Paths to Improving Pandemic Preparedness in Jails and Prisons: Perspectives of Incarcerated People and Correctional Staff

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People who live and work in carceral settings are at high risk for COVID-19.[1] As of September 30, 2022, at least 622 968 people incarcerated in US prisons and 230 168 staff members had been diagnosed with COVID-19, and 3185 had died.[2] Compared with rates among the general population, average COVID-19 case rates in state and federal prisons are five times higher[3] and mortality rates are at least double.[4,5] Likewise, communities that are near correctional facilities have higher rates of COVID-19.[6]

Carceral systems, however, have not been fully integrated into public health responses to the pandemic. Few local governments have incorporated jails and prisons into their strategies for COVID-19 response and preparedness.[7] The World Health Organization's recent comprehensive framework for COVID-19 response recommends that all countries conduct a substantive equity and inclusion analysis to inform programming, which should rely on "meaningful participation, collaboration, and consultation with subpopulations experiencing poverty and social exclusion."[8] Yet, the bulk of what has been written on prisons during this pandemic has been based on an external "expert" perspective, not grounded in the perspective of people who live and work in these environments.

We report on lessons learned in the first two years of the pandemic that were gleaned from a unique partnership with three carceral systems and based on 100 interviews we conducted with incarcerated people, correctional workers, and medical staff. They point to unique structural and operational challenges that carceral facilities face in prioritizing the goal of COVID-19 mitigation and highlight strategies that may improve pandemic preparedness. The methods of our study that generated these findings can be viewed in the Appendix (available as a supplement to the online version of this article at https://ajph.org). From this work, five dominant themes emerged that provide an "on-the-ground" perspective of living through COVID-19 in carceral settings and center the voices of those incarcerated and working in carceral spaces to capture the complexity of COVID-19 prevention and mitigation.

EXTERNAL AND INTERNAL COLLABORATIONS

Prepandemic governance structures did not pivot well to the collaborative decision-making that was necessary for COVID-19 prevention and mitigation. Community COVID-19 response largely excluded carceral facilities. A correctional leader described feeling left out of response efforts:

> There was no playbook of how to deal with things [in carceral facilities] and how do you adjust things. . . . The guidance I would have expected from a higher level of a state authority and even federal authority . . . was very behind with this pandemic.

When partnerships with departments of public health were initiated or fortified, carceral systems were better able to respond. For instance, one administrator noted, "Working with the department of health, all the testing got paid for through them, so it wasn't on the Department of Corrections budget other than the overtime for nurses."

Similarly, strategies executed by leadership or medical staff alone were often difficult to operationalize and

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unsuccessful. Medical staff said, "You cannot quarantine and isolate individuals without moving them, and their movement is dictated by security . . . and so there has to be some collaboration with security." Initially, correctional leaders were at the top of the hierarchy of medical decision-making, which meant that notions of safety superseded public health. When partnerships were developed between correctional leaders and medical staff, pandemic management improved:

> We meet every week and kind of just make sure, you know, are procedures working? Are there enough isolation beds? Are there too many people in isolation, such that they're having to be housed, you know, in . . . areas that . . . [are] unsafe?

The pandemic highlighted how carceral facilities often operate in siloes, and building partnerships between carceral systems improved collective learning. Leadership in one facility convened regular meetings with other facilities:

> We started to do a . . . [leaders'] meeting every Friday where we would talk about the issues around COVID and what everybody was doing to try to make sure we were all doing what was the best practice to everyone. We relied on each other for knowledge.

POLITICAL ECONOMY OF MASS INCARCERATION

Incarcerated people and correctional staff described the public health goals of COVID-19 mitigation, especially decarceration, as in conflict with the fiscal priorities of carceral systems. In one facility, decarceration affected the bottom line, as the operating budget was based on the population. As the facility stopped incarcerating those with low-level misdemeanors, their operating budget fell, leading to staff demotions and layoffs. Although all recognized the ability to better social distance, staff were demoralized. A correctional leader explained:

> When the pandemic hit . . . we didn't want to be transferring the inmate population . . . and possibly taking that risk of spreading COVID around. So that got shut down, which of course then we lost that revenue. And because of lost revenue, positions didn't get refilled.

