# Mass Incarceration: Evaluating Health Disparities Among Minority Offenders Pre- and Post-COVID-19

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**Abstract**

Mass incarceration has exacerbated pre-existing health disparities and spread of COVID-19 within U.S. correctional facilities. African American, Latinx, and Indigenous communities disproportionately endure these consequences (Kuper & Turanvoic, 2020; Nowotny & Kuptsevych-Timmer, 2018; Ostler, 2020; Yancy, 2020, as cited in Farr, 2021). Although prior research addresses the relationship between mass incarceration and associated disparities, there is little research on the relationship between race, health disparities, and COVID-19. This systematic literature review fills the gap by comparing racial health disparities before and after the emergence of COVID-19. Synthesizing literatures on mass incarceration, race, health, and COVID-19, this review discusses relevant theories and empirical findings concerning the relationship between mass incarceration and health disparities. Without immediate action by U.S. criminal justice authorities to combat new COVID-19 cases and deaths, the health of racial minorities will be significantly impacted (American Civil Liberties Union, 2020, as cited in Bradshaw, 2021).

**Introduction**

Mass incarceration is a persistent societal issue that disproportionately plagues communities of color (Alexander, 2020; Simes 2021; Western, 2006). The United States has a higher incarceration rate than any other country. Approximately 2.3 million individuals are currently incarcerated in the United States (Wang et al., 2020, as cited in Barsky et al., 2021). This number exceeds the population of some major metropolitan areas (Prison Policy Initiative, 2019). U.S. carceral facilities hold around 1,291,000 inmates in state prisons, 631,000 in local jails, and 226,000 in Federal prisons and jails (Prison Policy Initiative, Figure 1, as cited in Sawyer & Wagner, 2020).

Aside from the magnitude of the system, these carceral facilities exacerbate pre-existing health disparities and the spread of the SARS-CoV-2 Virus (COVID-19) through overcrowding, inadequate hygiene maintenance, and practice (i.e. limited decarceration) (Alexander et al., 2020; Farr, 2021). Scholars refer to these phenomena as epidemiologic pumps (Abraham et al., 2020; Barsky et al., 2021; Bradshaw, 2021). Mass incarceration, associated health disparities, and COVID-19, have disparate impacts on African American, Latinx, and Indigenous populations (Alexander, 2020; Golash-Boza, 2017b; Kuper & Turanvoic, 2020; Nowotny & Kuptsevych-Timmer, 2018; Ostler, 2020; Yancy, 2020, as cited in Farr, 2021; Western, 2006). African Americans, alone, are eight times more likely to be incarcerated relative to Whites (Western, 2006). Due to this disparity, coupled with higher rates of pre-existing medical conditions and inadequate medical care, African Americans have greater risk in contracting COVID-19 (Bullard & Wright, 2012; Golash-Boza, 2017a; Ostler, 2020; Yang, 2020, as cited in Farr, 2021).

Mass incarceration arose during the punitive get-tough social and political era of the 1970s. The criminal justice system shifted priorities from rehabilitation to punishment (Flores,

2018; Western, 2006). As a result, it became politically and economically advantageous to be tough-on-crime (Golash-Boza, 2017b; Western, 2006). Determinate sentences (i.e. mandatory minimums and truth-in-sentencing laws), limits on judicial discretion, and a surge in the U.S. incarceration rate all resulted from this “punitive turn” (Anderson 2017; Golash-Boza, 2017b; Tonry, 2019). Thus, the new Jim Crow, the mass incarceration primarily of people of color, emerged. The disenfranchisement minorities experienced (i.e. racism, educational injustices, health disparities, and lack of equal access to health care) during slavery and Jim Crow, became legal through making people of color into slaves of the state (Alexander, 2020).

Due to the increasing size of the carceral state and inadequate conditions in such facilities (i.e. lack of hygiene products), correctional facilities perpetuate multiple health-related disparities, particularly impacting minorities (Alexander et al., 2021). For instance, incarcerated individuals are at an increased risk of contracting communicable diseases, chronic and acute stress, discrimination, and physical and mental victimization (Alexander et al., 2020; Daza et al., 2020; Nowotny & Kuptsevych-Timmer, 2018). Correctional facilities are recognized as breeding grounds for disease with overcrowding, poor air quality, and a lack of permitted hygiene products (Abraham et al., 2020; Alexander et al., 2020; Nowotny & Kuptsevych-Timmer, 2018; Wallace et al., 2020, as cited in Bradshaw, 2021). However, little has been done to combat such disparities, which people of color disproportionately bear the brunt of. Historically, these populations have faced such disparities beyond correctional environments, specifically African Americans. Blacks have the lowest mortality rate, a lower life expectancy than their White counterparts, and face conditions such as cardiovascular heart disease and diabetes more often than Whites (Bullard & Wright, 2012; Golash-Boza, 2017a). These disparities are attributable to discrimination, racism, residential location, and explicit biases of physicians. Additionally,

unethical medical experimentation on African Americans contributes to medical mistrust of physicians (Bullard & Wright, 2012; Golash-Boza, 2017a).

Yet, the most current issue facing carceral facilities is the spread of COVID-19. Incarcerated individuals are more likely to contract and succumb to the virus (5.5 times more likely to contract and three times more likely to die) (Wang et al., 2020, as cited in Barsky et al., 2021). The SARS-CoV-2 virus has plagued over 1,470 U.S. correctional facilities, claiming the lives of over 2,700 inmates and staff (CDC, 2021b). There have been over 620,000 documented cases within U.S. correctional facilities alone (Barsky et al., 2021). The conditions created from mass incarceration have played a large role in the exacerbation of COVID-19 (i.e. the spatial density of cells) (Simpson et al., 2019, as cited in Abraham et al., 2020). Additionally, practices such as transporting inmates in and out of facilities, inadequate testing, prisoner intake, and mixing up test results have led to more outbreaks (Wallace et al., 2020, as cited in Bradshaw, 2021). Research shows that over 500,000 cases from the summer of 2020 can be linked to mass incarceration (Hooks & Sawyer, 2020). Despite recommendations from the CDC on testing, cleaning procedures, decarceration, and vaccination, the virus is still flourishing in these facilities. Mass decarceration/compassionate release and the vaccination of prisoners and staff have been called for, yet limited efforts have been made (Abraham et al., 2020; Barsky et al., 2021; CDC, 2021c; Mitchell & Williams, 2017, as cited in Alexander et al., 2020).

These issues are a threat to prisoners' lives and need to be addressed immediately. Specifically, if immediate measures are not taken to mitigate the spread of COVID-19 in these facilities, an influx of cases and fatalities will arise, particularly impacting minorities (American Civil Liberties Union, 2020, as cited in Bradshaw, 2021). Prisoners, especially minorities, will continue to face disparate incarceration rates, contract and succumb to more health ailments, and

face human rights violations(Alexander, 2020; Alexander et al., 2020; Bradshaw, 2021; Nowotny & Kuptsevych-Timmer, 2018). Disparities within carceral facilities extend post-release, such as unequal and inadequate health care and racism (Bullard & Wright, 2012; Cole et al., 2019; Cox, 2018; Gay et al., 2020; Weller et al., 2020, as cited in Kuper & Turanovic, 2021). Without progress, prisoners will have decreased life chances inside and outside U.S. correctional facilities.

The review has three overarching aims: 1) investigate the scope of mass incarceration to explore the racial impact of carceral health disparities, 2) investigate the impact COVID-19 has had on such disparities, and 3) put forth policy recommendations aimed at decreasing carceral populations and aiding minority offenders. The review is organized into five sections; theoretical perspectives; mass incarceration and race; racial health disparities;COVID-19, race, and the criminal justice system; and implications and recommendations. After establishing the origins and current status of mass incarceration, the review will describe how the phenomenon, race, health disparities, and COVID-19 are all intertwined, how African Americans, Latinx, and Indigenous populations disproportionately face said disparities, and that the issues presented call for immediate attention (foreseeable outcomes and recommendations). Therefore, the purpose of this review is to evaluate the relationship between mass incarceration, health disparities, and COVID-19 through a historical, social, political, and racial lens. To begin to understand such relationships, it is important to recognize the theoretical perspectives used for analyses of mass incarceration, race, and associated ills.

## Theoretical Perspectives

There are several theoretical perspectives that scholars utilize to analyze mass incarceration, the racial composition of correctional facilities, and disparities experienced within

such facilities (i.e. health disparities). However, this review will focus on three primary theories. These include strain theory, conflict theory, and critical race theory. The following sections will examine each theory and their relationship to mass incarceration, race, and associated disparities.

**Strain Theory**

Strain theory evolved out of multiple perspectives from several theorists, such as Merton (1938), Cohen (1955), Cloward and Ohlin (1960), Messner and Rosenfeld (2007), and Agnew (1992) (Agnew, 1992a). Originally, leading up to 1992, research mainly focused on the inability to achieve economic goals (Agnew, 2006b). Specifically, focus was placed on the lower-classes' inability to obtain monetary success or a higher status (i.e. middle-class) (Agnew, 1992a). For example, Cohen's (1955) structural-strain theory focused on the idea of a delinquent subculture, resulting from adolescent adaptations to the lack of legitimate means to obtain a middle-class status (i.e. blocked status). He argued that possessing middle-class values (i.e. ambition and self-control) was the normal way to obtain one's goals. However, adolescents lack the social and intellectual skills needed to go up against their middle-class counterparts (Vowell & May, 2000). Merton (1938) focused on the inability for such adolescents to achieve a higher status (i.e. middle-class) or financial success through legitimate means (Vowell & May, 2000). These early theorists contended that the "cultural system encourages everyone to pursue the ideal goals of monetary success and/or middle-class status" (Agnew, 1992a, p. 51). However, earlier versions of the theory were criticized and neglected to include other goals individuals pursue (i.e. educational and romantic), as well as other obstacles to achieving higher social status/class (Agnew, 1992a). Robert Agnew expanded upon earlier versions of strain theory to create general strain theory (Agnew, 1992a).

General strain theory (GST) focuses on three types of strain: the inability to achieve positively-valued goals (i.e. monetary), the loss of positively-valued stimuli (i.e. money or family), or the presentation of negatively-valued stimuli (i.e. physical or verbal abuse) (Agnew, 1992a; Agnew, 2006b; Agnew & Brezina, 2019; Barlow & Decker, 2010). These strains can be classified as objective or subjective and can happen or be threatened. The former are events or conditions that most individuals would react negatively to, while the latter are events and conditions that only specific individuals or groups may react negatively to (i.e. those currently experiencing or have experienced the strain) (Agnew, 2006b; Agnew & Brezina, 2019; Barlow & Decker, 2010). Strains can also lead to negative affective states, such as anger, fear, or depression (Agnew, 1992a; Agnew, 2006b; Agnew & Brezina, 2019; Barlow & Decker, 2010). Furthermore, Agnew's integrated GST focuses on five life domains theorized to be correlated with increased crime: self (e.g. low self-control), family (e.g. attachment to family), school (e.g. attachment to teachers), peer (e.g. frequency of peer delinquency), and work (e.g. attachment/devotion to ones work). The impact of the above on crime can be direct, indirect, moderated, or interactive, based on the motivation levels and constraint present (Agnew, 2005, as cited in Choi & Kruis, 2019). Ultimately, GST seeks to explain the types of strains that are most conducive to crime, why certain strains are solved with crime, and why certain individuals are more likely to respond to specific strains with crime (Barlow & Decker, 2010).

GST argues that the strains most conducive to crime are high in magnitude (i.e. frequent, long, or recent), viewed as unjust, and result from low social control or pressures/incentives for criminal behavior (Agnew, 1992a; Agnew, 2006b; Agnew & Brezina, 2019; Barlow & Decker, 2010). Examples of such strains include working in the secondary labor market, residence in an urban community, and discrimination. Additionally, vicarious strains (those experienced by

loved ones/those closest to us) or anticipated strains can lead to negative outcomes (Agnew, 2006b; Agnew & Brezina, 2019; Barlow & Decker, 2010). GST has also investigated group differences in crime, as certain groups can have more or less exposure to strain and be more or less prone to responding to such strain with crime (Agnew, 1992a; Agnew, 2006b; Agnew & Brezina, 2019; Barlow & Decker, 2010).

