COVID-19 in Correctional facilities in the U.S

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SCHOOL OF MEDICINE

“Our lives are not our own. From womb to tomb, we are bound to others, past and present, and by each crime and every kindness, we birth our future”

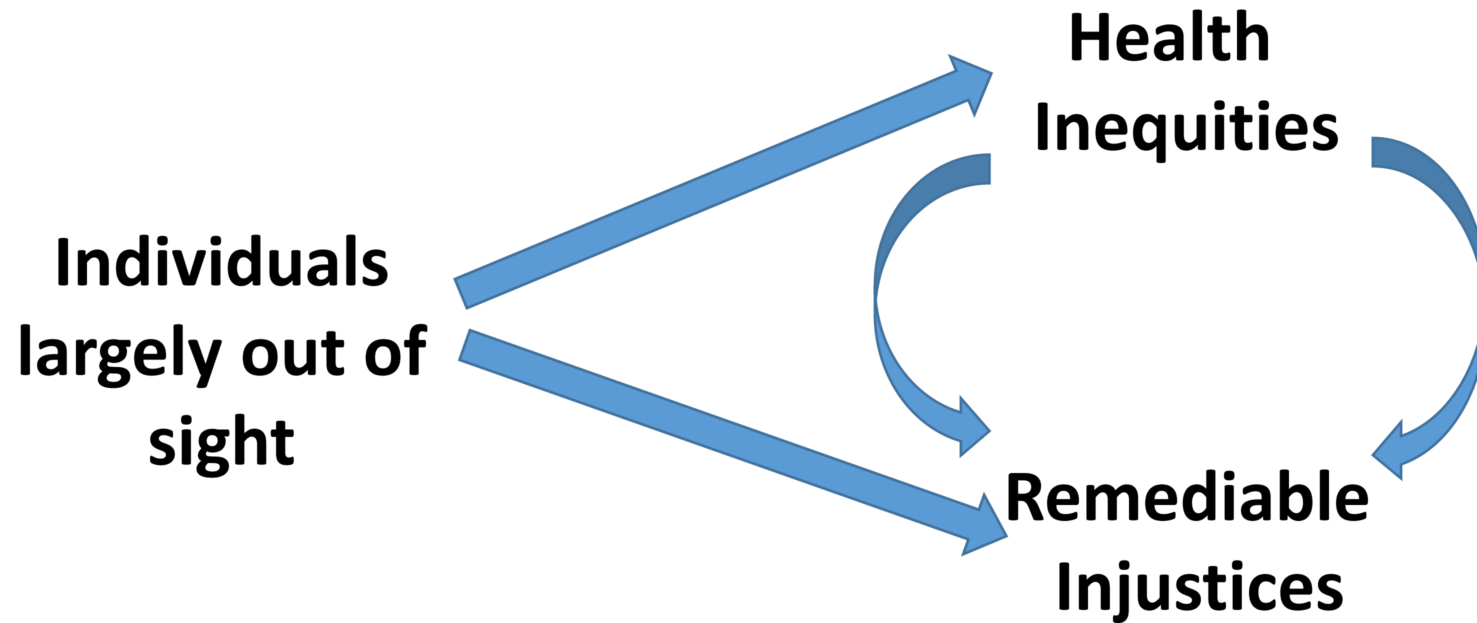
-Somni 451 Cloud Atlas

Mr. H. in a county jail

- *““Is dying from Covid-19 part of the incarceration punishment?”*

https://blogs.bmj.com/medical-humanities/2020/11/02/imprisoned-on-the-covid-19-death-row/

The Invisible Populations



COVID-19 CASES, HOSPITALIZATION, AND DEATH BY RACE/ETHNICITY

FACTORS THAT INCREASE COMMUNITY SPREAD AND INDIVIDUAL RISK

CROWDED SITUATIONS

CLOSE / PHYSICAL CONTACT

ENCLOSED SPACE

DURATION OF EXPOSURE

Rate ratios compared to White, Non-Hispanic Persons	American Indian or Alaska Native, Non-Hispanic persons	Asian, Non-Hispanic persons	Black or African American, Non-Hispanic persons	Hispanic or Latino persons
CASES[1]	2.8x higher	1.1x higher	2.6x higher	2.8x higher
HOSPITALIZATION[2]	5.3x higher	1.3x higher	4.7x higher	4.6x higher
DEATH[3]	1.4x higher	No Increase	2.1x higher	1.1x higher

Race and ethnicity are risk markers for other underlying conditions that impact health — including socioeconomic status, access to health care, and increased exposure to the virus due to occupation (e.g., frontline, essential, and critical infrastructure workers).

