COVID-19 shows us that prison healthcare is in dire need of reform




The spread of COVID-19 has had a huge negative impact on those involved with the criminal justice system – a group which already suffers from poorer healthcare outcomes. **Cynthia Golembeski, Ans Irfan, Brie Williams,** *and* **Homer Venters** *write that the COVID-19 pandemic is an opportunity to push for reforms to reduce prison populations and to move to a more humane evidence-based healthcare system for those involved with the justice system.*

Important works over the last two decades have analyzed the socio-historical and political antecedents of the "New Jim Crow," the US criminal justice system's undermining of the gains won in the civil rights movement. For many years, public health professionals and advocates, ourselves included, have been raising the alarm regarding the quality of health care within jails and prisons and the unhealthy environmental factors associated with correctional facilities that contribute to poorer health outcomes for an already medically vulnerable population. Such assertions were echoed in a 2014 article, written by affiliates of Vera Institute of Justice, which cautions against public health and corrections systems working in silos; encourages a public health approach rather than a punitive paradigm; and calls on policymakers, researchers, and advocates to form new partnerships, rethink drug policy, and improve health information technology. The onset of the COVID-19 pandemic in the US has shone a new and brighter light on the vast inequities that exist within our public health system in terms of access, screening, and care. Correctional health is chief among them.

The adverse health effects of criminal justice involvement

Inadequate treatment options and discontinuity of care both between correctional facilities and from prisons or jails to the community exacerbate health disparities further compromising an already high-need, medically underserved population. The medical vulnerability of the US prison and jail population is exemplified by one single statistic: there are three times as many people diagnosed with serious mental illness in jails and prisons than in psychiatric hospitals. Moreover, the majority of justice-involved individuals come from and return to under-resourced communities where access to high quality healthcare prevention, screening and treatment services is frequently limited. Such communities then struggle to reintegrate returning citizens with high rates of chronic conditions, mental illness, and substance use disorders back into their already-stretched public healthcare systems. Criminal justice involvement also has both direct and indirect adverse effects on the health of individuals, their families, and communities. As a result, understanding and addressing the healthcare needs of justice-involved individuals is one component of a comprehensive strategy to reduce health disparities and improve upon community health.

Criminal justice reform and public health experts have issued guidance on coordinated action to prevent the spread of COVID-19, coinciding with those put forth by the CDC, through improving testing and screening practices; increasing access to medical supplies; and improving continuity of care. Moreover, Cyrus Ahalt, a public health researcher at the University of California, San Francisco, calls for the incorporation of the correctional workforce, including clergy, teachers, caseworkers, and healthcare providers, in positing "how profoundly the lives of those living and working in US jails and prisons are intertwined." Some government and correctional authorities are placing medically vulnerable populations in harm's way despite the availability of evidence-based priorities for emergency discharge planning.

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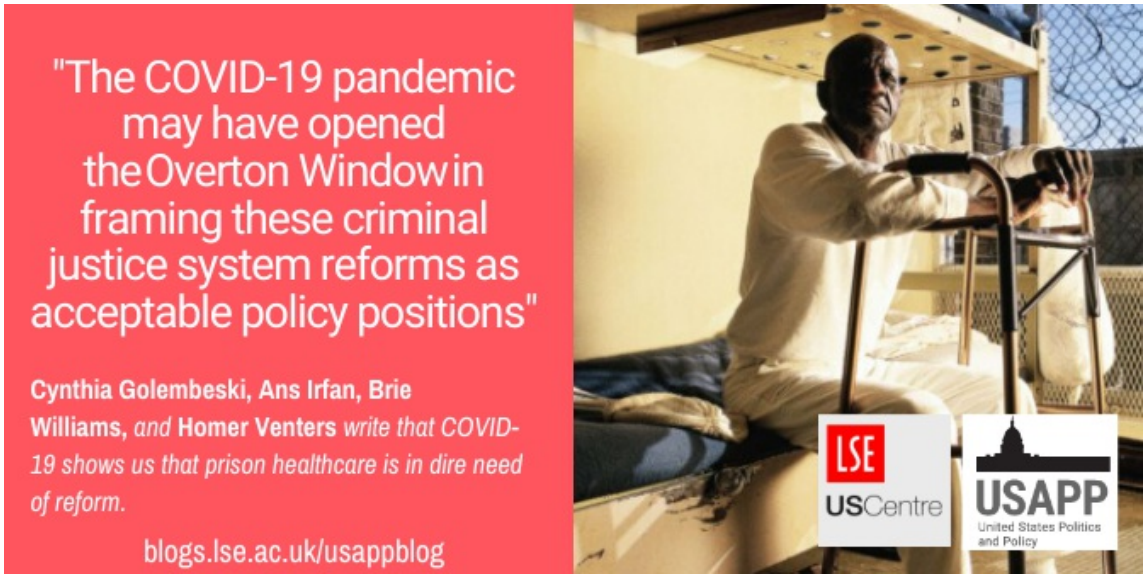
The New York Times has documented over 47,000 coronavirus infections and 485 inmate and staff deaths at federal prisons, state prisons, and local jails. The Marion Correctional Institution in Ohio contends with 2,439 cases of COVID-19 infection and over 1,300 cases constitute each of the three largest identified coronavirus clusters, which are in prisons. Jail populations have more significantly dropped due to bail reductions to as low as $0, particularly for many misdemeanors and some low level felony offenses. For instance, Los Angeles, Sacramento, and Orange County jails in California have decreased by 30-45 percent, whereas North Dakota county jails have declined by 30-50 percent. State level policy changes continue to reduce prison populations by abating admissions and releasing people are much smaller in scale and scope. For instance, Washington's Democratic governor, Jay Inslee's recent efforts to release at least 1,000 people from state prisons via commutation and a modified graduated reentry program, were blocked by the Washington State Supreme Court.

