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Feminist Abolitionist Nursing

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The converging crises of COVID-19 and racist state violence in 2020 shifted public discourse about marginalization, public health, and racism in unprecedented ways. Nursing responded to the pandemic with heroic commitment and new politicization. But public engagement with systemic racism is forcing a reckoning in nursing. The profession has its own history of racism and of alliance with systems of state control with which to contend. In this article, we argue nursing must adopt an ethics of abolitionism to realize its goals for health and justice. Abolitionism theorizes that policing and prison systems, originating from systems of enslavement and colonial rule, continue to function as originally intended, causing racial oppression and violence. The harms of these systems will not be resolved through their reform but through creation of entirely new approaches to community support. Nursing as a collective can contribute to abolitionist projects through advocacy, practice, and research.
Key words: *abolition*, *anti-racism*, *carcerality*, *nursing ethics*, *prison*, *social justice*

THE TWINNED CRISES OF COVID-19 outbreaks in prison and jails and racist, lethal police violence in spring 2020 briefly normalized public conversations about defunding police and abolishing prison systems in Canada and the United States. The pandemic exposed how custody facilities including prisons and jails are hotbeds for the transmission of infectious disease among incarcerated people and staff alike. People in prison are likely to experience chronic illnesses that increase their susceptibility to infection.[1] The prison environment itself exacerbates risks as it is unhygienic, crowded, and poorly ventilated. Prisons are also characterized by constant transport of people in and out, facilitating infection transmission. As of December 2020, a total of 210 000 people in US prisons had contracted COVID-19 and more than 1800 had died.[2] In February 2021, a total of 5550 cases of COVID-19 were linked to prison and jails in Canada.[3]

As Boyd described in the *Lancet*, "Police killing black Americans is one of the oldest forms of structural racism in the USA. The act traces its roots to slavery."[4(p258)] The murders by police in spring 2020 of Black medic Breonna Taylor, asleep in her bed, and of George Floyd, who witnesses videotaped being asphyxiated for more than 8 minutes, crossed a line in public consciousness and prompted international response. At the same time, across the United States and Canada, we

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Statements of Significance

What is known or assumed to be true about this topic?

COVID-19 has disproportionately affected marginalized and oppressed populations including Black, Indigenous, and People of Color.

Marginalized and oppressed populations including Black, Indigenous, and People of Color are disproportionately policed and incarcerated in Canada and the United States.

Prisons are harmful to health.

Abolitionism theorizes that policing and prison systems must be dismantled, not reformed.

What this article adds:

An argument that racism in nursing prevents the profession from addressing social and political determinants of health, including the harm to health caused by policing and prisons.

An argument that nursing must adopt an ethics of abolitionism to realize goals of health and justice.

Suggestions for how nursing as a collective can contribute to abolitionism through policy, practice, and research.

saw efforts at "policing the pandemic"[5(p5)] through ticketing the poor and unhoused for failure to stay home or social distance. Public health actions that impinge on personal liberty can be justified to protect society's most vulnerable but must respect human rights.[6] Snitch lines, fines, and criminalizing practices received widespread criticism as inappropriate, worsening inequities, exacerbating the pandemic problems of crowded jails and economic deprivation, and placing Black, Indigenous, and People of Color (BIPOC) at an elevated risk of police brutality.[7,8] Across the continent, we have heard calls for collective care and investments in community infrastructure in lieu of punitive methods.

Carceral systems include or relate to the act of imprisonment. The term "carceral" has come to encompass "forms of confinement, be they state-sanctioned, quasi-legal, ad-hoc, illicit, spatially fixed, mobile, embodied or imagined."[8(p668)] Human geographers explain carcerality as extending beyond a space, to an experience of being under surveillance, policed, controlled, or punished. Nursing interacts with carceral systems not only within prison health units, immigration detention centers, and forensic hospitals but also in community hospitals and clinics, harm-reduction services, research and education, public health surveillance, and in public policy development and implementation. We argue the realities of policing and prison operations conflict intractably with nursing ethics, and, moreover, nursing ethics require us to push beyond calls for reform to demand, and participate in, sustainable transformation of carceral systems.

Abolitionism is a theory and a practice of creative and compassionate responses to social harms that do not repeat the very violence the justice system ought to remedy.[9] We focus our discussion in this article on prison abolition. While there are many possible prison abolitionist platforms to examine, it generally includes (1) releasing people who are incarcerated; (2) reducing the budgets and presence of police and military in communities; (3) decriminalizing substance use, sex work, and poverty; and (4) ensuring equitable access to housing, food, economic security, and health care. Abolitionism balances investments to prevent harm, such as in meeting basic needs, with divesting from punitive systems rather than adjusting them. Abolitionism considers how reforms to improve conditions inside carceral facilities fail to address the root problems behind escalating detention and incarceration: poverty, racism, and trauma. Reforms, such as more education or body cameras for police officers, misdirect investment into carceral systems rather than toward upstream efforts to improve communities and reduce criminalization.

