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COVID-19 in Prisons and Jails in the United States

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VIEWPOINT

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In mid-March 2020, the first case of novel coronavirus 2019 (COVID-19) was diagnosed at Riker's Island, the main jail complex in New York City. Within 2 weeks, more than 200 cases were diagnosed within the facility, despite efforts to curb the spread. The situation at the Cook County jail in Chicago is similar, with about 350 incarcerated persons and staff members testing positive for the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) virus as of early April 2020. Many other jails and prisons have reported outbreaks of COVID-19 and related deaths.

Prior viral epidemics have wrought havoc in carceral settings. An account from San Quentin prison detailing the Spanish influenza of 1918 estimated that half of the 1900 inmates contracted the disease during the first wave of the epidemic; sick calls increased from 150 to 700 daily. Contrary to protocol, most of the ill were kept in the general prison population because the hospital ward was full.[1]

At present, jails (which house individuals awaiting trial or serving short sentences) and prisons (which house individuals who have been convicted of crimes and are serving longer sentences) are usually crowded. When they are unable to adhere to measures needed to contain and mitigate a viral epidemic, incarcerated persons, staff, and the wider community are endangered.

The Challenge of Social Distancing in Prisons and Jails

At San Quentin, a single incoming prisoner initiated each wave of the 1918 epidemic. Once introduced, the disease spread rapidly as a result of the inmates' close confinement and an inability to isolate the sick. The COVID-19 outbreak on the Diamond Princess cruise ship provides a contemporary analogy. With about 3700 passengers and crew held on board in separate but close quarters, about 700 people became infected and 12 died over a 4-week period. The rapid spread was attributed to a small number of kitchen workers housed together on Deck 3, who were responsible for feeding the quarantined passengers.[2] The infrastructure of most prisons and jails is similarly conducive to spreading disease. Moreover, people who are incarcerated will be at higher risk of exposure, as correctional officers and other staff frequently leave the facility and then return. In prisons and jails, social distancing is typically a physical impossibility.

Prisoners at High Risk for Severe Infection and Death

The elderly, and persons with underlying illnesses, are at high risk of severe illness and mortality from SARS-CoV-2 infection. As a result of longer sentences (mostly for non-violent offenses), the average age of the prison population has increased. In 2013, state prisons housed 131 500 persons older than 55 years, a 400% increase since 1993. Many incarcerated persons older than 55 years have chronic conditions, such as heart and lung diseases.[3] About half of the people incarcerated in state prisons have at least 1 chronic condition; 10% report heart conditions, and 15% report asthma, percentages far greater than those for the population at large, even when comparing similar age groups.[3]

Effects on Prison Health Care Systems

Few US prisons have health care systems able to accommodate a surge in sick calls similar to the situation at San Quentin during the Spanish influenza epidemic. Crowding and clinical vulnerability compound the barriers to adequate health care inherent in carceral settings. Although the US Constitution guarantees a right to health care for people who are incarcerated, available medical care varies greatly with regard to both access and quality, and services have been challenged by the increased needs of the aging prison population.[4] Incarcerated persons may be charged co-payments that are high relative to their wages, and this will deter their seeking care, although little revenue is generated. Moreover, when incarcerated persons do seek care, they often face long wait times for visits. The costs of hospital care, which prison systems bear, is a disincentive to referrals; several states have been scrutinized for providing substandard hospital-level care within their correctional systems.[5]

Solutions to Mitigate Harms

Even before COVID-19 cases were detected in prisons and jails, clinicians and advocates for incarcerated persons proposed measures to ameliorate the anticipated harms, such as the wide availability of protective equipment, testing and medical care, and the elimination of co-payments and other policies that may deter inmates from seeking care. Although these actions are essential, the most effective way to avoid an imminent outbreak, is, as others have argued, to drastically reduce the populations of jails and prisons.[6] Criminal justice systems can accomplish this by reducing unnecessary jail admissions and expediting prison release. Some prosecutors are already adjusting prosecutorial standards to reduce jail admissions and the length of stays. In Baltimore, prosecution of all drug possession and other minor crimes is being deferred. In San Francisco the district attorney has ordered the release of all persons in pretrial detention (who would be eligible for bail if they could afford it).[7] These steps may reduce crowding in some jails, but many other jails—and most prisons—are minimally affected.

Additional measures are required to reduce prison and jail populations. These include the release of those at high risk from COVID-19 owing to age or underlying conditions, those convicted of a nonviolent crime or

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incarcerated on a technical (crimeless) parole violation, and those with less than 2 years of their sentences remaining. In April 2020, US Attorney General William Barr ordered the release of many such persons incarcerated in federal prisons; it is unclear, however, how efficiently this order will be executed.[8]

Criminology data suggest that these steps would pose little risk to public safety. Those older than 65 years are very unlikely to reoffend. Moreover, long sentences required by sentencing guidelines in accordance with state and federal laws have not been shown to enhance public safety; many prisoners nearing the end of their sentences have already served long periods of time.

Preparing for Release Into the Community

In the 2 weeks following release from incarceration, people are at increased risk of death, particularly from drug overdose and cardiovascular disease.[9] If more people are to leave prisons and jails, correctional officials and community members should take steps to mitigate these risks. Pharmacologic treatment for opioid use disorder is now available via telemedicine, and all prisoners who might benefit from such programs should be referred to them. Similarly, older prisoners and those with chronic health conditions should have prearranged primary care follow-up, and the means (eg, an appropriate computer or smartphone) to engage in telehealth visits.

Those who are released from prison and are at risk for homelessness require additional measures and resources. In Connecticut, a widespread effort to provide housing for the homeless in hotels has emptied shelters, which are high-risk environments for SARS-CoV-2 transmission.[10] Additionally, streamlining access to and broadening eligibility criteria for safety net programs including Medicaid and food stamps are important.

Addressing the COVID-19 pandemic requires bold policy changes throughout society. In the criminal justice system, aggressive and proactive measures are needed to minimize the catastrophe brewing in prisons and jails.

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