MASS INCARCERATION IS A PUBLIC HEALTH ISSUE MORE DEADLY THAN COVID

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ABSTRACT

Historically, mass incarceration has proven to be more dangerous and deadly than Covid. This statement is not meant to downplay the severity of Covid or disrespect those who have lost their lives due to the virus, as it has affected many in my own family. Instead, it sheds light on the detrimental impact that Mass Incarceration has had on communities across America. Given its deadly consequences, I propose that Mass Incarceration be addressed with the same level of urgency and intensity as Covid. It is time to acknowledge mass incarceration as a cancer in our society and take immediate action to address it. It violates the core principles of Bioethics and will not pass any ethical inspection upon closer scrutiny. The principles of autonomy, beneficence, non-maleficence, and justice are not adhered to with the epidemic of Mass Incarceration. When the principles of agency, social justice, and solidarity are added as Urban Bioethical Principles, how unethical mass incarceration is becomes even more evident. I propose a multidisciplinary approach, highlighting the use of credible messengers, as a means to reintegrate incarcerated people into society as well as reduce the rate of incarceration by addressing the specific causes.

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CHAPTER 1

WHAT IS MASS INCARCERATION?

Mass incarceration, in the context of America, refers to the dramatic increase in the number of people who are incarcerated in prisons and jails. The term is typically used to describe the phenomenon of imprisoning a large percentage of a population, often disproportionately affecting African American and Latino communities specifically those communities in the lowest tax bracket.

The United States has the highest incarceration rate in the world, with more than 2.3 million people currently behind bars. The steep uptick in incarceration is largely a result of the "War on Drugs" policy instituted by Reagan and enforced by Bill Clinton's Crime Bill of 1994. This war on drugs allowed for harsher sentencing laws and mandatory minimum sentences for drug-related offenses.

Mass incarceration has been the vilest threat to many of these underserved communities since the oppressive Jim Crow era, and, in a lot of ways, more effective than slavery. It has dismantled families in a way not seen since slavery, which in turn destabilized communities and helped entrench poverty, inequality, and mistrust in the criminal justice system.

CHAPTER 2

FROM SLAVERY TO MASS INCARCERATION

The historical context of mass incarceration in the United States can be traced back to the country's origin and the need for free labor by enslaved peoples. Mass incarceration's grandfather is slavery. Slavery was deemed necessary by the ruling class of America because it allowed economic gains for the white majority despite the relative poorness of America. This was clear because having slavery as the labor force was an unpaid labor force. After the abolition of slavery, Jim Crow, the son of slavery, was born out of an adherence to black codes; and Jim Crow laws were created to maintain racial segregation and purposefully constructed the ability to retain the labor force under legal terms. Force and terror were often employed and applied. With the Civil Rights Movement happening 100 years after the abolition of slavery, we saw the dismantling of many of these laws. This began the slow death of Jim Crow and the need for a new system to take its space. The war on drugs policy was a clever way to ensure business as usual, with these policies increasing the number of incarcerated Black and Latino citizens. Like slavery and Jim Crow, the evilness of these institutions was created around the social ostracization of black people and the manipulation of this social difference for economic gain.

This period also saw the rise of tough-on-crime rhetoric and policies, with politicians competing to show that they were "tougher" on crime than their opponents. This led to the enactment of mandatory minimum sentences, punitive policies like the

three-strikes laws, and other policies that resulted in longer prison sentences and fewer opportunities for early release.

The privatization of prisons and the growth of the prison-industrial complex also played a role in the expansion of mass incarceration. Private prison companies lobbied for tougher sentencing laws and longer prison terms to increase their profits, while prison labor became a source of cheap labor for corporations.

All these factors contributed to the current state of mass incarceration in the United States, with more than 2.3 million people currently incarcerated and a disproportionate number of those being Black and brown people.