Abolitionism rejects the normalization of carceral systems in our daily lives. Hudson and Wright propose that nursing engage with

abolition politics to "expand its horizon of responsibility" and enter the "realm of legal and political change-making."[10(p354)] Given the pervasive harms of carceral systems, this engagement is an ethical responsibility for nurses in all areas of practice. Our embeddedness in White supremacy has prevented nursing from living up to our professional ideals. In this article, we build on the arguments of Hudson and Wright[10] to present abolition as a necessary foundation for nursing practice. As authors, our clinical and research interests include reproductive care, nursing leadership, and Black and Indigenous health and the intersection with the justice system. While we draw on examples from our respective foci, the abolitionist imperative transcends practice areas and addresses social inequities beyond health care environments. Shaped by gender bias, racism, and class oppression, policing and incarceration cumulate in poorer individual health outcomes, family disintegration, and threats to community and public health that are disproportionately experienced by groups of people already marginalized. Nursing has a long history of participation in carceral systems beyond prisons, such as eugenic control of reproduction,[11] intrusive public health monitoring, and involuntary psychiatric treatment.[12] But nursing has also long participated in action for social justice[13] and is positioned now to address social harms within and outside of carceral systems—including the gendered, raced, and classed experiences of economic deprivation, barriers to services, deepening emotional and mental health difficulties, and increasing exposures to violence wrought by the pandemic—through abolitionist practice.

This article comprises 5 sections. First, we explain the colonial, racist origins of policing, as policing is the precursor to incarceration. Second, we outline how the lived realities of people in prison substantiate the urgent need for abolition to address public health inequities and human rights abuses. Third, we discuss the need for nursing to accelerate and deepen its engagement in political advocacy. Fourth, we critique reformism and explain political and ethical concepts foundational to abolitionist nursing. Finally, we consider how to operationalize abolition in nursing policy, research, and practice.

THE COLONIAL, RACIST ORIGINS OF POLICING

Prison and policing systems in Canada and the United States are traceable back to the enslavement era and the beginning of colonialism. Knowing this history allows nursing to consider our complicity with policing and prison systems. Police and policing systems were first established in the colonized land that is now called Canada in 1873 as a means of controlling and punishing interference with developing the colonial state.[14] In Canada, the force's original function was to "keep order" and ensure the transfer of land from Indigenous Nations to the newly created Canadian federal government. The oppression and intergenerational trauma experienced by Indigenous peoples in Canada are directly linked to the creation of reserve lands, forced relocation of communities from their traditional territories, and the surveillance through pass and identification systems.[15] Although the pass system and the residential school regime were formally rescinded in the 1950s and as late as 1996, respectively, colonial control of Indigenous peoples remains a contemporary issue.

In the United States, chattel slavery was a precursor to the policing and confinement of Black people.[16] Armed patrols operated from early in the 18th century in the US South to police enslaved people. Formerly enslaved or freed Black people were commonly depicted as criminals to justify re-enslavement.[14] Slavery solidified the surveillance and discipline of enslaved Africans and reduced opportunities for resistance. As depicted in the 2016 film *13th*, the abolition of slavery through the 13th Amendment did not abolish racial hierarchy or discriminatory beliefs about Black people.[17] The 13th Amendment threatened the economic well-being of societies

that depended on the labor of enslaved people.[16] The growing realization that Black people could potentially "be free" festered a sentiment of fear. An exaggerated association between Blackness and criminality substantiated maintenance and enhancement of surveillance and control of Black people. Pathologizing Blackness, and regarding Black people as inherently criminal, enabled creation of racist laws in the name of maintaining peace.[14] Thus, African Americans were and continue to be "re-enslaved" through the prison industrial complex, which is documented as overincarcerating Black people, exploiting labor of prisoners, as well as physical, mental, and spiritual abuse.[16,17]

Policing and prisons continue to operate as they were originally intended—to uphold and reinforce oppressive racial, gendered, and socioeconomic hierarchies. A careful examination of law enforcement, prisons, the courts, and parole boards reveals the ways in which pieces of the criminal legal system interact to exert control.[14] Abolitionist approaches enlarge our field of vision so that rather than focusing myopically on these problematic institutions and asking how they need to be changed, we raise radical questions about the problematic organization of the larger society that relies on them.

Although we often hear about racism and policing in the United States, BIPOC are also disproportionately killed by police in Canada. Police killings of BIPOC in Canada in spring 2020 brought to the surface the contradiction of engaging police to address mental illness. These include D'Andre Campbell (Black) and Chantel Moore (Indigenous), who were shot, and Regis Korchinski-Paquet (Indigenous and Black), who fell from a balcony, all during calls to check on their mental health.

