

## **Roundtable on the Future of Justice Policy**

Examining Justice Reform and the Social Contract in the United States: Implications for Justice Policy and Practice

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### **Health (Care) as Justice Reform: Protecting the Health and Well-being of Incarcerated Populations, Their Families, and Their Communities**

Hedwig Lee, Professor of Sociology, Washington University in St. Louis

Liza Weiss, Executive Director, Missouri Appleseed

Finola Prendergast, Director of Research, Missouri Appleseed

The novel coronavirus 2019 (COVID-19) pandemic has brought into sharp relief the expansive nature of community. Many populations who have been invisible (e.g., incarcerated populations, undocumented populations, and families of incarcerated populations) in many communities are now front and center as the United States and the rest of the world contend with a virus that knows no boundaries. Patterns of racial residential segregation, racial disproportionality in mass incarceration, and racial inequalities in healthcare access serve to further amplify risk for all and not just some. To be sure, certain populations remain disproportionately burdened by COVID-19 infection risk, complications, and death, but, as we have seen, the rise in infection in any subpopulations can easily lead to infection in other communities.

This new reality requires us to reimagine in a more inclusive way what “community” and “safety” mean. It also requires us to act in a more deliberate and universal way to protect communities. For a community to be resilient, every member of the community must be resilient. In our essay, we suggest that policies to improve the health of communities need to target individuals in prison and jail both during incarceration and after release. Policies must also aid incarcerated people’s families and communities, which are too often unseen collateral damage in mass incarceration. These policies must extend beyond healthcare interventions to structural changes. Moreover, it is imperative to bring narratives of public health and public safety together: since public health *is* a matter of public safety, policies that threaten public health – including mass incarceration – cannot be considered public safety “wins.” As COVID-19 has shown, a community cannot be safe if it is not healthy (Sandoiu 2020).

#### **Health of Incarcerated Populations, Their Families, and Their Communities**

For far too long, incarcerated populations and the families and communities connected to these populations have largely been ignored in discussions of health and health disparities. This is despite a growing body of data suggesting negative health impacts of incarceration for incarcerated people and their families. Having ever been incarcerated increases the risk of negative health outcomes across the life course (Schnittkner and John 2007; Massoglia 2008; Esposito et al. 2017). The romantic partners and children of incarcerated people also tend to suffer negative physical and mental health outcomes as a result of their loved one’s incarceration (Dube et al. 2001; Lee, Fang, and Luo 2012; Roettger and Boardman 2012; Swisher and Roettger 2012; Wildeman, Schnittkner, and Turney 2012; White, Cordie-Garcia, and Fuller-Thompson 2016; Gaston 2016; Davis and Shlafer 2017; Heard-Garris et al. 2019). Because the United States disproportionately incarcerates racial minorities, especially

low-educated African-American men, mass incarceration has exacerbated racial disparities in health outcomes at the community and population level (Pettit and Western 2004; Massoglia 2008; Schnittker, Massoglia, and Uggen 2011; Wildeman 2012a; Lee et al. 2015).

Discussions of health as they relate to persons in prison often focus on infectious diseases such as Hepatitis C, HIV/AIDS, other sexually transmitted infections, and tuberculosis (Niveau 2006). Research on the health impacts of incarceration on incarcerated people's partners and communities often focus on infectious disease as well (Grinstead et al. 2005; Johnson and Raphael 2009). But a growing body of research indicates that individuals in prison and their families face multiple physical and mental health risks beyond infectious diseases.

People incarcerated in prisons and jails, and notably the growing populations of imprisoned women and elderly people, suffer a disproportionate number of health problems relative to their counterparts in the general population. After controlling for other risk factors, people incarcerated in prisons and jails have higher rates of many chronic medical conditions, including cancer, hypertension, and asthma (Binswanger, Krueger, and Steiner 2009). Women in prisons and jails have high rates of serious mental illness, histories of sexual abuse, substance abuse disorders, dental problems, and, if pregnant upon their incarceration, miscarriage (Taylor, Williams, and Eliason 2002). An increasing percentage of the U.S. prison population is elderly; elderly people in prisons and jails have high rates of physical disability, mental illness, and substance abuse disorders (Skarupski et al. 2018).

