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We must urgently do more to address COVID-19 behind bars and avoid mass infection and death: Guidance for Attorney General Barr, governors, sheriffs, and corrections administrators

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This country—indeed, the world—has not faced a health crisis of the urgency, magnitude, and scale of the one posed by the novel coronavirus. As the total number of infections in the United States tops 1.3 million and the death toll passes 80,000, two vulnerable groups remain largely ignored: people who are incarcerated and those who work in jails, prisons, and detention centers. There is no public safety without public health in this pandemic. We urge leaders across the country to take steps to protect our *whole* community, including people behind bars.

The *New York Times* reports that at least 10 of the 15 COVID-19 "clusters"—places that have the largest number of known infections in the country—are correctional facilities.[1] With 2.3 million currently behind bars, the United States is by far the most punitive and incarcerated country in the world. If our jail and prison incarceration rate were on par with the global average, there would be no more than 360,000 people incarcerated today.[2] Yet the known number of people who have been released from jails and prisons since March is only a small fraction of the 2.3 million behind bars—despite the looming threat of a pandemic within a pandemic in these facilities.[3]

The vast majority of jails, prisons, and detention centers house people in inhumane conditions that make it impossible to maintain six feet of distance; have not provided enough masks, disinfectant, and cleaning supplies to prevent infection and spread; and lack basic medical infrastructure to quarantine or medically isolate those who are symptomatic or who test positive.

This inaction is causing a tragic and avoidable spike in the overall COVID-19 crisis and exacerbating the racial and socioeconomic disparities already on stark display. Today, across the country's correctional facilities, there are more than 20,000 confirmed cases of COVID-19 and 325 known deaths. These numbers are undoubtedly an undercount, given the lack of comprehensive testing for, or tracking of, the virus. With the rate of spread increasing exponentially—especially in suburban and rural parts of the country—without immediate intervention, the COVID-19 crisis behind bars will continue to surge.[4] Prisons and jails are not equipped to treat people who require intensive care and, if nothing is done to "flatten the curve" behind bars, the transfer of critically ill patients to local hospitals will quickly overwhelm community capacity.

The Vera Institute of Justice (Vera) has worked with government partners across the country to respond to the pandemic's impact on jails, prisons, and detention centers, and is available to work with any jurisdiction that calls on us for help. We urge leaders at all levels of federal, state, and local government to immediately address the looming COVID-19 crisis behind bars by taking the following steps:

1. **Reduce the number of people behind bars.** Continue to *responsibly and rapidly decarcerate jails, prisons, and detention centers* for the health and safety of our communities, including those released, people who remain incarcerated, and staff who work in correctional facilities.

2. **Protect the people who remain incarcerated.** Enact emergency policies, practices, and conditions to *maintain the dignity and health of incarcerated people consistent with COVID-19 best practices* for social distancing and protective measures against infection and spread.

3. **Respond effectively to COVID-19 outbreaks behind bars.** Create *high-quality quarantine, medical isolation, and treatment units* within facilities without resorting to solitary confinement cells or practices.

STEP 1: Responsibly and rapidly reduce the population behind bars

Responsible and rapid decarceration must continue to be the first strategy for the health and safety of all—those who are released, those who remain incarcerated, and correctional staff. Current crowded conditions in prisons and jails, as well as the high turnover of both staff and incarcerated people coming in and out of a facility, make it impossible to implement social distancing and other preventive measures. At a minimum, jails and prisons should decarcerate sufficiently so that every person who remains incarcerated has a private cell or, for those held in dormitory settings, at least 150 square feet of personal space at all times.

While all incarcerated people should be considered for release, priority should be given to people at highest risk of illness and death due to COVID-19, including those who are elderly or have serious underlying medical conditions. Decisions about release should be viewed with an eye toward race equity, given the documented disproportionate impact of COVID-19 on Black communities, where rates of illness and fatality have been far higher than for other groups.[5]

- *Decarcerate jails.* Being held in jail following arrest may be a death sentence and should only be considered in exceptional circumstances. Local system actors, including police, prosecutors, judges, the defense bar, sheriffs, and city and county executives, have the authority to push for rapid decarceration by issuing citations instead of taking people into custody; holding timely bail hearings; and using statutory provisions for early release, furlough, and re-sentencing.[6]

- *Decarcerate prisons.* Despite the 1.5 million people incarcerated in state and federal prisons, the U.S. Department of Justice and most state governors have done relatively little to decarcerate. Elected officials have available to them the

tools of clemency, commutation, furlough, early release, refusing admissions, and nullifying holds for technical parole violations.[7]

- *Decarcerate immigration detention.* U.S. Immigration and Customs Enforcement (ICE) is responsible for release of people incarcerated for immigration purposes in local jails, prisons, and detention centers. Since the pandemic began, fewer than 200 out of the approximately 30,000 people in ICE custody have been released.[8] ICE can release people who already have bond set that they cannot afford, hold more bond hearings for people initially denied or not considered for bond, and refuse to accept new admissions to ICE custody.

