



Best Practices to Assuage COVID-19 Risk in Jails and Prisons

9

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Introduction

The 2019 novel coronavirus (SARS-CoV-2, which causes the disease COVID-19), has thus far (August 6, 2020) infected nearly 4.4 million people across the United States (CDC Covid Data Tracker, 2020). Approximately, 81,000 of those people are incarcerated in prisons (Covid Prison Project, 2020). Correctional settings and their residents have been disparately impacted by the virus, with a recent study from Johns Hopkins University indicating that infection rates are 5.5 times higher, and death rates 3 times higher, in prison facilities than in the general population (Saloner et al., 2020). Outbreaks are on the rise, as, according to the Covid Prison Project, 90 of the 100 largest clusters of COVID-19 in the United States can be found in prison and jail facilities (Covid Prison Project, 2020). Many of those incarcerated in prison facilities suffer from a conditions that increase the likelihood of severe illness and death due to COVID-19. Meanwhile, the facilities' built environments and poor sanitation practices inhibit residents from practicing social distancing and adhering to other precautionary and preventive measures recommended by the Centers for Disease Control and Prevention (CDC) (Kajstura & Landon, 2020). In order to stop the rapid, deadly spread of COVID-19 throughout prisons, efforts must be made to decarcerate via compassionate release and the elimination of cash bail. At the very least, mass testing, humane methods for medical quarantine and isolation, and vaccination, when available, must be instituted in prisons. Evolving policy and procedural changes must also be critically examined.

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Disproportionate Burden of Chronic Illness and an Aging Population

Many residents of prisons and jails have a higher burden of poor health outcomes, putting them at great risk for severe COVID-19 morbidity and mortality. Disparities in social and structural determinants of health disproportionately impact racial minorities, those experiencing homelessness, and persons with substance use disorders or mental illness, all of whom are more likely to be incarcerated due to mass incarceration's roots in racial inequities and discriminatory practices. People who are incarcerated also have a higher burden of poor health outcomes making them more likely to suffer severely from COVID-19 (García & Sharif, 2015). According to the Bureau of Justice Statistics, 43.9% of people detained in federal and state correctional facilities have experienced a chronic medical condition, compared to 31% of the general population (Maruschak et al., 2016). Specific conditions that disparately impact people in prisons and jails and pose an increased risk of severe illness in conjunction with COVID-19 include asthma, diabetes, hypertension, and human immunodeficiency virus (Saloner et al., 2020; Maruschak et al., 2016). Disparities in social and structural determinants of health disproportionately impact racial and ethnic minorities, those experiencing homelessness, and persons with substance use disorders or mental illness, all of whom are more likely to be incarcerated due to mass incarceration's roots in racial inequities and discriminatory practices (García & Sharif, 2015; Akiyama et al., 2020). People who are incarcerated also have a higher burden of poor health outcomes making them more likely to suffer severely from COVID-19 (Binswanger et al., 2012).

In addition, much of the US prison population is aging due to harsh sentencing policies. Specifically, 11% of those who are incarcerated (approximately 165,000 people) in US prisons are over the age of 55 (Li & Lewis, 2020). Meanwhile, eight out of ten COVID-19-related deaths in the United States have been of people over the age of 65 (Freed et al., 2020). This is all compounded by the reality that people may age faster in prison than in outside communities due to both histories of poor health and poor healthcare access as well as the psychological and physiological stress of carceral settings (Greene et al., 2018).

Built Environment Amplifies COVID-19 Risk

Essential to efforts to curb the spread of COVID-19 is the practice of social distancing. Unfortunately, social distancing is nearly impossible in prison and jail facilities, many of which are often overcrowded. In 2014, 18 states reported that they were operating correctional facilities overcapacity (McCarthy, 2018). This is unsurprising, as the US incarceration rate has grown by 500% over the past 40 years ("Criminal Justice Facts", 2020). Many residents of prisons also live in dormitory-style housing, sleeping, and using the restroom less than 6 feet apart from one another. The Centers for Disease Control and Prevention has advised that in order to prevent the spread of COVID-19 to this at-risk population, social distancing, quarantining, and medical isolation are necessary (Centers for Disease Control, 2020). Occupancy levels based on 2017 estimates place the US prison system at 99.8% of official capacity on average (World Prison Brief: USA, 2017; Kajstura & Landon, 2020). For example, lawsuits have been filed against California men's facility that was built to hold 80 people but was housing 129 in narrowly spaced bunk beds (Vansickle, 2020).

