

# The Contribution of Prisons and Jails to US Racial Disparities During COVID-19

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## ABOUT THE AUTHORS

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The United States has the unenviable distinction of having the highest rate of incarceration and the most people under correctional control—more than 6.7 million people. Although we often refer to this as “mass” incarceration, the criminal legal system’s discriminatory impacts are disproportionately concentrated in Black and Latino communities: one in three Black men and one in six Latino men born in 2001 can expect to go to jail or prison at some point in their lifetime. At this magnitude, mass incarceration is a key structural driver of not only individual and population health but also racial health disparities across numerous health outcomes.<sup>1</sup>

Although the role of incarceration in driving many racial health inequities has been long recognized, during the COVID-19 pandemic this attention was amplified because correctional facilities comprise the largest number of single-site cluster outbreaks. Given that Black, Latino, and Native American people are overrepresented in correctional settings, from a population health perspective, these groups will most certainly be most affected by COVID-19 outbreaks in prisons and jails. According

to COVID Prison Project data, as of October 2020 more than 10% of the US prison population has been infected with SARS-CoV-2 and more than 1200 people in prison have died from the COVID-19.

There are now documented racial disparities in COVID-19 case, testing, and mortality rates in the general population. In particular, there are large disparities in COVID-19–related deaths, with Black people having the highest mortality rate across age groups.<sup>2</sup> Yet, the role of incarceration in contributing to disparities is still being explored. Preliminary research from Cook County, Illinois shows that jail churn—the cycling of people in and out of jails—is associated with 15.9% of all COVID-19 cases in Chicago, making it a stronger predictor than other factors known to be associated with COVID-19 spread.<sup>3</sup> Although race was not directly assessed in the study, the authors noted, “In Chicago, although Black residents make up only 30% of the population, they represent 75% of the Cook County Jail population and 72% of the city’s COVID-19–related deaths.”<sup>3(p1417)</sup> Greater data transparency

with demographic disaggregation on the part of prisons and jails is necessary to understand inequities in prisons and jails as well as the role of correctional institutions in broader community-level disparities.

## DEMOGRAPHIC DISAGGREGATION

Early in the US pandemic, activist scholars raised legitimate concerns about racial equity in testing and transparency in reporting racial demographic data for COVID-19 cases and deaths.<sup>4</sup> In June 2020, the US Department of Health and Human Services released new requirements for states reporting data based on race, ethnicity, age, and sex to have a clearer picture of COVID-19–related disparities. However, many state departments of health reporting racial demographic data have a substantial amount of missing data, and county-level data remain sparse.

The departments of correction of only four states are reporting any demographic information about COVID-19: Massachusetts, Vermont, Tennessee, and Washington (Table 1). The Vermont Department of Corrections has the most comprehensive reporting, including COVID-19 testing and case counts by race/ethnicity, along with point-in-time population estimates. Given that Vermont is one of a handful of states to implement a universal testing strategy, it is not surprising that there are no large discrepancies in testing. Whites comprise 86.7% of the population and 86.7% of those who have been tested. Blacks comprise 8.6% of the population and 7.7% of those who have been tested. The cumulative prevalence for Black and White residents is 6.0% and 2.6%, respectively. In other words, in a context of

**TABLE 1— Prison Systems Reporting COVID-19 Data With Demographic Information, as of October 14, 2020: Massachusetts, Vermont, Tennessee, and Washington**

State	Data Quality	% of Population	% of Those Tested	% of COVID Cases	Test Positivity
Vermont <sup>a</sup>	Most comprehensive; universal testing	Black: 8.6	Black: 7.7	Black: 16.4	Black: 6.0
		White: 86.7	White: 86.7	White: 80.0	White: 2.6
Tennessee	80.6% unknown race; universal testing; data only for testing	Black: 42.3	Black: 38.4 <sup>b</sup>	NA	NA
		Latino: 2.1	Latinx: 2.1		
		White: 55.1	White: 59.2		
Massachusetts	Reporting data only for testing; universal testing; not cumulative	Black: 28.1	NA	NA	NA
		Latino: 26.4			
		White: 42.2			
Washington	Only for cases; 31.6% of prison population tested	Black: 17.8	NA	Black: 14.5	NA
		Latino: 14.6		Latino: 15.5	
		White: 69.5		White: 71.6	

Note. NA = not available.

Source. VT data accessed from <https://doc.vermont.gov/covid-19-information-page>; TN data accessed from <https://www.tn.gov/content/dam/tn/correction/documents/TDOCIInmatesCOVID19.pdf>; MA data accessed from <https://www.mass.gov/info-details/doc-covid-19-inmate-dashboard>; WA data accessed from <https://www.doc.wa.gov/corrections/covid-19/data.htm#demographics>.

<sup>a</sup>Among those housed in-state.

<sup>b</sup>Excludes unknown.

universal testing, Black prison residents have 2.3 times the risk for COVID-19 that White prison residents have. Black people comprise 16.4% of COVID-19 cases (test positivity: 6.0%), and White people comprise 80.0% of COVID-19 cases (test positivity: 2.6%).

