

## Mass Incarceration: The Subjugation of Black Men's Health

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## Abstract

There has been an ongoing effort to lessen racial health disparities in the United States, but little headway has been made. Despite tremendous advances in medicine, the life expectancy gap between black and white men has remained. This paper argues that because black men are imprisoned at a disproportionate rate to all other racial and ethnic groups, mass incarceration plays an integral role in maintaining this life expectancy gap. A study by the Centers for Disease Control and Prevention found that heart disease, cancer, stroke, and diabetes, which are all exacerbated by stressors like incarceration and reentry, are the causes of death that contribute most to the life expectancy gap between black and white men. Drawing on stories given by participants from Turnaround Tuesday, a jobs movement in Baltimore, I explore how incarceration shapes returning citizens' return to community, with a specific focus on social determinants of health, stigma, and status. This case study indicates that chronic stress puts returning citizens at risk for the four major causes of death, but that Turnaround Tuesday's focus on employment and social network building positions them to reduce this risk.

Key words: *incarceration, returning citizens, life expectancy, social determinants of health, employment, homeownership, marriage, status, and stress*

## Contents

Abstract .....	3
Start With a Story .....	4
Turnaround Tuesday .....	5
History of Incarceration .....	8
Health Disparities .....	12
Health Frameworks .....	14
Methodology .....	18
Chapter 1. Incarceration and Social Determinants of Health .....	24
Chapter 2. Social Determinants of Health and the Life Expectancy Gap .....	37
Chapter 3. Turnaround Tuesday: Narrowing the Gap .....	52
Conclusion .....	61
Appendix A .....	67
Appendix B .....	74
References .....	80

## Start With a Story

*When I first came home, I couldn't believe it! Everybody just kept telling me how big I got. I had all these tattoos and waves in my head. I went to jail and I became a whole different person. I grew up in the system cause I didn't have a father figure growing up. I haven't seen him in twenty years so the system helped me grow up and showed me what a man is supposed to do to take care of his own. The system helped me grow up, but I've also seen so many detrimental things in there like harmful things done to people. I've seen people getting stabbed and hit with the locks in socks, getting abused— sexually, mentally, physically, and emotionally. I've seen a lot of these things with my own two eyes and it traumatized me in a lot of ways. I never thought I'd be the same.*

*When I came home, I had to get a psychiatrist to talk to because I thought I was going to end up losing my mind. I'm back out in the world with no family and I'm on the streets. I became homeless. Many days I feel very depressed and stressed, and I've been homeless for five, almost six years now. A lot of people say I don't look like it because I try to keep my spirit uplifted. I lost everything else. I don't want to lose my mind, that would be a terrible thing to waste. I know if I still have my mind, I still have some hope for change and for a brighter tomorrow. I know I might not have this happy fairytale ending like everybody else, I might never get married or have a significant other, and I might not have this ending that everybody expects to have.*

*The suffering and trials and everything I've been through have led me to this point. It got me here because growing up, as a child— things were never easy. We didn't get fed with a silver spoon. My mother worked so hard. She was a single mom, and she used to have to go to the dollar store, and we used to eat with plastic spoons and forks, and there was times when there*

*was no food so we had to eat noodles or peanut butter and jelly, so I never had anything come easy. My hardships just got more intense as I got older, and I've just never had anything easy come to me. Thank God for putting some good people in my life along in this journey, but besides that, I feel alone in this society trying to find my way.*

*I've considered going back to school, but I have two kids so I need to work and do side jobs to provide and take care of my children so I've had to sacrifice getting an education. I was supposed to start classes, but I had to sacrifice that to get finance for my children because I don't get any support from my family, not a penny, not a bite to eat or anything so I've really got to fend for myself and my two kids. I'm on my own and it's so difficult sometimes. It led me to the streets and to break the law and get some dishonest gain here and there. I'm fortunate when I get a legal job and can make honest gain, but it's so hard to do. I'm really banking on getting a job here. I've got so much riding on this opportunity right here. I'm glad I just got off probation a few months ago so I can finally leave the state of Maryland so I feel like I'm free. I'm not trapped anymore. I felt like I was just trapped in the system and I could never go anywhere to explore and experience better opportunities in life. It feels like the system is just built to bring you down more. Like no matter how hard you try, there is another obstacle in your path.*

#### Turnaround Tuesday

This story was told to me by a participant of the Baltimore city, Maryland jobs movement, Turnaround Tuesday (TAT). The research presented in this paper was conducted in partnership with TAT and relies on interviews with its participants. This movement works to facilitate previously incarcerated citizens' return to their communities by preparing them for the

work force and finding opportunities for employment. Since its formation in 2014, TAT has been striving to change hiring practices across Baltimore. TAT developed as a branch of BUILD (Baltimoreans United In Leadership Development), a community-based, multiracial, interfaith organization with a mission to strengthen local communities through leadership development. TAT is aligned with BUILD's mission: the movement not only readies participants for the workforce, but trains them to be leaders in their communities and workplace. By engaging closely with community members and empowering them to become leaders in their own communities, TAT's work helps heal the scarred social fabric of historically and continually marginalized neighborhoods in Baltimore ("About BUILD" 2018). TAT has helped over 650 Baltimoreans find work and has built partnerships with employers like Johns Hopkins University and Medicine, Medstar Health, and the Parkway Theater. The co-directors are Terrell Williams and Melvin A. Wilson ("Turnaround Tuesday" 2018). Trainings are held on Tuesdays at two locations in Baltimore. During these meetings, participants, guests, and leaders engage in conversations about the community and proper workplace behavior. All attendees share and listen to each other's stories. One of the most empowering aspects of TAT is the emphasis the movement puts on storytelling; learning to frame a difficult past as a positive part of one's life is extremely powerful and equips participants with a tool to challenge people's prejudices. Participants are encouraged to meet with a case manager and to attend resource days. Resource days provide participants the opportunity to work with staff to build a strong resume, practice for job interviews, fill out job applications, and access other services they might need. It was during these days that I was able to interview participants.

I have been involved with TAT since 2016, my sophomore year at Goucher College, and collaborated with the movement to conduct research when taking the Goucher course titled Returning Citizens (PCE 315), in 2017. This research was inspired by the relationship I have built with TAT over the past two years and my interest in community health and social justice. Working with TAT has shaped this research as the leaders have worked with me to construct the interview questions and establish this research as a project that can be used to help TAT participants in the future. Using TAT as a case study, this paper seeks to uncover how the cycle of incarceration and its compounding effects on black communities enables the perpetuation of the life expectancy gap between white and black men and how employment can help interrupt the effects.

The story that begins this paper was told to me by the fourth person I interviewed at TAT. For the purpose of protecting the identities of the interviewed participants, they will be referred to by pseudonyms in the body of this paper. I will call this participant Daniel. Daniel's story is representative of a well-documented cycle that has been observed among black men in the United States. Young, black men often experience the prison system as part of their journey to adulthood and, therefore, lose opportunities to pursue a formal education or job experience. Daniel's story emphasizes that the circumstances in which people are raised contributes to their experience with the prison system and returning to community. Daniel grew up without a father and in a family that struggled to make ends meet. Upon his return, Daniel was no longer able to rely on the social connections in his community. With no support from family or a partner, no savings, and a very low chance of finding employment due to his criminal record and lack of past employment, Daniel found himself homeless and desperate to provide for himself and his

children. Later in the interview, Daniel explains that after serving five years in prison, he cycled back through the system several more times as he struggled to adjust to being back in his community. In fact, 70% of returning citizens reenter the prison system within three years of being released (Alexander, 2010). At the end of his story, Daniel mentions that he is relying on TAT to help him find a job. He also mentions how restrictive probation is and how opportunities felt out of his reach while being monitored. One of the most significant parts of Daniel's story is that he reveals how the hardships he faced before and after his incarceration were systematic. He says, *"It feels like the system is just built to bring you down more. Like no matter how hard you try, there is another obstacle in your path."* Daniel's story is positioned within a long history of a retributive carceral system that has developed to target and oppress black Americans. To understand Daniel's story fully, one must understand the history of incarceration in the United States.

### History of Incarceration

The end of the American Civil War in 1865 saw the emancipation of upward of four million enslaved people. At this time, the United States experienced its first prison population boom because multitudes of blacks were arrested for petty crimes (Geary, 2018). Through the following decades, segregation between whites and blacks, the formation of the Ku Klux Klan, lynchings, and later Jim Crow laws replaced the former social divides created by slavery, successfully forcing blacks to maintain a second-class citizen status (Wacquant, 2001). The white elite of the United States has perpetuated this second-class status for blacks; in the past, this division was accomplished through outright racial discrimination, but today it is maintained



through the association of criminality with blackness and operates largely through law enforcement and carceral practices (Alexander, 2010).

Although black men only make up about 13% of the United States population, they comprise 37% of the United States prison population (Glaze, 2011). In the United States, black males are incarcerated at a rate nearly six times that of white males and are disproportionately represented in the prison population (NAACP). The purpose of incarceration has changed in United States, resulting in a rapidly expanding prison population; from the 1970's to 2018, the purpose of incarceration has turned from indeterminate-sentencing and rehabilitation to retribution resulting in segregation and generalized criminalization of the black community, especially of black men (Alexander, 2010; Wacquant, 2001).

The prison population has increased from 196,429 in 1970 to 2.3 million in 2018 (Justice Policy Institute, 2018). This increase can largely be attributed to the harshening of laws and sentencing of drug-related crime, known as the War on Drugs. This shift in the sentencing was introduced by President Nixon in 1971 and expanded under the Reagan, Bush, and Clinton administrations (Wacquant, 2001). The War on Drugs replaced the indiscriminate sentencing era, which spanned the early twentieth century into the 1970s, with drastic effects on the operation of the United States justice system. During the indiscriminate sentencing era, judges were able to decide sentence length without set minimums and parole boards could determine a definite time of release from prison. Additionally, at this time, the national budget for drug treatment and rehabilitation was growing faster than that for law enforcement (Geary, 2018). This model was based on inmate rehabilitation and reintegration; emphasis was placed on inmates' readiness to reenter society, leading to a clear objective of directing inmates in their transition from prison

back to community (Western, Weiman, & Pattillo, 2004). However, the War on Drugs altered the carceral framework from reentry and rehabilitation to retribution. This reversal in purpose was accomplished by mandatory minimums, abolition of parole release, “three-strikes” laws, and other sanctions for felony convictions (Clear, 2009). By the mid 1980’s, 80% of the federal anti-drug budget was allocated to law enforcement and interdiction (Geary, 2018, p. 84). The budget spending mirrors the carceral system’s new alliance with retribution; the majority of funds going to law enforcement rather than rehabilitative programs, shows a stark abandonment of the treatment-centered method. The introduction of this retribution oriented framework reinforces and continues to perpetuate the socioeconomic marginality and vilification of urban black communities. The War on Drugs that brought about this policy shift not only increased the rate of incarceration across the United States (making it the country with the highest rate of incarceration); it dramatically expanded the disparity of incarceration rates between whites and blacks (Wacquant, 2001). As seen in figure 2, the 1970’s sees a tremendous upswing in incarceration rates in both prisons and jails and figure 3 illustrates the intensity of the gap in sentencing between white and black Americans (Appendix A).

The War on Drugs and the current carceral system have perpetuated ethnoracial division and domination in the United States and act as mechanisms for marginalizing black communities (Wacquant, 2001). Drug convictions account for the huge increase of United States prison population that occurred between 1985 and 2000, the period of the U.S. penal system's most dramatic expansion, and today, one in five incarcerated people is being held for drug offenses. Furthermore, regardless of the fact that whites and blacks use drugs at similar rates, blacks are targeted for drug use at such an elevated rate that in some states blacks make up about 90% of

imprisoned drug offenders (Alexander, 2010). Uneven sentencing with mandatory minimums for drug crimes also ensured a systematic and elevated rate of incarceration in black neighborhoods. The different sentencing for powder and crack cocaine highlighted direct targeting of blacks. Despite the fact that the two forms of cocaine are almost identical molecularly and both used more heavily by whites, widespread propaganda categorized crack cocaine as an impure cocaine alternative that was concentrated in poor, black, urban neighborhoods (Geary, 2018). Five hundred grams of powder cocaine had a mandatory minimum sentence of five years, whereas only five grams of crack gave the same sentence (Reno, 1998). With this sentencing structure in place, by the 1990's black Americans were serving prison sentences that were 49% longer than that of their white counterparts; before the War on Drugs that disparity was only 11% (Geary, 2018, p. 83). Today, the drug sentencing disparity is most obvious in charges associated with marijuana; marijuana possession accounts for over 45% of drug arrests and blacks are thirteen times more likely to be imprisoned on drug charges than whites despite approximately equal use by both groups (Dumont, Allen, Brockmann, Alexander, & Rich, 2013).

The disparity in sentencing between blacks and whites illustrates that the current purpose of prisons is to disenfranchise and isolate black men. The fact that increasing incarceration rates have been paired with a shrinking investment in programs designed for rehabilitation and reintegration further emphasises that the focus of incarceration has shifted away from rehabilitation and healing and towards the segregation and criminalization of the black population (Geary, 2018; Western et al., 2004). Overall, the changes in policy enacted by the

War on Drugs shifted the focus of the carceral system to one of retribution that segregates and disenfranchises blacks.

More than two million black Americans are currently under the control of the criminal-justice system (in prison or jail, on probation or parole) and during the past few decades, millions more have cycled in and out of the system (Alexander, 2010). With this many blacks cycling through the carceral system, it is crucial to examine the impacts this system has on black men in America. Although the economic, political, social, psychological, and physiological effects of incarceration are widespread and interconnected, this paper addresses the ways in which the system of incarceration interacts with health.

### Health Disparities

Black men have the lowest life expectancy of any racial, ethnic, and gender group in the United States (Treadwell, Xanthos, & Holden, 2012). A study conducted by the Centers for Disease Control and Prevention (CDC) found that from 1990 to 2013, life expectancy rose for both white and black men in the United States, but that black men continued to have a lower life expectancy; in 1990, life expectancy at birth was 74.6 years for white males and 71.4 years for black males, and in 2013, the life expectancy rose to 76.7 years for white males and 72.3 years for black males (Kochanek, Arias, & Anderson, 2015). Although both racial groups are living longer, the gap between their longevity has persisted. In fact, at no point in United States history have black men had a life expectancy higher than or equal to that of white men. In 2013, life expectancy for black males was 4.7 years lower than that of white males and this difference was due to higher death rates for black males for heart disease, cancer, stroke, and diabetes. (Kochanek, Arias, & Anderson, 2013). Compared to white men, black men experience a

mortality rate from heart disease that is 30% higher, mortality from cancers is 40% higher, mortality from stroke is 60% higher, and the mortality rate from diabetes is twice as high (Treadwell et al., 2012; U.S. Department of Health and Human Services [HHS], 2016). The CDC study also found that the rate of homicide and perinatal conditions contributed to the life expectancy gap, but as this paper looks at the interaction between incarceration and the biological health of returning citizens, homicide and perinatal conditions are not discussed in this paper.