Correctional Setting Best Practices

Decarceration

To curb the spread of COVID-19 among those who are incarcerated, the number of people housed in correctional facilities must be reduced. Population reduction combats strain on the resources and space required to keep people who are incarcerated free from infection. This could be achieved through early, compassionate release of those already incarcerated or detained as well as through the elimination of the practice of cash bail.

Compassionate Release

Across the country, a variety of stakeholders are calling for their community members to be released from correctional facilities in light of COVID-19. Many have rightfully argued that being incarcerated during a global pandemic has become a form of the death penalty or equivalent to a death sentence (Eisen & Sangree, 2020). Activists in Miami Dade county called for the release of all people in jail who are incarcerated pretrial on bondable offenses or who have fewer than 60 days of their sentence remaining as well as for the issuance of a moratorium on new bookings and incarceratory sentences (Dream Defenders, 2020). Researchers are calling for the release or parole individuals who have a residential placement option in the community and are within 1–2 years of their release, or who have served the vast majority of their sentence (Dream Defenders, 2020).

Many states have already adopted policies to reduce the populations of their correctional facilities in light of COVID-19 (“Criminal justice responses to the coronavirus pandemic”, 2020). Specifically, 23, or 45%, of states have adopted some type of policy focused on expedited or early release (Covid Prison Project, 2020). In California, all residents of state prisons who are serving time for nonviolent offenses and who have less than 180 days remaining to serve are now eligible for supervised release. In addition, people who are scheduled to return to the community in the near term and who are medically vulnerable are also being considered for early release (“Criminal justice responses to the coronavirus pandemic”, 2020). Legislators and organizers in New Jersey are working to pass groundbreaking legislation that would reduce sentences by 4 months for each month served (up to 8 months) during public health emergencies (“Criminal justice responses to the coronavirus pandemic”, 2020).

However, many policies have not been carried out as promised. For example, in Louisiana, 1100 people were scheduled to be considered for release. The panel reviewing these cases was only operational for approximately 2 months, during which time only 600 people had their cases reviewed and only 63 people were released (“Criminal justice responses to the coronavirus pandemic”, 2020). In Pennsylvania, as of April 2020, 1800 people were expected to be impacted by new release policies related to COVID-19. In reality, only 150 people have been released as a result of these policies (“Criminal justice responses to the coronavirus pandemic”, 2020).

Early releases have also been plagued by racial disparities. In Illinois, during the first 3 months of the coronavirus pandemic, 43% of people who were released early were white, while only 32% of the prison population is white. In contrast, 46% of people who were released early were Black, while 54% of the prison population is Black (Rivera, 2020). Such disparities have also been present in the release of youth from juvenile facilities. A report by the Annie E. Casey Foundation revealed that, prior to the coronavirus pandemic, white youth were released from juvenile facilities at a rate 7% greater than Black youth. As of May 2020, white youth were released from juvenile facilities at a rate 17% greater

than Black youth (“Youth Detention Admissions Remain Low, But Releases Stall Despite COVID-19”, 2020). Compassionate release must be equitable.

While early release policies have sparked criticism and concern about the safety of surrounding communities, early data demonstrate otherwise. As of early July 2020, out of 1400 people who were released early due to coronavirus in New York, only 50 returned to jail, a recidivism rate of approximately 4%. Meanwhile, the average recidivism rate between 2001 and 2008 was 53% (Wells, 2020). In Illinois, 1000 people were released from Kane County Jail in response to COVID-19. Only 28 returned to jail, a recidivism rate of approximately 2%. Prior to the pandemic, Kane County Jail boasted recidivism rates close to 60% (Wells, 2020).