ACTIONS TO REDUCE RISK OF COVID-19

WEARING A MASK

SOCIAL DISTANCING (6 FT GOAL)

HAND HYGIENE

CLEANING AND DISINFECTION

[1] Data source: COVID-19 case-level data reported by state and territorial jurisdictions. Case-level data include about 80% of total reported cases. Numbers are unadjusted rate ratios.

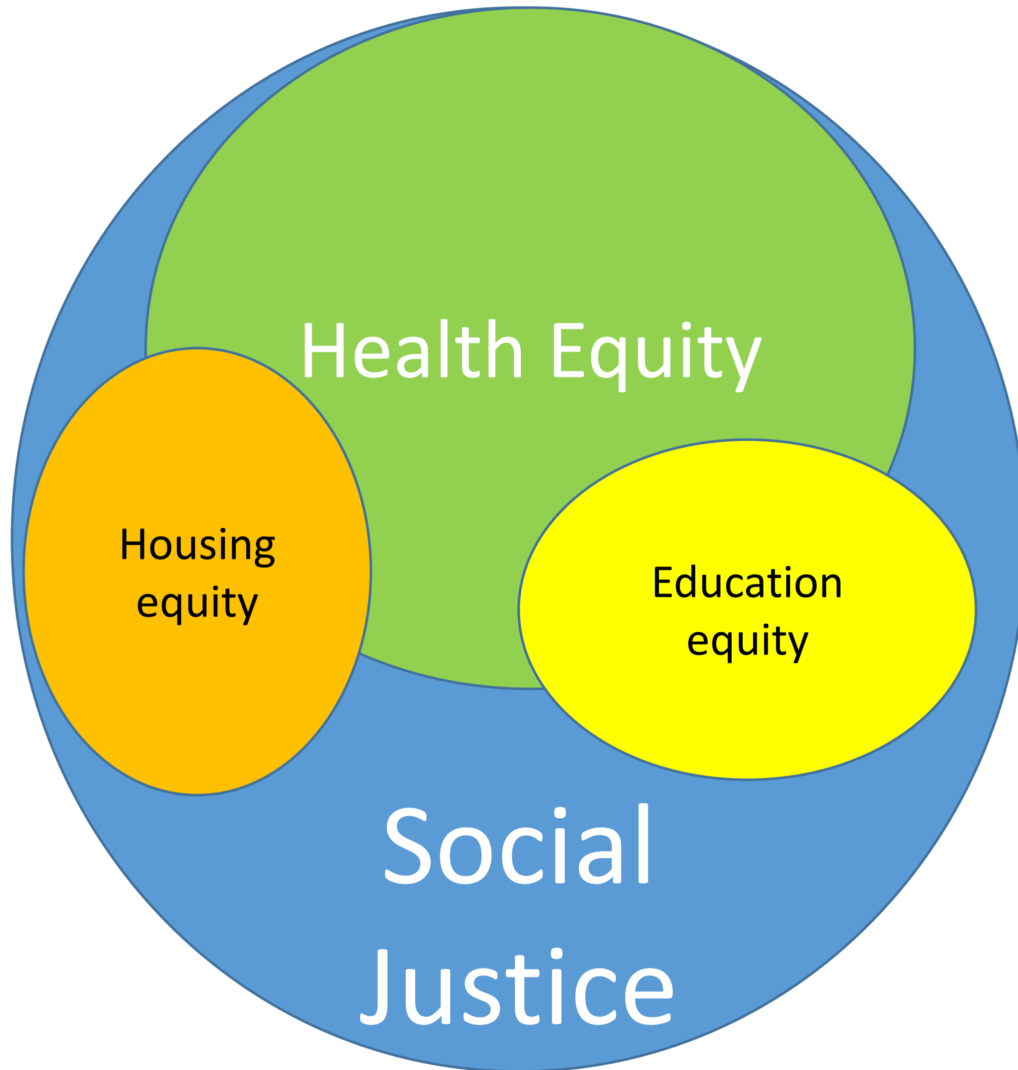
[2] Data source: COVID-NET (https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html, accessed 08/06/20). Numbers are ratios of age-adjusted rates.

