Advancing Public Health Interventions to Address the Harms of the Carceral System

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Abstract
Since January 2020, as many as 7 million cases and over 200,000 U.S. deaths have been attributed to the coronavirus disease 2019 (COVID-19). Yet, arguably no group of residents has been more affected than people incarcerated in jails, prisons and detention centers. These uniquely susceptible environments place incarcerated individuals at increased risk of not only contracting COVID-19 but developing severe infections that require hospitalization or result in death, given their older age and disproportionately high burden of underlying conditions. The conditions that created this crisis are long-standing (e.g., policies deploying the legal system to address public health concerns, unprecedented levels of incarceration, targeting of marginalized people), and in turn their adverse implications for population health and health inequity will only be exacerbated by the pandemic. Thus, public health solutions for addressing pressing COVID-19 concerns are the same as those needed to address more widespread, chronic health harms of carceral systems. Now, as ever, intervention necessitates prioritizing health by centering public health strategies. Therefore, APHA recommends moving toward the abolition of carceral systems and building in their stead just and equitable structures that advance the public's health by (both during and following the COVID-19 crisis) (1) urgently reducing the incarcerated population; (2) divesting from carceral systems and investing in the societal determinants of health (e.g., housing, employment); (3) committing to noncarceral measures for accountability, safety, and well-being; (4) restoring voting rights to formerly and currently incarcerated people; and (5) funding research to evaluate policy determinants of exposure to the carceral system and proposed alternatives.

Relationship to Existing APHA Policy Statements
The following APHA policy statements are relevant to the current statement:

- APHA Policy Statement 7106: Jails and Prisons—Public Health Response to a National Disgrace
- APHA Policy Statement 7315: Health Care in Jails and Prisons
- APHA Policy Statement 7921: Support for a National Strategy to Help Improve Health Care in Prisons, Jails, and Youth Detention Centers
- APHA Policy Statement 9123: Social Practice of Mass Imprisonment
- APHA Policy Statement 9929: Diversion from Jail for Nonviolent Arrestees with Serious Mental Illness
- APHA Policy Statement 200029: The Need for Mental Health and Substance Abuse Services for the Incarcerated Mentally Ill
- APHA Policy Statement 20048: Correctional Health Care Standards and Accreditation
- APHA Policy Statement 201310: Solitary Confinement as a Public Health Issue
- APHA Policy Statement 201811: Addressing Law Enforcement Violence as a Public Health Issue

Problem Statement

In January 2020, the first coronavirus disease 2019 (COVID-19) case was detected in the United States, and thereafter COVID-19 spread quickly and relentlessly across the country, with current reports attributing as many as 7 million cases and over 210,000 deaths to the disease.[1] Carceral settings account for some of the largest COVID-19 clusters in the United States, with 24 different institutions reporting clusters of more than 1,000 cases and some even approaching 3,000 cases.[2] Estimates suggest that case rates of COVID-19 in U.S. prisons are at least 5.5 times higher than in the general population.[3]

Outbreaks in these carceral institutions, as well as in nursing homes, in emergency shelters, and on cruise ships, demonstrate that COVID-19 spreads especially rapidly and uncontrollably in congregate settings. In carceral institutions specifically, the daily entering and exiting of staff—often with insufficient testing, poor personal protective equipment adherence, and the agency to move throughout the facility—serves as a chronic stressor for currently incarcerated people.[4,5] Once the virus enters these facilities, many of which are already over capacity, there is insufficient space to physically distance. Facilities are also not equipped to safely quarantine or medically isolate exposed individuals. Rising reliance on solitary confinement or other restrictive housing for symptomatic individuals, sites typically used for punishment and linked to psychological distress and trauma,[4,6] may exacerbate an already dire situation by deterring symptom reporting or seeking of medical attention. Other common conditions of physical spaces, such as aging infrastructure, poor ventilation, and shared living and hygiene facilities, contribute to the efficiency with which the virus spreads. These transmission-promoting conditions combine with the regular transfer of individuals into and between facilities to further amplify spread.[5]

Taken together, this uniquely susceptible environment places incarcerated individuals at increased risk of not only contracting COVID-19 but—given their older age and disproportionately high burden of underlying conditions—developing severe COVID-19 infections that require hospitalization or end in early death.[7] While the medical needs of incarcerated individuals were a notable public health crisis prior to the pandemic, that crisis is rapidly worsening in the present moment.

