MORE THAN A SOCIAL DETERMINANT OF HEALTH:
INCARCERATION AS A NEGATIVE
HEALTH OUTCOME

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ABSTRACT

The Healthy People 2020 initiative recognizes how the physical, emotional and mental toll of incarceration causes poorer health outcomes because of the health risks and exposures individuals face in the prison environment. However, incarceration in the urban setting is more than the social determinant of health. The social, political, and economic consequences of mass incarceration have disproportionately affected urban communities. By reviewing the research on the health and socio-economic status of incarcerated population prior, during and after imprisonment, I make the argument that prisoners have a predisposition to be incarcerated due the negative social determinants of health present in their natal neighborhoods. I illustrate how the evolution of mass incarceration is in part due to the United States (US) government imprisonment of many non-violent offenders by criminalizing drug abuse in part due to racial discrimination towards men of color, primarily African-American men. I examine how drug abuse as a mental illness has been disregarded by the US Criminal Justice System, and how racism has contributed to this factor. Furthermore, as the drugs policies have disproportionately affected these communities, additional consideration should be given to how the criminalization and demonization of drug abuse and addiction has impinged on the bioethical rights of the members of urban communities. I explain how mass incarceration in the urban setting violates each bioethical principle and how the racial disparities in mass incarceration is a reflection and is an extension of the problems of racism inherent to the US. Ultimately, I conclude that any new legislation passed to end mass incarceration should include policies that help to rehabilitate and to rebuild lives of those affected most by mass incarceration.
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CHAPTER 1: INTRODUCTION

The quality of housing and access to health care; the quality of work and life; the social and physical environment one resides in; and the social support networks and opportunities for civil and social engagement all influence one’s health. To create a basic level of understanding of what approach to use when we examine health outcomes, we must understand the relationships between health and biology, attitudes and behaviors and interactions with greater society that not only influence the health of individuals but of populations as well. Population health is influenced by how a population functions in terms of access to goods, social services, social capital, economic and political power (Marmor, Evans & Barer 1994). It is important to understand how to distinguish population health from personal health because individualism often clouts the ability to understand what is occurring on a larger scale. This is crucial when examining groups of people, especially within the US, where the conversation is complicated.

In the US, in order to have honest and productive conversations about population health, topics such as discrimination, oppression and racism in past and present legislative policies should be included. Furthermore, the differences in the histories of certain groups have created legacies of poverty and disenfranchisement which create, exaggerate, and continue to influence health disparities; the unfair and avoidable differences in health status seen within and between populations (CDC 2015) are required components to this discussion as well. Over the past few decades, the government has launched many policy initiatives to try to address health disparities by examining how different populations are susceptible to either higher rates of adverse health outcomes or vulnerable to unique
pathologies. These initiatives have the intentions of achieving health equity or the highest levels of health for all people by “valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities” (USHHS 2010). Due to the US history of slavery, institutional and structural racism and racial discrimination, the US government and its health service agencies are charged with the particular task of understanding how history, race, socioeconomic status, and health are intertwined. Policymakers require a reanalysis of how the histories of different groups who were recipients of both intentional and unintentional discriminatory and oppressive polices have created the various health disparities and health inequities seen in each community. Without this analysis, any efforts to reduce health disparities and health inequity will be short-sighted and thus, ineffective.

The history of explicit and implicit institutional discrimination and oppression have led to the overall worse health outcomes observed in ethnic and racial minority groups such as African-Americans, Hispanic-Americans and Native Americans. These groups tend to have significantly higher adult and infant mortality rates which include cardiovascular and cerebrovascular disease, most cancers, diabetes, HIV, unintentional injuries, pregnancy and sudden infant death syndrome compared to white Americans (OMH 2016). To better understand how racism is pervasive in medicine and health and how health disparities manifest let’s take the example of diabetes.

Diabetes is a national public health problem with 29.1 million Americans diagnosed with diabetes, it remains the seventh leading cause of death in the US (ADA 2014). Yet, when stratified by race and ethnicity, there are disparities in the prevalence of diabetes and
the rates of morbidity and mortality. The rates of diagnosed diabetes by race/ethnic background are: 7.6% of non-Hispanic whites, 12.8% of Hispanic-Americans, 13.2% of African-Americans and 15.9% of Native Americans (ADA 2014). As non-Hispanic whites make up 63% or 197 million people in the US (US Census 2010), even with a lower percentage of prevalence there are numerically more non-Hispanic whites who have diabetes compared to minorities. However, the heavier burden of disease for ethnic and racial minorities suggests there is more to this finding. In 2010, African-Americans were 3.4 times, Native Americans 2.7 times and Hispanic-Americans 2.6 times more likely to start treatment for end-stage renal disease related to diabetes as compared to non-Hispanic whites (OMH 2014). In 2013, African-Americans were 2.0 times, Native Americans 2.3 times and Hispanic-Americans 1.5 times as likely as non-Hispanic Whites to die from diabetes (OMH 2014). Increased rates of morbidity and mortality for minorities are worrisome as disparities in diabetes outcomes continue despite significant clinical advances which help reduce adverse health outcomes.

These numbers suggest either of two possibilities: either there is 1) a genetic predisposition or behavioral component amongst these groups which lead to an increase in the susceptibility to disease and poorer progression compared to White-Americans or 2) there are social determinants of health involved which increase the vulnerability for these groups to develop diabetes and additional components which prevent proper clinical management and increases the rates of morbidity and mortality. Either scenario is possible as well as a combination of the two. However, the first explanation primarily blames the individual members within the group and removes responsibility from any governing body or historical factors that may have contributed to the current conditions which foster an
environment where the disparities seen are almost inevitable. The first explanation is quite
dangerous, and allows room for racist ideals to prevail in the assessment and the
development of strategies to reduce disparities. The second explanation calls for self-
reflection by the US government and its healthcare system to face the health consequences
of inherent systematic racism in America and take accountability for their role in creating
the health disparities observed today. It is critical that both explanations are recognized and
appropriately addressed.

National surveys on the health disparities in diabetes management and health
outcomes have found those who suffer the poorest outcomes are patients with disabilities,
African-Americans, Hispanic-Americans and those with income levels less than $45,000
per year (NHDR 2011). The inclusion of discrimination against those who make less than
$45,000 per year is significant. In 2014, the median income of White-American households
was $60,256, for African-American households it was $35,398 and for Hispanic-American
households, the median income was $42,491 (US Census Bureau 2015). Thus, more
African Americans and Hispanic Americans experience discrimination that is compounded
by both their racial background and socio-economic status. One study on health care
disparities, diabetes, and primary care found that despite the best intentions of physicians
to use an egalitarian approach when treating their patients, many were observed exhibiting
behaviors such as unconscious bias and stereotyping referred to as cognitive shortcuts
when serving patients with minority ethnic/racial backgrounds (White, Breech & Miller
2009). Physicians made assumptions about their patients and set up expectations for
patients based of those assumptions that were primarily based off the patient ethnic/racial
background. These cognitive shortfalls are dangerous as they compromise patient care and
patient wellbeing and ultimately, perpetuate healthcare disparities. The reflexive response to reduce these cognitive shortfalls and health disparities in healthcare is by increasing the awareness of unconscious bias and stereotyping, increasing patient education, and promoting cultural competency. While diminishing these disparities through understanding and addressing the various factors influencing doctor-patient encounters such as health literacy, provider-patient communication, and cultural competence throughout medical education (White, Breech and Miller 2009) maybe be helpful, these efforts do not address the root cause. The cognitive shortfalls are an example of how discrimination and racism is pervasive in medicine however, it does not end there. To tackle racism and health disparities in medicine, understanding how racism operates and is manifested throughout society and in our personal lives is key.