The friends, family members, romantic partners, and communities of people who are incarcerated have also suffered due to mass incarceration. For example, women who are socially connected to incarcerated men suffer negative physical and mental health consequences, as well as socioeconomic stressors. The incarceration of a family member is associated with obesity, hypertension, stroke, and other cardiovascular risk factors for women; in particular, incarceration of family members and romantic partners may contribute to a high incidence of cardiovascular risk factors among African-American women (Lee and Wildeman 2013; Lee et al. 2014). Pregnant women who are incarcerated or who experience their romantic partner's incarceration in the year prior to childbirth are less likely to receive adequate prenatal care, especially early in their pregnancies (Dumont et al. 2014). Women with children by recently incarcerated men are at risk for major depression (Wildeman, Schnittker, and Turney 2012); they are also at risk of housing insecurity (Geller and Franklin 2014). Women romantically involved with men recently released from incarceration experience high rates of depression, anxiety, and PTSD (Wildeman, Lee, and Comfort 2013). Some of the health risks these women face, including obesity and cardiovascular ill health, increase risk of death from infectious disease like COVID-19 (Williamson et al. 2020).

Children suffer physically, mentally, and behaviorally if their parents are incarcerated. Children of incarcerated parents are at increased risk of asthma, migraines, high cholesterol, obesity, and later-life heart attack (Lee, Fang, and Luo 2013; Roettger and Boardman 2012; White, Cordie-Garcia, and Fuller-Thompson 2016). They are also at increased risk of depression, anxiety, PTSD, self-injury, and suicide (Dube, Anda, and Felitti 2001; Swisher and Roettger 2012; Lee, Fang, and Luo 2013; Davis and Schlafer 2017; Heard-Garris et al. 2019). Their educational attainment is negatively impacted (Hagan and Foster 2012; Haskins 2014; Turney and Haskins 2014; Huynh-Hohnbaum, Bussell, and Lee 2015). They are at greater risk of abusing illegal drugs (Roettger et al. 2011; Gifford et al. 2019).

In addition, parental incarceration indirectly hurts children's health by removing the economic support that parents provide. If they lived with their father prior to his incarceration, young children of recently incarcerated fathers are at greater risk of food insecurity (Turney 2015). Childhood food insecurity, as might be

expected, is associated with a decreased likelihood of good health during childhood (Gundersen and Kreider 2009). Children of incarcerated fathers are also at greater risk of homelessness; in fact, the mass incarceration of African-American fathers has driven racial disparities in U.S. child homelessness rates (Wildeman 2013). Moreover, homelessness is associated with poor health and early death (Fazel, Geddes, and Kushel 2014).

A burgeoning body of research also suggests that the health (and healthcare) of entire communities can also be impacted by mass incarceration with rates of incarceration associated with health (and health care access and usage) at the neighborhood, city, state, and even national levels (e.g., Hatzenbuehler et al. 2015; Schnittker et al. 2015, Wildeman 2012b, Wildeman 2016).

### **Healthcare of Incarcerated Populations, Their Families, and Their Communities**

The health disparities experienced by incarcerated people, their families, and their communities are exacerbated by inadequate access to healthcare for incarcerated people, both in correctional facilities and post-release. They are also exacerbated by inadequate healthcare safety nets for the families and communities left behind and who will receive individuals in prison post release.

Correctional health care is beset by problems. In the United States, people incarcerated in prisons and jails have a constitutional right to healthcare, but attempts to reduce the costs of correctional healthcare have led to prisons and jails contracting with private, for-profit correctional healthcare companies. Many of these companies are operating under perverse incentives. For example, some states pay the companies not for services but a flat rate per inmate, per day, so that the companies generate more revenue the less they spend on providing care (Coyle 2019). Perhaps unsurprisingly, prisons that have contracted out their healthcare services have seen rising mortality rates among their inmate populations (Bedard and Frech III 2009). People in prisons and especially in jails report difficulty obtaining medical treatments (Lindquist and Lindquist 1999; Wilper et al. 2008). If the medically indicated treatment for a given illness is expensive, correctional facilities may direct their healthcare workers to delay treatment until the illness has seriously adversely affected patients' health. For example, a number of states' Departments of Corrections face class action lawsuits for failing to provide effective new hepatitis C medications to the vast majority of people with hepatitis C in their prisons, even though untreated hepatitis C can lead to cirrhosis and liver cancer (Banks and Blakinger 2019; Hassan 2019; MacArthur Justice Center 2020). Those seeking to access healthcare within prisons and jails may face long wait times, burdensome co-pays, and accusations that they are feigning their illness (Aday and Farney 2014).