Ending Cash Bail

Common bail procedures currently discriminately punish those in poverty. The median felony bail bond amount is \$10,000, or the equivalent of 8 months’ income (Sawyer & Wagner, 2020). In addition, as detainment on cash bail can last anywhere from hours to months, the practice contributes to jail churn (the cycling of individuals in and out of correctional facilities) (Sawyer & Wagner, 2020). Jail churn, in turn, increases the risk that COVID-19 will be transmitted between correctional facilities and communities.

Baughman found that an additional 25% percent of defendants could be released pretrial without any increases to pretrial crime (Baughman, 2011). The study revealed that many counties could safely release older defendants, defendants with clean records, and defendants charged with fraud and public order offenses, all without threatening public safety (Baughman, 2011). Many police departments have also adopted “cite and release” policies for offenses that would have previously resulted in a jail booking (Surprenant, 2020). Cities across the country, including Baltimore, Los Angeles, Nashville, Philadelphia, and Portland, have issued statements indicating that they will no longer arrest, nor prosecute people for low-level offenses to limit population increases in correctional facilities (Miron & Partin, 2020).

Testing

Given that decarceration does not happen quickly, more widespread testing must be implemented rigorously within prisons and jails. Thus far, COVID-19 testing within prisons and jails has fallen into two broad categories: mitigation and surveillance. Mitigation strategies include robust testing efforts such as testing all new entrants and/or universal testing of all people who are incarcerated and staff. Surveillance strategies include public health surveillance (repeat testing for those at high risk due to exposure or health complications) or passive methods such as wastewater testing. For example, California has taken a public health surveillance approach, indicating that they are testing a representative sample that includes those at increased risk of both exposure and severe health complications from COVID-19 (i.e., elderly individuals), as well as engaging in repeat testing over time. Overall, California has administered 598 tests per 1000 incarcerated people (Covid Prison Project, 2020). Neither of these strategies is a panacea. While both mitigation and surveillance strategies are important, universal testing without repeat testing may miss outbreaks as they develop, and public health surveillance testing may miss asymptomatic carriers. Thus, it is important for facilities to conduct continual, comprehensive testing that includes both surveillance and mitigation strategies. To do this, states should partner with departments of health, political leaders, and policymakers to prioritize targeted and efficient administration of testing and contact tracing, as indicated by medical and public health professionals (Williams et al., 2020).

As of August 6, 2020, 10 states had yet to report any testing information regarding their correctional institutions (Covid Prison Project, 2020). Another 10 prison systems that have released testing information are testing fewer incarcerated people per 1000 than in their general populations (i.e., the “no testing” strategy). For example, Hawaii has tested only 63 incarcerated people, resulting in a testing prevalence of 15/1000. Other states in this category include Alabama, Illinois, Indiana, Louisiana, Mississippi, New Hampshire, New York, South Dakota, and Utah. (Covid Prison Project, 2020). These data are critical for understanding the prevalence of COVID-19. If states are testing very few incarcerated people, it is impossible to know the true impact of the virus on correctional facilities. Testing in these states must be improved upon.

Many states have started mass testing. 20 states (Alaska, Arkansas, California, Florida, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New Mexico, North Carolina, Rhode Island, Tennessee, Texas, Vermont, West Virginia, and Wisconsin) have administered more than 500 COVID-19 tests per 1000 incarcerated people. In these states, testing prevalence in correctional facilities surpasses that in the general population. Over the last few months, Maryland, Massachusetts, Michigan, Minnesota, New Mexico, Texas, Vermont, and Wisconsin have administered over one test per incarcerated person, indicating universal testing. However, some states claim to have expanded testing to all incarcerated people but, in reality, such expansion has been delayed or slowed. In Ohio, for instance, mass testing has been expanded in certain correctional facilities but not systematically throughout the state. Similarly inconsistent strategies have been implemented in Arizona and Florida. Arizona has administered more than one test per incarcerated person at its Phoenix and Safford facilities but few tests at many others (Covid Prison Project, 2020).