How Pervasive is Racism in Healthcare?

Racism in America perpetuates these health disparities by operating at three distinct levels: institutionalized policies and practices, individualized racial discrimination, and internalized oppression. Public health researchers Dr. Kevin Fiscella and Dr. David R. Williams explain how each aspect of racism validates and reinforces the other forms. They write, “institutionalized racism, manifested through long-standing racial inequities in employment, housing, education, healthcare, income, wealth, and criminal justice, is reinforced through racist beliefs” (Fiscella & Williams 2004). Individualized racism is perpetrated by any citizen with some form of power, includes forms of unconscious bias allowing for discrimination in housing policies, banking and employment practices, racial profiling by police, and inequitable sentencing for minority defendants, lower educational expectations for minority students by teachers and school administration, and unequal
medical treatment by healthcare providers and medical institutions (Goyette & Scheller 2014, Kennedy 2013, Brown, Hernandez & Saint Jean 2008, Fiscella & Williams 2004). Individualized racial stereotyping contributes to voting patterns and public policies that, in turn, reinforce institutionalized racism. Internalized racism is the acceptance of the caricature of the minority group members from the larger society by the minority group (Fiscella & Williams 2004). Internalized oppression may contribute to lower self-esteem and sense of self-worth and contributes to lower school performance, mental illnesses such as anxiety and depression, substance abuse, dropouts, and other high risk behaviors which vindicates the former two forms and justifies their actions (Fiscella & Williams 2004). This trifecta leads to racial disparities in health because it perpetuates racial disparities in access to goods, poverty, education, justice and economic opportunity that, in turn, drive health disparities (Goyette & Scheller 2014; Brown, Hernandez & Saint Jean 2008 Fiscella & Williams 2004). This can be further explained by continuing with the diabetes example using African-Americans as an example for a patient population.

The increased rates of morbidity and mortality amongst African-Americans has been discussed in the literature and many physicians are aware of these statistics before they meet any patient who is African-American. Thus, apprehension along with unconscious bias and stereotypes about the health outcomes of African-American patients are already in place before the first patient encounter. These biases and thoughts are confounded by preexisting racist thoughts about African-Americans held by greater society due to systematic racism coupled with individualized racism. On the patient’s side, he/she is a member of the aforementioned minority group. The patient is cognizant of negative stereotypes about African-Americans and because of either personal experiences
or having knowledge of past atrocities and injustices committed by US medical institutions on African-Americans and is skeptical of her/his healthcare provider regardless of whether or not the healthcare provider has personally mistreated the patient. These atrocities include the infamous US Public Health Service Syphilis at Tuskegee Study, where the federal government funded the study of the natural progression of untreated syphilis in rural African-American men in Alabama from 1932-1972. For 40 years, the participants in the study were not informed they were actually participating in a study, none were told they had the disease, and none were treated with penicillin even after it became an accepted treatment of syphilis (CDC 2016). The patient is aware of the prevalence of diabetes in the African-Americans but remains still suspicious of his/her healthcare providers. The mistrust is coupled with the shared experiences of the majority of African-Americans who face racism and discrimination in every other aspect of their lives.

During a patient encounter, whether it is the first encounter and/or subsequent ones, transference, the unconscious redirection of feelings from the patient onto the provider on the basis of other experiences and/or counter-transference, the unconscious redirection of feelings from the provider to patient on the basis of other experiences occurs as the physician is trying to manage the patient’s diabetes (Patterson 1959). The patient has not achieved the health goals directed the physician because some other underlying reasons (co-morbidities, low health literacy, residing in a food desert, cultural attitudes towards food and/or nutrition, inadequate access to recreational/green space for exercise, employment issues or family issues which impede patient’s ability to make appointments, health insurance issues for coverage for medications or visits) and feels judge and/or misunderstood by his/her physician. The physician develops feelings of frustration and
uncertainty about patient’s treatment failure and unconsciously or consciously attributes the patient’s noncompliance to their ethnic/racial background. As a result, the physician may choose to take a less aggressive course of treatment. Ultimately, the patient’s diabetes remains poorly controlled and the patient has a worse prognosis and develops end organ damage (i.e. kidney failure, leg amputation, blindness) due to diabetes or dies of complications secondary to diabetes. Although an oversimplified example, this situation occurs in varying degrees and extends to millions of people of color and constantly reoccurs inside and outside of the clinical setting. Eventually, healthcare disparities arise and healthcare providers and public health officials are left trying to explain and to reconcile these differences. This is why recognizing how racism operates is essential to understanding how to reduce health disparities.

In healthcare, there have been efforts to rationalize or to medicalize health disparities on the basis of inherent genetic or behaviors between these groups as opposed to the racial differences in socioeconomic status and subjection to systemic oppression and racism. However, genetics is not the cause of these health disparities but a consequence of social policy and racism. In an interview with medical scholar and author of *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present*, Dr. Harriet Washington discusses how the acceptance of the use of black bodies for medical experimentation stems from eugenics ideology, which propagates the notion that people of African descent are intellectually inferior to those of Caucasian decent and are considered subhuman (Democracy NOW, 1/19/07). Dr. Washington explains how throughout American history there were studies conducted by the US medical institution on African-Americans, many of them conducted without
consent, were supported by the notion of black inferiority legitimatize medical experimentation on African-Americans for medical advancement. Furthermore, the belief that African-Americans are genetically different from White Americans is still shared today. A recent study at the University of Virginia revealed that white medical students and residents were more empathetic towards White-Americans than towards African-Americans, particularly when related to medical treatment or pain. Moreover, it reported that two-thirds of doctors surveyed harbored unconscious racial biases toward patients and often undertreated African-Americans for pain (Samarrai 2016). What is terrifying about this study is when evaluating the cause for these bias in attitudes and treatment, many of the white medical students and residents surveyed in this study believed false biological differences between Whites and African-Americans. These beliefs included that African-Americans aged more slowly than White-Americans, African-Americans’ nerve endings were less sensitive than White-Americans’; African-Americans’ blood coagulated more quickly than White-Americans’ and African-Americans had thicker skin compared to Whites’ (Samarrai 2016). The results of the study enlighten us about how racism permeates the clinical decisions of healthcare providers and how this contributes to health and healthcare disparities as African-Americans are seen as inherently different from White-Americans.