The historical makings of the present crisis: Exacerbating the COVID-19 crisis in the United States is the unprecedented level of incarceration extending from punitive policies implemented at the federal, state, and local levels. It is through these policies that certain activities and identities are socially constructed as criminal and that legal ramifications are broadened. For example, while some policies have served to increase prison admissions (e.g., deploying the legal system to criminalize substance use),[8,9] others have extended the average length of incarceration sentences (e.g., the federal 1994 Violent Crime Control and Law Enforcement Act as well as state “three strikes” and truth-in-sentencing laws).[10]

These punitive policies and practices disproportionately harm historically and structurally marginalized communities. For example, stop-and-frisk, which was codified into law via a 1968 Supreme Court ruling, permits law enforcement officers to stop and pat down any individual they perceive has engaged or may engage in a criminalized activity.[11] Studies examining the use of stop-and-frisk show that this practice disproportionately targets Black people, with an overwhelming majority of stops resulting in no charge.[12,13] Notably, racism operationalized by these policies and practices is not restricted to policing. Data show that given the same charge, Black and Latinx people are more likely than White people to be detained pretrial, to be sentenced to incarceration, and, when sentenced in federal courts, to receive longer sentences.[8] While touted as universally applied, these “tough-on-crime” policies are rooted in efforts to exert social control over structurally marginalized people.[14] For example, legal scholar Dorothy Roberts argues that racialized notions of criminality and social control in the United States date back to slavery and that racist constructions of Black communities as criminal are used to justify contemporary racially discriminatory law enforcement policies and practices.[15] These ideologies also underlie race-based ideas of who is “deserving” of rehabilitation, ideas that have been shaping legal policy since at least the early 1900s.[16]

In turn, structurally marginalized people are overrepresented among those incarcerated in prisons, jails, and detention centers, suggesting yet another path through which existing health inequities may be exacerbated in the pandemic.[17] This includes people who identify as Black, indigenous, or a person of color[14]; people who are

undocumented[18]; those experiencing houselessness[19]; people with disabilities[20,21]; people who are lesbian, gay, bisexual, transgender, and/or queer[22,23]; people with mental illness[24]; people who use substances[25]; sex workers; and people who are economically disenfranchised.[26]

Health harms of incarceration on individuals, families, and communities: In addition to greater risk of COVID-19 infection, incarcerated people have a higher prevalence of acute and chronic health conditions than the general U.S. population.[27] This includes higher rates of HIV and other infectious diseases,[28] mental health diagnoses,[29] hypertension, heart-related problems, diabetes, asthma, and stroke, along with overall lower life expectancy.[30,31] Higher rates of these chronic conditions among incarcerated people have been attributed to the experience of incarceration itself as well as pre-incarceration exposures to adverse structural determinants such as poverty, houselessness, and racism.[32] Notably, several of these chronic conditions have been shown to predict severe COVID-19-related illness and death.

Violence—whether self-directed, interpersonal, or perpetrated by agents of the state—is one such documented harm of incarceration. While men are more likely to experience interpersonal violence from another incarcerated person,[33] women are more likely to be victimized by staff.[34] Strikingly, trans people are targeted at nearly 10 times the rate of other incarcerated people.[35] In 2012, approximately 40% of trans people incarcerated in the United States reported sexual assault or abuse by staff members or another incarcerated person.[34] Other known harms linked to incarceration include histories of extreme human rights violations such as mass forced sterilizations,[36] a most recent example exposed by the whistleblower complaint at a Georgia immigrant detention center, as well as the regular use of solitary confinement, a form of torture, as an extraneous tool for punishment.[37] Solitary confinement is most often imposed on incarcerated people with mental illness and results in deleterious effects.[38] A recent study showed that frequent or extended exposure to solitary confinement was associated with an increased risk of all-cause mortality in the year following release from prison.[39] Alarming as these data are, what is known regarding the prevalence of abuse in carceral settings is likely an underestimation given risks associated with reporting (e.g., retaliation, dismissal of reports, lack of institutional accountability).[40] In addition to the documented health harms of each of these practices, taken together these conditions serve to undermine public health efforts to stem COVID-19 that depend on symptom reporting or seeking of medical attention among those with early symptoms.

