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African American Men's Health and Incarceration: Access to Care upon Reentry and Eliminating Invisible Punishments

Amy L. Katzen

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Commentary

African American Men’s Health and Incarceration: Access to Care upon Reentry and Eliminating Invisible Punishments

Amy L. Katzen[†]

ABSTRACT

African American men suffer worse health outcomes and have a lower life expectancy than other demographic groups. The disproportionately high incarceration rates of African American men for drug and other crimes is a crucial factor in understanding and combating health inequities. Being imprisoned is very bad for inmates’ health because of damaging physical conditions and high levels of stress, as well as poor prison health care. Upon release, formerly incarcerated individuals have trouble accessing routine health care and are deprived of the traditional social safety net of health insurance, housing assistance, food assistance, and cash benefits. Unfortunately, constitutional challenges to prison health care systems are unlikely to eliminate the health risks of being incarcerated. Therefore, this Commentary argues that we must provide free or low-cost, culturally competent health care immediately and seamlessly upon prisoner release and work to reduce the impact of “invisible punishments,” those civil penalties that deny formerly incarcerated individuals access to social programs. Because these health disparities are avoidable, society has a moral imperative to reduce and eventually eliminate them.

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INTRODUCTION

Kenneth Mays Jr. is on parole in San Francisco, California.¹ After ten years of moving in and out of prison on a range of drug and robbery charges, he needs support to avoid going back to using cocaine, and he needs a doctor's help to manage his hypertension.² In prison, he explains, "I was just a number. . . . I was not a person, not a black man with high blood pressure. They have no ears for what's going on with you."³ Fortunately, Mr. Mays is a patient at San Francisco's Transitions Clinic, a health center designed to serve parolees from the state's prison system.⁴ He goes to the clinic once or twice a month, and reports that the Transitions staff is like his family, providing him with health care "as good as President Obama's."⁵ Another Transitions patient, Donald Bachman, has had great difficulty staying out of prison, in part due to mental health problems.⁶ When he is on parole, he depends on community health worker Ronald Sanders

† Amy L. Katzen is a joint J.D. and Masters in Public Policy student at the University of California, Berkeley, School of Law and Goldman School of Public Policy. She would like to thank Lisa Quay of the Chief Justice Earl Warren Institute on Law and Social Policy for her help in developing the concept for this Commentary, Professor Gillian Lester of Berkeley Law for her excellent feedback and advice on early drafts, and Allison Hartry and members of the Berkeley Journal of Gender, Law & Justice for their skilled and patient editing of many drafts.

1. April Dembosky, *Clinic Works to Include Ex-Inmates in Health Care's Embrace*, N.Y. TIMES, Feb. 5, 2010, at A19, available at <http://www.nytimes.com/2010/02/05/us/05sfprison.html>.

2. *Id.*

3. *Id.*

4. *Id.*

5. *Id.*

6. Bernice Yeung, *Ron Sanders: Standing between Parolees and Prison*, S.F. CHRON., Mar. 30, 2008, at P-9, available at http://articles.sfgate.com/2008-03-30/living/17169128_1_parolees-cell-phone-southeast-health-clinic.

to help him find a place to stay.⁷ "If he would have been out on the streets," Sanders explains, "that would have been it."⁸

The Transitions Clinic uses proactive outreach techniques, speaks to prisoners before their release to encourage them to visit the clinic, and offers a non-judgmental approach.⁹ As Mr. Sanders explains, drawing on his own experience in the criminal justice system, "You get out, and you're angry. A lot of these other clinics don't know how to deal with ex-cons, how to talk to them, how to approach them."¹⁰ Another member of the Transitions staff explains, "I've seen a lot of conflict in the public health care system. We carry a lot of resentment and trauma from the experience in prison, and sometimes that can be acted out. [Other health care staffers have] not been trained to be sensitive to that population."¹¹ The result of this disconnect is dramatic. Dr. John Stobo, senior vice president for health sciences and services for the University of California medical system, explains, "You have uncontrolled hypertension leading to stroke, heart failure; uncontrolled diabetes, leading to leg ulcers, kidney failure, blindness, heart failure; untreated cancers."¹² While the patients at the Transitions Clinic have a good chance of avoiding the worst outcomes, the clinic is the first of its kind and replication in other locations has been gradual.¹³ Formerly incarcerated people in the rest of the country are left to try their luck in a health care system that is ill prepared to meet their needs.

Many African American men face many serious challenges to staying healthy, including growing up in neighborhoods of concentrated poverty, receiving lower-quality education, and experiencing persistent racism that can limit employment opportunities. In many ways, however, the most distinctive challenge African American men face is that they are disproportionately locked away in our nation's prisons.¹⁴ Although all of these challenges contribute to the serious health inequities that lead to a life expectancy one decade shorter than white men's,¹⁵ the effect of incarceration and its aftermath is especially dramatic.

Prisons in the United States are distinctively male places, both in the sense that most prisoners are male¹⁶ and in the sense that male prisoners strongly ad-

7. *Id.*

8. *Id.*

9. Dembosky, *supra* note 1.

10. *Id.*

11. *Id.*

12. *Id.*

13. *Id.*

14. LOIS M. DAVIS, M. REBECCA KILBURN & DANA J. SCHULTZ, RAND CORP., REPARABLE HARM: ASSESSING AND ADDRESSING DISPARITIES FACED BY BOYS AND MEN OF COLOR IN CALIFORNIA 15 (2009).

15. PROOCHISTA ARIANA, HEALTH INEQUALITIES IN AMERICA 66 (2007).

16. THE HENRY J. KAISER FAM. FOUND., ADULT PRISONERS UNDER STATE JURISDICTION BY GENDER, 2007, <http://www.statehealthfacts.org/comparemaptable.jsp?ind=863&cat=1> (stating that, nationwide in 2007, there were 114,420 female prisoners and 1,483,896 male prisoners). However, it is also important to note that the rate of female incarceration is growing rapidly. ACLU, FACTS ABOUT THE OVER-INCARCERATION OF WOMEN IN THE UNITED

here to the dominant social ideal of masculinity that exists outside prison walls.¹⁷ Performance of this masculine ideal, both in the general population and among the formerly incarcerated, is only one factor that helps explain why men experience worse health outcomes than women.¹⁸ Men are less likely to access health care services, even when they have an existing health problem.¹⁹ This is partially because the dominant ideal of masculinity requires a demonstration of strength, while asking for help and caring for one's health is considered feminine.²⁰ For former prisoners returning to the community, accessing health care is not only difficult because they may lack insurance or money to pay for services but because asking for help risks undermining their male identities. While race is an essential element of the unequal health outcomes African American men suffer, gender is also an important issue, and solutions to health inequities must include ways to help men access services without abandoning closely held masculine values.

In Part I of this Commentary, I demonstrate that African American men suffer from worse health outcomes and a lower life expectancy than other demographic groups. Because these disparities are avoidable rather than the product of genetics or freely chosen behaviors, they represent a moral problem for society. In Part II, I describe how the incarceration of African American men for drug and other crimes is a crucial factor in understanding and combating health inequities. First, African American men are incarcerated at much higher rates than any other demographic group. Second, being imprisoned is very bad for inmates' health; the physical conditions are damaging, the stress of being in prison harms health, and prison health care is inadequate. In Part III, I discuss how, upon release, formerly incarcerated individuals have trouble accessing routine health care and are deprived of the traditional social safety net of health insurance, housing assistance, food assistance, and cash benefits.

To address these problems, in Part IV, I consider several possible reforms, beginning with constitutional challenges to prison health care systems. While constitutional challenges are crucial and should continue, they are unlikely to eliminate the health risks of being incarcerated. I then consider ways to improve health care access for formerly incarcerated persons and conclude that free or

STATES, Dec. 12, 2007, <http://www.aclu.org/womens-rights/facts-about-over-incarceration-women-united-states>.

17. James W. Messerschmidt, *Masculinities, Crime, and Prison*, in PRISON MASCULINITIES 67, 70 (Don Sabo, Terry A. Kupers & Willie London eds. 2001) (describing the dominant prison masculinity as "hard, silent stoicism" and explaining how this masculinity is based on the same hegemonic male ideal outside of prison—the ideal of "self-restraint, reserve, toughness, emotional balance, and loyalty") (quoting Gresham Sykes and Francis Cullen).
18. Will H. Courtenay, *Constructions of Masculinity and Their Influence on Men's Wellbeing: A Theory of Gender and Health*, 50 SOC. SCI. & MED. 1385, 1385 (2000) (noting that men in the United States die an average of seven years earlier than women, have higher death rates for all fifteen leading causes of death, and suffer from chronic diseases at greater rates and at earlier ages).
19. *Id.* at 1386.
20. *Id.* at 1389.

low-cost, culturally competent care made available immediately and seamlessly upon release is the key to helping the formerly incarcerated regain their health. In addition, we must work to reduce the impact of "invisible punishments," those civil penalties that deny access to social programs to people with criminal convictions, especially those with records of drug felonies. I conclude that political efforts are much more likely than legal challenges to succeed.

I. AFRICAN AMERICAN MEN SUFFER FROM SERIOUS AND PERSISTENT HEALTH INEQUITIES

An African American boy born today can expect to be sicker throughout his life and die significantly sooner than an African American girl or a white child of any gender. Specifically, an African American boy born in 2004 faces a life expectancy of 69.5 years while an African American girl born the same year can expect to reach 76.3 years, and white men and women can expect to live 78.3 and 80.8 years, respectively.²¹ An African American male newborn will die, on average, nearly a decade before the white male lying next to him in the hospital nursery.

Data for specific causes of death helps explain this stark gap.²² Nationally, 364.3 African American men per 100,000 will die of heart disease while only 286.9 white men per 100,000 will die of the same disease.²³ Similar patterns persist in cancer deaths: African American men suffer 301.2 cancer deaths per 100,000 compared to 224.4 per 100,000 for white men.²⁴ Morbidity data describing the disease burden suffered by different groups also confirms that African American men are more likely to be sick. African American men have the highest rates of hospitalizations for uncontrolled diabetes of any group at 88.1 per 100,000 in contrast to 17.3 per 100,000 for white men.²⁵ In California, African American boys and men are 3.7 times more likely to be hospitalized for childhood asthma, 6.9 times more likely to contract HIV/AIDS, and 2.5 times more likely to experience Post-Traumatic Stress Disorder than are white men or boys.²⁶

The mere fact that there are differences between groups is not necessarily cause for alarm. Although differences in health outcomes between various

21. ARIANA, *supra* note 15, at 66.

22. In this Commentary, I will focus on acute disease and chronic illness because they are responsible for a large portion of total mortality. However, mortality associated with violence is also an important factor in health inequities. In 2000, the homicide death rates for African Americans was 20.5 per 100,000 people, while for whites it was 3.6 per 100,000, making the homicide rate for African Americans 5.7 times higher. David R. Williams & Pamela Braboy Jackson, *Social Sources of Racial Disparities in Health*, 24 HEALTH AFF. 325, 326 (2005).