LIVED REALITIES OF PEOPLE IN PRISON

The COVID-19 pandemic brought attention to long-festering problems with health services in prison institutions. People experience complex health needs and barriers to care during and after incarceration. Prisons reflect classism, racism, colonialism, transphobia, and homophobia; the most excluded populations in society are most policed and incarcerated.

Racism, colonialism, and prison

The burden of incarceration is excessively born by BIPOC in the United States and Canada. These same populations also experienced excessive burdens from COVID-19.[18] The US rate of incarceration is 419 per 100 000 people, the highest in the world, but among Black residents the rate is 1096, more than double the average.[19] Black adults are imprisoned at 5 times the rate of White adults in the United States. In Canada, the rate of incarceration is approximately 114 per 100 000 people,[20] and yet among Indigenous people, it is 10 times higher (n = 1378).[21]

The high imprisonment rate of Indigenous people is a continuation of genocidal colonial state processes.[22] Over the course of the 20th century, hundreds of thousands of Indigenous children were forcibly removed from their homes to be sent to church-run Residential Schools, in which they were abused. In the 1960s, Indigenous children were placed in the permanent care of White parents in what is known as the Sixties Scoop, and in the ongoing Millennium Scoop, the child welfare system still disproportionately removes Indigenous children from their homes.

Roberts[23] coined the term "family policing" to describe how child welfare systems monitor and harm families. Although only 7.7% of children in Canada are Indigenous, they make up 52.5% of the children removed by the state.[24] When last studied, approximately two-thirds of Indigenous people in federal prison experienced adoption or placement outside their communities as children.[25]

Prison and child welfare are public systems that normalize state intervention and dismantling of communities. Overincarceration is both a consequence of and a pathway to child welfare system involvement. The Truth and

Reconciliation Commission of Canada, examining the impact of the Residential Schools, demanded action on the overincarceration of Indigenous people, the overrepresentation of Indigenous children in foster care, and health inequity attributable to colonial, racist policies.[26] Everyone in Canada is to heed these calls, including nurses, who are specifically named in the report.[26]

Health

COVID-19 transmission, as well as other infectious and chronic disease, chronic pain, mental illness, and substance use are all more common in prisons than in community.[1] The early experience of trauma, and subsequent mental illness and substance use, can create pathways to prison. The prison environment is also a site of elevated rates of injury, violence, sexual assault, self-harm, suicide, homicide, and death.[26]

Prison is often framed as an "opportunity" to seek treatment of people otherwise excluded from health care access and that the inadequacies of prison-based health services could be remedied with more investment or oversight. Although the American Nurses Association (ANA) Code of Ethics states health is a universal human right,[27] in the United States, incarcerated people are the only ones with a constitutional right to health care (*Estelle v Gamble*, 1976).[28] Despite this right on paper, prisons are sites of some of the poorest health service delivery. COVID-19 exposed how prisons are antithetical to health and how the risks of prison are unevenly experienced.

Gender and prison

Gender roles and discrimination cause women, transgender, and nonbinary people to experience criminalization and incarceration differently than men do. Most have experienced sexual trauma and physical abuse in childhood, economic deprivation, housing instability, unemployment, restrictions on educational, and barriers to health care.[1] In the United States, women are also burdened by the mass criminalization of male family members.[29] Abolition is a feminist issue.

Early trauma in the lives of women and BIPOC who experience incarceration is used to justify harsher punishment. Trauma continues to be applied as a dynamic factor in security-level risk assessment in Canadian federal prisons. Those who have experienced more trauma receive a higher classification score, resulting in restricted access to programming and visiting.[30-32] This has long-term consequences, as failure to complete programming hinders eligibility for parole.

The incarceration of women has extensive family and community implications. They are more likely than men to be the primary support for children; when women are incarcerated, their children are at risk of involvement in child welfare services. Children who are removed by the state are at an increased risk of criminalization. This multisystem interference threatens reproductive health and rights broadly speaking, including the rights of people to choose when to have children, and to have safe, supportive conditions for the pregnancy, birth, and raising of children.[33]

The increasing incarceration of women exposes inadequate access to reproductive health services and harms reproductive choices, family formation, and connection to community. Prison drives reproductive oppression through institutional control of body movement, limitations on reproductive decision-making and health services for women inside carceral spaces, and separation from children and disrupted reproduction.[29] Threats to reproductive justice include lack of family contact, trauma backgrounds that interfere with parenting, ethical problems and service gaps during pregnancy, inadequate support to retain legal custody of children, and challenges with co-parenting and engagement with child welfare regimes.[34] These experiences are also disproportionately borne by BIPOC and people who identify as members of lesbian, gay, bisexual, trans, queer, and Two-Spirit communities (LGBTQ2S+).

