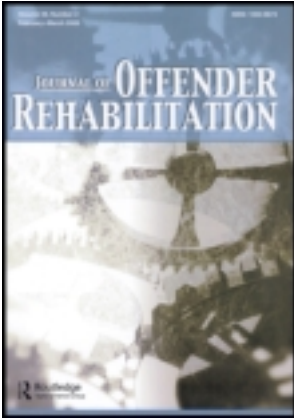


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Improving the Health of Minority Communities through Probation-Public Health Collaborations: An Application of the Epidemiological Criminology Framework

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This article explores the notion that common dynamic risks may underlie both criminal justice system involvement and poor health outcomes among members of minority groups in the U.S. We introduce the epidemiological criminology framework as a way of conceptualizing, researching, and intervening to reduce both health and criminal behaviors simultaneously among those on community supervision, or probation and parole. We use the lack of attention to community-supervised populations in previous research on sexually transmitted diseases as an illustration of lost opportunities. Suggestions for addressing these and other disease states and criminality simultaneously through the epidemiological criminology framework are provided.

KEYWORDS *criminality, dynamic risk, epidemiological criminology, health, HIV, STD*

Jails and jail populations remain elusive targets for utilization to improve the health of communities, especially predominately African American communities. The linkages among disease screening, treatment, and linkage

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to continuity of care services between jails and public health systems are generally not well understood. Determining how best to utilize the criminal justice process to enhance the health of communities, and vice versa, is an important step to improve community health. We will introduce the epidemiological criminology framework as a way of both looking at the causal pathways that underlie both health and criminogenic risks, and bringing community members into the realm of criminal justice involvement. Based on the brief analysis given, we plan to encourage thinking about community-supervision populations (i.e., probationers and parolees), as opposed to inmates and prisoners. We will use previous studies of HIV and STD testing in criminal justice-involved populations as our exemplar. To the authors, working with community-supervised populations would appear to be of greater value in terms of developing interventions to address health and criminogenic risk simultaneously.

“Corrections inherits the failures of every social system” (Potter, 2007, p. 41) is a statement of the importance of jails (as well as community corrections and prisons) to public health. Jails, processing an average 10 million bookings and an estimated 8.5 million unique individuals annually over the past decade (Spaulding et al., 2009), experience the largest inheritance. To remain in that metaphor, they also spend that inheritance much more quickly than do prisons. In an article on pandemic influenza planning and jails, Maruschak et al. (2009) pointed out that the turnover of individuals in the more than 3,200 jails across the nation was around 64% per week, ranging from 100% in small jails to around 54% in larger jails (i.e., average daily populations of 1,000 inmates or more). An analysis of inmate release data during 2004 (Beck, 2006; Cohen & Reaves, 2007), revealed that approximately 46% of jail inmates were detained fewer than 3 days, 16% detained between 3 and 7 days, and 18% between 8 and 30 days. Only 1% of inmates were detained for more than 1 year.

By far, the largest number and proportion of those under correctional control or supervision are found in communities, not sequestered behind jail or prison walls. Because most individuals pass through the jail setting at a relatively rapid pace and re-enter their community without much more than responding to a cursory health screening, it is probable that only a statistical handful are ever offered more than a functional health screening during their detention. If they did not know their health status before entering jail, it is unlikely they will know their status after being processed through the jail. While the more than 3,200 jails in the United States process the most individuals in the criminal justice system, most of our knowledge of the health burden in correctional populations is taken from studies conducted in prison systems. It is highly likely that some proportion of persons living with health problems, who process through jails, return to their community almost immediately after their arrest without knowing anything more about their health problems than they did when they were adjudicated.

For example, in 2008 there were 4,270,917 individuals on probation in communities across the United States. They represent approximately 70% of the population under correctional supervision during 2008. In the same year, more than 2.4 million new cases entered probation systems, nearly 2.2 million of those without any prior incarceration. New probation cases were at least 3 times greater than new admissions to state or federal prisons in the same year (Sabol et al., 2009). Moreover, approximately 2.3 million probation cases were terminated from the system, suggesting that “flow” across probation populations is as dynamic as that encountered in jail settings, though at a slower pace (Glaze & Bonczar, 2009). In effect, we see a three-tiered system—prisons, jails, and probation—that directly and indirectly impacts the way in which our systems of public health, correctional health, and incarceration converge.