*General Strain Theory and Mass Incarceration*

General strain theory maintains that certain individuals and groups can be more or less likely to experience strain, in addition to asserting that cumulative and/or frequent strains and unjust strains can be more conducive to crime (Agnew, 1992a; Agnew, 2006b; Agnew & Brezina, 2019; Barlow & Decker, 2010). Additionally, increased strain, anticipated strains, and vicarious strains can lead to individuals experiencing negative affective states, such as anger, fear, or depression (Agnew, 1992a; Agnew, 2006b; Agnew & Brezina, 2019; Barlow & Decker, 2010). By evaluating the strains most likely to lead to crime, and such negative emotional states, one can utilize GST to analyze the experiences of minorities, mass imprisonment, and other associated disparities. For example, the theory posits that holding a job in the secondary labor market, chronic unemployment, residence in poor communities, racial discrimination, and the failure to achieve ones' selected goals (i.e. educational, monetary, and social) are more conducive to crime (Agnew, 2006b; Agnew & Brezina, 2019; Barlow & Decker, 2010). Additionally, individuals lacking economic stability/financial resources and social support may see no other option than committing crime to cope with strain (i.e. property theft or drug crimes) (Agnew, 1992a; Agnew, 2006b; Agnew & Brezina, 2019; Barlow & Decker, 2010).

Since minorities are more likely to experience the conditions that lead to strain and criminal coping, one can infer they disproportionately experience various forms of strain (i.e.

objective, subjective, experienced, anticipated, and vicarious strains). For instance, minorities, including individuals of color within U.S. correctional facilities, are more likely to come from poor, disadvantaged, urban neighborhoods, have less educational attainment due to inadequate opportunity, face consistent discrimination and stereotyping, have encounters with the police, and have family members who have experienced and/or are experiencing incarceration (Alexander, 2020; Boen, 2020; Flores, 2018; McCormick et al., 2015, as cited in Bui et al., 2019; Reiman, 2007; Talkingsticktv, 2012; Western, 2006). Furthermore, these individuals are more likely to face unequal working conditions, hold jobs in the secondary labor market, face higher unemployment rates, and overall, lack social, educational, and economic opportunities compared to their middle-upper class counterparts and Whites, more generally (Alexander, 2020; Reiman, 2007; Talkingsticktv, 2012; Western, 2006). People of color, as a group, may be more likely to experience subjective strains as the subordinate class, meaning they are singled out in their experiences and others may view their struggles more lightly. Due to the aforementioned strains they face, they may be viewed as more likely to cope with strain through crime (i.e. drug crimes) (Barlow & Decker, 2010). Additionally, since neighborhoods with high minority populations tend to have more formal social control, they are more likely to be sanctioned for such responses to strain (Barlow & Decker, 2010).

The strains people of color face are not limited to the criminal justice system. Strains, such as lack of adequate and affordable health insurance/care, discriminatory medical care, and racism carry into U.S. carceral facilities, where minorities are more likely to be presented with negative stimuli/strain and the loss of positive stimuli (i.e. work and social/familial support) (Clear, 2007, as cited in Nowotny & Kuptsevych-Timmer, 2018; Gay et al., 2020; Kuper & Turanovic, 2021). For instance, minorities (particularly Blacks) are more likely to face harsh

treatment (i.e. solitary confinement and undesirable cell block placement), be exposed to health ailments (i.e. disease; mental and physical), contract and succumb to COVID-19, lack social support (i.e. financially and geographically unfeasible for family to visit), and face overall harsher/unjust sanctions (Adams, 1992; Alexander, 2010; Cochran et al., 2016; McDonald & Weisburg, 1992; Olson, 2016; Schnittker et al., 2011; Wildeman & Anderson, 2020, as cited in Kuper & Turanovic, 2021; Boen, 2020; Daza et al., 2020; National Center for Health Statistics, 2015, as cited in Bui et al., 2019; Ostler, 2020; Yancy, 2020, as cited in Farr, 2021; Shuey & Wilson, 2008, as cited in Cox, 2018). Due to this discriminatory and inconsistent treatment/sanctioning, crime (i.e. fights and racial divides) results in such facilities (Friedman, 2021). Such strain can also lead to negative emotions, particularly when viewed as unjust (Barlow & Decker, 2010). Ultimately, general strain theory can help one evaluate the subjective and cumulative strains people of color face and how such strain may lead to these individuals being funneled into the U.S. correctional system, where they are more likely to experience additional strain.

**Conflict Theory**

Conflict theory asserts that race, class, and threat are essential in understanding social control (Barlow & Decker, 2010). The theory posits that "society is made up of groups with competing norms and values and contends that the authority of the state is used to protect the interests of those in power" (Barlow & Decker, 2010, p. 239). Threat is a big part of the theory, as theorists state the law is utilized to protect the dominant societal group's interests from lower-class individuals and especially the poor and minorities (Chambliss & Seidmen, 1982; Quinney, 1970; Turk, 1969, as cited in Barlow & Decker, 2010). For example, when evaluating the same crime, lower-class individuals are more likely to be investigated, arrested, charged, charged more

harshly, convicted, and sentenced to prison for longer periods of time than well-off individuals, even if the crimes of the wealthy are more damaging (economically or physically) (Reiman, 2007). Specifically, the amount of power the dominant group exerts over these individuals depends on the legitimacy of the threat perceived (Barlow & Decker, 2010). For example, these groups (mainly racial minorities/Blacks, the poor, and unemployed) are often called the "surplus population," "rabble class," or "problem population," face legal sanctions more often than their powerful counterparts, and tend to receive harsher sanctions for crimes viewed as a threat to the dominant group (Box & Hale, 1985; Irwin, 1985; Liska & Chamlin, 1984; Spitzer, 1975; Quinney, 1977, as cited in Barlow & Decker, 2010). In particular, Blacks receive such sanctions when Whites' power is at stake (Barlow & Decker, 2010). Further, Karl Marx details how society is split into two classes: the Bourgeoisie (wealthy) and the Proletariat (working class), where the former owns the means of production (i.e. capital) and the latter are the suppressed, minority group. Therefore, unequal power dynamics result (Saroj & Dhanju, 2019).

Society fails to protect citizens due to fear of alleviating poverty, failing to label the acts of wealthier individuals as crimes, and failing to enforce violations of their acts already deemed crimes. Additionally, the U.S. criminal justice system paints a portrait of crime surrounding the poor, protecting the interests of those in power (Reiman, 2007). If some of the "haves" (i.e. those who have enough) would give to some of the "have-nots" (i.e. the impoverished), poverty could be greatly reduced or eliminated. Yet, those in power refuse to let that happen (Reiman, 2007). Essentially, conflict theorists posit that the more economically stratified communities become, the more those in power feel the need to coercively enforce conduct norms that underlie supremacy (Chambliss & Seidmen, 1982, as cited in Barlow & Decker, 2010). Overall, race and threat are intimately connected and, together, lead to the most explosive outcomes for

subordinate classes (Chiricos & Bales, 1991, as cited in Barlow & Decker, 2010). Young, Black men are more likely to face the worse outcomes, such as harsher and lengthier sentences (Darrell Steffensmeier et al., 1998, as cited in Barlow & Decker, 2010).

*Conflict Theory and Mass Incarceration*

Conflict theory can help one understand the disparate incarceration rates of minorities through the ideas of race, threat, power, and control (Barlow & Decker, 2010). Blacks, Latinx, and Indigenous communities disproportionately experience incarceration, get-tough sentences, harsh treatment, and medical vulnerabilities (Alexander, 2020; Borysova et al., 2012; Meierhoefer, 1991, as cited in Reiman, 2007; Golash-Boza, 2017b; Ostler, 2020; Yancy, 2020, as cited in Farr, 2021; Western, 2006). Conflict theorists assert that race and threat are both concepts that greatly impact decision-making in the criminal justice system (i.e. sentencing). For example, theorists found that race was one key factor impacting one's likelihood of being imprisoned as well as the length of their sentence (Barlow & Decker, 2010). Young Black and Hispanic men are more likely to be imprisoned (especially the unemployed) compared to their employed, White counterparts (Spohn & Holleran, 2000, as cited in Barlow & Decker, 2010). The theory can be used to examine residential disadvantage (i.e. living in poor, urban communities), economic disadvantage, and racial disadvantage impacting individuals' odds of being funneled into the U.S. correctional system (Barlow & Decker, 2010; Reiman, 2007).

Conflict theory also provides a unique perspective on disparate incarceration rates and vulnerabilities faced by people of color through exploration of the racial threat hypothesis. The hypothesis maintains that Whites utilize the racial concentration of their communities (all non-Whites) to determine their level of threat, how extensive crime will be in their neighborhoods, and the level of formal social control they would like exerted (Barlow & Decker, 2010). Thus,

communities with higher proportions of minorities will face increased discrimination, police control, higher arrest rates, and increased imprisonment rates (Barlow & Decker, 2010). Due to minorities being viewed in a threatening manner, there is less pushback when they face harsher sanctions and treatment. Then, the mass imprisonment of minorities is viewed as a legitimate form of punishment for Whites to maintain dominance and social, economic, and political advantage (Barlow & Decker, 2010).

The associated disparities minorities face (i.e. health-related and COVID-19) are ill-forgotten and result from prejudice, discrimination, and fear (CDC, 2020, as cited in Bradshaw, 2021; Farr, 2021). To some, less money simply means the inability to have everything one wants. However, this thought neglects the concept that less money leads to less access to healthy foods, health care (i.e. doctors check-ups, dental care, and surgeries), and reduced activity levels (Reiman, 2007). Furthermore, being a part of the have-nots (i.e. poor) is correlated with early mortality, decreased educational opportunities, and unhealthy neighborhood conditions. These disadvantages are more common for minorities (particularly African Americans) (Margolis et al., 1992, as cited in Reiman, 2007). African Americans have the lowest life expectancy in the U.S. and are more likely to suffer from poverty than their White counterparts (Cunningham et al., 2017; Gilbert et al., 2016, as cited in Nowotny & Kuptsevych-Timmer, 2018; Reiman, 2007). When being transitioned to carceral facilities, minorities are already more likely to come from disadvantaged neighborhoods and have higher rates of chronic and communicable diseases (Cox, 2018). Then, unequal access to care and pre-existing racial biases worsens the health of already vulnerable people of color (Stein, 2005, as cited in Reiman, 2007). Without assistance from the "haves" and their continued domination over the poor, our society becomes an accomplice to "murder" (Reiman, 2007).

Once funneled into the U.S. criminal justice system, people of color face a lower and immoral status that is viewed as necessary for Whites to protect their interests and power in society (Goffman 1961; Paterline and Petersen 1999; Thomas and Foster 1972, as cited in Friedman, 2021). This can help explain why certain crimes, such as drug crimes, are more heavily enforced on minorities, such as with the crack versus powder cocaine sentencing disparity (Golash-Boza, 2017b). Additionally, the concepts of "threat," "danger," and "fear" associated with people of color can help provide insight on the educational, economic, and carceral vulnerabilities minorities face and why they are funneled into correctional institutions more often than their White counterparts (Barlow & Decker, 2010). Being White is associated with a higher-class status causing the subordination and adversity of minorities in the system.

## Critical Race Theory

The basis of critical race theory emerged in the latter part of the 1960s and 1970s at Harvard and Berkeley in response to the backlash against progress made during the Civil Rights Movement (i.e. institutional racism and colorblind rhetoric) (Delgado & Stefancic, 2007). Critical race theory arose in the 1980s mainly from White men who identified as left-wing legal scholars and challenged the impartiality and fairness of "American legal liberalism" (Crenshaw 2002a, 2002b, as cited in Barlow & Decker, 2010). The theory contends that the law cannot be deemed neutral or objective because it oppresses certain societal groups (i.e. the poor and people of color) (Valdes et al., 2002, as cited in Barlow & Decker, 2010). Instead, "Critical race theory contends that the substance and procedures of American law, including antidiscrimination law, are structured to maintain white privilege" (McIntosh, 2007; Valdes et al., 2002, as cited in Barlow & Decker, 2010, p. 235). Additionally, the theory outlines how neutrality and objectivity

are unrealistic ideas that interfere with the normality of Whiteness seen in American law and societal norms (Valdes et al., 2002, as cited in Barlow & Decker, 2010).

Critical race theory has three key presumptions, while also three key rejections to beliefs surrounding racial injustices (Barlow & Decker, 2010; Delgado & Stefancic, 2007). The three central tenants include that race is ordinary and not exceptional (i.e. people of color experience it constantly), that there is interest convergence or material determinism at work (i.e. both White elites and Working Class members can be incentivized/gain from racism, causing little pushback), and that race is a social construct, as related to differential racialization (i.e. society made-up racial categories) (Delgado & Stefancic, 2007). Differential racialization also points to how the way the dominant societal group recognizes minorities can shift over time and place, depending on societal needs (i.e. labor market or laws). For instance, Blacks were "once" viewed as happy-go-lucky slaves, while then coming to be viewed as "menacing and brutish" in another era (Delgado & Stefancic, 2007). The theory infers and wants to uncover any links between liberal rights and racial oppression occurring in the post-civil rights era (Farr, 2021).