[3] Data source: NCHS Provisional Death Counts (https://www.cdc.gov/nchs/nvss/vsrr/COVID19/index.htm, accessed 08/06/20). Numbers are unadjusted rate ratios.

cdc.gov/coronavirus

CS319360-A 08/08/2020

https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html (accessed Sept 26, 2020)



Social Justice

Justice in terms of the distribution of wealth, opportunities, and privileges within a society

Health Inequity

Refers to the unfair, unjust, and avoidable differences in health

Sen, AS. Health Econ 2002; 11:659-66

Structural Racism

- Inequities perpetuated by social, economic, and political systems that results in systemic variation in opportunity and access to resources in society according to race or ethnic background
- Some examples include:
  - **Racial residential segregation**
  - **Discriminatory incarceration**
  - **Health-care quality and access**

Phelan J, Link BG. Ann Rev Sociol 2015; 41: 311-30; Williams DR, et al. Ann Rev Publ Health 2019; 40:105-25.

Racial Residential Segregation

Williams DR, et al. Ann Rev Publ Health 2019;40:105; Cutler DM, et al. Q. J. Econ 1997; 112:827-72.

- Higher levels of violence and crime
- Concentrating poverty and low-quality schools
- Environmental pollutants (Cancer related to air pollution)
- Infectious agents (HIV/AIDS) linked to the use of crack cocaine in the inner city
- Low-birth weight and preterm birth
- Delayed cancer diagnosis (breast, lung)

Demographics in Correctional Facilities

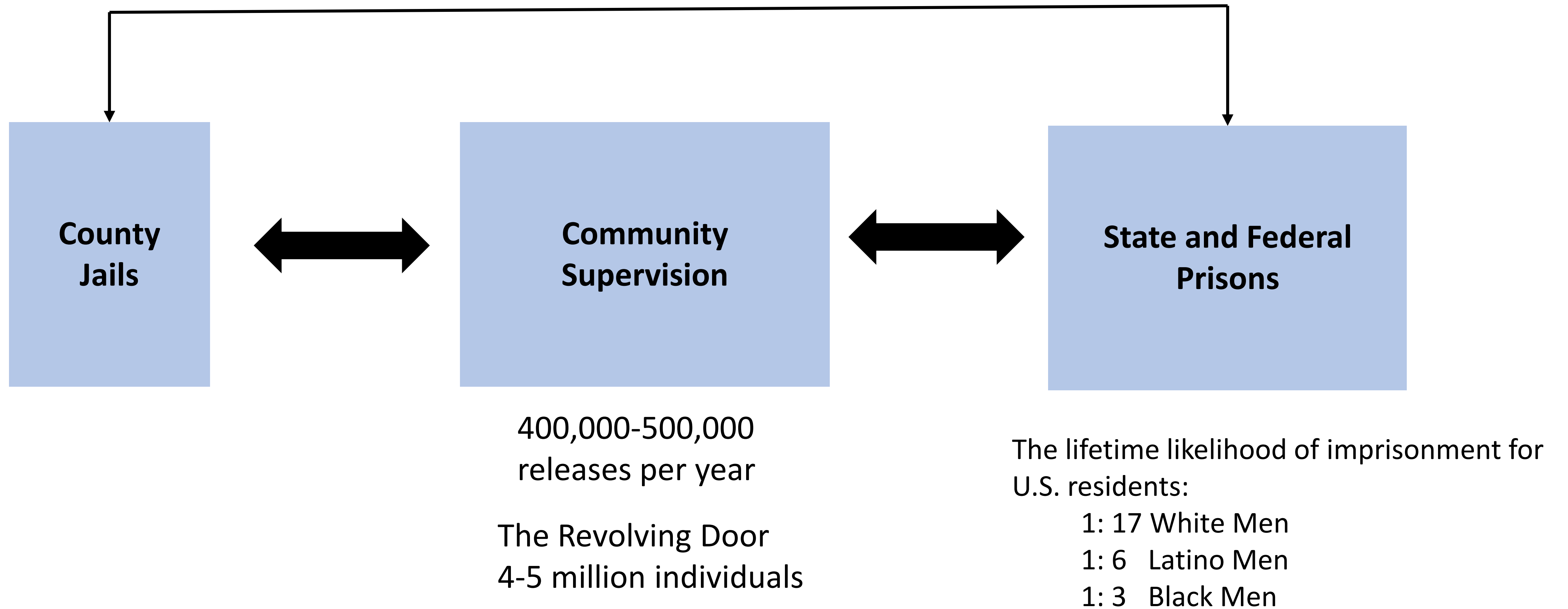
- The lifetime likelihood of imprisonment for U.S. residents:

White Men	1: 17
Latino Men	1: 6
Black Men	1:3

Colorado Criminal Justice Reform Coalition. https://www.ccjrc.org/ Accessed; January 4, 2021

The Criminal (Un)Justice System

2.2 million (~5% world's population has 25% of prisoners)



Franco-Paredes C, et al. PLoS Negl Trop Dis 2020

The perfect storm behind walls

- Built environment that enables outbreaks of infectious diseases (space and ventilation)
- Overcrowding
- Poor sanitation
- Insufficient and untimely medical care
- Accelerated aging
- High prevalence of chronic medical conditions (40-80%)
  - HIV (5X)
  - DM, COPD

Franco-Paredes C, et al. PLoS NTDs 2020.

