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The COVID-19 Pandemic and the Health of Incarcerated People

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ABSTRACT COVID-19 has upended the daily operations of the U.S. correctional system. Correctional COVID-19 policies have altered how incarcerated people navigate legal proceedings, receive visitors, procure healthcare services, and maintain mental well-being and physical health. Although some of these changes have been positive (e.g., increased access to tablets, de-incarceration policies), other strategies have exposed societal inequities that fail to meet the needs of people who are incarcerated. Lockdown orders have had unintended consequences for incarcerated people, particularly among those with mental health disorders. This commentary examines the impact of U.S. correctional system policies on the well-being of incarcerated people.

KEY WORDS COVID-19, U.S. correctional system, lockdowns

INTRODUCTION

Three years have passed since SARS-CoV-2 made headlines and COVID-19 was declared a pandemic. In the United States, long gone are the days of social distancing and interfacing with our social and familial contacts through video conferencing. As the nation's public consciousness shifts away from COVID-19, there is one segment of the population for whom this threat has made lasting effects: incarcerated people. In the United States, correctional facilities detain individuals who, by law, are innocent until proven guilty and are awaiting their trial date to be sentenced or released. Prisons, on the other hand, detain individuals with felony convictions longer than a year (National Institute of Justice, n.d.). Correctional facilities represented a disproportionately large number of COVID-19 cases early in the pandemic. There have been over 30,780 cases per 100,000 inmates infected with COVID-19 in the US prison population (Marquez et al., 2021). This figure represented an incidence rate over three times as high as the general population (9,350 cases per 100,000) (Marquez et al., 2021).

COVID-19 Related Policies for Incarcerated Populations

COVID-19 protocols for incarcerated individuals recommended enacting preventative strategies, such as quarantine orders and lockdowns, which minimized the spread of SARS-CoV-2 (Centers for Disease Control and Prevention, 2022)(Heard, 2021). The most stringent guideline for preventing SARS-CoV-2 transmission in corrections facilities was a 10-day quarantine period for individuals with symptoms regardless of vaccination and booster status (Centers for Disease Control and Prevention, 2020). In contrast, community guidelines

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recommend a 5-day isolation period for individuals who test positive or demonstrate signs of illness and may return to work or school without further testing depending on symptoms. These far more stringent quarantine periods aimed to minimize the spread of the virus for incarcerated people. However, this further increased the time which inmates spent alone and largely confined to their cells. Other policies and procedures for mitigating the spread of COVID-19 in corrections facilities, such as mass quarantine, have been left to the discretion of each facility (New Jersey Department of Health, 2022).

Strategies that prevent the spread of COVID-19 within this setting have been difficult to enact due to controversies. For example, in the United States, the use of face masks has become a politicized issue (Milosh et al., 2021). These divisions made policies on the mandatory use of face masks in this setting difficult to enforce and maintain. Correctional settings sought other strategies to prevent and control COVID-19 outbreaks. For instance, emergency releases were frequently implemented to limit COVID-19 transmission (Garcia et al., 2021). At the onset of the pandemic, even in politically conservative states, prison sentences were commuted, policing practices were modified, and eligibility for parole was expanded (James et al., 2022). However, this policy's overall scope varies from state to state.

Variations in Incarceration Rates due to COVID-19 Policies

Despite a decrease of 15% in the United States prison population from 2020-2021, many states are now close to pre-pandemic levels of incarceration or have exceeded them (Widra, 2022). For example, on December 15th, 2021; California's prisons held 113% of their capacity (Widra, 2022). The data now shows that prison populations have not been due to compassionate releases, but rather to temporary policies preventing new inmates from being detained (Sharma et al., 2020).

In the fall of 2021, as the Delta variant of SARS-CoV-2 became the most prevalent strain, jail facilities were already back to 87% of their pre-pandemic levels (Sawyer & Wagner, 2022). Despite the continued threat of COVID-19, the size of jail populations is problematic. Incarcerated people have been shown to have higher rates of medical comorbidities (Centers For Disease Control & Prevention, 2019) and remain at higher risk for SARS-CoV-2 related complications. Unfortunately, the policies governing which individuals are eligible for release without needing bail are state-dependent (Jorgensen & Smith, 2021). In many jails in the United States, poor individuals who cannot afford to post the average bail of \$10,000 for a felony charge are forced to await their court date behind bars (Prison Policy Initiative, 2016). This income disparity disproportionately impacts people of color who are less likely to afford bail (Binswanger et al., 2010). This places racial and ethnic minority individuals at heightened risk of contracting COVID-19 while still being legally innocent. Some states mitigated the risk to highly vulnerable populations during the early months of the pandemic with compassionate release programs (United States Sentencing Commission, 2022).