The three arguments the theory rejects include that "blindness" to race will eliminate racism," "racism results from the behavior of individuals and is not systemic or institutional," and "one can fight racism without paying attention to sexism, heterosexism, economic exploitation, and other forms of oppression or injustice" (Valdes et al., 2002, as cited in Barlow & Decker, 2010, p. 235). The first rejection speaks to how there are foreseen psychological benefits to one's racial identity, such as individual self-esteem or gaining political advantages that impact policy-making (Crenshaw, 2002a, 2002b, as cited in Barlow & Decker, 2010). Bonilla-Silva (2003) defines colorblind racism as a racial ideology and political tool used to express how racial inequality is no longer the result of viewing minorities as both biologically

and morally inferior (as Jim Crow laws presented) to Whites, yet is the result of nonracial factors. Whites have come to justify the status of racial minorities as resulting from the market, natural occurrences, and the cultural limitations of Blacks themselves (as cited in Thomas, 2000). Hence colorblind racism may be referred to as “racism lite” (not as overt). The second rejection speaks to how courts tend to interpret antidiscrimination law in a way that makes out certain offenders and victims, all while failing to see racism’s every day impacts on the innocent and guilty (Valdes et al., 2002, as cited in Barlow & Decker, 2010). The third rejection speaks again to how race is a social construct and that, without an intersectional approach (i.e. taking into account race, class, and gender), one will fail to see how racial stratification is “ordinary, ubiquitous, and reproduced” (Brown, 2003, as cited in Barlow & Decker, 2010).

Additionally, there is a critical race theory of state, which asserts the state, itself, is utilized as a tool by Whites to advance their interests and goals (Bracey II, 2015). Whites’ control of the state is deemed permanent and a threat to the abrogation of policies dealing with racial justice (Bell, 2004, as cited in Bracey II, 2015). The theory assumes that Whites hold more power than people of color and that said power gives Whites the ability to be racist. Additionally, the theory assumes White power allows for the exclusion of minorities in politics, that people of color cannot fully eliminate, yet only fight the White power differential, and that the position of Whites dictates their interests and politics (Bracey II, 2015). Therefore, the state serves as a producer of White supremacy, while Whites utilize the state, institutional spaces, and power to establish laws favoring their race and interests (Bracey II, 2015). Overall, critical race theory insists that race is a socially constructed, historical phenomenon deeply embedded within U.S. law and policy and that it is Whites, themselves, that can dictate minorities’ rights (Barlow & Decker, 2010; Bracey II, 2015).

*Critical Race Theory and Mass Incarceration*

Since critical race theory seeks to analyze the relationship between race and power structures, institutional and systemic racism, as well as the post-civil rights era, it does a good job of helping to explain mass incarceration and associated disparities. For instance, CRT can be used to evaluate the post-abolition period where slavery was expanded in a different capacity (i.e. shifting folks to carceral institutions) and the post-Civil War/civil rights era (Farr, 2021). During this time, it was shown that prisons arose to embrace White dominance and serfdom, and how policing shifted (Blackmon, 2008, as cited in Farr, 2021). For instance, during the post-bellum period, Blacks, Latinx, and Indigenous communities were policed, incarcerated, and punished differently/harshly, specifically in terms of the War on Drugs, school-to-prison pipeline, and colorblind policing (Alexander, 2010; Gonzalez-VanCleve and Mayes, 2015; Fornili, 2018, as cited in Farr, 2021). U.S. law became a tool for domination and subordination, where the interests of Whites were most important, the social construction of race was used for power, monetary/budget allocation advantages, and prisons became instruments in enforcing White supremacy (Omi & Winant 1986, as cited in Friedman, 2021). Despite the 13th Amendment of 1865, the advantage of transitioning certain societal groups (i.e. Black, Latinx, and Indigenous communities) to become slaves/prisoners of the state was advantageous and viewed as a legitimate form of punishment (Friedman, 2021).

In the post-civil rights era, mass incarceration emerged as a tool of dominance and subordination, as well as a way to continue emphasizing law and order (Alexander, 2020; Crenshaw et al., 1995, as cited in Friedman, 2021). A multi-billion-dollar prison-industrial complex surfaced (with both public and private prisons), state and federal partnerships, and convict leasing to accommodate monetary/property loss from abolition (Blackmon 2008;

LeFlouria 2015, as cited in Friedman, 2021; Brewer and Heitzog, 2008, as cited in Farr, 2021). Critical race theory shows that the U.S. correctional system directly resulted from White supremacy and the dominant group's efforts in maintaining power once brought from slavery, neoliberalism, and colonialization (Farr, 2021). Mass incarceration became a solution to White rage, as well as a method of formal social control that can create conditions "where criminalization flourishes and violent routine solutions levied against Black people are legitimized through the lens of public safety (white safety)" (Friedman, 2021, p. 4). Alexander (2020) poses that, after whole groups of African American men are funneled into carceral facilities, they enter "the period of formal control," where every aspect of their lives is subjected to monitoring and swift punishment for defiance (p. 230). This pertains, largely, to drug offenders. Correctional institutions increasingly held minorities and migrants and became punishment grounds, where humanness was forgotten and there was a "totalistic" feel (Romero, 2008; Sanchez and Romero, 2010; García, 2017, as cited in Farr, 2021; Goffman, 1961, as cited in Friedman, 2021). Additionally, the theory can show how the arisen U.S. laws and policies worked to hide systemic racism and disparities, particularly health disparities (Farr, 2021).

Through a disregard of race and hierarchies enforced within society, carceral facilities became viewed as "racialized organizations," where one's race dictates everything that happens within the walls of the facilities (Ray, 2019). Racialized organizations are those "social structures that limit the personal agency and collective efficacy of subordinate racial groups while magnifying the agency of the dominant racial group," demonstrated through the stripping away of minorities' humanity by carceral facilities (Ray, 2019, p. 36). For example, Correctional personnel play a large role in enforcing racial/ethnic divisions within corrections (Friedman, 2021). They are "taught" to see prisoners as below everyone else and as individuals who need

strict control over them, as well as to remain docile due to their degraded status. Additionally, due to power differentials, staff are viewed as higher up in status and morality, allowing them to view prisoners as an immoral, lower-class (Goffman 1961; Paterline and Petersen 1999; Thomas and Foster 1972, as cited in Friedman, 2021). Further, staff themselves may spread rumors and spark racial or ethnic fights/divides in corrections, which could lead to social death (Friedman, 2021). Social death can cause prisoners to be degraded by outsiders, change viewpoints of themselves, and lose social relationships (Patterson, 1982, as cited in Friedman, 2021).

Ultimately, critical race theory can assist in seeing how mass incarceration emerged, how carceral facilities became racially concentrated, and how systemic and institutional racism impact and impede change. Citizens can take one look at the conditions and racial concentration of correctional facilities and say that each offender deserves to be there for their crimes. However, they would be disregarding how race is socially constructed, how racism is embedded in laws, how rehabilitation can be a more successful and affordable option than incapacitation, historical disadvantages for minorities, and stereotypes (Campbell, 2018; Delgado & Stefancic, 2007; Flores, 2018; Western, 2006). Individuals and colorblind rhetoric, as well as get-tough laws created by powerful members of society, allow such ignorance (Alexander, 2020; Delgado & Stefancic, 2007; Golash-Boza, 2017b; Meierhoefer, 1991, as cited in Reiman, 2007; Tonry, 2019). Mass imprisonment, health disparities, and racial divides in COVID-19 can be viewed as resulting from power struggles, historical disadvantage, and institutional and systemic racism. With a clearer understanding of how mass incarceration is theorized, it is critical to analyze what the phenomenon is and how it has evolved over time.

## Mass Incarceration and "Get-Tough" Crime Rhetoric

Mass incarceration is an enduring social phenomenon within the United States. The U.S. is the number one incarcerator in the world, housing 1,291,000 inmates in state prisons, 631,000 in local jails, and 226,000 in Federal prisons and jails (Sawyer & Wagner, 2020). Further, the U.S. incarceration rate is approximately 750/100,000, comparatively higher than any other countries' (Pew Center, 2008, as cited in Alexander 2020; Talkingsticktv, 2012). Economically, mass imprisonment funnels underprivileged, jobless, and poverty-stricken populations into corrections. Elected officials often benefit politically from get-tough on crime campaigns, while the marginalized are disproportionately targeted (Western, 2006).

Historical, political, educational, and economic forces shaped the carceral state (Wacquant 2009). Its growth is often attributed to policy changes, anti-crime rhetoric, and shifts in political norms. After the Civil-Rights Movement, there was a change in rhetoric and policy, with extensive changes in the 1960s and 1980s (i.e. mandatory minimum sentences, changing police practices, and punitive laws) (Campbell, 2018; Flores, 2018). There was a shift in crime rhetoric, mainly from rehabilitation to punitive (Flores, 2018; Golash-Boza, 2017b; Western, 2006). Several politicians, such as Goldwater, Nixon, Clinton, and Regan, used get-tough rhetoric as political capital (Golash-Boza, 2017b; Western, 2006). For example, Barry Goldwater's, Richard Nixon's, and Ronald Regan's campaigns emphasized law and order (Alexander, 2020; Western, 2006). Furthermore, Lyndon B. Johnson put forth the Omnibus Crime Control and Safe Streets Act of 1968, which fostered anti-crime rhetoric due to political advantages. This act is attributed to the switch from seeing prisons as barbaric institutions and drugs as a public health problem to viewing prisons as a key controller of crime (Golash-Boza, 2017b). Politicians competed to see who was the toughest on crime, as they ascertained anti-

crime rhetoric could be the difference in winning elections (Alexander, 2020; Gottschalk, 2016; Murakawa, 2014, as cited in Golash-Boza, 2017b). This rhetoric had an influence on correctional departments across the United States.

By the 1970s, the purpose of correctional facilities shifted from rehabilitation to punishment, incapacitation, and deterrence (Flores, 2018; Western, 2006). Criminal justice policies became more punitive which resulted in higher incarceration rates (Beckett & Francis, 2020). The incarceration rate doubled between 1972-1984 and again between 1984-1994, with a five-fold increase from 1970-2000, due mostly to drugs (Golash-Boza, 2017b). Despite these increases, homicide rates decreased and the U.S. crime rate was lower than the international average (Alexander, 2020; Beckett & Francis, 2020).

In addition, the War on Crime shifted to a War on Drugs, leading to further prison construction and less budgetary focus on education and work programs (Western, 2006). The War on Drugs (1982) painted Blacks as “crackheads,” “drug dealers,” and violent, even though crack did not truly hit the streets until 1985 (Flores, 2018; Golash-Boza, 2017b). From 1993-2011, there were thirty million arrests for drug crimes because of punitive drug laws (Golash-Boza, 2017b). For example, in 1973, Governor Nelson Rockefeller of New York State passed the Rockefeller drug laws, some of the most punitive drug laws ever passed. These laws imposed severe sanctions for narcotic/drug possession, in addition to enacting new mandatory minimums for offenders with second felonies. They impacted thousands and did not significantly reduce crime (Farrell, 1973; Kohler-Hausmann, 2017, as cited in Williams, 2021). However, Ronald Reagan may have been one of the most influential politicians who led the way for the enactment of get-tough policies, particularly racialized ones. Aside from declaring a War on Drugs in 1982, he fostered “colorblind” rhetoric, aggressively focused on crime and welfare reduction, and

enacted "Reaganomics," which largely cut social programs, and gave significant funding to federal law enforcement agencies (Alexander, 2020; Golash-Boza, 2017b). However, the most consequential may have been his sentencing policies. By signing the Anti-Drug Abuse Acts of 1986 and 1988, mandatory minimums for drug offenses began, which led to a host of other determinate sentencing practices that expanded the carceral state (Golash-Boza, 2017b).

Other Presidents contributed to this get-tough sentiment through policy enactment. For example, Bill Clinton "ended" welfare, altered budget usage, and impacted housing (Alexander, 2020; Beckett & Francis, 2020). Further, Clinton endorsed a "three strikes and you're out" law, that cut funds for government programs (i.e. food stamps and public housing), as well as passed Temporary Assistance to Needy Families (TANF). TANF placed a lifetime ban on access to food stamps and welfare if having a drug felony, which includes possession of marijuana. These laws directly targeted racial minorities (Masci, 1994, as cited in Alexander, 2020). In response to requests for a more punitive approach to crime, Clinton also signed the Violent Crime and Law Enforcement Act of 1994 which allocated the following funds and increased the size of the carceral state: "$10.8 billion for state and local law enforcement; $2.6 billion for federal law enforcement; $9.7 billion for prison construction; and $7.1 billion for crime prevention" (Cullen et al., 2002; LAO, 1994, as cited in Rosenfeld, 2020, p. 2).

