I. TITLE: Advancing Public Health Interventions to Address the Harms of the Carceral System

II. SPONSORSHIP/CO-SPONSORSHIP

III. COLLABORATING UNITS

This statement was reviewed by all endorsing units listed.

IV. ENDORSEMENTS

Organizations within APHA Endorsing:
- International Health Section
- LGBTQ Health Caucus
- Caucus on Homelessness
- Injury Control and Emergency Health Services Section
- Justice and Incarcerated Health Committee
- Medical Care
- Metropolitan Washington Public Health Association
- Black Caucus of Health Workers
- Peace Caucus
- Latino Caucus

Organizations Outside of APHA Endorsing:
- Health and Medicine Policy Research Group
- Collaborative for Health Equity Cook County
- Critical Resistance
- Deeper Than Water Coalition
- Black and Pink Boston
- SURJ Boston
- Abolition Action Partnership
- Student National Medical Association (SNMA)
- Medical Student Pride Alliance (MSPA)
- Transitions Clinic Network
- Community Justice Exchange
- Seamen Society for Children and Families
- Life After Release
- Drug Policy Forum of Hawaii
- Hawaii Health and Harm Reduction Center
- Hep Free Hawaii
- Human Impact Partners
- Radical Public Health
- University of Illinois at Chicago
- FreeThemAll WA
- Mirror Memoirs
- Amplify, Inc.
- South Asian Public Health Association (SAPHA).

V. SUMMARY

Keywords: COVID-19, incarceration, abolition, racism, health inequities, state violence

**Note: Bolded in-text language has been explicitly defined in the Glossary**

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 longstanding (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 towards 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 non-carceral 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.

VI. RELATIONSHIP TO EXISTING APHA POLICY STATEMENTS

The following APHA policy statements are relevant to the current statement:

- APHA Policy Statement 7921: “Support for a National Strategy to Help Improve Health Care in Prisons, Jails, and Youth Detention Centers”
- 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”

VII. RATIONALE FOR CONSIDERATION

This policy statement is presented for urgent consideration in light of the rapidly evolving COVID-19 pandemic and its disproportionate harms on 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 — given their older age and disproportionately high burden of underlying conditions — developing severe infections that require hospitalization or result in death. While the health harms of incarceration in U.S. jails,
prisons, and detention centers have long been a public health crisis, their coupling with the ongoing pandemic have made them simultaneously hyper-visible and unprecedentedly exacerbated. Through an examination of the long-standing conditions that precipitated this crisis, this policy statement identifies and recommends critical public health solutions to mitigate pressing COVID-19 concerns and prevent future harms. Specifically, it updates archived policy statement 9123 “Social Practice of Imprisonment” (adopted 1991) by explicitly addressing the urgency raised by the COVID-19 pandemic. It also renews calls to invest in creating healthy communities, ending the expansion of carceral facilities, and prioritizing equitable alternatives to the carceral system. Finally, it adds recommendations for research objectives dedicated to documenting the structural determinants of carceral system exposure and evaluating the effectiveness of non-carceral alternatives. Notably, APHA does not currently have a policy statement explicitly addressing the pressing issue of COVID-19 in carceral settings. Now, as ever, guidance from this body is key to ensuring that interventions prioritize health by centering prevention-focused public health strategies.

VIII. PROBLEM STATEMENT

In January 2020, the first Coronavirus Disease 2019 (COVID-19) case was detected in the U.S., thereafter spreading 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 These carceral settings presently account for some of the largest COVID-19 clusters in the U.S., with 24 different institutions reporting clusters greater 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, 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 PPE 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 the
seeking of medical attention. Other common conditions of the physical spaces, such as an 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 this COVID-19 crisis in the U.S. is the unprecedented levels of incarceration extending from punitive policies implemented at 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 or may engage in a criminalized activity.\(^11\) Studies examining the use of stop-and-frisk show 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, sentenced to incarceration, and when sentenced in federal courts, more likely 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 U.S. date back to slavery and that the racist construction of Black communities as criminal are used to justify contemporary racially discriminatory law enforcement policies and practices. These ideologies also underlie race-based ideas of who is “deserving” of rehabilitation which have been shaping legal policy since at least the early 1900s.

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. This includes people who identify as Black, Indigenous, or People of Color (BIPOC); people who are undocumented; those experiencing houselessness; people with disabilities; people who are lesbian, gay, bisexual, transgender, and/or queer (LGBTQ+); people with mental illness; people who use substances; sex workers; and people who are economically disenfranchised.