Carceral facilities, especially jails, also contribute to community transmission of SARS-CoV-2.[41] High rates of jail incarceration combined with frequent churn of individuals and staff, many of whom commute long distances from surrounding communities, place incarcerated individuals as well as surrounding communities at risk.[42] Indeed, on average, jails hold more than 700,000 people and have a turnover rate of 54%.[43] Cook County jail in Chicago, for example, was reported to be the “largest-known node” of SARS-CoV-2 spread in the United States, and the cycle of people through this facility was associated with 15.7% of all documented COVID-19 cases in Illinois as of April 2020.[44] As incubators of COVID-19 transmission, carceral facilities can quickly overwhelm local health care resources, taxing already critically stretched systems.[17,45]

In addition to the spread of COVID-19 from carceral facilities to communities, the harms of the carceral system also extend to families and communities of incarcerated people through mechanisms such as family separation and disruption of community cohesion.[46] For example, parental/caregiver incarceration is associated with limited or no access to prenatal care, an increased risk of infant mortality, and a greater risk of living with mental health issues in childhood and adolescence.[47–49] These detrimental consequences extend to adult partners and relatives, inducing relationship strain and onset of depression and anxiety—conditions that will likely be exacerbated by the suspension of family visitation during the pandemic.[48,50] Notably, some of the carceral system’s harms are indirectly mediated through pathways such as added economic pressures (e.g., household income loss and paying for fees and fines) and housing precarity, which have been linked to adverse health.[49] Furthermore, many family members experience stigma and isolation.[51,52] Emerging public health research also points to “spillover” effects associated with heavily incarcerated communities for non-incarcerated community members, including county-level mortality,[53] individual-level preterm birth,[54] and depression and anxiety.[55]

The adverse effects of incarceration on individuals and communities do not end upon release. After incarcerated individuals are released from confinement, they are found to be nearly 10 times more likely to experience houselessness than the general public[56] and face numerous barriers to achieving health, including restricted access to education, employment,[57] and public housing[58] and, in many states, felony disenfranchisement. Indeed, given state laws on voting rights for incarcerated and formerly incarcerated people, in 2016 an estimated 6.1 million Americans were barred from voting,[59] thus excluding them from participation in political decisions affecting their health and that of their families and communities.

The problem of incarceration includes immigration detention: The deportation and detention of undocumented people is part of the carceral system. Between 1997 and 2015, there were more than 5 million deportations from the United States—two and a half times the sum total of all deportations prior to 1997.[60] In terms of scope, in 2019 the U.S. government booked 510,854 people into an Immigration and Customs Enforcement (ICE) detention facility, an increase of 29% over 2018.[61]

The vast majority of immigrants who are deported are Black and Latinx men; nearly 90% of deportees are men, and over 97% are Latin American or Caribbean nationals.[62] As with U.S. jails and prisons, these patterns of detention and deportation reflect policies designed to target structurally marginalized people. In 1996, when immigration law (although, notably, not criminal law) recategorized a range of criminalized activities as "aggravated felonies," the numbers of mandatory detentions began to rise.[63] Just as incarceration is a method of social control, so too is the detention and deportation of largely Latinx and Black men. Incarceration, detention, and deportation all provide a mechanism to remove excess workers who are no longer "needed" in the increasingly deindustrialized, gendered service economy.[60]