An incarcerated person gave this summary:

> Everything's a numbers game. . . . They've got to keep the population steady. That way . . . they don't lose their jobs. . . . 'Cause if they release too many . . . we're the ones putting food on their table and putting their kids through college. Without us, there's no them.

INTERCONNECTED HEALTH RISKS

Implementing new policies was often difficult because relationships between incarcerated people and correctional staff were positioned as adversarial. An incarcerated person described their perception of correctional officers: "They are not here for you, and they are not here to provide for you. That's not their job. Their job is just to pass the room and make sure you're still alive, and that's basically what you're told." A correctional officer explained:

> We implemented masking policy for the inmates in custody when they were outside their assigned cells. We were not given clear direction to the degree this should be enforced. Because of this, it went entirely unenforced because enforcing rules in a carceral setting leads to conflict.

The perspective of incarcerated people and correctional staff offered glimpses of a more unified approach to infection control in these ecosystems. As one incarcerated person said:

> [I was] having conversations with the correctional officer, 'cause we were all in a similar boat. They were scared. The inmate population was scared. The nursing staff was scared.

Officers too could see the frustrations of incarcerated people, with one saying, "If there's some kind of COVID-related delay, even just a supply chain delay, . . . their commissary gets delayed. There's all these things that, you know, they rely on to make their day go by."

However, policies on COVID-19 mitigation often exacerbated a mentality of difference. Educational, testing, and vaccine campaigns were separate for staff and incarcerated people, which created different expectations and a false sense of difference in risk, when in fact both groups are at higher risk for acquiring COVID-19. Interviews revealed opportunities for a more unified approach to COVID-19 that recognized the interconnectedness of the health of the two groups. Some people said joint vaccination and testing campaigns would facilitate trust in both groups; others said mental health services for correctional staff would foster professionalism in their interactions with incarcerated people.

DISPARITY IN COVID-19 RESPONSES

The lack of parity between COVID-19 responses in the facility and the community was felt by incarcerated people

and correctional staff and was mentioned across many domains. For example, when congregate settings and first responders were named as a national priority for vaccination and carceral facilities and workers were not included as prioritized populations, incarcerated people and correctional staff reported feeling disenfranchised. A correctional leader expressed frustration about vaccine scarcity:

> Clearly, I would say from the beginning, it may have been that we didn't have enough. . . . Then I often wonder is there a political arm in that. Are there people politically that don't necessarily wanna give it to incarcerated people 'cause they're incarcerated? That honestly [I] don't know because my staff—same thing. My staff members couldn't do it either.

Incarcerated people felt the disparity in access to health information, which bred distrust:

> I can't pick up my phone and do Google right here. I can't pick up the paper and read. I can't pick up my phone and read Newsbreak. I can't—you know what I'm saying? I can't find out information I wanna find out in here. That would change my mind if I could find out more information. . . . I'm not taking anyone's word from their mouth.

Perhaps the most extreme example came in the ways that isolation, quarantine, and lockdown policies took form. Isolation and quarantine often approximated the punitive conditions of solitary confinement. Lockdowns often lasted months, during which people could not leave their cell for up to 23 hours of the day, normal programming was eliminated, and cold meals were served in the cell. An incarcerated person described it as follows:

> You're locked in a cell 23 hours a day, you know, maybe even longer during the pandemic, because they weren't really letting us out of our cells. We were eating in our cells. You only got like maybe a 10-minute shower.

Furthermore, when community standards for social distancing relaxed once vaccinations were available, programming and movement in facilities continued to be restricted.

But when correctional leadership changed policies to simulate parity with community standards, mitigation efforts improved. For instance, when financial incentives for vaccination were being offered in the community, medical leadership in one carceral system advocated the same incentive for incarcerated people and eventually succeeded. A medical leader said:

> I had been talking with a colleague who I meet with pretty regularly at the State Department of Health about this and saying like, "You know, there's all these community incentives. Like, why are we not giving people in jail these same incentives that they'd otherwise get in the community?"