Glaze and Bonczar (2009), noted that 30% of probationers in 2008 were under supervision for a drug crime, ranging from possession to sales convictions. Substance use is a recognized risk factor for a myriad of sexually- and blood-transmitted diseases, as well as for a variety of chronic diseases. In the community, even on probation, behaviors conducive to the acquisition and/or transmission of HIV (or other sexually-transmitted infections) are less constrained than they would be in either jail or prison, while behaviors associated with chronic diseases or disabilities from injuries, to name a few, may not be as constrained. Health promotion, disease and disability testing, and treating those under correctional supervision in the community whose behavior is likely to include risk behaviors for acquiring and transmitting infectious diseases or developing chronic diseases should be a priority for public health purposes. While these may not be the “low-hanging fruit” favored by current public health practices, they do represent the proportion of the criminal justice-involved population with the greatest risk profiles.

THE EPIDEMIOLOGICAL CRIMINOLOGY FRAMEWORK

Akers and Lanier (2009) recently introduced the idea of *epidemiological criminology* to the public health literary world, though the basics of the idea were formally presented at the Centers for Disease Control and Prevention (CDC) in both 1999 and 2003 by Akers and Potter. Subsequent publications and scientific presentations have advanced the process of sharpening the framework of the emerging paradigm first proposed (Akers, 2008, 2009; Akers & Lanier, 2009; Lanier, Lucken, & Akers 2009; Lanier, Pack, & Akers, 2010; Luty, 2009; Lanier, 2010; Akers & Whittaker, 2010; Potter, 2008; Akers & Potter, 1999, 2003; among others). We continue that work here by explicating the framework further.

In the original article by Akers and Lanier (2009), they followed scientific convention by describing an emerging paradigm and its intrinsic value, so as to begin the process in stimulating scientific interests and debate.

However, they stopped short of giving a detailed definition in order to encourage scientific dialogue. Counter to this process, Lanier (2010, p. 72) proceeded to define epidemiological criminology as “the explicit merging of epidemiological and criminal justice theory, methods and practice.” Our divergence from Lanier’s (2010) definition is to, first and foremost, conceptualize epidemiological criminology as a “framework” that focuses on the study of those “dynamic” variables, factors, and/or characteristics that contribute to both criminogenic and health risk (i.e., the common causal pathways). Our working definition of epidemiological criminology is an epistemological and etiological integration of the theories, methods, practices, and technologies used in public health and criminal justice that incorporates the broader interdisciplinary framework of epidemiology and criminology. Such variables include biological, psychological, and social factors—a bio-psycho-social approach, or what Akers and Whittaker (2010) described as a case for sociobiological determinism (see Figure 1). The scope of variables includes geospatial, legal, and social boundaries. Behavior is a bio-psycho-social product; law is a social product. Without law there is no crime, only behavior judged to be “harmful” or “deviant” by some groups. For something to fall within the domain of epidemiological criminology, then, it must acknowledge the primacy of the legal definition of a behavior as criminal (or delinquent). The co-occurrence with health issues brings phenomena into the framework.

Contributors to and readers of this journal are among the most active in the world in defining and researching criminogenics. The basic framework of

Epidemiological Criminology Framework

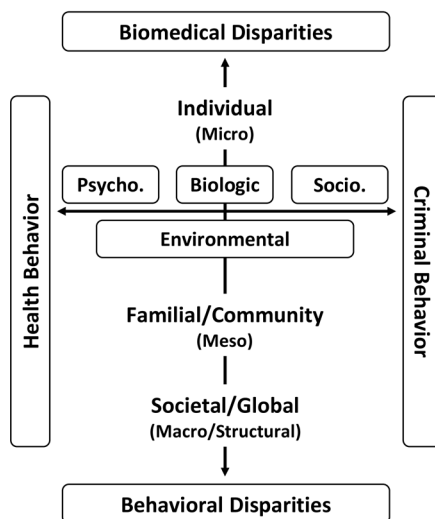


FIGURE 1 Epidemiological Criminology Framework.

epidemiological criminology is the merging of dynamic criminogenic and health risks in order to prevent criminal recidivism, on-set or exacerbation and transmission of infectious and chronic disease or injuries from criminal activity, or what we also refer to as *epidemiological recidivism*. As an example, intervening to reduce violence victimization will also reduce injury potential among both perpetrators and possible victims. Identifying and targeting the risk behavior(s) to achieve both outcomes is the key to an epidemiological criminology analysis and an epidemiological recidivism approach. Whether one domain of risk is on a higher order of importance to achieve both outcomes is an empirical question for epidemiological criminology researchers. Here we want to concentrate on one of the most common public health interests among criminal justice-involved populations—sexually transmitted diseases.