23. ARIANA, *supra* note 15, at 71.

24. *Id.* at 72.

25. Carolina Casares et. al., *Prevention and Men of Color in the U.S.: Findings from the National Healthcare Disparities Report*, CHALLENGE: A JOURNAL OF RESEARCH ON AFRICAN AMERICAN MEN, Fall 2006, at 10.

26. See DAVIS, KILBURN & SCHULTZ, *supra* note 14, at 16.

groups of people are not uncommon, these differences fall into the category of “health inequities,” which the World Health Organization defines as “differences [in health status], which are unnecessary and avoidable but, in addition, are also considered unfair and unjust.”²⁷ In general, health differences that are due to genetic differences or health-damaging behaviors that individuals choose freely are not considered health inequities.²⁸ In the case of persistent racial health disparities, both genetic and behavioral factors, though not irrelevant, cannot come close to explaining the gaps.

Differences in socioeconomic status, behavior, access to and quality of health care, and the environment to which different groups are exposed each contribute to health disparities.²⁹ Socioeconomic status, behavior, and health care quality cannot account for the full difference in health outcomes, however.³⁰ Individual genetics, meanwhile, can have a significant effect on a given person’s health outcomes but contribute little to our understanding of population differences. Most genetic predispositions interact crucially with environmental factors before leading to a particular result, and individuals of the same race vary much more in their genes than genes vary across races, so genetics cannot help explain differences in health outcomes between these groups.³¹ Therefore, in order to combat the health inequities that leave African American men with a decade less to live, we must examine environmental factors.

The Alameda County Public Health Department has identified a set of factors closely linked to inequities in health outcomes. These include income, wealth, and employment; education; housing; transportation; air quality; food and liquor store access; physical activity and neighborhood conditions; access to health care; community relationships; and criminal justice and incarceration.³² Of these factors, most have similar effects on both men and women. However, high incarceration rates disproportionately impact African American men and therefore merit particular attention here.

27. Margaret Whitehead, *The Concepts and Principles of Equity in Health*, 6 HEALTH PROMOTION INT’L 217, 219 (1992).

28. *Id.* at 219-20.

29. D. Phuong Do et. al., *Does Place Explain Racial Health Disparities? Quantifying the Contribution of Residential Context to the Black/White Health Gap in the United States*, 67 SOC. SCI. & MED. 1258, 1258 (2008).

30. *See id.*; ALAMEDA COUNTY PUB. HEALTH DEPT., LIFE AND DEATH FROM UNNATURAL CAUSES: HEALTH AND SOCIAL INEQUITY IN ALAMEDA COUNTY viii (2008) [hereinafter UNNATURAL CAUSES] (quoting former U.S. Surgeon General David Satcher that access to health care only accounts for 15-20 percent of the variation in morbidity and mortality across different groups in the U.S.); *see also* U.S. DEPT. OF HEALTH AND HUM. SERVS., CTRS. FOR DISEASE CONTROL AND PREVENTION, ESTABLISHING A HOLISTIC FRAMEWORK TO REDUCE INEQUITIES IN HIV, VIRAL HEPATITIS, STDs, AND TUBERCULOSIS IN THE UNITED STATES 7 (2010) (explaining that there are five factors that determine population health: biology and genetics, individual behavior, social environment, physical environment, and health services).

31. Do, *supra* note 29, at 1259.

32. UNNATURAL CAUSES, *supra* note 30, at xii-xv.

II. HIGH RATES OF INCARCERATION AND THE HEALTH-DAMAGING EFFECTS OF PRISON COMBINE TO EXACERBATE THE HEALTH PROBLEMS FACED BY AFRICAN AMERICAN MEN

African American men are incarcerated at high and disproportionate rates, especially for drug crimes, and are more likely than other groups to face long sentences under the state “Three Strikes” laws discussed below. The prison system in the United States seriously damages health, and part of the reason African American men suffer worse health is that they spend more time on average in prison, a place that undermines health. This explains part of the reason that African American men experience such dramatic and severe health inequities.

A. Disproportionate Incarceration of African American Men

African American men are 5.5 times more likely than white men to go to prison in their lifetime. One in three African American men go to prison in their lifetime, while only one in seventeen white men do so.³³ African American men are represented in prisons at 4.3 times their proportion of the general population.³⁴ African Americans are 14 percent of regular drug users but represent 37 percent of those arrested for drug offenses, demonstrating that the high rates of incarceration are not—or at least not exclusively—based on higher rates of criminal activity.³⁵

A study of Seattle, Washington’s drug enforcement policies illustrates one example of how African American men are at higher risk of incarceration.³⁶ The authors note several competing explanations for African Americans’ high drug arrest rates, including higher rates of drug dealing due to socioeconomic need, greater likelihood of selling in outdoor spaces where dealers are more likely to be seen by police, overt racist motives on the part of police, and implicit bias that leads police to perceive African American offenders as more dangerous and therefore in greater need of arrest.³⁷ The study concludes that Seattle law enforcement’s focus on outdoor drug markets where more African American dealers are present and on those drug market areas that are racially heterogeneous rather than predominantly white, as well as the disproportionate focus on dealers selling crack cocaine instead of drugs used more by whites, all contribute to the disproportionate numbers of arrests of African Americans for drug delivery in Seattle.³⁸ These law enforcement decisions cannot be explained by race-neutral rationales such as citizen complaints, crime rates, or efficiency.³⁹ Each city is

33. DAVIS, KILBURN & SCHULTZ, *supra* note 14, at 16.

34. *Id.* at 104.

35. UNNATURAL CAUSES, *supra* note 30, at 114.

36. Katherine Beckett et. al., *Race, Drugs, and Policing: Understanding Disparities in Drug Delivery Arrests*, 44 CRIMINOLOGY 105 (2006).

37. *Id.* at 106-07.

38. *Id.* at 129.

39. *Id.*

different, so law enforcement patterns will likely vary considerably. This study indicates, however, that we should not assume that differences in the rate of actual crime commission are primarily responsible for different arrest rates.

In addition, “Three Strikes” laws disproportionately affect African Americans. Twenty-four states had variations on a “Three Strikes” law in 2006.⁴⁰ The specifics of these laws vary across states, but they all serve to increase punishment for successive crimes; a person who has already committed a crime will receive a longer sentence for a subsequent crime than a person who commits the same crime but does not have a criminal record.⁴¹ In California, the law requires that a person convicted of a third felony serve twenty-five years to life in prison—that is, the person is “out” of society after his or her third “strike.”⁴² Although these policies vary in the number of strikes required to receive a longer sentence, the crimes that qualify as strikes, and how much prison time is added to a sentence, they all share the capacity to significantly increase the number of people in prison.⁴³ In California, the “Three Strikes” law operates to increase prison sentences dramatically.⁴⁴ Once again, African American men bear the brunt of the policy; the incarceration rate under “Three Strikes” is nineteen times higher for African Americans than for whites.⁴⁵

B. Increased Health Risks of Incarceration

Incarceration increases the risk of many health problems, both acute and chronic. The acute illnesses most disproportionately represented in prisons include HIV, hepatitis C, and tuberculosis.⁴⁶ Of the 229,000 people infected with HIV in the U.S. in 1996, 17 percent had been in jail or prison that year, while 29 to 32 percent of the 4.5 million people infected with hepatitis C had been in jail or prison.⁴⁷ The prevalence of HIV in the U.S. prison population is five times higher than in the general population, the prevalence of hepatitis C is nearly ten times higher, and the prevalence of tuberculosis is between four and seventeen times higher.⁴⁸

HIV and hepatitis C rates are higher partly because many people are in prison for drug use. Because injection drug use can transmit both HIV and hepa-

40. Kelly Ann Cheeseman et. al., *Three Strikes and You're In: The Effect of Ewing v. California and Three Strikes Legislation on Prison Population and Resource Management*, 3 JUST. POL'Y J. 1, 14-17 (2006).

41. *Id.* at 4.

42. CAL. PENAL CODE § 667(e) (West 2010); *Id.* at 14.

43. *Id.* at 14-17.

44. *See id.* at 14 (stating that 42,322 people were imprisoned under California's Three Strikes Law in 1997).

45. UNNATURAL CAUSES, *supra* note 30, at 117.

46. *Id.* at 115.

47. NAT'L COMM'N ON CORRECTIONAL HEALTH CARE, *THE HEALTH STATUS OF SOON-TO-BE-RELEASED INMATES: A REPORT TO CONGRESS, VOLUME 1* 3 (2002).

48. *Id.* at 17-18, 20.

titis C, many people arrive at prison with existing infections.⁴⁹ In addition, although both sexual intercourse and drug use are forbidden in prisons, prisoners nevertheless do have sexual intercourse and can access injection drugs, so these infections continue to spread in prisons.⁵⁰ Prison tattooing has also been linked to transmission of HIV, although Centers for Disease Control and Prevention officials believe more education about the importance of clean needles could reduce this problem.⁵¹

Tuberculosis tends to spread in prisons for two main reasons. First, the poor ventilation and overcrowding of many prisons increase exposure to the airborne disease.⁵² Second, the disease is more likely to become active—that is, to produce coughing, leading to the infection of nearby people—in those whose immune systems are already compromised, and many prisoners' immune systems are compromised by HIV.⁵³

Prisoners also suffer disproportionately from chronic diseases such as asthma and heart disease. In a study of New York City adults, the rates of asthma were twice as high for people with a history of incarceration—12.7 percent as opposed to 6.2 percent.⁵⁴ Also, those individuals with asthma who had been incarcerated were more likely to have suffered an asthma attack or gone to the emergency department in the previous year, irrespective of access to primary care or health insurance.⁵⁵ This indicates that those with incarceration histories either developed more severe asthma or were less able to control their symptoms with appropriate care and management while in prison. Higher rates of incarceration among African Americans could be part of the reason African Americans have higher rates of asthma, according to a statistical analysis examining the relationship between incarceration, race, and asthma.⁵⁶ Possible explanations for this link include the fact that prisons tend to be poorly ventilated, overcrowded, and in poor repair—possibly leading to mold and mildew—and inmates have few opportunities to learn how to successfully manage a chronic disease such as asthma.⁵⁷ Prison violence may increase psychological stress, which in turn may

49. Ronald L. Braithwaite & Kimberly R.J. Arriola, *Male Prisoners and HIV Infection: A Call for Action Ignored*, 93 AM. J. PUB. HEALTH 759, 759-60 (2003); Andrew Brunnsden, *Hepatitis C in Prisons: Evolving Toward Decency Through Adequate Health Care and Public Health Reform*, 54 UCLA L. REV. 465, 471 (2006).