The 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 compared to the general U.S. population. This includes higher prevalence of HIV and other infectious diseases, mental health diagnoses, hypertension, heart-related problems, diabetes, asthma, stroke, and overall lower life expectancy. Higher prevalence of these chronic conditions among incarcerated people have been attributed to the experience of incarceration itself, as well as pre-incarceration exposure to adverse structural determinants such as poverty, houselessness, and racism. 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, women are more likely to be victimized by staff. Strikingly, trans people are targeted at nearly 10-times the rate of other incarcerated people. In 2012, approximately 40% of trans people incarcerated in the U.S. reported sexual assault or abuse by staff or another incarcerated person. Other known harms linked to incarceration include histories of extreme human rights violations such as mass forced sterilizations, 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. Solitary confinement is most often imposed on incarcerated people with mental illness and results in deleterious effects. A recent study found 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. 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). In addition to the documented health harms of each of these practices, taken together, these conditions also serve to undermine public health efforts to stem COVID-19 that depend on symptom reporting or the seeking of medical attention with early symptoms.

Carceral facilities, and especially jails, also contribute to community transmission of SARS-CoV-2. High rates of jail incarceration combined with frequent churn of individuals and staff, many of whom commute long distances from surrounding communities, put incarcerated individuals as well as surrounding communities at risk. Indeed, on average, jails hold over 700,000 people, and have a turnover rate of 54%. Cook County jail in Chicago, for example, was reported to be the “largest-known node” of SARS-CoV-2 spread in the U.S., 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. What’s more, as incubators of COVID-19 transmission, carceral facilities can quickly overwhelm local healthcare resources, taxing already critically stretched systems. 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 like family separation and disruption of community cohesion. For example, parental/caregiver incarceration is associated with limited or no access to prenatal care; an increased risk of infant mortality; and greater risk of living with mental health issues in childhood and adolescence. 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. Notably,
some of the carceral system’s harms are indirectly mediated through pathways like added economic pressures (e.g., household income loss, and paying for fees and fines, bail, visitation and communication, and incarcerated people’s food and clothing) and housing precarity, which have been linked to adverse health.49 Further, 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 and individual-level preterm birth,54 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 ten 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 about 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 that affect 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 over five million deportations from the United States — two and 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 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 (though, notably, not criminal law) re-categorized 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. These include low birthweight, preterm delivery, and post-traumatic stress disorder among others.\textsuperscript{64–66} Further, 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.\textsuperscript{67,68} Outbreaks in these detention centers have also resulted in deaths.\textsuperscript{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 U.S. are confined in state or federal prisons and local jails.\textsuperscript{8} However, the modern era has seen a rapid expansion of the carceral system, encompassing additional institutions (e.g., detention centers, hospitals, schools, homes)\textsuperscript{8,70} and deploying novel methods (e.g., digitally monitored E-carcercation).\textsuperscript{71} For example, in addition to jails constructed explicitly to incarcerate young people (i.e., “youth jails”),\textsuperscript{8} incarceration also manifests in their school spaces through the use of seclusion as a form of discipline (i.e., isolated confinement).\textsuperscript{70} Similarly varied are the governing bodies that coordinate this carceral system. These range from the Department of Homeland Security, to the U.S. Bureau of Prisons, to state departments of correction, to county and municipal departments,\textsuperscript{8} as well as private (for-profit) corporations (e.g., GEO Group).\textsuperscript{72} For example, over 73% of immigrant detention facilities are privately owned and operated.\textsuperscript{63} Recognizing the multiple modes by which people are incarcerated, understanding their shared and unique consequences, and identifying the governing bodies overseeing these institutions are key to designing appropriate solutions to stem incarceration and its health consequences.

**IX. EVIDENCE-BASED STRATEGIES TO ADDRESS THE PROBLEM**

**A Public Health Approach**

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

Despite sufficient evidence that incarceration does not achieve safety and does perpetuate violence, health inequity — including that related to COVID-19 — and social inequity, most public health recommendations to-date propose reforms as opposed to the aforementioned primary prevention strategies. That is, they advocate for additional funding to improve health conditions during incarceration rather than directing those funds towards preventing incarceration altogether. While efforts to improve health conditions both during and after incarceration are important, neither address the root causes of incarceration nor 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 engrained 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 towards preventive strategies that abolish the need for carceral systems. Indeed, as a field concerned with population health, the harmful consequences of incarceration on individuals, their families, their communities, and the general public demands 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, good jobs and stable housing, instead of criminalizing houselessness. Moreover, affordable and accessible health care, including mental health services in communities can avoid funneling individuals with mental health and substance use disorder into the criminal legal system. 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 to policing and releases from carceral facilities could prevent 23,000 COVID-19 infections among incarcerated people and 76,000 infections in surrounding communities. Community organizations - such as those that employ formerly incarcerated people - and evidence-based re-entry approaches, including 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.

