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Social Distancing and Incarceration: Policy and Management Strategies to Reduce COVID-19 Transmission and Promote Health Equity Through Decarceration

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Abstract

Incarcerated people are at disproportionately high risk of contracting COVID-19. Prisons are epicenters for COVID-19 transmission, including to the community. High rates of preexisting health conditions, limited access to quality health care, and inability to social distance make it impossible to reduce the impact of COVID-19 in prisons. Due to a history of compounded social determinants, incarcerated populations are disproportionately composed of people of color and people with stigmatized behavioral health disorders. Rapid decarceration is needed to promote health equity. Historical mass decarceration events demonstrate feasibility to rapidly release large groups of people while maintaining public safety. Iran and Ireland have released substantial portions of their prison populations by transitioning people to home confinement. In the United States and Uganda, some jurisdictions have reduced new incarcerations through policies that decrease arrests. These policies must be globally expanded to contain the epidemic, and its potential health consequences, while addressing health equity.

Keywords

coronavirus; COVID-19; health equity; incarceration; policy; prison; social determinants of health

Social distancing is the most effective strategy to decrease COVID-19 transmission (Chen et al., 2020). However, it is nearly impossible to social distance in prisons,¹ since they are epicenters of infectious diseases (Kinner et al., 2020). Incarcerated people are more vulnerable to COVID-19 infection (World Health Organization, 2020) due to their disproportionately high physical and behavioral health needs, limited access to quality health care, and environmental design, which promotes rapid disease transmission (Hammett et al., 1998). These factors are also a recipe for disastrous community health consequences as staff travel between facilities and communities potentially spreading COVID-19 (Wurcel et al., 2020).

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¹The term “prison” is used in the article to encompass all settings of incarceration, including prisons, jails, and other detention centers.

Governments have addressed COVID-19 transmission associated with prisons through decarceration and social isolation. Decarceration is superior, as it promotes health equity and avoids health consequences associated with solitary confinement, or prolonged social isolation within prison. Even before COVID-19, incarceration was identified as a contributor to morbidity and mortality (Binswanger et al., 2007; Binswanger et al., 2011), particularly among people of color and people with stigmatized behavioral health disorders due to racist and biased laws that skew representation of these groups within prisons (Neugebauer, 2000). Without action to counteract historical oppression, carceral policies will be a vector of COVID-19 transmission that will disparately affect people of color and people with stigmatized behavioral health disorders.

Decarceration and Social Determinants of Health

A social determinants framework explains how factors outside of individuals influence health (Krieger, 2001; Schulz et al., 2002) and contribute to risk for incarceration (Henry, 2020). Racism contributes to increased risk of both poor health and incarceration through racist application of policies, and direct oppression codified by policies (Bailey et al., 2017; Shelton et al., 2017). Social determinants are leading to a disproportionate impact of COVID-19 on African American and Latinx populations in the United States, where a history of racist policies has led to high levels of racial disparities in socioeconomic status and underlying health conditions (Ray, 2020).

These same racist policies contribute to social determinants of incarceration (Bailey et al., 2017; Dumont et al., 2013; Neugebauer, 2000) resulting in prisons disproportionately confining people from marginalized groups including African Americans, Latinx immigrants, indigenous people (Carter & Forsyth, 2007; Neugebauer, 2000), and people of low socioeconomic status (Rabuy & Kopf, 2015). People with stigmatized health conditions including mental illness (Fazel & Seewald, 2012; Prins, 2014) and substance use disorders are also overrepresented in prisons (Fazel et al., 2017; James & Glaze, 2006; Mumola & Karberg, 2006). Social determinants and biased policies are also pathways to incarceration for these populations (Henry, 2020). In the Philippines these populations are directly criminalized (Dombrowski et al., 2017). Social isolation within prison is associated with negative mental health outcomes (Arrigo & Bullock, 2008; Haney, 2012). Therefore, encouraging widespread use of isolation to reduce the spread of COVID-19 is dangerous as it could exacerbate mental health symptoms, self-injury, and suicide. Health equity cannot be achieved until incarcerated people have equal access to quality prevention and treatment resources for COVID-19.

Policies in Response to COVID-19

Decarceration allows some confined people to move back to their communities and access community resources, which are generally higher quality than those in prison. It also reduces the population of people who remain incarcerated, which allows for greater social distancing and improved access to limited available resources. Decarceration includes reducing the flow of people into prisons and accelerating the flow of people out of prisons by reducing arrests and increasing early release (Akiyama et al., 2020). Arrests can be replaced with

citations and other noncarceral alternatives. Populations with readily available policies for early release include people held pretrial on cash bail, eligible for release on probation/community supervision, and eligible for medical/compassionate release.