50. Braithwaite & Arriola, *supra* note 49, at 760.

51. Ctrs. for Disease Control and Prevention, *HIV Transmission Among Male Inmates in a State Prison System: Georgia, 1992-2005*, 55 MORBIDITY AND MORTALITY WKLY. REP. 421, 425 (2006), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5515a1.htm>.

52. Greg Wees, *Deadly Encore: Tuberculosis in American Prisons*, CORHEALTH, <http://www.purairuv.com/pa%20graphics/CorHealth.pdf> (last visited Mar. 8, 2011).

53. *Id.*

54. Emily A. Wang & Jeremy Green, *Incarceration as a Key Variable in Racial Disparities of Asthma Prevalence*, 10 BIOMED CENTR. PUB. HEALTH 1, 4 (2010), available at <http://www.biomedcentral.com/content/pdf/1471-2458-10-290.pdf>.

55. *Id.* at 5.

56. *Id.* at 6.

57. *Id.* at 1, 6.

also aggravate asthma.⁵⁸

In addition, incarceration is linked to increased risk for hypertension and left ventricular hypertrophy.⁵⁹ A review of the Coronary Artery Risk Development in Young Adults study found that, while 7 percent of the sample without an incarceration history developed hypertension, 12 percent of those who had been incarcerated had developed the condition.⁶⁰ The relationship between incarceration and hypertension was even stronger, however, for the two groups most disproportionately represented in prisons, African Americans and those with low educational attainment, meaning that an African American man in prison has an even higher risk of developing hypertension either during incarceration or in the years following release.⁶¹ When the researchers controlled for age, sex, race, use of drugs and alcohol, and poverty, they found that the effect of incarceration did not disappear; there remained a link between incarceration and hypertension even after these other factors were considered.⁶² The authors suggest that this may point to the stress induced by the prison environment as an important factor: dysregulation of stress hormones can cause hypertension, and prison is an extremely stressful environment.⁶³

According to an Urban Institute study of prisoner reentry, 49 percent of men had chronic physical health conditions that required long-term management upon their release, most commonly asthma, hypertension, and diabetes, while one fifth reported a communicable disease, including HIV, tuberculosis, and hepatitis B and C.⁶⁴ When mental health and substance abuse conditions were included, 84 percent of men were suffering from some type of health problem and 39 percent had more than one condition.⁶⁵ In addition, it is important to note that these statistics are all based on self-reports from prisoners, which suggests that the true numbers may be higher. Because many chronic conditions persist for many years before a person develops symptoms, a prisoner might not be aware of his condition and therefore would not report it.⁶⁶

African American men are disproportionately incarcerated, especially for

58. *Id.* at 6.

59. Emily A. Wang et al., *Incarceration, Incident Hypertension, and Access to Health Care*, 169 ARCH. INTERN. MED. 687, 689 (2009). Left ventricular hypertrophy (LVH) is a condition where the walls of the left ventricle of the heart become thicker as the heart works harder to pump blood. It is a marker of diseases like hypertension, so the presence of LVH indicates more severe and longer-term hypertension, and it can also cause heart failure as the heart's ability to pump hard enough is decreased. Mayo Clinic, *Definition: Left Ventricular Hypertrophy* (May 1, 2010), <http://www.mayoclinic.com/health/left-ventricular-hypertrophy/DS00680>.

60. Wang et al., *supra* note 59, at 689.

61. *Id.*

62. *Id.*

63. *Id.* at 691.

64. KAMALA MALLIK-KANE & CHRISTY A. VISHER, URBAN INST. JUST. POL'Y CTR., HEALTH AND PRISONER REENTRY: HOW PHYSICAL, MENTAL, AND SUBSTANCE ABUSE CONDITIONS SHAPE THE PROCESS OF REINTEGRATION 24 (2008).

65. *Id.*

66. *Id.*

drug offenses, and are more likely to have their sentences extended through “Three Strikes” laws. Incarceration increases the risk of both infectious diseases, like HIV and tuberculosis, and chronic diseases, such as asthma and hypertension, which helps explain the differences between the life expectancy of African American men and other racial and gender groups. Unfortunately, health challenges continue after prisoners are released.

III. “INVISIBLE PUNISHMENTS” ERECT POST-INCARCERATION BARRIERS TO HEALTH AMONG AFRICAN AMERICAN MEN

Upon release, former prisoners face a variety of barriers to health. First, they face difficulty accessing health care itself, both because many people lack health insurance post-release⁶⁷ and because existing services may not address social barriers to health care access experienced by previously incarcerated African American men.⁶⁸ Beyond health care itself, however, there is a range of health resources that the formerly incarcerated, especially those convicted of drug offenses, are barred from accessing. This includes cash assistance under Temporary Aid to Needy Families, food stamps, and federal housing assistance.⁶⁹ These barriers exacerbate the health problems that incarceration creates, in effect continuing the punishment beyond release. Since these punishments are not part of the original sentence for the crime, they may be considered “invisible punishments,”⁷⁰ because they exist outside the criminal justice system yet operate to the continued detriment of those we have convicted of violating the law.

A. Barriers to Health Care Access

The moment a prisoner is released, his or her right to government-provided health care vanishes. This is unfortunate, because the formerly incarcerated population is particularly unlikely to have health insurance; only 10 percent of those released have insurance upon their departure, compared to 83.3 percent of the general population.⁷¹ One reason for this is that any prisoner who qualified for

67. See Henrie Treadwell, *Population-Based Approaches to Inform Policy: Men's Health Disparities and Opportunities for Nonprofits and Philanthropy to Leverage Change*, 37 *NONPROFIT & VOLUNTARY Q.* 25S, 26S (2008) (stating that less than 10 percent of people released from prison and jail have health coverage).

68. See, e.g., Dembosky, *supra* note 1 (quoting ex-inmate Clifton Martin: “We carry a lot of resentment and trauma from the experience in prison, and sometimes that can be acted out. They’ve not been trained to be sensitive to that population.”).

69. See, e.g., 21 U.S.C. § 862a (2006) (denial of Temporary Aid to Needy Families and food stamps to people convicted of a felony); 42 U.S.C. § 13661 (2006) (denial of federal housing assistance for drug convictions).

70. For the origins of the term “invisible punishment,” see Jeremy Travis, *Invisible Punishment: An Instrument of Social Exclusion*, in *INVISIBLE PUNISHMENT: THE COLLATERAL CONSEQUENCES OF MASS INCARCERATION* 15 (Marc Mauer & Meda Chesney-Lind eds., 2002).

71. Treadwell, *supra* note 67, at 25S, 26S (stating that less than ten percent of men released from prison and jail have health coverage); Carmen DeNavas-Walt et. al., U.S. CENSUS BUREAU, *INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2009* 15

Medicaid before imprisonment would lose that coverage while incarcerated and need to reapply upon release, a process that can last several months.⁷² This could be solved if prisons began the application process before release as part of pre-release planning so that coverage would be in place upon release. In fact, Centers for Medicare and Medicaid Services policy requires that prisoners who had Medicaid before imprisonment be returned to the program upon release.⁷³ However, many men do not qualify for Medicaid, because coverage in most states is limited to families with dependent children and the disabled,⁷⁴ leaving non-disabled men who do not have children—or who do not live with their children—without coverage. More men will be eligible for Medicaid after 2014, when eligibility will expand to anyone below 133 percent of the federal poverty level under the Patient Protection and Affordable Care Act of 2010.⁷⁵ However, the problem of enrollment will continue absent prison policies to enroll prisoners who are about to be released.

Partially due to the lack of insurance, former prisoners tend to have poor access to health care, especially preventive services and chronic disease management services. Among people with hypertension, those with a history of incarceration are 2.5 times less likely than people who have not been incarcerated to have a regular source of care, and African American men who have been incarcerated are 2.9 times less likely to have a regular source of care.⁷⁶ In the Urban Institute's *Returning Home* study, eight to ten months after release, only 48 percent of men reported receiving treatment for existing chronic conditions, compared to 64 percent who received care while in prison.⁷⁷

African American men in general tend to be less likely to access routine health care that can help manage and prevent chronic disease. Irrespective of the severity of a health problem, African American men are less likely than African

(2010) (reporting that 16.7 percent of the United States population is uninsured).

72. MALLIK-KANE & VISHER, *supra* note 64, at 13.

73. Letter from Tommy Thompson, United States Secretary of Health and Human Services, to Representative Charles L. Rangel (Oct. 1, 2001) (on file at Women in Prison Project) (describing Center for Medicare and Medicaid Services policy that prisoners eligible for Medicaid should be enrolled upon their release).

74. For an overview of Medicaid eligibility rules, see CTRS. FOR MEDICARE & MEDICAID SERVS., MANDATORY ELIGIBILITY GROUPS, http://www.cms.gov/MedicaidEligibility/03_MandatoryEligibilityGroups.asp#TopOfPage (last visited MAR. 8, 2011); CTRS. FOR MEDICARE & MEDICAID SERVS., OPTIONAL ELIGIBILITY GROUPS, http://www.cms.gov/MedicaidEligibility/04_OptionalEligibility.asp#TopOfPage (last visited MAR. 8, 2011).

75. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2010). This statute is currently being challenged by litigation and, as of February 23, 2011, has been upheld by two federal district courts. *See generally* Thomas More Law Ctr. v. Obama, 720 F. Supp. 2d 882 (E.D. Mich. 2010); Liberty University v. Geithner, 753 F. Supp. 2d 611 (W.D. Va. 2010). Parts of the law, however, have been struck down by two other district courts. *See generally* Virginia v. Sebelius, 728 F. Supp. 2d 768 (E.D. Va. 2010); Florida v. U.S. Dep't of Health & Human Servs., No. 3:10-cv-91, 2011 WL 285683 (N.D. Fla. Jan 31, 2011) (striking down the entire law).