Evidence-Based Strategy #2: Investing in transformative justice. Restorative justice is a non-punitive, non-retributive process to address interpersonal harm that brings together all of those affected to decide together how to heal and to repair the interpersonal harm done. 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 that harm to occur. Though 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 that higher levels of satisfaction from individuals involved in the process (including those who were harmed and those who did harm), greater likelihood of adhering to restorative agreements, and decreased rates of recidivism compared to those who did not participate in a restorative justice process. Another meta-analysis of restorative justice programs with young people under 18 found a general trend of decreased re-engagement 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 than those who did not participate in restorative justice programs. These outcomes suggest better mental well-being for all individuals involved when using a restorative justice process as an alternative to the carceral system. Indeed, one study showed that symptoms of post-traumatic stress disorder, including avoidance and intrusion, were reduced among those who had been harmed and underwent a restorative justice process. 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 healthcare professionals to reduce incarcerated populations as a public health imperative to prevent COVID-19 transmission, many practices and policies falling under a wide umbrella term of “decarceration” have begun to be implemented in recent years across the U.S. These decarceration practices include: (1) ending cash bail; (2) moving people living with mental health issues and substance use disorders from locked facilities to community-based treatment; and (3) employing community-based interventions to address medical and social needs of people who have been harmed by the criminal legal system including those transitioning from incarceration; (4) decriminalizing substance use, houselessness, and other “quality of life” charges instead approaching them as public health issues; and (5) decriminalizing sex work.

Evidence-Based Strategy #4: Investing in community-based mental healthcare. Due to the criminalization of people living with mental health issues, the most recent data provided by the Bureau of Justice statistics suggests 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. Further, approximately 14% of people incarcerated in federal and state prisons and 26% of people incarcerated in jails reported experiences that met the threshold for serious psychological distress (compared to 5% in the general population). Notably, one national study found that among the 26% of people incarcerated in state prisons diagnosed with a mental illness in their lifetime, only 36% were receiving counseling services while incarcerated. 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., ability to assert choice in treatment without fear of retaliation), and fails to meet service needs - the public health and clinical evidence urges 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 healthcare systems given not only a lack of evidence around the effectiveness of institutionalized settings, like inpatient psychiatric care, but documented harms.94,95 Bolstering the community-based mental health care system includes investing in non-police responses to mental health crises, which is especially critical given people with serious mental illnesses are 16 times more likely to be killed by law enforcement than those without.96 Community-based mental healthcare services like 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, one study in California found that over the span of one year, jail bookings for people enrolled in ACT were 36% lower than those not enrolled in this type of treatment.97 Investing in services such as supported housing, which includes both a housing subsidy and social support such as case management for people living with mental health issues, has also been shown to reduce incarceration rates. For instance, an Ohio study found that formerly incarcerated people who received supported housing services were 40% less likely to be re-arrested and 61% less likely to be re-incarcerated.98

X. 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 only be addressed 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 question found that increased incarceration rates accounted for only 6-12 percent of the subsequent reduction in property crime in the 1990s and accounted for less than 1 percent 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.\textsuperscript{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 in self-defense, often against physical or sexual abuse.\textsuperscript{119} 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.\textsuperscript{120} 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 context of racist and classist intergenerational health disparities including unequal opportunities in employment, housing, and education, their impact on mental health and drug use, and then criminalizing these behaviors, the United States needs to confront our conflation of punishment with accountability and begin to repair harms.\textsuperscript{119} As stated in the evidence-based strategies, more effective solutions include non-carceral 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 individuals are held accountable for interpersonal harms or harms to society.\textsuperscript{101} This argument is premised on the idea that the loss of freedom over daily routines, bodily habits, pastimes, relationships, and mobility, are appropriate consequences for certain actions and necessary to prevent convicted people from repeating these actions.\textsuperscript{99}

Response: However, incarceration has little to no effect on deterring crime.\textsuperscript{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 context 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. Further, a nationally representative survey of people who survived various levels of interpersonal harm found that 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, or community service.\(^{102}\)

**Opposing Argument #3: Prisons and jails exist for the purposes 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 will not only prevent people from engaging in criminalized activities upon release, but may serve as access to care points that are otherwise unavailable in community.

