Who CARES? COVID in Corrections

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Unspent CARES Act dollars represent a once-in-a-generation opportunity to address a persistent gap in corrections capacity: onsite medical facilities. Too often corrections administrators are incurring large, unplanned additional security costs to provide basic healthcare, for lack of simple onsite capacity. Social distancing behind bars is difficult, and the number of elderly (and sicker) inmates has risen dramatically - 400% between 1993 and 2013.[[1]](#footnote-1)

In early September the U.S. Treasury issued updated guidance on “COVID-19-related expenses of maintaining state prisons and county jails.” The notice stated costs related to the “improvement of social distancing measures [and] ... compliance with COVID-19 public health precautions” were allowable. This extended the original guidance on the “building of construction of temporary structures ... and surge capacity” in Public Law 116-139, Title I (the CARES Act).[[2]](#footnote-2)

Corrections have been hit hard by the COVID-19 outbreak. Inmates and corrections officers have died from the virus, and corrections outbreaks have sustained community transmission. In some states more than 35% of the inmate population have been infected, and there are many states where the number is more than 15%. By the middle of September more than 125,000 people have tested positive and the number is increasing by 4% per week. Infections in corrections mirror those in the general population; spiking in April, slowing in June and peaking again in August. There have been large case increases in recent weeks in Florida, California, Arkansas, Oklahoma and the federal prisons.

Corrections began to feel the impact of COVID about mid-March 2020; the first case of novel coronavirus 2019 (COVID-19) was diagnosed at Riker’s Island in New York City. According to a report from the JAMA Network, “within 2 weeks, more than 200 cases were diagnosed within the facility, despite efforts to curb the spread.”[[3]](#footnote-3) By mid-March Cook County, Illinois faced similar conditions with about 350 incarcerated persons and staff members testing positive, and on April 19, 2020, the first inmate in the California Department of Corrections system died from COVID.

There are significant differences between the numbers of people being tested in different corrections settings, and there is no systematic or national mandate for testing corrections workers who move in and out of the jails and prisons on a daily basis. The pattern of whether the disease is moving from the community to corrections with workers, or is being spread by new inmates is hard to establish. What is clear is that swiftness and intensity of the spread stretched available medical resources and showed gaps in the ability to isolate sick and infectious populations. Basic medical facilities and quarantine capacity can help stop the spread.

Prior viral epidemics have wrought havoc in carceral settings. An account from San Quentin prison detailing the 1918 Spanish Influenza estimated that half of inmates contracted the disease during the first wave of the epidemic; sick calls increased from 150 to 700 daily. Contrary to protocol, most of the ill were kept in the general prison population because the hospital ward was full. San Quentin has seen more than 25 deaths during the COVID outbreak.[[4]](#footnote-4)

Corrections officials in some states have designed early release, bail waivers and other non-custodial programs for non-violent offenders. At present, jails (which house individuals awaiting trial or serving short sentences) and prisons (which house individuals who have been convicted of crimes and are serving longer sentences) are still too crowded too contain the outbreak. In Montana where the inability to transfer offenders has exacerbated outbreaks in jails where COVID-infected inmates were crowded together and further.[[5]](#footnote-5) Unable to adhere to containment measures has put not just incarcerated persons, but staff, and the wider community in danger.

COVID is not the only disease of concern, HIV, tuberculosis and measles all have been linked to the back and forth movement of the population between corrections and community. The movement of HIV in and out of jails and prisons in the United States has long been recognized as sustaining and extending the cycle of infection. The rate of infection among the incarcerated in more than five times that in the general population. Lack of testing as well as lack of community treatment options for recently released inmates compounded the outbreak from the 1990s until recently.[[6]](#footnote-6)

Inmates have a constitutional right to healthcare that meets community standards. The Eighth Amendment to the United States Constitution, require corrections officials and provide prisoners with "reasonably adequate" medical care. Courts have defined adequate medical care as "services at a level reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards," and at "a level of health services reasonably designed to meet routine and emergency medical, dental and psychological or psychiatric care.[[7]](#footnote-7)

Correctional administrators must adhere to best practices to avoid Eighth Amendment violations. The American Bar Association recommends that correctional authorities screen each prisoner as soon as possible upon the prisoner’s admission to a correctional facility to identify the prisoner's immediate potential security risks, including vulnerability to physical or sexual abuse, and should closely supervise prisoners until screening and follow-up measures are conducted.[[8]](#footnote-8) During this COVID era, screening can best be done in an intake setting designed for this purpose. The good news for correctional administrators is that CARES Act dollars can fully fund this.

As the COVID-19 virus continues to circulate and grow in a majority of the states, we can expect it to be a continued threat to inmates, corrections officers and the wider community as it circulates into and out of jails and prisons. We need the “all of community” effort envisaged in the CARES Act to be applied and used to help halt transmission in corrections.

Data cited from numerous sources including: <https://covidprisondata.com>, the <https://marshall>

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4. Rong-Gion Lin II and Kim Christensen, “San Quentin’s coronavirus outbreak shows why ‘herd immunity’ could mean disaster,” *Los Angeles Times*, August 11, 2020. [↑](#footnote-ref-4)
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