In addition to policy changes, practices within police departments, courts, and corrections adapted to new get-tough objectives. With a new focus on punishment, what is defined as crime, who is targeted, what is targeted, and how they are targeted has shifted. For example, police departments adopted broken windows policing. This method increased control and surveillance over specific neighborhoods which led to increased arrests for low-level offenders, and expanded the power of the police and courts (Beckett & Francis, 2020).

Further, practices within corrections shifted. In 1984, private prisons emerged through contracts with the government. Although struggling to fill their beds, they managed to increase federal lobbying funds from $410,000-$3,000,000 in 4 years (2000-2004) (Golash-Boza, 2017b). Privatizing services puts the burden of costs on prisoners and their families (i.e. phone calls and medical care). Even though private prisons only hold approximately 8% of prisoners today, they indicate what political ties and power can do to reform (Beckett & Francis, 2020; Wagner, 2015, as cited in Golash-Boza, 2017b). Despite the lack of prisoners filling beds, punitiveness was key. "Speculative prisons" were constructed with confidence there would be no problem filling beds with economic advances from political ties (Wood, 2007, as cited in Golash-Boza, 2017b). Increases in immigrant detention and Donald Trump's mass deportation campaign assisted with this (Golash-Boza, 2012, as cited in Golash-Boza, 2017b).

Restrictive immigration laws were also prevalent during this time. Felipe Hernandez (2019) states being tough-on-immigration starts with an assumption that immigrants are criminal aliens. He describes policy that impacts this belief. For example, the War on Drugs created a massive legal force (i.e. military, police, and prisons) to control undocumented immigrants. Additionally, Clinton's Illegal Immigration Reform and Immigrant Responsibility Act of 1996 helped expand mandatory detention policies for more crimes (i.e. drug crimes) (Migration Policy Institute, 1790-Present, as cited in Hernandez, 2019). As of 2020, 39,000 immigrants were detained due to being undocumented (U.S. Immigration and Customs Enforcement, 2020, as cited in Sawyer & Wagner, 2020).

Punishment may have been most clear behind bars through the increased usage of solitary confinement, often placing prisoners in cells for twenty-three hours a day. Inmates face restrictions on meals, access to physical exercise, and medical treatment/medications (Garcia et

al., 2016, as cited in Jahn et al., 2022). For example, a Pennsylvania study of 99 prisoners showcased the following: only 61% of prisoners seeking physical treatment and 28% seeking mental health treatment received care, 70% of prisoners felt their daily food was inadequate, and 40% of prisoners were upset with the time it took to receive medical attention/medications (Jahn et al., 2022). This practice is considered so punitive it is called "social death" for prisoners, in addition to being labeled a predictor of death (Friedman, 2021). It has been shown that prisoners from disadvantaged backgrounds (i.e. African Americans and Latinos) are more likely to face this form of confinement, which can lead to psychological damage (Williams et al., 2020). Prisoners are put at increased risk of PTSD and suicidal ideations (Kaba et al., 2014, as cited in Jahn et al., 2022). By June 2020, there were 300,000 individuals (i.e. detainees, inmates, and prisoners) within solitary confinement, an increase of 500% (Solitary Watch, 2020, as cited in Friedman, 2021). Annually, approximately 20% of prisoners experience solitary, with approximately 50% for a minimum of thirty days (Beck, 2015, as cited in Jahn et al., 2022).

**Mass Incarceration and Race**

The impact of the carceral state is racialized. Mass incarceration is experienced unequally among segments of society. Incarceration has become a key life outcome for minorities, especially within disadvantaged communities. African Americans and Hispanic/Latinos are disproportionately incarcerated relative to their White counterparts (Golash-Boza, 2017b; Western, 2006). Some contributing factors include: the War on Drugs, stereotypes/biases, stigma created from social movements from the 1950s-1990s, harsh sentencing, and political rhetoric (Flores, 2018). African Americans and Latinos are more likely than Whites to be arrested, charged, convicted, sentenced longer, and to face death, with Blacks being sentenced eight times the rate of Whites (Golash-Boza, 2017b; Western, 2006). By the end of 2015, 1.6% of White,

9.1% of Black, and 3.9% of Hispanic men aged 20-34 were within prisons or jails, up from a little over 3% of Hispanics and approximately 8% of Blacks in 2000 (Pettit & Gutierrez, 2018; Western, 2006). The carceral state is concentrated, creating vulnerability among populations. Scholars, such as Bruce Western (2006), argue that mass incarceration is more focused on incarcerating entire populations than punishing people for crimes. Specifically, these groups come from disadvantaged, minority communities (Talkingsticktv, 2012). Consequently, incarceration has become more common than joining the Military or earning a Bachelor's degree (Golash-Boza, 2017b; Talkingsticktv, 2012; Western, 2006).

It is often young, uneducated, and jobless people of color who are disproportionately incarcerated. By 2000, 5.5% of Hispanic men and 17% of African American men under age forty-one, with no college education, were in prison or jail (Western, 2006). If incarceration was eliminated, the Hispanic poverty rate would see a 3% reduction and Blacks a 14.5% reduction. If African Americans and Whites were locked up equally, over six million individuals would be behind bars today (Western, 2006).

Additionally, Simes (2021a), details how incarceration can be place-specific, where neighborhood disadvantage becomes an indicator of criminal justice contact. This is especially true for African Americans and Latinos within urban communities. In this way, disadvantage becomes concentrated, the terms “urban” and “crime” become linked, and a carceral continuum is created, where young, African American men are stuck in a cycle of imprisonment and marginalization. Simes (2021b) also describes how pervasive incarceration can cause whole communities harm and serve as an indicator of a community’s social well-being. Further, hypersegregation and the level of formal social control in a neighborhood, can lead to increased incarceration rates. Such disparities have impacts beyond an individual level.

Incarceration brings collateral consequences that extend beyond the walls of correctional facilities for offenders and their families/communities. These consequences include diminished earnings mobility, difficulty securing work, disenfranchisement, lower marriage rates, and increased divorce rates, lack of access to government assistance, and diminished social relations (Alexander, 2020; Jarecki, 2012; Talkingsticktv, 2012; Western, 2006). Post-release, access to housing, educational opportunities, food stamps, and other types of government assistance are decreased and/or eliminated for ex-convicts (Alexander, 2020). Collateral consequences are disproportionately felt by minorities from disadvantaged communities.

Scholar Bruce Western detailed how incarceration diminishes the economic status of individuals already faced with low-end wages and higher unemployment rates. He found their earnings mobility was only approximately 24.6% over a 20-year period. This disproportionately impacts African Americans due to their disparate incarceration rates, substantial declines in the unemployment rate of low-skilled Blacks when including incarcerated individuals, and the number of uneducated Blacks incarcerated (37%, under 35, with no highschool diploma) (Talkingsticktv, 2012). Similarly, Devah Pager (2007) conducted a study on securing work with a felony record with two key goals: to determine how much a felony record stigmatizes those released and to see if the stigma is racialized. A large finding was that a White felon had a better chance of receiving a callback for a job than a Black non-felon and 75% of those released from prison are unable to secure work within a year (as cited in Golash-Boza, 2017b).

Michelle Alexander refers to mass incarceration as the new Jim Crow. As Alexander (2020) states, “Today it is perfectly legal to discriminate against criminals in nearly all the ways that it was once legal to discriminate against African Americans” (p. 2). The War on Drugs greatly contributed, as poor communities with people of color have been viewed as the “enemy”

(Alexander, 2020). As a result, families and whole communities have suffered. Largely, minority children have suffered. By 2008, 600,000 Latino children and over one million Black children (11%) had incarcerated parents (Talkingsticktv, 2012). They face stigma, lack of a father figure, poverty, and are more likely to face mental health problems, creating long-term intergenerational effects (Golash-Boza, 2017b; Talkingsticktv, 2012). Tough-on-crime rhetoric paved the way for such consequences.

**Sentencing in the "Get-Tough" Era**

Along with the "get-tough" movement came harsher sentencing laws. Since 1975, there have been statutory sentences, mandatory minimums, truth in sentencing laws, life without parole (LWP), and more, contributing to lengthier sentences (Golash-Boza, 2017b; Tonry, 2019). Disproportionately, Blacks and Hispanics receive such sentences, along with the death penalty (Alexander, 2020; Meierhoefer, 1991, as cited in Reiman, 2007). Once again, the War on Drugs contributed. Specifically, there was a 100:1 sentencing ratio for crack to powder cocaine, causing approximately 93% of crack convictions to be African Americans and only 5% Whites (Alexander, 2020). Policy also played a role; the Anti-Drug Abuse Act of 1988 set a 5-year mandatory minimum just for possession of crack (Golash-Boza, 2017b). This determinate sentencing gives judges little choice (Tonry, 2019).

Harsh sentences, largely, resulted from the criminal justice system switching focus from rehabilitation to punishment and from indeterminate sentencing to determinate sentencing. While the prior gave judges judicial discretion to consider the offender's background and case-specific details, the latter took away such discretion and strives to merely punish offenders for their actions (Tonry, 2019). Now, criminals are viewed as static and non-redeemable.

Along with determinate sentencing came tougher policies, namely the 1984 Crime Control Act, which enacted the use of mandatory minimums and eliminated Federal parole (Golash-Boza, 2017b). These sentences have had little deterrent effect and tend to be disproportionately attached to crimes committed by minorities, particularly drug crimes (Golash-Boza, 2017b; Tonry, 2019). During the War on Drugs in the 1980s, discretionary power shifted, due largely to the fear judges would be "too soft" with sentencing (Golash-Boza, 2017b). This was coupled with policy. For example, the Anti-Drug Abuse Act of 1986 enacted a mandatory five-year sentence for the possession and/or sale of five grams of crack (used primarily by Blacks) or five-hundred grams of powder cocaine (used primarily by Whites). In 1988, this Act was revamped to include a five-year mandatory minimum just for possession of crack cocaine (Golash-Boza, 2017b). Blacks are 21% more likely to receive mandatory minimums and approximately 20% more likely to go to prison for drugs (Mauer, 2009, as cited in Golash-Boza, 2017b).

Two other notable policies were Clinton's Crime Bill of 1994 and the passage of the Federal Sentencing Guidelines Act. Clinton's mentality was to be toughest on crime, showcased in the 1994 bill. The bill, worth $30 billion, created new federal crimes, enacted life sentences for select offenders with three-strikes, and worked to expand state prisons and police forces (Masci, 1994, as cited in Alexander, 2020). Yet, the Federal Sentencing Guidelines Act of 1984 may have set some of the harshest penalties and was viewed as the most controversial and detested attempt at sentencing reform. Starting out as mandatory guidelines, they were shown to be "too severe, too complex, and too detailed" (Tonry, 2019, p. 10). The guidelines were a sign of change. After nearly eliminating probation for federal sanction, upsetting several sitting

judges, and their disparate racial impact, the Supreme court made the guidelines advisory (Tonry, 2019).

## Health Disparities

With the tough-on-crime environment, more and more individuals have been sentenced to correctional facilities, where they are more likely to face adverse health outcomes (Bui et al., 2019; Cox, 2018; Daza et al., 2020). Incarceration has become a primary social determinant of health, as well as a main contributor to both individual and population-level health disparities (Boen, 2020; Bui et al., 2019; Nowotny & Kuptsevych-Timmer, 2018). Correctional facilities are overcrowded, often provide only limited access to basic health services, and have been known for staff's inhumane practices (Nowotny & Kuptsevych-Timmer, 2018). In addition, these are often deprived and unsanitary environments with poor ventilation, tight and shared spaces, uncleaned facilities, nutritional deficiencies, and lack of adequate hygiene products. Further, these facilities often place restrictions on access to basic products such as hand sanitizer (Alexander et al., 2020).

Due to the previously stated carceral conditions, these environments are prone to increased physical and mental illnesses, infectious diseases, communicable diseases, primary and secondary stressors (chronic and acute), violent victimization (especially sexual), mortality, chronic illnesses, and fostering of unhealthy behaviors (Alexander et al., 2020; Daza et al., 2020; Nowotny & Kuptsevych-Timmer, 2018). These may include the following: the use of solitary confinement, self-harm caused by constant high-stress exposure, HCV (hepatitis C) exposure through drug injections, underground tattoos, or unprotected sex (anal), TB (tuberculosis), fights instigated by correctional staff, and social deprivation (Daza et al., 2020; Friedman, 2021; Nowotny & Kuptsevych-Timmer, 2018). These conditions can worsen with age.

