or older increased from 16 to 40 percent, while the median age of state prisoners

 Copyright 2019 Robert Wood Johnson Foundation

rose from 27 to 36 years old.[88,89] This shift largely reflects the proportion of incarcerated individuals who are aging while in prison. Admissions to prison, however, are highly concentrated among people under age 30.[90]

Men are more likely than women to be incarcerated, but rates of incarceration among women are increasing.

At the end of 2016, 93 and 85 percent of the U.S. prison and jail populations, respectively, were men.[1,2] Research shows that when men and women are arrested for the same federal crime, men are significantly more likely to be charged and convicted. On average, men receive 63 percent longer sentences than women convicted for the same crime.[91] At the same time, the number of incarcerated women has increased while the number of men behind bars has decreased; nearly 110,000 women were in jail during 2014 compared with fewer than 8,000 in 1970.[92]

Incarceration rates are also higher among persons with existing health problems and disabilities.

As mentioned earlier, incarcerated adults and juveniles are predominantly from poor, medically-underserved communities[3] where residents are more likely to be exposed both to harmful environmental toxins in their homes and neighborhoods and to greater levels of drug use and trafficking. At the same time, residents of these communities are far less likely to have access to needed health care and/or rehabilitation services. Poor health and minimal, low-quality, or nonexistent medical care all increase a person's likelihood of arrest and incarceration.[31,32] Given the starkly inadequate medical and substance abuse treatment available in most prisons and jails, inmates' health problems are likely to worsen during incarceration and after release.[3]

Persons with disabilities also represent a large proportion of incarcerated individuals; people with disabilities are 3 and 4 times as likely as non-disabled people to end up in prison and jail, respectively.[93] The Center for American Progress calls the incarceration of persons with disabilities "unjust, unethical, and cruel" as well as economically foolish, given that providing community-based prevention and treatment is far less costly than holding an individual in confinement.[93]

Many people are incarcerated because they cannot afford bail or court fees.

Nationally, 65 percent of jail inmates have not yet been convicted of a crime[2] but are detained as they await trial—often because they cannot afford cash bail; in 2015, the median cash bail set nationwide was $10,000.[94] Additionally, many people are incarcerated because they cannot afford court-imposed fees, fines, or restitution that often are mandatory regardless of a defendant's economic status. In felony cases, legal financial obligations average $2,540, and this amount can increase rapidly due to high statutorily-mandated interest

rates when defendants cannot pay their fees at once.[95] Many states also charge additional late fees and payment plan fees when defendants do not pay their debts in a lump sum.[96] Although debtors' prisons have been illegal in the United States since 1833, thousands of Americans continue to be arrested and jailed each year because they owe consumer debts—such as utility bills, medical bills, and student loans—that may be as low as a couple of dollars.[97]

People with disabilities are 3 and 4 times as likely as non-disabled people to end up in prison and jail, respectively.[93]

Most incarcerations are for non-violent crimes.

Approximately 60 percent of incarcerated individuals are jailed or imprisoned for a non-violent offense such as theft, drug possession, drug trafficking, or driving under the influence.[98] Drug offenses account for 20 percent of total jail and prison sentences[98] and over 25 percent of sentences served by parents.[12] In 2016, over 74 percent of convicted drug trafficking offenders were black or Latino,[99] although, on average, individuals in these groups use, buy, and sell drugs at similar rates as whites.[3] Nearly 23 percent of confined youth are incarcerated for a technical violation or status offense such as violating curfew, not reporting to their probation officer, or failing to follow through with referrals.[98]

Detention of Immigrants and their Children is a Threat to Health Equity

The United States maintains the largest immigration detention system worldwide, with approximately 400,000 immigrants incarcerated each year.[100] The annual U.S. Immigration and Customs Enforcement (ICE) budget has increased steadily almost every year since 2005 and currently totals $7.6 billion.[101] Over the years, ICE has increased its reliance on private for-profit prisons to manage immigrant detention; the detention of migrant children alone has produced $1 billion annually in profit for firms that have contracts to incarcerate immigrants.[102] ICE is the only U.S. law enforcement agency with a minimum statutory quota—currently set to 34,000 daily—on the number of individuals to incarcerate.[103]

In an effort to deter undocumented individuals from crossing the southern border, President Trump's administration recently separated over 2,000 immigrant parents and children and deported hundreds of parents without their children. The vast majority (88%) of detained immigrant families from Central America "have demonstrated to a Department of Homeland Security asylum officer that they have a credible fear of persecution if deported."[104] These families have not violated any laws.[105] In fact, international laws—to which the United States is a signatory—stipulate that people seeking asylum from persecution must be given the opportunity to make their case. They should not be treated as criminals when seeking refuge from one of the world's most dangerous regions where children and adults are often physically abused, raped, and murdered; perpetrators are not prosecuted; and no place is safe.[104] Family separation has not proven to substantially reduce immigration at the southern border or make America safer.[105] It has, however, caused thousands of innocent children and their parents to suffer extreme psychological trauma that will likely dramatically damage their health for many years to come.[106]

Inequitable Policies and Practices Drive Dramatic Disparities in Incarceration

The unprecedented growth in the U.S. incarcerated population since the 1980s primarily reflects the emergence of policies from the 1970s to the 1990s mandating more severe sentencing for lesser crimes, longer minimum sentences for violent crimes and minor repeat offenses, and harsher policing of drug crimes, particularly street trafficking in urban areas. Even while crime rates remained stable or declined from the 1970s to the early 2000s, many new prisons and jails were built and anti-crime policies became increasingly severe.[3] Such policies have contributed to high rates of incarceration among black Americans in particular, and have both created and perpetuated significant public health problems in our nation's most vulnerable communities.

Even while crime rates remained stable or declined from the 1970s to the early 2000s, many new prisons and jails were built and anti-crime policies became increasingly severe.[3]

Beginning in the 1960s, the federal government began closing in-patient mental health facilities and releasing patients to the community without adequate supports in place. Funding was inadequate for providing comprehensive treatment programs, including for severely mentally ill persons who required 24-hour in-patient care. The lack of adequate treatment, rehabilitative services, and supportive housing arrangements for mental health patients led to significant increases in homelessness and the shunting of people with psychiatric illnesses into the justice system.[107,108]

The baby boom from the end of World War II to 1960 and resulting increase in the youth population during the 1960s corresponded with a sharp rise in crime that was consistent with population growth.[109,110] Another key development during this period was the passage of the Civil Rights Act of 1964, which marked the end of the era of Jim Crow laws that systematically and explicitly supported racial segregation and discrimination. Civil rights protests and public disorder were linked together by some politicians,[111,112] as reflected in the "law and order" emphasis of President Nixon's 1969 presidential campaign. The media popularized the term "War on Drugs" shortly after a press conference given by Nixon on June 18, 1971—the day after he declared drug abuse to be "public enemy number one" in a special message to Congress. Increasing racial tensions and intolerance of drug crime contributed to expanded enforcement within impoverished black communities, where crack cocaine use was more common than in white communities.[113] In 1982, President Reagan announced his own administration's War on Drugs, which led to markedly increased funding of federal law enforcement agencies. At the same time, the Reagan administration gave lower priority to public health initiatives, including drug treatment, rehabilitation, prevention, and education.[114] The Anti-Drug Abuse Act of 1986 imposed mandatory minimum sentences for the trafficking of cocaine, with far harsher punishment for crack (used more often by blacks) than powder cocaine (used more often by whites).[113]