Racism and Creating Urban America

The false biological basis for the subjection of African-Americans to unethical medical experimentation and inferior medical treatment is an another extension of the same racist ideology which supported the notion for racial segregation in every aspect of American life beginning from slavery until present day. One of the more devastating
consequences of racism has been racial housing segregation as it has led to the further concentration of poverty, social and economic isolation, and marginalization of minority communities. Racial segregation has existed in the United States since slavery. Segregation was legal in every American public institution until the passing of Brown vs Board of Education (Brown Foundation for Educational Equity, Excellence and Research, 2015). Racial housing segregation, particularly in the case of African Americans and the formation of urban America, was an explicit and implicit process predating the Great Migration where millions of ex-slaves from the Southern states moved to the Northern states between 1980-1940. African-Americans were force to live in socially secluded and well defined sections of cities regardless of their socioeconomic status and solely based on the color of their skin (Logan, Zhang, Turner, & Shertzer 2015). With a concentration of African-Americans in specific locations, it allowed for politicians and policymakers to be inattentive to the needs of these communities and the development of entrenched poverty in urban America is a reflection of that negligence.

Racial housing segregation still exists today (ASA 2012) and the ramifications from the social, economic and political isolation of segregation continues to plague urban community. Furthermore, the suburbanization of America; the racial riots during the Civil Rights Movement; the loss of the industrial and manufacturing jobs in the 1960s-1980s; and the twin rising epidemics of drug abuse and mass incarceration has resulted in widespread urban decay. Urban decay is recognized as the social and spatial marginalization associated with white flight and segregation which reinforces substandard and unsafe housing, inadequate or limited access to medical treatment, underfunded schools and classroom overcrowding, lack of employment and increased exposure to crime
and violence and exposure to environmental hazards that is seen in many American inner
city communities (Ross and Mirowsky 2001; Semuels 2015). Ultimately, urban decay has
resulted in increasing the pre-existing health disparities created by racism.

Addressing Problems in Urban Health

In recognition of the multiple influences involved within urban health issues, the
Office of Disease Prevention and Health Promotion has initiated the Healthy People 2020
program which includes targeted policies to address negative social determinants of health
and to create and to examine social and physical environments that promote good health
for all with the overarching goal to promote health equity by declaring, “all Americans
deserve an equal opportunity to make the choices that lead to good health” (CDC 2012).
The Healthy People 2020 program specifically looks at five social determinants: economic
stability, education, health and healthcare, neighborhood and built environment and social
and community context with each social determinant is divided into subcategories.
Economic stability includes exposure to poverty, opportunities for and maintaining
employment, food security and housing stability. Education encompasses the completion
and attainment of a high school diploma, enrollment into a post-secondary education
program, language capacity, and literacy level. Health and healthcare accounts for access
to primary care, access to healthcare, and the health literacy of an individual. Neighborhood
and built environment are defined as access to healthy foods, quality of the housing
environment and general environmental conditions such as the lack of green space or close
proximity to industrial plants, toxicities and waste sites, and exposure to crime and
violence. Finally, social and community context looks at social cohesion, civic
engagement, perceptions of discrimination and equity and incarceration or
institutionalization (CDC 2012). Although I do applaud the initiative, I wonder if the frameworks being used to examine the social determinants of health in the urban environment are appropriate. In the urban environment, understanding the health of this population requires the inclusion of other factors and influences which may not be presented or play a minor role in the rural or suburban populations. Public health researchers investigated how living in urban centers affects the health of populations and argues how the different circumstances in the urban environment require a different set of methodological tools because “failure to acknowledge, and more importantly, to understand the role of social determinants in health and access to health and social services will hamper any effort to improve the health of the population” (Vlahov, Gibble; Freudenberg, Nicholas; Galea, Sandro 2004). Furthermore, given the history and the evolution of urban America there are fundamental differences in the lives of cities’ inhabitants which leads them to live lives which are characteristically unique compared every other population in America.

Incarceration in the urban setting is more than the social determinants of health as described by the Healthy People 2020 initiative. The Healthy People 2020 initiative recognizes how the physical, emotional and mental toll of incarceration causes poorer health outcomes because of the health risks and exposures individuals face in the prison environment. Examining incarceration as solely a social determinant of health tells an incomplete story because it fails to include why people are incarcerated in the first place. To complete the approach, incarceration must be analyzed as an adverse health outcome. By reviewing the research on the health and socio-economic status of incarcerated population prior, during and after imprisonment I make the argument that
prisoners have a predisposition to be incarcerated due the negative social determinants of health present in their natal neighborhoods. Furthermore, I illustrate how the evolution of mass incarceration is in part due to the US government imprisonment of many non-violent offenders by criminalizing drug abuse in part due to racial discrimination towards men of color, primarily African-American men. Also, I examine how drug abuse as a mental illness has been disregarded by the US Criminal Justice System and how racism has contributed to this factor. The dramatic increase in incarceration in the past four decades has been driven, by the coupling failures of the U.S Criminal Justice System to response to the drug crisis of the 1970s and 1980s with fair and comprehensive legislation to decrease the rate of drug abuse in this country and U.S. Healthcare System to appropriately delineate mental illness and addiction from criminality especially, in the urban communities. Ultimately, I explain how mass incarceration in the urban setting violates of each bioethical principle and how the racial disparities in the mass incarceration is a reflection and is an extension of the problems of racism inherent to the US and represents how limited progression has been in the fight to end racism in the US.

The Drug War and the Criminalization of Drug Abuse

America’s War on Drugs since the 1970s has resulted in the incarceration of millions of citizens without reducing the rate of drug use the US, in fact the rate of drug abuse has increased in recent years. In 2013, an estimated 24.6 million or 9.4% of Americans aged 12 or older had used an illicit drug in the past month compared to 8.3 percent in 2002 (NIH 2015). In the late 1970s, when the Nixon Administration declared a war on against the rising drug epidemic in the US, it created the Special Action Office for Drug Abuse Prevention (SAODAP), increased the presence of federal drug control
agencies, and pushed through drug policing measures such as mandatory sentencing and no-knock warrants (Frontline 2015). Under the Regan Administration, the anti-drug campaign “Just Say No” was launched and there was an expansion the prison system with the start of mass incarceration, the number of people behind bars for nonviolent drug law offenses increased from 50,000 in 1980 to over 400,000 by 1997 (DPA 2014). Furthermore, during the Reagan Era there were racial undertones used for the association of poor blacks, criminality and the crack epidemic. Therefore, when the Anti-Drug Law of 1986 passed and it created mandatory minimum sentences for drug trafficking crimes and it included the 100-to-1 crack-powder disparity where five grams of crack and 500 grams of powder cocaine had a five-year mandatory minimum; 50 grams of crack and five kilograms of powder cocaine trigger a ten-year mandatory minimum. The disparity in sentencing was based of unsupported claims that crack was more dangerous and addictive to users than powder cocaine, that prenatal crack exposure was more harmful and would lead to increasing amounts of crack babies born and that crack trafficking involved more guns and violence than powder cocaine trafficking. In 1988, Congress passed a five-year mandatory minimum for first-time simple possession of 5 grams of crack cocaine (FAMM 2012). The enactment of a five-year minimum prison sentence for even a first-time simple possession drug offense was alarming as the federal government was no longer punishing drug traffickers for drug crimes but was now punishing drug abuse and drug addiction.