PROBATION, HIV/STD TESTING AND PREVENTION, AND LINKAGE TO SERVICES

To date, the vast majority of published data on HIV/AIDS or other STDs among criminal justice-involved persons has been carried out on detained or incarcerated populations (see Table 1). The data in Table 1 represents published studies of rates of various STDs among criminal justice populations. These are often cited as sources of knowledge about the burden of the particular disease amongst correctional populations. However, they represent only a small slice of those who process through the criminal justice system in any given time period. Their relationship to total disease burden in the community, however, may be considered quite high. Data in Table 1 help to point out a difference in the ways in which public health and jail professionals view the relative importance of disease screening. As a general note, the burden of disease in relation to the total population processed through these nonrepresentative jail systems is low. Especially when detainees are not held in the jail long enough to complete treatment, such small proportions may seem less important to a jail administrator. To the public health professional, the rates in relationship to the community rate may seem much more important. Given that so few individuals remain in the jail for much more than a few days, but may process on to community supervision, the lack of attention to community-supervised populations by public health agencies is astounding, given the overwhelming utilization of this sanction in the criminal justice system.

The HIV/AIDS Reporting System data, or HARS (Dean, Lansky, & Fleming, 2002), indicates that between 1994 and 2000, in the 25 states using a “named” reporting system, 6% of all new HIV diagnoses were reported from persons being tested while incarcerated in a jail or prison system. A follow-up in 33 states with “mature HIV reporting systems” for the 2001 to 2005 period

TABLE 1 STD or HIV Focus Studies of Criminal Justice-Involved Persons

Study	Geographic location of study	Point of data collection	Conditions measured	Type of measures reported	Number of jail systems studied	Number of respondents	Average length of stay of respondents
Van Hoeven et al. (1990)	New York City, NY	Admission history and physical exam—"any newly admitted inmate . . . suspect for gonorrheal infection after admission"	Medical records for those testing positive for gonorrhea postadmission	Observed positive cases ($n = 285$), admission date ($n = 262$; 92%), positive culture >1 week ($n = 58$), and 27 developed symptoms >1 week postadmission	1	Male positive gonorrheal cultures from October–December, 1986 ($n = 27$)	Length of confinement reported by positive case: 3 cases within 3 weeks, 11 cases within 6 weeks and 4 months, and 6 cases within 5–12 months; others unknown length of stay
Minshall et al. (1993)	Lake County Jail, IN	576 of 650 arrestees remaining at time of attempted interview at 72 hr postbooking (49%), October 28, 1991–January 17, 1992	Serum analysis results from 319 of 650 arrestees (49%) for syphilis, hepatitis B, and HIV (blinded)	Number and % of sample testing positive for each illness; logistic regression on risk factors measured	1	Within 72 hr of arrest all new arrestees approached, 49% ($n = 576$) agreed to blood draw	72 hr of admission (89% remaining postbooking)

Chen et al. (2002)	Los Angeles County Jail Men's Central Jail; self-identified gay and transgender male inmate section	While housed in gay and transgender male section, "All current and newly incarcerated inmates were offered screening"	Syphilis testing initially (March–August, 2000), chlamydia and gonorrhea added later; serum and urine testing; behavioral questionnaire	% of inmates tested positive for disease and responses to questionnaire	1	811 inmates screened for syphilis; 430 inmates completed behavioral questionnaire (ADP* of unit = 300)	Not specified
Kahn et al. (2002)	East Baton Rouge Parish Jail, LA	Arrestees admitted to the jail between July 1994 and December 1998 within 24 hr of admission	Serum	% testing positive for syphilis; 1.3% average over 5 years (all stages); demographics and relationship between demographics; booking charge and testing positive	1	50,941 tests conducted, 76% of those admitted were tested; average over 5 years	Not specified
Kahn et al. (2004)	30 county jails in counties with high syphilis morbidity	No data on point of collection provided	Positive laboratory results for primary syphilis cases	% of all primary syphilis cases reported from correctional facilities and demographic characteristics of positive cases	30	Reported cases of primary syphilis from all corrections facilities in the 30 counties (may include juveniles and prisoners)	Not specified