Black men have a lower life expectancy than white men, and incarcerated populations within the United States experience disproportionate rates of morbidity and mortality than the general population (Kochanek et al., 2015; Davis et al., 2011). Although health disparities exist across many dimensions (such as gender and sexual orientation), racial and ethnic health disparities have historically comprised the least improved of these inequities despite the attempts to improve health in the United States (Diez Roux, 2012, Weinstein, Geller, Negussie, & Baci, 2017). For this reason, exploration of racial health disparities and possible solutions must take into account the social, political, and historical context of race and ethnicity in this country. This paper begins with a brief history that emphasizes how the United States justice system has developed to target black communities and operates by associating criminality with blackness. The purpose of this history is to highlight the parallel between the racial health disparities associated with adversities such as unemployment and homelessness and the high rate of black incarceration. As emphasized by Daniel's story, the vast majority of returning citizens re-enter their communities of origin having lost the opportunity to pursue a formal education or gain work experience in the professional world. With the added burden of a criminal record and the

all-too-often hardship of losing social networks, finding stable employment that pays a living wage is nearly impossible (Western et al., 2004; Travis, Western, & Redburn, 2014). A cycle of growing poverty and social disorganization is created as the returning citizens, lacking resources, return to neighborhoods overwhelmed with need. Without any support, returning citizens often become homeless or rely on unstable living situations and are often driven to rely on illegal means to make ends meet (Davis et al., 2011). This trend results in most returning citizens reentering the prison system within three years of being released. Additionally, the health risks upon release are staggering; in the first two week following release, returning citizens are nearly 13 times more likely than the general population to die and are 129 times more likely than the general population to die of an overdose (Travis et al., 2014). In the long run, incarceration, as a disruptive life event experienced disproportionately by black men, has adverse effects on social determinants of health that become concentrated in black communities.

### Health Frameworks

Framing the lower life expectancy and worse health of black men as a symptom of social systems rather than as an issue of individual health behavior reveals the intersection of social factors and health. Health status is influenced by personal, social, economic, and environmental factors. These factors are known as determinants of health and fall under several broad categories including individual behavior and social factors. Individual health behavior looks at the impacts of an individual's habits such as diet, exercise, and utilization of health care on health and has been a predominant lense through which health disparities have been examined (Williams, 1997; HHS, 2014). This health behavior framework is part of the determinants of health framework and acknowledges that black men have a disproportionately high mortality rate

and are disproportionately sicker than their white counterparts, but fails to recognise that negative social and environmental factors influence black Americans' health and health behaviors. In fact, examining this issue through the lens of individual health behaviors without positioning behavior in the context of social factors can be misleading and detrimental in that it places the blame of worse health on the individual (Diez, 2012; Treadwell et al., 2012). Failure to contextualize black men's health in social systems ignores the drastic implications that social disparities have for health disparities. In contrast, a social determinants of health framework holds social systems at the center of its focus and examines the intersection of social factors and health. Therefore, social determinants is a more useful tool for understanding health in the context of incarceration and its associated social disparities. Most importantly, the social determinants framework's ability to pinpoint the intersection of health and social systems indicates possible areas of change.

The World Health Organization defines social determinants of health (SDOH) as “ the conditions in which people are born, grow, live, work and age” (2018). These conditions are impacted by the distribution of money, power, and resources, and as these are not distributed evenly, they in turn inform health disparities. Some widely studied SDOH include access to education, housing, and employment, but there are a multitude of factors that work together to shape living conditions, circumstances, and by extension, health. As mentioned previously, black men in the United States experience health inequalities on a profound level, but it is not enough to simply define the gap; it is crucial to bring the examination of health disparities to a level that addresses their determinants. By identifying the social factors that determine the health disparities that most impact black men, it is possible to identify areas of change. This paper looks

at incarceration as a SDOH for black men because of the ways in which incarceration interacts with almost every social determinant in black communities. Incarceration is intertwined with employment, housing, education, and even marriage, which are all factors that inform health.

Fundamental cause theory is a way of asking what causes the causes of poor health, and the following case study examines racism and stigma as fundamental causes for the lower health status of black men. Like SDOH, fundamental cause theory addresses the impact of social factors on health and health disparities. The theory also predicts that interventions that aim solely to change individual risk factors will tend to worsen social inequalities in health (Rojas-Burke, 2015). Persistent health inequalities despite profound advancements in health treatment, lowering health risks, and outbreaks of disease is an indication of fundamental cause. Because racial inequalities in health have endured over time, racism is considered a fundamental cause of health disparities. Furthermore, racism can be considered a fundamental cause in that it can be used to examine why advancements in medicine do not reach racial groups equally (Phelan, & Link, 2015). Stigma and racism are connected, and together, they disrupt access to resources and social relationships. Stigma (often related to racism) causes social disadvantage for the stigmatized and is a pervasive source of stress in their lives. Together, stigma and racism drive morbidity and mortality at a population level (Hatzenbuehler, Phelan, & Link, 2013). These specific fundamental causes are pertinent to this case study, first, because incarceration and the related health disparities are disproportionately experienced by black men and are, therefore, inexorably linked to race and racism; and, second, because the stigma of carrying a criminal record is a prevalent, harmful factor in a returning citizens' life (Wallace, 2012). Fundamental cause is a theory interconnected with SDOH and works to support the framework.



Positioning on the social hierarchy is intimately related to one's chance of getting ill and to length of life. Health follows a social gradient with those of higher status living longer, healthier lives and those with lower status living shorter lives with more risks of illness and poor health. Michael Marmot, a professor of epidemiology and public health at the University College London, calls this gradient of health the status syndrome. Status syndrome states that the amount of control one has in one's life and opportunities for social engagement are crucial for health. Control over life circumstance and ability to participate fully in society are distributed unequally (they are granted to those with higher status), so that health is distributed unequally as well. Because incarceration lowers returning citizens' ability to attain homeownership, education, employment, or marriage, among other socioeconomic indicators, it lowers status and health (2004).

This paper uses a social determinants framework paired with fundamental cause and status syndrome to explore how incarceration and the adversities it inflicts upon black communities facilitate the perpetuation of the life expectancy gap between white and black Americans. The SDOH that were widely discussed in the interviews were homelessness, marriage, and unemployment, and the body of this paper begins with a description of how incarceration interacts with each of these social determinants. Next, fundamental cause and status syndrome are used to detail how the stress and lack of control over one's life that occurs due to incarceration's impact on the previously mentioned SDOH, increase the risk of heart disease, cancer, stroke, and diabetes, and by extension, life expectancy. In addition to discussing incarceration as a social determinant of health, this research adds to the recent scholarship surrounding the social and health impacts of incarceration through its use of first person

narratives of those directly experiencing the effects of incarceration. This case study finishes with an examination of how TAT's mission of employment, leadership, and community building creates the potential to combat the negative effects incarceration has had on participants' lives; this argument is based on well-established correlations between SDOH, the risk of heart disease, cancer, stroke, and diabetes, and the ability for increased status and social capital to buffer negative health outcomes associated with stress (Putnam, 2000).

## Methodology

### *Starting the Interviews*

This research relies on the interviews I conducted with participants at TAT. Because I was interviewing a vulnerable population, my research was evaluated by Goucher's Institutional Review Board (IRB). This process ensured that I was conducting my research responsibly and in a manner that reduced the potential harm caused to the interviewees. Part of the IRB process included completing a National Institutes of Health course called Protecting Human Research Participants. This course guided me through methods for ensuring the protection of my participants throughout the research process. Once the IRB application was approved, I began the process of gathering participants.

The most important and most challenging element of these interviews was ensuring that participants felt comfortable sharing their often traumatic experience of incarceration with me. Keeping the information private from peers was imperative, as was letting the participants guide the interviews towards topics to which they felt connected, thereby ensuring that they had the power not to disclose any information they did not wish to share. As a volunteer, it would not have been appropriate (and potentially harmful to participants) for me to openly ask participants

if they had a criminal record. Because of this positionality, I relied on TAT's director of operations, Shunbrika Johnson, and former case manager, Tia Gross, to select TAT participants that had been previously incarcerated for my interviews. Gross compiled a list of participants, and Johnson introduced me to them at the weekly Resource Day, where volunteers, including myself, assisted participants in preparing for job interviews. As a TAT leader, Johnson has a close relationship with participants and her introduction made them interested in helping me with my project.

I informed the selected participants about my project, the nature of my research, and the utility to TAT. Once individuals verbally agreed to participate, they were given two copies of the attached Informed Consent Form, one to keep and one that was returned to me. Subjects were interviewed at Zion Baptist Church and were given the description of my research detailed in the consent form (Appendix B).

#### *A Typical Interview*

Interviews were conducted in a private room to protect the participants from exposing personal information to their peers, and were reminded that they could answer as much or as little of the questions as they felt comfortable doing so or skip the question entirely. The interviews averaged thirty minutes, but participants who were less interested in the project had interviews as short as 12 minutes and those who were intrigued had interviews up to 96 minutes. Questions pertaining to health were grouped into one section of the interview so that I could inform participants before I started asking these more private questions and remind participants that they could skip any question they did not wish to answer and/or stop the interview at any time. A password protected phone was used to record audio, and interviews and all related files

(transcribed interviews) were stored in password protected files as well. Files will be deleted at the end of the year. After the interview, I offered participants a list of local health services (see Appendix B).

These interviews involved a tremendous amount of emotional labor from the interviewees and myself. As a listener, it was very hard for me not to offer help in a more direct way to the people who were so vulnerable with me and openly needing support on many levels. Although most participants shared their stories in great detail, signs indicated that doing so was hard. Participants often became more withdrawn as the interviews progressed; their open body language changed to be more inward with eyes and voice lowered, and hunched shoulders or arms crossed. In three of the interviews we cried together. The strength with which these participants discussed past pain, loss, and hope was very moving and brought up many experiences from my own life. These moments of connection were meaningful to me and have stayed with me throughout the writing of this paper. Other participants were very open and jovial, but tended to share slightly less of their stories.

### *Obstacles and Subjectivity*

Because I am a white woman from California who has never been incarcerated, there are many ways in which my presence and positionality as a researcher at TAT was intrusive and potentially harmful. I am not from the same community, and as an outsider, I am removed from the struggles that this community faces. Furthermore, my whiteness allows me to benefit from the system that oppresses the people I am researching (McIntosh, 1990). This research bridges the gap between medical and social, so it is crucial to acknowledge the racist history of the medical research conducted in Baltimore. There is a rampant history of white (predominantly

male) researchers using and harming black people and communities to benefit their research. One of the most well known instances of this racism is story of Henrietta Lacks who died of cervical cancer in Baltimore in 1951. Her tumor cells were the source of the first immortal cell line that is one of the most utilized in medical research, but she never consented to this use nor was her family informed or compensated for their use (Johns Hopkins Urban Health Institute, 2016). As a researcher following this history of manipulation of black bodies and communities, I made every attempt to be transparent and vulnerable with participants. When I inferred that participants were experiencing difficulty discussing their experiences based on withdrawn body language, I reiterated that they did not need to continue and/or I would thank them for being so open with me in an attempt to ensure that participants knew they did not have to discuss topics that were too hard and that I knew that I was privileged to be hearing their stories. To reciprocate, I often helped the interviewees with their resumes, job searching, or job interview practice immediately after or before the interviews. This process built a very intimate relationship between myself and the interviewees as we were both working to help each other.

As mentioned previously, I relied on TAT leaders to facilitate the interviews. This was entirely necessary and very positive as it built an immediate trust between myself and the participants and brought me closer to TAT leaders, but it also provided an obstacle. As they are working for a small, nonprofit, TAT leaders are often overcapacity with participants. I attended Resource Day for about three months and was able to conduct a total of nine interviews. There were days when I did not get an interview and a day when I got three. This variation was influenced by a variety of factors such as poor weather, Johnson going out of town or

overwhelmed with participants, and participants not attending resource days on the days for which they signed up.

### *Analysis*

I transcribed the interviews by hand and compiled them into a Google doc. on a password protected account. Interviews were typically transcribed within a week of their recording. Once all nine interviews were transcribed, I went through each several times. I began to code these interviews using a top-down approach. Each time I went through the interviews, I searched for different topics until sections or lines from the interviews were grouped together under several broad categories with associated sub categories. Some sections or lines were in more than one category. The categories were background, marriage, violence, stress, prison health care system, food, and specific health issues. Each of these broad categories had several subcategories. For example, background had the subcategories of single mother and parent with substance abuse. The following case study uses the content of these interviews to detail how incarceration shapes the lives of these participants, and support the understanding that incarceration lowers the life expectancy of black men.

## Chapter 1. Incarceration and Social Determinants of Health

Incarceration interacts with nearly every social determinant that informs the health of black men (Nowotny & Kuptsevykh-Timmer, 2018). These social determinants are interdependent and work together to inform health. Recognizing the interconnection between these determinants is vital to understanding health in the context of incarceration and its associated social disparities.

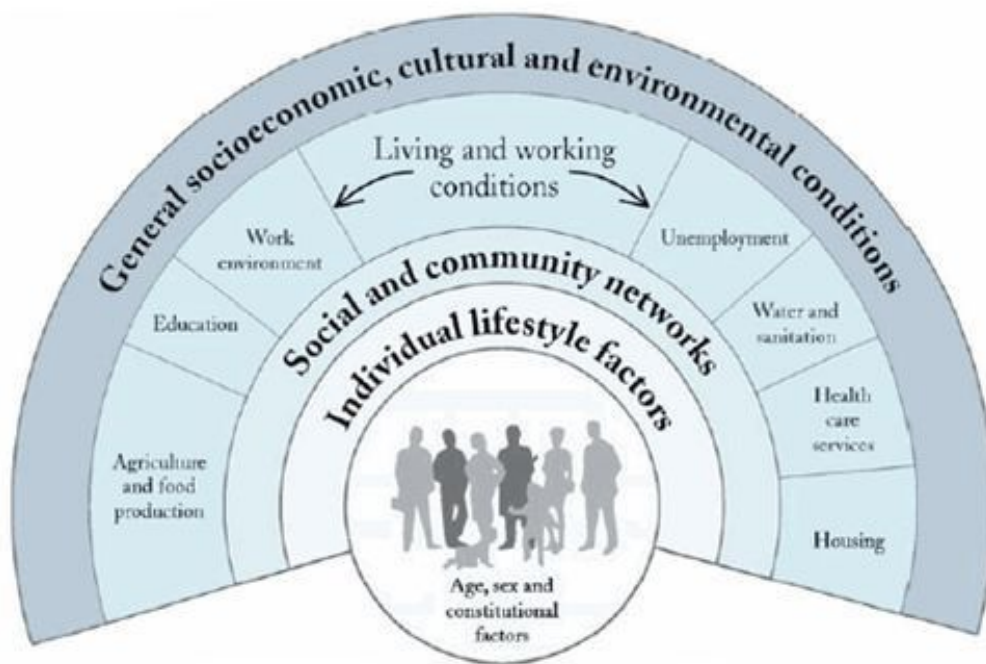


Figure 1. Model of determinants of health (Dahlgren & Whitehead, 1991).

