Prisons: Amplifiers of the COVID-19 Pandemic Hiding in Plain Sight

See also Morabia, p. 923, Tarantola et al., p. 925, and the *AJPH* COVID-19 section, pp. 939–977.

On February 29, 2020, nearly half of incident cases (233 of 565) of COVID-19 reported in Wuhan, China, were from the city's prison system. A separate prison outbreak, 450 miles away, in Shendong, China, was traced to officials who had visited Wuhan and infected seven prison guards and 200 inmates.[1] Modern prisons have faced infectious outbreaks but none at the scale of COVID-19's. On March 26, 2020, the United States reported its first death of an incarcerated patient, in Georgia, and New York City jails reported an infection rate seven times higher than in the rest of the city, a current US epicenter of COVID-19.

For many Americans, it is easy to forget the experiences of our detained community members. But custodial facilities are vulnerable to devastating COVID-19 outbreaks that pose disproportionately high health risks to detained and incarcerated people, elevate transmission risk in surrounding communities, and would likely trigger an occupational health crisis for hundreds of thousands of professionals performing essential work in custodial facilities around the nation. In view of the considerable yet poorly understood and little discussed health risks, public health and custodial leadership must take urgent measures to keep COVID-19 out of custodial settings and develop stringent mitigation strategies for when it does.

CUSTODIAL SETTINGS' VULNERABILITY TO COVID-19

Custodial settings (prison, jails, juvenile detention, and immigrant detention facilities) in the United States are highly vulnerable to the global COVID-19 pandemic. The United States holds 2.3 million people in involuntary confinement, including 2.2 million adults and 44 000 youths in corrections and 42 000 people in immigration detention centers.[2] Many incarcerated individuals have considerable health morbidity, and a significant proportion are older than 60 years, known predictors of COVID-19 severity and fatality. Overcrowding in dormitory-style housing or in small double- or triple-occupancy cells, inadequate ventilation, and insufficient hygiene increase the risk of COVID-19 spread. Additionally, physical and emotional responses to custodial settings may weaken the immune system; for example, involuntary confinement is stressful and poor sleep is common.

Custodial facilities also experience a daily influx of individuals that poses great risk for the spread of infection between facilities and surrounding communities. These include the arrival of new detainees and ingress and egress of residents for court appearances and specialty medical appointments, custodial staff (e.g., officers, health care, maintenance), and visitors (personal, legal).

Most custodial settings operate at or above capacity—overcrowding is the norm—and many are understaffed. Should COVID-19 infect residents and staff, facilities will be challenged to identify the housing, staff, and equipment needed for effective quarantining. Facilities may also face secondary health crises if they become underresourced for mental health care and crisis management. To compound the problem, the limited respiratory care available in most custodial facilities (generally supplemental oxygen delivered by nasal canulae or face mask) will become quickly overwhelmed, as most emergency and inpatient care is delivered in outside community health systems. For these reasons, correctional health experts have called for limiting all nonessential movement while maintaining access to adequate legal and psychosocial support to the extent possible.[3]

Indeed, the most urgent first-line strategy to limit spread and improve containment is population reduction. Iran temporarily released 70 000 prisoners to contain the spread of COVID-19, prioritizing individuals with underlying health conditions to ensure more medical supplies and social distance for those who remained.[4] In the United States, a growing number of state and city governments are releasing individuals they believe pose little or no public safety risk. But far more is required to further mitigate COVID-19's impact, including prioritizing the release of older adults, the chronically or seriously ill, and pregnant women.

Because custodial settings are so uniquely vulnerable to outbreak, custodial agencies must adopt stringent, evidence-based infection control policies and practices.[3] The Centers for Disease Control and Prevention, the World Health Organization, and

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the National Commission on Correctional Health Care have published resources to guide such efforts. Adhering to principles of screening, social distancing, education, hygiene, disinfection, isolation, testing, and prompt treatment are paramount (see the box on this page). COVID-19 must not be used as an excuse to worsen care or to engage in mistreatment of residents.

COMMUNITY AND OCCUPATIONAL HEALTH

Protecting detained and incarcerated people from COVID-19 is a critical public health priority that will also benefit community health more broadly. Millions of Americans return home from custodial settings each year. Most are from racial/ethnic minority groups and low socioeconomic backgrounds, meaning that marginalized communities will likely be hardest hit by COVID-19 transmission in custodial settings. Jails and juvenile detention facilities tend to have a "revolving door" of relatively short-term detention, with people—many of whom are homeless—frequently moving between custodial and community settings. In addition, a substantial number of residents who become seriously ill with COVID-19 will require care in local community hospitals, exacerbating the crisis already present in many public health care systems.