Without distinguishing the difference between the intent to distribute and the intent to use, these anti-drug laws affectively equated drug use with criminality and thus, millions of drugs users and addicts were labeled as criminals. “In every year between 1980 and 2007, arrests for drug possession have constituted 64 percent or more of all drug arrests.
From 1999 through 2007, 80 percent or more of all drug arrests were for possession” (Human Rights Watch, 2009). The 1994 Crime Bill passed by the Clinton Administration escalated the War on Drugs with the ‘3-Strikes Law’ which gave life sentencing to those with two prior felonies which included drug crimes, increased arrests and incarceration rates by increasing the police force by 110,000, abolished the use of federal Pell grants for prisoners’ college tuition and expanded capital punishment (Shapiro 2016). Essentially all of the legislation passed to combat America’s drug epidemic was to punish drug abuse and not to treat or to provide chances for rehabilitation. The approach used combatting drug use, crime and the direction incarceration that has resulted in racial disparities in mass incarceration that requires inquiry. There has been and continues to be a specific targeting of African-Americans in the War on Drugs that requires special recognition as it is quite disturbing. In 2002, despite that fact that more than two-thirds of crack cocaine users in the U.S. are white or Hispanic, 80% of those incarcerated under the federal crack cocaine laws were black (NACCP 2016). These statistics reinforce the need to understand how racism and discrimination are the cause for why men of color, especially African-American men, have higher rates of incarceration compared to whites even the rates of drug use are not higher in the African-American community. Reevaluation of how the US Criminal Justice System functions will enlighten us about racism plays a determinant factor in who is incarcerated in the United States.

Who Goes to Jail and Prison in the US

At the end of 2014, 1,561,500 Americans were incarcerated in the US federal and state prisons, adding the jailed population that number increases to over 2.2 million (BJS 2015; BOJ 2015). According to the US Department of Justice, 50% of federal inmates and
16% of state prisoners were convicted drug offenders. In comparison, 53% of state prisoners and 7% of federal prisoners were serving time for violent offenses (BJS 2015). Additionally, according to a study published in 2010, prison and jail inmates were seven times likelier than the general population to have a substance use disorder (NCASA 2010). Nearly 63% of state prisoners who had a mental health problem had used drugs in the month before their arrest, compared to 49% of those without a mental health problem. (DOJ 2006). From the 2004 Department of Justice's Survey of Inmates in State and Federal Correctional Facilities and the 2002 Survey of Inmates in Local Jails, where a mental health problem was defined as receiving a clinical diagnosis or treatment by a mental health professional, 64.2 % of inmates met criteria (DOJ 2006). There is clear indication that substance abuse/addiction is a confounding factor for the increase likelihood for being arrested and convicted for a crime. However, as drug use was criminalized by the Nixon and Regan Administrations, this outcome is surprising but not totally unexpected. What is alarmingly and frankly scary is the amount of inmates who have been diagnosed with mental health illnesses.

Overall, incarceration of millions of mentally-ill individuals should raise questions about how mental health is approached and treated in the US. There are many ethical questions about autonomy, beneficence, non-maleficence and justice because those who are mentally ill, those who are drug abusing, and incarcerated populations are all considered special populations where the traditional conceptual understanding of the ethical principles are complicated by the limited ability for members of each group to act as the independent, well-informed and autonomous individuals. There should be health services provided to those with diagnosed mental health illness to help reduce the chance
of incarceration. The lack of proper infrastructure to prevent the incarceration of the mentally ill is even more troublesome as people of color and low income people are most likely to suffer the most from inadequate access mental healthcare services (NIMH 2015). As a result, poor people of color who have mental health illnesses have a greater risk of being incarcerated.

The majority of those convicted of what are defined as crimes are from low-income urban communities. According to the Department of Justice Statistics, African-Americans and Hispanic-Americans are disproportionately overrepresented in the criminal justice system. Nearly 3% of African-American males and 1% of Hispanic-American males were serving sentences of at least 1 year in prison at the end 2014, compared to less than 0.5% of non-Hispanic white male (BJS 2015). Of the male prison population, in 2014, an estimated 516,900 African-American males (37%), 453,500 White-American males (32%), and 308,700 Hispanic-American males (22%) were incarcerated (BJS 2015). Therefore, African-American and Hispanic-American men comprised 59% of all prisoners in 2014, even though African-American and Hispanic-American men make up approximately one quarter of the US population. Furthermore, African-American men have the highest rates of imprisonment in every age group. African-American men are 3.8 to 10.5 times more often than white men and 1.4 to 3.1 times more often than Hispanic men to be incarcerated (BJS 2015). For almost two decades, the Department of Justice has warned that if these incarceration rates persist, an African-American man has a greater than 1 in 4 chance of going to prison in his lifetime, a Hispanic-American man has a 1 in 6 chance, and a white man has a 1 in 23 chance of serving time (BOJ 1997). Despite these warnings, the incarceration rates for African-American and Hispanic-American men have
remained the same regardless of studies indicating the crime rates between the different racial groups are the same (NAACP 2016). As for women, although the female inmate population is significantly smaller than the male, as females accounted for approximately 7% of the total prison population in 2014 (BJS 2015) the number of women in prison increased by 646% between 1980 and 2010 (The Sentencing Project 2012). However, the same racial disparities are observed as the percentage of African-American and Hispanic-American women incarcerated is significantly higher than that of white women. According to the Sentencing Project, as of 2001, “the lifetime likelihood of imprisonment was “1 in 19 for black women, 1 in 45 for Hispanic women, 1 in 118 for white women” (The Sentencing Project 2012). Furthermore, in 2010, African-American women were incarcerated at nearly 3 times the rate of white women while Hispanic-American women were incarcerated at 1.6 times the rate of white women (The Sentencing Project 2012). There is a clear income disparity in the incarceration population as most inmates are from low income backgrounds, “in 2014 dollars, incarcerated people had a median annual income of $19,185 prior to their incarceration, which is 41% less than non-incarcerated people of similar ages” (Rabuy and Kopf 2015). As the average annual household incomes are lower for African-American and Hispanic-American households than that of White-American households, more poor racial and ethnic minorities have higher likelihoods to be incarcerated. The increase percentage of poor minorities incarcerated in the US is a problem that must be addressed.