Transphobia, homophobia, and prison

Recent policy changes in Canada allow transgender and nonbinary people to be admitted to federal prisons for men or women according to their gender expression, not anatomy.[35] The 2011 *Adams v Bureau of Prisons* decision affirmed the right to access hormonal treatment of transgender people incarcerated in the United States. Despite these changes, prisons remain institutions that enforce the gender binary. Research with people in prison is rarely trans-inclusive or specific to gender minorities, although 1 in 6 transgender people in the United States and 1 in 2 Black transgender women have experienced incarceration.[36] Furthermore, 42% of women in prison in the United States identified as sexual minorities,[37] and a recent study in Canada found 29% of women in a provincial jail identified as lesbian or bisexual.[38] Prisons are ill equipped to address the health needs of LGTBQ2S+ communities. For nursing to address the intersecting impacts of racism and colonialism, sexism, homophobia, and transphobia on the health of people experiencing incarceration, nursing must engage with political action. Our profession must reckon with its own oppressive practices.

NURSING, RACISM, AND POLITICAL ADVOCACY

For nursing to confront the racism, colonialism, and other systemic oppressive forces at work in carceral systems, nursing must first look inward. Nursing continues to be, as Puzan[39] articulated nearly 20 years ago, "unbearable" in its whiteness. There continues to be little to no data available about race and racism in the contemporary nursing profession in Canada. The Canadian Institutes of Health Information report *Nursing in Canada 2018* does not mention race.[40] Canadian schools of nursing do not routinely collect or publish these statistics. However, racism in nursing is closely tracked in the United States, where more than 75% of nurses identify as White and only 9.9% identify as Black.[41]

Color blindness crafted through lack of data masks pernicious harm. In a 2012 qualitative study of Indigenous nurses' experiences of racism in Canada, participants described being treated as outsiders, judged, and feeling uncertain to speak up.[42] Indigenous nurses face barriers to including traditional knowledge and aspects of their identity in their practices.[43] Exclusion of Black nurses can translate into mistrust of the health system by Black patients.[44]

The racism enacted through the profession causes harm to health. The well-publicized, disproportionate burden of COVID-19 in Black, Indigenous, and other racialized communities laid bare how racism manifests in health systems. Nurses bear some responsibility for this consequence. Ruha Benjamin describes how, in response to an analysis of racism and the pandemic's impact on Black people, a self-identified White nurse insisted, "It is a choice of their own.... They damaged themselves."[45] Nursing cannot critique carceral systems while clinging to racist narratives of personal responsibility and "choice," and without understanding structures of oppression.

Politicizing nursing

In response to the spring 2020 police killings of Black civilians in the United States and Canada, many nursing organizations released anti-racism statements that recognized the participation of nursing in "centuries-old injustice" and called for the removal of "areas of bias that perpetuate negative behaviors and reinforce harmful stereotypes and stigmas.[46,47] This extends to those biases held by nurses.[46] The calls urged nurses to respond to racism when they saw it occur,[46] presumably in interpersonal health care interactions, but provided less clarity about how nursing could hold powerful and punitive institutions to account. Notably, these nursing organizations did not join the calls to defund police and decarcerate prisons. Dismantling

racism requires dismantling these violent systems, contemporary forms of slave patrols, and Residential Schools. But nursing works in collaboration with these institutions.

Consider a passage in Dorothy Roberts' canonical text on racism and state reproductive control, *Killing the Black Body.* She describes how Shirley Brown, a White nurse in South Carolina, spearheaded a campaign in the 1980s to criminalize and force treatment on Black women for prenatal drug use.[48] Now, half of US states label and prosecute drug use in pregnancy as child abuse and require health professionals report suspicions about it to child welfare agencies.[49] In Canada, pregnant people cannot be charged with child endangerment for actions during pregnancy. However, they can have their children immediately removed at birth. Nurses, other care providers, and social workers initiate "birth alerts" that notify child welfare agencies of a birth in a family already under its surveillance. In 2019-2020, 442 infants were removed from their parents in Ontario alone, with half of the referrals from health care professionals.[50] Birth alerts are widely criticized for their basis in racist and colonial belief that Indigenous mothers are unable to safely care for their babies.[51] In response to calls to end the practice, 6 provinces and territories have announced plans to ban the practice.[50] Nursing organizations have avoided political leadership in these discussions.