76. Wang et al., *supra* note 59, at 692.

77. MALLIK-KANE & VISHER, *supra* note 64, at 24.

American women to get medical help and are less likely than non-Hispanic white men to schedule routine office visits.⁷⁸ Although it is true that African American men are less likely to have health insurance than other groups, and that health insurance can be a prerequisite for accessing routine care in many situations, having health insurance alone is not a significant factor in whether men schedule and receive routine care—rather, having a usual source of care was the significant access factor.⁷⁹ However, certain psychosocial factors also play a major role.

Medical distrust is higher among African Americans than among whites. African Americans have higher distrust with respect to “values” issues such as honesty, respect, caring, confidentiality, and honoring fiduciary duties, as opposed to distrust of the physician’s competence.⁸⁰ A lack of trust in medical personnel is associated with underutilization of health services.⁸¹ This suggests that a lack of trust can be a significant reason for underutilization of services by African American men released from prison, who may be especially likely to distrust medical providers after experiencing a prison health care system where staff may not have treated prisoners with respect or dignity.

In *Plata v. Schwarzenegger*, as part of his explanation of the California prison health care system’s failures, Federal District Court Judge Thelton E. Henderson recounted several troubling stories of prisoners who died from medical neglect.⁸² In one case, the prisoner was denied treatment because the doctor was irritated that the prisoner had arrived at his appointment having already diagnosed his own condition.⁸³ When questioned by the court, the doctor explained her view that most of the prisoners were faking their illnesses in order to take advantage of the medical system.⁸⁴ Although this doctor may have observed some prisoners faking illness, it is clear from the high rates of acute and chronic illness in prison that many prisoners are indeed in need of assistance, and prisoners’ experiences with these skeptical prison health officials can be expected to decrease their trust in the system. In another case, a prisoner told prison staff he had experienced two weeks of fever and chills and asked for medical care.⁸⁵ He was examined several times and repeatedly sent back to his cell in spite of clear evidence that he was suffering from a heart problem, which was eventually diag-

78. Wizdom Powell Hammond et al., *Psychosocial Factors Associated with Routine Health Examination Scheduling and Receipt Among African American Men*, 102 J. NAT’L MED. ASS’N 276, 276 (2010).

79. *Id.* at 286.

80. Katrina Armstrong et al., *Differences in the Patterns of Health Care System Distrust Between Blacks and Whites*, 23 J. GEN. INTERN. MED. 827, 828, 830 (2008).

81. Hammond, *supra* note 78, at 277.

82. *Plata v. Schwarzenegger*, No. C01-1351, 2005 WL 2932253, at *1, *6 (N.D. Cal. Oct. 3, 2005).

83. *Id.* at *6.

84. *Id.*

85. *Id.*

nosed as a potentially fatal condition.⁸⁶ It would have been treatable with an antibiotic, but he was not given any medication and eventually went to the prison emergency room with blue fingertips and severely low blood pressure.⁸⁷ Over a nurse's objections, the physician on duty tried to return him to his cell and then decided to simply keep him for observation, even though his symptoms indicated that his blood flow was far too slow and that he was probably in shock, which meant he needed to go to a hospital emergency department.⁸⁸ He died of cardiac arrest shortly thereafter.⁸⁹ Incidents like this, apparently widespread in California prisons, may explain why formerly incarcerated persons have difficulty trusting medical personnel.

Gender intersects with race to increase distrust of the medical establishment. Medical mistrust is higher among African American men who endorse more traditional male roles.⁹⁰ In addition, men of any race tend to access less medical care when they subscribe to traditional masculine ideals and are subject to traditional masculine socialization.⁹¹ One explanation for this underutilization is that, in order to receive medical care, patients often need to disclose certain vulnerabilities, usually with respect to their physical health but also regarding mental health issues and possible health-damaging behaviors such as smoking and poor eating habits. The possibility of appearing vulnerable can be an affront to traditional masculinity, which emphasizes strength and retaining control.⁹²

For African American men, there may be special reasons to fear appearing vulnerable in a medical setting. There are both historical and personal reasons to mistrust the system and therefore feel that a loss of control is especially threatening.⁹³ The central historical touchstone of ongoing African American distrust of the medical system is the Tuskegee Syphilis Experiment, in which researchers told African American men with syphilis that they were being treated while in fact they were left untreated for researchers to observe the course of the untreated disease.⁹⁴ Although this episode is often cited as the primary reason for African American distrust of the medical system, it must be seen in a greater historical context of medical mistreatment of African Americans dating back to the use of African American slaves for medical experiments in the antebellum period, the theft of African American corpses for use as medical cadavers, and the modern fear that AIDS could have been created as a tool of genocide against

86. *Id.*

87. *Id.*

88. *Id.*

89. *Id.*

90. Hammond, *supra* note 78, at 277.

91. James R. Mahalik et. al., *Masculinity and Perceived Normative Health Behaviors as Predictors of Men's Health Behaviors*, 64 SOC. SCI. & MED. 2201, 2207 (2007).

92. Hammond, *supra* note 78, at 286.

93. *Id.*

94. Jeff Stryker, *Tuskegee's Long Arm Still Touches a Nerve*, N.Y. TIMES, April 13, 1997, at E4, available at <http://www.nytimes.com/1997/04/13/weekinreview/tuskegee-s-long-arm-still-touches-a-nerve.html>.

African Americans.⁹⁵ When these historical trends are added to the problems many African Americans experience with prison health care systems, it is not surprising that they are especially unlikely to access services.

B. Invisible Punishments Exacerbate Incarceration-Related Health Problems

When a prisoner is released, whether he has served his entire sentence or has been released on parole, he will find that his access to traditional safety net programs has been severely curtailed by his criminal history. These restrictions may apply to cash aid in the Temporary Aid to Needy Families (TANF) program, the food stamp program, and federal housing assistance. In particular, individuals who have committed felonies involving the possession, sale, or distribution of illegal drugs are often banned from TANF and food stamp eligibility, while any criminal history can limit eligibility for federal housing assistance.

Part of the 1996 welfare reform states that any person convicted of a crime including the possession, use, or distribution of a controlled substance is not eligible for TANF or food stamp benefits.⁹⁶ However, a state may enact a statute to exempt its residents from this eligibility ban.⁹⁷ Currently, seventeen states have adopted the ban in full, twelve have opted out of the ban entirely, and twenty-one states have modified the ban by, for example, lifting it for possession-only offenses, lifting it after some number of years, or lifting it for those in treatment for substance abuse.⁹⁸

The food stamp program, now known as the Supplemental Nutrition Access Program, provides money that can be used only to purchase food.⁹⁹ Historically, this money was provided in the form of coupons but today, recipients are issued a plastic card, known as the EBT card, that is loaded with the recipient's monthly benefit.¹⁰⁰ The program helps millions per year—in 2010, about 40 million people in 18 million households received benefits¹⁰¹—but the eligibility ban means that very few of these recipients have been convicted of a drug felony.

Congress, after hearing testimony during the welfare reform debate that recipients were trading food stamps for drugs, may have enacted the eligibility ban due to this concern.¹⁰² Having described this problem, however, the House Re-

95. Vanessa Northington Gamble, *Under the Shadow of Tuskegee: African Americans and Health Care*, 87 AM. J. PUB. HEALTH 1773, 1774-75 (1997).

96. 21 U.S.C. § 862a(a)(2) (2006).

97. 21 U.S.C. § 862a(d)(1)(A) (2006).

98. Legal Action Ctr., *Opting Out of Federal Ban on Food Stamps and TANF*, <http://www.lac.org/toolkits/TANF/TANF.htm> (last visited Feb. 12, 2011).

99. 7 U.S.C. § 2013(a) (2006).

100. 7 U.S.C. § 2012(i) (2006).

101. DOTTIE ROSENBAUM, CTR. ON BUDGET & POL'Y PRIORITIES, *THE FOOD STAMP PROGRAM IS EFFECTIVE AND EFFICIENT 1* (2010), available at <http://www.cbpp.org/files/7-23-10fa.pdf>.

102. The House Committee on Agriculture explained:

The committee heard reports and witnessed undercover video footage of food

port goes on to explain that the use of EBT cards, stricter penalties for those found to have committed fraud, and better oversight of retailers that accept food stamps will sufficiently address the problem; there is no mention of the ban on eligibility for those convicted of drug crimes.¹⁰³ Indeed, the use of EBT cards would seem to significantly restrict recipients' ability to trade food stamps for drugs, and the House Report notes that "EBT has the potential to severely curtail street trafficking because such systems can only be used in conjunction with an authorized point-of-sale terminal at an authorized retail food store or wholesale food concern."¹⁰⁴ It seems more likely, therefore, that Congress viewed this as part of the war on drugs, a way to deter drug use or encourage former prisoners to take responsibility for their actions.¹⁰⁵ It is difficult to be sure what the full rationale was, however, because Congress passed the ban after barely two minutes of debate.¹⁰⁶ In addition, there has been no research on whether the policy has had a deterrence effect, and it seems more likely that the denial of benefits after release would instead encourage him or her to sell drugs as a way to survive without access to public assistance.¹⁰⁷

TANF replaced Aid to Families with Dependent Children in 1996, following major welfare reform legislation entitled the Personal Responsibility and Work Opportunity Reconciliation Act.¹⁰⁸ This program provides cash assistance to very poor families with children and can also provide work supports to parents, including childcare vouchers and payment for some education expenses.¹⁰⁹ In order to qualify, an adult must be caring for children,¹¹⁰ so a father who is not

stamps being traded for cash, drugs, guns, and a stolen car.

. . . In Smithfield, North Carolina, OIG agents and other law enforcement officers successfully penetrated an organized drug trafficking ring that was transporting large quantities of "crack" cocaine from Florida to Smithfield. During the investigation, OIG documented members of the gang exchanging cocaine on numerous occasions for over \$23,000 in food stamps. In Los Angeles, an undercover OIG agent contacted a street trafficker who agreed to buy \$30,000 in food stamps from the agent. A subsequent search of the trafficker's residence and automobile uncovered an additional \$82,000 in food stamps that had been improperly acquired from recipients.

H.R. Rep. No. 104-651, at 68 (1996).

103. *Id.*

104. *Id.* at 69.

105. Recent Legislation, *Welfare Reform—Punishment of Drug Offenders—Congress Denies Cash Assistance and Food Stamps to Drug Felons—Personal Responsibility and Work Opportunity Reconciliation Act of 1996*, Pub. L. No. 104-193, § 115, 110 Stat. 2105 (To Be Codified at 42 U. S. C. § 862a), 110 HARV. L. REV. 983, 985-86 (1997) [hereinafter Recent Legislation].