 Copyright 2019 Robert Wood Johnson Foundation

The explosive growth of the incarcerated population in the 1980s led to other changes as well, notably the advent and dramatic expansion of private for-profit prisons.[115] This allowed accommodation of substantially greater numbers of prisoners and introduced monetary incentives for these for-profit companies to incarcerate large numbers of prisoners while spending as little as possible.[115] Flawed program evaluations led to the conclusion that within-prison rehabilitation efforts were ineffective.[116] In fact, the Supreme Court once ruled to end rehabilitation programs completely. In the 1989 case Mistretta v. United States, judges decided: "Defendants will henceforth be sentenced strictly for the crime, with no recognition given to such factors as amenability to treatment, personal and family history, previous efforts to rehabilitate oneself, or possible alternatives to prison."[117] This belief was shared widely by both Democratic and Republican leaders at the time.[116]

By 1991, the U.S. incarcerated population reached numbers that were unprecedented in world history, and 1 in 4 young black men was incarcerated or otherwise involved in the justice system (for example, was arrested or on trial).[118] In 1994, President Clinton signed a law that included a federal three-strikes provision that mandated life sentences for offenders convicted of a violent crime after two or more prior convictions, one of which could be a non-violent crime such as a drug offense. Growing support for more aggressive policing of lower-level crimes also proliferated during this time. For example, in the 1990s under Mayor Giuliani, the New York City Police Department (NYPD) adopted an aggressive strategy known as "stop and frisk" in which police stop, detain, question, and search civilians on the streets for weapons, drugs, and other contraband, often without any evidence of criminal activity. From 2002 to 2014, the NYPD stopped and frisked five million New Yorkers; 88 to 91 percent of the people stopped were people of color, and 82 to 90 percent of the people stopped had committed no offense.[119] While intended to reduce major crime by targeting minor offenses, in practice "stop and frisk" has operated as a racial profiling practice that increases the likelihood of incarceration for African Americans and Latinos.[120]

Decades of tough-on-minor-crime policing and sentencing produced the cumulative effect of massively increasing the rates of incarceration among residents of poor communities of color.[7] Whether these policies were motivated by any deliberate racial targeting remains debated, but it is undisputed that they created enormous disruptions within communities and further exacerbated the negative effects of mass incarceration for often-minor crimes.[119-121]

Black Americans continue to be unfairly targeted and racially profiled, especially for minor crimes. On average, black and Latino suspects are 30 percent more likely to be arrested than white suspects, regardless of other factors known to influence police officers' decisions to arrest.[122] Taking into account both

From 2002 to 2014, the NYPD stopped and frisked five million New Yorkers; 88 to 91 percent of the people stopped were people of color, and 82 to 90 percent of the people stopped had committed no offense.[119]

Policies that may not have been consciously race-driven in their intent have in practice resulted in the disproportionate incarceration of people of color.

criminal history and the nature of the arrest charges, black people also are significantly more likely than white people to receive a prison sentence rather than a drug treatment referral for drug-related crimes.[123]

Over the last two decades, "zero tolerance" policies for misbehavior in public schools have resulted in an alarming number of suspensions, expulsions, and youth arrests for non-violent disruptive behavior that schools previously considered routine and managed internally.[124] Lacking resources and teachers with specific training to maintain discipline, many schools—primarily those that serve children of color—have become increasingly reliant on metal detectors, surveillance cameras, and police officers to patrol school hallways. This shift has effectively turned many schools into prison-like security environments that can further promote problematic behavior and disengagement from school.[125] Black children are significantly more likely to be disciplined than other children, despite the lack of conclusive evidence that they misbehave at higher rates.[126] Nationwide between 2011 and 2012, black students accounted for 31 percent of all in-school arrests but only 16 percent of school enrollment.[127] The phrase "school-to-prison pipeline" was coined to reflect this phenomenon, which condemns many children of color to years, or even their entire lives, behind bars for behavioral issues—often arising from traumatic experiences—that could be better addressed through supportive social and mental health services rather than punishment.

What Can Be Done to End the Vicious Cycle?

The Eighth Amendment to the United States Constitution prohibits the federal government from imposing excessive bail, excessive fines, or cruel and unusual punishments. Americans deserve an equitable justice system that deters crime, protects public safety, rehabilitates offenders, and treats people fairly. The evidence shows that our current system of mass incarceration generates questionable benefits for public safety[7] while wasting immense levels of government resources[15] and producing serious negative health effects for incarcerated persons, their families and communities, and the nation as a whole.[3,13,21] There are, however, reasons to be optimistic that our current justice system can be reformed, with corresponding reductions in health inequities, given an emerging consensus across the political spectrum that the justice system should be fundamentally altered.[128] Numerous bipartisan efforts (described below) are underway to reduce our nation's incarceration rates. Not surprisingly, however, the issues are complex and multifactorial, requiring multiple strategies at the local, state, and federal levels.[129] Some reforms have already reduced incarceration and crime rates simultaneously, but further steps are needed. The following section provides an overview of some key approaches that have been pursued or suggested to end mass incarceration and thereby achieve a more equitable and healthier society.

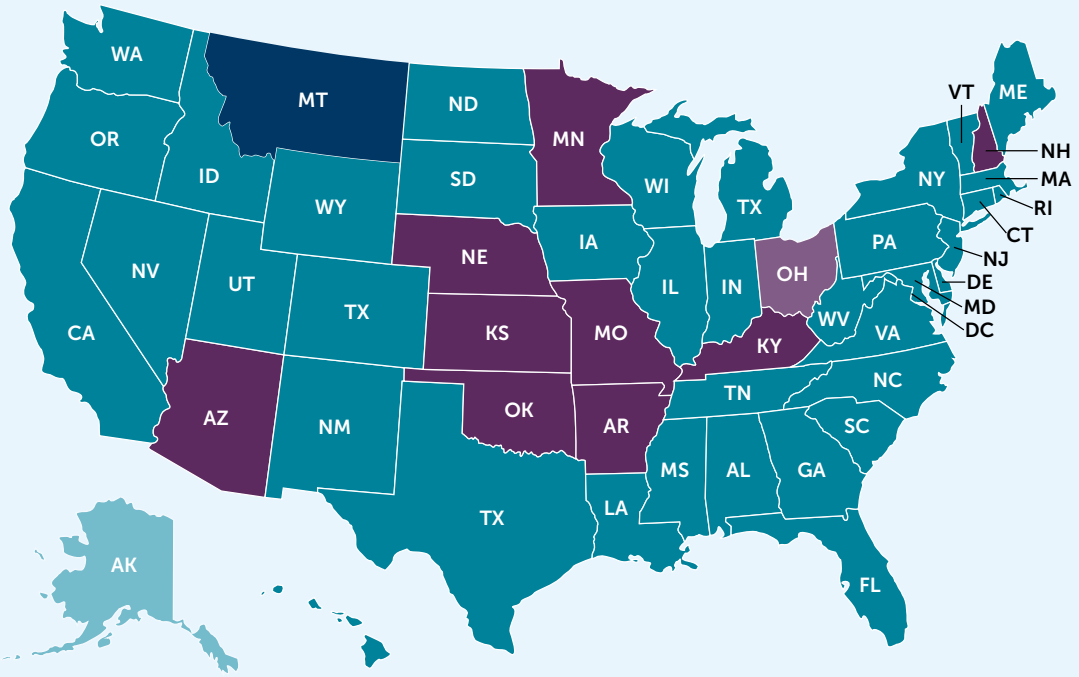
To advance equity, many states are reducing their incarceration rates while improving public safety and minimizing costs.