Social distancing and sheltering in place, hallmarks of mitigating the spread of COVID-19, as well as the appropriate use of medical isolation and quarantine are necessary to achieve the triple aim of public health: improving the patient experience of care; improving the health of populations; and reducing per capita cost. Yet, Brookings' Andre M. Perry reminds us that this approach to public health is tricky at best, as Black Americans were forced into 'social distancing long before the coronavirus in the form of "segregation, discrimination, and devaluation." Mass incarceration, food insecurity, substandard housing and schools, a lack of paid leave and a livable wage, are hallmarks of an alternate form of social distancing that profoundly impacts those with justice-involvement, their families, and their communities. Ultimately, COVID-19 has exacerbated health inequities.



Photographer Ron Levine took the photo of William Howard "Tex" Johnson when Johnson was 67 and serving time for snatching $24 in 1959 in Birmingham, AL. The photo is part of the "Prisoners of Age" series, which includes interviews with aging inmates and corrections personnel conducted in US and Canadian prisons. Used with permission.

The high rates of associated physical and mental health conditions, detainment without charge or for lower-level or non-violent charges, increasing concentration of people aging in prison, and the racial and class disproportionality of policing and criminal justice practices warrant close attention during this pandemic. Poor people of color have been most adversely impacted by COVID-19. For instance, in Chicago black people are dying at a rate nearly six times as high as white Chicagoans and in Milwaukee county where the average life expectancy for blacks is 14 years shorter than if one was white, blacks comprise half of the COVID-19 cases and constitute 81 percent of related deaths.

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More often than not, those who are currently incarcerated or who are returning home, have experienced a lifetime of unequal access to health and social services. Researchers also confirm the immediate aftermath of release is a particularly risky period—a worsening of chronic medical conditions, and substance use, plus a high risk of hospitalization and death. Moral, as well as economic reasons, support improved public health and justice reform efforts and more integrated resources that address the needs of those who are currently incarcerated, under community supervision, and reentering the community.

Criminal justice is a health equity issue

Healthcare for incarcerated people is not delivered, measured or funded with the same evidence-based structures that exist in the community. Instead, incarcerated people receive care and protection via the Eight Amendment's prohibition against cruel and unusual punishment and constitutionally guaranteed the right to health care, yet the level of care is inadequate when there is no pandemic.

Previous research suggests that incarceration, in itself, increases the likelihood of infectious diseases. This is not accounting for the compounding effects of overcrowding and other structural failures in extending basic protections to detained and imprisoned populations, which are vulnerable due to disproportionate complex medical needs. Delays in receiving treatment and worsening mental, physical, and occupational health impacts have also been noted. Justice-involved populations have a higher prevalence of HIV, tuberculosis, hepatitis B, hepatitis C, gonorrhea, and other infectious diseases. The control of infectious diseases in correctional facilities remains a crucial public health challenge. Chronic health conditions such as asthma, arthritis, and certain cancers also remain a public health challenge for this population and correctional contexts. Mental health challenges are an added burden for this population. Last, but not least, research suggests a decrease in lifespan and potential negative health impacts for communities in association with incarceration.

Public health has been slow to take on criminal justice as a health equity issue. The Robert Wood Johnson Foundation, the largest US philanthropy explicitly focusing on health, only recently added incarceration as one of its 35 national-level measures being utilized to track the nation's progress toward the vision of a culture of health. Correctional health organization structures, per-inmate expenditures, and health care quality and availability, vary widely across institutional contexts at the local, county, state and federal levels. National jail health standards are voluntary as are the guidelines developed by the American Public Health Association and the American Medical Association. Safely and ethically reducing prison and jail populations and strengthening resources and supports for those with justice-involvement is critical given how difficult physical distancing is in correctional contexts and certain communities. We acknowledge the false narrative of "law and order" and the lack of political will associated with challenging the special interests, namely the prison-industrial complex, in reducing the prison population.

Similarly, state and local approaches to the COVID-19 pandemic amidst carceral contexts are diverse in scope, intensity, and practice regarding: releasing people from prisons and jails; reducing jail and prison admissions; reducing close contact during parole and probation; eliminating medical copayments; and reducing video and phone call costs. However, the COVID-19 pandemic may have opened the Overton Window in framing these criminal justice system reforms as acceptable policy positions given the difficulty of implementing social distancing and sheltering in place within carceral contexts. We urge the public health community, criminal justice reform advocates, and policymakers to seize this opportunity for cardinal reform of the criminal justice system as part of a responsive COVID-19-related legislative agenda.

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