(Continued)

TABLE 1 Continued

Study	Geographic location of study	Point of data collection	Conditions measured	Type of measures reported	Number of jail systems studied	Number of respondents	Average length of stay of respondents
Solomon, et al. (2004)	Baltimore City Detention Center, MD	1st day of detention	Serum samples tested for HIV, syphilis, hepatitis B and C; demographic and arrest charge variables	% of inmates testing positive for each condition and association to demographic and arrest variables	Baltimore City "intake facilities"	2,833 detained individuals giving serum between January 28 and March 28, 2002	1 day
MacGowan et al. (2009)	Florida (1 jail) Louisiana (1 jail) New York (multiple jails) Wisconsin (1 jail)	Florida >24 hr; Louisiana >72 hr; New York >24 hr Wisconsin >24 hr after admission—average 6% of booked tested	HIV rapid test and risk factor survey	% testing positive and demographic and risk behaviors	Multiple jail facilities	6% of all bookings received HIV rapid test (33,211/55,000)	Not specified
Javanbakht et al. (2009)	Los Angeles County Jail Men's Central Jail self-identified gay and transgender male inmate section	"Generally" upon completion of jail intake	Serum samples for HIV and syphilis testing; urine samples for chlamydia and gonorrhea testing; demographic information; arrest information	% testing positive and associations with demographic and arrest information	1	7,004 tested for one or more diseases between March 2000 and December 2005; mandatory syphilis testing begun in 2005	Not specified

Burke and Rhodes (2009)	Nashville (Davidson County), TN	"During medical intake"; average 58.3% of booked tested	Serum testing for Syphilis	% positive for syphilis and stage of disease	1	1999–2005	Not specified
Barry et al. (2009)	San Francisco Jail, CA	At intake, when health staff present; offered in units to those missed	Urine-based testing for chlamydia; demographic information	% positive for chlamydia	1	1997–2004	Not specified
Pathela et al. (2009)	New York City (Rikers Island), NY	Not specified	Chlamydia	% of New York City positive chlamydia tests originating from jail facility	1	2004–2006	Not specified

*average daily population held in facility.

revealed 5.4% of all new diagnoses were among persons incarcerated at the time of testing (Hernandez, 2007). Unfortunately, neither of those studies was able to separate jail from prison testing settings. In jail-specific voluntary testing programs spread across four states (ranging from one county to multiple counties in those states), rates of newly diagnosed HIV ranged from .08 to 1.3% among those tested. On average, only 6% of those “booked” into the jails were tested in that study (MacGowan et al., 2009).

Testing among jailed and imprisoned individuals is not uncommon. In 2002, 63% of a nationally representative sample of jail inmates reported they had submitted to a HIV test at least once in their lives; 18.5% since admission to jail (Maruschak, 2004). By 2004, 73% of state prisoners in a nationally representative sample reported having had a HIV test at some point in their lives (Maruschak, 2008). Confined populations appear to be among one of the most tested segments of the U.S. population. Testing of detainees and prisoners for HIV and other STDs remains an important public health resource, though as demonstrated in the results from Table 1 for jail studies, new cases discovered in jails are relatively small as a proportion of the total population processed. It should be emphasized that in jail populations, these are primarily sentinels for community-acquired disease. Given the rapid return of most individuals processed through jails, the follow-up back in the community for individuals living with these diseases by local treatment providers deserves special attention.

As noted earlier, most individuals pass through the jail setting at a relatively rapid pace and re-enter the community without much more than responding to a cursory health screen. Thus, it is probable that only a statistical handful is ever offered a HIV testing opportunity in jail. If they did not know their HIV status before entering jail, it is unlikely they will know their status after being processed through the jail. While the more than 3,200 jails in the United States process the most individuals in the criminal justice system, most of our knowledge of HIV burden in correctional populations is taken from studies conducted in prison systems. To reiterate, it is highly likely that some proportion of persons living with HIV who process through jails return to the community almost immediately after their arrest without knowing their HIV or any other STD status. Research utilizing data from a Southern U.S. state with mandatory HIV testing upon prison admission demonstrates that, for a substantial population of “late testers” for HIV, many had multiple jail experiences where their HIV was undiagnosed (Duffus et al., forthcoming). Whether probation-based HIV and/or STD testing would have diagnosed those individuals is an intriguing question.