106. Herman Schwartz, *Out of Jail and Out of Food*, N.Y. TIMES, Mar. 21, 2002, at A37.

107. Recent Legislation, *supra* note 105, at 987.

108. Pamela Loprest et. al., *Welfare Reform under PRWORA: Aid to Children with Working Families?*, 14 TAX POL'Y & ECON. 157, 161 (2000).

109. *Major Provisions of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193)*, ADMIN. FOR CHILD. & FAMS., U.S. DEP'T OF HEALTH & HUM. SERVICES, <http://www.acf.hhs.gov/programs/ofa/law-reg/finalrule/aspesum.htm> (last visited Feb. 12, 2011).

110. *See id.*

living in the home with his children will not qualify. Unfortunately, even though many prisoners are fathers¹¹¹ who may return to live with their children upon their release,¹¹² those with drug felony histories may not be eligible for aid under TANF.¹¹³ Again, it seems this ban is based on a goal of deterrence or an effort to encourage people convicted of drug offenses to take responsibility for their actions, but as with the food stamp ban, it seems more likely to encourage reliance on the drug trade to survive.¹¹⁴

Access to federal housing programs is very limited for individuals who have histories of substance abuse or who have been in prison. For example, a person who has been evicted from public housing due to drug use is ineligible for housing assistance for three years unless he or she completes an approved rehabilitation program.¹¹⁵ Any person who uses illegal drugs is prohibited from living in public housing or any housing paid for with federal housing assistance.¹¹⁶ Also, public housing agencies or owners of federally subsidized housing may deny admission based on past or present criminal activity, including violent offenses and drug offenses, as well as any other criminal activity that would adversely affect the health, safety, or right to peaceful enjoyment of the premises by the other residents, a provision known as the "One Strike and You're Out" policy.¹¹⁷ Finally, owners of federally subsidized housing may lose their approval for the program if they refuse to evict tenants for drug-related or violent crimes.¹¹⁸ Although the focus of this Comment is on prisoners reentering the community, it is worth noting that these policies do not require that an individual have been convicted of a crime to restrict his or her access to housing.¹¹⁹

These policies appear to have been a response to the problem of crime concentrated in public housing developments. The U.S. Department of Housing and Urban Development (HUD) hailed the development of these programs in July 2000 as a way to reduce crime in public housing. The One Strike and You're Out policy was cited as a major part of the campaign to make public housing safer. HUD proudly noted that 75 percent of public housing authorities had implemented the policy by May 1997, leading some developments to see significant drops in crime—34 percent in one Florida development and 57 percent in Green-

111. CTR. FOR BEST PRACTICES, THE CHALLENGES AND IMPACTS OF PRISONER REENTRY 2 (2004), available at <http://www.nga.org/Files/pdf/REENTRYBACKGROUND.pdf> (observing that 55 percent of men in prison have minor children).

112. MALLIK-KANE & VISHER, *supra* note 64, at 10 (noting that 29.6 percent of men in the *Returning Home* sample had lived with their children before incarceration).

113. 21 U.S.C. § 862a(a)(1) (2006).

114. Recent Legislation, *supra* note 105, at 987.

115. 42 U.S.C. §13661(a) (2006).

116. *Id.* §13661(b)(1)(A).

117. *Id.* §13661(c), (c)(1).

118. ANDREW CUOMO & HAROLD LUCAS, U.S. DEP'T OF HOUS. & URBAN DEV., A PROMISE BEING FULFILLED: THE TRANSFORMATION OF AMERICA'S PUBLIC HOUSING 9 (2000), available at <http://archives.hud.gov/reports/pubhouse/phreport.pdf>.

119. 42 U.S.C. § 13661(c), (c)(1).

sboro, North Carolina.¹²⁰ This illustrates an important tension between the goals of housing former prisoners and maintaining a safe living environment for public housing tenants. However, as I will discuss when addressing possible solutions to the problems of invisible punishments, we can ease this tension by focusing on individual assessments rather than using blanket rules to exclude nearly all former prisoners.

1. Food Stamp Ineligibility

A 2004 literature review by the United States Department of Agriculture (USDA) examined the multitude of studies conducted to assess the effects of food stamps.¹²¹ The USDA concluded that the program allows recipients to spend their cash on other basic needs while using food stamps to cover food expenses.¹²² In other words, the program increases income and can help families and individuals working for minimum wage move out of poverty. In 2003, the program moved 1.8 million people over the poverty line and another 1.8 million over 150 percent of the poverty line.¹²³

The food stamps program increases the amount of money spent on necessary food more than an equivalent cash supplement would, so families on food stamps have more food available to them.¹²⁴ In addition, research indicates that access to food stamps increases the availability of food energy and protein and may increase the availability of some nutrients and vitamins.¹²⁵ This may be because some foods rich in nutrients and vitamins, such as fresh vegetables, may be too expensive to buy without food assistance. The relationship between food insecurity and food stamps is complicated because there is a significant selection bias. The individuals and families experiencing the most trouble getting enough to eat are the most likely to apply for the program in the first place, and much research indicates a positive relationship between food stamps and food insecurity.¹²⁶ However, research controlling for this selection bias indicates that the program is not associated with higher levels of food insecurity and in fact may do a better job of reducing food insecurity than programs that only provide cash.¹²⁷

Depriving people of food stamps because they have committed a drug felony is a significant deprivation. Not only are such individuals left further below the poverty level and therefore less able to afford necessities other than food,

120. CUOMO & LUCAS, *supra* note 118, at 26.

121. U.S. DEP'T OF AGRIC., EFFECTS OF FOOD ASSISTANCE AND NUTRITION PROGRAMS ON NUTRITION AND HEALTH: VOLUME 3, LITERATURE REVIEW (Mary Kay Fox, William Hamilton & Biing-Hwan Lin eds., 2004).

122. *Id.* at 84.

123. DOROTHY ROSENBAUM & ZOE NEUBERGER, CTR. ON BUDGET & POL'Y PRIORITIES, FOOD AND NUTRITION PROGRAMS: REDUCING HUNGER, BOLSTERING NUTRITION 4 (2005), available at <http://www.cbpp.org/files/7-19-05fa.pdf>.

124. U.S. DEP'T OF AGRIC., *supra* note 121, at 84.

125. *Id.*

126. *Id.*

127. *Id.*

they are forced to survive on less food, with concomitant health repercussions.

2. TANF Ban

If a former prisoner with a drug felony on his record returns to live with his children and the family is enrolled in TANF, the family's grant will be calculated as if he did not live there, but any money he earns will be counted against the family's eligibility and grant level.¹²⁸ This is a strong inducement for the former prisoner not to live with his children. If he earns money, he will be a drain on their eligibility for benefits. If he does not earn money, he will not receive any benefits for himself but will presumably consume family resources. This is particularly unfortunate because many individuals rely heavily on family upon being released.¹²⁹ This reduction in per-person resources and the related increase in stress are harmful to the whole family's health.

This is also a problem that disproportionately plagues African American men and families—although African Americans make up only 14 percent of drug users, they are 37 percent of those imprisoned for drug use.¹³⁰ Policymakers often discuss the importance of helping families stay together, and there has been a great deal of controversy about marriage incentives in TANF.¹³¹ Yet this policy, which hits the African American community especially hard, directly contravenes those goals by discouraging drug offenders from reuniting with their families.

3. Limited Access to Federally Assisted Housing

When formerly incarcerated persons are excluded from federal housing assistance, they may be harmed in several ways. First, having to pay more for housing reduces the resources available for other necessities. Second, having less money available for housing increases the risk of substandard housing, which in turn may have serious health consequences. Finally, paying more in rent increases the risk of homelessness, which increases the risk of many health problems.

When a person spends one-third or less of their income on housing, they have more resources left over to pay for other health-protective resources, such

128. 21 U.S.C. § 862a(b)(1) (2006).

129. MALLIK-KANE & VISHER, *supra* note 64, at 2.

130. UNNATURAL CAUSES, *supra* note 30, at 114.

131. See Daniel T. Lichter et. al., *Welfare Reform and Marriage Promotion: The Marital Expectations and Desires of Single and Cohabiting Mothers*, 78 SOC. SERV. REV. 2, 3, 20-21 (2004). Lichter explains that some policymakers want to fund marriage promotion in TANF because marriage is associated with lower poverty rates, less welfare dependency, better physical and mental health, higher productivity, and better child outcomes. However, others are concerned that these policies are invasions of privacy that divert attention and funds from the root causes of poverty. An empirical analysis demonstrates that most women, including mothers on welfare, consider marriage to be desirable, but that many nevertheless do not marry, indicating that any policy effort to promote marriage will have to identify and reduce the barriers to marriage that keep women single when they prefer to marry. *Id.*

as fruits and vegetables, health care, and recreation.¹³² Being excluded from the programs that limit housing costs to one-third of income means that formerly incarcerated individuals will have to pay more of their income toward housing, reducing the resources they can spend on staying healthy.

When a person cannot pay for affordable housing, they are more likely to end up in substandard housing that may exacerbate respiratory illness or pose safety concerns.¹³³ Current and former prisoners have high rates of asthma. This means that they are especially likely to be harmed by substandard housing, which tends to have poor insulation, lead paint, pest infestations, and mold due to inadequate weatherproofing, all of which can worsen asthma symptoms.¹³⁴

Finally, when a person must spend a high percentage of their income on rent, any interruption in the income flow, such as losing a job or even losing some hours at work, can leave the person unable to pay the rent, dramatically increasing the risk of homelessness.¹³⁵ In addition, people with criminal convictions are already at a higher risk of homelessness, especially immediately upon their release.¹³⁶ Although many can rely on family members, those with family in public or Section 8 housing risk causing their family to be evicted if they move in because of eligibility restrictions. Homelessness is very dangerous for health. Constant exposure to the elements increases the risk for respiratory problems, and the instability of the situation reduces the chance of accessing adequate nutrition.¹³⁷ Even being forced to move due to failure to pay rent can have negative effects on health; displacement is associated with high rates of stress and mental health problems.¹³⁸ The increased stress from housing insecurity and homelessness is likely to exacerbate mental health and substance abuse problems, which are also endemic among the formerly incarcerated population.¹³⁹ Depriving formerly incarcerated people of housing assistance increases their risk of homelessness and the attendant health problems.