Ultimately, many correctional systems, even those that have not engaged in mass testing, have a testing prevalence per 1000 that exceeds that of the general population (Covid Prison Project, 2020). However, given that prison settings are congregant and have proven to be susceptible to outbreaks, testing rates must both increase and be continuous. Even in states that have been sites of devastating correctional outbreaks, testing remains inadequate.

In addition, even if testing has been scaled up for those who are incarcerated, information and policies regarding staff testing remain insufficient. Many states do not report staff testing or allow staff to self-report testing on a voluntary basis (Covid Prison Project, 2020). All long-term testing strategies must include testing of staff who move in and out of facilities and have community exposures to COVID-19 that they could transmit behind the walls of prisons and jails. With facilities closed to visitations, staff are the primary mode of entry into prisons and jails for COVID-19.

Medical Isolation and Quarantine

In the general population, both medical isolation and quarantine are recommended in certain circumstances to slow the transmission of COVID-19. In the context of correctional settings, medical isolation refers to isolating incarcerated people from the rest of the prison population when they show symptoms of or test positive for COVID-19. Quarantine refers to the separation or restriction of the movement of those that may have been exposed to COVID-19 until the results of tests confirm their COVID-19 status (Cloud et al., 2020). Unfortunately, in many correctional facilities, solitary confinement has been used as a mechanism through which to medically isolate and/or quarantine people who are incarcerated. The utilization of solitary confinement isolates individuals from their peers while simultaneously imposing penalties such as major restrictions on visitation, phone/video calls, recreation and outdoor time, and access to personal property.

Moreover, public health experts have argued that the use of solitary confinement as medical isolation and/or quarantine may actually worsen the spread of COVID-19 in prison facilities. Many people who are incarcerated may fear that if they show symptoms of the virus they will be placed in solitary confinement and thus choose not report feeling unwell. The use of solitary confinement and excessive lockdown also lessens the amount of time incarcerated people interact with prison staff, ultimately reducing the likelihood of symptoms being detected (Cloud et al., 2020). In addition, research has found that any exposure to solitary confinement is associated with an increased risk of death post-release, underscoring that it should only be used limitedly (Brinkley-Rubinstein et al., 2019).

In contrast to solitary confinement, it is recommended that those who are put in medical isolation as a result of COVID-19 be closely monitored by medical staff, have access to personal items and the telephone, be permitted to receive mental health services, and be advised exactly how long they will be isolated for (Centers for Disease Control and Prevention, 2020). It should be noted that the cells most often used for new COVID-19 medical isolation are the same cells that are commonly used to punish people and may still cause substantial psychological trauma and distress (Cloud et al., 2020). The collateral physical and mental health consequences of medical isolation, quarantine and lockdowns should be carefully considered and addressed. Clear delineation between solitary confinement and medical isolation will ensure that those who contract COVID-19 while incarcerated are not further punished, both mentally and physically, for circumstances beyond their control.

Vaccines

As the race to create and deploy vaccines to combat COVID-19 continues, people who are incarcerated and those who work in correctional facilities must not be forgotten. Decision-makers have discussed who ought to be prioritized during vaccine distribution. Conversations have thus far focused on a variety of groups, including healthcare providers, first responders, and pregnant people (Cohen, 2020). The comorbidities faced by people who are incarcerated, the built environment of correctional facilities, and the outbreaks that have thus far occurred in prisons and jails across the country suggest that those who are incarcerated should be prioritized in vaccine distribution.

Other Safety Measures

Per CDC guidance, best practices include reassigning and rearranging bunks to provide more space between individuals. The number of individuals housed in the same room should be minimized as much as possible. Ideally, there should be 6 feet or more between individuals in all directions. Bunks may be arranged so that individuals sleep head to foot to increase the distance between their faces. Facilities can also adjust scheduled movements to minimize the mixing of individuals from different housing areas (Centers for Disease Control and Prevention, 2020). The medical evaluation of individuals with COVID-19 symptoms should occur in a designated room near each housing unit so that they do not need to move through the facility in order to receive treatment. Additionally, there should be dedicated spaces within correctional facilities for the isolation of persons with confirmed or suspected COVID-19 who are not ill enough to warrant hospital transfer (Wurcel et al., 2020). If this is not feasible, facilities should consider staggering individuals' sick call visits (Centers for Disease Control and Prevention, 2020).

