Prison Pandemic
Public Health Confronts the Incarceration Epidemic

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In 1972, 300,000 Americans were incarcerated. Crime rates have tumbled in recent years, yet today more than 3 million Americans are locked up. Another 6 million are on probation or parole. Nationwide, 68 million Americans have criminal records and one in 28 children—about 2.7 million kids—has a parent behind bars. In recognition of that sobering fact, the Sesame Workshop has introduced to its cast Alex, a green-nosed, blue-haired Muppet whose dad is in jail.

For Americans, contact with the criminal justice system is pervasive; the public health implications are profound. Our incarceration epidemic transforms communities and wreaks havoc that persists for generations—from the agony of ruptured family bonds to the exacerbation of conditions that precede incarceration: grinding poverty, homelessness, poor education, joblessness, physical and mental illness, substance abuse, and violence.

“Public health has a responsibility to look at incarceration in the same way it addresses air pollution, depression, and infection,” says medical sociologist Lisa Metsch, PhD, the Stephen Smith Professor and chair of Sociomedical Sciences. “Our scholarship is focused on prevention; if public health learns how to prevent an individual’s first exposure to criminal justice and the deluge of negative outcomes that follows, we’ll be able to interrupt a cycle that causes tremendous damage to individuals, families, communities, and society as a whole.”

That cycle has deep roots. The war on drugs declared by President Richard Nixon in 1971 transformed addiction from a medical condition into a criminal offense and has brought millions of people—particularly poor African-Americans and Hispanics—into the criminal justice system on low-level charges. In the 1980s, three-strikes mandatory sentencing laws swept the nation, superseding judges’ discretion. A decade later, flawed theories about delinquent children destined to become “super-predators” turned the juvenile justice system into a portal to lifelong incarceration: grinding poverty, homelessness, poor education, joblessness, physical and mental illness, substance abuse, and violence.

Juvenile Justice Initiative advocates for policy reform, the program brought together leaders from more than 50 public health schools with advocates including Bryan Stevenson, founder of the Equal Justice Initiative, and former New York Times executive editor Bill Keller of the Marshall Project, a not-for-profit news organization dedicated to covering America’s criminal justice system. The conference concluded with the crafting of a draft statement of purpose in which the signatories pledge “to work collectively to introduce incarceration in our curricula and research, to raise awareness and concern, and to inspire and support our fellow scholars.”

The symposium emerged from work by a think tank convened in 2012 by Metsch and Ernest Drucker, PhD, author of the book A Plague of Prisons: The Epidemiology of Mass Incarceration in America. Metsch and Drucker, an adjunct professor of Epidemiology, co-direct the School’s Incarceration and Public Health Initiative, collaborating with faculty from their departments, as well as Health Policy and Management and Population and Family Health, to determine how public health approaches might alleviate the burden of incarceration—from interrupting the “school-to-prison pipeline” to improving access to healthcare and higher education in correctional institutions. “Our group focused on a range of contributing factors, and we tried to emphasize primary prevention approaches and new solutions that cut across health systems,” says Metsch, “as well as current alternatives to incarceration, including diversion programs, probation, and community and drug courts.” Metsch is a principal investigator, with Nabila El-Bassel, PhD, a professor at Columbia’s School of Social Work, on a new National Institute of Drug Abuse grant to train postdoctoral and doctoral students in research techniques appropriate to investigating
Last year, a Department of Health and Mental Hygiene STI clinic sent a patient to Alwyn Cohall, MD. It was not, he says, “an unusual referral.” This 19-year-old was like a lot of the patients Cohall sees: African-American, overweight, hypertensive, pre-diabetic, and newly HIV-positive.

But the man’s story stuck with Cohall, an HIV expert and specialist in adolescent medicine who is a professor of Sociomedical Sciences and of Population and Family Health. The young man had recently done a stint at Rikers Island, the city jail. He’d been HIV-negative when he arrived, but like a lot of people who have been incarcerated, says Cohall, upon release, “he was making up for lost time,” using drugs and having unprotected sex. A 2007 New England Journal of Medicine study suggests the young man was relatively lucky. In the two weeks after their release, former prisoners were nearly 13 times more likely to die than those in the general population; the most common causes of death were drug overdose and heart disease.

New York City offers discharge plans for prisoners with HIV and some other health conditions, to make sure they get medical treatment—and other help they need—once they are released. But many HIV-negative prisoners leave without such referrals—a huge missed opportunity. Young men, particularly low-income men of color, are much less likely to seek medical attention. They are also much more likely to be involved in the criminal justice system. So why not use contact with the criminal justice system to facilitate connections with the healthcare system?

Cohall, founder of Project Stay, which provides comprehensive healthcare for high-risk and HIV-positive youth, partnered with Young Men’s Clinic founder Bruce Armstrong, DSW ’84, an associate professor of Population and Family Health, and Renee Cohall, LCSW. Working with community groups that serve justice-involved youth, they provide screening and counseling for HIV, STIs, and other health issues.