Longer sentences have caused an influx of older prisoners. From 1993-2013, the state prison population aged 55+ saw a 400% increase and 48% of state prisoners released are in the 35+ age group (Cox, 2018). Boen (2020) found that incarceration over one year can increase physical ailments (i.e. inflammation). Additionally, Daza et al. (2020) found that by age 45, four-five years of life are lost, accounting for 13% of a U.S. male's life expectancy. Further, Patterson (2013) found that with each additional year an individual is incarcerated, life expectancy decreases by two years (16% of one's life) (as cited in Daza et al., 2020).

Despite incarcerated individuals being the only group constitutionally protected for access to health care, they still fare worse than the general population. One-third of prisoners and two-thirds of jail inmates have at least one disability (i.e. hearing, visual, and cognitive) (Bronson & Maruschak, 2015, as cited in Nowotny & Kuptsevych-Timmer, 2018). Additionally, state and federal prisoners are 1.5 times more likely to indicate they have had a chronic condition and approximately 50% have had one (i.e. asthma and diabetes) (Bui et al., 2019). Part of the reasoning for this was the get-tough measures enacted, which shifted the goals of different agencies. Although health services are available, the quantity and quality of such care varies by factors such as institution and gender housed within, as well as on how physicians deal with the balance between punitiveness and well-being (Allen et al., 2010, as cited in Nowotny & Kuptsevych-Timmer, 2018; Cox, 2018).

Carceral health disparities extend post-release. Ninety-five percent of prisoners are eventually released and return to disadvantaged neighborhoods with sparse labor opportunities and disruptive familial settings (Cox, 2018; Daza et al., 2020). With little to keep them going, these individuals still face health inequities including difficulty accessing medications, loss of Medicaid, limited health care access, and increased risk of mortality (3.5 times the rate of the

general population) (Binswanger, 2007, as cited in Daza et al., 2020; Cox, 2018; Kuper and Turanovic, 2021; Travis, 2005, as cited in Nowotny & Kuptsevych-Timmer, 2018). This struggle persists due to lack of assistance upon release. Most inmates are released with no follow-up appointments and are already less likely to have a primary care physician (Daza et al., 2020).

Additionally, inmates are likely to leave facilities either with a condition or an untreated condition. Even though over $12 billion is spent annually on correctional health care, there is still a need for federal funding to adequately access the overall health of inmates (Ahalt et al., 2015; Wagner & Rabuy, 2017, as cited in Bui et al., 2019). Further, due to “costs” of screening and treatment options, many individuals are left unevaluated for health concerns (Rich et al., 2014, as cited in Alexander et al., 2020). This is important not only because resources are distributed unequally, yet race plays a large factor in correctional/general health disparities. These health disparities go beyond incarceration to historical periods of time.

**Historical Context on Health Disparities and Race**

Historically, minorities have fared worse from health disparities, specifically African American men. Blacks have the lowest mortality rate, have a life expectancy seven years behind Whites, and are more likely to die prematurely (prior to age 65) from an extensive illness (i.e. diabetes, stroke, and cancer) (Golash-Boza, 2017a). Additionally, they are more likely to have the highest rates of cardiovascular heart disease, hypertension, and diabetes, which are prevalent within corrections (Bullard & Wright, 2012; Golash-Boza, 2017a). Some documented causes of this are racial discrimination, racism leading to poor health, racial biases of physicians, and neighborhood conditions (Bullard & Wright, 2012; Golash-Boza, 2017a). These disparities can be stark. For example, Golash-Boza (2017a) stated that in 2000, ⅓ of Black deaths in Chicago (a segregated city) were considered excess due to the extent of the Black-White mortality gap. This

meant that one out of three Black individuals passed away due to differences in their life expectancy relative to their White counterparts. Further, in 2002, there were 83,570 excess Black deaths (approximately 100,000 today) (Satcher, 2005, as cited in Golash-Boza, 2017a).

Racial inequality in housing and neighborhoods also plays a key role in the aforementioned disparities. African Americans and Latinos are more likely to reside in neighborhoods located near toxic waste facilities (Golash-Boza, 2017a). Hyde Park was a prime example, with polluted ditches, ecological resource contamination, lack of indoor plumbing, running water, or stoves to cook on, and racial discrimination. Residents in these neighborhoods were left with cancer and skin diseases, poverty (67.4% below the poverty line), and no say in the environmental laws and land use surrounding them (Checker, 2005). The Flint Water Crisis serves as another example. After the city switched water sources to the Flint River in 2014, without adding a corrosion control, health effects began to surface. The water was murky and had a bad taste and smell. However, complaints were ignored. Residents, mostly African Americans, began to experience rashes, hair loss, and lead poisoning (children) (Clark, 2018; Golash-Boza, 2017a). Economically, residents suffered too. They paid upwards of $140/month for water they were not using, while buying bottles. Around 80% of those working only made less than $40,000/year (Clark, 2018). These residents were poor and had little power to spark change.

In addition to clear signs of environmental residential impacts on minorities, there are "hidden" health effects as well. For example, African Americans and Latinos are more likely to reside in neighborhoods with a lack of fresh produce, parks, and nutritious foods. These groups are also more likely to live farther from supermarkets and closer to fast-food outlets and convenience stores, impacting access to healthy foods (Golash-Boza, 2017a). These

neighborhoods are less likely to have quality health resources. Bullard and Wright (2012) stated that racial and ethnic minorities are less likely to receive basic medical procedures and when they do, are more likely to receive low-quality health service. Additionally, they found that African Americans receive lower quality care than their White counterparts within the same facilities, that there are racial biases shown by physicians, and that they are less likely to receive or have access to cardiac medications, transplants, kidney dialysis, or treatment for diabetes, all which can be necessary for survival.

Due to the above racial health disparities, African Americans show greater distrust in physicians and overall health treatment. It was found that "44% of African Americans but only 33% of whites reported having low levels of trust in health-care providers" (as cited in Bullard & Wright, 2012, p. 184). Yet, some of the worst distrust may have come from unethical medical experimentation on this group. Growing up within the Jim Crow era, African Americans went through unbearable experimentation, such as intensive exposure to heat, the Tuskegee Syphilis experiment, and sterilization. In 1989, 10,000 human bones were found at the Medical College of Georgia. Despite African Americans making up less than 50% of the local population, 75% of the remains belonged to them (Golash-Boza, 2017a). The government also played a role. The U.S. Army had performed chemical and biological experiments that targeted African Americans, causing dengue fever and yellow fever within poor housing developments. Overall, due to historical health disparities, African Americans are less likely to receive their annual flu shots and to get vaccinated (Bullard & Wright, 2012). These disparities carry into corrections.

**Health Disparities, Incarceration, and Race**

Since minorities disproportionately face incarceration, relative to their White counterparts, they face adverse health outcomes to a greater extent. Specifically, African

American men tend to bear the brunt of these disparities. Mass incarceration plays a key role. As the African American imprisonment rate continues to rise, the White imprisonment rate has continued to decline (Cox, 2018). Additionally, Blacks are sentenced approximately 10% longer than Whites, putting them at greater risk of experiencing health effects (Rehavi & Star, 2012, as cited in Boen, 2020). Although some studies have shown that incarceration improves the health of African Americans, such as taking advantage of health care and protection in prisons, they have the highest mortality rates and lowest life expectancy in the U.S. (Cox, 2018; Cunningham et al., 2017; Gilbert et al., 2016; Patterson, 2013; Nowotny, 2016; Spaulding et al., 2011, as cited in Nowotny & Kuptsevych-Timmer, 2018).

African Americans are more likely to experience the following: increased C-Reactive Protein (CRP; i.e. caused by stress and inflammation), depressive symptoms, non-communicable diseases (i.e. cardiovascular, cancer, and diabetes), discrimination and structural barriers, and solitary confinement (also long-term) (Arrigo & Bullock, 2008; Haney & Lynch, 1997, as cited in Nowotny & Kuptsevych-Timmer, 2018; Boen, 2020; Cox, 2018; Everett et al., 2014; Steptoe et al., 2007, as cited in Boen, 2020). In Boen et al.'s (2020) study, they found that Blacks not only face more depressive symptoms, yet the average depressive score for Whites would increase by 1.01 symptoms if they had similar carceral histories. It is likely this develops from the conditions they face. For example, Blacks are shown to face harsher treatments, including discrimination/stereotypes, segregated housing, and lack of access to beneficial programs. Additionally, they are more likely to face written misconduct reports and biases when evaluated for restricted and/or segregated housing (Alexander, 2010; Andrews et al., 1990; Cochran et al., 2016; Olson, 2016; Potter, 2010; Ramirez, 1983; Schnittker et al., 2011, as cited in Kuper & Turanovic, 2021).

Correctional facilities have become hot spots for contracting/possessing illnesses, victimization, and exposure to stress (Boen, 2020; Daza et al., 2020; Nowotny & Kuptsevych-Timmer, 2018). For example, African Americans are seven times more likely than non-Hispanic Whites to succumb to HIV, which is more prevalent in correctional facilities than the general population (Hu et al., 2016; Maruschak et al., 2015, as cited in Bui et al., 2019). Minorities are also more likely to be discriminated against and victimized within corrections. African Americans and Hispanics, possessing a mental disorder, are at an increased risk for sexual victimization, which can lead to a variety of social, mental, psychological, and physical consequences (Dumond, 2000; Wolff et al., 2007, as cited in Nowotny & Kuptsevych-Timmer, 2018).

Additional stress comes from impacts on the families of those incarcerated. For example, African Americans are more likely to be sentenced farther from home, placing an economic and emotional toll on families looking to visit (Cochran et al., 2016, as cited in Kuper & Turanovic, 2021). As of 2006, 44% of African American women had a family member incarcerated, compared to 12% of White women (McCormick et al., 2015, as cited in Bui et al., 2019). Just to remain in contact with the incarcerated family member, Black women spent $298/month in 1998 (equal to $440/month today), which was 9-26% of their overall incomes (Grinstead et al., 2001, as cited in Cox, 2018). Further, the children of those incarcerated are 26% more likely to have unmet medical needs and 60% more likely to have mental health care needs left untreated (Turney, 2017, as cited in Nowotny & Kuptsevych-Timmer, 2018). In addition, children may face homelessness, financial instability, academic issues, and behavioral conditions (Anne E. Casey Foundation, 2016, as cited in Bui et al., 2019). Mentally, these families go through a lot, sending whole communities into shame and deep silence (Alexander, 2020).

Research indicates that quality of care may vary based on an officer's viewpoints of gender, racial, or cultural differences of inmates (Shavers & Shavers, 2006, as cited in Kuper & Turanovic, 2021). For example, Whites have been more likely to receive desirable cell blocks and better carceral job opportunities that help mitigate stress and health effects, while Blacks are often placed in solitary confinement with limited access to care, a conducive environment for increased stress, and risk of mortality (Adams, 1992; McDonald & Weisburg, 1992; Olson, 2016; Wildeman & Anderson, 2020, as cited in Kuper & Turanovic, 2021). Some of the greatest racial health disparities become prevalent upon release. A large proportion of inmates come from vulnerable, disadvantaged and impoverished neighborhoods, and already have higher rates of chronic illness and communicable diseases (Cox, 2018).

Blacks face some of the worse health consequences upon release, yet are less likely to report poor health and are less likely to receive needed medical care after their first incarceration experience (Kuper & Turanovic, 2021). In part, this is because they return to what are deemed "medically underserved places" (Obosogie et al., 2017, as cited in Kuper & Turanovic, 2021). Upon returning to impoverished neighborhoods, accessing resources becomes difficult (i.e. medical support and healthcare) (Cole et al., 2019; Weller et al., 2020, as cited in Kuper & Turanovic, 2021). Blacks are more likely to face medical/trauma deserts, decreased health insurance, and inadequate quality of care (Gay et al., 2020).

Aside from the above conditions and barriers, there are collateral consequences for these men post-incarceration. These include decreased marriage rates, stigma, and the depreciation of economic health (i.e. decreased potential for earnings, disrupted economic stability, unsteady employment, and disparate hiring practices) (Cox, 2018; Kuper & Turanovic, 2021; Western, 2006). Scholar Devah Pager (2007) performed a study on the stigma of a record and found that a

White felon has a better chance of receiving a callback for a job than a Black nonfelon (as cited in Golash-Boza, 2017b). Even post-incarceration, the punitiveness within still follows on the outside. COVID-19 has exacerbated such disparities (Western 2018).