**Response:** Unfortunately, in the U.S., the focus has always been punitive rather than rehabilitative. More than half of all incarcerated people don’t receive rehabilitation services.\(^ {103}\) 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 occurring in Oakland and Sacramento, California is Mental Health First, non-police, community-led response to mental health crises.\(^ {104}\) 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. Rationale for these designs endeavor to overcome the punitive nature of incarceration by changing facility architectural plans, building materials, landscaping surrounding facilities, and through staff training.
Response: However, 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.” Further, 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). As one of the most recognized examples of this approach, Norway’s reformed prison system has demonstrated success across legal system indicators like recidivism; however, concerns remain regarding poorer health-related outcomes, including higher suicide rates and low satisfaction with health services provided.

Opposing Argument #5: Public health should play an oversight role to ensure prisons and jails use a trauma-informed care approach. Relatedly, another reform-based approach to intervening on the health harms of incarceration suggests 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, a public health approach to addressing incarceration requires consideration of preventative measures and alternatives to the health harms of incarceration. While the carceral system shapes health via inadequate health care while incarcerated, incarceration also harms the individual via exposure to acute and chronic stress, infectious disease (including COVID-19), and impediments to social integration. Health consequences extend to others in the individual’s community. Incarceration of a member of the household is a type of Adverse Childhood Experience (ACE) associated with a higher risk of poor health-related quality of life during adulthood, indicating long-term harm to those with incarcerated caretakers during childhood. Additionally, 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.
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) which, critics say are still mechanisms of surveillance and control, often at 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. 112

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. 113 For example, one study of judges in the U.S. found that the use of risk assessment algorithms in a judge’s decision-making about pretrial incarceration increased judges’ likelihood of incarcerating poor people, while it reduced the likelihood of incarceration for the affluent. 113 Another study found that Black-White racial inequities in pretrial incarceration increased by 8% after risk assessments were mandated in the state of Kentucky. 114 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 healthcare, housing, and food. A frequent argument against decarceration in the midst of COVID-19 is also that housing, healthcare, and food access is better in jails and prisons as compared with communities. Proponents point out that relative to uninsured community control
samples, access to health care can sometimes be better in jails, 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 ability to take proper public health precautions. Overwhelmingly, instead of healthcare, 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 healthcare while in a jail, prison, or a 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. The same study found that although more than 1 in 5 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 the medication upon incarceration. Furthermore, instead of adequate food during incarceration, those incarcerated report food with inadequate portion sizes, inadequate nutritional content, and prepared without sanitary precautions. Investing in community-based healthcare, housing, and food is a more effective way to meet physical and mental health needs than relying on the carceral system.

XI. ACTIONS STEPS

To move towards 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 during and following the COVID-19 crisis:
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, including those transitioning from incarceration, particularly those being released in response to COVID-19;

3. Re-allocate funding from the construction of new jails and prisons to the societal determinants of health, including affordable, quality, and accessible housing, healthcare, 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 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 for people with mental illness and substance use disorder;

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

7. Develop, implement, and support non-carceral 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, like 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.

Further, APHA urges that Congress, the Centers for Disease Control and Prevention (CDC), and the National Institutes of Health (NIH) to:

10. Fund research on the effectiveness of alternatives to incarceration (e.g. transformative justice);
11. Fund research on policy determinants of exposure to the carceral system, with a particular focus on policies that disproportionately target marginalized communities;

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

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

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

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

XII. GLOSSARY & FURTHER READINGS

- **1994 Violent Crime Control and Law Enforcement Act**: The Violent Crime Control and Law Enforcement Act of 1994, signed by President Bill Clinton, is the largest-ever crime bill in U.S. history, providing for 100,000 new police officers and allocating $9.7 billion for prisons.\(^{117}\) Scholars note that the successful passage of the bill was predicated on “fear of Black crime in the wake of racially motivated riots in Los Angeles, Chicago, and New York. Each of these events heightened fear of Black people and incited politicians in the federal government to declare a need to ‘restore order in society’”\(^{118}\)

- **Abolition**: According to the work of abolitionist scholar Ruth Wilson Gilmore, “Abolition is about presence, not absence. It is about building life-affirming institutions.” Abolition is a process of changing the social and economic conditions that lead to harm and of ensuring that people have what they need to thrive and be well, thereby eliminating the need for jails, prisons, detention centers, and policing. For additional reading on abolition, please see: Are Prisons Obsolete? by Angela Davis.
● **Carceral System**: An extensive interconnecting network of both public and private institutions and structures designed for imprisonment, policing, and surveillance based in policies and practices relying on punishment, social control, and criminalization. The carceral system includes prisons and jails; immigrant as well as juvenile detention centers; the courts, probation and parole programs; law enforcement including immigration enforcement agencies; and other types of incarceration (e.g. e-carceration; confinement in schools, hospitals, and homes).