Immigration raids, detention, and deportation have also been linked to a range of adverse health outcomes, including low birthweight, preterm delivery, and posttraumatic stress disorder.[64–66] Furthermore, mirroring practices in U.S. jails and prisons, the conditions in detention centers as well as the continued transfers of detained people between facilities despite public health warnings around COVID-19 transmission have been linked to superspreader events.[67,68] Outbreaks in these detention centers have also resulted in deaths.[69]

Types of incarceration: Lastly, it is critical to identify the different ways incarceration operates across institutions and domains. The majority of incarcerated people in the United States are confined in state or federal prisons and local jails.[8] However, the modern era has seen a rapid expansion of the carceral system, encompassing additional institutions (e.g., detention centers, hospitals, schools, homes)[8,70] and deploying novel methods (e.g., digitally monitored E-carceration).[71] For example, in addition to jails constructed explicitly to incarcerate young people (i.e., "youth jails"),[8] incarceration also manifests in school spaces through the use of seclusion as a form of discipline (i.e., isolated confinement).[70] Similarly varied are the governing bodies that coordinate this carceral system, which range from the Department of Homeland Security to the U.S. Bureau of Prisons, state departments of correction, county and municipal departments,[8] and private (for-profit) corporations (e.g., the GEO Group).[72] For example, more than 73% of immigrant detention facilities are privately owned and operated.[63] Recognizing the multiple modes by which people are incarcerated, understanding their shared and unique consequences, and identifying the governing bodies overseeing institutions are key to designing appropriate solutions to stem incarceration and its health consequences.

Evidence-Based Strategies to Address the Problem

A public health approach: Deploying the carceral system largely remains the default policy approach to societal concerns.[15,73,74] Yet, this continued investment in a punitive paradigm was, and continues to be, avoidable. In fact, state governments pursuing public health priorities such as policies and public investments designed to bolster the social safety net (e.g., Medicaid, primary and secondary education, unemployment insurance) have had lower average prison incarceration rates[75] and better health outcomes.[76] Similarly, locales providing community-based support to people navigating substance use disorder, rather than responding with criminalization and punishment, have minimized stigma and increased uptake of treatment.[77]

Despite sufficient evidence that incarceration does not achieve safety but perpetuates violence, health inequity (including that related to COVID-19) and social inequity, most public health recommendations to date have proposed reforms as opposed to the aforementioned primary prevention strategies. That is, they have advocated for additional funding to improve health conditions during incarceration rather than directing those funds toward preventing incarceration altogether. While efforts to improve health conditions both during and after incarceration are important, they do not address the root causes of incarceration or prevent the associated negative health consequences. Incarceration is an ineffective intervention to resolve social problems, and jails, prisons, and detention centers should not be the point of access for necessary resources aimed at improving any number of social, emotional, or economic conditions. Abolition requires that we take a critical approach and investigate the root cause of the various levels of policy and the ingrained frameworks that limit our conceptions of—and responses to—safety, punishment, and violence.

Public health researchers and practitioners can play a key role in shifting away from these punitive paradigms toward preventive strategies that abolish the need for carceral systems. Indeed, the harmful consequences of incarceration for individuals, their families, their communities, and the general public demand a preventive public health response.

Evidence-based strategy 1—Investing in communities and alternatives: An abolitionist public health approach advocates for primary prevention as opposed to carceral solutions. These preventative solutions include providing access to basic resources that communities need to thrive, including quality education,[70] good jobs, and stable housing[69] (instead of criminalizing houselessness[78]). Moreover, affordable and accessible health care (e.g., mental health services in communities) can avoid funneling individuals with mental health and substance use disorders into the criminal legal system.[79,80] In the context of COVID-19, limiting police contact with the public and ending pretrial detention can prevent viral transmission. Recent estimates suggest that changes in policing and releases from carceral facilities could prevent 23,000 COVID-19 infections among incarcerated people and 76,000 infections in surrounding communities.[41] Community organizations, including those that employ formerly incarcerated people, and evidence-based reentry approaches such as transitional care coordination are especially needed to coordinate reentry and assist with securing stable and safe housing as well as medical and mental health care.[81–83]