This determinants of health model contextualizes health-influencing factors within larger social systems. Of particular importance is the way this diagram shows how social factors interact with one another, shaping an overall impact on health. Although factors such as

employment and marriage may seem unrelated, each factor contributes to building social and health conditions.

This chapter uses information from the interviews conducted at TAT and discusses how employment, homeownership, and marriage are impacted by incarceration. Although there are many other social determinants influenced by incarceration, the factors detailed in this case study are those that resounded throughout the interviews. Based on the determinants model, these determinants are not only individually impacted by incarceration, but the impact of one informs the others. The connection between employment and housing may be more apparent as employment supplies an income and homeownership requires finances while not having a home makes it harder to find and keep a job, but marriage is interconnected as well. Marriage advances an individual's social network and can supply an additional source of financial support. Additionally, of these three factors, marriage is most closely connected to life expectancy; unmarried people die younger than their married counterparts (Gardner & Oswald, 2004; Marmot, 2004). Incarceration dramatically decreases returning citizens' access to these factors and correspondingly creates conditions that lower health.

### *Employment*

Incarceration impedes the capacity for work by damaging social networks returning citizens might use to find jobs and stigmatizing people convicted of crimes. All the participants I interviewed were attending TAT because they were seeking employment. Because I was conducting the interviews with a movement focused on helping its participants find employment, they were all under- or unemployed. However, incarceration's impact on returning citizens' employment stretches beyond the individuals at TAT. Labor market research shows that males



with a criminal record earn less and experience more unemployment than comparable men who have not been to prison or jail. Returning citizens have extreme difficulty finding stable and well-paying jobs, and encounter discrimination in labor markets (Western et al., 2004). There is also evidence that incarceration confines returning citizens to jobs that are characterized by high turnover rates and limited opportunity for promotion (Clear, 2009). This is supported by the fact that several studies found that despite 65% of returning citizens reporting being employed at some point after release, 50% of the same population remains unemployed a year after returning to their communities (Travis et al., 2014). The findings of these studies emphasize that when returning citizens are able to find work, these jobs tend to be unstable.

Daniel described his experience working temporary assignments.

*I got laid off because they said they were over capacity, and because I was coming from another company (a temp agency), they let the people from their company stay and I had to be the one let go, so that brought me back here [to TAT]. I never meant to leave [TAT], but I got employment during those hours so I took it. I have to pick up my last check from them tomorrow and I guess that's closure for that job and I'm back here where I started. Hopefully something permanent is coming.*

Daniel's narrative speaks to the turbulence returning citizens face as they seek employment.

When Daniel says that he never meant to leave TAT, he is discussing the choice he had to make between working a temporary job or continuing to make progress towards a more permanent job. Ultimately, Daniel was not able to sacrifice the opportunity for immediate work even though it meant prolonging the wait for stable employment.

Incarceration makes it harder for returning citizens to find employment by interrupting social networks. Moreover, the concentration of incarceration in specific communities disrupts the social connections among families and friends that people can usually rely on to network and find employment (Western et al., 2004). A social network can be considered a social resource and people can use their networks to better attain their goals. However, when incarceration continuously removes people from specific neighborhoods, the people in those neighborhoods are unable to build widespread, reliable social networks, and without social networks, people's employment opportunities are limited. For example, a person with limited or no social network would be less likely to learn about new jobs or services or have access to a friend who can offer employment or put in a good word with their employer (Clear, 2009; Lancee, 2012). In fact, about 50% of people get their jobs through a friend or relative (Putnam, 2000, p. 320-321). The fact that so many people come to TAT to get help finding jobs highlights the importance of social connections in looking for work.

Employment for returning citizens is made less attainable because of the stigma of criminal records. The legal and social stigma of a criminal record implies that even brief contact with the criminal justice system leads to lasting consequences for employment. State and federal laws restrict people with criminal records from a range of employment opportunities. These restrictions vary widely, but in some states there are restrictions on about 40% of jobs in popular job sectors (Travis et al., 2014). According to a survey, 82% of US employers conduct criminal background checks. Employers are increasingly relying on background checks to inform hiring decisions and according to the data from the federal bureau of investigation, the use of criminal history records for purposes not related to criminal justice increased by 22% between 2010 and

2014). Furthermore, these data underestimate how often employers rely on criminal background checks because they do not include checks performed by commercial vendors (Duane, La Vigne, Lynch, & Reimal, 2017). One TAT participant, Kevin, discussed how the the legal stigma surrounding background checks impacts his employment prospects: *“I have an extensive background. I have charges, over charges, over charges, but it's been over 20 years. I haven't been in trouble for over 20 years. It shouldn't be a problem. It should be let go, but that's not the law and I understand that.”* Kevin's experience was shared by other participants and they commonly referred to the fact that their criminal records were from a time in their lives to which they no longer relate. Additionally, many interviewees shared the frustration of having something holding them back from changing their lives even after serving their time.

Even when there are no legal restrictions, employers are often reluctant to hire applicants with a criminal record. Employers may be unlikely to hire an applicant with a criminal record because of a perceived increased tendency to break rules, steal, or harm customers. A study that surveyed employers from four metropolitan cities in the United States found that over 60% of employers would “probably not” or “definitely not” hire an applicant with a criminal background (Western et al., 2004, p. 211). Furthermore, an experiment was conducted in 2006 in which resumes with profiles equivalent in all regards except for the presence of a criminal record were presented to employers in Milwaukee, Wisconsin and New York City, New York. The experiment resulted in a 30-60% reduction in callbacks for the applicant with the the criminal record (Travis et al., 2014). As James, a TAT participant, explained his experience with employers during the first seven months back in his community, *“I have applied for at least 200 jobs since I got out. Fifteen were willing to hire me, but once they did a background check, it*

*was, 'Sorry, there's nothing we can do.'*” The sheer number of jobs to which James has applied without finding employment illustrates the challenges facing a returning citizen due to their criminal record. As incarceration blocks returning citizens from employment, it also hinders their ability to find housing.

### *Homeownership*

Many returning citizens lack the resources and support to obtain secure housing upon their release due to depleted financial prospects, stigma around criminal backgrounds, and frayed social networks. Using a Bureau of Justice Statistics survey, for which the last available year of data was from 2008, a new report from the Prison Policy Initiative found that among formerly incarcerated people, the average rate of homelessness that year was 10 times that of the general public (Couloute, 2018). This is a staggering difference and serves to highlight incarceration's impact on homelessness. It was also found that people who have a cyclic interaction with incarceration (i.e. are incarcerated more than once) experience a higher rate of homelessness than those incarcerated just once. People who are incarcerated more than once experience a rate of homelessness 13 times higher than the general population and for people who were incarcerated just once, the rate of homelessness is 7 times higher than the general population (Couloute, 2018). Furthermore, city and state-level studies of homeless shelters found that many formerly incarcerated people rely on shelters not only immediately after their release, but over the long term as well (Remster, 2017). Returning citizens are at the highest risk of becoming homeless during the first two years of being back in their communities, but continue to experience elevated rates of homelessness even after several years spent in their communities. Within the first two years of reentry, returning citizens are more than twice as likely to be

homeless than those who have been out of prison for four years or longer, but even after several years back in their communities, returning citizens are 4 times more likely to experience homelessness than the general population (Couloute, 2018).

As returning citizens are typically drawn from poor neighborhoods at young ages, when they return to their communities, they are not in a financial position that would allow them to take the first steps towards securing an apartment (or even other, more temporary housing such as hotel or motel rooms), let alone homeownership (Dennis, Locke, Khadduri, 2007). Some states provide a nominal amount of “gate money” upon release, ranging from \$25 to \$300 for transportation or other immediate needs, but it is hardly enough to cover the cost of a security deposit and rent for an apartment, especially when that money may also need to be used for food and transportation (Solomon, Waul, Van Ness, Travis, 2004; La Vigne, Davies, Palmer, & Halberstadt, 2008, p. 15). Additionally, because returning citizens are unlikely to find stable, legal employment, they are not only unlikely to change their financial prospects quickly, but are also unlikely to be eligible to open a credit line with or receive a loan from a bank (Clark, 2007; Turney & Schneider, 2016).

The unattainability of finding a home due to financial hardship is compounded by the fact that public and private landowners often discriminate against applicants with criminal records due to stigma. Legally, stigma takes its form in the several federal laws that bar people with certain criminal offenses from applying for public housing and federally assisted housing programs (Solomon et al., 2004). In addition, landlords typically ask applicants to list employment and housing references and to disclose financial and criminal history information. This puts returning citizens at a disadvantage because if they answer questions about their

employment, housing, and criminal history truthfully, the landlord may disqualify the applicant based on stigma associated with a criminal record. On the other hand, if they choose not to disclose this information, they could be disqualified for not being forthcoming (Clark, 2007). There is a stigma that a criminal background is an indication of untrustworthiness, and as returning citizens do not usually have good credit scores (if they have one at all), pay stubs, or rental history, they are often unable to prove otherwise to potential landlords (Western et al., 2004; Solomon et al., 2004). Employers and landlords both view a criminal record as a liability due to a common conception that individuals with criminal records are more likely to behave violently and break rules. In addition, employers fear that returning citizens will not come to work regularly, and landlords fear that they will not follow through with payments (Clark, 2007; Western et al., 2004). Although there is little literature specifically dedicated to the source of stigma associated with criminal records, it is clear that it stems from a place of mistrust. A criminal record indicates that a person has most likely committed a crime and this further indicates that this individual has been willing to break rules in the past. However, studies have found that individuals with criminal records have a much longer tenure and are less likely to quit their jobs voluntarily than other workers. This outcome has been attributed to the fact that returning citizens will face discrimination in future hiring practices and therefore have fewer job prospects outside of their current position (Minor, Persico, Weiss, 2018). As returning citizens are painfully aware of this position, they are likely to take extra measures to maintain employment. Although most literature in this area focuses on the impact of stigma on employment, the same concept could be expanded to include housing because the stigma stems from similar uncertainties.

Often, financial instability and discrimination from landowners forces returning citizens to rely on family and friends to provide housing (Solomon et al., 2004). However, incarceration often disrupts these social ties, forcing many returning citizens to seek support from local shelters or live on the street. During my interview with Paul, who was incarcerated as a youth, he shared that after his release, he found a place to stay with his sister.

*I did 28 years and 5 days and when I came home, I came home to my sister because my mother passed away while I was still incarcerated and I had to sleep on the couch because they had taken in some guy that I came to find out was my niece's boyfriend. He was staying up in the empty room and what not and I had to wait 'til he went off to school before the bedroom would become available so I just slept on the couch for maybe five days.*

Paul's story illustrates how entering the prison system makes returning citizens turn to close connections to survive the transition back to community. Similarly, Travis discussed being able to rely on romantic partners for housing, but also recognising that others in his position are not able to find that security.

*I've always had a woman in my life that I could stay with, and that's really been by me. so I've never been homeless or had to do the things that I did, I just chose to do them. I never been hungry. My story isn't like most. I didn't live outside or in abandoned houses.*

Unlike Paul or Travis, Daniel's story includes that the severed tie with his family led him to live on the streets. He recounted, *"I'm back out in the world with no family and I'm on the streets. I became homeless. Many days I feel very depressed and stressed, and I've been*

*homeless for five, almost six years now.*” Without close social connections or employment, Daniel could not find a home upon reentry and continues to face the instability of homelessness. Other participants mentioned experiencing periods of homelessness, but did not wish to discuss this part of their reentry process with me. Incarceration also impacts returning citizens’ chance of marriage.

### *Marriage*

Being incarcerated reduces marriage prospects for black men by removing them from their neighborhoods and as the result of the stigma associated with a criminal background (Clear, 2009). Harvard economist Adam Thomas found that following incarceration, the probability of marriage for black males over 23 is 50% lower than those who did not experience incarceration (as cited in Clear, 2009). In general, the rate of marriage for incarcerated men is half that of non-incarcerated men (Wyse, Harding, & Morenoff, 2014). Furthermore, the likelihood of marriage for a couple that is not living together before the incarceration of the husband is half of that for a husband that is not incarcerated (Western et al., 2004).

The removal from community (via incarceration) is enough to diminish a person’s chances of marriage. This outcome is true for all races, but as black men experience the highest rate of incarceration, they are also the most affected by it (Clear, 2009). Incarceration reduces marriage rates by removing men from poor, urban neighborhoods and therefore from the pool of possible marriage partners. While incarcerated, men not only have extremely limited opportunity to meet potential partners, but also little opportunity to engage in courtship or supportive social activities with partners they may have had from before their time incarcerated (Lopoo, & Western, 2005).



Once back in their communities, returning citizens continue to experience low rates of marriage due to stigma. Marriage rates for poor, single men with criminal records are affected because bearing the stigma of a criminal record makes it hard for them to compete in the marriage markets of disadvantaged urban neighborhoods (Huebner, 2005). Ethnographic research found that stigma of incarceration makes single mothers reluctant to marry or live with fathers of their children (Clear, 2009; HHS, 2009). A woman's decision to marry is partly based on her perception of her partner's social respectability and trustworthiness, and these characteristics often found to be perceived as low in men with a history of incarceration (Western et al., 2004). Additionally, as men who have been involved in crime often have limited social and economic capital, these deficiencies can support the stigma. Many of the participants I interviewed had children, but few of them were married. Wayne described his position on intimacy.

*A week and a half before I got locked up, my fiance passed away. We were childhood sweethearts everything we did together. She was the only person in my life that knew everything about me. when she passed away it was super hard. I am used to loss—I was in the system so I got used to loss all my life. She was there the whole time so when I lost her, I crashed. I've talked about this so much so I don't know why I'm crying. I don't think I'll ever be able to open up the way I opened up to her because we went through the same stuff growing up, but I'm not really trying to put myself out there so I can be vulnerable and lose again. I really fear losing somebody.*

Hesitancy to be vulnerable with and reliant on a partner speaks to the ways in which incarceration lowers returning citizens' chances to marry. Daniel also described his fear of never

finding a partner. *“I know I might not have this happy fairytale ending like everybody else, I might never get married or have a significant other, and I might not have this ending that everybody expects to have.”* These stories reveal profound experiences of loneliness and extreme social isolation. The hopelessness with which these participants discuss their chances of marriage and intimacy suggests that they are well beyond an average age for marriage, but both of these participants are in their late twenties. The fact that they are so young and feeling so defeated emphasizes the unattainability of marriage to returning citizens.

It is clear that incarceration diminishes returning citizens’ ability to gain employment, homeownership, and marriage. Incarceration’s ability to impede returning citizens’ access to these SDOH operates primarily through the stigma associated with a criminal background; this stigma factors into the lowered likelihood of employers, landowners, and potential partners to choose returning citizens over other competitors due to lack of trust. Returning citizens also face legal barriers associated with employment and housing that compound their already diminished chances of accessing these resources. Moreover, the barriers to employment and housing further reduces their chances of marriage by making returning citizens even less competitive in the marriage market. Unfortunately, being unmarried continues to reduce chances of finding employment or housing due to diminished social network and income creating a cycle that feeds an overwhelming blockade to resources. All three of these social determinants are related to one another and work together to inform the health of returning citizens. The next part of this study looks at how being barred from each of these areas of life increases the risk for heart disease, cancer, stroke, and diabetes.