● **Decarcerate**: To reduce the number or rate of people incarcerated at the federal, state, and municipal levels or in any particular jurisdiction, including mental health treatment facilities. A range of practices and policies may fall under the practice of decarceration, all with the result of removing people from carceral institutions (i.e. the opposite of incarceration).

● **Detention Centers**: Detention centers in this document refers to any place where people who are awaiting a determination of their immigration status or potential deportation are incarcerated. Immigrants in detention can be undocumented or documented immigrants, including people whose immigration status is not current, is expired or is under review. Many of the immigrants detained in Immigration and Custom Enforcement’s (ICE) nominally civil system are held in county and local jails that contract with ICE to detain immigrants. The rest are held in dedicated immigration detention facilities run by ICE or contracted to private prison corporations, including family detention centers that hold mothers and children. ICE’s detention system is built and operated on a correctional model, in direct conflict with the civil nature of immigration detention.

● **E-carceration**: E-carceration is an alternative system of incarceration that deprives people of liberty through tracking, surveillance, and control outside of prisons by technological means. Electronic monitoring technologies that are used to monitor individuals in pre-trial, probation, parole, or immigrant deportation proceedings, include ankle bracelets, GPS monitors, or phone apps that track the person’s location at all times.
Due to the restrictions placed on those being monitored, the physical jail becomes an electronic jail in our homes and communities, severely limiting where someone can go within certain boundaries and punitively tracking a person’s behavior. Typically, the state, usually via the criminal legal system, enforces E-Carceration. But corporations may also be contracted by the state and often charge fees for repressive regimes of parole and probation which frequently include monitors.

For additional reading on e-carceration, please see Chaz Arnett’s excellent analysis, “From Decarceration to E-carceration.”

- **Jails vs. prisons:** Jails are typically short-term facilities that predominantly incarcerate people who are either pretrial or who are convicted of misdemeanors and serving relatively short sentences, generally less than one year. Unless they are private jails run by corporations, jails are run and operated by local governments and county sheriff’s departments. More recently, jails have also been used as immigration detention sites. Prisons, on the other hand, are typically run by state or federal government and are meant for people who have been convicted of more serious offenses and who have received longer sentences. As of 2019, there are 3,163 local jails, 1,719 state prisons, and 109 federal prisons operating in the U.S.

- **Reform vs. abolition:** In contrast to abolition, which seeks to invest in the health and safety of communities using non-carceral means, reformist approaches seek to make changes to the current carceral system requiring further investments, including that of financial and human resources while perpetuating systems that rely on punishment, isolation, and incarceration. For specific examples, please see Critical Resistance’s chart “Reformist reforms vs. abolitionist steps in policing” at [https://tinyurl.com/reformvsabolitionCR](https://tinyurl.com/reformvsabolitionCR).

- **Risk Assessments:** an instrument used to attempt to determine the likelihood that one will return to court or be arrested again. While promoted as race-neutral, these prediction tools encode the racial bias in criminal legal system data, thus perpetuating inequity.
● **Stop-and-Frisk:** Stop-and-frisk, which allows law enforcement officers to stop a person if they assume the person is involved in criminalized activities, and to frisk a person if they presume the person may be armed, was codified into law in 1968 via a U.S. Supreme Court ruling.

● **Three strikes laws:** The first three strikes law was enacted in California in 1994, but similar laws are now prevalent in states across the U.S. The laws impose a longer prison sentence, usually a mandatory life sentence, to individuals who were previously convicted of certain felonies. Three strikes laws and truth-in-sentencing laws, below, have been widely criticized for increasing prison sentence lengths and therefore contributing to the large number of people who are incarcerated.

● **Truth-in-sentencing laws:** These laws require individuals to be incarcerated for the entire duration of their sentence, instead of becoming eligible for early release or parole on the basis of “good behavior”, usually participation in educational or work programs.

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