CHAPTER 3

HEALTH OUTCOMES OF COMMUNITIES WITH HIGH INCARCERATION RATES

It is important to recognize that high incarceration rates in certain communities are considered normal, and this is often linked to poor health outcomes in those communities. It is not sufficient to only consider the health of those who are incarcerated, as they are also individuals with family and social ties. (Gifford,2019)

This disparity is evident along racial lines, with black individuals being disproportionately affected. For instance, in 1990, a black child had a 1 in 4 chance of having a father in prison, and this increased to 1 in 2 for fathers who didn't complete high school. (Gifford, 2019) Furthermore, approximately 40% of black men and women know someone who is incarcerated, while over 40% of black women have a family member who is incarcerated. (Gifford, 2019) Outcomes like these are clearly in violation of social justice a principle expanded upon the core principle of justice in bioethics. Justice speaks to fairness and equitable consideration of laws and policies. Here there is no consideration at all, just increased efforts to disadvantage certain communities.

Imprisoning large proportions of a community has significantly negative impacts on those communities. Firstly, there is a significant financial burden on the community. The imprisoned individuals lose their income, and their assets are often seized, which further harms their beneficiaries. Additionally, there are financial burdens associated with staying in contact with the incarcerated individual, as well as costs associated with

spending in prison, such as commissary expenses. Furthermore, individuals who have been previously incarcerated are less likely to find stable employment and earn a living wage, as documented in various studies. (Wildeman and Wang 2017)

Beyond financial implications, incarceration also destroys social capital. Incarceration leads to literal space, time, and communication barriers between individuals, making it difficult for relationships to persist. Whether it be romantic, parental, close, or otherwise, many relationships are severely strained as a result. Moreover, the stigma attached to incarceration often makes it challenging for families of the incarcerated to receive social support from their community, which they should not have to suffer. These outcomes directly influence the agency of these individuals. Whether or not the desire to participate in their communities exists their ability to do so is greatly hampered.

Children of incarcerated parents are at increased risk for negative health outcomes, including higher mortality rates for infants and male children. This may be due to a decrease in parental time available for household duties, as well as health-related and extracurricular activities. In addition, these children often experience worse mental health outcomes, including higher rates of asthma, depression, anxiety, and obesity. (Gifford 2019)

High levels of incarceration are linked to asthma, sexually transmitted infections (STIs), and psychiatric challenges at the population level. (Gifford, 2019) It is difficult to

determine which comes first, as it is unclear whether these health issues are the cause or effect of incarceration. However, it is evident that there is a negative feedback loop between these health issues and high levels of incarceration. For instance, densely populated and impoverished areas are associated with high rates of allergen exposure, leading to increased asthma rates. Incarceration may also contribute to the incidence of asthma, as incarcerated individuals may lack the resources to leave polluted environments or dispose of waste adequately. Furthermore, it is uncertain whether psychiatric challenges are caused by incarceration or if individuals with poor judgment and mental instability are more likely to be incarcerated. Nevertheless, research has shown that there is a correlation between these health issues and high levels of incarceration. (Gifford,2019)

Taking a broader perspective, the negative impacts of incarceration extend to the state and national levels. For example, a study has shown that high levels of incarceration are almost entirely responsible for the prevalence of AIDS in women. (Johnson and Raphael, 2009) Additionally, tuberculosis has been linked to an increase in incarceration rates at the national level. These findings underscore the profound impact of incarceration on public health, suggesting that policies and interventions aimed at reducing incarceration rates may be critical to improving health outcomes.

CHAPTER 4

STIGMA

Systemic racism has a profound impact on the collective consciousness of communities, which is often overlooked in discussions of incarceration. This insidious form of racism can erode the self-worth of individuals, particularly in communities where incarceration rates are high. As someone who grew up in a family affected by incarceration, I have firsthand experience with how incarceration can diminish self-worth in subtle ways that are not immediately apparent. In communities where incarceration is the norm, there can be a sense of cognitive dissonance where individuals recognize that systemic racism is responsible for the high rates of incarceration, yet still view criminal behavior as a natural response to this oppressive system. This can lead to a fraying of social bonds as individuals struggle to reconcile these conflicting beliefs. Some may even glorify the circumstances that led to their loved ones being incarcerated, while simultaneously harboring disdain for the punitive forces that put them there. This is an unhealthy and unsustainable dynamic, and it is not the responsibility of those under the surveillance of these punitive authorities to correct it. Instead, there needs to be a fundamental restructuring of the system to ensure that authority is appropriately appreciated and that communities are able to heal from the wounds inflicted by systemic racism.

