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COVID-19 and Correctional Facilities

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Most people understand that jails and prisons are fertile spaces for the COVID-19 virus. Fewer probably realize the magnitude of the problem or the combination of actions necessary to address it. Public health and public education coincide, so the purpose of this educational brief is to provide information about these subjects.

The most recent data from the U.S. Justice Department indicate that there were over 1.4 million adults in state and federal prisons at the end of 2019 (https://www.bjs.gov/content/pub/pdf/p19.pdf) and almost 740,000 in jail at midyear 2018 (https://www.bjs.gov/content/pub/pdf/ji18.pdf) . There are also thousands of correctional staff working in facilities. The Marshall Project has tracked prison COVID cases since March 2020. By mid-October 2020, there were almost 153,000 positive prisoner cases and about 34,200 staff cases. There had been almost 1,300 prisoner deaths, and at least 86 staff deaths (https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons). There have also been thousands of positive cases among persons incarcerated and working in jails, including several well publicized outbreaks. The Equal Justice Initiative estimates that the viral infection rate among incarcerated populations is five times the rate in the U.S. overall (https://eji.org/news/covid-19s-impact-on-people-in-prison/). When confronted with a potentially lethal airborne virus that readily spreads, jails and prisons relinquish their typical "out of sight and out of mind" status. These facilities are part of the larger communities where they are located. Threat of viral spread runs from inside institutions outward to the community and from the outside inward.

After more than 40 years of mass incarceration in American penology, many jails and prisons are dangerously overcrowded and densely populated, significantly more so than hospitals and nursing homes. Density is especially high in the large number of open or barrack style housing units. The lengthy sentences characteristic of mass incarceration have resulted in an aging incarcerated population at escalated risk of health issues. The population consists disproportionately of individuals with preexisting medical problems, together with a history of high-risk health activities and subpar or neglected health care. Safe distancing is frequently unrealistic in prisons and jails; ventilation systems are often faulty; surface contamination is typically rampant; disinfecting supplies are limited (and may even constitute contraband); protective gear like masks, face shields, and gloves can be in precious short supply (and may also be considered contraband); testing is likely to be erratic or nonexistent; and logistical challenges associated with contact tracing are exacerbated. Plus, it is impossible to overemphasize the fact that numerous jail and prison systems faced serious inadequacies and crises in correctional health care service provision and funding *before* the pandemic. These realities are not lost on those who live and work in jails and prisons. It is little wonder that large numbers of prisoners and staff experience continual angst over infection and illness. And collective angst over personal health and safety only further elevates the usual high stress and volatility levels of these environments, increasing the chances of serious disturbances.

Without effective action, prison and jail environments of the pandemic era are "perfect storms" for: (a) preventable sickness and deaths among prisoners and staff; (b) higher than normal levels of institutional disturbances; (c) time consuming and expensive law suits from both prisoners and staff that will span many years to come and, in so doing, detract from needed improvements getting made; as well as (d) higher than the normally high levels of staff demoralization, turnover, and shortages. Two standard "go-tos" for jail and prison problems are the lockdown – either the entire facility or major portions – and segregation of select prisoners. But these are, at best, stopgap measures that might (or might not) help mitigate viral outbreaks. Applied as longer-term fixes, lockdowns and segregation provide a false sense of virus control with much potential to exacerbate tension and turmoil among prisoners and staff.

In an article titled "Jails, Prisons, and the COVID-19 Virus" (*Correctional Law Reporter*, Vol. 32, No. 2, 2020), Schwartz and Venters discuss seven viable alternatives to reliance on lockdowns and segregation. The first measure, and a foundation for the rest to work well, is reducing facility population sizes to manageable levels. This can be pursued through accelerated release policies, prisoner transfers meant to optimize safe distancing in available spaces, and sensible sentencing decisions that avoid or shorten incarceration to the extent feasible. Schwartz and Venters recommend population reduction goals of 25-50 percent for most facilities. This is a tall order, but anything less is likely inadequate. The second measure is to establish separate, dedicated housing units for temporarily housing COVID-positive prisoners as well as units for those who require two-week quarantine and close medical monitoring. The third involves infection control measures like increasing visitation alternatives (phone and computer); sufficient availability of protective gear, disinfectant and hygiene supplies, and testing, combined with mandates that these be used; elimination of large, dense gatherings in such spaces as dining halls and rec or programming areas; and regular symptom monitoring (e.g., temperature checks). Symptom monitoring must include persons entering and exiting facilities. The fourth measure is frequent, proactive, and honest communication among staff, especially between administrators and line staff. The fifth measure extends the fourth one to include such communication with prisoners. All communication needs to be two-way, with individuals in subordinate roles being free to ask questions and voice concerns without worry over adverse repercussion. Communication is essential. If it is absent or flawed, rumors and misinformation will abound; people will fill in the blanks. The sixth measure is to expand mental health service provision and target more of this specifically around virus issues. More prisoners should receive mental health checks and services more frequently. Seventh is preparation for and response to emergencies, with the goal of devising and implementing an effective written pandemic emergency plan. This may be accelerated by modifying an existing emergency or disturbance plan. Regardless, the plan must provide for timely identification of persons in need of more advanced medical attention than can be provided onsite at the facility and for timely transport to a health care center. To Schwartz and Venters' list, we can add the importance of ongoing, substantively valid, and regularly updated virus education and training efforts geared toward staff, prisoners, and members of the public. There are clearly other (and better) options than over or exclusive reliance on lockdowns and segregation. Ultimately prison/jail staff, prisoners, and the public share a common interest of sustaining health and safety during the COVID pandemic.