Evidence-based strategy 2—Investing in transformative justice: Restorative justice is a nonpunitive, nonretributive process to address interpersonal harm that brings together all of those affected to decide together how to heal and repair the interpersonal harm done.[84] Transformative justice builds upon this process by focusing not only on the individuals involved but also on the larger systems and structures that created the conditions for harm to occur.[85] Although restorative and transformative justice processes vary widely in implementation, making evaluation of their effectiveness challenging, research on restorative justice shows it to be a promising solution to the problem of incarceration. For example, one of the most comprehensive meta-analyses on restorative justice revealed higher levels of satisfaction among individuals involved in the process (including those who were harmed and those who did harm), a greater likelihood of adhering to restorative agreements, and decreased rates of recidivism relative to those who did not participate in a restorative justice process.[86] Another meta-analysis of restorative justice programs with young people less than 18 years of age showed a general trend of decreased reengagement with the criminal legal system, a greater sense of fairness among both the young people who did harm and the people who were harmed, and greater satisfaction in comparison with those who did not participate in a program.[87] These outcomes suggest better mental well-being for all individuals involved when a restorative justice process is used as an alternative to the carceral system. Indeed, one study showed that symptoms of posttraumatic stress disorder, including avoidance and intrusion, were reduced among those who had been harmed and underwent a restorative justice process.[88] Further research is needed to evaluate programs explicitly identified as transformative justice.

Evidence-based strategy 3—Decarceration with no conditions of electronic monitoring or use of risk assessments: Decarceration practices and policies are those that are aimed at reducing the number and rate of people imprisoned in a particular jurisdiction. In addition to many recent calls by public health and health care professionals to reduce incarcerated populations as a public health imperative to prevent COVID-19 transmission,[89] a number of practices and policies falling under a wide umbrella term of “decarceration” have begun to be implemented in recent years across the United States. These decarceration practices include (1) ending cash bail[90]; (2) moving people with

mental health issues and substance use disorders from locked facilities to community-based treatment; (3) employing community-based interventions to address the medical and social needs of people who have been harmed by the criminal legal system, including those transitioning from incarceration[81,82]; (4) decriminalizing substance use,[91] houselessness, and other "quality of life" charges instead of approaching them as public health issues; and (5) decriminalizing sex work.

Evidence-based strategy 4—Investing in community-based mental health care: The most recent data provided by the Bureau of Justice Statistics suggest that 37% of people incarcerated in federal and state prisons and 44% of people incarcerated in jails have been diagnosed with a mental illness by a mental health professional.[92] Furthermore, approximately 14% of people incarcerated in federal and state prisons and 26% of people incarcerated in jails have reported experiences meeting the threshold for serious psychological distress (relative to 5% in the general population).[92] Notably, one national study showed that among the 26% of people incarcerated in state prisons who had been diagnosed with a mental illness in their lifetime, only 36% were receiving counseling services while incarcerated.[93]

Rather than deploying the carceral system—which exposes people living with mental illness to trauma, is punitive in nature and therefore likely cannot uphold patient rights requirements for care settings (e.g., the ability to assert choice in treatment without fear of retaliation), and fails to meet service needs—public health and clinical evidence shows an urgent need for the use of community-based mental health systems as the primary population-level policy for providing care. This literature also emphasizes investing in these community-based mental health care systems given not only a lack of evidence around the effectiveness of institutionalized settings (e.g., inpatient psychiatric care) but documented harms.[94,95] Bolstering community-based mental health care systems includes investing in nonpolice responses to mental health crises, which is especially critical given that people with serious mental illnesses are 16 times more likely to be killed by law enforcement than those without such illnesses.[96]

Community-based mental health care services such as assertive community treatment (ACT), which provides comprehensive, team-based, non–law enforcement support services to people living with mental health issues, have been shown to reduce involvement in the criminal legal system. For example, a study in California showed that over the span of 1 year, jail bookings for people enrolled in ACT were 36% lower than those for people not enrolled in this type of treatment.[97] Investing in services such as supported housing, which includes both a housing subsidy and social support (e.g., case management) for people living with mental health issues, has also been shown to reduce incarceration rates. For instance, an Ohio study revealed that formerly incarcerated people who received supported housing services were 40% less likely to be rearrested and 61% less likely to be re-incarcerated.[98]