Since 2007, at least 33 states have passed laws—often unanimously—intended to simultaneously reduce incarceration, control justice system costs, and improve public safety. Such reforms have included "reducing lengthy prison sentences, eliminating mandatory minimum sentences, expanding parole eligibility, establishing and strengthening diversion programs, and investing the savings in evidence-based prison alternatives that can help break the cycle of recidivism."[130] Some states and local jurisdictions have developed promising alternatives to incarceration for non-violent offenders who do not pose a threat to community safety. Most alternative programs include mental health and/or substance abuse treatment services and require counseling, community supervision, and community service.[131] Many of these programs, particularly those designed for mentally ill offenders, have been shown to produce long-term cost savings and improvements in recidivism.[132] As of 2015, eleven states enacted broad juvenile justice reforms intended to divert low-risk youth offenders from the system and increase investment in evidence-based alternatives.[133] Most states that have decreased their incarcerated populations have experienced concurrent declines in crime. On average, from 2010 to 2015, crime rates decreased more in the 10 states with the greatest declines in incarceration rates than in the 10 states with the largest increases.[134]

Strategies to End Mass Incarceration and its Harmful Effects on Health

- Reduce excessively long sentences and eliminate mandatory minimum sentences.
- Invest in alternatives to incarceration, including diversion programs for adults and youths.
- Stop incarcerating people for inability to pay cash bail and court-imposed fines and fees.
- Address discriminatory policing through training and monitoring.
- Eliminate private prisons.
- Invest in inmate rehabilitation and community reintegration programs.
- Ensure access to high-quality healthcare, drug treatment, and education, including while confined.
- Address the overuse of solitary confinement.
- Implement policies that show promise for reducing poverty and eliminating racial discrimination.
- Invest in programs and services for children with incarcerated parents.

Since 2007, More Than 30 States Have Reduced Both Incarceration and Crime



State imprisonment and crime rates, 2007–2016[135]

- Imprisonment down, crime down
- Imprisonment up, crime down
- Imprisonment up, crime up
- Imprisonment unchanged, crime up
- Imprisonment unchanged, crime down
- Imprisonment down, crime up

Data source: Gelb A, Denney J. National Prison Rate Continues to Decline Amid Sentencing, Re-Entry Reforms. Philadelphia, PA: Pew Charitable Trusts; 2018.

States, counties, and nongovernmental organizations are leading efforts to eliminate inequitable fees, fines, and bail.

The American Bar Association (ABA) recently adopted a set of guidelines for legislative, judicial, and other government entities at the federal, state, local, territorial, and tribal levels to avoid incarcerating people for inability to pay court-imposed fines and fees.[136] The guidelines urge jurisdictions to limit fees to what an individual is able to pay and waive fines completely when payment would cause a significant hardship. They also state that courts should hold "ability-to-pay" hearings before imposing sanctions for nonpayment, and that incarceration, deprivation of fundamental rights (such as revoking the right to vote), or other disproportionate sanctions (such as suspending a driver's

Most states that have decreased their incarcerated populations have experienced concurrent declines in crime. On average, from 2010 to 2015, crime rates decreased more in the 10 states with the greatest declines in incarceration rates than in the 10 states with the largest increases. [134]

license) should never result from inability to pay a fine, fee, or restitution. The ABA also calls for making fine and fee information publicly available and monitoring collection agencies' compliance with ABA guidelines.[ii]

The Vera Institute of Justice called 2017 a "breakthrough year for bail reform."[94] **The Bronx Freedom Fund** and other nonprofits have established over thirty charitable bail funds that, in 2017 alone, paid bail for 2,000 individuals who could not afford it.[94] Several bail funds employ the **Revolving Bail Fund Model**, which recycles refunded bail money to cover other people's bail. This makes it possible for offenders and innocent persons to avoid pleading guilty simply because they cannot afford bail.[137] New Jersey implemented a new bail system that requires judges to conduct risk assessments and consider nonfinancial conditions of release before permitting the use of cash bail as a last resort. Since its implementation, New Jersey's pretrial jail population has dropped over 16 percent. Risk assessments, however, may be based on criteria such as income, education, and employment, which would tend to discriminate against low-income people, especially low-income people of color.[138] Many other states and local jurisdictions have passed similar legislation limiting cash bail amounts and eliminating bail for some nonviolent and misdemeanor-level offenses (an approach that has been criticized, however, when pretrial detention is mandatory for those who do not qualify for exemption from bail).[139]

Jurisdictions across the United States are implementing approaches to build more trusting police-community relationships and minimize use of force in police-civilian interactions.

Local governments are taking steps to prevent unnecessary arrests.

Another potential strategy to reduce the incarceration rate is to combat our country's legacy of discriminatory and excessively aggressive policing practices in communities of color. In an effort to improve public safety, decrease unnecessary arrests, and end police brutality, jurisdictions across the United States are implementing approaches to build more trusting police-community relationships and minimize use of force in police-civilian interactions. Such programs train officers on relationship-based policing, procedural justice, appropriate use of force, and crisis intervention for the mentally ill; provide cultural competency and language instruction to officers working in immigrant communities; and promote constructive dialogue between community members and law enforcement in multiple ways.[140] Many police departments now also require use of body-worn cameras that record encounters with civilians; regularly report use-of-force incidents; and follow strict investigation, discipline, and accountability procedures.[141] Such policies—which typically resulted from community pressure following several high-profile incidents in which excessive force by police caused fatalities or serious injuries in communities of color—have not been used long enough or implemented widely enough to gather sufficient evidence of effectiveness.

ii The ABA's full set of guidelines on court fines and fees is available here.

Some reforms are achieving more humane, rehabilitative conditions of confinement.

For the estimated 2.2 million adults[1,2] and more than 45,000 youths[5] currently behind bars, the conditions of incarceration should be humane and rehabilitative and must not pose significant health risks to inmates. Unfortunately, the reality of mass incarceration is that efforts for rehabilitation often are neutralized by the unhealthy conditions of U.S. correctional facilities discussed earlier.[33] A systematic review of randomized studies across the globe identified 59 interventions in prisons, jails, juvenile facilities, forensic psychiatry hospitals, and/or communities associated with improvement in one or more health outcomes during incarceration and the year after release.[142] Successful interventions took place across several states and countries, and varied by the population served (for example, persons with chronic medical conditions or substance use disorders). The review stated that the number of randomized studies focused on current and former inmates is small relative to their high rates of disease.[142]

State legal services organizations such as **California's Legal Services for Prisoners with Children** and the **Texas Civil Rights Project** can help people receive appropriate medical and psychiatric care while incarcerated. In 1995, the World Health Organization began its **Health in Prisons Programme**, which works to ensure prisons "operate within the widely recognized international codes of human rights and medical ethics in providing services for prisoners."[143] The program is known for its focus on the integration of public health and prison health care, rehabilitation, and infectious disease prevention.

A landmark Supreme Court decision in 2011 ruled that overcrowding in California's prison system violated inmates' Eighth Amendment rights and ordered the state to reduce its prison population from the previous level of nearly 200 percent of capacity to 137.5 percent of capacity within two years.[144] Washington state has piloted the **Prison Violence Intervention**, which engages prison staff, former inmates, current inmates, and inmates' families in activities designed to enhance safety and create optimal conditions for treatment, rehabilitation, and successful reentry.[145]

The National Research Council recommends that use of solitary confinement be minimized (and prohibited for certain vulnerable populations, including inmates with mental illnesses); that criteria for solitary confinement be more strict; and that solitary confinement be reviewed regularly to ensure that those confined are returned promptly to regular cells.[146] **The American Public Health Association** has urged correctional facilities to "eliminate solitary confinement for security purposes unless no other less restrictive option is available to manage a current, serious, and ongoing threat to the safety of others," and has recommended eliminating the use of solitary confinement as a

The pension boards of New York City and Philadelphia voted in 2017 to divest from private prisons, and New York has become the first state to withdraw its stocks completely.[149]

punitive measure.[147] Solitary confinement of youth in the federal prison system was banned in 2016, and ten states have enacted legislation to limit or prohibit the use of solitary confinement in juvenile detention centers.[148]

Local governments are reducing reliance on private for-profit prisons.

Growing recognition of the high costs, substandard conditions, and safety and security problems of private prisons has led to efforts to reduce reliance on private for-profit prisons. President Obama's administration began phasing out the use of private contractors to run federal prisons in 2016, but U.S. Attorney General Sessions reversed the order the following year. Local governments, however, have continued to withdraw their investments in the private prison industry. The pension boards of New York City and Philadelphia voted in 2017 to divest from private prisons, and New York has become the first state to withdraw its stocks completely.[149]

The United States can learn from other countries that use far less punitive and dehumanizing approaches to incarceration with far better outcomes.