The disruptive political work demanded of nursing to intervene in carceral systems will not come easily.[10] Sexism, the medical hierarchy, employer nondisclosure agreements, and fear of reprisal subjugate nursing's voice and agency.[52] Nursing education and practice privilege task orientation over theory. In the COVID-19 era, nurses are exhausted and overworked by the immediate and day-to-day demands of pandemic response. However, the pandemic has also politicized nurses perhaps more than ever. Much of this advocacy centered on the rights of nurses themselves, such as nursing unions fighting for adequate personal protective equipment and safety standards,[53] priority access to vaccination,[54] and solutions to chronic understaffing.[55] Some of the advocacy extended beyond the safety of the professional context to address social issues. For example, nursing organizations, recognizing the disproportionate burden of COVID-19 on Black and racialized communities, campaigned for improved collection of race-disaggregated data regarding COVID-19 vaccination.[56]

Legal and regulatory requirements on nurses in carceral contexts

Nurses practicing in carceral contexts experience "dual loyalty,"[57] the conflict between duty to care for their incarcerated patients and duty to the carceral institution. Nurses' and correctional officers' responsibilities and goals are likely to be at odds with each other; however, nurses may want to maintain positive relationships with correctional officers to support safety within the institution and because of the nursing profession's patriarchal tradition of following orders.[58] Clinical care for the purposes of investigating patients, such as blood and urine toxicology screens, slips one role into the other.

Nurses working in carceral contexts are legally obligated to provide care at standards that are incompatible with incarceration, an ethical dilemma that itself supports an abolitionist politic. In Canada, the *Corrections and Conditional Release Act* requires that federally sentenced people be provided with essential health care and reasonable access to nonessential health care.[59] The Eighth Amendment to the US Constitution protects against cruel and unusual punishment and is interpreted as requiring the state to provide health services to incarcerated people.[27] The United Nations' Minimum Standards for the Treatment of Prisoners (the *Mandela Rules*) state health care professionals must treat patients in prisons with the same ethical and professional standards as they do patients in community, and they are prohibited from engaging in acts of cruelty or punishment,

such as solitary confinement.[60] Despite the best efforts of many health care professionals who work in carceral systems specifically to address the inhumane conditions and disproportionate burden of illness therein, ethical practice is out of reach in a fundamentally unethical context. The requirements of the *Mandela Rules* are aspirational, and violated routinely, undermining their enforceability and value.

Multiple nursing organizations have issued position statements regarding care inside correctional facilities. The ANA published nursing scope and standards specific to carceral settings.[61] The Association of Women's Health, Obstetrics and Neonatal Nurses issued a position statement advocating for community alternatives to incarceration and for laws against shackling of pregnant people.[62] The International Council of Nurses (ICN) endorsed the *Mandela Rules*.[63]

The ICN asserts prisoners' rights to health care and condemns denial of care or acts that could harm mental or physical health and requires that nurses who are aware of maltreatment of prisoners act to protect them.[63] There are many examples of courageous nurse whistleblowers who faced punishment for doing just that. Nurse Jose Vallejo was terminated after speaking out about understaffing, lack of training, and unsafe practices at an Arizona prison.[64] Nurse Dawn Wooten publicly alleged medical neglect, COVID-19 mismanagement, and forced sterilizations of women in an immigration detention facility in Georgia. Her whistleblowing came at enormous personal cost—demotion and reprimand for alleged complicity in the harms.[65]

Nurses are not routinely taught the *Mandela Rules*, or how to navigate real-life challenges to upholding them. Without a strong understanding of both legislated requirements and international standards for health practices in prisons, nurses risk becoming subsumed into carceral functions. There may be individual professional consequences for nurses who do not, including civil lawsuits and discipline from regulatory bodies. Foundational nursing ethics are protective and align with abolitionism.

Nursing ethics

The code of ethics for nurses in Canada describes 7 primary values to govern personal practice, beginning with "providing safe, compassionate, competent and ethical care."[66] To do so requires building "trustworthy relationships" and having the ability to intervene, report, and address unsafe and unethical conditions. The ANA Code of Ethics begins similarly with the provision, "The nurse practices with compassion and respect for the inherent dignity, worth and the unique attributes of every person," and continues "The nurse's primary commitment is to the patient."[27] Conflict is to be avoided, and when conflicts arise, nurses are required to work in the patient's best interests.

The experience of incarceration and the conditions in prisons interfere with patients' emotional and physical safety, and institutional policies often place security concerns over basic norms of compassionate care. The ethical principles of these Codes rub up against what is possible in the carceral context. Many of the other principles align with abolitionist political action, including "promoting justice" in the Canadian Nurses Association (CNA) code and "Protect human rights" in the ANA code. In Canada, this principle requires respecting the Truth and Reconciliation Commission of Canada Calls to Action for the Rights of Indigenous Peoples and a prohibition on any form of engagement in punishment or complicity in punishment. In the United States, the provision requires nurses address social contexts where human rights are under threat or violated. These nonnegotiable stipulations in both codes of ethics are a sound foundation on which to build abolitionist practice.