Outbreaks of COVID-19 within facilities should not be used as an excuse to stop releasing people. To continue to responsibly decarcerate, especially in facilities where people have tested positive for COVID-19, system actors must coordinate plans for quarantine and medical isolation with service providers. These plans can include provisions to release incarcerated people to their homes or to safe temporary residences like motel and hotel rooms if quarantine is necessary, as well as to provide information about best practices to protect against COVID-19, hand sanitizer, cloth masks, and necessary supplies, like extra doses of medication.[9]

For more detailed guidance on ways to effectively reduce the incarcerated population, see Vera's series of briefs for criminal, immigration, and youth legal system actors.

STEP 2: Protect the safety, dignity, and health of all who remain behind bars

As COVID-19 grows and spreads in jails, prisons, and detention facilities, so does real fear among incarcerated people facing imminent sickness and potential death with no ability to protect themselves. That danger is also true for staff and law enforcement officers—frontline essential workers who are at high risk for infection and spreading the virus to their families and communities as they enter and leave facilities each day.

The virus does not respect the walls and bars of jails, prisons, and detention facilities. Yet the responses to COVID-19 to date have largely centered on lockdown measures, prohibiting in-person visits with family members and loved ones; limiting movement or access to programs, activities, time in the yard, or classes; and, for facilities with single units, requiring people to stay in their cells. The exponential rate of infection and increasing death toll demonstrate that these tactics are ineffective.

Governors, sheriffs, and corrections administrators must take more steps to proactively and effectively manage the potential for infection and spread in their facilities in ways that respect the dignity of incarcerated people, do not compromise freedom of movement within facilities, and at least meet, if not exceed, the Centers for Disease Control and Prevention and World Health Organization guidelines to respond to COVID-19. All these measures should be conveyed to staff and incarcerated people—through trainings, socially distanced small group and individual meetings, workshops, and written materials. Those same written materials and information should be provided to the family members of incarcerated people and the public.

For staff, especially, it should be emphasized that changing typical policies and practices in light of the pandemic will not result in less security in the facility. Use examples, drawing from Germany and some U.S. facilities, demonstrating that these changes will lead to more stability, increased safety and health, and a sense of community.

- *Provide personal protective equipment (PPE) to all incarcerated people and staff*. Facilities must distribute cloth masks, hand sanitizer, disinfectants and cleaning supplies, and unlimited free soap, as well as increase access to showers and laundry daily to prevent infection and spread.

- *Clean common spaces and provide access to hygiene products*. The most effective measure, beyond PPE, for managing COVID-19 is increased cleaning and disinfecting of shared spaces. Facilities must invest in bleach, disinfectant, and cleaning supplies and wipe down surfaces frequently (several times a day for high-traffic areas). Incarcerated people must have access to the same supplies for their own spaces. Facilities should invest in ultraviolet machines, common in medical spaces to keep facilities clean for people with compromised immune systems, to disinfect entire rooms at a time.[10]

- *Provide free tablets and phone calls to replace lost in-person visits*. Virtually all facilities have prohibited in-person visits of family and friends to prevent and contain infection. However, abundant contact with loved ones is critical to good mental health and well-being, especially in this time of heightened anxiety. Facilities must provide free tablets and phone calls to substitute for the lack of in-person visits. Where tablets and phones must be shared, disinfect and clean the devices after each use.

- *Test as widely as possible*. Some facilities have taken the necessary and important step of testing everyone, both staff and incarcerated people. In those facilities, more than 75 percent of incarcerated people have tested positive for COVID-19, including many who show no symptoms.[11] All facilities should take this critical step to identify and manage outbreaks. If mass testing is unavailable, jails, prisons, and detention centers should implement daily sick calls for all incarcerated people to identify potential infection early; temperature checks; and contact tracing when people test positive. Incarcerated people and staff who may have been exposed to the virus should be quarantined. (For quarantine best practices, see next section.)

- *Change routine practices and train staff to limit unnecessary contact*. Many aspects of daily corrections life involve contact, including cuffing people to move within a facility, conducting pat downs or searches, or using keys to lock and unlock doors. Administrators should immediately review which routine policies and practices needlessly increase contact between staff and incarcerated people or with surfaces in highly trafficked areas and train staff to approach those interactions differently to uphold public health best practices, maintain dignity, and respect personal space. Many of these contacts can be eliminated during the pandemic to prevent infection and spread. Where this is not feasible, stringent infection control practices must be enforced.