Correctional facilities are replicating model efforts to reshape incarceration.

The United States can learn from other countries that use far less punitive and dehumanizing approaches to incarceration with far better outcomes. In Germany and the Netherlands, for example, retribution and incapacitation are not the primary goal of incarceration; rather, the incarceration systems in those countries are "organized around the central tenets of resocialization and rehabilitation."[150] In the United States, incarceration is a deeply dehumanizing and traumatizing experience, and too many offenders return to being confined.[61] We need to fundamentally redesign the system by considering why we lock people up and how their experiences while incarcerated will affect them after they are released. Connecticut's Cheshire Correctional Institute is piloting "**T.R.U.E.**"—an innovative program for male inmates ages 18 to 25 that uses mentorship, conflict resolution and personal development training, and therapeutic conditions to promote success after release.[151] Missouri's approach to juvenile incarceration, which has moved away from prison-like facilities in favor of smaller facilities offering comprehensive individualized treatment regimens, has long been considered an excellent model but has not been widely replicated.[152]

Policies and programs are helping inmates transition successfully back into society.

An equitable justice system would make it possible for released inmates to become productive members of society with meaningful employment, family involvement, community ties, and good overall health. Relapsing into repeat offending often happens because a released prisoner cannot meet life's basic requirements—such as employment, a livable income, and stable housing. Addressing this requires high-quality transition programs, effective social policies to enhance access to services, and coordination across programs and services.

Maryland's Montgomery County Pre-Release Center is a good example of a comprehensive, government-run transitional facility that has reduced both recidivism and justice system costs.[61] The center provides eligible soon-to-be released inmates with "structured, community-based, residential and non-residential alternatives to secure confinement, in which they engage in work, treatment, education, family involvement and other supportive programming and services to prepare them for release."[153] There are several high-quality government- and nonprofit-run reentry programs in operation throughout the country; programs that have been evaluated for effectiveness are featured on the website What Works in Reentry Clearinghouse maintained by the Council of State Governments.

Recognizing the limits and barriers posed by a past criminal conviction, several public housing authorities across the country have implemented policy changes and reentry programs to promote housing stability for former inmates and their families. In 2016, for example, the **Housing Authority of New Orleans (HANO**) revised their criminal background screening policy to assess applicants and their crimes more holistically.[154] **Public Housing Authority Reentry Programs** partner with corrections, social services, and other community agencies. For example, **Burlington's Offender Re-Entry Housing Program**, funded by the Vermont Department of Corrections, provides housing and referrals to behavioral counseling, substance abuse treatment, and Social Security representatives, and works closely with vocational service organizations and community justice centers to offer former inmates job search assistance and supplemental case management services.[155]

Receiving education while incarcerated reduces the odds of recidivism and increases the odds of obtaining a job after release by 43 and 13 percent, respectively, and every dollar invested in correctional education saves $4–$5 in re-incarceration costs.[156]

To ensure that inmates are equipped with the skills they need to obtain employment upon release, it is important that they receive **adequate educational and vocational training while incarcerated**. A 2013 RAND Corporation study concluded that receiving education while incarcerated (including adult basic education, GED, postsecondary, and vocational programs) reduces the odds of recidivism and increases the odds of obtaining a job after release by 43 and 13 percent, respectively, and that every dollar invested in correctional education saves $4–$5 in re-incarceration costs.[156] While most states offer inmates adult basic education, GED, and vocational programs, college is available to inmates in only 32 states. In 28 of these states, inmates and/or their families must pay to participate in post-secondary education classes.[157] Pell grants—federal subsidies that cover the costs of higher education for low-income students—were available to prisoners until Congress banned inmates from the program in 1994. In 2015, the Obama administration initiated the **Second Chance Pell Pilot Program** for state and federal prisoners. There are approximately 4,000 inmates currently enrolled in Pell-funded programs, but the future of the program, which must be renewed every year, is uncertain under the Trump administration.[158] A critical first step would be to overturn the ban on Pell grants for inmates.

Copyright 2019 Robert Wood Johnson Foundation

Better Futures Minnesota is a non-profit organization dedicated to helping formerly incarcerated men reach self-sufficiency and create better futures for themselves and their communities. The program provides job preparation and aims to improve men's confidence in their ability to achieve career success. At this point, less than 15 percent of Better Futures participants have returned to prison within a year after release.[159]

For people living with HIV, there are several models designed to improve linkage to care after release from prison or jail. Unfortunately, however, most models have not been widely replicated despite producing positive results in research studies. One example is the **Corrections Demonstration Project**, implemented by the Health Resources and Services Administration and the Centers for Disease Control and Prevention from 1999 to 2004. The project funded seven state health departments to connect correctional and community health efforts—such as HIV screening, health education, counseling, and primary care—to social services.[160]

By limiting incentives to relapse into offending and by creating alternatives, policies to reduce barriers to employment for former inmates may help to end cycles of recidivism and thus enhance public safety.[161] As of 2018, 32 states and over 150 local jurisdictions have embraced **"ban the box" and/or "fair chance" policies** that remove conviction history questions from job applications and delay background checks until later in the recruitment process. **The Work Opportunity Tax Credit (WOTC)**, created in 1996, is a federal tax credit for employers who hire people from groups facing significant barriers to employment—including ex-offenders within one year of their conviction or release. Unfortunately, however, ex-offenders account for a small percentage of employees for whom employers obtain WOTC benefits.[162] Some states such as California, Illinois, Iowa, and Louisiana utilize their own employer tax credits or deductions to promote ex-offender employment. Based on a study of employer preferences for policy options intended to incentivize employment of ex-offenders, the RAND Cooperation makes several recommendations to improve such efforts. These include a guarantee to employers to replace an ex-offender employee if the initial assignment is not a good fit; ensuring that employees have reliable transportation to job sites; and reducing the amount of paperwork required of employers.[163]

By limiting incentives to relapse into offending and by creating alternatives, policies to reduce barriers to employment for former inmates may help to end cycles of recidivism and thus enhance public safety.[161]

Policies to increase access to economic opportunity and eliminate racial discrimination can help break the cycle of incarceration.

Reducing the severity of punishment in the justice system will not, by itself, alleviate the underlying problems of racism and lack of opportunity that drive high rates of incarceration and recidivism in America's most disadvantaged communities.[3,164-166] Efforts must also focus attention on breaking the cycles of economic disadvantage and racial discrimination that underlie and perpetuate enormous disparities in who ends up behind bars. A range of policy changes

and programs is needed across many sectors. For example, research shows that expanding the **Earned Income Tax Credit (EITC)** for childless workers and **raising the federal minimum wage** would simultaneously reduce crime and incarceration, improve public safety, and save the United States billions of dollars each year.[167,168] Increased investment in **community development programs** also is critical for improving conditions in neighborhoods and regions that have historically been excluded from opportunities for upward economic mobility.[iii]

Several programs could protect the health of children with incarcerated parents.

Given the enormous adversity confronting children with parents who are currently or have been incarcerated, scaling up interventions that support the developmental, health, and social needs of these vulnerable children is critical. As noted earlier, these children experience disproportionate rates of parental absence, foster care placement, and educational disadvantage, as well as incarceration and poor health later in life—even after considering their well-being before their parents' incarceration. Programs and policies—such as the **Community-Centered Responsible Fatherhood Ex-Prisoner Reentry Pilot Projects**[169]—that can reduce financial strain, promote family stability, and improve parent-child relationships before, during, and after incarceration show promise for reducing the social and health disadvantages these children experience.[170] For children placed in foster care as a result of parental incarceration, efforts should focus on enhancing the quality and stability of placements, improving access to and quality of mental health and substance abuse treatment, and strengthening support for young adults exiting foster care by providing increased access to health care, housing, employment, educational opportunities, and legal services.[171] Notable models that have been tried and evaluated in small-scale studies include the **Multidimensional Treatment Foster Care Program** and **kin-based care**.[171]

Efforts must also focus attention on breaking the cycles of economic disadvantage and racial discrimination that underlie and perpetuate enormous disparities in who ends up behind bars.

iii Another RWJF report, Wealth Matters for Health Equity, describes a range of promising initiatives to reduce economic inequality in the United States and improve the social and economic conditions of individuals, families, and communities who have historically been denied opportunities.