The Tennessee Department of Correction is reporting race/ethnicity information for testing only, with 75% categorized as “unknown” race. Tennessee has also implemented a universal testing strategy. Population data from the Bureau of Justice Statistics show that White people comprise 55.1% of the incarcerated population, Black people 42.3%, and Hispanic people 2.12%. The distribution of COVID-19 testing is 59.2%, 38.4%, and 2.1%, respectively. Similar to Tennessee, the Massachusetts Department of Correction is reporting demographic data for testing. However, these data are not being reported cumulatively, and counts less than five are masked, making the

data uninterpretable. The Washington State Department of Corrections is reporting race/ethnicity information for cases only and provides proportions for racial/ethnic categories for the total population. Washington has tested only an estimated 31.6% of the prison population. Based on these data, there do not appear to be substantial race/ethnic disparities in COVID-19 cases.

### WE NEED MORE DATA TRANSPARENCY

Table 1 details the sum total of available COVID-19 data by race/ethnicity in US prison systems to date, which is unacceptable if we truly want to combat this pandemic equitably. It is nearly impossible to monitor the degree to which the racial/ethnic disparities in COVID-19 cases, hospitalizations, and mortality present in the general population are also present in prison systems and how prisons and jails may be contributing to

population-level disparities in COVID-19. It took great advocacy efforts to have this information systematically reported by departments of public health for the general population (e.g., <http://d4bl.org/action.html>), but we have yet to see this detailed level of reporting by departments of correction. In August 2020, Senator Elizabeth Warren (D, MA) and other congresspeople introduced the COVID-19 in Corrections Data Transparency Act, which would require federal, state, and local correctional facilities to submit comprehensive data on COVID-19 to the Centers for Disease Control and Prevention, including mandating that the data collected and reported be disaggregated by demographic characteristics.<sup>5</sup>

Beyond documenting disparities, comprehensive and disaggregated COVID-19 data should be used to take action, such as ensuring equitable testing in correctional facilities. Testing rates and test positivity rates vary substantially among

prison systems, with only a small number of prison systems engaging in universal repeat testing. There are known racial inequities in diagnosis and in access and timeliness of health care, which extend to our prisons. Prisons, overall, have received less policy attention and COVID-19 resources than other group living quarters (e.g., skilled nursing facilities). With limited resources, it is imperative that COVID-19 testing and treatment be administered equitably in prisons. Additionally, these data should inform the release of individuals from jails, prisons, and Immigration and Customs Enforcement detention centers. Correctional facilities should, at a minimum, reduce their population to a level that allows proper social distancing and should provide equitable, comprehensive, and responsible discharge planning so people can safely reenter communities.<sup>6</sup>

To stem community spread following decarceration, resources should be devoted to testing upon release, access to safe places to quarantine, and retesting at 14 days during community reentry. Looking ahead, vaccine administration should be prioritized in prisons and jails given the heightened vulnerability of the population to COVID-19, and protocols for vaccine administration should be codeveloped with incarcerated and formerly incarcerated people.<sup>7</sup>

Mass incarceration is a key driver of racial health disparities in the United States, and prisons and jails are amplifiers of diseases. It is critical that we have timely, accurate, comprehensive, and disaggregated data about COVID-19, including information on testing, symptoms, cases, and outcomes (e.g., hospitalizations, recovery, death) to document and act on racial inequities. **AJPH**

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The authors contributed equally to this editorial.

## CONFLICTS OF INTEREST

The authors disclose no conflicts of interest.

## REFERENCES

1. Brinkley-Rubinstein L, Cloud DH. Mass incarceration as a social-structural driver of health inequities: a supplement to *AJPH*. *Am J Public Health*. 2020; 110(suppl 1):S14–S15. <https://doi.org/10.2105/AJPH.2019.305486>
2. Ford T, Reber S, Reeves RV. Race gaps in COVID-19 deaths are even bigger than they appear. 2020. Available at: <https://www.brookings.edu/blog/up-front/2020/06/16/race-gaps-in-covid-19-deaths-are-even-bigger-than-they-appear>. Accessed November 6, 2020.
3. Reinhart E, Chen DL. Incarceration and its disseminations: COVID-19 pandemic lessons from Chicago's Cook County jail. *Health Aff (Millwood)*. 2020;39(8):1412–1418. <https://doi.org/10.1377/hlthaff.2020.00652>
4. COVID Tracking Project. About the racial data tracker. 2020. Available at: <https://covidtracking.com/race/about>. Accessed November 6, 2020.
5. Warren E. Warren Pressley, Murray Booker, Garcia Clarke, Kelly introduce the COVID-19 in Corrections Data Transparency Act. 2020. Available at: <https://www.warren.senate.gov/newsroom/press-releases/warren-pressley-murray-booker-garcia-clarke-kelly-introduce-the-covid-19-in-corrections-data-transparency-act>. Accessed November 6, 2020.
6. Howell BA, Ramirz Battle H, Ahalt C, et al. Protecting decarcerated populations in the era of COVID-19: priorities for emergency discharge planning. 2020. Available at: <https://www.healthaffairs.org/doi/10.1377/hblog20200406.581615/full>. Accessed November 6, 2020.
7. Wang EA, Zenilman J, Brinkley-Rubinstein L. Ethical considerations for COVID-19 vaccine trials in correctional facilities. *JAMA*. 2020;324(11):1031–1032. <https://doi.org/10.1001/jama.2020.15589>