When African American men leave prison, they face a range of health barriers, including poor access to routine health care and exclusion from social safety net programs like TANF, food stamps, and housing assistance. This is especially troubling in light of the fact that upon release, they are significantly more

132. UNNATURAL CAUSES, *supra* note 30, at 66.

133. *Id.*

134. *Id.*

135. *Id.*

136. CTR. FOR BEST PRACTICES, *supra* note 111, at 2, 4 (citing a New York study that 11 percent of returning prisoners entered a homeless shelter within two years of release and observing that, in major cities, 30 to 50 percent of returning prisoners are homeless upon release). In addition, sex offender registries and rules for where those with sex crime convictions may live create a high risk of homelessness and isolation for this population. *See, e.g.*, Paul A. Zandenberg & Timothy C. Hart, *Reducing Housing Options for Convicted Sex Offenders: Investigating the Impact of Residency Restriction Laws Using GIS*, JUST. RES. & POL'Y, Fall 2006, at 1.

137. UNNATURAL CAUSES, *supra* note 30, at 66.

138. *Id.*

139. *Id.*

likely than the general population to experience poor health. This formulation of the problem suggests that we can address it by improving health inside prisons, improving access to care after release, and including former prisoners in the social safety net.

IV. POSSIBILITIES FOR REFORM

Considering the reality of mass incarceration and its disproportionate effect on African American men, the best solution, and the simplest, would be to stop incarcerating so many people. Some offenses could be downgraded to citations, requiring only that the perpetrator pay a fine, while others could be addressed through alternatives such as drug treatment programs¹⁴⁰ and restorative justice.¹⁴¹ Unfortunately, the political reality is that politicians fear voters will throw them out of office for showing any mercy to “criminals,” and that concern may be well-founded.¹⁴² Therefore, it makes sense to pursue other potential reforms even while advocating for reductions in the prison population.¹⁴³ Examining the interlocking causes of health inequities, a few points of possible intervention stand out. First, we can focus on making prisons healthier places so the health effects of being incarcerated are less severe. Second, we can improve access to care upon release so former prisoners are more likely to recover from acute conditions and be better able to manage chronic illnesses. Third, we can work to eliminate invisible punishments so former prisoners are not systematically excluded from the traditional social safety net.

A. Litigation as an Unlikely Route to Improved Health Care

The problem of inadequate prison health care systems has traditionally been litigated under the Eighth Amendment's prohibition on cruel and unusual punishment.¹⁴⁴ The United States Supreme Court has recognized that the government must provide adequate health care for prisoners, but in order to rise to the level of a constitutional violation, prison officials must have shown “delibe-

140. See, e.g., Gary A. Zarkin et al., *A Benefit-Cost Analysis of the Kings County District Attorney's Office Drug Treatment Alternative to Prison (DTAP) Program*, 7 JUST. RES. & POL'Y 1 (2005) (describing a drug treatment diversion program, analyzing its effects, and determining that it saves money compared to incarceration for nonviolent drug offenders.).

141. For a discussion of restorative justice internationally and its efficacy, see Jeff Latimer et. al., *The Effectiveness of Restorative Justice Practices: A Meta-Analysis*, 85 PRISON J. 127 (2005).

142. Erwin Chemerinsky, *The Essential But Inherently Limited Role of the Courts in Prison Reform*, 13 BERKELEY J. CRIM. L. 307, 310 (2008) (explaining that no politician can afford to be seen as “soft on crime”).

143. For a discussion of why the current prison system is so entrenched and how we might begin to shrink it, see generally ANGELA Y. DAVIS, *ARE PRISONS OBSOLETE?* (2003); MARC MAUER, *RACE TO INCARCERATE* (1999); LAURA MAGNANI & HARMON L. WRAY, *BEYOND PRISONS: A NEW INTERFAITH PARADIGM FOR OUR FAILED PRISON SYSTEM* (2006).

144. U.S. CONST. amend. VIII.

rate indifference” to prisoners’ serious medical needs.¹⁴⁵ The official must therefore have had actual knowledge of the health problem.¹⁴⁶ Even once a violation is identified, remedies may be restricted, and the problems of prison health care systems are difficult to solve. For these reasons, it has been and will likely continue to be difficult to use Eighth Amendment litigation to significantly improve prison health conditions.

The first case to apply the Eighth Amendment’s prohibition on cruel and unusual punishment to prison health care was *Estelle v. Gamble*, a 1976 case in which a Texas inmate filed a pro se complaint against the prison officials under the civil rights statute 42 U.S.C. § 1983.¹⁴⁷ The Court held when the government incarcerates someone, it assumes the obligation to provide medical care; otherwise, the prisoner may experience a torturous, lingering death or serious suffering with no penological purpose.¹⁴⁸ The Court specified that “deliberate indifference to serious medical needs of prisoners” violates the Eighth Amendment, whether it is indifference on the part of prison medical staff or guards.¹⁴⁹ Thus, the test for Eighth Amendment violations in the prison health care context has two prongs: “(1) that a prisoner demonstrate a ‘serious medical need,’ and (2) that prison officials were deliberately indifferent to this need.”¹⁵⁰ This requirement of deliberate indifference strictly limits the range of situations in which a prisoner can win a § 1983 case.

Another serious limitation came from *Farmer v. Brennan*, which held that prison conditions creating a substantial risk of serious harm to prisoners are not considered “punishment” for Eighth Amendment purposes unless prison officials have actual knowledge of the condition and disregard it.¹⁵¹ This case provided a definition of “deliberate indifference” that *Gamble* had not. In order to prove deliberate indifference, the plaintiff must show (1) that prison officials were aware of facts that allow an inference that there was a substantial risk of harm, and (2) that the officials actually drew that inference.¹⁵² This is equivalent to a criminal, rather than civil, recklessness standard—the prison official must disregard a risk of harm of which he is aware, not simply fail to act in the face of an unjustifiable risk of which he either was aware or should have been aware.¹⁵³

Prison officials are likely to be perfectly aware of situations where prisoners receive terrible medical care, because it is the prison officials who design and

145. *Estelle v. Gamble*, 429 U.S. 97, 104 (1976).

146. *Farmer v. Brennan*, 511 U.S. 825, 837 (1994).

147. *Gamble*, 429 U.S. at 98.

148. *Id.* at 103.

149. *Id.* at 104.

150. Richard Siever, *HMOs Behind Bars: Constitutional Implications of Managed Health Care in the Prison System*, 58 VAND. L. REV. 1365, 1371-72 (2005) (quoting *Gamble*, 429 U.S. at 104-105).

151. *Farmer*, 511 U.S. at 837.

152. Siever, *supra* note 150, at 1373.

153. Alice Ristroph, *State Intentions and the Law of Punishment*, 98 J. CRIM. L. & CRIMINOLOGY 1353, 1381 (2008).

operate the medical care system. However, with respect to other conditions that lead to poor health outcomes, this can pose a significant barrier to litigation. Officials may not be aware that poor ventilation can cause asthma to become more severe, for example, or even necessarily know that the ventilation is inadequate. Further, officials may be unaware of specific instances of violence that contribute to the stress of the prison environment. In *Farmer*, for example, a transgender woman was incarcerated with male inmates in a prison known for a high rate of rapes and other assaults.¹⁵⁴ She suffered a severe beating and rape, but the fact that prison officials allowed this to happen was not enough to demonstrate a violation—the prisoner had to show that the officials had subjective knowledge that she was in danger.¹⁵⁵ *Farmer* does not expressly limit prisoners' rights to sue over prison conditions, but it makes it much more difficult for them to win because the plaintiff must show that defendants had actual knowledge of the conditions.¹⁵⁶ Defendants can defeat such a claim by characterizing the problems as risks inherent to incarceration¹⁵⁷—in *Farmer*, this was a risk of violence, but it could also be the poor ventilation and overcrowding issues that plague many facilities. Defendants can also defend suits by showing that they acted reasonably in light of the risks,¹⁵⁸ such as by trying to hire better medical personnel. Finally, they can simply lie and say they were not aware of the problematic conditions,¹⁵⁹ and if plaintiffs cannot show that the condition was so obvious that defendants' lack of knowledge is impossible, the lie will probably be believed. However, the *Farmer* standard does have several benefits for prisoners, because they need not prove that they told officials about the risk of harm, wait for the harm to be realized, or prove that officials intended for the harm to occur.¹⁶⁰

The Prison Litigation Reform Act of 1995 (PLRA)¹⁶¹ created yet another limitation on prisoners' ability to bring § 1983 claims for Eighth Amendment violations. The PLRA restricts prisoners' ability to bring suit until all administrative remedies are exhausted¹⁶² and requires the court to dismiss claims that are frivolous, malicious, fail to state a claim upon which relief can be granted, or

154. *Farmer*, 511 U.S. at 829-31.

155. *Id.* at 847.

156. Ahmed A. White, *The Concept of "Less Eligibility" and the Social Function of Prison Violence in Class Society*, 56 *BUFF. L. REV.* 737, 784 (2008).

157. *Id.*

158. *Id.*

159. *Id.*

160. *Id.* at 783.

161. 42 U.S.C. § 1997 (2006).

162. There is some debate on exactly what is required to exhaust administrative remedies, but the basic definition supplied by the United States Supreme Court is that a prisoner must "complete the administrative review process in accordance with the applicable procedural rules, including deadlines, as a precondition to bringing suit in federal court." *Woodford v. Ngo*, 548 U.S. 81, 87 (2006). This means that if a prisoner misses an administrative deadline within the prison's grievance system, the defendant prison can use this failure to argue for dismissal of the case.

seek monetary relief from a defendant who is immune from relief.¹⁶³ The PLRA also limits the availability of attorney's fees to situations where the fee was incurred while proving an actual violation of a prisoner's rights or in enforcing an order for relief, and it applies some of the prisoner's award to attorney's fees, essentially reducing the total award.¹⁶⁴ In addition, the law requires a showing of physical injury before a civil action can be brought for emotional or mental injuries.¹⁶⁵ This element of the law, however, may be unconstitutional. In *Siggers v. Barlow*, the Federal District Court for the Eastern District of Michigan found it to be unconstitutional with respect to First Amendment violations, which will rarely have a physical component.¹⁶⁶ In *Mason v. Schriro*, the Federal District Court for the Western District of Missouri held it does not apply to Fourteenth Amendment violations because holding otherwise would deprive prisoners of a remedy for serious violations.¹⁶⁷

An even more significant portion of the PLRA is 18 U.S.C. § 3626, which addresses remedies for unconstitutional prison conditions. Under the PLRA, a court may only order injunctive relief that is narrowly drawn to solve the alleged violation of the plaintiff's rights and must give "substantial weight" to any risks to public safety or the operation of the prison system when crafting a remedy.¹⁶⁸ To order a prisoner release as a remedy, the court must have already tried a less intrusive remedy and given the prison system a reasonable amount of time to comply with that remedy, and only a three-judge panel can order the release, depriving the original trial judge of independent authority.¹⁶⁹ The limitations created by the PLRA led Erwin Chemerinsky to note, "[t]he PLRA does not make it impossible for federal courts to act to remedy unconstitutional prison conditions, but it surely makes it much more difficult."¹⁷⁰

Even when a prisoner is able to show deliberate indifference and even when a court crafts a remedy that is allowed under the PLRA, however, change can be very slow to come. Several cases in California demonstrate the difficulty of using Eighth Amendment lawsuits to improve prison medical care systems in order to eliminate serious health risks. In *Plata v. Schwarzenegger*, which began in 2001, prisoners alleged that the delivery of medical care in state prisons was

163. 42 U.S.C. § 1997e(a), (c)(2) (2006).