Given that a large proportion of probationers are likely to have at least monthly “check-ins” at the office of the probation service, it would seem that the development of public health-probation screening and referral partnerships should be a key objective. To date, however, few such programs appear to exist around the nation. One question that arises is the funding

of such programs. While incarcerated, inmates or prisoners health care is generally funded by state and local tax revenue, though some systems do charge a co-pay for services. In many of the studies in Table 1, explicit funding for the projects came from federal program dollars. Once an individual is released back into the community, regardless of whether on county (generally misdemeanor) or state (generally felony) probation, the responsibility for health services falls back upon the individual, charity, or health department funds. Based on cost and depending on reimbursements, there may be a disincentive for health systems to provide such services to a large, defined population.

APPLYING AN EPIDEMIOLOGICAL CRIMINOLOGY APPROACH

In 2008, Akers, Potter, and others presented the epidemiological criminology concept to the American Public Health Association, where they brought forth the paradigm into public and scientific debate (Akers, 2008, 2009; Potter, 2008). The focus was to introduce the public health community to time-tested and age-old criminological and criminal justice theories that have spurred health debates for decades. Some have suggested that the employment of epidemiological methods to criminal justice populations is one of the key features of epidemiological criminology (Lanier, 2010). Lanier's historical outline and the explication of these methods applied to criminal behavior by Cressey (1960) underlie one of the authors' first questions in regard to developing an epidemiology of crime: "So, what's new?" What we now call epidemiological methods have been utilized to study criminal behavior since the foundation of the modern social sciences, dating back to the recent past of what is referred to as the Chicago School. Simply applying newer technologies of surveillance or statistical analysis does not constitute epidemiological criminology, nor is it of particular advantage to current practice.

What we believe is truly new in employing an epidemiological criminology framework is the exploration of the common developmental trajectories of both disproportionate minority involvement in the juvenile and criminal justice systems, and the disproportionate health and criminal justice disparity burden borne by African Americans, Latinos, and low-income populations. This is a refinement of the general question addressed by the epidemiological criminology framework: What dynamic risk variables or factors contribute to both criminogenic and health risk? Where does the intersection converge at the crossroad between these two seemingly distinct disciplines?

This is not a "one size fits all" attempt, as we may find different dynamic risk patterns across a variety of groups and areas. It is an attempt to determine whether there are dynamic risk factors that can be addressed to accomplish at

least two desired social outcomes—the reduction of criminal behavior and morbidity and mortality due to preventable disease and injury.

As Hirschi (1969) noted in his revitalization of control theory, sometimes it is asking the question differently that spurs new growth in a field. In this case, rather than asking what corrections can do for public health, it is time to ask the more difficult yet pertinent question of, “What do health and criminal behaviors in communities have to do with each other, and how can we address both simultaneously in the context of their inseparable characteristics that are dynamic to community?” For too long we have waited until “hard to reach” individuals, males in particular, have entered the deep end of the system to intervene in their health and criminal behaviors. It is our goal that the epidemiological criminology framework can allow us to develop more upstream interventions to address dynamic health and criminal risk in situ, not in sequestration.

It is not our intention that epidemiological criminology be simply an academic enterprise. Rather, we see utilization of the framework as a way to develop interventions that address multiple dynamic risks and needs underlying health and criminal behaviors at the biological, psychological, and social-cultural levels. Through this process of interdisciplinary interaction, we anticipate stimulating a new era of enlightenment across disciplines. As a case in point, during the 2008 American Public Health Association presentation of the emerging paradigm of epidemiological criminology, a well-known and well-published epidemiologist in the audience spoke openly about having never considered delving into the theories and practices of the criminological and criminal justice literature until the presentation.

While we are focused on STDs in this article, the framework could be applied to issues of mental health and substance abuse in relation to criminality. The interdisciplinary nature of the health and criminal justice systems require that we think more holistically and analytically about those we see as inmate patients and community-supervised ill persons. Seeking the common dynamic factors that can deliver better health and crime prevention outcomes in the community strikes us as a worthy cause and new way of approaching this body of research and advancing the emerging paradigm of epidemiological criminology.

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