In addition to the problem of perverse economic incentives, correctional healthcare may suffer due to the role confusion it poses to doctors and nurses. Vaughn and Smith (1999) argue that the demonization of incarcerated people, coupled with healthcare workers' professional identification with the prisons and jails controlling and disciplining their patients, may encourage some correctional healthcare workers to adopt unprofessional behaviors, including delaying or denying care, delivering substandard care, reflexively disbelieving patients' medical complaints, and falsifying medical records to cover up inadequate care. Critics of this argument claim that it illicitly generalizes from a few unethical doctors and nurses and makes unfair claims about the culture of correctional healthcare overall (Kerle et al. 1999), similar to the "few bad apples" claims used to dismiss systematic racism in law enforcement. Surveys of correctional nurses, however, have found that correctional nurses themselves describe role confusion, subordination of healthcare concerns to security concerns, and limitations on the actionable health advice they can provide incarcerated patients (e.g. inability to advise patients to eat more

healthily, given the food available in prisons and jails) as some of the defining aspects of correctional healthcare jobs, along with a suspicion of patients' self-reported symptoms and motives for seeking care (Flanagan and Flanagan 2001). Thus, there are organizational obstacles to providing the best healthcare in correctional settings, even beyond the imperative of for-profit correctional healthcare companies to cut costs. These obstacles are not due to “bad apples” but to the different, often conflicting priorities of healthcare and correctional facilities.

People leaving incarceration also face barriers to accessing adequate healthcare, which is worrying because the mortality rate of formerly incarcerated people, especially their mortality rate from drug overdoses, is elevated in the post-release period (Zlodre and Fazel 2012; Joudry et al. 2019). People who have ever been incarcerated access medical and dental care less frequently than those who have not, independent of related factors such as insurance or employment (Kulkarni et al. 2010). Many people post-release from prison experience discrimination from healthcare workers due to their formerly incarcerated status (Frank et al. 2014; Fahmy et al. 2018). Those who do experience discrimination from healthcare workers post-release report worse overall health (Redmond et al. 2020).

A large proportion of families and communities impacted by incarceration are socioeconomically disadvantaged individuals of color – African American, Native American, and Latinx. These populations also face disparities in healthcare. While the Affordable Care Act (ACA) increased insurance coverage across racial groups, it reduced but failed to eliminate racial and socioeconomic disparities in coverage and quality of care (Sommers et al. 2017; Angier et al. 2019). This is partly because while insurance coverage increased overall after the ACA, it increased more among citizens than among noncitizen immigrants, who are disproportionately Latinx (Stimpson and Wilson 2018). It is also partly because residential segregation creates racially disparate access to healthcare resources. As an example of the impact of segregation on the distribution of healthcare resources, zip codes where the majority of the population is African American or Latinx are much more likely to be primary-care physician shortage areas, i.e., areas where there is less than one primary care physician per 3,500 residents (Gaskin et al. 2012a). In the same vein, people who live in predominantly minority neighborhoods, especially Latinx neighborhoods, are less likely to access adequate physical or psychiatric healthcare than people who live in predominantly white neighborhoods (Gaskin et al. 2012b; Dinwiddie et al. 2013). Disparities start young; in the U.S., children of color are less likely to receive adequate mental or physical healthcare (Kataoka, Zhang, and Wells 2002; Flores 2010). All of this means that the populations at greater risk of suffering negative health consequences due to a family member's incarceration are also less likely to receive adequate healthcare.

Supporting communities requires efforts to support the health and wellbeing of individuals in prison, post-release, and the families and communities they return to. For individuals in prison and jail, this requires revamping delivery of care in prison and healthcare post-release. Unfortunately, relatively few high-quality randomized studies have been performed on how to best deliver healthcare in prison and in the critical post-release period (Kouyoumdjian et al. 2015). Research has shown that people who are enrolled shortly after post-release in a primary care-based care management program, such as the Transitions Clinic in San Francisco, will access primary healthcare more and use the emergency department less, but such enrollments are not standard practice (Wang et al. 2012). More programs and more research studies are needed.