## Chapter 2. Social Determinants of Health and the Life Expectancy Gap

Now that incarceration's impact on these SDOH has been illustrated, fundamental cause and status syndrome will be used to explain how being barred from accessing these areas of social stability and advancement increases the risk of heart disease, cancer, stroke, and diabetes due to lowered control over life circumstance and social exclusion. Both a lack of control and social isolation make individuals more vulnerable to stressors, promoting chronic stress in these individuals. This chapter details the body's physiological response to stress in order to illustrate how continual stress (or chronic stress) puts returning citizens at a higher risk for the four diseases. This paper discusses heart disease, cancer, stroke, and diabetes because these are the causes of death that most significantly contribute to the life expectancy gap between white and black males in America (Kochanek et al., 2013; HHS, 2016).

### *Low Status, High Stress*

Employment, homeownership, and marriage are all indications of status. Lacking a reliable home, a partner, and/or stable employment all lead to lower status and, according to status syndrome theory, lowered control over life circumstance and limited opportunity for social participation (Marmot, 2004). Low control over life circumstance is linked to chronic stress due to an increased experience of stress from a higher number and wider variety of situations. For example, an individual who is unemployed with no steady income, is unmarried, and lives in their car will experience much more stress from having their car towed than a person who is employed with a steady income, partner, and house. The unemployed person cannot pay the release fee for their car, or turn to a partner for financial support, and will have lost their sense of home. Furthermore, this stress may ripple out into other areas of their life, causing even more

instability and stress. For instance, the loss of a car is also a loss of reliable transportation and therefore leads to fewer opportunities for employment (Ong, & Houston, 2002). On the other hand, although the situation is still stressful for the employed person, the stress is greatly diminished by the fact that this person can pay the fee for the car, rely on their partner's income to supplement the extra expenditure, and return to their home for the night. This example emphasizes that lower status leads to lower control and more stress (Marmot, 2004). The instance of receiving a traffic citation provides another example illustrating how a representative unemployed returning citizen could experience heightened risk of stress. If this individual is unable to pay a traffic citation, the unpaid fine may lead to late fees, collection agency involvement, license suspension, or a warrant for arrest. These consequences add stress to an already stressful situation and are avoided by those with income as they have the financial means to pay the fine. In this situation, an individual who works a minimum wage job will experience more stress in this situation than an individual making a more substantial salary; for instance, a low income may mean making the decision to pay the fine or pay rent that month. These examples reiterate that low status reduces control and provokes stress. As incarceration keeps returning citizens lower on the social hierarchy, they experience less control over their lives and more stress.

To exemplify how incarceration lowers control, I will analyze the examples of housing discussed in chapter 1 from the experiences detailed by TAT participants. Three participants gave three different experiences with housing. However, regardless of whether they were able to stay with family, a romantic partner, or ended up homeless, all three participants experienced a lack of control over their living situations. Paul may have been able to stay with his sister upon

his release, but he was not able to sleep in a bedroom due to circumstances outside of his control. Paul spent his first week home sleeping on the couch because somebody he had never met before had joined the family. Additionally, both Paul's and Travis' complete reliance on their social connections for their housing lowered their control over and the stability of their living situations; a falling out with their connection would mean not only a jeopardize relationship, but precipitate a loss of home as well.

Returning citizens who become homeless experience even more instability and lack of control (Travis, 2014). For Daniel, homelessness provides a host of stressors and destabilizing factors. He told me, *"When I'm at work, I'm just hoping that nobody is stealing any of my stuff. There is just no stability; it's so hard, but I should be out of this situation soon."* This added vulnerability and lack of stability increases Daniel's experience of stress. Leaving his possessions unattended while at work causes stress, but if he stays with his possessions, he runs the risk of losing his job and has to worry about work. Homelessness also holds countless other stressors such as targeting by police and lack of privacy (Couloute, 2018).

Status syndrome also states that a lower standing within the social hierarchy limits social participation which generates stress. Incarceration creates a society with widespread inequalities, severe social hierarchies, and less cooperation; by allowing black men to be shunted into the prison system, the United States keeps black men from fully developing their capabilities and excludes them from full social participation while simultaneously supporting a white hierarchy (Marmot, 2004; Wacquant, 2001). Lack of social participation is also linked to stress. Furthermore, looking at stigma as a fundamental cause further supports the idea that social exclusion leads to intensified health inequalities (Geronimus, Hicken, Keene, & Bound, 2006;

Hatzenbuehler et al., 2013). There are several hypotheses about the link between social networks and health, but the most obvious association is that involvement in social networks provides various forms of social support that influences health by functioning as buffer for stress (Berkman, Kawachi, & Glymour, 2014). Several studies conducted across the United States found that social connectedness is one of the strongest determinants of health. Consequently, a long term study found that people with the fewest social connections are at the highest risk of dying from heart disease and cancer (Putnam, 2000). As incarceration diminishes social networks, returning citizens are not awarded this stress buffer upon their return to community and the stigma of a criminal background keeps them from easily building a new one. Additionally, as many returning citizens are unemployed and/or homeless, these stigmas also contribute to social exclusion and escalated instances of stress (Hatzenbuehler et al., 2013; Massoglia, & Pridemore, 2015; Travis et al., 2014).

Daniel described to me how the stigma of his criminal record keeps him from achieving the aspirations he has for his life.

*I've had a few employers look down on me for something I did in 2010, almost a decade. I'm a totally different person from back then. The way I listen and everything has changed, my whole personality and everything, but I lost two jobs because of my background. They let me start working, but then a week later say, "oh we've got to let you go- you failed the background check." I started to lose hope. I felt hopeless and got discouraged and everything and that was a year before I came here. Then I worked another job. I worked a couple days, the background came back, and they let me go, so my background has really hindered my future-- my past is really hindering my future so*

*much and in so many dramatic ways and it still hurts me to this day. It feels like a heavy burden; I'm carrying this big weight on my shoulders. I've got these issues and problems with life which we all do, so I'm just trying to cope with them the best way I can.*

For Daniel, the stigma of his criminal record keeps him from relying on a job because he knows that he probably will not be able to stay once his employers receive his background check. He includes how this form of social exclusion makes him feel hopeless, and makes his life more stressful.

John also faced a loss of social network and experienced extreme social exclusion when he returned from prison. John expressed the fears he had about returning to his community, and detailed his experience of being on parole.

*When I got out, I was more worried about my partner than myself because it was like what are my neighbors going to think. I don't get my neighborhood newsletter anymore because of my record. So now I can't even know what's going on in my neighborhood. That was tough for me not knowing how my neighbors would react.*

*They will monitor me for five years. I can only use my computer for work related stuff. I can't send personal emails and they monitor my phone. It's like they expect you to live in a cave for five years. It's so isolating.*

John is not only stressed because of his own isolation from society, but he is also worried about the impact on his partner. John's story is heartbreaking because he is such a kind, social person, so the exclusion from his social networks is particularly hard on him. He repeated several times throughout the interview that his isolation makes him feel overly reliant on his partner and that

because he has not been able to find a job, he feels like a burden. This story highlights that the social exclusion due to lowered status and stigma can be drastic.

It is clear that incarceration's ability to make employment, homeownership, and marriage less attainable escalates returning citizens' experience with stress by restricting them to a lower status. There is a rich body of literature dedicated to the study of stress and related health outcomes; as a result, there are many ways to define stress and examine its impacts on individual and population health. I examine the effects of chronic stress, or long term stress, and use the definition of chronic stress as sustained activation of the body's stress mechanisms. Chronic stress increases risk for heart disease, cancer, stroke, and diabetes due to increased allostatic load (overexertion of body systems in order to maintain function during adaptation to change) and taxation on the cardiovascular and immune systems (Anisman, 2015; Marmot, 2004; Massoglia, 2008; Massoglia, & Pridemore, 2015).

#### *Stress from the Physiological Perspective*

Physiologically, chronic stress involves prolonged activation of the body's stress response due to the glucocorticoid, cortisol. The body's immediate response to stress is regulated by epinephrine, but cortisol is responsible for maintaining the body's elevated state beyond the first rush of epinephrine. Cortisol increases blood pressure, glucose levels in the blood, and inhibits digestion, reproductive and growth processes. Stress changes several functions of the body to ensure that energy is readily available for the muscles. The release of specific hormones meets this need by signalling the liver to release glucose into the blood. These hormones are also responsible for elevating heart rate and respiration to carry glucose and oxygen to the muscles



and brain at a much higher rate and concentration than during homeostasis. The impact of the stress response is illustrated below and are further detailed in the following paragraphs.

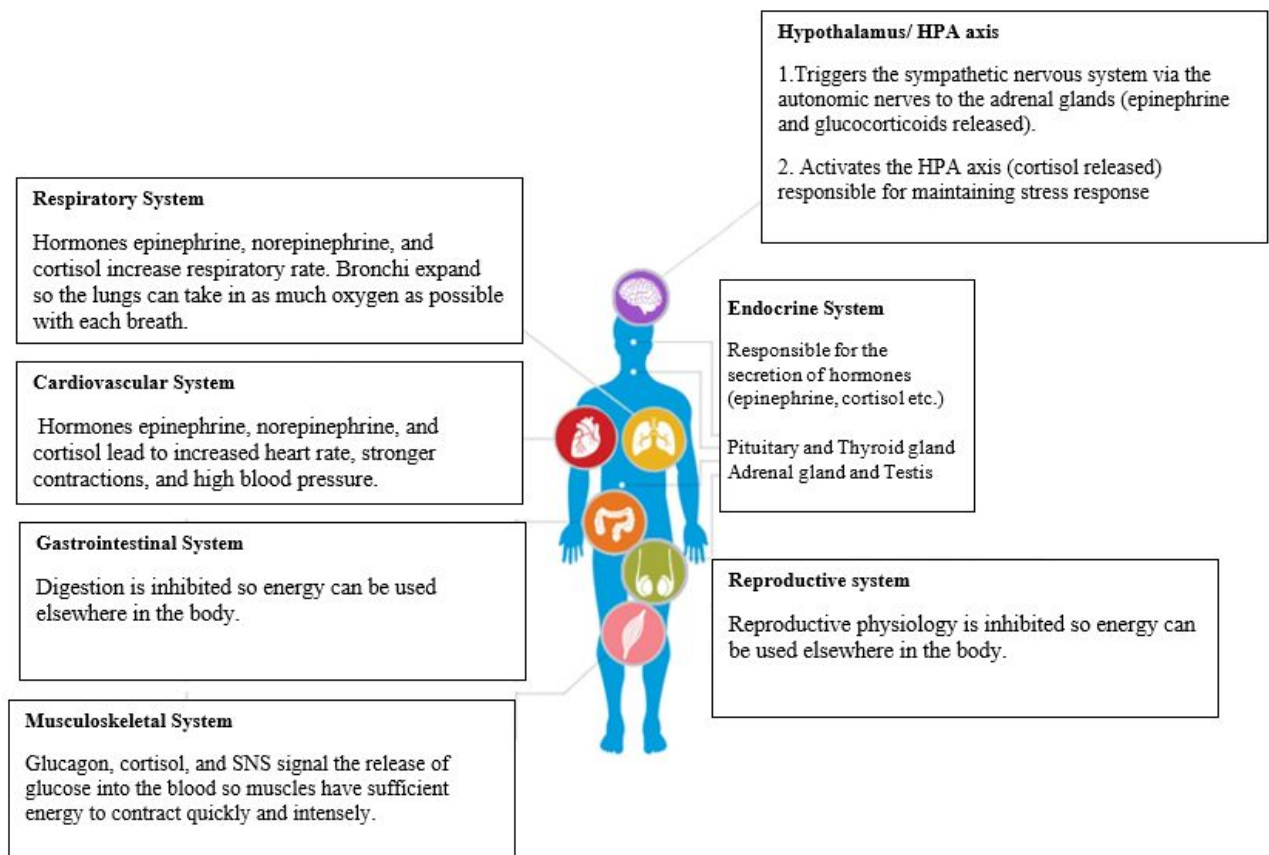


Figure 2. This image outlines the chemical and physical effects involved in the stress pathway.

Areas of the body most drastically impacted by the stress pathways are shown. Image constructed by author.

Summary of Hormonal Influences on Metabolism			
Hormone's effects	Glucagon	Epinephrine /Norepinephrine	Cortisol
Stimulates glycogenolysis (break-down of glucose storage, glycogen)	✓	✓	
Stimulates lipolysis and fat mobilization (so the body can use fatty acids for energy)	✓	✓	✓
Stimulates gluconeogenesis (generates glucose)	✓	✓	✓
Stimulates protein breakdown (so the body can use amino acids for energy)			✓

Figure 3. This chart indicates some of the effects of the major hormones involved in the stress response and highlights that the hormones induce similar activities in the body's metabolic pathway (adapted from Marieb & Hoehn, 2010).

When the human body experiences stress, a biochemical response is initiated. A series of chemical signals and physical reactions occur throughout the body to help it cope with intense situations. This response is commonly referred to as the fight-or-flight response and is characterized by elevated heart rate and respiration, sweating, tight muscles, and for some, trembling or nausea. As illustrated in figure 2, the nervous system, endocrine system, and hypothalamic-pituitary-adrenal (HPA) axis are utilized by the body during this response. The functions of the nervous system are divided into two main branches: the somatic (or voluntary) component and autonomic (or involuntary) component. The body's response to stress is controlled by the autonomic nervous system which is further broken down into sympathetic and parasympathetic divisions. The sympathetic division typically stimulates activity in the body and is responsible for controlling the body's response during a perceived threat whereas the parasympathetic division is responsible for maintaining the body's homeostasis. The sympathetic nervous system uses the catecholamines epinephrine and norepinephrine to regulate body functions. The endocrine system is responsible for the release and regulation of hormones such as insulin and glucagon, and the hypothalamic pituitary adrenal axis (HPA axis) releases cortisol (a glucocorticoid) (Hickman, Roberts, Keen, Eisenhour, Larson, l'Anson, 2014; Tsigos, & Chrousos, 2002).

In a situation of acute stress (stress that is short term or immediate), the body diverts energy to the muscles by inhibiting the parasympathetic system and secretion of insulin while simultaneously activating the sympathetic system, and circulation of glucose via increase of epinephrine and norepinephrine, glucocorticoids, and glucagon. Subsequently, heart rate, blood pressure, and the rate of respiration are increased by epinephrine and glucocorticoids to get

glucose to the muscles as quickly as possible. These mechanisms are detailed in figure 2 and 3. To conserve energy, digestion and salivation are inhibited as well as any growth, inflammation, tissue repair, reproductive physiology, or immune function.