Demographically, cities have more poor people, more people of color, higher rates of mental illness and reported crime rates thus, urban populations are overrepresented in the nation’s jails and prisons. As a result, US incarceration policies and programs have a
disproportionate impact on urban communities, especially in African-American and Hispanic-American communities, and contribute towards many issues which already plagued these communities. The potential health risks that the inmate and ex-prisoner populations pose to both themselves and to the communities they return to upon release is a very concerning matter as those communities are already vulnerable and have long histories of health disparities and health inequity. This call for the reanalysis of how the incarceration practices and policies affect the health of individuals, families, and communities. This is crucial as these health concerns are a relatively new area of study because of mass incarceration in this country is a relatively recent phenomenon. However, understanding the health conditions of prisoners before, during, after their incarceration is required first.

Health of Inmates Prior and During Incarceration

People who are incarcerated not only have a higher rate of mental illness compared to the general population but appear to have a higher rate of chronic medical illness and an increase risk communicable and sexually transmitted infections as well. The increase prevalence of medical issues in the incarcerated might reflect the poorer socioeconomic backgrounds the majority of inmates. And, the environments where inmates come from where the living conditions promote poorer health outcomes and riskier behaviors are coupled with a lack of access to healthcare providers. Also, given the racial disparities in incarceration, these numbers may reflect the extension of racism experienced in the health care system. According to the US Department of Justice’s Special Report “Medical Problems of State and Federal Prisoners and Jail Inmates”, in 2011–12, an estimated 40% of state and federal prisoners and jail inmates were reported to having a current chronic
medical condition while about half reported ever having a chronic medical condition. High blood pressure was the most common chronic condition reported by prisoners (30%) and jail inmates (26%). The majority of prisoners (74%) and jail inmates (62%) were overweight, obese, or morbidly obese. According to the CDC, in 2012, about 70 million American adults (29%) have high blood pressure, an estimated 69% of Americans were overweight and an estimated 35.1% were considered obese (CDC 2015). Higher rates of medical and mental illness highlights how the incarcerated population is a sick population in need of medical attention and care. Again, the higher prevalence of illness could serve as a reminder and a warning about the type of health environments many inmates are coming from. In other words, if the inmates are sicker than the general population upon entrance to prison then, we should inquire about the conditions within these environments which are making inmates sicker and potentially predisposing them to be incarcerated at a higher rate the general population.

Mass incarceration is a manner of public concern and health as incarcerated populations tend to have higher rates of infectious diseases. Amongst infectious diseases, the US Department of Justice reports an estimated 21% of prisoners and 14% of jail inmates reported ever having tuberculosis, hepatitis B or C, or other STDs excluding HIV or AIDS in 2012 (BOJ 2015). However, the rates of these infections are much lower in the general population, In the United States, 700,000-1.4 million people or less than .05% are estimated to be infected with the hepatitis B virus and an estimated 3.2 million or about 1% of the general population who are chronically infected with Hepatitis C in 2013 (CDC 2015). Currently, 1.2 million people in the United States are living with HIV infection with an estimated 536,000 who are unaware of their infection status (CDC 2015). The Department
of Justice calculated that in 2010 the prevalence of HIV/AIDS amongst inmates 146 per 10,000 at year (BJS 2010). This translates into a risk five times greater than the rate among people who were not incarcerated of contracting the virus while incarcerated. Although, most inmates with HIV acquire it in their communities, before they are incarcerated it remains a great public health concern. Fortunately, “the estimated rate of HIV/AIDS among state and federal prison inmates declined an average of 3% each year. During the same period, the AIDS-related death rate declined an average of 13% per year among inmates with HIV/AIDS and 16% among all prison inmates”. (BJS 2015) The decline in HIV/AIDS rates may be attributed to increase rapid HIV testing amongst inmates early in their incarceration, advances in the HAART therapy and increase access to healthcare to incarcerated population (CDC 2015). However, lack of awareness about HIV and lack of access to care back in the inmates’ communities, social stigma surrounding HIV/AIDS and high inmate turnover in county jails are still obstacles public health officials must overcome to address the high HIV/AIDS prevalence in the incarcerated and new released population (CDC 2015). Moreover, as these inmates return back to their communities there are larger concerns and questions about the effects of incarceration on community health.

Pre-Release and Challenges Facing Ex-Prisoners

While incarcerated, inmates have access to healthcare services that while limited, do allow these inmates to benefit from the managed healthcare provided by the prison system. Upon release many inmates lose their healthcare services. While incarcerated no one is Medicaid eligible, even if they were eligible prior to incarceration (USDHHS 2016). Restoring eligibility could take several months, and this interrupts access to prescription drugs and puts individuals at high risk of health risks and drug relapse. Many inmates often
face limited access and insufficient linkages to community-based health care upon release. According to the *Returning Home Study published* by the Urban Institute in 2006, which focuses on the many health-related challenges associated with reentry, including a special focus on returning prisoners with serious mental and physical illness and their families in four separate US states (Maryland, Ohio, Illinois and Texas). The majority or at least three quarters of the study’s respondents acknowledged they would need help getting health care after release (Bear, et al., 2006). The vast majority of returning prisoners did not have any form of medical insurance. Furthermore, many corrections agencies lacked proper or prior discharge planning and preparation for addressing health care needs upon release, making continuity of care difficult (Bear, et al., 2006). Having adequate access to healthcare services is vital, especially with the higher rates of physical and mental illnesses which put ex-prisoners at risk for a serious adverse health outcome without proper continuity of care or access to rehabilitation and community mental health programs.

The most dangerous time for an ex-prisoner is in the period immediately after their release. The New England Journal of Medicine published a study on the risk of death among former inmates soon after their release from Washington State prisons. The study indicated the leading causes of death among former inmates were drug overdose, cardiovascular disease, homicide, and suicide. Authors found the adjusted risk of death among former inmates was 3.5 times that among other state residents (Binswanger, Stern, Deyo, 2007). Strikingly, the study concluded that ex-inmates have the highest risk of death during the first 2 weeks after release. It found the risk of death among former inmates was 12.7 times higher than among other state residents in the first 2 weeks after release, with drug overdose being the most cause of death (Binswanger, Stern, Deyo, 2007). Therefore,
it is imperative for re-entry programs and systems to be in place to help with the transition from managed care while incarcerated to outpatient care upon release. Furthermore, as drug overdose is the most likely cause of death, mental health services including rehabilitation and substance abuse counseling both while incarcerated and after release are necessary to help prevent deaths and even reduce recidivism. Currently, 76.9% of drug offenders are re-arrested for a new crime within 5 years of release (BJS 2014). Without ignoring the multiple institutional barriers facing ex-inmates such as access to public housings, welfare benefits, social stigma associated with having a felony status such as loss of employment opportunities, individual choice that leads these individual to commit more crimes, the lack of proper rehabilitation and re-entry programs for former inmates is a matter of public health and proper implementation can help save lives. Fortunately, the Affordable Care Act of 2009 provides opportunities for prisoners to gain health insurance by giving them eligibility to apply for Medicaid and/or the health market up to 60 days after their release (ACA 2009; Rich, Wakeman and Dickman, 2011). New studies are required to see if there have been increase in the percentage of ex-prisoners enrolled into health insurance within the eligibility time frame and if there any effects on the overall health outcomes of these individuals.