Abolitionism as collective praxis

Abolitionism may be threatening to nurses educated in systems that emphasized professionalism and clinical skills performance

with individual patients above community engagement and political solidarity. Nursing's obligation to advance social justice must be borne by nursing *collectively*.[67] In the cases we describe earlier, it was individual nurses who bore the cost of systemic problems with prison health services. This is both unfair and ineffective. Nurses are not liable for injustice, but we are responsible. We are better equipped as a group to bring about social justice than as individuals.[67]

Nurses are an enormous social group. There are 3.8 million registered nurses in the United States[41] and more than 400 000 in Canada[40]—more than 1 in every 100 people in these countries is a nurse. This is a powerful political lobby to demand not only an end to human rights violations by police and prisons but also an end to policing and prisons as state instruments of oppression, and the alternate investment in safe, equitable, health-promoting services.

For nursing to move from acknowledgment of injustice to action is theorized by Chinn and Kramer[68] as *emancipatory knowing*. The need for nursing to apply criticality and take action to address social inequity may also be found in the work of Kagan et al,[69] a volume highlighting the work of more than 40 nurse scholars to advance emancipatory frameworks. Adoption of abolitionism forces nurses to politicize outside of the prison health system, and the health system, to engage in emancipatory praxis in community. Nursing unions, schools, professional associations, regulatory bodies, and specialty organizations have a key role to play in collectivizing abolitionist nursing praxis.

ABOLITION VERSUS REFORM

Prison health researchers, advocates, and practitioners may recommend improvements in capacity, staff, and resources inside prisons to address urgent threats to health. They argue it is necessary to match the pace of increasing rates of incarceration with increasing investment to avoid the worst human rights abuses. We argue that reforms addressing the health experiences of incarcerated people without also calling for decarceration only further entrench the normalization of incarceration. We present 4 examples that problematize reform: (1) Creating Choices; (2) Mother Child Programs; (3) harm reduction; and (4) carceral feminism.

Creating Choices in Canada

The *Creating Choices* project is an example of how idealistic, feminist recommendations for prison reform resulted in expansion of the carceral system in Canada.[70] *Creating Choices* recommended closing the lone Prison for Women at the time. It introduced a new empowerment-focused model that recognized the trauma histories of women experiencing incarceration, their overall low security risk, and need for support over punishment. Despite its lofty goals, *Creating Choices* resulted in more prison facilities, more people behind bars, and tighter restrictions. In 1991, approximately 141 women per year received a federal sentence.[71] That number has risen steadily over time, and in 2019, a total of 357 women received a federal sentence,[72] an increase of 253% over almost 30 years. The failed legacy of *Creating Choices* is a powerful marker of how prison reform may result in increased incarceration.

Abolitionists conceive of the prison itself as a human rights violation, unamenable to remediation and unable to "solve the crises it creates."[73(p1)] By ostracizing people who have experienced incarceration from society, prisons relieve us "of thinking about the real issues afflicting those communities from which prisoners are drawn in such disproportionate numbers."[9(p16)] If we focus solely on the problems *in* prisons instead of the problem *of* prison, we risk losing our grasp on the need to dismantle punitive social systems. Nursing can address immediate threats to human rights inside while not losing sight of the greater goal of abolition.

Mother Child Programs

Around the world, nurseries in which children live with their incarcerated mothers are held up as a remedy to the harm of incarceration-related separation.[74] However, strict eligibility criteria result in highly unequal access. In Canada, infrequent use of and unequal access to the costly federal Mother Child Program reinforces inequity among incarcerated women.[74] Mothers may be ineligible for the program due to racism in assessments of their security risk.[32] There are only about 12 prison nursery programs in the United States, and in some of these states, women with a history of involvement with child welfare, itself influenced by systemic racism, may be restricted from participating. These inequities impact infant and maternal health. Instead of only advocating for programs inside prisons, abolitionist nursing practice works toward keeping families together within their own communities.

Harm reduction in prisons

Reforms to reduce the morbidity and mortality of substance use are becoming more common in prisons. In Canada, colonial trauma results in high rates of substance use and associated injuries. Injection drug use increases risk of blood-borne infection. While only 5% of the population in Canada, Indigenous people make up 10% of those diagnosed with HIV infection.[75] In 2018, Canada launched a prison needle exchange program (PNEP), now in 11 institutions including all 5 large women's facilities.[76] Globally, PNEP have successfully reduced needle sharing and transmission of infection among incarcerated people: "Such harm reduction programs are morally, fiscally, and pragmatically responsible and contribute to the protection of the community at large—in essence, prison health is public health."[76(p123)] Nurses must not only understand the evidence behind them and support their implementation but also recognize the limitations of harm reduction. People experiencing incarceration continue to risk discipline because drug use itself is not permitted. Furthermore, PNEP does not address the harms of prison: dehumanization, isolation, and violence. PNEP does not remedy reliance on substance use for relief.