Growing up with incarceration as the norm created a sense of confusion for me when I traveled to Rwanda last summer for a wedding. Despite being a comparatively

poor country, Rwanda has made impressive strides towards development, and their progressive attitudes towards their police and government were striking to witness as a black person. I was struck by the fervor and praise that was given to law enforcement and military in Rwanda, which is not uncommon in many white communities. This contrasted sharply with my experiences growing up, where there was often a sense of distrust and even disdain towards law enforcement and other authorities.

CHAPTER 5

THE BIOETHICAL PROBLEM WITH MASS INCARCERATION

We have discussed the impact of incarceration on communities and populations, but it is important to remember that incarcerated individuals themselves also experience worse health outcomes within the prison system. In fact, prisoners have higher rates of chronic health conditions than those who have never been incarcerated in almost all categories. (Selan, 2022) There are multiple factors that contribute to these worse outcomes, including the financial barriers to receiving adequate medical care within the prison system. For example, incarcerated individuals must pay a co-pay for medical services, but their only source of income is usually from commissary purchases or labor within the prison. The minimal amount of money they earn makes it nearly impossible for many to afford the co-pay without outside help, further exacerbating their already challenging circumstances. This elucidates a greater problem regarding autonomy. A significant proportion of incarcerated individuals with persistent medical issues did not receive any medical examination since incarceration. Specifically, 13.9% of federal inmates, 20.1% of state inmates, and 68.4% of local jail inmates fall under this category. Additionally, more than one-fifth of inmates were on prescription medication when they entered prison or jail. However, after incarceration, a considerable number of inmates stopped taking their medication. This includes 26.3% of federal inmates, 28.9% of state inmates, and 41.8% of local jail inmates. Prior to their incarceration, slightly over one-seventh of inmates were routinely taking prescription medication for an active medical problem. The methods section defines such medical issues as those requiring medication.

Among these individuals, following incarceration, 20.9% of federal inmates, 24.3% of state inmates, and 36.5% of local jail inmates their medication**.** (Wilper et al, 2009)

Incarcerated individuals may face inhumane conditions, such as being subjected to involuntary experimentation and lacking control over their own healthcare. Such circumstances are a clear violation of the ethical standards beneficence, non maleficence, and autonomy. (Cohen, 2022). Unfortunately, these factors contribute to poor health outcomes among the incarcerated population. If individuals were given agency and allowed to direct their own care, they would be able to seek medical attention more promptly and consistently.

Another barrier to care is inmate data. The lack of inmate data collection is a common issue in all care categories, which makes it challenging to determine appropriate care locations and staffing needs. State departments of corrections collect very little information on inmate-patients, such as daily census, health conditions, wait times, exam and treatment room utilization, and transportation to community-based facilities. (Redemske, 2018) They also do not collect information on staffing, construction, and maintenance costs of prison healthcare facilities, care expenses in external facilities, and clinical outcomes. This lack of data collection puts state departments of corrections at a disadvantage compared to community health providers who utilize evidence-based and data-driven practices to determine inmate healthcare needs. (Redemske, 2018) This is a stark contrast from the focus on health in the free world where data has largely driven improvements in quality and safety. Many of the metrics in the primary care now

wouldn't be possible without the analysis of large data sets. As a result, we have seen improvements in management of chronic conditions. Just a lack of data is a clear example of injustice and lack of social justice.

Insufficient community-based services for inmates were identified as another major barrier to providing quality healthcare and increasing recidivism. Lack of community-based services impacts the social implications of released inmates, making it difficult for them to re-establish themselves and apply for assistance programs. (Redemske, 2018) Insufficient community-based services also lead to untreated medical and mental health conditions among inmates, resulting in increased demand for healthcare services in prison. The lack of funding for community-based outpatient treatment centers for mentally ill individuals has resulted in an increase in the number of mentally ill individuals being sentenced to prison. (Redemske, 2018) Insufficient community-based services make it difficult for released inmates to reintegrate into society and access necessary medical and mental health services after their release from incarceration. Not to mention the obvious misplacement of persons identified with certain health issues. This violates a clear principle of urban bioethics; solidarity.