After the initial rush of epinephrine subsides, the hypothalamus activates the second component of the stress response system — known as the HPA axis. The HPA axis relies on a series of hormonal signals to keep the sympathetic nervous system activated. If the brain continues to perceive something as dangerous, the hypothalamus signals the adrenal glands to release cortisol. Resultantly, the body stays on high alert. Once the perceived threat has passed, cortisol levels fall, signalling the parasympathetic nervous system to restore homeostasis. The parasympathetic nervous system functions by lowering heart rate and respiration, reactivating digestive pathways, and relaxing muscles (Sapolsky, 2004). The body's stress response can be life saving when encountering a situation that requires fast action. However, this response is also triggered by more symbolic stressors like paying a bill or a job interview. Stress is not inherently bad for health; the problem arises when the threat and subsequent stress response is experienced over long periods of time without allowing the body to return to homeostasis.

Allostasis is another way of examining the stress response. Allostasis refers to the body's ability to maintain relative homeostasis while undergoing the changes initiated by a stressor. This framework does not hold stress and homeostasis entirely separate; rather it takes into account that the body must adapt to new environments. The idea of allostasis was introduced by Sterling and Eyer in 1988 and they described it as, "maintaining stability through change" (as cited in Ramsay & Woods, 2014). Allostatic load refers to the wear and tear on the body as it responds to repeated cycles of allostasis. When a person is regularly exposed to stressors, the body

experiences allostasis and adaptation. Over time, allostatic load can accumulate, and the overexposure to neural, endocrine, and immune stress mediators can have adverse effects on various organ systems, leading to disease (McEwen, 2005).

Looking at the stress response in the example of having one's car towed described earlier can help outline why allostatic load and diseases associated with increased allostatic load are more prevalent among those who are more vulnerable to stressors (ie those with lower status like returning citizens). A man walks around the corner expecting to see his car parked right where he had left it hours before. Nearing the end of the block, the man comes to a stop not having seen his car. Maybe he is just misremembering where he parked. He feels his heart beating faster in his chest, he catches his breath, and sweat tickles the palms of his hand as his eyes fall on the tow away zone sign partially concealed behind a tree. His hands shake as he dials 311 to inquire about where his car has been towed and how much it will cost to recover it.

The intensity of this response may vary slightly between individuals, but is primarily the same; where the response differs is in the following hours, and potentially weeks or months. For a married man with a home and an income, his body will return to homeostasis after calling his partner and scheduling a time to collect the car together. He is disappointed about having made such an avoidable mistake, but begins to calm down as his partner reminds him that they can afford to make mistakes every once in a while. Conversely, an unmarried man who relies on his car as a place of home and has no steady income will experience an extended period of stress and frequent cycling of allostasis as stressors related to the incident continue to arise. The man may spend the entire day or even many following days trying to figure out what to do. The stress response continues as he realizes that he will not be able to make the job interview that was

scheduled for later that afternoon. Frustrated, he recalls previous interviews when employers refused to hire him due to his criminal record; he thinks bitterly that this interview probably would not have been any different. His chest tightens again as he considers spending the night in the shelter. The last time he had spent the night there was before he had his car and somebody had taken his shoes as he slept. Over the next few weeks, he becomes desensitized to the constant tightness in his chest and rest of his muscles.

These scenarios emphasize that an individual's experience of stress varies drastically based on their status. Lower status leads to a prolonged stress response due to lack of control and inability to resolve or avoid stressful situations and factors (Marmot, 2004). The following sections discuss how chronic stress interacts with each of the four causes of death that contribute to the life expectancy gap between black and white men in the United States.

### *Heart disease*

People who experience chronic stress have a 25% higher risk of developing heart disease than somebody who does not experience this long term exposure to stress (Anisman, 2015, p. 110). A study of over 18,000 British civil servants found that mortality associated with heart disease was more prominent among those of lower rank. Lower rank equates lower status and therefore more stress, so these findings support the status syndrome theory (Marmot, 2004). Elevated heart rate and blood pressure is one of the first ways our body responds to stress. These factors can lead to damaged or weakened artery walls. Additionally, elevated concentrations of cortisol are present in the body when experiencing stress. High cortisol leads to lowered HDL cholesterol which is associated with increased risk for heart disease (Anisman, 2015).

*Cancer*

Studies in humans suggest that stress is linked to cancer progression, cancer-related mortality, and increased aggression of some forms of cancer. Cancer is a condition in which certain cells undergo uncontrolled growth. This growth leads to the formation of tumors and there are over 200 forms of cancer that involve different organs and cells within these organs. Although the link between stress and the development of cancers is fairly weak, there is strong evidence that stressors can exacerbate existing cancers. Because stress response stimulates endocrine function, this can influence the growth of tumors. Additionally, when the body experiences stress, the function of the immune system is suppressed which inhibits the body's ability to attack cancer cells (Anisman, 2015).

*Stroke*

Stress can also lead to increased risk of stroke. An experiment designed to test the connection between stress and the risk of stroke found that bcl-2, a proto-oncogene (a gene that regulates cell activity) expression was reduced by about 70% when subjects were exposed to stressors. Bcl-2 promotes cell survival and protects against apoptosis and cellular necrosis in many neurodegenerative disorders, including stroke (Devries, Joh, Bernard, Hattori, Hurn, Traystman, & Alkayed, 2001, p.11824). Chronic stress contributes to long-term suppression of bcl-2, lowering the body's ability to protect against cell death and leading to increased risk of stroke. More indirectly, stress's impact on blood pressure and cholesterol also increase the risk of stroke ("Blood pressure," 1998). These factors increase the risk of heart disease, which in turn,

increases the risk of stroke. Diabetes also increases the risk of stroke (CDC, 2018). Both of these disease can lead to inhibited blood flow to the brain.

### *Diabetes*

In Type 1 diabetes, the body is unable to produce insulin. Because insulin is responsible for signalling cells to take up glucose, the body is unable to take sugar out of the blood without it. As a result, blood sugar spikes and damages various organs. Chronic stress results in a sustained, increased level of cortisol which leads to lowered concentrations of insulin in blood circulation. The ability of stress to cause additional inhibition of insulin production can intensify the symptoms of the disease. Type II diabetes also involves reduced insulin levels and the insulin resistance caused by stress can not only worsen the condition, but contribute to its development. The findings of a 35-year study indicate that diabetes among unskilled and semiskilled workers was about 50% more common than among those of higher rank. Lower rank is associated with fewer opportunities to make decisions and a higher job demand which are closely related to type 2 diabetes (Anisman, 2015, p.124).

In summary, chronic stress increases the risk of developing or worsening heart disease, cancer, stroke, and diabetes. Incarceration lowers returning citizens' status via blocked access to employment, homeownership, and marriage. Lower status makes individuals more vulnerable to stressors and, therefore, increases the frequency with which the body experiences the stress response. Repeated cycling through allostasis increases allostatic load, leading to overexertion of the heart and lungs, suppressed immune functions, and overexpression of hormones that raise blood sugar. Because incarceration lowers status and increases stress, and black men are disproportionately incarcerated, they are also disproportionately impacted by these effects; in



short, incarceration's tendency to restrict the status of black men lowers their life expectancy.

However, there are mechanisms that can be used to protect against some of these effects. The next chapter discusses how TAT provides pathways to increasing status that have the potential to lessen incarceration's impacts on its participants.

### Chapter 3. Turnaround Tuesday: Narrowing the Gap

As employment is a crucial social determinant for the health of returning citizens, this chapter examines how TAT's mission to change hiring practices across Baltimore and prepare returning citizens to reenter the workforce has the potential to counteract the negative health effects related to incarceration. TAT's two locations are both within areas of Baltimore that experience high rates of incarceration, poverty, and unemployment. These neighborhoods are also majority black. According to data from the Baltimore Neighborhood Indicators Alliance (2017), TAT's East side location is within a neighborhood that experiences a 23.06% unemployment rate, 24.2% of families live below the poverty line, and 94% of residents are black. The West side location is within a neighborhood that experiences 12.5% unemployment, 43% of families live below the poverty line, and 91.6% of residents are black. Additionally, both of these neighborhoods experience incarceration rates five times that of the state average (Appendix A; figure 4, 5, 6, & 7). These factors inform the population TAT is able to reach and the dynamic of the communities in which TAT works. This chapter argues that TAT's dual focus on building social capital as part of its jobs mission is crucial to the well-being of current and future participants.

Securing a stable job is enough to begin counteracting the negative health effects of incarceration. Although transitioning to a new job can be stressful, the overall benefits reduce chronic stress. Gaining employment equates higher status, and higher status means more control over life circumstance, and more opportunity for social participation (Marmot, 2004). Stable employment not only reduces chronic stress by providing a steady income, a more reliable schedule, and a wider social circle, but also by increasing returning citizens' opportunity to gain

homeownership and marriage. As discussed in chapter 1, social determinants are interrelated, and therefore gaining employment can help mend other social determinants. In this case, gaining employment reduces the stigma associated with a criminal record because it provides evidence of trustworthiness. This reduced stigma leads to expanded social inclusion by increasing the likelihood of future employers, landowners, and potential romantic partners to accept returning citizens (Clear, 2009; Hatzenbuehler et al., 2013). Having a steady income is also a factor that generates new possibilities for returning citizens to find housing and feel more autonomy in their lives. Obtaining full-time employment also increases the social capital of men, further enhancing their capability to compete in the marriage market (Huebner, 2005). When romantic partners are able to see returning citizens' ability to provide financially, gain upward mobility, and stay committed to their position, they are much more likely to choose them as a permanent partner. Marriage also increases social capital, raises status, and reduces the number of instances that cause stress, as well as lowering the severity of the stress when it is experienced (Berkman, Kawachi, & Glymour, 2014; Marmot, 2004).

The connections that TAT has built with local employers also help returning citizens to reach higher status and reduce stress by diminishing stigma. Paul discussed that it is different to apply for jobs through TAT than through programs in prison. *"I go online and I fill out job applications and I go down to organizations and I put BUILD and TAT and I'm so excited to put it down because it's different from the organizations we knew in the penitentiary."* Paul's statement reveals that participants know TAT's connections with employers gives them an increased chance of getting hired; applying for jobs through TAT reduces stress because employers that are partnered with TAT will not judge applicants based on their background as

non-partnered employers might. One of the reasons that TAT is successful in building this relationship with employers is by bringing them face to face with participants. TAT invites participants to self-select to be mentored in public action through storytelling so that they can lead in negotiations with potential and current employers. Telling their stories to executives in small settings or one-on-one meetings is a leadership experience for participants and is a powerful mechanism for breaking stigma; when powerful executives listen to a participant's story, their formerly, well-entrenched opinions often change as a result. Participants are able to identify the political and economic outcomes of their activism and see others benefit from their leadership. TAT has built connections with prominent employers like Johns Hopkins and the University of Maryland hospitals and is working to continue to expand this network. Creating this network challenges employers to change their hiring practices, and creates a city that provides more equal opportunity to its citizens.

TAT's focus on community building is equally important for developing the type of public relationships that facilitate healing. The opportunity to build ties outside of their immediate, often narrow social network is beneficial to returning citizens' well-being. TAT provides a place for returning citizens to feel a sense of connection with leaders and other participants and learn community conscious behaviors. Every Tuesday, people are encouraged to share their stories and hear the stories of the people around them without judgement. Tuesdays end with people forming a circle, holding hands in a moment of reflection with one another. James expressed his gratitude to TAT for providing a social space that is free of judgement and full of support.

*I enjoy holding hands at the end, but my favorite thing is the five minute meeting at the end. Each week I meet somebody new and each week I get to hear their story. The staff, the volunteers, the people, the friendliness, the smiles, the open arms—it's just a breath of fresh air. This movement, it's really helpful and I've been here for nine Tuesdays and I enjoy it.*

The ability to meet new people and feel connected is particularly important for James because he is experiencing such extreme isolation in other parts of his life. As many other returning citizens are subjected to social isolation due to stigma, it is important for spaces like TAT to challenge that stigma and provide opportunities for returning citizens to show that they are not defined by their record or their past actions. James was not the only participant to acknowledge that TAT's social focus is unique in the neighborhood. Wayne confided, *"I've only been here for a couple weeks, but the times I've been here I've been feeling at peace and getting respect. You don't get that on the streets, but I'm out on the streets anyways."* Like James, Wayne feels that TAT gives participants the opportunity to engage in a positive social atmosphere that is rare to find within the community.

In addition to appreciating the community focus, Richard detailed the importance of the social skills with which TAT equips participants.

*TAT is so amazing. For someone like me for example, I never had to deal with all the stupid stuff that goes on in companies and stuff like that. One of the things that TAT teaches you is how to maneuver through these systems, how to deal with regulating emotions in the workplace (not to become aggressive when you feel danger). If someone is being passive-aggressive with me, I'm going to be aggressive aggressive because I'm a*

*survivor. I'm educated and I have my masters, but I'm still street. They teach us that in any place there is going to be somebody who doesn't like you, but how are you going to deal with that at work, how are you going to maneuver, how are you going to keep your emotions out of it, and that's what I need. I need to be conditioned in that, and no one ever taught me that. They're so good because they tell you 1,2,3 this is what you can do—these are steps, these are the coping skills that you have to use. They tell you that when you're out there, you cannot have emotions.<sup>1</sup> Take your emotions out of it. Emotion is for home, for the people that you love. You have a public face and a private face. All this stuff I didn't know. I just thought I had to be by myself all the time. I'm authentic and that's what I thought I had to be, and if I acted in a different way I felt like I was being fake, but they're saying no, it's not that, this is just how things are done.*

Many of the participants I interviewed also acknowledged that TAT was giving them skills that they could use in the workplace and use to de-escalate conflict in their lives. There was a dominant motif of participants acknowledging that they are street, but that changing their behavior and way of relating to other people in their community was imperative to keeping themselves from reoffending. However, many participants also spoke about the torn social networks that come from distancing themselves from their past connections.

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<sup>1</sup> In public relationships, regulation of emotional response is expected, but TAT teaches participants how to use self-expression in the appropriate places as a method for building social connections. Participants are taught how to cope with emotions on the job instead of being overwhelmed by them so they are able to resolve conflict appropriately and maintain social connections. Control over emotional response is especially helpful for participants who have experienced trauma because it allows them to protect themselves against interactions that may make them feel vulnerable and unsafe.

The concentration of incarceration in neighborhoods that experience high rates of unemployment and poverty influences the community life within those locations. Criminologist Todd Clear defines neighborhoods as the place where people live or work in proximity to one another and typically share similar living experience and social circumstance. Clear also discusses that inner city neighborhoods, like the ones in which TAT works, tend to house people who are stuck there due to poverty and are therefore also isolated socially and economically. This isolation generates a community where people keep to themselves (within their own homes) and surrender the street to deviant behavior (2009). Social isolation and a pervasive feeling of general unsafety and mistrust lead to weak social networks and high levels of chronic stress. Because these neighborhoods inhibit the formation of social networks, returning citizens' hardship of losing of past connections is exacerbated. TAT's ability to build social networks is vital in these neighborhoods as it is one of the only sources of social networking available to returning citizens. In my interview with Troy, he illustrated how TAT provides a mechanism for healing social networks in these communities.