Female Incarceration and Health

When divided amongst genders, another health disparity issue arises. Although the research on incarcerated women is limited, there are clear indications that female prisoners are a very vulnerable group and deal with a unique set of circumstances. Like their male counterparts, incarcerated women have higher rates of chronic diseases, infectious disease and mental illness when compared to the general population. However, compared to male
prisoners, there is a larger percentage of women with reported physical and/or mental health issues. Women in prison (59%) are more likely than are men (43%) to have chronic and/or communicable medical problems, including HIV, Hepatitis C, and other sexually transmitted diseases (The Sentencing Project 2012). Women tend to be at greater risk than men of entering prison with sexually transmitted diseases (STDs) and HIV/AIDS because of their greater participation in prostitution (BJS 2013). Further, 73% of women in state prisons in 2004 had symptoms of a current mental health problem, compared to 55% of men (The Sentencing Project 2012). The rates of self-harm and suicide are noticeably higher among female than among male prisoners (van en Bergh, Gatherer, Fraser, & Moller, 2011). Furthermore, female offenders have reproductive health needs, including those related to gynecological problems and prenatal and postpartum care.

Commentary about the relationship between the likelihood of incarceration and a background of physical and sexual abuse suggests that women with histories of trauma have a greater risk of being incarcerated in their lifetimes. In fact, women are documented likely than men to have poor mental health, often associated with experiencing domestic violence and physical and sexual abuse (UNODC, 2014). Studies indicate women in prison are twice as likely as women in the general public to report childhood histories of physical or sexual abuse (CANY 2013) and significantly more likely than male prisoners to have histories of abuse. Previous studies suggest that drug-dependent women offenders with multiple childhood traumatic events are at high risk for associated physical health problems (Jordan, Federman and Burns 2002). One study demonstrated a direct relationship between the increase rate of certain health disorders (e.g., addiction, gynecological problems, eating problems, suicidality, and symptoms of traumatic distress) in relation to the number of
traumatic childhood events experience by a drug dependent female offender in California’s prison system (Messina and Grella 2006) Also, the relatively small percentage of the incarcerated women compared to men puts them at risk for abuse and neglect given a male-dominated prison system. Female prisoners have higher rates of sexual and/or physical assault while incarcerated compared to men, these assaults are committed by both inmates and correctional staff. 2.5% of former female prisoners reported unwilling sexual activity with the facility staff compared to 1.1% of former male prisoners (BJS 2014). The large percentage of women prisoners with histories of violence, physical/sexual abuse, substance abuse, and mental illness is alarming. It also raises questions about the structure of societal and individual violence against women and how we understand criminality in women. Additionally, we should examine how we can better protect our female inmates from further abuse and trauma while incarcerated.

Without excusing criminal behavior, when a case is presented where a female defendant is noted to have a history of abuse and mental illness who commits a non-violent crime, is incarceration appropriate? Knowing there is an increase likelihood of more abuse and trauma once incarcerated, are we as a society comfortable with sending survivors of abuse and those with mental health issues to prison instead treatment? Unfortunately, we are too comfortable. This applies to both men and women. Too many times, the labeling of a person as ‘criminal’ allows for the general public to disregard the humanity of that individual. When an individual is labeled as a criminal then s/he is guilty and s/he is supposed to be punished. Crime and punishment becomes a zero sum game in the US Criminal Justice System, especially, when mandatory sentencing removes any room for judicial opinion to alter sentencing of an individual if the circumstances permit special
consideration. Thus, the nuances associated with criminality are forgotten and humanism in the US Criminal Justice System is lost. Without reexamining how we look at criminality, in terms of how we define a crime, criminal behavior and how we choose to punished those who violate our laws, we are in danger of infringing the bioethical rights of all incarcerated individuals as we jeopardized their health in the process.
CHAPTER 2: INCARCERATION AND URBAN BIOETHICS

The Urban Environment and Autonomy

Ethical questions arise concerning incarceration and health and health care as the physical state of incarceration itself inevitably conflicts with the all principles of bioethics: autonomy, beneficence, non-maleficence and justice. In the urban setting, as the drugs policies have disproportionately affected these communities, additional consideration should be given to how the criminalization and demonization of drug abuse, and how addiction has impinged on the bioethical rights of the members of urban communities. Autonomy is the first and most obvious one. Autonomy is defined as the right for a person with decision making capacity to voluntarily make informed medical and health choices on her/his behalf (Beauchamp and Childress 2012). In general, prisoners are considered a vulnerable patient population and they cannot legally give consent therefore, they cannot advocate for their own choice of health care providers or medications as imprisonment often forgoes their right to autonomy (Beauchamp and Childress 2012). At best, healthcare providers can negotiate with prison officials on behalf of prisoners to provide them necessary and decent care, yet these providers are somewhat preselected by the US Criminal Justice System and may have their bias towards inmates. Without surprise, the loss of personal freedom as a punishment for committing a crime coincides with loss of choice. Yet, as the loss of personal choice extends to loss of agency and its implications, especially in the context of urban health and incarceration, there is another layer of complexity to this issue.

In urban bioethics, the principle of autonomy incorporates how past and present institutional discrimination and oppression have politically disenfranchised and socially
ostracized members of urban communities and disallows them from acting as the autonomous individuals envisioned by the founders of bioethics. Prior to incarceration, people from underserved urban communities are already imprisoned by their immediate external environments and by the greater society. Living in these impoverished communities with high crime and violence, inadequate housing, lack of educational options and opportunities, low employment rates and opportunities for employment, food deserts, and low access to green spaces, does not automatically increase the likelihood of committing crime (especially drug-related crimes) but does increase the likelihood of being convicted of a drug-related offense. Furthermore, growing up in these communities does not automatically mean that an individual will have an increased likelihood of using drugs. The real problem is that there is the automatic association between urban poverty and increased drug use and criminal activity. Studies have indicated that there is similar substance use among residents in underserved urban communities when compared to more white and middle-class communities (Saxe, et al., 2001) (Drug Policy Alliance, 2015). Drug sales in disadvantaged neighborhoods, neighborhoods with high concentrations of minorities, and neighborhoods with high population densities were 6.3 times more likely to be reported in the most disadvantaged neighborhoods than in the least disadvantaged, while illicit drug use was only 1.3 times more likely (Saxe and Kadushin 2001). Researchers on patterns of incarceration found that incarceration affects urban communities more because “historically arrests rates have been much greater for blacks than whites” (Neal and Rick 2014) not because drug use is more prevalent. The grouping of criminality, drug use, and urban poverty has led to the general endorsement of harsh penalization by the criminal justice system for drug crimes and allows for increase rates of
arrest in low income urban communities. As recipients of societal neglect and targeted communities of the war on drugs, the autonomy of the both the urban community as a whole and the individuals who reside in it is constantly undermined. A majority of the community’s members are not empowered to make informed decisions about the conditions of their communities which would improve the health of the entire community and quality of life. This lack of power to promote community uplift, plus the continual devastating effects of the mass incarceration should question how we are defining autonomy in the urban setting. Furthermore, given the history of the War on Drugs and its effect in the urban community, a conversation about the criminalization of drug use, how we understand drug dependence, and how drug addiction should alter how we define autonomy is necessary.