Yet another issue is the lack of nationally recognized standards and variations in care processes consistently cited as a problem in correctional healthcare. In the elder care category, lack of national standardization affects inmate healthcare, such as the definition of what constitutes elderly and activities of daily living, which limits data sets for research and quality and quantity of care. (Redemske, 2018) Lack of nationally

recognized standards is also present in palliative care, where there is no standard for acceptance into palliative or hospice care programs, variation in pain medication use, and no national standard on what can constitute an inmate's family. Variations in the selection, training, and responsibilities of inmate volunteers for prison hospice programs are also a significant issue. (Redemske, 2018)

All these issues pose risks of opening the state departments of corrections to litigation and affect the quality and quantity of care. The lack of continuity of care for incarcerated individuals, both before and after their incarceration. It suggests that partnerships with public health and academic medical centers can help support continuity of care but highlights specific issues in providing care for elderly inmates due to the lack of case management and social work services. (Redemske, 2018) The lack of continuity of care can lead to inefficiencies in healthcare resources and harm to inmates upon release, as they may struggle to obtain follow-up care. The use of technology in correctional health care is limited, as referenced by various studies. Although telemedicine is becoming more popular, other technologies such as electronic medical records (EMRs), picture archiving and communication systems (PACS), and mobile technology are lacking. (Redemske, 2018) This limits the ability of state departments of corrections to partner with community-based providers who routinely use these technologies, potentially impacting the standard of care provided to the community. Here is clearly a space where the principles of agency and non-maleficence are violated.

The proposed economic incentives for mass incarceration are prevention of crime which avoids the associated costs of crime. Such incentivies also clearly violate the principles of beneficence, agency, non-maleficence, social justice, and justice. This can be hard to measure, admittedly, because it's not like crime has a one size fits all price tag. We do have to admit that it is reasonable to calculate how much damaged goods and stolen property cost; however, it is not so easy to measure the social and emotional cost of crime. There are also the costs that the justice system incurs to respond to offenses of the system which can also be easily measured. The government expenses incurred to operate prisons within the state correctional system neared 50 billion with most of it going towards the operation of prisons. There is also the cost of lost productivity estimated to be somewhere between 9k and 18k. All of this is clear. (Gifford, 2019)

However there's an entire part of the equation that hasn't been studied. The cost of crime in prison which is rampant. (Gifford, 2019) Therefore, it's not possible to delve into the economics of the prison system. We do know, however, that privatization of the prison industrial complex is a huge driver of mass incarceration. Proponents of privatization argue that private contractors can provide better quality prison services at lower costs. (Gifford, 2019) The 1995 Census of State and Federal Adult Correctional Facilities was used to examine claims of improved quality. Privately managed prisons performed better on some measures of quality of confinement, specifically in terms of avoiding inmate assaults on staff members or other inmates. Even after controlling for other variables, private prisons were less likely than federal prisons to experience violence. (Gifford, 2019)

Of course, in a capitalist society everyone is operating off incentives so these industries that thrive off black and brown bodies that literally create industry and towns off of the incarceration of black and brown people much like slavery, have no vested interest in the end of mass incarceration. We must remain cognizant of that fact and continue to find alternative means to address some of our other concerns around the economics of prison such as crime prevention and losses of productivity. These incentives often create an environment that does not promote health and an environment that violates the bioethical principles of autonomy and justice.

In addition to the shadow of capitalism in mass incarceration, structural RACISM is also very evident and present in a way that prevents the ethical treatment of prisoners within the healthcare realm. Mass incarceration exists in space that is quite literally a tool of the capitalism. Throughout history, there has been a connection between capitalism and racism, particularly in the context of colonialism, slavery, and imperialism. These systems were built on the exploitation and subjugation of people of color for economic benefits, which were often rationalized through racist beliefs. Today, capitalism can contribute to the continuation and worsening of racial inequality through factors like unequal access to education, healthcare, and job opportunities, as well as the accumulation of wealth and influence among a primarily white privileged class. As a result, this can perpetuate and reinforce racial divisions and bias within the economic structure. When capitalization and racism infiltrate any health related interaction, the bioethical principles of autonomy, agency, social justice and justice disappear.