Mass Incarceration—We Know Enough to Act

Mass incarceration and confinement under inhumane conditions represent major threats to health equity in the United States. The health damage that results from mass incarceration takes a disproportionate toll on people of color, poor people, and people with disabilities. The profound damage is inflicted not only on the individuals who are incarcerated, but also on their families and entire communities. The U.S. incarceration rate by far exceeds those in other nations and are driven by economic and racial inequities. Our inequitable justice system exacerbates ongoing disparities in multiple domains—including health. Few would dispute that eliminating mass incarceration and inhumane treatment of the incarcerated is a critical moral and human rights imperative for our nation.

Eliminating mass incarceration and inhumane treatment of the incarcerated is a critical moral and human rights imperative for our nation.

There is clear evidence that ending mass incarceration and inhumane prison conditions also represents an economic necessity for our nation. Cities, states, and the federal government currently spend billions of taxpayer dollars to incarcerate vast numbers of people, most of whom have not committed a violent or otherwise serious crime. Many people—including those who have not yet been tried—are behind bars simply because they are poor. At the same time, financial investments in mass incarceration have not been found to be associated with reductions in crime rates or other societal benefits. In fact, most cities and states that have recently lowered their incarceration rates have experienced corresponding decreases in crime and improvements in public safety, with significant financial savings.

With high rates of recidivism, many jails, prisons, and juvenile correctional facilities are largely revolving doors. This underscores the importance of prioritizing rehabilitation and post-release economic self-sufficiency, using evidence-based approaches with demonstrated potential for success. Although the issues are complex and challenging, bipartisan reform efforts are now underway in many states and county jurisdictions. These actions should be rigorously evaluated, and those strategies found to be most effective should be replicated at multiple levels, including federally. We have a choice as a society: We can continue to approach crime and punishment in ways that violate some of our most fundamental and deeply-held values and that drain immense levels of government resources, or we can redirect our efforts away from mass incarceration—choosing instead to focus on treatment, rehabilitation, and providing equitable opportunities for every American to live a dignified and healthy life free of unjust, inhumane, and unnecessary incarceration.

Resources

The following organizations provide a range of information about efforts to end mass incarceration and its harmful effects on health and well-being.

- American Civil Liberties Union, www.aclu.org
- American Friends Service Committee, www.afsc.org
- Center for Court Innovation, www.courtinnovation.org
- Center on Juvenile and Criminal Justice, www.cjcj.org
- Equal Justice Initiative, www.eji.org
- Fines and Fees Justice Center, www.finesandfeesjusticecenter.org
- John Jay College of Criminal Justice, www.jjay.cuny.edu/research
- MacArthur Foundation, www.macfound.org
- The Marshall Project, www.themarshallproject.org
- National Institute of Justice, www.nij.gov
- National Police Foundation, www.policefoundation.org
- Office of Juvenile Justice and Delinquency Prevention, www.ojjdp.gov
- PolicyLink, www.policylink.org
- Prison Policy Initiative, www.prisonpolicy.org
- Stanford Center on Poverty and Inequality, www.inequality.stanford.edu
- The Sentencing Project, www.sentencingproject.org
- Urban Institute, www.urban.org
- Vera Institute of Justice, www.vera.org
- What Works in Reentry Clearinghouse, whatworks.csgjusticecenter.org