Addiction, Mental Illness and Autonomy

Is incarceration an appropriate punishment for a drug dependent offender whose crime is possession or a non-violent charge? If we consider drug addiction as a medical problem then, the drug-dependent non-violent offender should have the right to be offered and to receive medical treatment before imprisonment is considered as an option. The argument that an offender can seek drug abuse counseling if he/she chooses to exercise their right to autonomy before committing a crime or while and/or during their incarceration is naïve at best. There are mandatory drug sentencing laws which imprisons millions of Americans every year. Those who are suffering from addiction are aware of penalties (whether or not they understand the severities of those penalties is debatable) but repeatedly break the law regardless because of their addiction. Drug addiction is well-recognized to have cognitive, behavioral, and physiological characteristics that contribute
to continued use of drugs despite the potential negative consequences. Further, chronic drug abuse alters the brain’s anatomy and chemistry and these changes can last for months or years and lead to relapse even after a long period of abstinence (NIDA 2012). According to the BOJ, among state prisoners who were dependent on or abusing drugs, 53% had at least three prior sentences to probation or incarceration, compared to 32% of other inmates (BOJ 2004). Also, at the time of arrest, drug dependent or abusing state prisoners (48%) were also more likely than other inmates (37%) to have been on Probation or Parole supervision (BOJ 2004). Yet, only 40% of state and 49% of federal inmates who were classified as drug dependent/abusing prisoners took part in drug abuse treatment or programs since admission to prison (Mumola & Karberg, 2006). Of those who participated in such programs, inmates were more likely to report participation in self-help or peer counseling groups and education programs (35%) than to receive drug treatment from a trained professional (15%) (Mumola & Karberg, 2006). If help is not provided to all those who meet the criteria for drug abuse/addiction, then incarceration does not allow an individual to act autonomously in even the slightest degree because options are not provided for a prisoner to make an informed decision about their health. Having empathy for those we consider guilty is difficult. However, we empathize for people who suffer from coronary heart disease and have a serious adverse event such as a myocardial infraction (MI). It is common knowledge a certain lifestyle and eating habits will increase the odds of sudden death secondary to a MI yet, we do not think of imprisoning those types of patients nor do we under treat those patients.

Ultimately, the problem is two-folded. First the US Criminal Justice System punishes a person for having a drug addiction and second, the health care system fails to
protect them from persecution and has failed has a provided substantial mental health and abuse counseling programs to help with prevention. We must ask ourselves: is an offender who is drug-dependent able to act autonomously? If we decide this individual is autonomous as we define the term and issue punishments in accordance to the drug laws then, we are refusing to acknowledge the nuances associated with autonomy amongst those with drug addiction and this decision leads to the violation of bioethical principles such as beneficence, non-maleficence and ultimately justice when examined in a larger societal context.

Beneficence, Non-Maleficence and Incarceration

Beneficence and non-maleficence are aimed to protect patients and optimize their potential health outcomes. Beneficence is defined as the healthcare provider’s obligation to work in the best interest of the patient and non-maleficence is defined as a principle to do no harm to the patient. Beneficence is based in the understanding there is a duty to help others by preventing and/or removing harm and by promoting good (Beauchamp and Childress 2012). According to Beauchamp and Childress, beneficence extends to “protect and defend the rights of others, prevent harm from occurring to others, to remove conditions that will cause harm to others, to help persons with disabilities and rescue persons in danger” (Jones and Bartlett, 52). Non-maleficence extends more specific moral rules “like do not kill, do not cause pain or suffering, do not incapacitate, do not cause offence and to do not deprive others of the goods of life” (Jones and Bartlett, 52).

Incarceration does not protect inmates or does it guarantee rehabilitation. If examining beneficence and non-maleficence as guiding principles to protect the larger society from the dangers (and thus people) associated with drugs then, one could argue harsh
penalization for drugs makes America safer. However, does mass incarceration make our society safer? The simple answer is no. Almost 45% of the 95,305 individuals in federal prison for drug offenses are in the lowest two criminal history categories and an estimated 26% have no prior criminal history (Urban Institute, 2014). Therefore, incarcerating citizens for drug offenses does not reduce violent crime. Also, mass incarceration for drug offenses has not solved America’s drug problem. Although the United States has the most stringent drug penalties, more Americans use illicit drugs compared to any other developed country in the world and rate of illicit drug use has remained relatively stable (United Nations Office on Drugs and Crime, 2013) Sadly, America’s War on Drugs has done more harm than good.

Incarceration increases risk of exposure to disease and violence, especially for women. Statistically, those who are sicker, who carry a high burden of disease and those with substance abuse disorder are more likely to be incarcerated, especially if he/she comes from an urban setting (BOJ 2015). The predisposition for a person who comes from an urban environment to be incarcerated indicates incarceration is not only a social determinant of health but is consequence of ill-directed policy. Given that statistically African-American men have a 1 in 4 chance of going to prison in their lifetime and Hispanic-American men have a 1 in 6 chance of going to prison in their lifetime (BOJ 1997) then, incarceration becomes an integral part of urban life. Incarceration becomes a cultural norm and an anticipated life experience like marriage, childbirth and graduations. Therefore, incarceration is not social determinant of health, incarceration is an expectant outcome in these communities.
The danger when incarceration becomes a normal life experience is that the ramifications of incarceration extend beyond the physical state of imprisonment. Incarceration compromises the development of social capital and community development in urban communities. Historically underfunded and underinvested, communities are further disadvantaged by incarceration. The imprisonment of large percentages of members from certain communities ultimately harms the entire communities as prison removes caretakers and potential contributors from both the home and the community (Massoglia 2008; Massogila and Pridemore 2015). Many states bar former inmates from educational loans, welfare, public housing and other forms of public assistance and most former prisoners, particularly African-American men—have difficulty finding employment. Without employment, the hopes for rehabilitation and stabilization and the chances of ex-prisoners becoming productive members of societies drastically decreases and the chances of them recommitting crime increase (Petiti & Western 2004; Pager, Western & Sugie 2009). Therefore, if the goals of incarcerations are to rehabilitate an individual, incarceration hinders that process because the social stigma and the loss of access to social goals places great limitations on their abilities to reconstruct their lives.