*We have to do whatever it takes for us to really get back into being a community state. Like right now, everybody is in this isolated state; they live around people, but they don't live with people, and that's how I relate to TAT. TAT kinda gives us those relationships, those bonding factors that would help. TAT gives us a chance to kinda coexist again. Like when you're here, It's not, "what you looking at," it's like, "hey, how you doing?" And those who can help you will sit right next to you and have that conversation with you and while you become naked, and the mentality they're like wow I probably could hire this person. Then you find out that they possibly could hire you and*

*you didn't even know, so it's not an act. Everything is raw. It's not somebody sitting behind a desk pushing a thousand papers at you saying, "if you can't sign that then I can't help you," it's somebody saying, "wow that's an amazing story, I'd like to know more about that young man or that young woman," so that's kinda what did it for me.*

Troy's description of TAT highlights its positioning within a fragmented community and the importance of providing a space dedicated to non-judgemental social connections. When Troy comments, *"Like when you're here, It's not, "what you looking at," it's like, "hey, how you doing?"*, he is pointing out how people in his neighborhood typically view social interactions as invasive or unsafe, but at TAT people feel comfortable checking in with one another and assuming good intentions. This description also shows that TAT provides a rare opportunity for people to feel that they can be open about their past and still receive constructive support from those who are positioned to help.

TAT's social network has been hugely beneficial to returning citizens. Not only has TAT helped over 650 participants find work, but participants have also been able to find opportunities for housing through their connections at TAT. The social network at TAT bridges a large social gap between those who have high social capital and those with very little, connecting those in different social spheres. Individuals who have strong social capital move through society with greater success and ease than those who do not, and TAT's collective social capital is used to support individuals with limited social capital. Dr. Bess, a professor at Goucher College, has worked with TAT since 2015 and described some of the ways in which TAT's social network functions beyond finding returning citizens jobs.



*I have worked personally with three people whom I know for certain obtained permanent, safe housing as a result of their relationship with TAT, in a specific professional way as in through a one on one meeting on a Wednesday, or something like that, or through just networking. Like one person was just crying in the hallway and we were trying to problem solve and then Rob [English, lead organizer for BUILD] walked by and we snagged him and then she got a house. I also happened to be present with various emergency conversations, people living in their cars, people homeless—really homeless on the street—where they [TAT leaders] were jumping into action looking for something temporary and then something permanent.*

Dr. Bess' story illustrates that social network functions to make resources more accessible to those with low social capital. Even though the focus at TAT is not on homeownership, social capital is used to obtain resources for participants who would not have access otherwise. According to Dr. Finney, TAT's senior program manager, TAT leaders work with about one participant a month to find housing, and about five participants have found stable housing through associated programs like ReBUILD Metro. With about 20 participants a year finding housing through their connections with TAT and many more finding employment, TAT is actively disrupting the barriers that block returning citizens from achieving upward mobility and gaining higher status. Once TAT participants have housing they begin to experience more autonomy and control over their life circumstance. Having stable housing reduces stress and decreases the risk of heart disease, cancer, stroke, and diabetes. Furthermore, stable housing also promotes status and enhances returning citizens ability to hold a job and find a partner, thereby further reducing stress and risk of disease.

Overall, TAT has the potential to disrupt some of the negative health impacts of incarceration on its participants by providing employment opportunities and repairing social networks. Both employment and improved social connection ultimately buffer the effects of stress, reducing the risk for heart disease, stroke, cancer, and diabetes. Gaining access to either or both of these resources (employment or social network) provides returning citizens with more autonomy and therefore reduced stress. Moreover, acquiring these resources moves returning citizens closer to accessing even more resources; employment provides support along the path to homeownership and social network can provide resources through social capital. TAT's dual focus is particularly important for returning citizens because employment itself reduces stress, but can also lead to social network building and heightened chances of finding stable housing and marriage which further reduce stress. The social network building within TAT immediately broadens returning citizens' social network while teaching prosocial skills that will help them maintain employment and build even stronger, wider social networks. Although TAT has not been in operation long enough to allow for the health impacts of its work to be measured, the fact that TAT provides access to SDOH via its connection with employers and bridging social capital indicates that TAT has the capability to disrupt incarceration's influence on lower the life expectancy of black men.

## Conclusion

The disproportionate rate at which black men are incarcerated in the United States informs life circumstance and health for this population. Upon their return to community, returning citizens face severely reduced prospects of finding employment, housing, and marriage primarily due to stigma and low status. In this manner, incarceration blocks returning citizens from reaching a higher status while simultaneously limiting full social participation. Low status and social isolation elevate the experience and intensity of stress. Due to the physiological strain the body's stress response puts on major organ systems, chronic stress places returning citizens at a higher risk for developing heart disease, cancer, stroke, and diabetes, which are the leading contributors to the life expectancy gap between black and white men in the United States. It is well-documented that increasing access to SDOH and social capital have positive effects on health (Marmot, 2004); this paper suggests that TAT's focus on employment and social networks gives them the potential to combat the negative impacts incarceration has on returning citizens.

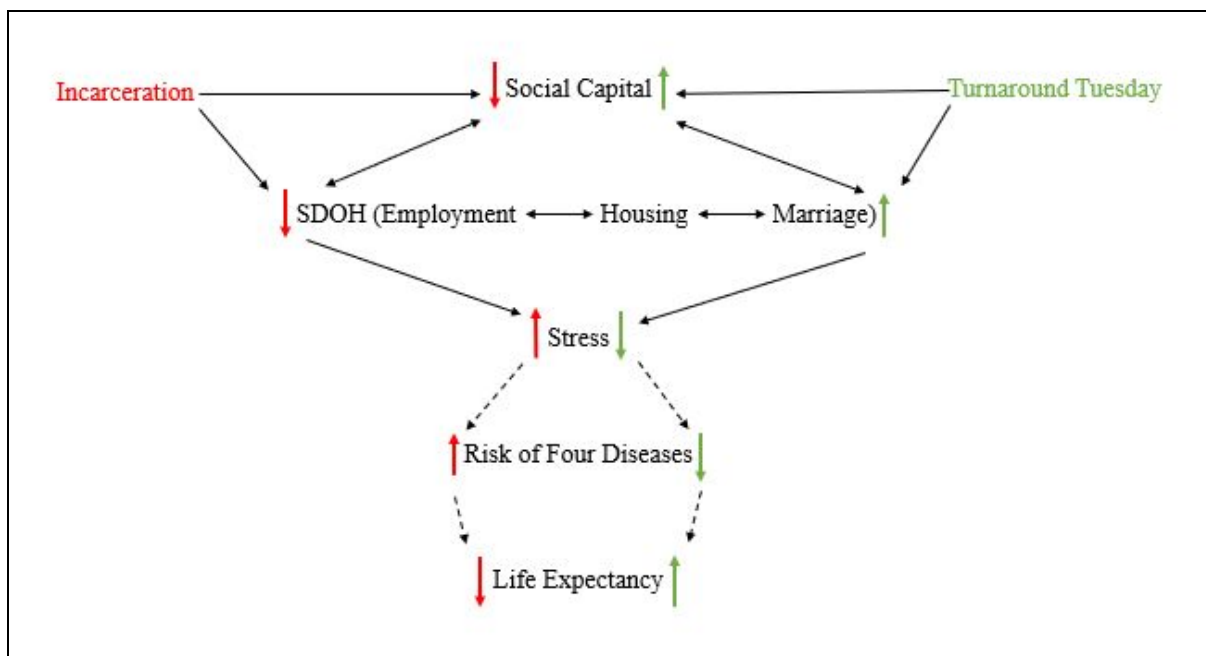


Figure 4. Conceptual model of how incarceration and Turnaround Tuesday interact with factors that influence the health of returning citizens. Image constructed by author.

Figure 4 provides a visual representation of the interconnections among the factors discussed in this paper. The red arrows indicate how incarceration impacts each factor and the green arrows shows TAT's impact. Some of the arrows are double-headed, indicating a interdependent relationship. For example, this paper emphasizes the ways in which increasing social capital can lead to increased SDOH and that increased SDOH can lead to increased social capital. The dotted lines between stress, risk for four diseases, and life expectancy indicate that these are the pathways that my paper attempts to outline based on the established relationships between the preceding/influencing factors. Because it has not yet been documented that participation in TAT leads to reduced risk of heart disease, cancer, stroke, and diabetes in comparison to formerly incarcerated male population, it is important to emphasizing that TAT's impacts on health outlined in this paper are predictive. However, the fact that the predictions are based in well-documented correlations between SDOH and health gives them gravity.

While this paper focuses on the impacts of incarceration post-release, the participants' interviews also overwhelmingly focused on incarceration's immediate impact on emotional distress, access to health care, and diet during their time in prison or jail. These factors are important to include in the discussion surrounding incarceration and life expectancy as they put inmates at a higher risk of developing or worsening pre-existing heart disease, cancer, stroke, and diabetes.

Every participant included stress as part of their experience with incarceration. Participants described moments of intense, acute stress and more generalized chronic stress

while in prison. This is not surprising as there is extensive literature dedicated to this subject (Massoglia & Pridemore, 2015). Participants' stories were graphic and both hard to listen to and hard to tell. When participants recounted these moments in their interviews, they often became withdrawn. Paul described how these experiences in prison makes him feel desensitized to hardship in his community.

*I watched twenty seven people die within my 28 years. Two people got burnt in the cell. I saw someone burn to death, I looked up and a guy was at the grate and he had yellow nylon underwear on and they burned off of him, and then he burnt just like that. Things like that traumatize you to a point that nothing bothers me now. I can go through the streets or watch somebody get killed and it's like I've seen that before.*

The horrors conveyed in Paul's story reveal the intense stress individuals experience while in prison. Paul and other participants reported feeling as though their experiences in prison were so traumatizing that it hardened them to other stressors. When incarcerated, individuals have very little to no control over their circumstances and are therefore extremely vulnerable to stressors. Severe emotional distress is associated with the risk of stroke. Moreover, the constant stress of overcrowding, lack of privacy, and fear of harm that participants discussed in their interviews inform chronic stress. This suggests that the chronic stress returning citizens face upon returning to their communities is a continuation of chronic stress experienced during their time incarcerated. A prolonged experience of chronic stress puts returning citizens at an even greater risk for heart disease, cancer, stroke, and diabetes.

It is also well-documented that prison conditions are substandard, often with overcrowding, lack of ventilation or temperature control, and unhealthy diet options (Davis et al.,

2011). Many participants included their living condition as a source of stress. Andrew disclosed, *“I had high blood pressure when I was in there. Your body changes while you’re over there because you don’t get the healthier stuff, you’re not in the healthiest environment.”* Richard and Troy also described the impact of the living conditions and diet. Richard stated, *“I was losing a lot of hair, probably because of stress, and I was gaining weight and I haven’t been able to shed it. The food is horrible there.”* Troy focused more specifically on poor diet. He told me,

*I noticed from some of the things that the drinks and the food is made with is not healthy for you. They had this drink (it’s called base) and you could clean the floor with it. If you spill it (you know how Pepsi or Sprite you can clean the rust off of chrome pieces) well Base is just that. A lot of times I tried to avoid it, but the water wasn’t all that great either.*

All of these descriptions emphasize the lack of dietary options. The nutritional value of meals is far from ideal, because high-fat, high-calorie diets are common for prison meals (Smith, & Institute of Medicine, 2013). A high-fat, high-calorie diet is linked to weight gain which puts individuals at risk for heart disease, some forms of cancer, stroke, and type 2 diabetes (American Cancer Society, n.d.; MedlinePlus, n.d.).

Furthermore, all participants discussed the inaccessibility of health care in prison.

Richard shared,

*The health system in prison was horrible—it was so bad. You couldn’t get your medicines that you used, they didn’t care. The conditions there were awful. Sometimes I couldn’t get my medication, or see a doctor, or anything. It wasn’t accessible—it was so hard, like if I had a stomach ache or once I had a rash all over my body (a reaction to*

*something) and all I could think was, if it reaches my throat and I die then at least people will know about how bad this system is. When I told them that, it was the only time I got their attention because they don't want a dead body.*

This sentiment resounded throughout all of the interviews. Not having access to care can not only lead to untreated symptoms and diseases, but increased stress and lack of control.

Participants described feeling powerless because they did not have access to the care they needed. It was only in cases of dire medical situations that participants received what they felt was proper medical care. Travis told me that he was so desperate to see a doctor to get medication for his asthma that he made himself throw up and pretended to faint. He said it was the only way he could get any attention. This level of powerlessness and desperation also contributes to chronic stress. Living with chronic stress for months or years during incarceration puts individuals at risk for heart disease, cancer, stroke, and diabetes, and that risk is only intensified by the stressors of reentry.

This paper has examined the ways in which TAT is positioned to disrupt the negative health impacts incarceration inflicts upon returning citizens. TAT's focus on employment and social network building provides mechanisms of upward mobility for returning citizens. Increased status reduces chronic stress, and by extension reduces risk for the four major contributors to the life expectancy gap. As mentioned in chapter 3, TAT is located in neighborhoods that experience high rates of incarceration, unemployment, poverty, and are majority black. Because the findings of this paper suggest that TAT's work has the potential to increase life expectancy, making its resources (or social movements that provide similar resources) available in communities that share these circumstances would have an even greater

potential to combat incarceration's impact on returning citizens' longevity. The case study presented in this paper demonstrates the importance of TAT's social capital that bridges people from more distant social platforms. When these bridges are formed from the heart of a community, they provide life-saving resources.

### *Future Research*

To continue this research, the interview process I initiated should be maintained at TAT as well as starting this process with returning citizens involved in similar social movements (both within Baltimore and in other urban areas) and with those who are not participating in these movements or programs. Tracking returning citizens who are not involved in social movements would pose a challenge, but interviews could begin pre-release to facilitate relationship building through the returning process and/or could be conducted at halfway houses or through parole and probation departments. Great lengths would need to be taken to ensure that interviewees are not harmed by this process and interviews would have to be 100% voluntary. This information gathering would create the potential to run a more extensive analysis of TAT's impacts as it adds an element of control and comparison.

Furthermore, interviewing physicians who serve people from this population would yield valuable information about more specific medical trends. Moreover, running a parallel between the impacts of direct medical treatment and the health impacts of social movements has the potential to reveal where these forms of care could work together, in which areas each is lacking, and in which ways each could be changed to create better support for returning citizens. It would be important to include an analysis of the ways in which medical treatment fails to address SDOH. This interview process provides an opportunity to find specific areas in which medical



care and social movements can work together to correct this failing and more effectively raise the life expectancy of black men.