Supporting communities affected by high incarceration rates also means ensuring healthcare access to families connected to these individuals. Some of these interventions need to take place in the political arena. In states that did not expand Medicaid under the ACA (e.g., Missouri), people living at or below 138% of the federal poverty line have less access to healthcare in general and less access to preventative care in particular than their

economic equivalents in Medicaid expansion states (Han et al. 2015). While the ACA is not a panacea, expanding Medicaid in the 13 states that have still failed to do so is an important step in improving healthcare equity.

Other interventions need to take place in the healthcare profession. People who have been incarcerated are less likely to access healthcare. In addition, children who experienced parental incarceration, especially maternal incarceration, are less likely to use primary healthcare and more likely to use emergency departments as adults (Heard-Garris et al. 2018). Healthcare professionals need to figure out how to connect these populations with adequate care. Given the discrimination that formerly incarcerated people report experiencing in healthcare settings, doctors, nurses, and other healthcare workers may have to prove themselves trustworthy and unbiased to their formerly incarcerated patients before adequate healthcare can be provided. It would be advisable for medical schools to provide students with cultural competency training that combats negative stereotypes about justice-involved people and alerts students to justice-involved communities' health needs. Moreover, care must address both physical and mental health, as well as preventative care, not solely substance abuse and treatment.

### **Beyond Healthcare: The Social Determinants of Health of Incarcerated Populations, Their Families, and Their Communities**

Healthcare is an important avenue but there must be other supports for communities. Using a social determinants of health frame suggests that we must consider the social, economic, and environmental factors which shape health. While medical care is of critical importance, other conditions such as the quality of schools, affordability and stability of housing, access to good and safe jobs with fair pay, and proximity to low-cost health foods in neighborhoods can keep individuals healthy in the first place (Robert Wood Johnson Foundation 2020).

Such considerations extend to the jail and prison setting. Correctional facilities tend to be unhygienic in ways that negatively affect the health of people incarcerated in them: overcrowded and poorly ventilated, with insufficient access to soap and water and uncontaminated food (Guo et al. 2019). Outbreaks of COVID-19 in correctional facilities have likely been made worse by insufficient access to soap and water, as well as inability to socially distance (Williams and Ivory 2020).

The St. Louis-based legal nonprofit Missouri Appleseed, which focuses on policy issues at the intersection of criminal justice reform and public health, is involved in several projects that can serve as case studies for intervening in the pre-incarceration, incarceration, and post-incarceration stages of health and healthcare for justice-involved individuals, families, or communities. These case studies may be of particular interest to advocacy groups with limited resources in states, like Missouri, with conservative-dominated legislatures.

**Pre-Incarceration:** In the past decade, three states – Washington, Massachusetts, and Tennessee – have passed “Primary Caretaker” laws, which give judges greater discretion to sentence primary caretakers of minor children to non-custodial sentences like probation or community service, rather than prison or jail time, when those caretakers are convicted of a nonviolent crime. Another state, Oregon, has started a five-county pilot program to test a Primary Caretaker diversion program based on Washington’s. State legislators in Louisiana and Texas have also filed Primary Caretaker legislation, but without successful passage.

Missouri Appleseed identified Primary Caretaker Legislation as a way to preserve families and improve childhood health. The Missouri state legislature was receptive, firstly due to a bipartisan desire to protect child

welfare, and secondly due to the Republican majority's fiscal conservatism. As detailed above, parental incarceration is an adverse childhood experience, which tends to hurt children's physical, mental, and behavioral health and reduce the economic resources available to them. It seemed that if advocates educated Missouri state lawmakers on the adverse effects of parental incarceration on children, the legislature might pass a bill to prevent those effects.

Additionally, the fiscal Republicans who dominate the Missouri state legislature might want to reduce costs for the state's overburdened foster care system and prison system. Ten percent of the children in Missouri's foster care system ended up in foster care partly due to parental incarceration, as compared to 8% of foster care children in the U.S. overall (Child Trends 2017). This situation may be due to Missouri's high rate of female incarceration, as children with incarcerated mothers are more likely to end up in foster care than children with incarcerated fathers (Mumola 2000). Missouri has the 8<sup>th</sup> highest overall incarceration rate in the U.S. and the 5<sup>th</sup> highest female incarceration rate (Missouri Department of Corrections 2020). Primary Caretaker legislation is an opportunity for fiscal conservatives to lighten caseloads in foster care and corrections, thereby reducing government spending and avoiding the necessity of building additional prisons, which would cost the state hundreds of millions of dollars.