Opposing Arguments/Evidence

Opposing argument 1—Incarceration increases public safety: A primary opposing argument suggests that prisons and jails improve public safety by securing people convicted of criminalized activities behind bars. This argument is predicated on conceptualizing criminalized activity as a static individual attribute that can be addressed only via incapacitation.[99] A similar argument that has been leveraged to deny needed action during the pandemic is that releasing incarcerated people convicted of "violent" crimes is a risk to public safety.

Response: While failing to weigh the outsized magnitude of health and safety harms perpetrated directly and indirectly by the carceral system, such conceptualizations are also not consistent with the available evidence. For example, incarceration rates have not been shown to increase public safety. An empirical study examining this issue showed that increased incarceration rates accounted for only 6% to 12% of the subsequent reduction in property crime in the 1990s and has accounted for less than 1% of the decline in property crime this century. Many states, including California, Michigan, New Jersey, New York, and Texas, have reduced their prison populations while crime rates have continued to fall.[100]

Notably, those who argue that incarceration increases public safety often focus on "violent" charges. However, many actions that a court defines as "violent" do not cause physical harm to others (e.g., in some states, marijuana possession), or they involve actions committed in self-defense, often against physical or sexual abuse.[101] In cases of violence against another person, existing restorative justice programs in California and New York have demonstrated

effective accountability approaches that center survivors, heal trauma, and build communities. These programs acknowledge that violence is not happening within a vacuum but is borne of violence—structural and interpersonal—and aim to address the root causes of violence by interrupting the cycle.[102] Rather than addressing the root causes of violence, the criminal legal system imposes the label of "violent," with far-reaching legal and health consequences (e.g., longer mandatory-minimum sentencing, voting disenfranchisement, deportation), and conflates punishment with accountability.

Instead of denying the social and historical contexts of racist and classist intergenerational health disparities, including unequal opportunities in employment, housing, and education and their impact on mental health and drug use, and then criminalizing behaviors, the United States needs to confront our conflation of punishment with accountability and begin to repair harms.[101] As stated in the evidence-based strategies, more effective solutions include noncarceral measures to ensure accountability, safety, and well-being (e.g., programs based in restorative and transformative justice) and primary prevention through investment in the societal determinants of health.

Opposing argument 2—Punishment through incarceration advances justice and accountability. A second opposing argument suggests that punishment is necessary for ensuring that individuals are held accountable for interpersonal harms or harms to society.[103] This argument is premised on the idea that the loss of freedom over daily routines, bodily habits, pastimes, relationships, and mobility is an appropriate consequence for certain actions and necessary to prevent convicted people from repeating these actions.[99]

Response: Incarceration has little to no effect on deterring crime.[100] Conceptually, the U.S. legal system has conflated punishment with accountability. By investing in a punitive paradigm, it fails to account for the social and historical contexts that created unequal access to material and social goods and manifests health inequity. Interdisciplinary scholars, researchers, and practitioners propose moving away from this racialized, punitive system toward evidence-based prevention strategies and community solutions for accountability. Furthermore, in a nationally representative survey of people who survived various levels of interpersonal harm, an overwhelming majority of respondents reported that they would prefer accountability measures facilitated outside of the carceral system such as rehabilitation, mental health treatment, drug use disorder treatment, community supervision, and community service.[104]

Opposing argument 3—Prisons and jails exist for the purpose of rehabilitation. Another justification for incarceration is that rehabilitation services can be provided in prison. This idea proposes that the skills, medical care, and treatment offered through incarceration not only will prevent people from engaging in criminalized activities upon release but may serve as access to care points that are otherwise unavailable in the community.