## Appendix A

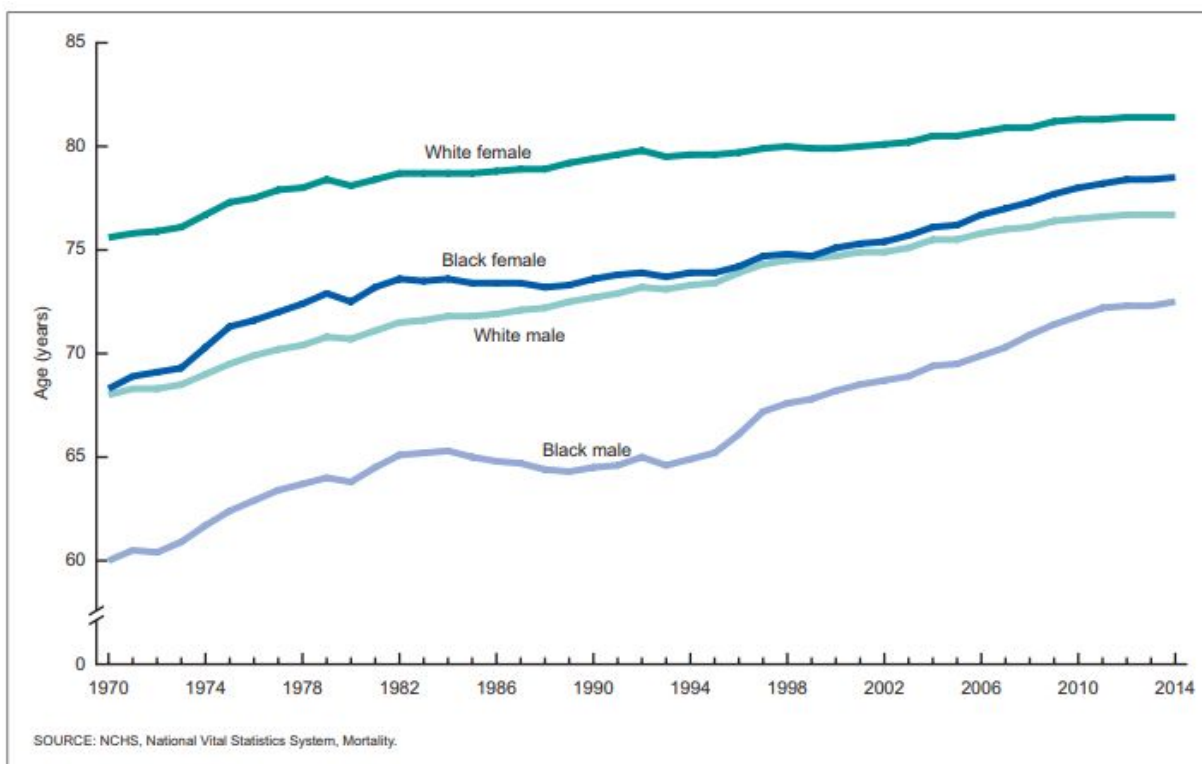


Figure 1. Life expectancy at birth, by race and sex: United States, 1970-2014

(Kochanek et al., 2015)

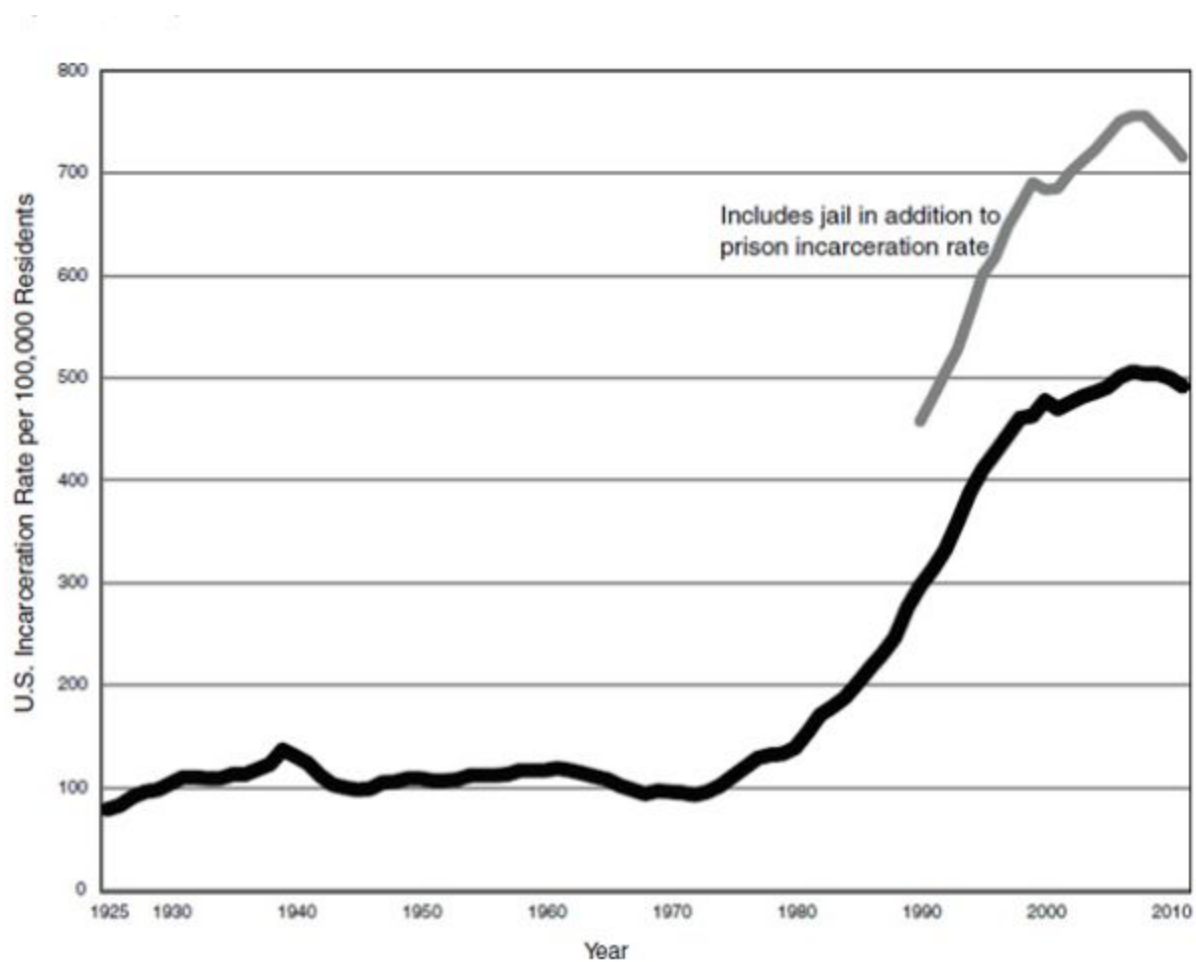


Figure 2. United States Incarceration rates over time

(Smith, & Institute of Medicine, 2013)

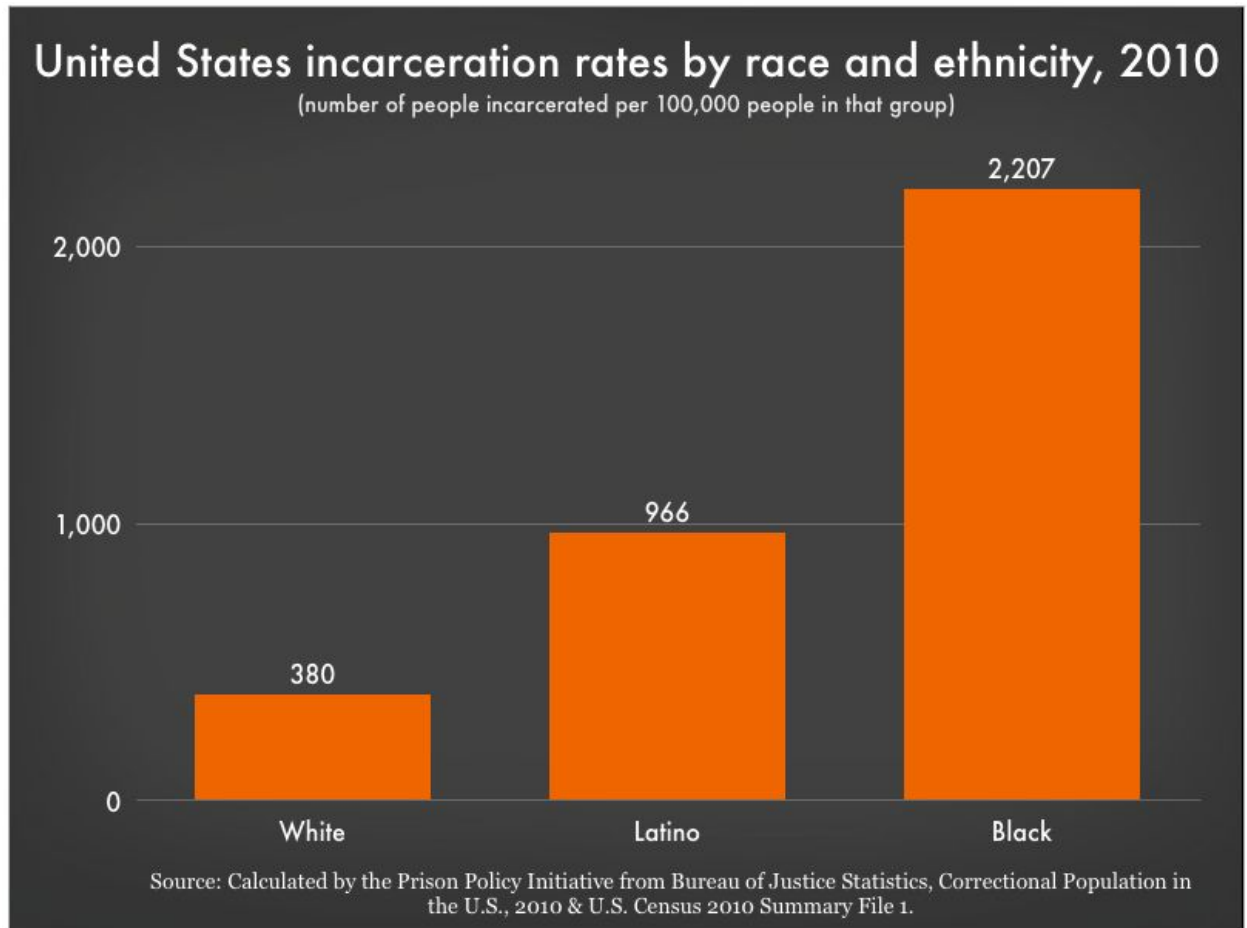


Figure 3. Incarceration rates by race in the United States, 2010

(Prison Policy Initiative, & Bureau of Justice Statistics, 2010)

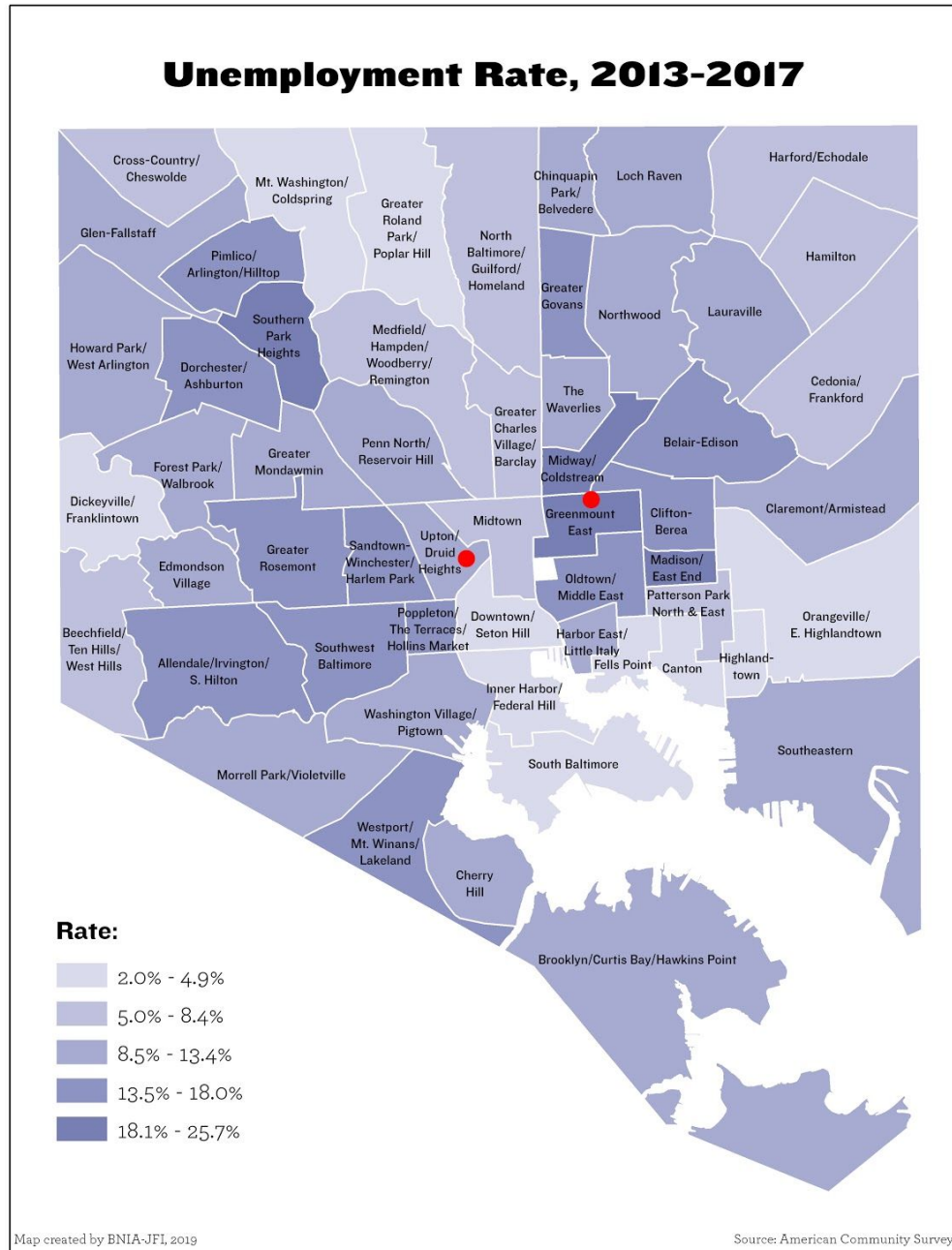


Figure 4. Map of Baltimore city colored by unemployment rate. TAT East and West location indicated in red (Baltimore Neighborhood Indicators Alliance. (n.d.).



Figure 5. Map of Baltimore city colored by incarceration rate. TAT East and West locations indicated in red (Justice Policy Institute and the Prison Policy Initiative. (n.d.).