Missouri Appleseed drafted language for a Primary Caretaker bill in cooperation with a St. Louis University law school class, Grassroots Health Policy and Advocacy. Two Republican legislators agreed to file the bill in the 2020 legislative session: Senator David Sater, who filed it as standalone legislation in Senate Bill 813, and Representative Mary Elizabeth Coleman, who included in it an omnibus child welfare reform bill, House Bill 2216. Additionally, Representative David Evans filed House Bill 1291, which gave judges discretion to make a determination of a defendant's primary caretaker status post-conviction and consider a non-custodial sentence, but unlike SB 813 and HB 2216, did not *require* judges to make a determination. Missouri Appleseed advocated for these bills with All of Us or None, a national grassroots organization of incarcerated and formerly incarcerated people with a St. Louis chapter. All of Us or None had final say on which versions of the bills the coalition would support, based on which convictions the bills excluded from eligibility for non-custodial sentences. House Bill 2216 was the most successful of the bills. It had passed out of the House Judiciary Committee and was on the Formal Perfection Calendar of the Missouri House of Representatives when COVID-19 ended the regular legislative session. Missouri Appleseed and All of Us or None plan to advocate for Primary Caretaker legislation again in the 2021 legislative session.

**During Incarceration:** In 2017, the Federal Bureau of Prisons issued a memorandum mandating that its prisons provide menstruating inmates with free tampons (regular and super-sized), sanitary pads with wings (regular and super-sized), and panty liners that meet industry standards (Federal Bureau of Prisons 2017). In 2018, the First Step Act codified this policy into law (Congressional Research Service 2019). Unfortunately, this change only applies to federal prisons. At the time the First Step Act was passed, the Missouri Department of Corrections (MDOC) provided only single-sized, wingless pads produced by a correctional supplies company to its women's prisons. Brand-name pads and tampons were also available for sale at the prisons' canteens.

In concert with the MDOC's Director of Research, and with funding from the Missouri Foundation for Health, Missouri Appleseed developed and disseminated surveys to understand how the state of access to menstrual hygiene products affected people incarcerated in Missouri's prisons. In September 2018, surveys were disseminated to 90 incarcerated people randomly selected but evenly divided between Missouri's two state prisons for women. The survey had a 91.1% response rate; 86.6% of respondents reported still menstruating. Of

menstruating respondents, 87.3% reported using the free MDOC pads, but these pads were poor quality and not very absorbent: 50.0% of respondents who used the free pads reported needing to change their pads every 30 minutes or more frequently on days of heavy flow. (These numbers may actually overstate the pads' absorbency, as marginal comments on surveys suggested that menstruating inmates almost always wore multiple pads at the same time.) 88.7% of respondents reported having had period accidents in which their blood leaked onto their clothes, their bedding, or the floor. Perhaps as a result of inadequate free products, 80.3% of respondents also reported having used homemade tampons constructed of materials available in the prison (e.g. toilet paper or cotton stuffing and dental floss). Homemade tampons are not hygienic and may have had negative health consequences: while 22.5% of all menstruating respondents reported a vaginal infection in the six months before the survey, 28.1% of respondents who had used homemade tampons reported vaginal infections.

Brand-name tampons were for sale at the prison canteen (sometimes also called a "commissary"); however, they were too expensive for many respondents. Of the respondents, 43.7% reported having bought canteen tampons at some point; of those who had not, 72.% said they did not buy canteen tampons because the tampons cost too much money. An incarcerated person with a high-school degree makes \$8.50 a month at a Missouri prison job; at the time of Missouri Appleseed's survey, the prison canteen sold Tampax tampons for \$5.63 per 20-tampon box and Always Maxi pads for \$5.38 per 18-pad box. In other words, absent external financial support, people incarcerated in Missouri prisons would have to spend nearly two-thirds of their monthly salary, every month, to buy a single box of name-brand menstrual hygiene products. Unfortunately, situations like this are common in U.S. prisons. The items that prisons disperse for free are of such poor quality that inmates end up buying necessary items at the prison commissary. When the inmates' monthly salaries run out, their families may transfer them funds. In this way, prisons shift the cost of purchasing necessary items to justice-involved families (Raheer 2018). Keeping in contact with people who are incarcerated – whether by visiting, calling, or sending packages – can also cost hundreds of dollars a month, so that the economic consequences of a family member's incarceration go far beyond lost income. Thus, mass incarceration further jeopardizes the financial security of many already financially insecure families (Grinstead et al. 2001; Comfort 2007).