164. *Id.* § 1997e(d)(1).

165. *Id.* § 1997e(e).

166. *Siggers v. Barlow*, 433 F. Supp. 2d 811, 816 (E.D. Mich. 2006), *aff'd*, 412 F.3d 693 (6th Cir. 2005).

167. *Mason v. Schriro*, 45 F. Supp. 2d 709, 719 (W.D. Mo. 1999). The U.S. Court of Appeals for the Eighth Circuit, however, has declined to follow *Mason*, holding that PLRA's limitation on damages to plaintiffs who sustain physical injuries does apply to alleged First Amendment violations. *Royal v. Kautzky*, 375 F.3d 720, 723 (2004) (noting that a majority of courts have held that § 1997e(e) does require physical injury for First Amendment violations).

168. 18 U.S.C. § 3626(a)(1).

169. *Id.* § 3626(a)(3).

170. Chemerinsky, *supra* note 142, at 316 (2008).

so poor that it violated the Eighth Amendment.¹⁷¹ In 2002, the state agreed to implement changes to bring the medical system up to constitutional standards, but by 2005, the changes had not actually been implemented in any of the state's prisons in spite of close monitoring by the court and several time extensions.¹⁷² For this reason, in 2005, Judge Henderson ordered that a federal receiver oversee the state prison system.¹⁷³ Five years later, the problems persisted and plaintiffs in that case joined the plaintiffs in the other major case, *Coleman v. Schwarzenegger*.¹⁷⁴ *Coleman* began in 1990 and alleged constitutional violations in mental health care for state prisoners.¹⁷⁵ Since by 2009 neither physical nor mental health care problems had been resolved, the plaintiffs requested that the court order a release of prisoners, because the severely overcrowded prison conditions made it impossible to maintain an adequate health care system within the prisons.¹⁷⁶ The requisite three-judge panel approved the prisoner release, and the panel's decision was recently upheld by the United States Supreme Court.¹⁷⁷

Regardless of whether the PLRA precludes a prisoner release in California, it is clear that prisoners face an uphill battle in the fight to improve prison conditions. If prison officials lack actual knowledge of a substantial risk to a prisoner's health or safety, there is no Eighth Amendment violation, even where officials should have known of the problem. The difficulty in remedying identified violations is also significant, in part because the PLRA prevents reducing the overcrowded conditions responsible for many problems. For this reason, it makes sense to look outside the prison for solutions to the health problems prisons create.

B. The Need for Culturally Competent and Patient-Centered Services

We know that many people are not in good health when they are released from prison. Many have received treatment while incarcerated and need a new regular source of care to maintain that treatment regimen. Others may not even realize they need medical attention because diseases like Type II diabetes and

171. *Plata v. Schwarzenegger*, No. C01-1351, 2005 WL 2932253, at *1 (N.D. Cal. Oct. 3, 2005). This was not Federal District Court Judge Thelton E. Henderson's first prison conditions case, although it was his first case that addressed the entire state corrections system. In 1995, Judge Henderson ruled in *Madrid v. Gomez* that the medical and mental health care at Pelican Bay State Prison violated the Eighth Amendment. 889 F. Supp. 1146, 1200, 1215 (1995). Judge Henderson explained that inadequate staffing levels, poor staff training and supervision, disorganized medical records, low frequency of screening for common illnesses, inadequate access to care due in part to inappropriate gate-keeping by unqualified staff, and poor quality of care all contributed to the Eighth Amendment violation. *Id.* at 1200-15.

172. *Plata*, WL 2932253, at *1-2.

173. *Plata*, WL 2932253, at *2.

174. See *Eastern District of California Holds That Prisoner Release is Necessary to Remedy Unconstitutional California Prison Conditions* – *Coleman v. Schwarzenegger*, 123 HARV. L. REV. 752, 752-53 (2010).

175. *Id.* at 752.

176. *Id.* at 753.

177. *Brown v. Plata*, No. 09-1233 (U.S. May 23, 2011).

hypertension can persist for years before people experience symptoms,¹⁷⁸ and most prison health care systems do not screen for disease very well. We also know that African American men are particularly at risk for many conditions yet are the least likely to schedule and receive routine check-ups.¹⁷⁹ With these factors in mind, our goal should be to increase utilization of routine check-ups among recently released prisoners, with a special focus on the need for cultural competence to address the psychosocial barriers that African American men face when contemplating the medical system.

A crucial question is what entity should bear responsibility for making this happen. The most natural answer is that the prison system and outside health providers will need to collaborate. Prison officials should incorporate scheduling a check-up into their pre-release planning efforts so a prisoner will be able to visit his new medical home within a week of release. For those with ongoing substance abuse problems, appointments should occur within twenty-four hours to prevent immediate relapse. Further, just as prisons in two-thirds of states release people with a small amount of cash to start out their reentry,¹⁸⁰ prisons should also bear the cost of this initial visit. This will provide funding to the safety net providers likely to be involved in these projects. In addition, prison officials should remain in close communication with outside health centers, whose staff can provide valuable insight into the health status of prisoners who may not have been identified as needing services inside the prison.

Some non-profit organizations have had great success serving low-income African American men with incarceration histories. They can provide examples of how to serve this population, including how to gain and maintain trust and credibility. One such organization is the Transitions Clinic, described in the Introduction, a partnership started in 2006 between doctors at the University of California San Francisco-San Francisco General Hospital and the Southeast Health Center.¹⁸¹ Designed to serve the reentry population specifically, Transitions provides primary health care services and case management to help recently released prisoners find housing and jobs as well as health care services beyond the clinic's scope.¹⁸² Case manager and community health worker Ronald Sanders understands his clients' needs because he spent years in and out of prison.¹⁸³ The Transitions Clinic receives funding from the San Francisco Foundation, the California Endowment, and Catholic Healthcare West,¹⁸⁴ demonstrating that philanthropy can plan an important role.

178. MALLIK-KANE & VISHNER, *supra* note 64, at 21.

179. *See supra* Section III.A.

180. *See* JOAN PETERSILIA, WHEN PRISONERS COME HOME: PAROLE AND PRISONER REENTRY 7 (2003) (explaining that prisoners released on parole receive between \$25 and \$200 in the two-thirds of states that provide this "gate money").

181. Yeung, *supra* note 6.

182. *Id.*

183. *Id.*

184. *Id.*

Another organization is Healthy Oakland, a community health organization located in Oakland, California and modeled on the example set by the Transitions Clinic.¹⁸⁵ The organization works to improve health in the African American community and reduce violence by offering a wide range of services.¹⁸⁶ Medical services are provided in collaboration with a separate health center and are available at several locations, as well as from a mobile health van.¹⁸⁷ Community members can access screenings for many common conditions and get help managing them. Services are provided regardless of ability to pay, although Healthy Oakland does accept Medicaid and other insurance.¹⁸⁸ Healthy Oakland has deep connections in the community, in part because members of the clergy are heavily involved, and it serves many recently incarcerated men.¹⁸⁹ The organization is simultaneously connected to the financial resources it needs to provide services. The Alameda County Public Health Department, two health centers, and six major foundations, including the California Endowment, support Healthy Oakland.¹⁹⁰

Delivery of health care services is an area that would benefit from both government and philanthropic investment. When local governments and foundations work with community leaders, they can develop excellent programs. At the same time, however, it is important for prisons to contribute to these organizations, because prison conditions help create many of the health problems that then need to be addressed.

C. Challenging Invisible Punishments

1. Considering an Eighth Amendment Challenge

Legal efforts to eliminate prohibitions on eligibility for public benefits face an uphill battle. The Court of Appeals for the Seventh Circuit rejected Due Process, Equal Protection, and Double Jeopardy challenges to the food stamp and TANF ban for drug felons in *Turner v. Glickman*.¹⁹¹ The court held that the ban did not implicate any fundamental rights or a suspect class, which meant the Due Process and Equal Protection claims had to be assessed under the deferential rational basis test.¹⁹² Two explanations for the policy satisfied the court that the legislature had a rational basis for banning those with drug felonies from receiving food stamps: deterring drug crime and reducing fraud.¹⁹³ It seems likely that other courts would follow the Seventh Circuit in holding that these explanations

185. HEALTHY OAKLAND, <http://www.healthyoakland.org> (last visited Nov. 17, 2010).

186. *Id.*

187. *Id.*

188. *Id.*

189. *Id.*

190. *Id.*

191. *Turner v. Glickman*, 207 F.3d 419, 423 (7th Cir. 2000).

192. *Id.* at 423-24.

