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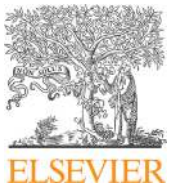

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Commentary

Women, Incarceration, and Health

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Incarceration has become the default response to a host of social problems in the United States, from mental illness and illicit substance use to poverty and unemployment (Rich, Wakeman, & Dickman, 2011). "A New Vulnerable Population? The Health of Female Partners of Men Recently Released From Prison," in this issue of *Women's Health Issues*, highlights growing concern with the collateral consequences of the U.S. epidemic of incarceration and especially the consequences for families. Men constitute nearly 90% of all prisoners. As the authors show, however, women's health is directly affected by incarceration whether they are prisoners themselves or whether their partners are. The full implementation of the Affordable Care Act (ACA) provides what may be a once-in-a-generation opportunity to address the pressing health needs of this population. Because some of these health issues are the underlying causes of behaviors culminating in incarceration, the ACA may also begin to chip away at the incarceration rates that disproportionately affect Blacks and Hispanics.

Prisoners are more likely than the general U.S. population to be unemployed, poor, Black or Hispanic, homeless, and uninsured. Well over half suffer from mental illness and/or addiction. Rates of HIV, sexually transmitted diseases, and other infectious diseases are far higher than in the general public, meaning that their partners are also at high risk of infection. Although many individuals' health can improve during incarceration, there is also evidence that the conditions of incarceration—for example, diet, risk of sexual assault or other violence, and especially the mental health repercussions of both crowding and prolonged isolation—cause health to deteriorate. Release from incarceration is also a profoundly stressful and high-risk transition, because releasees often struggle to reestablish housing, employment, and social/family relationships.

As we show in this and previous work, incarceration and reentry affect not only the health of female prisoners, but also the much larger population of women with incarcerated male partners. There is now a well-established body of research documenting the increased risk for HIV and sexually transmitted diseases among women with incarcerated partners (Epperson, Khan, El-Bassel, Wu, & Gilbert, 2011; Grinstead Reznick, Comfort, McCartney, & Neilands, 2011; Khan et al., 2011). Recent research, to which "A New Vulnerable Population?" adds important detail, shows higher rates of poor health behaviors and chronic disease outcomes among women with incarcerated male partners or sons (Green, Ensminger, Robertson, & Juon, 2006; Lee & Wildeman, 2011, forthcoming; Wildeman, Schnittker, & Turney, 2012).

The ACA has great potential for criminal justice-involved women in two ways. First, it promises to vastly improve access to health care by reducing financial barriers to care. Most criminal justice-involved women with children under age 18 have Medicaid themselves, but a large number of women prisoners and partners of prisoners are uninsured. Some of them will become eligible for subsidized private insurance on the state exchanges under the ACA, and many more will become newly eligible for Medicaid under the expansion of coverage to childless adults under 138% of the federal poverty line, at least in those states adopting expanded eligibility guidelines.

The criminal justice system can play a central role in this process, and it is in the interests of state, local, and correctional officials to do so. Policymakers and correctional administrators may or may not be concerned with inmates' health per se, but they are increasingly preoccupied with the effects of rapidly escalating costs of correctional health care on their budgets. Because recidivism rates are high, even health problems that develop after release can become the responsibility of a correctional facility upon re-incarceration. Some administrators have proved willing to enter into partnerships with public health practitioners to utilize their institutional framework to capitalize on public health opportunities. There are already efforts in some states to extend those partnerships to include Medicaid offices. Both prisons and jails house inmates with much lower rates of high school completion than the general population, so that inmates often require extra assistance in navigating the forms

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and procedures necessary for enrollment. Correctional facilities can work with Medicaid offices to ensure navigators are available to assist inmates with enrollment before release.

In addition to helping incarcerated women apply for Medicaid—and it is important to take advantage of such structures to ensure enrollment in Medicare where appropriate, given the aging of the prison population—corrections systems could work with two much larger groups of criminal justice-involved women. First, the number of women in community corrections (probation and parole) is far larger than the number of women incarcerated in jails and prisons. Departments of corrections could utilize probation and parole meetings as a point of contact to direct the uninsured toward the navigators mandated by the ACA to assist with Medicaid enrollment. Second is the vaster and more diffuse population of uninsured women who might be identified and assisted to enrollment through their close relationships with incarcerated men. As we suggest, prison visiting hours are an underutilized opportunity to reach out to these women who are predominantly partners and family members of the inmates.

A second crucial element of the ACA for this population is its expanded coverage of behavioral health care (i.e., treatment for mental illness and/or illicit substance use). Rates of mental illness and addiction are even higher among female prisoners than male prisoners, and treatment is available to only a fraction of those in need. Treating these conditions is crucial to both addressing other health needs and reducing recidivism. Given the authors' findings, it is likely that even increasing male access to behavioral health will improve their female partners' health by reducing the stress and strained resources associated with having an addicted or mentally ill partner. Release from prison is a deeply stressful transition for many people who struggle to restore housing, personal relationships, and employment. Those with behavioral health needs are at especially high risk. The mentally ill are generally released from prison with a few days' supply of necessary psychiatric medications, after which they lapse from care. Those with substance dependence are frequently offered illicit drugs as soon as they step off the bus. These are challenges for not only releasees, but the family members dealing with their health problems, often while struggling with their own at the same time. Even with the expansion of coverage in 2014, women in either category will continue to encounter barriers to accessing behavioral care, including transportation, patients' health literacy, and providers' cultural competence. The ACA contains provisions seeking to decrease some of these barriers, for example, by including support for cultural competence training programs, but major concerns continue regarding whether sufficient community-based care exists to serve those who will be newly enabled to access it.

By identifying the partners of prisoners as a vulnerable population, the authors bring attention to the consequences of incarceration as a social determinant of health. There seems to be little agreement on the parameters of the term "vulnerable population." The U.S. Centers for Disease Control and Prevention (2011), for instance, designates vulnerable populations as "defined by socio-economic status, geography, gender, age, disability status, risk status related to sex and gender, and other populations identified to be at-risk for health disparities," compared with the authors' definition as a group at high risk of "weathering." The authors make a strong case that these women constitute a vulnerable population, even accounting for the frequent coexistence of other markers such as poverty and homelessness. In doing so, they simultaneously make a significant step forward in quantifying the health risks associated with exposure to incarceration and highlight the fact that we have come to utilize incarceration as the major response to the complex problems of illicit substance use and even mental illness. Without a doubt, many people need to be incarcerated for the safety of the community and even themselves in some cases. However, large numbers of people, disproportionately Blacks and Hispanics, are incarcerated for nonviolent offenses such as marijuana possession and missing probation meetings. Even more are in prison because their untreated mental illness and addiction led to behaviors that brought them to the attention of law enforcement. The health consequences of the epidemic of incarceration in the United States for the partners and children of prisoners are a public health crisis and should be addressed as such.

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