**Covid-19 Pandemic**

COVID-19 is a short-term virus that was first discovered in Wuhan, China in November-December 2019 and in the U.S. by January 2020 (Alexander et al., 2020; CDC, 2020a, as cited in Farr, 2021; Gay et al., 2020). By December 2020 there were over 15 million cases and approximately 300,000 documented deaths within the U.S. alone (Halcombe & Andone, 2020, as cited in Farr, 2021). The virus eventually spread to the United States. The United States became an epicenter of COVID-19 with large case numbers and deaths (Abraham et al., 2020; Barsky et al., 2021; Bradshaw, 2021). All 50 states had confirmed cases by March 2020 (Renken & Wood, 2020, as cited in Alexander et al., 2020).

According to the World Health Organization (2020), approximately 80% of individuals infected can recover, while ⅙ of those infected will experience severe health problems or death (as cited in Alexander et al., 2020). Despite these statistics, many have succumbed to the virus. The death toll in the U.S. is so high, with 606,618 deaths as of July 19th, 2021, it may surpass the number of American deaths in the Korean, Iraq, Afghanistan, and Vietnam wars combined (Abutaleb et al., 2020, as cited in Abraham et al., 2020; CDC, 2021d). Those identified most at risk of contracting the virus include immunocompromised individuals, individuals with chronic health maladies (i.e. diabetes and respiratory disease), and those of older age (over 60) (Alexander et al., 2020). Government agencies had to act fast.

In response to the pandemic, the World Health Organization and CDC recommended several precautions including social distancing (6ft apart), mask wearing, and increased hygiene

maintenance. Social institutions were directly impacted as schools, entertainment venues, restaurants, and more had to shut down (Abraham et al., 2020; Alexander et al., 2020). The government issued guidelines and recommendations to states, put forth initiatives, decreased social gatherings and travel, and increased the availability of personal protective equipment (PPE). However, many of their strategies proved ineffective, as the U.S. continued to have the highest case numbers, new cases, and deaths overall (Bendix & Gould, 2020, as cited in Farr, 2021). While holding only 4% of the world's population, the U.S. contains ¼ of COVID-19 cases and deaths (John Hopkins University, 2020; The Atlantic, 2020, as cited in Lemasters et al., 2020). Today, Numbers have begun to decrease, as more individuals receive the COVID-19 vaccine. However, despite 67.1% of U.S. adults having at least their first dose of the vaccine as of July 6th, 2021, there are still seven-day increases in new cases and deaths with an overall case total of 33,530,880 since the start of the pandemic (CDC, 2021d). The picture in correctional facilities is more pronounced.

**COVID-19 within Correctional Facilities**

By March 15, 2020, the first employee within a Pennsylvannia correctional facility tested positive for COVID-19, while by April 7th, 2020, the first prisoner died at Rikers Island and five federal inmates were deceased at a Louisiana federal facility (Alexander et al., 2020). Today, there have been over 620,000 cases within the correctional system, with carceral facilities being described as epidemiologic pumps (Barsky et al., 2021). The following are the current statistics, as of July 6th, 2021, on the facilities impacted, total case numbers, and total deaths in both U.S. correctional facilities and detention centers. Overall, there have been 1,470 affected facilities. Out of these facilities, there are 523,962 documented cases. These include 421,706 resident cases and 102,256 staff cases. Further, there have been 2,772 documented deaths. These include 2,607

resident deaths and 165 staff deaths (CDC, 2021b). As these facilities were unprepared for a profound health crisis, prisoners, staff, and their communities have suffered (Abraham et al., 2020).

Incarcerated individuals are 5.5 times more likely to be afflicted with the SARS-CoV-2 virus and are three times more likely to die from the ailment than the general population (Wang et al., 2020, as cited in Barsky et al., 2021). There are several causes for this increased risk, largely attributable to the design and operation of correctional facilities themselves. For example, these facilities are overcrowded making it nearly impossible to socially distance, have inadequate general hygiene uptake and sanitation procedures, and suffer from poor air circulation. Additionally, prisoners have shared lavatories, confined quarters, lack access to basic hygiene products, and are more likely to be in poorer health and suffer from low-quality healthcare access (Abraham et al., 2020; Farmer, 2002; Wildeman & Muller, 2012, as cited in Alexander et al., 2020; Farr, 2021; Wallace et al., 2020, as cited in Bradshaw, 2021).

Overcrowding has played a large role in exacerbating the spread of COVID-19. For instance, it has been shown that the spatial density of cells increases the spread of infectious diseases (Simpson et al., 2019, as cited in Abraham et al., 2020). Additionally, some facilities constructed many years ago utilize pole barns, where eight men are confined to a 10ft by 12ft space and 160 inmates share two bathrooms and three showers. This makes it easier for COVID-19 to spread (Bradshaw, 2021). Practices within correctional facilities also contribute. These include the following: the continuous movement of prisoners and staff, allowing asymptomatic staff with a positive test result to work (Arizona), pat-downs of inmates with no gloves and/or contaminated ones, few medical resources, prisoner intake, and the transport of inmates despite delayed testing, COVID-19 exposure, or a positive test result (Abrams et al. vs. Chapman et al.

2020; Wallace et al., 2020, as cited in Bradshaw, 2021; Alexander et al., 2020; Gill, 2020, as cited in Abraham et al., 2020). Staff also were under pressure. They had minimal options for sick leave, facilities were understaffed, and PPE was limited (Alexander et al., 2020).

Testing has played a large role in defining COVID-19's impact on carceral facilities. Despite the lack of testing, overall, it has revealed stark disparities today. Namely, when testing, there have been large lab mix-ups and the wrong test results have been reported (Bradshaw, 2021). In particular, Michigan correctional facilities have been investigated in this regard. The Michigan Department of Corrections (MDOC) has been criticized for crucial mistakes that left the virus undetected within facilities for long durations of time, despite being the first state to mass test. For instance, after conducting mass testing of prisoners in Macomb, the department incorrectly diagnosed fifty-four prisoners as negative when positive and fifty-four prisoners who were positive as negative. This left untreated prisoners housed with "healthy" prisoners (Jackson, 2020b, as cited in Bradshaw, 2021). In April 2020, one of MDOC's facilities (Parnall) was listed as a national hotspot for the virus, when 10% of their prisoners and 21% of their staff tested positive. Parnall also had a 92% positivity rate with optional antibody testing (Jackson & Tanner, 2020a, as cited in Bradshaw, 2021). By May 2020, Michigan topped the charts for the highest death rate and third-largest positive case rate among prisoners, with totals higher than the federal carceral population (Jackson & Tanner, 2020c, as cited in Bradshaw, 2021).

The obstacles U.S. correctional facilities currently face with COVID-19 were foreseen long before the virus's existence. The pandemic has exacerbated decades of injustices within the U.S. correctional system such as health disparities, racial disparities, and the vulnerabilities prisoners face. This resulted from the aforementioned draconian policies during the get-tough era (i.e. punitive sentencing) that led to mass incarceration (Abraham et al., 2020; Bradshaw, 2021).

For perspective, over half a million COVID-19 cases within the summer of 2020 have been attributed to mass incarceration (13% of all cases) (Hooks & Sawyer, 2020). It has been stated that pre-COVID-19, health officials already foresaw the dangers associated with corrections (i.e. spread of communicable diseases) (Widra, 2020). Some individuals refer to jails and prisons as "petri dishes" for their lack of cleanliness (Williams et al., 2020, as cited in Abraham et al., 2020). A study conducted by Lemasters et al. (2020) showed that, out of fifty-three prison systems, thirty-four had a COVID-19 rate higher than the general population.

Not only does the Vera Institute of Justice (2021a) recognize that carceral populations would be safer from COVID-19 outside of jails, yet they also found that the U.S. would need to reduce their jail and prison populations by 85% to meet international averages, speaking to the impact mass incarceration has had on perpetuating the virus. Yet, existing health disparities also came to be exacerbated in corrections. With the current "gray wave," or aging of prisoners, the number of prisoners already impacted by chronic illnesses, the "torture" within prisons, and lack of access to public health insurance, prisoners who are already at a medical disadvantage fare worse with COVID-19 (Abraham et al., 2020; Bradshaw, 2021; Eisen, 2015; Roth, 2010; Urahn et al., 2017; AAFP, 2019, as cited in Farr, 2021). For example, solitary confinement has been used as a method of social distancing, perpetuating negative consequences (i.e. physical or psychological) (Andersen et al., 2000; Bonner, 2006; Kupers, 2008, as cited in Alexander et al., 2020).

Further, policies put forth to combat COVID-19 in corrections have resulted in several system failures. For example, the halt of in-person visitation opportunities and the decreased availability of carceral programming (i.e. educational and social), have caused prisoner suffrage (Alexander et al., 2020). Despite the federal government putting forth contradictory information

on what should be done to stop the spread of COVID-19 in corrections, decarceration has been called for. Specifically, compassionate release has been most explored (Abraham et al., 2020; Alexander et al., 2020). Two acts give the power to do so: the Cares Acts gave additional authority to release high-risk inmates to home confinement, while the Sentencing Reform Act of 1984 established the ability for compassionate release under "extraordinary and compelling circumstances" (U.S. Congress, 2020, as cited in Abraham et al., 2020; Wylie et al., 2018, as cited in Alexander et al., 2020, p. 651).

Although almost all fifty states have implemented some form of compassionate release, few incarcerated individuals have been released (Mitchell & Williams, 2017, as cited in Alexander et al., 2020). In a study performed by Wylie et al. (2018), they found that approximately ⅔ of jurisdictions allow for the release of inmates with a chronic or untreatable illness and approximately 50% allow the release of inmates facing mental illness or old age (as cited in Alexander et al., 2020). Overall, in terms of COVID-19, it has been most important to consider whether the inmates would fare better medically with a mitigated sentence (Berry, 2009, as cited in Alexander et al., 2020). Efforts have been mixed.

Decarceration data from the Vera Institute of Justice provides insight into the extent to which a variety of correctional facilities worked to either directly or indirectly reduce their carceral populations. Direct reductions refer to reducing the number of inmates through release, while indirect reductions can result from changes in criminal justice operations, such as jail admissions, arrests, transfers, and law enforcement (Vera Institute of Justice, 2021a). To evaluate efforts made, an evolving table on jail decarceration within U.S. counties can be viewed on the Vera Institute website. Specifically, one can look at percentage changes (whether positive or negative) of jail populations since February 2020. After adding up how many facilities noted a

100% reduction, a reduction over 50%, an increase over 50%, any increase at all, or no change, the following conclusion can be made: as of July 6th, 2021, approximately 13 facilities have noted a 100% reduction, approximately 12 facilities have noted a decrease over 50%, approximately 7 facilities have increased their capacity over 50%, approximately 104 facilities have had some increase in their capacity, and approximately 6 facilities have had no change (Vera Institute of Justice, 2021b).

One policy, aside from decarceration, is vaccination. However, prisoners and staff have been given little to no education on the vaccine and its benefits/downfalls and the CDC has unethically omitted carceral populations in plans for vaccine distributions, making large-scale decarceration even more fundamental. Only approximately 40% of incarcerated individuals indicated they would be willing to get vaccinated as a result (Barsky et al., 2021). Further, even if the vaccine had an efficacy rate as high as 90%, with the current state of corrections (i.e. overcrowded, high traffic, limited PPE, and testing inadequacies), COVID-19 risk is high, with the SARS-CoV-2 reproduction rate of jails at 8.44 (highest) (Puglisi et al., 2021, as cited in Barsky et al., 2021). As of May 2021, only approximately 55% of the carceral population have been vaccinated, overall, while under 50% in seventeen prison systems. For correctional staff, 48% has been the median (Herring & Widra, 2021). COVID-19 is not experienced equally among incarcerated individuals.

**COVID-19, Corrections, and Race**

COVID-19 has disproportionately impacted African American, Latino, and Indigenous carceral populations in rate of infections and mortality (Ostler, 2020; Yancy, 2020, as cited in Farr, 2021). In New York State alone, 75% of prisoners who succumbed to the virus were African American or Latinx (Friedman, 2021). Additionally, ICE (2020) found that a little over

1/10 of U.S. detained migrants test positive (as cited in Farr, 2021). However, the virus has proven to be profound within African American populations. Despite there being a lack of state-reported data on the relationship between COVID-19 and race, Michigan has reported statistics. The following information was reported: there is a racialized pandemic disproportionately impacting African American and elderly carceral populations, approximately 53% of those infected and approximately 50% of mortalities are people of color (primarily Blacks), and 48% of prisoner mortalities are African Americans, compared to 40% of those who succumb to the virus in Michigan overall. Additionally, African American prisoners make-up 49% of positive COVID-19 tests, compared to 31% of African Americans in general (Chammah & Meagher, 2020, as cited in Bradshaw, 2021).