Carceral feminism

"Carceral feminism" describes the reliance on prosecution, policing, and prison to address sexual or gendered violence.[77] In the age of #MeToo, the solution to sexual violence is often framed as harsher punishment and longer periods of incarceration. Forensic nursing care plays a critical role in justice seeking for survivors.[57] Despite, or perhaps because of this critical role, nursing must reckon with the fact that carceral facilities are sites of sexual violence. In 2017, the Correctional Services Canada investigated more sexual assaults than it had in the 5 years prior.[35] In the United States, reports of sexual assault in prisons tripled between 2011 and 2015, from 8000 to 25 000.[78]

Abolition acknowledges that not only has carceral feminism failed to reduce gender-based violence but also more policing and prisons inevitably amplifies the racism and discrimination already evident in policing and prisons.[79] Police may fail to investigate reports of sexual assault, fail to make arrests, and fail to refer those arrested to prosecution, and those prosecuted are rarely convicted. Studies in the 1990s found high rates of intimate partner violence in the homes of police officers; recent data are notably sparse.[80] Officers may commit sexual assault and violence against women while on the job. Abolition recognizes policing is not an appropriate or effective pathway toward justice for survivors of gendered violence. Prevention of violence must be fundamental to nursing work.

Reform ideas, such as prisons closer to home, children inside with their mothers, harm-reduction programs, or longer sentences for sexual offenses may sound on the surface like practical solutions to gendered problems with incarceration as it stands. Reform fails to take up the problems from their roots, however, and nurses should approach

these suggestions with critical thinking and creative alternatives.

ABOLITIONIST NURSING

Abolition is often criticized as unrealistic and idealistic. However, the abolition of slavery, for which nurse icon Harriet Tubman resolutely worked, was also considered unrealistic and idealistic. In this section, we present ideas to bring abolitionism to nursing work in policy, research, and practice.

Policy

Abolitionism includes not only divesting from prisons but also minimizing the possibility of criminalization. Nursing, from its historical position of White, middle- and upper-class privilege must reckon with what and who is criminalized in our society: people have experienced harm and who use substances to escape trauma and turn to theft for economic survival. We must also address violence in ways that provide true healing for those who are victimized and those who perpetrate violence. Abolitionism recognizes that the harms of policing and prison are disproportionately experienced by those who experience oppression and that criminalization is a tool of oppression. Nurses must participate in redefining criminalization, starting with calls to completely decriminalize substance use and sex work, and to divert people with serious mental illness from incarceration at every opportunity. Professional nursing bodies such as the CNA and the ANA have a role to play in advancing these calls and to advocate that public resources be directed into supportive services such as universal, publicly insured access to safe supplies of substances, to contraceptives, and to high-quality psychiatric services. Nursing regulatory bodies mandated to support public safety must recognize people who experience criminalization are part of that public.

Urgently, nursing must lead opposition to human rights abuses in contexts of policing and prisons. For example, nurses and health care providers can join the campaign to eliminate dry celling, the practice of holding an incarcerated person alone in a room without plumbing, under surveillance 24/7, until they defecate or vomit alleged contraband from their body cavities. This practice is retraumatizing and humiliating. Nurses are also well positioned to prevent shackling during clinical care, in particular the shackling of incarcerated pregnant people. Although no Canadian law stipulates prohibition of this practice, there are now about 30 US states with anti-shackling laws.[81]

We must exercise care with efforts to augment services for incarcerated people, however. For example, there are laudable efforts in Canada and the United States to improve perinatal care and support to incarcerated pregnant women, arguably the most sympathetic incarcerated group. The first author of this article is engaged in this very work. While well meaning, these efforts inevitably increase carceral budgets and risk making perinatal incarceration more acceptable. Instead of building new prison nurseries, we could support decarceration of prospective parents. Brazil no longer allows the pretrial detention of pregnant people, and in Italy, mothers of children younger than 10 years can serve their sentences at home, effectively eliminating the need for perinatal services.[82] Family supportive housing is also being used as a custody alternative for pregnant people and women with minor children.[83] Abolition does not suggest ignoring the immediate harms people in prison face or abandoning them. It requires careful consideration of why and how we could use our political clout to create new possibilities.