193. *Id.* at 425.

meet the requirements of rational basis review.¹⁹⁴ The court further held that the ban was not a criminal punishment but rather a civil penalty, and therefore it did not violate Double Jeopardy.¹⁹⁵ This decision is based on the two-prong test in *United States v. Ward*,¹⁹⁶ which directs courts to determine whether Congress, in passing a law, expressed or implied a preference for labeling a penalty civil or criminal.¹⁹⁷ If Congress intended to create a civil penalty, courts must determine whether the penalty is so punitive as to negate this intention.¹⁹⁸ Although other federal courts have not ruled on this question, it is not encouraging for advocates¹⁹⁹ that the first circuit to do so has rejected the idea that the ban on eligibility is a punishment. In another context, the Supreme Court of the United States has ruled that denial of “noncontractual governmental benefits” does not impose restraints, affirmative disabilities, punishment, or imprisonment.²⁰⁰

The Eighth Amendment prohibits both excessive fines and cruel and unusual punishment. Although the bans on food stamps and TANF and the restriction on access to federal housing assistance are directly tied to criminal convictions and unquestionably harm those affected, it will be difficult to convince a court that these policies constitute part of the criminal punishment. As long as the court can conceive of a reason other than punishment for the policies, it is likely to conclude that it is not intended as a punishment.²⁰¹

Unfortunately, this same problem plagues the excessive fine analysis. On its face, deprivation of a government benefit seems functionally equivalent to the demand of a payment—in both cases, the person subject to the policy is deprived of resources she would otherwise have. However, the Supreme Court interprets the Excessive Fine Clause as limiting “the government’s power to extract payments, whether in cash or in kind, ‘as punishment for some offense.’”²⁰² For this reason, it is likely that a challenge on Excessive Fine Clause grounds will hinge on whether a court views the ban as a punishment. As discussed above, it is un-

194. See Deborah N. Archer & Kele S. Williams, *Making America “The Land of Second Chances”*: Restoring Economic Rights for Ex-Offenders, 30 N.Y.U. REV. L. & SOC. CHANGE 527, 552 (2006) (“Legal advocates seeking to challenge the TANF ban would have a difficult time convincing any federal court applying a similarly deferential review that the ban does not further a valid state interest.”).

195. Turner, 207 F.3d at 430-31.

196. 448 U.S. 242 (1980).

197. *Id.* at 248.

198. *Id.* at 249; Michael Pinard, *An Integrated Perspective on the Collateral Consequences of Criminal Convictions and Reentry Issues Faced by Formerly Incarcerated Individuals*, 86 B.U. L. REV. 623, 640 (2006).

199. By “advocates” I mean individuals and organizations working to eliminate invisible punishments. This includes attorneys involved in litigation, community-based organizations, and policy-oriented advocacy groups whose missions are enhanced by the removal of these barriers to health and health care access.

200. *Flemming v. Nestor*, 363 U.S. 603, 617 (1960) (holding that the disqualification of deportees from receiving Social Security benefits while out of the country is not a punishment).

201. See Turner, 207 F.3d at 431.

202. *U.S. v. Bajakajian*, 524 U.S. 321, 328 (1998) (quoting *Austin v. United States*, 509 U.S. 602, 609-610 (1993)).

likely that this will happen.

There does not appear to be a winning constitutional challenge to the bans on public benefit eligibility. Rational basis analysis will probably always preclude success on Due Process and Equal Protection grounds, while the reluctance to view denial of benefits as a punishment makes success on Double Jeopardy or Eighth Amendment grounds quite unlikely. For this reason, it makes sense to consider political alternatives.

2. Political Challenges to Bans on Food Stamps and TANF

It is difficult to imagine that the federal rules on food stamps and TANF will change soon. Republican control of the House of Representatives and the need for sixty votes to overcome a filibuster in the Senate mean that conservatives will have no trouble defeating legislation that would seem both to increase expenditures for the poor and benefit drug felons. However, advocates may be able to gain traction in state legislatures.

In those states where the ban remains completely intact, it makes sense to push for loosening the restrictions. One persuasive argument is that recidivism rates are likely to go down when people with substance abuse problems are able to access benefits that increase stability, such as food and cash assistance and, in particular, when they are able to live with their families.²⁰³ In addition, advocates should emphasize that denying benefits makes it harder for families to stay together, and that former prisoners are in great need of family caring and support.²⁰⁴ Finally, it is worth noting that loosening the ban can bring more federal money to a state,²⁰⁵ which helps alleviate economic woes.

States that have already made some adjustments to the ban may be more likely to make further changes. For example, since 2004, California has allowed people with drug possession convictions to access food stamps as long as they are in treatment, and California is now considering lifting the treatment requirement to allow people with distribution convictions to also receive benefits upon release.²⁰⁶ Thus, advocates in states with less drastic bans can push for reform by showing that these restrictions are bad policy because of the extensive damage

203. See Gwen Rubinstein & Debbie Mukamal, *Welfare and Housing—Denial of Benefits to Drug Offenders*, in *INVISIBLE PUNISHMENT* 42, *supra* note 70 (“Without access to subsistence benefits, treatment, and safe and sober housing, it is much less likely that [individuals with drug felony convictions] will be able to live drug-free in the community and avoid recidivism.”).

204. Christy A. Visher & Jeremy Travis, *Transitions from Prison to Community: Understanding Individual Pathways*, 29 *ANN. REV. SOC.* 89, 97 (2003) (explaining that reestablishing a commitment to family roles is very important after incarceration and helps ex-offenders establish new identities as prosocial, law-abiding citizens).

205. See, e.g., CAL. HEALTH & SOC. SERVS., *ANALYSIS OF THE 2004-05 BUDGET BILL: FOOD STAMPS PROGRAM* (2004), available at http://www.lao.ca.gov/analysis_2004/health_ss/hss_20_foodstamps_anl04.htm (explaining that federal food stamp money is a direct infusion of funds to California families and also creates a ripple effect through which greater revenue is generated for the General Fund).

206. Cathy Bussewitz, *Assembly Backs Food Stamps for Drug Felons*, *BAKERSFIELD NOW*, May 13, 2010, available at <http://www.bakersfieldnow.com/news/local/93719214.html>.

they cause.

Efforts to eliminate the ban on TANF and food stamp eligibility for those convicted of drug offenses are most likely to succeed at the state, rather than federal, level and may be most effective where advocates can promote modifications to state bans to achieve elimination incrementally. Political challenges to eligibility restrictions for housing assistance, by contrast, may proceed at federal, state, and local levels, but advocates will need to offer a more nuanced policy than simple elimination of all restrictions.

3. Political Challenges to Restrictions on Federally Assisted Housing

The limits on federal housing assistance are somewhat more complicated because there is, as discussed previously, a genuine tension between protecting residents of public housing and providing housing to people who may commit crimes. However, with respect to individuals with criminal records, this may be a false tension. While a person currently engaged in criminal activity indeed poses a danger to the community, a person who has committed crimes in the past may not be a threat and, depending on the situation, may be a model tenant.²⁰⁷ Community Voices: Healthcare for the Underserved, a group of community-based demonstration projects focused on improving health care access and quality to under-served groups, recommends moderate policies that acknowledge the need for safety while striving to improve re-entry conditions for former prisoners.²⁰⁸

Focusing on the choice of whether to admit an individual to public housing or approve him for a voucher program, Community Voices suggests training public housing staff to conduct individualized assessments that seek to determine the person's level of rehabilitation and whether the offense committed would affect safety and quality of life in the development.²⁰⁹ Further, the group recommends that this assessment take into account the impact on family formation, minor children who would benefit from having the applicant in their home, and the risk that without public housing, the applicant would be homeless.²¹⁰ These considerations can help balance the impact of a person's past offenses with their potential for a positive future. Also, the group notes that it makes sense to only consider crimes committed within the past ten years and to focus on crimes for which the applicant was convicted, unless a pattern of arrests suggests an ongoing problem.²¹¹ This is especially important because current policy allows public housing agencies to accuse an individual of committing a crime and force him or her to leave, leaving the family with the choice of abandoning the person or leav-

207. KAY RANDOLPH-BACK, CMTY. VOICES: HEALTHCARE FOR THE UNDERSERVED, PUBLIC HOUSING POLICIES THAT EXCLUDE EX-OFFENDERS: A HOUSE DIVIDED 6 (March 16, 2007) (referencing a Human Rights Watch study concluding that the One Strike policy excludes some individuals who would make the best tenants).

208. *Id.* at 9-10.

209. *Id.* at 10.

210. *Id.*

211. *Id.*

ing as well, without requiring that the agency prove any crime was actually committed.²¹² Finally, the group recommends stronger due process rights for those denied access to public housing so that these variables can be considered more than once if necessary.²¹³ These policy changes do not suggest that all former prisoners should be admitted to public housing or that no one should be evicted from public housing for criminal activity, but they do have the power to maintain protections for residents while reducing the harm to former prisoners and their families.

Advocates may bring these problems to the attention of Congress, which has the power to require individualized assessments, to HUD, which can write regulations implementing these changes, or to local public housing authorities, which already have discretion to implement any of these changes if they so choose. Depending on the location, any or all of these levels of authority could be receptive audiences. For example, in a neighborhood where the public housing agency may be amenable to negotiation, advocates may be able to help community members discuss these issues with local officials and arrive at solutions that will benefit that community. Where the local officials are not interested in discussions, it might make more sense to appeal to HUD or the local representative or senator. In any case, the key may be to present a united front in which the residents of public housing and former prisoners work together to promote workable compromises, such as those suggested by Community Voices.

Any kind of political effort to rescind invisible punishments, whether the effort is directed to the ban on food stamps and TANF or to restrictions on public housing, is likely to be a long and difficult project. However, if successful, it may help alleviate the health inequities that lead African American men to suffer from worse health problems and live shorter lives.

CONCLUSION

We know that prisons make people sicker, both in body and mind. The ideal solution would be to stop incarcerating so many people, especially so many African American men. However, because that solution is probably many years away, society should act now to mitigate the harms that mass incarceration inflicts. Although litigation using the Eighth Amendment to improve prison medical care is crucial, it does not seem likely to change the basic fact that the experience of incarceration is damaging to inmates' health. In the United States, the combination of drug laws, "Three Strikes" laws, and over-policing of African American neighborhoods means that African American men are much more likely to be in prison, and be in prison longer, than any other group. The evidence shows that African American men suffer higher morbidity and mortality rates than any other group, and it seems that there is a strong connection between

212. *Id.*

213. *Id.*

mass incarceration and the high disease burden African American men face.

To ameliorate these problems, society must provide much better access to culturally competent health care to men immediately upon their release from prison. Prison officials, local governments, and philanthropies need to collaborate to make this goal a reality. In particular, community organizations have a vital role to play in creating health care environments that provide excellent care and allow men to feel and be strong even while asking others for help. At the same time, we must address the fact that former prisoners face many ongoing “invisible” punishments upon their release, notably the ban on eligibility for most public benefits. This is an ongoing assault on health and family stability, and it only exacerbates the health problems that all prisoners, and African American men in particular, face. For this reason, advocates should consider campaigning for their states to opt out of federal default rules that ban eligibility for these programs. After creating many of the circumstances leading to the health inequities that harm African American men, society can begin to heal the damage by implementing reforms that change this system.