Countries where decarceration policies have been applied include Iran, Ireland, Uganda, and the United States. Each of these countries has released people from prisons, primarily to community supervision or home confinement. In Iran, at least 70,000 people were released (Akiyama et al., 2020), while in Ireland at least 300 were released (Lally, 2020). In Uganda, new admissions to prison have been suspended and 2,000 people have been identified for release (Mukhaye, 2020). Within the United States, where prison systems exist under fragmented jurisdictions, some policy makers have also applied decarceration, including numerous district attorneys, sheriffs, and governors who have directed release and ordered arrests be reduced (Prison Policy Initiative, 2020; Surprenant, 2020). The greatest percentage of decarceration in the United States occurred in several small counties where 51% to 77% of incarcerated people were released. Even in these places the incarceration rate remains above the international per capita average (Henrichson & Hinds, 2020) indicating it should be further reduced.

To date, there have been no new reported outbreaks of COVID-19 in areas where decarceration has been applied. Evidence from past episodes of rapid decarceration offer evidence that support it as a sound public safety policy. A 2011 California (United States) law realigned imprisonment for certain crimes from the state to the county, leading to the release of nearly 30,000 people in about a year, without impact on violent crime (Sundt et al., 2016). In 2001, Russia passed a similar law that reduced their prison population by releasing 101,000 juveniles, people held on bail, and people convicted of minor crimes in a year, without impact on national crime (Kalinin, 2002).

There have been negative consequences in countries increasing social isolation within confinement as a response to COVID-19. In Brazil, Colombia, and Italy, there have been prison riots and breakouts (Avafia et al., 2020). Several prisons are epicenters of COVID-19 transmission. The largest cluster of COVID-19 cases in the entire United States is connected to Chicago's Cook County Jail (448 cases), while the third largest in the country is connected to Parnall Correctional Facility in Jackson, Michigan (194 cases; The New York Times, 2020).

Policy and Management Strategy Recommendations to Promote Health Equity

Choosing not to decarcerate is a policy decision that actively facilitates high rates of new COVID-19 infections, and ultimately deaths, among an already vulnerable and marginalized population. By choosing confinement, policy makers are exposing incarcerated people to much higher odds of COVID-19 infection. Limited data are available to make direct comparisons. However, in Cook County, Illinois (the site of the United States' largest cluster of COVID-19 cases inside the county jail), the percent of people infected with COVID-19 is about 0.2%² while the percent of people infected in the county's jail is about 5%—although likely an underestimation.³ By these estimates, Cook County policy makers are subjecting

incarcerated people to an infection rate that is at least 25 times higher than they would face in the community. While high, an infection rate of 5% indicates that there is time to move more uninfected people out of the jail and into communities where their chance of infection is lower.

Arrests should be reduced to prevent increases in the prison population. Regional authorities (e.g., district attorneys, sheriffs, governors, presidents, etcetera) should immediately identify as many people as possible for rapid release. Existing policies suggest political feasibility of releasing certain groups of people to home confinement, including people held pretrial on bail, approved for community supervision, close to their release date, held on minor charges, and those who qualify for medical release. Jurisdictions should expand on these groups to ensure maximum benefit from decarceration.

Most people released under decarceration due to COVID-19 have been placed in home confinement, and are required to remain at home. The World Health Organization recommends that people releasing from prisons where there is COVID-19 quarantine for 14 days, and that prison health authorities provide release planning to identify appropriate quarantine locations and connect people to follow-up care (World Health Organization, 2020). Most jurisdictions have issued social distancing guidelines, which may be sufficient to prevent unintended spread of COVID-19 during decarceration. In Europe (e.g., Austria, Czech Republic, France, Italy, Norway, and Spain) stay at home orders have been issued, except for essential activities (Broom, 2020). People releasing from incarceration to their homes can follow these regulations to prevent unintentional spread of COVID-19. Assistance with finding housing may be required for some people and should be provided by prison staff.

For people who remain incarcerated, management strategies that promote harm reduction must be applied. Access to the following must be universally available to both staff and incarcerated people free of charge:

- COVID-19 screening, testing, and health care
- Soap and sanitation facilities
- Space to maintain social distancing (working, sleeping, eating, and recreation locations that are at least 6 feet apart)
- Appropriate personal protective equipment, such as face masks

To promote mental health, access to the outdoors, mental health care, socialization (including telephones) must also be universally available without charge. Telehealth should be applied where appropriate (Wurcel et al., 2020). Finally, staff should be provided with paid sick time to be mandated if exposed to or sick with COVID-19. Failing to apply these

².Cook County, Illinois, COVID-19 infected percentage of population calculated by author using the reported number of cases = 12,472 (The New York Times, 2020) divided by the most recent county population estimate from 2019 = 5,150,233 (U.S. Census Bureau, 2019).

³.Cook County Jail COVID-19 infected percentage of population calculated by author using the reported number of cases = 238 divided by the reported jail population = 4,500 (Williams & Ivory, 2020).

policies will lead to continued epicenters of COVID-19 in prisons, which expose all of society to the deadly virus.

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