Research

Clinical research exploring the impact of incarceration on health experiences in Canada largely excludes consideration of reproductive health and the health of women.[1] As nurse scientists, we could focus on this clinical area and petition for access to prisons

for women, which may be particularly restricted to researchers. We could pilot initiatives to remedy inadequate service delivery, such as the benefits of introducing sexual and reproductive health services, staffed by nurses.[38] But these projects will not reduce incarceration.

In response to a court ruling that substandard prison care violated the rights of the incarcerated, Wang et al[84] studied the impact of a clinic for people *released* from prison in California. They found this successfully reached people at an extraordinarily high risk of being underserved: 86% of patients were BIPOC and 89% did not otherwise have a primary care provider. Researchers in Canada found providing permanent housing to people experiencing serious mental illness and chronic homelessness reduces their involvement with police systems.[1] Nursing research can similarly examine how introduction of accessible and appropriate health services may prevent criminalization in the first place.

Abolitionist nursing research could examine the health outcomes associated with alternatives to incarceration. For example, instead of pursuing research into the potential benefit of prison nurseries, we focus on noncarceral arrangements. There are several US examples, mostly attached to substance use treatment facilities.[81] As alternative programs grow, we can attain samples with adequate power to assess effects.

Consider Sanctum 1.5, a program created to reduce the harm of child removal from mothers who use substances or live with HIV infection. The program opened in 2018 in the province of Saskatchewan as housing with wraparound nursing support. Early findings are promising: very low rates of child removal, no vertical transmission of HIV, and overdose prevention.[85] Nurses can examine alternatives such as this to keep mother and child together outside of the prison walls.

In spring 2020, with monumental coordination, goodwill, and minimal funding, 41% of people incarcerated in the province of Nova Scotia were released to reduce the risk of a prison outbreak of COVID-19.[86] Unfortunately, in the haste and chaos of early pandemic response, arrangements were not made to study implications to health stemming from this intervention. Prison populations rose again thereafter. Should compassionate and prudent releases be successful again, we must seize this opportunity.

Clinical practice

Nurses will encounter criminalized individuals in all aspects of practice. However, it is nurses in prisons who are most directly imposed upon by this call for abolition. Prison abolition is often met with community concerns about the economic consequences of divesting; small, often rural economies would be drained of the resources prison building and operations bring. Similarly, abolition may be perceived as a direct threat to correctional nurses. We believe that correctional nurses are motivated by interest in improving the lives of criminalized people. Just as small and rural economies can be bolstered by alternative industries, so can correctional nurses work to advance the lives of oppressed individuals in nonpunitive settings.

Consider another example. Strip searching of incarcerated people is routinely required before and after clinical encounters both within correctional institutions and when people are transported to external health centers. Visitors to institutions may also be strip-searched. The objective of strip searching is, generously, to identify contraband that could cause harm to the person or others inside the institution. Researchers in Canada have found that strip searching is used incoherently across institutions and is experienced as sexual assault.[87,88] In her autobiography, Assata Shakur describes the nurse's involvement: "The 'internal search' was as humiliating and disgusting as it sounded. You sit on the edge of this table and the nurse holds your legs open and sticks a finger in your vagina and moves it around."[89(p83)] In our resistance to participating in searches for contraband, we can

advocate for decriminalization of substances and prescribe safe supplies.

We must consider how nursing invites policing into noncarceral settings, including health care institutions. Despite the intention of increasing security, placing guards and police inside health facilities risks public health and trust. Rather than liaise with or enact policing, nurses can consider how White supremacy and racism affect our interpretation of patient (or parent/spouse/visitor) distress. Instead of policing, nurses can contribute to developing policies and practices that center patient and family needs.

CONCLUSION

COVID-19 presented what could be the final breaking point in our reliance on criminalization as a response to structural inequity in Canada and the United States. Prisons and police are too harmful to public health for nurses to ignore the call for substantive change to these systems. Meaningful change will require not reform, but abolition. The patient-centered, justice-oriented, and practical orientation of nursing positions the discipline to adopt an abolitionist approach. Abolitionist practice demands reckoning with the social forces of colonialism, racism, and misogyny not only in prisons but also in nursing itself and of nursing's role in prisons and policing. Abolition honors the resistance, resilience, and power of women, gender minorities, and BIPOC experiences in carceral contexts and crafts social justice through actions and services that reduce the size and scope of the prison industry.

In policy, for nurses to take up this framework has the potential to shift belief in the appropriateness of criminalization as a response to harm and to advance conceptualizations of a broadly defined *public* that includes people in prison. In nursing research, abolition can expose the consequences of incarceration to health and equity and be the very ground to propose alternatives to prison and to examine their functioning. In practice, nurses can oppose policies that violate the rights of patients, even and especially if those patients are marginalized, isolated, and imprisoned. Nurses can seek to practice in ways that recognize our connectedness and are restorative to communities experiencing marginalization and criminalization.

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