Response: Unfortunately, in the United States, the focus has always been punitive rather than rehabilitative. More than half of all incarcerated people do not receive rehabilitation services.[105] Furthermore, if the goal is rehabilitation, this can be accomplished without the harms and costs of imprisonment. There are many examples of successful substance use disorder treatment, job training, food, community-based conflict-resolution, anger management, adult education, and mental health programs that can be implemented in the community. One example is Mental Health First, a nonpolice, community-led program responding to mental health crises in Oakland and Sacramento, California.[106] Such programs provide examples of opportunities to invest in communities rather than in the criminal legal system.

Opposing argument 4—We can improve the carceral system by building more humane jails. Citing examples in other nations, this approach seeks to intervene on the harms of incarceration by reforming jails and prisons through human-centered, trauma-informed planning. These designs endeavor to overcome the punitive nature of incarceration by changing facility architectural plans, building materials, and the landscaping surrounding facilities and by training staff.

Response: These designs may be insufficient to overcome the health-harming premise of incarceration itself, which is "being deprived of one's liberty and confined against one's will."[107] Furthermore, while these novel designs seek to incorporate trauma-responsive approaches, they may still rely on practices and policies associated with chronic stress

(e.g., use or threat of solitary confinement, punitive-based policies enacted by prison staff).[107,108] As one of the most recognized examples of this approach, Norway's reformed prison system has demonstrated success across legal system indicators such as recidivism; however, concerns remain regarding poor health-related outcomes, including high suicide rates[109] and a low level of satisfaction with the health services provided.[110]

Opposing argument 5—Public health should play an oversight role to ensure that prisons and jails use a trauma-informed care approach. Relatedly, another reform-based approach to intervening on the health harms of incarceration suggests that carceral facilities should come under the purview of public health officials. These models propose that by incorporating public health frames and practices in carceral settings, documented health harms can be minimized.

Response: While APHA has established standards for health services within prisons and jails since 1976,[111] a public health approach to addressing incarceration requires consideration of preventative measures and alternatives to the health harms of incarceration. The carceral system shapes health via inadequate health care during incarceration,[112] but incarceration also harms the individual via exposure to acute and chronic stress, infectious disease (including COVID-19), and impediments to social integration.[51] Health consequences extend to others in the individual's community. Incarceration of a member of the household is a type of adverse childhood experience associated with a higher risk of poor health-related quality of life during adulthood,[113] indicating long-term harm to those with incarcerated caretakers during childhood. In addition, evidence suggests an association between incarceration and poorer population health through studies examining indicators such as infant mortality, female life expectancy, infection rates of immunodeficiency syndromes, and racial disparities observed with AIDS infection rates.[51]

Opposing argument 6—Decarceration to address COVID-19 can be facilitated through furloughs, electronic monitoring, parole, and other surveillance tactics.

Response: The implementation of decarceration policies can sometimes lead to increases in alternative forms of state-supervised monitoring such as electronic monitoring (e.g., ankle monitors); according to critics, these are still mechanisms of surveillance and control and often involve a high financial cost for the person made to wear them. Indeed, many of the efforts to decrease jail and prison capacity to reduce COVID-19 transmission have hinged on parole and continued carceral supervision. As a coercive and punitive strategy, this is not an effective means of connecting recently incarcerated individuals to needed services, including substance use disorder treatment.[114]

COVID-19 response efforts by jails and prisons have also been rolled out using a punitive criminal legal system approach rather than being informed by public health imperatives. For example, decarceration efforts, currently and previously, have prioritized criminal record history or risk assessments over clinical risk.[90] Although these algorithms are intended to reduce incarceration, in practice they perpetuate criminal legal system inequities along lines of race and class.[115] For example, one study of U.S. judges showed that the use of risk assessment algorithms in a judge's decision making about pretrial incarceration increased the judge's likelihood of incarcerating poor people while reducing the likelihood of incarceration for the affluent.[115] Another study revealed that Black-White racial inequities in pretrial incarceration increased by 8% after risk assessments were mandated in the state of Kentucky.[116] Instead, many organizers and community health advocates are increasingly calling for decarceration on one's own recognizance without conditions that expand the reach of the carceral system, during and after the pandemic.