- *Change schedules and methods of running programs, activities, and religious services—but don't eliminate them*. Administrators, staff, and incarcerated people value the role of programs, classes, and activities for the benefits to social and emotional health. During a time of crisis and heightened stress, those opportunities are more critical than ever to maintaining people's dignity, autonomy, and sense of community and safety within a facility. Instead of canceling or scaling back on these measures, stagger and schedule programs, classes, and activities to allow for more social distancing. It is ideal to provide multiple opportunities throughout the day for time outside or time spent connecting with family. Consider making classes remote and accessible via tablets if social distancing within classrooms isn't possible.

- *Align facility design to meet public health recommendations.* The congregate dorm settings of most facilities make social distancing impossible. Wherever possible, administrators should close dorm-style housing areas and provide people with their own cells and more private space. Even in dorm settings, people incarcerated should have at least a six-foot radius of space to maintain the physical distance needed to prevent infection. That translates to approximately 150 square feet of private space per person.[12] Consider using all parts of a facility to create more personal space during the pandemic—including gyms, visiting areas, staff offices, and private rooms. In highly trafficked areas of the facility, such as dining halls, bathrooms, and other common spaces, paint the walls or surfaces a bright color to remind people to wash their hands immediately after contact.

- *Publish policies and track data publicly.* Share detailed information on measures being taken to prevent the spread of COVID-19, including how those who become ill are treated. Provide daily updates on the number of COVID-19 tests performed and their results, the number of staff and incarcerated people who have tested positive and at which facilities they are located, the number of people in medical isolation and quarantine at each facility, and the number of staff and incarcerated people who have died from COVID-19. Make this information widely available to the public, incarcerated people, and their families by posting it daily on agency websites and hanging printed versions in the common areas of facilities.

STEP 3: Respond to COVID-19 outbreaks without resorting to solitary confinement

Medical units within jails, prisons, and detention centers are designed to manage routine and minor medical needs, not respond to a crisis that has, even in the community, overwhelmed health care systems.

Every single jail, prison, and detention center in the country must have a plan for quarantine and medical isolation in order to contain an outbreak when it occurs. The term *quarantine* refers to confining people who may have been exposed to COVID-19. *Medical isolation* refers to separating people confirmed to have COVID-19 to reduce the

risk of transmission by limiting physical contact with others. Some facilities are using solitary confinement to respond to COVID-19, creating distrust and a culture of under-reporting among incarcerated people as they do not want to be "sent to solitary." Others are imposing solitary confinement–like conditions on people incarcerated in general population units made up of individual cells.

We know from decades of research that the isolating conditions of solitary confinement—generally defined as holding someone in a cell for 22 to 24 hours a day, often with little to no human interaction; access to programs, activities, and classes; or contact with the outside world—can result in significant harm to people's mental and physical health.[13] A plan for quarantine and medical isolation must not rely on the use of solitary confinement cells or the conditions used in solitary confinement.

- *Designate specific areas of the facility for quarantine and medical isolation.* A specific, isolated area of a facility that can be shut off by a hallway and a door should be designated for quarantine. For medical isolation, people should be housed in the infirmary to have the best access to care. If needed, an entirely separate unit or wing should be set up as an infirmary if multiple incarcerated people need medical attention related to COVID-19.

- *Communicate to staff and incarcerated people about quarantine and medical isolation.* To overcome the distrust that incarcerated people understandably have that quarantine or medical isolation may simply be solitary confinement by another name, use roll call, one-on-one meetings, and socially distanced town halls to communicate that quarantine and medical isolation are not solitary confinement and people will receive care while also having access to the same activities, classes, and services when in general population. Share with incarcerated people information about the units or areas of the facility designated for quarantine and medical isolation, including written directives and guidelines for their operations, and answer questions to address any anxiety or skepticism.

- *Provide the same level of access to programs, services, and outside communications.* The conditions within quarantine and medical isolation must mirror those in general population. Incarcerated people should be able to communicate with loved ones and the outside world via a dedicated tablet or phone provided free of charge; engage with corrections officers and staff from a safe distance; have continued access to the canteen or commissary, including food and postage stamps; use a private shower and toilet; and continue to participate in classes, activities, time outside, and meaningful interaction with others.

- *Ensure frequent physical <u>and</u> mental health services in quarantine and medical isolation.* The experience of potentially being infected or diagnosed with COVID-19 is stressful and anxiety-provoking. Medical staff can address those fears by using their rounds as an opportunity to ask how people are doing; answer questions; and engage a social worker or mental health professional, if necessary, in addition to monitoring symptoms and addressing emergent issues.

Staff safety and well-being. While this guidance is focused on the urgent and immediate need to do more to protect the 2.3 million incarcerated people in this country, we must also do more to protect the corrections staff and workers who play a critical role in fighting COVID-19 behind bars. In states that have conducted extensive testing, the numbers of staff infected are sometimes as high as or even higher than the known cases of COVID-19 among incarcerated people. System actors must provide the same transparency to staff and workers that we urge them to provide to people behind bars, as well as access to PPE, guidance on managing the stress of working during the pandemic, and supports for their health and safety during an unprecedented time.