Swift action to limit COVID-19's impact on detained and incarcerated populations is needed to also minimize as much as possible an occupational health crisis in US custodial facilities. Hundreds of thousands of people who work in custodial facilities nationwide, including custodial staff, educators, social workers, clergy, and health providers, are relied on for daily operations of these facilities. Most, if not all, of the custodial systems reporting COVID-19 cases are reporting infection among both residents and staff at a time when custodial staff are already experiencing a profound occupational health crisis unlike in any other profession in the United States. Custodial officers have disproportionately high rates of chronic illness and stress-related health conditions compared even to community law enforcement officers, indicating high susceptibility to COVID-19 morbidity.[5] As in community hospitals, COVID-19 transmission affecting custodial officers and health care providers could severely limit capacity to respond to and mitigate further outbreaks in custodial facilities. Finally, this sizable workforce returns every day to their surrounding communities and households, serving as potential carriers of infection to the public living near any one of the nation's more than 5000 detention facilities.

LET'S PLAN FOR THE PROBLEM, NOT IGNORE IT

In the era of mass incarceration, an effective response to the COVID-19 pandemic must include our custodial settings. Failure to develop a comprehensive plan for these individuals would be akin to cruel and unusual punishment. Individuals

RESOURCES AND APPROACHES FOR ADDRESSING COVID-19 IN CUSTODIAL SETTINGS

Resources for COVID-19 in custodial settings

- Centers for Disease Control and Prevention: https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html
- World Health Organization: http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/news/news/2020/3/preventing-covid-19-outbreak-in-prisons-a-challenging-but-essential-task-for-authorities
- National Commission of Correctional Healthcare: https://www.ncchc.org/COVID-Resources

Approach to COVID-19 in custodial settings

1. Screen for exposure and symptoms at any change in housing and before all health encounters, including by verbal report and measurement of signs of disease (e.g., fever, cough, shortness of breath). Custodial officers can carry out screening with guidance and training from health agencies.
2. Enact social distancing measures within residential settings, including at meal times, in bathrooms, in sleeping quarters, during recreation activities, and in clinical spaces (including waiting areas). Nonurgent health concerns requiring in-person care may be deferred or responded to using ramped-up telehealth capacity.
3. Educate residents and staff in custodial settings. All staff must receive robust education in the basics of COVID-19 transmission and prevention. Residents must receive comprehensive information at an appropriate literacy level in their native language explaining COVID-19, including an explanation of transmission and measures to safeguard their health. Education on hand washing, strong messaging regarding self-monitoring and symptom reporting, and empowering residents to contribute solutions and play an active role in reducing risk is essential.
4. Promote hygiene and disinfection practices, including ensuring the availability of adequate soap and clean water or hand sanitizer, as well as opportunities for hand washing. Ensure that facilities are disinfected regularly, especially high-touch metal surfaces and areas infectious droplets may gather.
5. Isolate, test, and trace those suspected of infection with COVID-19. Custodial facilities will need to work with health departments to trace exposure chains. To encourage reporting of exposure and symptoms, it is important that isolation procedures be nonpunitive and clearly explained and that isolation last only as long as medically necessary. Given the high risk of outbreak, when testing becomes more available universal testing may be appropriate.
6. Treat individuals with COVID-19 upholding the same standards of care delivered in community settings. Supportive care, treatments, and eventually immunization should reach custodial facilities in at least the same pace of deployment as in community settings.

not released must be met with compassion; many will have in-person visitation and rehabilitative programming suspended and may experience pervasive fear as the pandemic worsens. Poorly managing these risks within custodial walls will also potentially have devastating consequences for surrounding communities, ranging from the homeless encampments in Los Angeles, California, to the rural households surrounding Maine State Prison. Residents and custodial workforces must be empowered to bring frontline knowledge and ideas to the forefront. Accurate data monitoring and reporting will be critical. California's Department of Corrections and Rehabilitation is publicly reporting all staff and resident COVID-19 cases, enabling nearby community hospitals to incorporate them in surge planning. During the COVID-19 pandemic, we must uphold the human rights and dignity of people who live and work in custodial settings by strengthening infection control and prevention measures and addressing the looming occupational health crisis among staff who return home to their communities at the end of each day. AJPH

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

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