There are several outlined causes of the aforementioned disparities including the following: the exacerbation of historical systemic disparities, poverty levels, unequal access to healthcare, disparate incarceration rates, and mass incarceration (Abraham et al., 2020; Barsky et al., 2021; Friedman, 2021). Additionally, African Americans, Latinos, and Indigenous carceral populations are more likely to experience chronic and infectious diseases including hypertension, hepatitis C, TB, and asthma, impacting their risk of contracting COVID-19 (Binswager et al., 2012; Borysova et al., 2012, as cited in Farr, 2021). Pre-incarceration incomes are lowest for these three populations, making it difficult to secure medical care inside and outside of corrections. Furthermore, due to punitiveness and harsh sentences, these populations are aging quicker, increasing their risk for COVID-19 (Abraham et al., 2020; Binswager et al., 2012; Borysova et al., 2012; Hawks et al., 2020; Rabuy & Kopf, 2015, as cited in Farr, 2021).

It is important to note, as Beaman (2020) does, “communities marginalized during the COVID-19-related quarantine are those marginalized *before* COVID-19” (p. 517). The pandemic

has only come to exacerbate this suffrage. The CDC (2020) identifies, "health care access and utilization, occupation, housing, and education, income and wealth gaps as contributing factors to increased risk of infection and mortality for racial and ethnic minorities" (as cited in Bradshaw, 2021, p. 38). From 2010-2018, Blacks were 1.5 times and Hispanics 2.5 times as likely to be uninsured than their White counterparts. Additionally, these communities already face lower wages and salaries, leaving them with little chance to seek medical resources (Economic Policy Institute, 2020; Kaiser Family Foundation, 2020, as cited in Gay et al., 2020).

Furthermore, minority prisoners' communities have suffered from COVID-19 due to historical disadvantages and the set-up of corrections. For example, the virus has spread to more segregated African American neighborhoods, where prisoners are more likely to return to (Gay et al., 2020). One way this spread occurs is through correctional workers themselves. With daily movement in and out of facilities, coming into regular contact with infected inmates and staff, correctional workers have brought the virus to their home communities. These communities are more likely to be predominately made up of racial and ethnic minorities, similar to the neighborhoods prisoners return to and would return to with compassionate release (Ransom, 2020, as cited in Friedman, 2021).

Ultimately, COVID-19 has made it more pertinent for those in power to consider reducing carceral populations. It has been shown that the way prison order works, or the way of life in prison, can impact whether people of color live or die during this public health crisis (Friedman, 2021). Friedman (2021) also speaks on how prisons are used more for structural punishment today, which has played a role in authority figures choosing not to issue guidance on mass releases of carceral populations. For these figures, and the correctional facilities themselves, it is an economic advantage to keep these individuals incapacitated. In order to spark

necessary change during the ongoing COVID-19 crisis and decades of injustices within the U.S. criminal justice system, policymakers need to act.

## Implications and Recommendations

The current review was written with three key objectives/impacts in mind. First, investigating the breadth of mass incarceration with a focus on the concentration of racial minorities in correctional facilities. Second, evaluate the role mass incarceration plays in perpetuating carceral health disparities (with a racial focus). Third, examining mass incarceration's role in exacerbating the ongoing COVID-19 pandemic within correctional facilities. By synthesizing several literatures, this review brings awareness to the web of intertwined issues facing the U.S. criminal justice system. I specifically focused on systemic disparities that have disadvantaged entire segments of the population (Alexander, 2020; Talkingsticktv, 2012; Western, 2006). The analyses in this review show that the phenomenon of mass incarceration and associated ills (i.e. health disparities and the spread of COVID-19) are prevalent and intertwined today. Without attention from both criminal justice personnel and policymakers, consequences will continue to arise and remain stagnant. Additionally, communities of color and whole families will continue to face higher COVID-19 infections and deaths, deep shame and silence, economic instability, adverse health risks and inadequate unequal healthcare, and the disruption of familial and social relationships (Alexander, 2020; Bui et al., 2019; Cochran et al., 2016; Leitch et al., 2020, as cited in Kuper & Turanovic, 2021).

In addition to covering the three impacts of the review, this section will cover three key foreseeable implications/outcomes and three recommendations to mitigate the magnitude of mass incarceration, associated health disparities, and COVID-19. The three implications that will be discussed include the following: continuous increases in the minority imprisonment rate in

comparison to Whites will cause communities of color suffrage, if mass incarceration and associated health disparities are not mitigated, minorities will continue to succumb to diseases at faster rates, human rights will be violated, and staff and whole communities will suffer, and without increased compassionate release efforts, thousands of additional COVID-19 cases will appear. The three key recommendations that will be discussed include re-evaluating get-tough policies, smart decarceration, and revamping current COVID-19 strategies and compassionate release efforts.

## Impacts

### *Impact 1: Mass Incarceration, Health Disparities, and Race*

Mass incarceration has disproportionately impacted racial minorities in terms of imprisonment rates, carceral health disparities, and COVID-19. Mass incarceration is an ineffective four-decade-old “policy” that has led to overcrowding, victimization, the contraction of illnesses, and physical and psychological pain within U.S. correctional facilities. This “policy” has disproportionately impacted racial minorities (Boen, 2020; Daza et al., 2020; Epperson et al., 2021; Golash-Boza, 2017b; Nowotny & Kuptsevych-Timmer, 2018; Western, 2006). Bruce Western indicated that incarceration is no longer centered around incapacitating and punishing one individual, yet locking up whole communities. These communities are primarily made up of racial and ethnic minorities (Talkingsticktv, 2012). African Americans, Latinos, and Indigenous populations are most at risk of experiencing incarceration and carceral health disparities, causing both the offender and their families/communities suffrage (Binswager et al., 2012; Borysova et al., 2012 ;Ostler, 2020; Yancy, 2020, as cited in Farr, 2021; Golash-Boza, 2017b; Western, 2006). Specifically, there is a need to address the social determinants of health to aid these

communities both inside and outside of corrections (Bui et al., 2019; Nowotny & Kuptsevych-Timmer, 2018).

Largely, the review indicates the aforementioned systemic disparities began historically with get-tough policies, including disparate sentences handed out for crack and powder cocaine and the implementation of determinate sentences (i.e. mandatory minimums and three-strikes laws) that limited judicial discretion (Alexander, 2020; Golash-Boza, 2017b; Masci, 1994, as cited in Alexander, 2020; Tonry, 2019). It is important to draw attention to these penal changes, as it is conflict caused by competing power groups in society that spark such change, which has idealized the backbone of White supremacy (Campbell, 2018; Farr, 2021). In order to begin advocating for penal change that will address the unbearable conditions within carceral facilities, pressing health concerns, and the ongoing death toll from COVID-19, focus will need to be placed on the systemic nature of these policies and disparities (Epperson et al., 2021).

Importantly, the disparate rate of overall cases and deaths of the SARS-CoV-2 virus among minority prisoners is stark and requires immediate attention. There is an urgent call to address this racial disparity, as actions both within correctional facilities and general society can dictate whether the incarcerated live or die (Friedman, 2021). Since the general population and/or "free society" is deemed more important than the incarcerated, it is known the non-Hispanic Black death rate is currently five times the rate of non-Hispanic White individuals, versus the nature of this disparity in corrections (CDC, 2020b, as cited in Friedman, 2021). Additionally, despite limited efforts to release vulnerable individuals, several jurisdictions have focused more on releasing White offenders, despite correctional facilities' high proportion of minorities (Friedman, 2021). For example, in Illinois alone, out of the 3,400 individuals released between March 1st, 2020-June 4th, 2020, 46% of Blacks were released (while making up 54% of

the carceral population). However, 43% of Whites were released, while only making up 32% of their carceral population (Rivera, 2020, as cited in Friedman, 2021).

*Impact 2: Mass Incarceration and Health Disparities*

Mass incarceration has contributed to the exacerbation of health disparities within corrections for minorities and all other incarcerated individuals. Overcrowding, lack of medical supplies, limitations on hygiene products permitted, poor air circulation, tight spaces, and more have been perpetuated by mass incarceration and have led to such conditions (Alexander et al., 2020; Nowotny & Kuptsevych-Timmer, 2018; Wallace et al., 2020, as cited in Bradshaw, 2021). With the extent of the health conditions within these facilities (i.e. HIV, diabetes, and heart disease), there is a need for action (Hu et al., 2016; Maruschak et al., 2015, as cited in Bui et al., 2019). There needs to be a collaborative effort to gain more data on the link between incarceration and health, which have been shown to be intimately connected (Bui et al., 2019; Nowotny & Kuptsevych-Timmer, 2018). Bui et al. (2019) have called for this collaborative effort between the US Department of Health and Human Services (HHS), the US Department of Justice, public health officials, and the entire criminal justice system itself. Then, more "innovative and effective" policies, in addition to new programs, can be enacted and aimed at aiding the well-being of justice-involved individuals, increasing overall societal safety, and minimizing collateral consequences post-release.

There has been a lack of advocating for incapacitated individuals (Bradshaw, 2021). Despite being constitutionally protected in terms of medical needs, prisoners fare much worse from physical and mental ailments than the general population and, once released, return to their communities with illnesses and little support for treatment and survival (Daza et al., 2020; Nowotny & Kuptsevych-Timmer, 2018). Additionally, these disparities are taking a large toll on

minorities (largely African Americans). This is not due to these individuals possessing a higher susceptibility to medical conditions, yet to carceral conditions (i.e. overcrowding, lack of medical resources, and lack of support), misconduct and human rights violations by criminal justice personnel, racism, increased victimization rates, disparate incarceration rates, inequitable medical treatment, and an overall lower life expectancy than their White counterparts (Bullard and Wright 2012; Daza et al., 2020; Golash-Boza, 2017a; Nowotny & Kuptsevych-Timmer, 2018; Wallace et al., 2020, as cited in Bradshaw, 2021). With little aid in corrections and limited assistance post-release, individuals are set up for failure and are at increased risk for immediate or prolonged death (Binswanger, 2007, as cited in Daza et al., 2020). Swift action is required.

*Impact 3: Mass Incarceration and COVID-19*

Mass incarceration has significantly contributed to the exacerbation of COVID-19 in carceral facilities (Farr, 2021). For instance, a major setback of preventing the SARS-CoV-2 virus in these facilities is the magnitude of these systems, larger than any other country (Farr, 2021; Sawyer & Wagner, 2020). Once again, the conditions brought by mass incarceration (i.e. poor air quality and tight cell blocks) have led to facilities being called epidemiologic pumps for the virus, while practices within these facilities have also contributed (i.e. transfer of positive prisoners, new admissions, and isolation of COVID-19 prisoners with negative prisoners) (Alexander et al., 2020; Barsky et al., 2021; Jackson, 2020b; Wallace et al., 2020, as cited in Bradshaw, 2021). Further, the death rate continues to rise for prisoners and staff (CDC, 2021b). Despite the extent of outbreaks, there have been limited efforts to follow compassionate release guidelines and strategies from the CDC, mainly due to a focus on being an “arbiter of punishment” and lack of available resources (Mitchell & Williams, 2017, as cited in Alexander et al., 2020; Friedman, 2021).

There has been a lack of effort in releasing vulnerable populations and evaluating whom can be released (i.e. Whites, minorities, and violent offenders), which has allowed COVID-19 to spread within facilities and to staff and prisoners' home communities (Ransom, 2020, as cited in Friedman, 2021; Widra & Hayre, 2020, as cited in Bradshaw, 2021). Minorities (African American men in particular) are experiencing higher rates of the virus in corrections yet are released less than their White counterparts (Friedman, 2021; Ostler, 2020; Yancy, 2020, as cited in Farr, 2021). Although there needs to be more data provided on the relationship between race and COVID-19, immediate efforts are warranted, such as educating and prioritizing inmates on/for the vaccine (Barsky et al., 2021; Chammah & Meagher, 2020, as cited in Bradshaw, 2021). This is not just an instance of punitiveness or advocating, yet life or death.