The results of Missouri Appleseed's menstrual hygiene survey were sufficient to spur Missouri legislators to action. Democratic Representative Tracy McCreery added an amendment to another representative's bill language that would have required Missouri prisons to provide industry-standard pads and tampons free of charge; unfortunately, her amendment was stripped off in the senate. Republican Representative Mary Elizabeth Coleman filed a bill that would have required Missouri prisons *and* jails to provide industry-standard pads and tampons free of charge, but this bill did not make it far in the legislative process. Finally, a coalition of lawmakers and MDOC administrators convinced the governor to add a line item to the state budget fully funding the provision of free tampons in Missouri's state prisons for women. That funding has been renewed for a second year in a row. Currently, Missouri Appleseed plans to advocate for legislation in the 2021 legislative session that will mandate the provision of industry-standard pads and tampons in state prisons and county and municipal jails, rather than leaving the provision of products as a matter of policy.<sup>1</sup>

**Post-Incarceration:** Until recently, Missouri terminated the Medicaid coverage of any individual entering incarceration, whether pre-trial or post-conviction. Because prisons and jails have a constitutional obligation to

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<sup>1</sup> It is also worth noting that in marginal notes on the surveys and during interviews with formerly incarcerated people conducted while Missouri Appleseed was developing the surveys, respondents and interviewees mentioned a multitude of related issues impacting health and well-being in prisons: inadequate quantities of essential hygiene items, essential hygiene items that caused skin rashes, and delayed medical care, for example.

provide healthcare to the people they incarcerate, Missouri terminated the Medicaid coverage of incarcerated people as a way to avoid double billing the government for healthcare services. Unfortunately, the termination policy meant that Medicaid-eligible people leaving incarceration lacked health insurance upon their release and had to reapply for coverage. This byzantine process could take months to complete, during which the Medicaid-eligible person would not have access to doctor's visits or necessary medications.

During the 2019 state legislative session, Missouri Applesseed coauthored a letter asking the Director of MO HealthNet, Missouri's Medicaid program, to implement regulatory changes that would suspend rather than terminate the health insurance of Medicaid-eligible people entering prison or jail. Suspension allows health insurance to be immediately reactivated upon release, to ensure continuity of care and access to essential medications. The letter was cowritten and cosigned by a large coalition, including St. Louis University Law students, local nonprofits, and national nonprofits' state branches. Missouri Applesseed also advocated for bills that would change Missouri's policy from termination to suspension as a matter of law. Republican Senator Lincoln Hough filed Senate Bill 393 on the issue; the bill was heard in committee with only supporting testimony and unanimously voted out of committee. Ultimately, Senator David Sater's Senate Bill 514 passed and was signed into law in July of 2019 with an amendment that mandated Medicaid suspension rather than termination for individuals entering incarceration. Unfortunately, Missouri Applesseed has heard from directly impacted individuals that MO HealthNet has not yet enacted the change in the law. Missouri Applesseed is currently working to determine how enactment of the change can be expedited.

## **Conclusion**

All Americans should have the opportunity to make the choices that allow them to live a long, healthy life, regardless of their prior contact with the criminal justice system, education, income, or racial/ethnic background. Opportunity for health begins in our families, neighborhoods, schools, and jobs (Frieden 2010). We must begin to see health in all policies – “a collaborative approach that integrates and articulates health considerations into policymaking across sectors to improve the health of all communities and people” (Centers for Disease Control and Prevention 2016). In many cases and as our examples show, the kinds of policies that will support individuals, their families, and communities are beyond the scope of healthcare or even traditional public health activities.

When advocates point out the negative consequences that mass incarceration has had on public health, opponents may seek to frame the debate as a trade-off between public health and public safety. Yet an unhealthy public is an unsafe public. Women who suffer cardiovascular disease due to their loved ones' incarcerations are less safe from premature mortality. Children who suffer depression, anxiety, and PTSD due to their parents' incarcerations are less safe from self-harm and suicide. Individuals and communities suffering the collateral consequences of incarceration should not be ignored in debates that invoke public safety. In fact, debates about public safety must incorporate discussions of health and well-being, because, as the COVID-19 pandemic has clearly shown us, a sick society can never be a safe society.



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