 Copyright 2019 Robert Wood Johnson Foundation

References

1. Carson EA. Prisoners in 2016. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics;2018. NCJ 251149.
2. Zeng Z. Jail Inmates in 2016. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics;2018. NCJ 251210.
3. National Research Council. The Growth of Incarceration in the United States: Exploring Causes and Consequences. Washington, DC: The National Academies Press; 2014.
4. Gramlich J. America's Incarceration Rate is at a Two-Decade Low. Washington, DC: Pew Research Center;2018.
5. Sickmund M, Sladky TJ, Kang W, Puzzanchera C. Easy Access to the Census of Juveniles in Residential Placement: 1997-2015. Washington, DC: Office of Juvenile Justice and Delinquency Prevention;2017.
6. Roeder O, Eisen LB, Bowling J. What Caused The Crime Decline? New York, NY: Brennan Center for Justice at New York University School of Law;2015.
7. Stemen D. The Prison Paradox: More Incarceration Will Not Make Us Safer. New York, NY: Vera Institute of Justice;2017.
8. Rabuy B, Kopf D. Prisons of Poverty: Uncovering the Pre-Incarceration Incomes of the Imprisoned. Northampton, MA: Prison Policy Initiartive;2015.
9. U.S. Census Bureau. QuickFacts United States: Population Estimates. 2017; https://www.census.gov/quickfacts/fact/table/US/PST045217#viewtop. Accessed 6/14/18.
10. Fact Sheet: Trends in U.S. Corrections. Washington, DC: The Sentencing Project;2018.
11. Looney A, Turner N. Work and Opportunity Before and After Incarceration. Washington, DC: The Brookings Institution;2018.
12. Western B, Pettit B. Collateral Costs: Incarceration's Effect On Economic Mobility. Washington, DC: The PEW Charitable Trusts;2010.
13. Massoglia M, Pridemore WA. Incarceration and health. Annu Rev Sociol. 2015;41:291-310.
14. Mauer M, Nellis A, Schirmir S. Incarcerated Parents and Their Children: Trends 1991-2007. Washington, DC: The Sentencing Project;2009.
15. Wagner P, Rabuy B. Following the Money of Mass Incarceration. Northhampton, MA: Prison Policy Initiative;2017.
16. Spohn C, Holleran D. The effect of imprisonment on recidivism rates of felony offenders: A focus on drug offenders. Criminology. 2002;40(2):329-358.
17. Garland D. Introduction: The meaning of mass imprisonment. In: Imprisonment: Social Causes and Consequences. London, UK: Sage Publications; 2001:1-3.
18. The Sentencing Project. Private Prisons in the United States. Washington, DC: The Sentencing Project;2017.
19. Kaeble D, Glaze L. Correctional Populations in the United States, 2016. U.S. Department of Justice, Office of Justice Programs;2016. NCJ 250374.
20. Fazel S, Baillargeon J. The health of prisoners. Lancet. 2011;377(9769):956-965.
21. Wildeman C, Wang EA. Mass incarceration, public health, and widening inequality in the USA. Lancet. 2017;389(10077):1464-1474.
22. Mumola CJ. Medical Causes of Death in State Prisons, 2001-2004. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics;2007. NCJ 216340.
23. Schnittker J, John A. Enduring stigma: The long-term effects of incarceration on health. J Health Soc Behav. 2007;48(2):115-130.
24. Barnert ES, Abrams LS, Tesema L, et al. Child incarceration and long-term adult health outcomes: A longitudinal study. Int J Prison Health. 2018;14(1):26-33.
25. Coffey C, Veit F, Wolfe R, Cini E, Patton GC. Mortality in young offenders: Retrospective cohort study. BMJ. 2003;326(1064):1-4.
26. Massoglia M. Incarceration, health, and racial disparities in health. Law Soc Rev. 2008;42:275-306.
27. Massoglia M. Incarceration as exposure: The prison, infectious disease, and other stress-related illnesses. J Health Soc Behav. 2008;49:56-71.
28. Patterson EJ. The dose-response of time served in prison on mortality: New York State, 1989-2003. Am J Public Health. 2013;103(3):523-528.
29. Binswanger IA, Stern MF, Deyo RA, et al. Release from prison—a high risk of death for former inmates. N Engl J Med. 2007;356(2):157-165.
30. Fazel S, Ramesh T, Hawton K. Suicide in prisons: An international study of prevalence and contributory factors. Lancet Psychiat. 2017;4(12):946-952.
31. Dumont DM, Brockmann B, Dickman S, Alexander N, Rich JD. Public health and the epidemic of incarceration. Annu Rev Public Health. 2012;33:325-339.
32. Barnert ES, Perry R, Morris RE. Juvenile incarceration and health. Acad Pediatr. 2016;16(2):99-109.
33. National Research Council and Institute of Medicine. Health and Incarceration: A Workshop Summary. Washington, DC: National Academic Press; 2013.
34. Mendel RA. Maltreatment of Youth in U.S. Juvenile Corrections Facilities: An Update. Baltimore, MD: The Annie E. Casey Foundation;2015.
35. Perry RC, Morris RE. Health care for youth involved with the correctional system. Prim Care. 2014;41(3):691-705.
36. Eisen LB. Charging Inmates Perpetuates Mass Incarceration. New York, NY: Brennan Center for Justice at New York University School of Law;2015.
37. Sawyer W. How Much Do Incarcerated People Earn In Each State? Northampton, MA: Prison Policy Initiative;2017.
38. Cruel and Unusual: A National Prisoner Survey of Prison Food and Health Care Quality. Incarcerated Workers Organizing Committee;2018.
39. Review of the Federal Bureau of Prisons' Management of Its Female Inmate Population. Washington, DC: U.S. Department of Justice, Office of the Inspector General;2018. Evaluation and Inspections Division 18-05.
40. Marlow MA, Luna-Gierke RE, Griffin PM, Vieira AR. Foodborne disease outbreaks in correctional institutions—United States, 1998–2014. Am J Public Health. 2017;107(7):1150-1156.
41. Sawyer W. Food for Thought: Prison Food is a Public Health Problem. Northampton, MA: Prison Policy Initiative;2017.
42. Juvenile Offenders and Victims: 2014 National Report. Pittsburgh, PA: National Center for Juvenile Justice, Office of Juvenile Justice and Delinquency Prevention;2014.
43. Growing Inmate Crowding Negatively Affects Inmates, Staff, and Infrastructure. United States Government Accountability Office, Federal Bureau of Prisons;2012.
44. Beck A, Berzofsky M, Caspar R, Krebs C. Sexual Victimization in Prisons and Jails Reported by Inmates, 2011-12. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics;2013. NCJ 241399.
45. Wolff N, Blitz CL, Shi J. Rates of sexual victimization in prison for inmates with and without mental disorders. Psychiat Serv. 2007;58(8):1087-1094.
46. Modvig J. Violence, sexual abuse and torture in prisons. In: Enggist S, Møller L, Galea G, Udesen C, eds. Prisons and Health. World Health Organization, Regional Office for Europe; 2014:19-26.
47. Wolff N, Blitz CL, Shi J, Siegel J, Bachman R. Physical violence inside prisons - rates of victimization. Crim Justice Behav. 2007;34(5):588-599.
48. Kubiak SP, Brenner H, Bybee D, Campbell R, Fedock G. Reporting sexual victimization during incarceration: Using ecological theory as a framework to inform and guide future research. Trauma Violence Abus. 2018;19(1):94-106.
49. Baumgartel S, Guilmette C, Kalb J, et al. Time-In-Cell: The ASCA-Liman 2014 National Survey of Administrative Segregation in Prison. New Haven, CT: The Liman Program, Yale Law School, Association of State Correctional Administrators;2015.
50. Méndez JE. Seeing into Solitary: A Review of the Laws and Policies of Certain Nations Regarding Solitary Confinement of Detainees. Washington, DC: United Nations General Assembly;2016.
51. Shames A, Wilcox J, Subramanian R. Solitary Confinement: Common Misconceptions and Emerging Safe Alternatives. New York, NY: Vera Institute of Justice;2015.
52. Haney C. Prison effects in the era of mass incarceration. Prison J. 2012(Published online before print).
53. Gilligan J, Lee B. Report to the New York City Board of Correction. 2013; http://solitarywatch.com/wp-content/uploads/2013/11/Gilligan-Report.-Final.pdf. Accessed 08/27/18.
54. Shalev S. A Sourcebook On Solitary Confinement. London, UK: Mannheim Centre for Criminology, London School of Economics and Political Science 2008.
55. Lerman A. Officer Health and Wellness: Results from the California Correctional Officer Survey. Berkeley, CA: Goldman School of Public Policy, University of California, Berkeley;2017.
56. Soloman L, Montague BT, Beckwith CG, et al. Survey finds that many prisons and jails have room to improve HIV testing and coordination of postrelease treatment. Health Aff (Millwood). 2014;33(3):434-442.
57. Binswanger IA, Stern MF, Deyo RA, et al. Release from prison: A high risk of death for former inmates. New Engl J Med. 2007;356:157 - 165.
58. Binswanger IA, Blatchford PJ, Mueller SR, Stern MF. Mortality after prison release: Opioid overdose and other causes of death, risk factors, and time trends from 1999 to 2009. Ann Intern Med. 2013;159(9):592-600.
59. Aizer A, Doyle JJ. Juvenile incarceration, human capital, and future crime: Evidence from randomly assigned judges. Q J Econ. 2015;130(2):759-803.
60. Makarios M, Cullen FT, Piquero AR. Adolescent criminal behavior, population heterogeneity, and cumulative disadvantage: Untangling the relationship between adolescent delinquency and negative outcomes in emerging adulthood. Crime Delinquency. 2017;63(6):683-707.
61. Lobuglio SF, Piehl AM. Unwinding Mass Incarceration. National Academies of Sciences, Engineering, and Medicine;2015. 0748-5492.
62. Mendel RA. No Place for Kids: The Case for Reducing Juvenile Incarceration. Baltimore, MD: The Annie E. Casey Foundation;2011.
63. Adams BL. Paternal incarceration and the family: Fifteen years in review. Sociol Compass. 2018;12(3).

64. Wildeman C, Western B. Incarceration in fragile families. Future Child. 2010;20(2):157-177.

65. Wildeman C. Parental incarceration, child homelessness, and the invisible consequences of mass imprisonment. Ann Am Acad Polit Ss. 2014;651(1):74-96.

66. DeVuono-Powell S, Schweidler C, Walters A, Zohrabi A. Who Pays? The True Cost of Incarceration on Families. Oakland, CA: Ella Baker Center;2015.

67. Geller A, Cooper CE, Garfinkel I, Schwartz-Soicher O, Mincy RB. Beyond absenteeism: Father incarceration and child development. Demography. 2012;49(1):49-76.

68. Wildeman C, Goldman AW, Turney K. Parental incarceration and child health in the United States. Epidemiol Rev. 2018;40(1):146-156.

69. Dworsky A, Harden A, George R. The relationship between maternal incarceration and foster care placement. The Open Family Studies Journal. 2011;4(2):117-132.

70. Zlotnick C, Tam TW, Soman LA. Life course outcomes on mental and physical health: the impact of foster care on adulthood. Am J Public Health. 2012;102(3):534-540.

71. Lee RD, Fang XM, Luo FJ. The impact of parental incarceration on the physical and mental health of young adults. Pediatrics. 2013;131(4):E1188-E1195.

72. Simmons CW. Children of Incarcerated Parents. Sacramento, CA: California Research Bureau;2000.

73. Clear TR. Imprisoning Communities: How Mass Incarceration Makes Disadvantaged Neighborhoods Worse. New York, NY: Oxford University Press; 2007.