After helping this young man start HIV treatment, reducing his viral load to undetectable levels, the team also helped him address his weight and blood pressure. But, says Cohall, his patients’ chaotic lives often turn progress—medical or otherwise—into a case of two steps forward, one step back. Feeling stress from a loved one’s illness, the young man increased his marijuana consumption; the team redoubled their efforts to help him adopt more health-promoting stress management techniques. “Behavior change is difficult,” Cohall says. “It’s an ongoing process. That’s why these programs need to exist, and must be continually supported.”

— Alisa Roth

WITH SUPPORT FROM institutional seed funds, the think tank’s first order of business was to frame key research questions. In its second phase, supported by the Robert Wood Johnson Foundation, the group facilitated several new educational initiatives, including a course for MPH students taught by Drucker. Think tank member Monica Sweeney, MD, MPH ’92, an adjunct assistant professor of Sociomedical Sciences, led a clinical practicum for faculty.

A monthly series—co-sponsored by Metsch and Dean Linda P. Fried, MD, MPH—extended the think tank’s reach, bringing in experts on solitary confinement, sentencing policies, racial disparities, and welfare reform for seminars open to faculty and students throughout the School. Drucker gave the inaugural address before a standing-room-only audience in 2013. “This new epidemic exhibits all the characteristics of an infectious disease—spreading most rapidly by proximity to prior cases,” he says. “It is a public health catastrophe—because of its scale, the severity of the effects it has, the size of the populations it affects. And it warrants the attention we would give other catastrophes in public health, like HIV.”

Incarceration also compounds more conventional public health risks: People in jail and prison have higher rates of infectious diseases like HIV and hepatitis B and C, as well as higher rates of chronic disease such as hypertension and diabetes.
Drug-resistant tuberculosis, antibiotic-resistant staph infections, syphilis, and scabies are all on the rise among people who are incarcerated, and nearly 50 percent have a diagnosable mental health disorder. Necessarily, prisons and jails become de facto providers of an array of health services once the domain of community clinics. Ten times as many severely mentally ill individuals are housed within the criminal justice system as are housed by state psychiatric hospitals.

As a health advocate intent on disentangling the relationship between mental illness and criminal justice, David Cloud, JD, MPH ’14, enrolled at the Mailman School to augment his legal training. “I knew the criminal justice system was broken and I wanted to do something about it, but I didn’t want to use a criminology lens,” says Cloud, who works for the Vera Institute of Justice as a senior program associate in the substance use and mental health program. “Public health gives us a paradigm to engage not just the classic American conception of health as healthcare, scanners, and stethoscopes but the health of a population—including health departments, criminal justice, courts, employment, and education—in our search for answers.

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As a student, Cloud founded Columbia’s Association for Justice and Health and worked with Drucker on an analysis of the implications of solitary confinement in U.S. jails and prisons, forthcoming in the American Journal of Public Health. “If you start to look at the populations affected,” says Cloud, “you see the intergenerational aftermath of young, poor minorities plucked from the system, the disruption to their family systems, and the inequalities in their health outcomes.”

Often, says Robert E. Fullilove, EdD, associate dean of Community and Minority Affairs and a professor of Sociomedical Sciences, “people return from a period of incarceration in poorer health than when they left.” The synergy between HIV infection and mass incarceration is particularly stark. In a paper published in the Ohio State Journal of Criminal Law, Fullilove writes that a concentration of HIV infection in poor communities of color, coupled with high incarceration rates in those same neighborhoods, has fueled the rise of HIV infection nationwide. “The greatest engine driving the epidemic,” he writes, “was the cycling of inmates in and out of prison and in and out of their communities of origin.”

Through its destabilizing effect on communities, incarceration also further speeds the spread of HIV and other diseases among young people. “This is a vacuum,” says Fullilove. “There isn’t a live; having a criminal record, especially with a felony conviction, can complicate either effort. Being homeless or without access to regular, healthy meals can make it hard to control chronic illnesses such as diabetes. Pamela Valera, an assistant professor of Sociomedical Sciences, investigates health, particularly cancer, in incarcerated populations; in her free time, she runs a program to help people with re-entry. Valera says former prisoners often struggle to take responsibility for their health. “If someone’s been incarcerated for so long,” she says, “they’re used to just telling a guard that they’re not feeling well and submitting a paper to sick call, and someone would check up on them.” After their release, former prisoners need to learn how to find a doctor, make an appointment, call a pharmacy, and even take their medications.

The challenges are immense, says Cloud, yet cause for optimism remains. “Policymakers are … increasingly turning to solutions that prioritize access to healthcare, education, and economic opportunity to prevent crime,” he writes in a March 2014 editorial for the American Journal of Public Health. “The current alignment of funding opportunities, political will, and technical capacity to provide coordinated services across systems creates a momentous opportunity for public health to reinvigorate its core values in social justice to improve the health of poor, underserved communities afflicted by mass incarceration.”