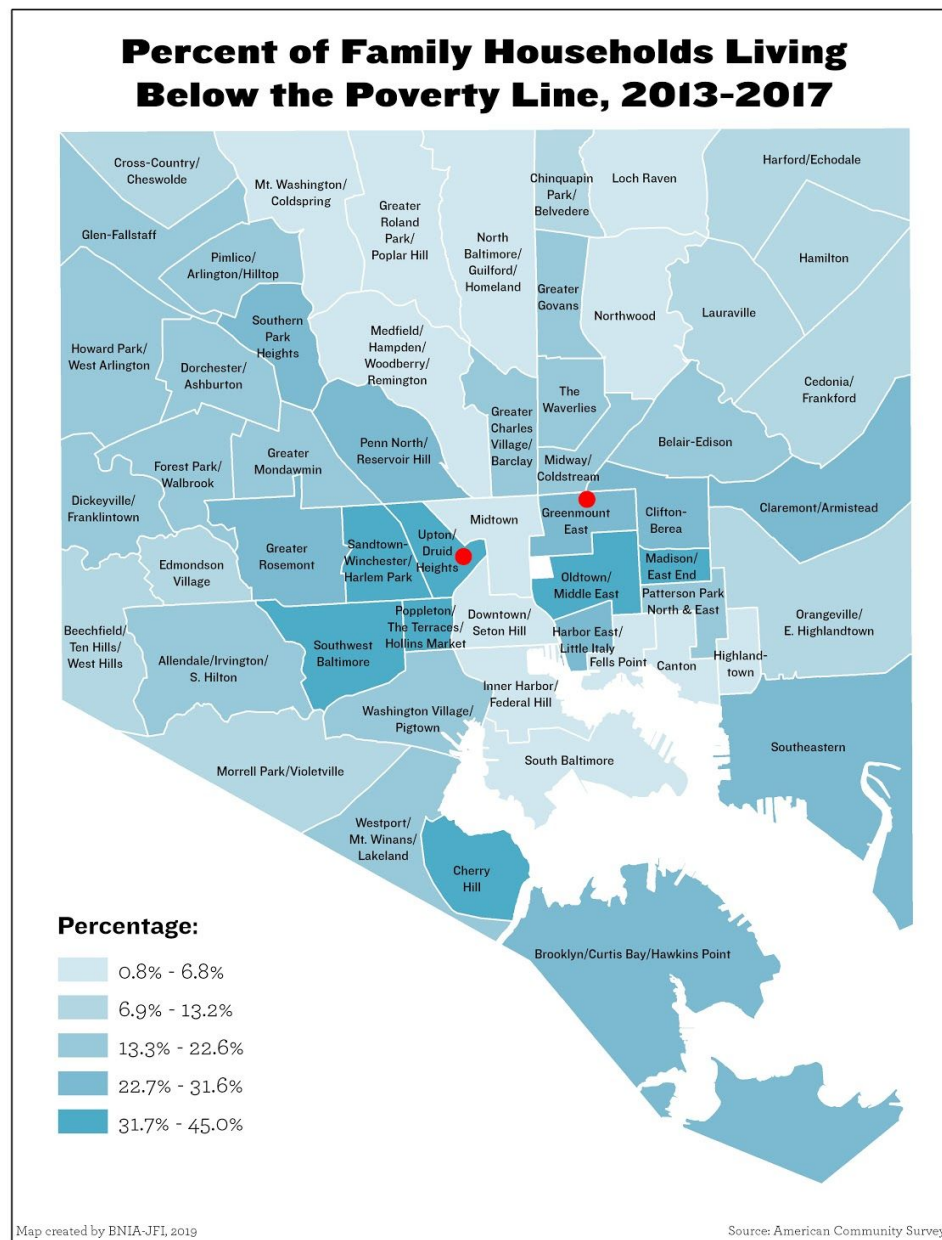


Figure 6. Baltimore city colored by poverty rate. TAT East and West locations indicated in red. (Baltimore Neighborhood Indicators Alliance. (n.d.).



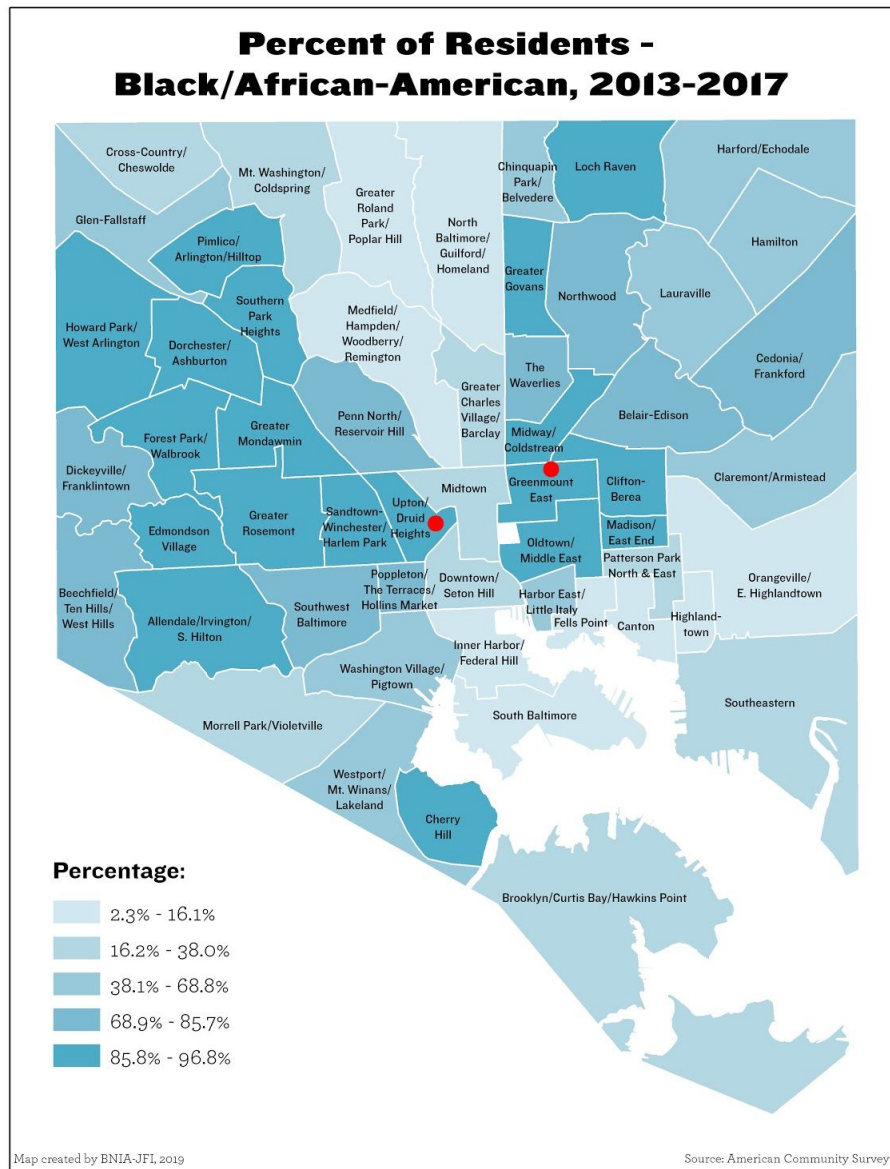


Figure 7. Baltimore city neighborhoods colored by percent of black/African-American residents. TAT East and West locations indicated in red (Baltimore Neighborhood Indicators Alliance. (n.d.).



## Appendix B

## G O U C H E R C O L L E G E

## IRB CONSENT FORM

*[To be used with adult participants who can give consent. Those doing research with children, use the parent-consent and child-assent forms on the website.]*

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**Title of Study:** “Mass Incarceration: The Marginalization of Black Health”

For questions regarding the research project, please contact:

**Researcher(s):** Bianca Stern  
biste002@mail.goucher.edu

**Supervisor:** Jennifer Bess, Ph.D., Goucher College  
jbess@goucher.edu

For questions regarding your rights as a research subject, please contact:

**IRB Contact:** Provost’s Office  
410-337-6044

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**Description**

I am interested in collecting information about how incarceration and the process of returning to communities after time incarcerated impacts health (mental and physical). My goal is to use this information to give Turnaround Tuesday more insight into what health needs participants have and how to address those needs. I will be asking some questions related to accessing health care inside and outside of prison/jail, and your personal experience with TAT, health, and incarceration. Your participation is voluntary, and you may terminate interviews at any time. In order for an interview to take place, you’ll need to read, approve and sign this consent form. Interviews will take place at Zion Baptist Church and will take 15-40 minutes, depending on your interest in it. I may ask for follow-up interviews, and you can choose to participate again or to refuse. All research will be turned over to TAT at the end of the semester. Final documents (without your names) will be maintained over time so that we can understand trends related to Turnaround Tuesday’s mission. Information from your interview will be used in my senior thesis for Goucher College and the final product will be shared with TAT.

**Risks**

The risks related to this study are minimal. If you are asked questions that you're not comfortable answering, you are welcome to skip the question or stop the interview. Risks regarding confidentiality are also minimal. Names will be deleted from notes, and you'll be referred to only via data or a pseudonym in written documents and only by pseudonym in recorded interviews.

**Payments**

No payments will be provided for participating in this study.

**Confidentiality**

Confidentiality will be maintained throughout this study. A voice recorder may be used to record interviews, but recordings will be saved in password-protected files. Transcriptions and written documents will not include your names. At the end of the school year (May 2019), all recordings will be deleted. Information will be kept in password-protected files and will not contain your names. Final written documents will not contain your names.

**Right to Withdraw**

Your participation is completely voluntary. You have the right to take a break, skip questions, or terminate interviews at any time with no consequences. Please only answer questions and participate to the extent you feel comfortable.

**Voluntary Consent**

[The following statement of consent must be included]

1. I have read the information above and freely volunteer to participate in this research project.
2. I understand that all aspects of this project will be carried out in the strictest of confidence and in a manner in which my rights as a human subject are protected.
3. I have been informed in advance as to what my task(s) will be and what procedures will be followed.
4. I have been given the opportunity to ask questions, and have had my questions answered to my satisfaction.
5. I am aware that I have the right to withdraw consent and discontinue participation at any time, without prejudice.
6. If I decide not to participate in this research project my performance and/or grade in any course associated with this research project will not be affected.
7. I understand that I must be at least 18 years old to participate in this project, or have a "Parental Consent Form for Research Participation" on file with the Provost's Office with my parent's or guardian's signature. I also understand that I must present a copy of this form to the researcher prior to consenting to this study.
8. My signature below may be taken as affirmation of all the above, prior to participation.

I confirm that I am at least 18 years old:   yes       no

For Goucher students under the age of 18: I have a form on file with the Provost's Office with parent/guardian approval that permits me to choose to consent to participate in research. I am giving a copy of this form to the researcher now.

yes       no

*[Note to researchers doing research on children: please use parent-consent and child-assent forms on the IRB website, in place of this consent form.]*

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date       \_\_\_\_\_

## Local Health Services in Baltimore

## Baltimore Medical System

Description: payments are based on a sliding scale that depends on your income. Cost of a visit or medication is adjusted based on income. Service is offered to people underinsured and uninsured. Services include: general health, children's health, women's health, mental and social health, pharmacy

## Locations:

1. Bel-air Edison Family Health Center:  
Address: 3120 Erdman Ave. Baltimore, MD 21213  
Contact: 410-558-4800  
Hours: M 10am-8pm, Tu-F 8am-8pm, 2nd and 4th Sat 9am-1pm
2. Orleans Square:  
Address: 2323 Orleans St. Baltimore, MD 21224  
Contact: (410) 558-4747  
Hours: M-F 8am-5pm
3. Highlandtown Healthy Living Center:  
Address: 3700 Fleet St Baltimore, MD 21224  
Contact: 410-558-4900  
Hours: M, Tu, W, F 8am-5pm, Th 10am-7pm, Sat 9am-1pm

## Shepherd's Clinic:

Address: 2800 Kirk Ave, Baltimore, MD 21218

Contact: (410) 467-7140

Hours: Tu-Th 9am-4pm Friday 9am-1pm

Description: Clinic offers free medical service to people from the following zip codes:

21211, 21212, 21213, 21214, 21215, 21218, 21234, 21239, and 21206

No insurance needed, but \$9.00 suggested donation for an office visit. Services include clinical, mental health, wellness, and pharmacy.

## Health Care for the Homeless

Address: 2000 W. Baltimore St., Suite 247, Baltimore, MD 21223

Contact: 443-703-1400

Hours: Monday, Tuesday, Wednesday, Friday – 8am-5pm; Thursday – 8am-12pm

Description: medical care provided regardless of insurance or citizenship status, if patient is living on the streets, in shelters or transitional housing, living in abandoned buildings or vehicles, "doubled up", or staying with friends, neighbors or relatives, released from a hospital or prison without a stable housing situation to go to.

### Health Care Access Maryland

Description: Program that can help enroll you in insurance programs or can help find health programs in your community

#### Locations:

1. Baltimore City Health Department (East)  
Address: 620 N Caroline Street Baltimore, MD 21205  
Contact: 410-500-4710  
Hours: Monday: 8:30am - 5:00pm, Tuesday: 8:30am - 5:00pm
2. Baltimore City Health Department (West)  
Address: 1515 W. North Avenue Baltimore, MD 21217  
Contact: 410-500-4710  
Hours: Wednesday: 8:30am - 5:00pm, Thursday: 8:30am - 5:00pm, Friday: 8:30am - 5:00pm

### Total Health Care

Description: offers free and discounted services to those underinsured or uninsured. Must apply for these services ahead of time. There are several locations that provide different services including general health, men's health, STI/STD screenings, children's health, substance abuse, pharmacy.

Hours vary from location to location. Contact (410) 383-8300 for times and services at your preferred location unless other contact information is specified. Most of the center are open M-F 8:30am-5:30pm

#### Locations:

1. Open Gates Health Center:  
Address: 1111 Washington Boulevard Baltimore, MD 21230
2. Mt. Royal Health Center:  
Address: 922 W. North Avenue Baltimore, MD 21217
3. Men's Health Center:  
Address: 1515 W. North Avenue Baltimore, MD 21217
4. Division Health Center:  
Address: 1501 Division Street Baltimore, MD 21217
5. Kirk Health Center  
Address: 2400 Kirk Avenue Baltimore, MD 21218
6. Mondawmin Mall Health Center

Address: 2401 Liberty Heights Avenue, Suite 111-113 Baltimore, MD 21215

7. Odenton Health Center

Address: 1215 Annapolis Road Suite 107 Odenton, MD 21113

Contact: (410) 735-5719

8. Saratoga Health Center

Address: 1501 W. Saratoga Street Baltimore, MD 21223

9. Westside Health Center

Address: 2449 W. Frederick Avenue Baltimore, MD 21223

### STD Clinics

Description: These clinics provide free and confidential testing, diagnosis and treatment for STIs, including chlamydia, gonorrhea, trichomonas, NGU, syphilis, herpes simplex virus, genital warts (HPV), and HIV. They also provide testing, diagnosis and treatment for yeast infections, bacterial vaginosis, and Hepatitis C. Most services are free and no appointment needed.

Hours: Monday - Wednesday: 8:30AM - 5:00PM (must register at the clinic by 4:00PM)

Thursday: 8:30AM - 1:00PM (must register by noon)

Friday: 8:30AM - 5:00PM (must register at the clinic by 4:00PM)

1. Druid STD Clinic

Address: 1515 W. North Ave, Baltimore, MD 21217

Contact: (410) 396-0176

2. Eastern STD Clinic

Address: 620 North Caroline St., Baltimore, MD 21205

Contact: (410) 396-9410

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