74. Hatzenbuehler ML, Keyes K, Hamilton A, Uddin M, Galea S. The collateral damage of mass incarceration: Risk of psychiatric morbidity among nonincarcerated residents of high-incarceration neighborhoods. Am J Public Health. 2015;105(1):138-143.

75. Cloud D. On Life Support: Public Health in the Age of Mass Incarceration. New York, NY: Vera Institute of Justice;2014.

76. Pettit B. Invisible Men: Mass Incarceration and the Myth of Black Progress. New York, NY: The Russel Sage Foundation; 2012.

77. Harlow CW. Education and Correctional Populations. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics;2003. NCJ 195670.

78. Inmate Statistical Profile: Inmates Admitted During FY2016. Atlanta, GA: Georgia Department of Corrections, Operations, Planning, and Training Division, Planning and Analysis Section;2016.

79. Adult Prison Population Summary. St. Paul, MN: Minnesota Department of Corrections;2018.

80. Nellis A. The Color of Justice: Racial and Ethnic Disparity in State Prisons. Washington, DC: The Sentencing Project;2016.

81. Pettit B, Western B. Mass imprisonment and the life course: Race and class inequality in U.S. incarceration. Am Sociol Rev. 2004;69:151 - 169.

82. Pettit B, Sykes B. State of the Union 2017: Incarceration. Palo Alto, CA: The Stanford Center on Poverty and Inequality;2017.

83. Prison Policy Initiative. Montana profile. https://www.prisonpolicy.org/profiles/MT.html. Accessed 08/21/18.

84. Prison Policy Initiative. North Dakota profile. https://www.prisonpolicy.org/profiles/ND.html. Accessed 08/21/18.

85. The Sentencing Project. Black Disparities in Youth Incarceration. Washington, DC: The Sentencing Project;2017.

86. The Sentencing Project. Native Disparities in Youth Incarceration. Washington, DC: The Sentencing Project;2017.

87. The Sentencing Project. Latino Disparities in Youth Incarceration. Washington, DC: The Sentencing Project;2017.

88. Porter LC, Bushway SD, Tsao HS, Smith HL. How the U.S. prison boom has changed the age distribution of the prison population. Criminology. 2016;54(1):30-55.

89. Carson EA, Sabol WJ. Aging of the State Prison Population, 1993–2013. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics;2016. NCJ 248766.

90. Carson EA, Golinelli EA. Prisoners in 2012: Trends in Admissions and Releases, 1991–2012. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics;2014. NCJ 243920.

91. Starr SB. Estimating gender disparities in federal criminal cases. Am Law Econ Rev. 2014;17(1):127-159.

92. Swavola E, Riley K, Subramanian R. Overlooked: Women and Jails in an Era of Reform. New York, NY: Vera Institute of Justice;2016.

93. Vallas R. Disabled Behind Bars: The Mass Incarceration of People With Disabilities in America's Jails and Prisons. Washington, DC: Center for American Progress;2016.

94. Vera Institute of Justice. The State of Bail: A Breakthrough Year for Bail Reform. https://www.vera.org/state-of-justice-reform/2017/bail-pretrial. Accessed 08/21/18.

95. American Civil Liberties Union of Washington and Columbia Legal Services. Modern-Day Debtor's Prisons: The Ways Court-Imposed Debts Punish People for Being Poor. Seattle, WA: American Civil Liberties Union of Washington;2014.

96. Bannon A, Nagrecha M, Diller R. Criminal Justice Debt: A Barrier to Reentry. New York, NY: Brennan Center for Justice at New York University School of Law;2010.

97. Turner J. A Pound Of Flesh: The Criminalization of Private Debt. New York, NY: American Civil Liberties Union;2018.

98. Wagner P, Sawyer W. Mass Incarceration: The Whole Pie 2018. Northampton, MA Prison Policy Initiative; Mar 2018.

99. Quick Facts: Drug Trafficking. Washington, DC: United States Sentencing Commission;2018.

100. Reyes RJ. Immigration Detention: Recent Trends and Scholarship. New York, NY: Center for Migration Studies;2018.

101. The White House. Strengthening Border Security: An American Budget. Washington, DC: Executive Office of the President of the United States;2019 Budget Fact Sheet.

102. Associated Press. Detaining Immigrant Kids Is Now a Billion-Dollar Industry. Los Angeles Times. 07/13/2018;Business.

103. Sinha A. Arbitrary detention? The immigration detention bed quota. Duke Journal of Constitutional Law & Public Policy. 2017;12(2):77-121.

104. American Civil Liberties Union. Family Detention. https://www.aclu.org/issues/immigrants-rights/immigrants-rights-and-detention/family-detention. Accessed 09/07/18.

105. MacKenzie EJ, Sharfstein JM, Minkovitz CS, Beyrer C, Splegel P. Separating Families at U.S. Borders is a Public Health Issue. Baltimore, MD: Johns Hopkins Bloomberg School of Public Health;2018.

106. Henry J Kaiser Family Foundation. Key Health Implications of Separation of Families at the Border (as of June 27, 2018). Menlo Park, CA: Henry J Kaiser Family Foundation;2018.

107. Lamb HR. Deinstitutionalization and the homeless mentally ill. Hosp Community Psychiatry. 1984;35(9):899-907.

108. Reingle Gonzalez J, Jetelina KK, Roberts M, et al. Criminal justice system involvement among homeless adults. Am J Crim Justice. 2018;43(2):158-166.

109. Cohen LE, Land KC. Age structure and crime: Symmetry versus asymmetry and the projection of crime rates through the 1990s. Am Sociol Rev. 1987;52(2):170-183.

110. Ferdinand TN. Demographic shifts and criminality: An inquiry. Br J Criminol. 1970;10(2):169-175.

111. Loo DD, Grimes RM. Polls, politics, and crime: The "law and order" issue of the 1960s. W Criminology Rev. 2004;5(1):50-67.

112. Finckenauer JO. Crime as a national political issue: 1964-76. Crime Delinq. 1978;24(1):13-27.

113. Nunn KB. Race, crime and the pool of surplus criminality: Or why the "War on Drugs" was a "War on Blacks". Gender Race & Just. 2002;381.

114. Rosenberger LR. America's Drug War Debacle. Brookfield, VT: Avebury; 1996.

115. Shapiro D. Banking on Bondage: Private Prisons and Mass Incarceration. New York, NY: American Civil Liberties Union;2011.

116. Miller JG. The Debate on Rehabilitating Criminals: Is It True that Nothing Works? Washington Post. 03/1989.

117. Mistretta v. United States, 488 U.S. 361, 109 S. Ct. 647, 102 L. Ed. 2d 714, 1989 U.S. LEXIS 434, 57 U.S.L.W. 4102 (United States District Court for the Western District of Missouri 01/18/89).

118. Alexander M. The lockdown. In: The New Jim Crow: Mass Incarceration in the Age of Colorblindness. New York, NY: The New Press; 2012.

119. Cooper HL. War on Drugs policing and police brutality. Subst Use Misuse. 2015;50(8-9):1188-1194.

120. Fagan J, Davies G. Street stops and broken windows: Terry, race, and disorder in New York City. Fordham Urb L J. 2000;28:457-504.

121. Stewart EA, Baumer EP, Brunson RK, Simons RL. Neighborhood racial context and perceptions of police-based racial discrimination among Black youth. Criminology. 2009;47(3):847-887.

122. Kochel TR, Wilson DB, Mastrofski SD. Effect of suspect race on officers' arrest decisions. Criminology. 2011;49(2):473-512.

123. Nicosia N, MacDonald JM, Arkes J. Disparities in criminal court referrals to drug treatment and prison for minority men. Am J Public Health. 2013;103(6):E77-E84.

124. American Civil Liberties Union. School-to-Prison Pipeline. 2018; https://www.aclu.org/issues/juvenile-justice/school-prison-pipeline. Accessed 08/28/18.