This approach was also applied to guide decision-making in returning to prepandemic operations. A medical leader said:

> We're always keeping in mind community standards, so recognizing that we're in a [carceral facility] but also being aware of what people just in general in our community have access to. So, when the health department here was making recommendations to open things up in our community due to the vaccination status of people . . . it makes some sense to us to try and extend that . . . for our patients here.

INCLUSION IN DECISION-MAKING

Incarcerated people and correctional staff have a unique role to play in pandemic preparedness. Incarcerated people provided ideas for improvements, including testing logistics, vaccination campaigns, best practices dissemination, and approaches to building trust between medical staff and patients. A medical staff member explained the informal role incarcerated people played in collaborating for COVID-19 testing and education:

> The public health staff were hearing from other inmates that would say, "I know how you can get so-and-so to get tested," or "Let me get so-and-so to come in, and we're gonna have a little discussion," because at that point it was like peer pressure because people didn't wanna see their friends get sick from it. A lot of them saw some very sick people.

Several people remarked on the importance of cultivating leadership among correctional officers to operationalize mitigation strategies as well. For instance, a medical worker said:

> [Security leadership] talked about wanting to make sure that a lot of the union leaders were on board and making sure that they had gotten it. Again, 'cause people respected them and felt that, you know, well, if this person is getting it and trusts it, then I can trust it.

In this study we relied on experts who live and work in carceral settings

to understand the COVID-19 response and how to facilitate public health preparedness in these settings. Existing public health structures did not adequately facilitate collaboration in facilities and across sectors. Our data support a recent policy analysis of the existing linkages between states' departments of health and departments of corrections, which revealed that only nine states had a comprehensive working relationship between corrections and health.[9]

Even in places that have preparedness plans in place, our results indicate that COVID-19 responses would be more successful if existing norms in carceral systems were challenged. First, decisions that prioritized health were possible when carceral systems moved to a collaborative process that included medical professionals in decision-making. Second, anchoring decisions and policies to mirror community trends (e.g., vaccine access and testing, quarantine and isolation, and return to prepandemic policies) was a powerful advocacy tool for leadership. Third, underscoring a unified approach to interventions for staff and incarcerated people is crucial.

These strategies require disrupting power structures to improve health and save lives. The prevailing organizational structures of most carceral settings compromise health promotion and pose challenges to effective COVID-19 mitigation strategies. Furthermore, the dominant structures of public health and community health care systems do not include carceral systems as relevant partners. Intentional maintenance of multisector partnerships, even in nonpandemic times, is vital to ensuring that carceral facilities are agile enough to respond to emerging public health crises. These efforts should include public health experts, health care providers, incarcerated people, and carceral entities.

Another important finding from these interviews is that the fiscal model of carceral institutions was at odds with public health goals. These are not novel findings, as other scholars have reported on decarceration and its political consequences in rural communities.[10] However, our study confirms that respondents who worked in carceral facilities often found decisions about COVID-19 to be in conflict with the financial realities of running a carceral system and suggests that for sustained decarceration, investment in other sectors, particularly local economies where facilities are sited, are required to avert harm to families who work in corrections.

There are some limitations to the study we conducted that led to these core themes. We conducted interviews in carceral settings that were open to research partnership and may not wholly reflect the circumstances of many people who live and work in carceral systems. Also, we were unable to conduct in-person interviews, which may have affected personal connection during interviews. Nevertheless, the themes that emerged from this work were robust and encompassed input from a wide array of people from multiple facilities.

State and federal governments should take steps now to improve the preparedness of carceral systems for future waves of COVID-19 and subsequent public health emergencies. Our study reveals the invaluable contributions that those affected by COVID-19 in carceral settings could offer in redefining carceral governance and operations so that they are aligned with the goals of public health. AJPH

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The authors have no conflicts of interest to disclose.

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