For more information

For more information about this brief or guidance on implementing these recommendations, please contact Insha Rahman, director of strategy and new initiatives, at irahman@vera.org. The Vera Institute of Justice is a justice reform change agent. Vera produces ideas, analysis, and research that inspire change in the systems people rely on for safety and justice and works in close partnership with government and civic leaders to implement it. Vera is currently pursuing core priorities of ending the misuse of jails, transforming conditions of confinement, and ensuring that justice systems more effectively serve America's increasingly diverse communities. For more information, visit www.vera.org.

Endnotes

[1] "Coronavirus in the U.S.: Latest Map and Case Count," *New York Times*, accessed May 11, 2020, https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html#hotspots.

[2] The estimate of 360,000 people in jails, prisons, and detention centers combined is if the United States incarcerated at the same rate as the rest of the world. For more information about the international average incarceration rate, see World Prison Brief, https://www.prisonstudies.org/, and the data used to assemble Vera's COVID-19 spotlights, https://www.vera.org/projects/covid-19-criminal-justice-responses/covid-19-data.

[3] Vera, the NYU Public Safety Project, the UCLA COVID Behind Bars Project, and The Marshall Project, among other organizations, are tracking real-time data of the impact of COVID-19 on jail and prison populations. The estimate of 40,000 fewer people in jail and prison since the beginning of the pandemic is based on the hundreds of jails and prisons where real-time data collection is possible. This does not capture the trends in jails and prisons that do not regularly publish their data. This figure is therefore likely lower than the actual number of releases.

[4] The ACLU has found that models predicting total U.S. deaths from COVID-19 to be less than 100,000 "may be underestimating deaths by almost another 100,000 if we continue to operate jails as usual." ACLU, *COVID-19 Model Finds Nearly 100,000 More Deaths than Current Estimates, Due to Failures to Reduce Jails* (Washington, DC: ACLU, 2020), https://www.aclu.org/sites/default/files/field_document/aclu_covid19-jail-report_2020-8_1.pdf.

[5] Kelly Malcom and Jina Sawani, "Racial Disparities in the Time of COVID-19," Michigan Health Lab, May 4, 2020, https://labblog.uofmhealth.org/rounds/racial-disparities-time-of-covid-19.

[6] A handful of jurisdictions have drastically reduced their jail populations by a third or even a half, including big cities like San Francisco (~50 percent) and rural counties such as Eau Claire, Wisconsin (49 percent).

[7] Jurisdictions that have decreased their prison populations slightly include Kentucky (4 percent), Iowa (~6 percent), and California (3 percent).

[8] American Immigration Lawyers Association, "ICE Issues Guidance on COVID-19," May 7, 2020, https://www.aila.org/infonet/ice-issues-guidance-on-covid-19.

[9] For example, New York City allocated 1,500 local motel and hotel rooms to be used for people coming out of jail and prison during the pandemic.

[10] Abby Lutz, "Indiana Jail Uses Ultraviolet Light Machine to Fight COVID-19," WHAS-11, May 1, 2020, https://www.whas11.com/article/news/health/coronavirus/indiana-jail-ultraviolet-light-machine-to-fight-covid-19/417-0e60bf6b-e82b-4c11-a01f-0dbfc874245a.

[11] See for example Jeremy Roebuck and Allison Steele, "Montgomery County's Jail Tested Every Inmate for COVID-19—and Found 30 Times More Cases Than Previously Known," *Philadelphia Inquirer*, April 28, 2020, https://www.inquirer.com/news/coronavirus-testing-montgomery-county-jail-asymptomatic-philadelphia-prisons-20200428.html; and Josiah Bates, "Ohio Began Mass Testing Incarcerated People for COVID-19. The Results Paint a Bleak Picture for the U.S. Prison System," *Time*, April 22, 2020, https://time.com/5825030/ohio-mass-testing-prisons-coronavirus-outbreaks/. Also see Cary Aspinwall and Joseph Neff, "These Prisons Are Doing Mass Testing for COVID-19—and Finding Mass Infections," The Marshall Project, April 24, 2020, https://www.themarshallproject.org/2020/04/24/these-prisons-are-doing-mass-testing-for-covid-19-and-finding-mass-infections.

[12] MASS Design Group, "The Role of Architecture in Fighting COVID-19: Rethinking Carceral Environments During and After COVID-19," May 2020, https://massdesigngroup.org/covidresponse.

[13] See for example Craig Haney, "The Psychological Effects of Solitary Confinement: A Systematic Critique," *Crime and Justice* 47, no. 1 (2018), 365-416, https://www.safealternativestosegregation.org/wp-content/uploads/2018/07/The-Psychological-Effects-of-Solitary-Confinement-A-Systematic-Critique.pdf.