CHAPTER 6

WHAT IS THE CURE?

So far, we have discussed the historical context of mass incarceration, the detrimental effect on the community, the detrimental effect on the people, how incarceration is viewed in space, and what forces would like to see it continued. How do we bring a cure and ensure the work follows the basic principles of urban bioethics.

One thing I'm arguing for is that mass incarceration been as the public health crisis and an ethical ignominy that it is. It affects more people than Covid-19, but, because it largely affecting black and brown people, it isn't taken serious in the appropriate context. Not seeing a health crisis as a health crisis because of racism is a fundamental violation of non-maleficence and justice. This inherently makes mass incarceration as a practice unethical as it relates to the health continuum.

Over a period of approximately 1.5 years, from the beginning of the pandemic in late 2019 to September 2021, 4.6 million people died from Covid worldwide. (WHO, 2021) Meanwhile, every year 2.2 million people suffer from incarceration and about 4 million individuals are on parole or probation. (Sawyer and Wagner, 2020) And then when u think about all the families affected and the people in the community also affected, it is clear that this pandemic is just as serious. The fact that it is not seen as pandemic is based in the inability of societal leaders to justly view marginalized communities in the same way they view majority communities.

I have often thought about how to help alleviate the burden of mass incarceration. I was honestly thought the only way was through criminal justice reform until I came to Temple in 2018. I then began work with the Center for Urban Bioethics and really appreciated the approach they took towards research always making it interventional. At that time, I was introduced to the organization called Philadelphia Ceasefire now Cure Violence.

Cure Violence is a public health approach to violence prevention that was first implemented in Chicago, Illinois, in 2000. It was developed by epidemiologist Dr. Gary Slutkin, who drew on his experience working on infectious disease epidemics in Africa to design a strategy to address the spread of violence in urban communities. (Butts et al, 2015)

The Cure Violence model views violence as a contagious disease that can be transmitted from person to person and seeks to interrupt its transmission through targeted intervention. The approach involves identifying and mediating conflicts between individuals or groups, providing support and resources to those at risk of violence, and changing community norms and attitudes towards violence through education and outreach. Cure Violence has been implemented in cities across the United States and around the world, including in Latin America, the Middle East, and Africa. It has been shown to be effective in reducing violence and has received recognition from organizations such as the World Health Organization and the United Nations. (Butts et al, 2015)

In addressing the issue of gun violence, I believe a multidisciplinary approach is necessary for successful outcomes. One way to achieve this is through community engagement, which can occur at various levels to reduce disparities and improve outcomes. Providing economic opportunities through peer-to-peer interactions is the first and most crucial step in this approach. Many incarcerated individuals struggle to secure employment due to their criminal backgrounds and lack of skills. Empowering them to prevent incarceration and recidivism can improve their agency and that of their communities. They can serve as culturally competent touchpoints for community members, directing them to resources that may prevent criminal activity, especially nonviolent offenses. Access to childcare, education, familial support for those with incarcerated family members, and necessities like shelter, food, and healthcare should also be available. This approach embraces the principles of urban bioethics but trying to increase agency for a person negatively impacted by violence as well as increasing the positive impact of justice, social justice, and solidarity. Treating violence strictly as a criminal justice problem when the Centers for Disease Control has clearly stated it is public health epidemic means we are violated the principles of beneficence and non-maleficence with every interaction.

Additionally, there needs to be a push in medicine to frame incarceration as a health issue first. By humanizing incarcerated and formerly incarcerated individuals, we can

destigmatize incarceration and hope to see more support for these people as individuals. Legal reform is necessary as well to change the federally acceptable living standards, and medical education should promote med students' interaction with the prison industrial system beyond just the prisoners who require hospitalization. This would allow physicians of the future to witness the conditions and hear the stories of individuals who cope with the system daily.

Ultimately, these steps would align with the core principles of bioethics and address the

principles of urban bioethics – primarily agency and social justice. These tenets must be considered and addressed in any attempt to reform the prison system and focus on the health of the most affected communities.

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