Opposing argument 7—We cannot decarcerate because people do not have access to health care, housing, and food. A frequent argument against decarceration in the midst of COVID-19 is also that housing, health care, and food access is better in jails and prisons than in communities. Proponents point out that relative to uninsured community control samples, access to health care can sometimes be better in jails[117] and that group-housing infrastructure for houseless people may contribute to the spread of COVID-19.

Response: Such an argument makes clear the grave health consequences of economic disenfranchisement, lack of affordable housing, inadequate access to healthful foods, and lack of health insurance. Rather than invest more in incarceration, the argument underscores the need for better public health and social policy solutions for all

marginalized populations, during and beyond the COVID-19 pandemic. During the pandemic, incarcerated people are indiscriminately exposed to COVID-19 in confined and overpopulated spaces without the ability to take proper public health precautions. People who are incarcerated often face unhealthy conditions such as poor ventilation, extreme temperatures, black mold, poor plumbing infrastructure, and lack of nutritious food that exacerbate sickness and poor health outcomes, with or without a pandemic. Furthermore, they are unlikely to receive needed health care while in a jail, prison, or detention center. One study showed that among incarcerated people with chronic medical issues, 13.9% of federal prisoners, 20.1% of state prisoners, and 68.4% of people incarcerated in local jails had not received a medical examination since incarceration.[118] The same study revealed that although more than one in five people were on prescription medications prior to incarceration, almost 30% of people incarcerated in federal and state prisons and 41.8% of people incarcerated in jails stopped their medication upon incarceration.[118] Furthermore, instead of adequate food during incarceration, those incarcerated report food with inadequate portion sizes and nutritional content and food prepared without sanitary precautions.[103] Investing in community-based health care, housing, and food is a more effective way to meet physical and mental health needs than relying on the carceral system.

Action Steps

To move toward the abolition of jails, prisons, and detention centers and to build in their stead just and equitable systems that advance public health and well-being, APHA urges federal, state, tribal, territorial, and municipal governments and agencies, both during and after the COVID-19 crisis, to:

1. Immediately, urgently, and safely reduce the number of people incarcerated in jails, prisons, and detention centers, regardless of conviction, especially in light of pressing concerns related to COVID-19 transmission.

2. Immediately and urgently develop, implement, and support existing community-based programming interventions, including by using emergency funding, to address the medical and social needs of people who have been harmed by the criminal legal system. These people include individuals transitioning from incarceration, particularly those being released in response to COVID-19.

3. Reaollocate funding from the construction of new jails and prisons to the societal determinants of health, including affordable, quality, and accessible housing, health care, employment, education, and transportation.

4. Remove policies and practices that restrict access to stable employment and housing for formerly incarcerated people, including immediately investing in housing for quarantine purposes after release from carceral settings.

5. Meet patient rights requirements for people with mental illness and substance use disorder to be in the least restrictive environment for care by redirecting funding and referrals from jails, prisons, and involuntary and/or court-mandated inpatient psychiatric institutions to inclusive, community-based living and support programs.

6. End the practice of cash bail and pretrial incarceration.

7. Develop, implement, and support noncarceral measures to ensure accountability, safety, and well-being (e.g., programs based in restorative and transformative justice).

8. Decriminalize activities shaped by the experience of marginalization, including substance use and possession, houselessness, and sex work.

9. Restore voting rights for all formerly or currently incarcerated people to ensure their basic democratic right to participate in elections.

Furthermore, APHA urges Congress, the Centers for Disease Control and Prevention, and the National Institutes of Health to:

10. Fund research on the effectiveness of alternatives to incarceration (e.g., transformative justice).

11. Put forth a set of recommendations that will decrease the population within carceral settings based on the principles of human rights and health justice.

Finally, APHA calls on state and local health departments to:

12. Provide accurate, timely, and publicly available data on incarcerated and released populations at the state and facility levels, as well as data on COVID-19 testing, positive and resolved cases, and mortality.

13. Advocate for and support the decarceration and defunding of all carceral facilities and systems.

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