Policy Update

According to an evaluation conducted by the Covid Prison Project, there have been various policy and procedural responses from state departments of correction in an effort to curb the spread of COVID-19 and to provide relief to those who are incarcerated.

Some states have suspended medical co-pays for those who are incarcerated who are presenting flu-like symptoms (Covid Prison Project, 2020). Many facilities have publicly announced that they have curbed medical procedures and community health visits in an effort to prevent the spread of COVID-19, leaving prisons and jails to serve as the primary providers of health services for those who are incarcerated. However, many correctional facilities lack the medical supplies needed to treat people who get seriously ill from COVID-19, such as oxygen tanks, nasal cannulae, and oxygen face masks (Williams et al., 2020). Under these conditions, widespread community transmission of COVID-19 within a correctional institution is likely to result in a disproportionately high COVID-19 mortality rates.

Nearly all correctional facilities across the country suspended in-person visitation for incarcerated people in March of 2020 (Covid Prison Project, 2020). Many have also limited access to programming and various privileges. Some facilities have responded to this lack of connection with family, friends and legal counsel by instituting new technologies and supplementing costs. For example, correctional facilities have provided incarcerated individuals with a set amount of free phone calls and/or a set amount of free video calls (Covid Prison Project, 2020).

It should be noted that the success of implementing COVID-19 mitigation policies in correctional facilities is directly tied to access and availability of resources and labor. For example, many states require that all individuals who are incarcerated wear masks. However, as of April 2020, only 34 states reported providing masks to individuals who are incarcerated (Covid Prison Project, 2020). According to the Covid Prison Project, 34 states have reported bolstering their hygiene procedures, i.e., increasing access to hand sanitizer and/or soap (Covid Prison Project, 2020). However, some states have not done so, maintaining that those who are incarcerated should not have access to hand sanitizer due to its alcohol content (Tolan, 2020). In addition, many correctional facilities report instituting procedural changes, but use the substantially underpaid or unpaid labor of those who are incarcerated to enact such changes. For example, in many prisons, incarcerated individuals have been made to mass-produce masks (Covid Prison Project, 2020).

Finally, with employees acting as the bridge from correctional facilities to surrounding communities, it is essential to monitor staff health. Many facilities require monitoring employee symptoms, but different methods have varying levels of accuracy. 37 states require temperature checks as a screening precaution for staff (Covid Prison Project, 2020). Other employee policies range from general self-report, administration of screeners for symptoms, or, as previously noted, official routine testing (Covid Prison Project, 2020).

Conclusion

The issues of hyperincarceration and pandemic response, specifically COVID-19 response, have become increasingly interconnected. COVID-19 cases are highly concentrated in prisons and jails. Despite this, those who live and work in correctional facilities have received little attention and limited support, resulting in outbreaks, severe illness, and death. Progressive criminal legal system reform focused on decarceration methods, such as compassionate release and the elimination of cash bail, is necessary (Nowotny et al., 2020). Simultaneously, mitigation practices such as rigorous testing, social

distancing, humane medical isolation, and vaccination are critical to both determining the true prevalence of COVID-19 within prisons and jails and stopping its rapid spread. In addition, the COVID-19 pandemic has shed light on the relationship between prisons and jails and their surrounding communities. The virus is transmitted to prisons and jails through both staff and jail churn and, upon release, those who have been incarcerated return to communities that have been disproportionately impacted by COVID-19. Ultimately, COVID-19 poses a unique opportunity to revisit the issue of hyperincarceration in the United States, as decision-makers are forced to question the presumed health and safety of correctional facilities.

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