Without widespread criminal justice reform, defendants and court judges were left to work with a compassionate release program that was never intended to release a significant number of individuals (Prison Policy Initiative, 2020a). Public policy shortcomings were further highlighted when the highly contagious Omicron variant led the Federal Bureau of Prisons [BOP] to announce more than 10,000 active COVID-19 cases in federal prisons in the beginning of 2022 (Klonsky & Johnson, 2022). As correctional facilities returned to their pre-pandemic levels, containing this highly transmissible variant became more challenging. Lockdowns and unit-wide quarantines became the preferred policy for limiting the spread of the virus (Prison Policy Initiative, 2020b).

On Lockdown: The Cost of Current Mitigation Strategies on Inmate Mental Health

Lockdowns are defined as suspending recreational activities where incarcerated persons are restricted in their cells or housing areas for 22 to 24 hours a day (Izadi, 2017). Lockdown measures can be applied to restore order or, in the case of the pandemic, to reduce the spread of COVID-19 (Blakinger, 2020). Strict legal guidelines for their duration and frequency do not exist. Instead, the statute on the length of lockdowns is: *"a lockdown should last no longer than necessary"* with essential privileges such as medical care, access to food, and water maintained except in cases of an emergency that, for security purposes, requires denial of access for less than 72 hours (American Bar Association, 2011). If not managed appropriately, lockdowns may resemble punitive measures such as solitary confinement or administrative segregation. In solitary confinement, incarcerated people are placed in an isolated unit for up to 23 hours a day (citation). Solitary confinement has been linked to increased rates of inmates dying by suicide and persistent trauma long after an individual is released (Luigi et al., 2020). During COVID-19, the number of people held in solitary confinement in the United States was estimated to be around 300,000 (a 500% increase over pre-pandemic levels) (Solitary Watch, 2020).

Although these strategies have been instrumental in controlling COVID-19 outbreaks, there has been little public attention on the frequency of lockdowns and their impact on visitations, religious services, educational programming, and the mental and physical well-being of incarcerated persons (Kinner et al., 2020). Consequently, incarcerated people subjected to frequent lockdowns are now experiencing heightened stress and anxiety (Johnson et al., 2021). This further compounds the higher prevalence rates of mental health disorders within correctional facilities. Their prevalence rates vary by race/ethnicity. In the United States, one study estimated that across prison facilities nationwide, 62.2% of White people, 46% of Latinos, and 55% of African-American individuals have been diagnosed with a mental health disorder (James & Glaze, 2006). The severity of mental health disorders has worsened for many during incarceration due to exposure to violence (Yi et al., 2016). COVID-19 restrictions on activities such as family visitations, recreational access, education, and educational training may amplify these adverse effects.

Walking on a Tightrope: Difficult Ethical Dilemmas Facing Correctional Administrators

The long-term impact that COVID-19 will have on incarceration remains unclear (Wertheimer & Velázquez, 2022). It is essential to balance the risk of COVID-19 transmission, the impact of mitigation strategies on inmate mental health and physical well-being, and fluctuating community transmission rates. Comartin et al. (2022) showed that the rates of incarcerated people with severe mental health disorders increased in one jail as prison admissions decreased, and COVID-19 restrictions were imposed, since in-person visitation and medical services were all limited except for those deemed ‘essential’.

In states where bail reform exists, individuals with highly complex medical and psychiatric conditions can remain in jail for hours or days. Bail reform seeks to release inmates from low socioeconomic status shortly after booking for misdemeanors or minor offenses. Many individuals were previously held for a span of months or a year due to their inability to pay for their conditional release before trial. This reform shortens the window in which many inmates can receive what has, unfortunately, become the only accessible healthcare provider for many disenfranchised groups— the correctional system.