Ultimately, incarceration harms more than the individual who is incarcerated. As African-American and Hispanic-American men are disproportionately incarcerated, the cumulative effects of incarceration are greater in their respective communities. Additionally, as incarceration removes large numbers of young men in some communities and as most inmates will eventually return to the community, those communities are more susceptible to infectious diseases like TB, Hepatitis B and C, HIV and other STDs because incarceration creates social structures conducive transmission of those diseases.
Furthermore, as treatment is frequently interrupted upon release, there is the potential for increase rates of resistance to current medical therapies (Dumont, Allen & Brockmann 2013; Gaiter, Potter & O’Leary 2006), which would create additional public health concerns for those communities and the larger society. The health, economic and social burdens placed on these communities as ex-prisoners face challenges with re-entry back into their communities are issues which should be addressed with new legislation and policies. However, if the principles of beneficence and non-maleficence are to be upheld in the discussion of mass incarceration, it most important that the conditions not only created by incarceration be prevented but the drivers of mass incarceration be addressed and prevented as well.

Justice for All… Maybe

The criminality imposed on drug abuse and addiction, the racial discrimination apparent in drug laws and sentencing along police targeting of urban communities has created the racial disparities seen in mass incarceration and has had and continues to have detrimental effects on urban communities. The additional loss of rights and access to public goods to ex-prisoners acts as continual punishment. Worst of all, mass incarceration has created an urban underclass that is mostly comprised of African-American men. In her book, The New Jim Crow: Mass Incarceration in the Age of Colorblindness, legal scholar Michelle Alexander explains how the mass incarceration of African-American men is a continuation of the systematic racist oppression that has existed in the US since slavery. Alexander argues that the increase incarceration rates of African-American men predates the US War on Drugs (Alexander 2010). She claims that the so called ‘tough on crime rhetoric’ spouted by both Republicans and Democrats in the past few decades were tainted
with coded language that equated drug use with black criminality. Thus, the popular support for the passage of legislation which rendered millions African-Americans to second class citizenship with the loss of civil rights and access to social goods was underpinned by the same ideology that justified to the oppressive conditions of slavery and Jim Crow as black men were considered dangers to society and a threat to white people (Alexander 2010). Recognizing how drugs were plaguing urban communities and the call by African-American leaders to stop the violence that was associated with drugs in the inner cities, Alexander clarifies that increase of policing of urban communities and implementation of drugs laws and mandatory sentencing was an incomplete and disastrous approach as the root causes for crime in urban communities were ignored by the US government but punishment was sensationalized.

There have been efforts made to reduce the racial disparity in incarceration. The Obama administration has worked to reduce jail time for federal prisoners in for some drug offenses with the passage of The Fair Sentencing Act of 2010 the sentencing disparity between crack-cocaine from 100:1 to 18:1 (ALCU 2012). Recently, there was another attempt made to address the problem of mass incarceration in the US, the Smarter Sentencing Act of 2015 was introduced to the Senate, it another attempt by the federal government to address the problems associated with mass incarceration, include overcrowding and cost. “This bill does not repeal any federal mandatory minimum sentences, but instead reduces prison costs and populations by creating fairer, less costly minimum terms for nonviolent drug offenders” (FAMM 2015). Although these attempts are aimed at eliminating or reducing new injustices and reconciling some of the past ones, as along as the disparity in arrests and imprisonment still exists, the injustice continues.
Although legislative action is required to prevent future arrests and to either release or reduce the sentences of those currently serving time for non-violent drug offenses, any legislation passed should include policies that help to rehabilitate and to rebuild lives of those affected by mass incarceration. This extends the urban communities themselves as “the principle of justice underlies concerns about how social benefits and burdens should be distributed” (Jones and Bartlett, 58). The burden of mass incarceration has disproportionately affected urban America. Therefore, urban communities should receive more aid from the federal and state governments in the form of reparations for the social, economic, and political grievances created by the destructive laws and policies which severely decrease the potential for the development for social capital, growth and wealth. These reparations are reinvestments into urban communities. They include but are not limited to improving public housing and providing favorable mortgage loans to those who qualify, investing in all levels of education and providing free/low cost vocational training, employment opportunities through small business grants/loans, reducing discrimination in the job market for ex-prisoners by providing monetary incentives like tax breaks for employers who hire individuals with criminal records, creating strong community health programs with dedicated funding and resources for combatting drug abuse/addiction and other mental services, reinstating voting rights for all, creating strong community associations with a system of accountability with local government to deal racial profiling and policing targeting in these urban communities. These are simple examples of how we can begin to repair the damage inflicted on these communities in the form of distributive justice.
Distributive justice focuses on the right of all individuals to be treated as equals. This equality extends to include the concept of equity, which includes the right of every individual to an equal share according to need, effort, contribution, merit and free market exchanges (Beauchamp and Childress 2012). Importantly, distributive justice recognizes that in order for everyone to be as equals, people must be treated unequally in order to achieve equity for all. In other words, those who are poorer or are in greater needs of social goods should receive more goods compared to those who are more self-reliant and self-sufficient to reach the same basic standard of living. Urban communities have disproportionally been the recipients of these destructive policies therefore, it is our responsibility to repair the situation. Ultimately, this course of action benefits the entire society as whole. Reparations are investments for America as the current system is not only costly to urban communities but to all Americans. Mass incarceration costs the country about $70 billion annually (NAACP 2016), this money would be better allocated in funding social capital development programs. If distributive justice is the goal, as African-American and Hispanic-American men and the urban communities they come from bear the greatest share of the social burdens associated with incarceration; then it is only fair and just that African-American and Hispanic-American men and those same urban communities receive the greatest share social benefits gained by reducing racial disparities in incarceration.

Conclusion

Mass incarceration has been and continues to be detrimental to urban communities across the US. The criminalization of drugs coupled with racist drugs laws and police practicing have led to the incarceration of millions of people of color, especially African
American men. The racial disparities seen in mass incarceration demonstrate how much racism continues to play major role in American society and comprises the health of some more vulnerable members of our society. For the past few decades’ urban communities, have been punished disproportionately for what we have labeled as crimes. Yet, mass incarceration has not halted drug use in the United States, but the consequences of incarceration have increase poverty and limited the progression of urban America. Mass incarceration has destroyed lives, families and communities. Also, as drug abuse and addiction are treated with incarceration instead of rehabilitation, we are in danger of incarcerating some of the most vulnerable of our society. As poor people in urban communities have greater chance of experiencing health and health disparities, they have a greater likelihood to be incarcerated for failure to gain access to proper medical care and treatment for all illness including mental health illness and drug abuse. There is a need for action and social justice for all those affected by mass incarceration. Urban bioethics is based off the concept that each bioethical principle confronts the challenges that are present in the urban environment and to the members of those communities and tries to empower them to act in their best interest. In order to empower the members of urban communities, we must address the underlying causes of their troubles which includes the inherent racism that predisposing them to the conditions of poverty and social, political, economic isolation that imprisons their communities long before physical incarceration.
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