125. Mallett CA. The school-to-prison pipeline: A critical review of the punitive paradigm shift. Child Adolesc Soc Wo. 2016;33(1):15-24.

126. Nelson L, Lind D. The School to Prison Pipeline, Explained. Washington, DC: Justice Policy Institute;2015.

127. Data SnapShot: School Discipline. U.S. Department of Education, Office for Civil Rights, Civil Rights Data Collection;2014.

128. Bellamy J, Zeidman D, Jayaram A. Promising Beginnings: Bipartisan Criminal Justice Reform in Key States. New York, NY: American Civil Liberties Union;2012.

129. Berman G, Adler J. Start Here: A Road Map to Reducing Mass Incarceration. New York, NY: The New Press; 2018.

130. Gelb A, Gramlich J, Stevenson P. State Reforms Reverse Decades of Incarceration Growth. The Pew Charitable Trusts; Mar 2017.

131. Camilletti C. Pretrial Diversion Programs: Research Summary. Washington, DC: Bureau of Justice Assistance, U.S. Department of Justice;2010.

132. Horne C, Newman WJ. Updates since Brown v. Plata: Alternative solutions for prison overcrowding in California. J Am Acad Psychiatry Law. 2015;43(1):87-92.

133. Brown SA. Trends in Juvenile Justice State Legislation. Washington, DC: National Conference of State Legislatures;2015.

134. National Imprisonment and Crime Rates Continue to Fall. Philadelphia, PA: The PEW Charitable Trusts;2016.

135. Gelb A, Denney J. National Prison Rate Continues to Decline Amid Sentencing, Re-Entry Reforms. Philadelphia, PA: Pew Charitable Trusts;2018.

136. Laird L. ABA adopts guidelines aimed at preventing fines and fees that penalize poverty. 2018 ABA Annual Meeting. http://www.abajournal.com/news/article/aba_adopts_guidelines_aimed_at_preventing_fines_and_fees_from_penalizing_po. Accessed 08/17/18.

137. The Bail Project. Revolving Bail Fund Model. https://bailproject.org/. Accessed 10/22/18.

138. Skeem JL, Lowenkamp CT. Risk, race, and recidivism: Predictive bias and disparate impact. Criminology. 2016;54(4):680-712.

139. Wilson S. California abolishes cash bail, aiming to treat rich and poor defendants equally. The Washington Post. 08/29/2018.

140. PolicyLink and Advancement Project. Engaging Communities as Partners: Strategies for Problem Solving. Oakland,CA: PolicyLink;2014.

141. PolicyLink and Advancement Project. Limiting Police Use of Force: Promising Community-Centered Strategies. New York, NY: PolicyLink;2014.

142. Kouyoumdjian FG, McIsaac KE, Liauw J, et al. A systematic review of randomized controlled trials of interventions to improve the health of persons during imprisonment and in the year after release. Am J Public Health. 2015;105(4):E13-E33.

143. World Health Organization Regional Office for Europe. WHO Health in Prisons Programme (HIPP). 2018; http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/who-health-in-prisons-programme-hipp. Accessed 10/08/18.

144. Newman WJ, Scott CL. Brown v. Plata: Prison overcrowding in California. J Am Acad Psychiatry Law. 2012;40(4):547-552.

145. Issue Brief: Prison Violence Intervention. National Network for Safe Communities, John Jay College of Criminal Justice.

146. National Research Council. The Growth of Incarceration in the United States: Prison Conditions. The National Academies;2014.

147. Solitary Confinement as a Public Health Issue (Policy Statement). Washington, DC: American Public Health Association;2013. Policy Number 201310.

148. Teigen A. States That Limit Or Prohibit Juvenile Shackling and Solitary Confinement. Washington, DC: National Conference of State Legislatures;2018.

149. Stringer SM, Valdés JH. More Cities and States Should Divest From Private Prisons. The New York Times. 07/30/2018.

150. Subramanian R, Shames A. Sentencing and Prison Practices in Germany and the Netherlands: Implications for the United States. New York, NY: Vera Institute of Justice;2013.

151. Think Justice Blog. Dispatches from T.R.U.E. 2018; https://www.vera.org/blog/dispatches-from-t-r-u-e. Accessed 08/28/18.

152. Mendel RA. The Missouri Model: Reinventing the Practice of Rehabilitating Youthful Offenders. Baltimore, MD: The Annie E. Casey Foundation;2010.

153. Meiello L, Lopez M, Warwick K. Montgomery County, Maryland Master Facilities Confinement Study: Final Report. Montgomery County, MD: Department of Correction and Rehabilitation;2014.

154. Walter RJ, Viglione J, Tillyer MS. One strike to second chances: Using criminal backgrounds in admission decisions for assisted housing. Hous Policy Debate. 2017;27(5):734-750.

155. Bae J, Finley K, diZerega M. Opening Doors: How To Develop Reentry Programs Using Examples From Public Housing Authorities. New York, NY: Vera Institute of Justice;2017.

156. Davis LM, Bozick R, Steele JL, Saunders J, Miles JNV. Evaluating the Effectiveness of Correctional Education: A Meta-Analysis of Programs That Provide Education to Incarcerated Adults. Santa Monica, CA: RAND Corporation;2013.

157. Davis LM, Steele JL, Bozick R, et al. How Effective Is Correctional Education, and Where Do We Go from Here? The Results of a Comprehensive Evaluation. Santa Monica, CA: RAND Corporation;2014.

158. Lewis N. The Uncertain Fate of College in Prison. New York, NY: The Marshall Project;2018.

159. Better Futures Enterprises. Better Futures Minnesota. 2018; https://betterfuturesminnesota.com/. Accessed 10/01/18.

160. Bishop J. Models for Improving Linkage to Care for People Living with HIV Released from Jail or Prison. Boston, MA: National Center for Innovation in HIV Care;2017.

161. Duane M, La Vigne N, Lynch M, Reimal E. Criminal Background Checks: Impact on Employment and Recidivism. Washington, DC: Urban Institute, Justice Policy Center;2017.

162. WOTC Certifications by Recipient Group, Regional and National Details for Fiscal Year 2016. Washington, DC: U.S. Department of Labor, Employment and Training Administration;2016.

163. Hunt P, Smart R, Jonsson L, Tsang F. Incentivizing Employers to Hire Ex-Offenders: What Policies Are Most Effective? Santa Monica, CA: RAND Corperation;2018. RB-10003-RC.

164. Hipp JR. Income inequality, race, and place: Does the distribution of race and class within neighborhoods affect crime rates? Criminology. 2007;45(3):665-697.

165. Patterson EB. Poverty, income inequality, and community crime rates. Criminology. 1991;29(4):755-776.

166. Kelly M. Inequality and crime. Rev Econ Stat. 2000;82(4):530-539.

167. West R. EITC Expansion for Childless Workers Would Save Billions—and Take a Bite Out of Crime. Washington, DC: Center for American Progress;2016.

168. White House Council of Economic Advisers. Economic Perspectives On Incarceration And The Criminal Justice System. Washington, DC: Executive Office of the President of the United States;2016.

169. Fontaine J, Cramer L, Paddock E. Encouraging Responsible Parenting among Fathers with Histories of Incarceration. Washington, DC: Urban Institute;2017. OPRE Report #2017-02.

170. Turney K, Goodsell R. Parental incarceration and children's wellbeing. In: Reducing Justice System Inequality. Vol 28. 1 ed.: Princeton University and The Brookings Institution; 2018:147-164.

171. Yi Y, Wildeman C. Can foster care interventions diminish justice system inequality? In: Reducing Justice System Inequality. Vol 28. 1 ed.: Princeton University and The Brookings Institution; 2018:37-58.

UCSF
University of California
San Francisco

ucsf.edu

Robert Wood Johnson
Foundation

rwjf.org