Lastly, it is imperative to note that the unsafe conditions correctional facilities have created also impact the personnel working within these institutions. These environments are unsafe for everyone exposed, as communicable diseases, victimization, stress, confined spaces, and lack of cleanliness do not discriminate (Alexander et al., 2020; Daza et al., 2020; Nowotny & Kuptsevych-Timmer, 2018). The staff who run programs, work directly with prisoners, transfer inmates, and more are just as at risk. This risk is prevalent with COVID-19. This review can show that staff need to be offered sick leave when exposed or testing positive for COVID-19, need adequate PPE, need to be educated, encouraged, and prioritized in vaccination efforts, and paid leave should be an option when contracting an illness out of their control (Alexander et al., 2020; Barsky et al., 2021). Additionally, research shows that staff are bringing the virus home to their families and communities, which are largely made up of racial and ethnic minorities, reiterating that communities of color are facing suffrage and now is the time to help

them (Ransom, 2020, as cited in Friedman, 2021). On a final note, society favors punishing those who offend. However, would society view it as favorable to punish those who are the punishers?

**Implications**

It is important to evaluate what would happen if advocates and policymakers did not work to mitigate the aforementioned ills associated with mass incarceration and the status quo was maintained. Three key observations can be made. Firstly, if minority incarceration rates continue to rise while their White counterparts decline, both themselves and their communities will suffer (Cox, 2018). Their education levels will decrease, their incomes and representation in the job market will decline, prison will continue to be a common life outcome versus retrieving a Bachelors' degree, more children will have fathers behind bars, marriage rates for these populations will decrease, and African Americans, Latinos, and Indigenous populations will suffer (Golash-Boza, 2017b; Jarecki, 2012; Ostler, 2020; Yancy, 2020, as cited in Farr, 2021; Talkingsticktv, 2012; Western, 2006).

Second, if the magnitude of mass incarceration remains the same and health disparities do not dissipate, carceral deaths will increase, minorities will continue to contract illnesses and succumb to them at higher rates than their White counterparts, staff will suffer, human rights will be violated, and families/communities will suffer (Alexander, 2010; Schnittker et al., 2011, as cited in Kuper & Turanovic, 2021; Alexander, 2020; Alexander et al., 2020; Bradshaw, 2021; Ransom, 2020, as cited in Friedman, 2021). For instance, incarceration has already been associated with a decrease in one's life expectancy (4-5 years lost by age 45) and increased risks of self-harm from carceral conditions (Daza et al., 2020). Communities of color within and outside of corrections face economic disadvantage and medical vulnerabilities (i.e. medical deserts, inadequate healthcare, and biased physicians) (Bullard and Wright, 2012; Cox, 2018;

Gay et al., 2020). Additionally, inmates are often left with no medication or follow-up appointments, while facing a mortality risk 2.41-2.69 times higher than non-incarcerated citizens (Daza et al., 2020). If these health disparities do not subside, adverse health outcomes will continue to spread to home communities (primarily of color). Research has shown that carceral medical staff need improvement and there are alternative ways to offer medical treatment (i.e. telehealth) (Institute of Medicine, 2003; Solomon et al., 2014, as cited in Kuper and Turanovic, 2021). It is also important to note that correctional staff and their communities are at risk of facing disease, stress, and vulnerabilities (Abraham et al., 2020).

The third and final key observation pertains to compassionate release. If compassionate release and/or decarceration efforts do not pick up, over 100,000 additional COVID-19 deaths could result, which would disproportionately impact minorities (American Civil Liberties Union, 2020, as cited in Bradshaw, 2021). Additionally, if the speed at which decarceration occurs does not increase over time, it has been shown that the State and Federal governments will need until the year 2093 just to reduce their carceral populations by 50% (Ghandnoosh, 2018, as cited in Farr, 2021). This is a large problem, as the issues presented call for immediate action to prevent inhumane conditions with the potential for death. Lastly, there are still 99% of federal prisoners, 95% of state prisoners, 70% of individuals in jails, and roughly 100% of detained migrants who have not been assisted in COVID-19 release efforts (Farr, 2021). Although the length of time COVID-19 will continue to be a large issue is unforeseen at this time, efforts are necessary to alleviate cases and deaths.

Overall, this review has important implications for correctional facilities and those incapacitated, yet has the most potential to aid in advocating for and supporting communities of color, with the inclusion of staff. By taking into consideration the research discussed, the

necessity of actions called for, and the current scope of mass incarceration, action should arise. This action will not just require the attention of policymakers and those in power, yet the whole criminal justice system, society, and those directly impacted (Epperson et al., 2021). This review offers three key recommendations in igniting such reform.

## Recommendations

Based on current research, three key recommendations for combating mass incarceration and COVID-19 in correctional facilities have arisen. These recommendations include tackling punitive, get-tough policies, with a focus on systemic racism, smart decarceration, and revamping COVID-19 strategies with a focus on compassionate release. As these recommendations are discussed, it is important to recognize scholars have suggested several strategies.

### *Recommendation 1: Re-evaluating Get-Tough Policies*

In order to begin addressing disparate and high incarceration rates, change will need to be enacted at a beginning stage of the criminal justice system: lawmaking. Punitive, get-tough policies are at the forefront of mass incarceration. It is crucial to look at penal change through a historical lens, making sure to consider "power, oppression, and control" dynamics (Campbell, 2018; Epperson et al., 2021). It has demonstrated that punitive sentences and get-tough laws ,enacted over time, have contributed to spikes in mass incarceration, disproportionately impacting minorities (Alexander, 2020; Bradshaw, 2021). Specifically, determinate sentencing practices (i.e. mandatory minimums and truth-in-sentencing laws) that disproportionately impact minorities, have little deterrent effect, and limit judicial discretion need to be re-evaluated (Alexander, 2020; Golash-Boza, 2017b; Tonry, 2019). Determinate sentencing has contributed to lengthier sentences and systemic disparities that have caused an influx in prisoners, while often

used on non-violent crimes (i.e. drug crimes) (Golash-Boza, 2017b; Tonry, 2019). This reform, in the 1970s, proved to have negative implications (i.e. racial injustices and failed crime reduction) that still affect the system today (Tonry, 2019). To prevent historical failure, change is needed.

Additionally, to gain support for sentencing reform, the politics attached to punitive policies will need to be addressed (Beckett & Francis, 2020). Instead of focusing merely on punishing offenders, the system will need to look past their main focus on the "legitimacy of punishment" and social control, back to rehabilitation efforts (Epperson et al., 2021; Flores, 2018; Friedman, 2021). By focusing less on incapacitation and punishment, reform may be advocated for more strongly, politicians will not foster tough-on crime competitions for political advantage and the fear of being "too soft" on crime, and justice-involved individuals of color may begin to be viewed in a different light (Alexander, 2020; Golash-Boza, 2017b; Western, 2006).

*Recommendation 2: Smart Decarceration*

Scholars are calling for smart decarceration, which is an "evidence-based, transdisciplinary approach aimed at addressing the disparities in the criminal justice system… and reducing incarceration while maximizing public safety and well-being" (Epperson, 2017, as cited in Alexander et al., 2020, p. 650). In particular, this decarceration needs to have a racial focus (i.e. Black, Latinx, and Indigenous populations) (Farr, 2021). Without these efforts, carceral health will continually plummet and inmates' life chances lowered, disproportionately impacting Black offenders and their communities (Davis, 2003, as cited in Nowotny & Kuptsevych-Timmer, 2018). Currently, mass releases are viewed as illegitimate options by

prison officials, policy writers, and free society, as they merely focus on the “legitimacy of punishment” (Friedman, 2021). This mindset will need to shift for successful reform.

*Recommendation 3: Revamping COVID-19 Strategies/ Compassionate Release Efforts*

In order to combat COVID-19 within carceral facilities, current strategies will need to be revamped and compassionate release efforts re-evaluated. Moving forward, it is recommended that facilities implement long-term testing strategies and map their test results, implement safe and effective cleaning practices, prioritize prisoners and staff in vaccination efforts (with decarceration), and eliminate solitary confinement as a form of social distancing, as prisoners are refusing to report symptoms out of fear of “social and psychic” torture (Barsky et al., 2021; CDC, 2021c; Friedman, 2021; Lemasters et al., 2020). The CDC (2021c) offers a whole interim guide for facilities and all personnel covering a range of mitigation strategies, including guidance on vaccination efforts, cleanliness, and testing. The CDC, states, and the federal system will need to work together to obtain resources to follow such strategies.

However, the most heavily called for/explored strategy is compassionate release (Abraham et al., 2020; Alexander et al., 2020). Although efforts have been made, more Whites have been prioritized for release than minorities, few inmates have been released despite guidance to do so, medically vulnerable inmates are being kept in institutions without an evaluation of both offense type and risk level to society, and governors are not maximizing their ability to use pardons, commutations, and reprieves for release (Brennan Center for Justice, 2020; Widra & Hayre, 2020, as cited in Bradshaw, 2021; Friedman, 2021; Mitchell & Williams, 2017, as cited in Alexander et al., 2020). Further, increasing good time credits, limiting debt prisoners accrue, delaying ones sentencing, and utilizing home confinement could aid these efforts (Brennan Center for Justice, 2020, as cited in Bradshaw, 2021). Once again, it is

important to look past punishment and consider the benefits of releasing qualified individuals (Alexander et al., 2020). By prioritizing decarceration efforts and revamping COVID-19 strategies, mass incarceration, health disparities, and the spread of the virus can be greatly reduced, all while aiding minority offenders and tackling systemic disparities.

## Conclusion

The purpose of this review was to explore the interconnectedness among mass incarceration, health disparities, and COVID-19 within U.S. correctional facilities, with specific attention paid to racial, historical, and social factors. The review establishes that mass incarceration has led to the exacerbation of pre-existing carceral health- and race- related disparities. Such inequalities are disproportionately experienced by African American, Latinx, and Indigenous populations, with a large toll on African Americans. The unbearable conditions plaguing U.S. correctional facilities have long been predictable in regard to the vast number of prisoners and the conditions that have led to such facilities becoming breeding grounds for health ailments, discrimination, and hygienic deficiencies. With carceral facilities being unprepared for a crisis such as COVID-19, the virus has swept through these facilities, impacting prisoners and staff. Despite guidelines and recommendations on how to alleviate new cases and deaths, little effort has been made to do so. Without efforts moving forward, prisoner suffrage will precede.

The conditions created by mass incarceration are not new, nor avoidable, yet are systemic. These circumstances are attributable to the historical get-tough era and draconian sentencing measures as well as social conditions and societal racial inadequacies. Punitive and harsh sentencing have replaced alternative forms of punishment. Such measures will need to be re-evaluated to combat the extent of mass incarceration. Additionally, decarceration and/or compassionate release efforts are of the utmost importance when considering ways to alleviate

the life or death situation carceral facilities are facing. The sheer magnitude of the system calls for direct efforts to reduce carceral populations or the more focused release of those most vulnerable to COVID-19.

Although the review provides new collaborative insight and synthesis on mass incarceration, race, health, and COVID-19, it is important to note the limitations of the review. First, this review strictly focuses on the experiences of men within correctional facilities. It is additionally important to evaluate the experiences of women, as they also face carceral disparities. Second, although this review focuses on individuals incapacitated within jails, prisons, and detention centers, it leaves out individuals sentenced to probation, parole, home confinement, and other community sanctions. Lastly, this review only includes available data on COVID-19. With there being a lack of overall state-reported data on the relationship between COVID-19 and race, the information presented may not be generalizable to whole populations (Chammah & Meagher, 2020, as cited in Bradshaw, 2021).

With the recommendations and limitations of this review in mind, future research is necessary. Scholars can include analyses of women, members of the LGBTQ community, as well as individuals with disabilities and their experiences with carceral health and COVID-19. Future research can also work to include those sentenced to community sanctions. Lastly, as the forthcoming ills created from COVID-19 are unforeseen at this time, scholars can continue to build off current research and seek more data on the relationship between COVID-19 and race.

In order to address some of the issues discussed within the review, power dynamics within the system, as well as current sentencing practices, will need to be reflected upon and greatly reformed. There will need to be a collaborative effort made between everyone in the system, including personnel tasked with following up with recently released offenders. These

individuals are most at risk of immediate or prolonged death and inadequate health care treatment (Binswanger, 2007, as cited in Daza et al., 2020). Yet, most important, sentencing reform, smart decarceration, and the revamping of COVID-19 and compassionate release efforts will need to be synchronously tackled to achieve efficient reform. Such reform includes reducing carceral populations and aiding offenders, especially minorities. Mass incarceration has not only exacerbated pre-existing carceral conditions, health disparities, and COVID-19, yet has decreased the life prospects of whole communities of color within U.S. correctional facilities and beyond. At this time, reform is invaluable and time is indispensable as people of color continue to suffer and die at the hands of the U.S. criminal justice system.

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