Navigating the U.S. Correctional System and Public Policy Recommendations Post-COVID-19

The COVID-19 pandemic has exposed the challenges of imposing COVID-19 restrictions on incarcerated adults with mental health disorders; particularly the negative aspects of using lockdowns. Physical distancing protocols caused a shift emphasizing telehealth solutions to take hold. Unfortunately, not all facilities were equipped with the proper technology to and had to scale back or terminate many mental-health services due to physical distancing protocols (Johnson et al., 2021).

Depopulating is one strategy to reduce the spread of COVID-19 in correctional settings (Schuck et al., 2020). However, funding and coordination are needed to bolster reentry programs offering mental health and behavioral services, medications, and housing (Franco-Paredes et al., 2020). One way to ensure the continuity of medical and mental health care services available for people returning to the community from a correctional setting is to ensure that they are automatically enrolled in Medicare and Medicaid services before release (Albertson et al., 2020). Public policies regarding Medicare/Medicaid and incarceration's impact on eligibility and status vary primarily by state. As of 2019, eight states (i.e., Idaho, Illinois, Kansas, Missouri, Nevada, North Carolina, Oklahoma, Utah, and Wisconsin) terminated Medicaid eligibility for inmates in jails. Seven states (i.e., Alabama, Idaho, Kansas, Missouri, Nevada, Oklahoma, Utah, and Wisconsin) terminated Medicaid eligibility for inmates in prisons (Kaiser Family Foundation, 2019). The practice of suspending Medicaid enrollment for later reactivation has been linked to reduced jail/prison recidivism and saves taxpayer dollars (The Pew Charitable Trusts, 2020). Suspending Medicaid enrollment rather than terminating coverage and forcing individuals to reapply to the program as a new patient is far easier from a paperwork and resource perspective. To address the disparities in coverage made worse by the COVID-19 pandemic, the Centers for Medicare and Medicaid Services [CMS] developed a section 1115 demonstration in 20XX. Section 1115 allowed inmates in states that were previously excluded from applying for Medicare/Medicaid benefits to apply and be covered during incarceration (Centers for Medicare & Medicaid Services, n.d.). Political willpower is needed at the state and federal levels to make this a permanent policy.

Although the increased risk for COVID-19-related outbreaks cannot be ignored, the Federal Prisons Bureau and Corrections Departments by State must prioritize adaptation strategies for controlling COVID-19 transmission. The authors propose that preparedness plans include investing in widespread access to digital mental health

services such as telehealth appointments to manage medications and receive therapy, as well as enhancing COVID-19 vaccinations and booster rates. Facilities should also provide access to technology like tablets, electronic communication, video conferencing. Access to this would allow for therapeutic counseling from trusted mental health services while minimizing the likelihood of COVID-19 transmission during times of heightened risk (Hagan, 2023).

There is a need for both comprehensive COVID-19 testing (rapid-antigen, PCR) throughout correctional facilities (Tavoschi et al., 2020) and an increase in COVID-19 treatment, such as the FDA-approved drug Paxlovid. Paxlovid is known to reduce the risk of hospitalization by up to 89% in high-risk adult patients and is currently under-prescribed within correctional settings (Florko, 2022). These strategies can be used alongside public health and wastewater surveillance data that serves as an early warning of increased community-level spread (Centers for Disease Control and Prevention, 2021). Environmental health and safety measures are necessary to effectively track COVID-19 infection cases, and implement additional safeguards that protect incarcerated persons by adjusting medical and mental health treatment delivery as transmission rates fluctuate (i.e., shift to telehealth during outbreaks). Administrators within the correctional system must also plan for ways to transition mental health programming and treatment on a scale, quality, and quantity comparable to a digital platform should a COVID-19 outbreak occur. Altogether, these strategies prioritize the well-being of incarcerated people and provide the space for adaptation should a COVID-19 outbreak occur.

CONCLUSIONS

The pandemic has shone a glaring light on the unique vulnerabilities of incarcerated populations, underscoring the urgent need for systemic reforms in public health policy and correctional management. Lockdowns and stringent quarantine measures, while necessary for controlling virus spread, have had deleterious effects on the mental health of inmates, exacerbating pre-existing conditions and creating new challenges. The pandemic has also highlighted the broader issues of healthcare access and quality within the correctional system. Jails and prisons must incorporate forward-thinking strategies to prepare for future COVID-19 outbreaks. This involves investing in digital health infrastructure, such as telehealth services, which can provide continuous mental health support while minimizing infection risks.

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