Table 1

Three overlapping waves of structural vulnerability related to COVID-19 among communities in the United States

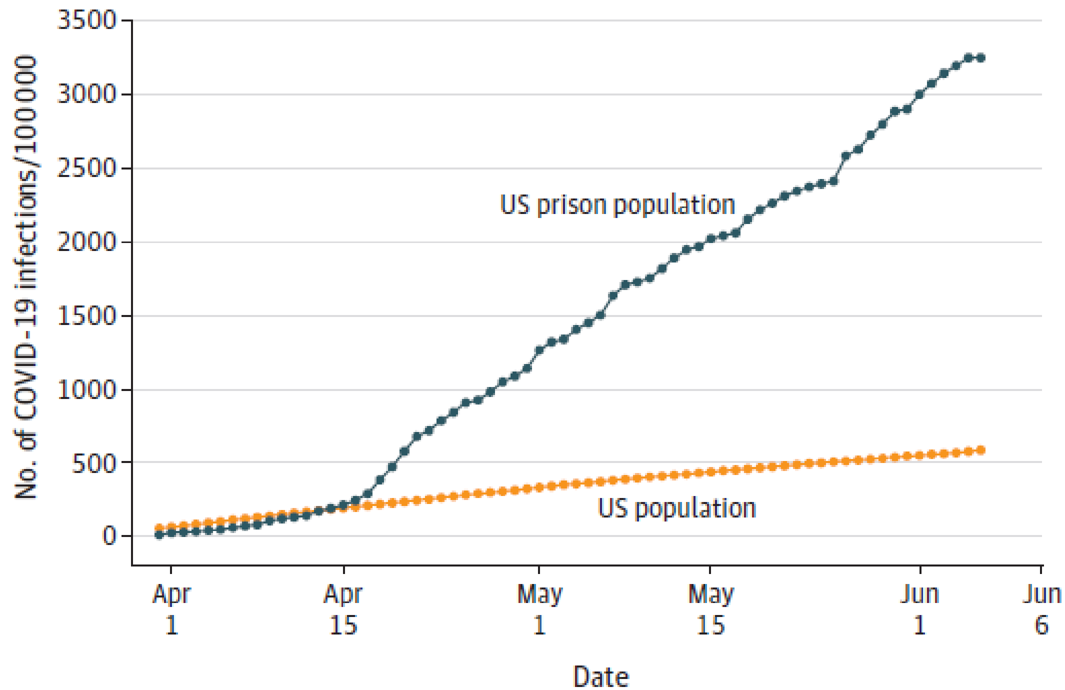
Overlapping waves and approximate dates	Timeline	At-risk populations and patterns of spread	Biological vulnerability	Social vulnerability
Initial wave January 22 to present	First case identified in Washington State	Limited community transmission	Population immunologically naive to SARS-CoV-2	Travelers from areas with active community transmission in Europe, South Korea, China, or other settings traveled to the Pacific Northwest
February 27 to present	First outbreak in a nursing home in Washington State†	Frail elderly individuals in nursing homes, long-term care, and assisted residential living facilities	Immune senescence* High prevalence of underlying chronic diseases	Less visible population Insufficient medical and preventive monitoring programs at long-term care facilities and nursing homes
Second wave Early March to present	All U.S. states with COVID-19 cases by mid-March	Sustained community transmission in cities and towns with large population density Underserved minorities in low-income inner-city communities (African American, Hispanics, and Native American such as Navajo Nation)	High prevalence of underlying chronic diseases such as hypertension, obesity, and diabetes mellitus	Increased frequency of exposure as day laborers or by working in the service industry with increased person-to-person interaction Lack of medical insurance coverage Undocumented immigrants afraid to reach healthcare system Documented immigrants on the path to citizenship afraid to use Medicaid under current administration policies Delayed lockdowns in some states
Third wave Early April to present	Increasing number of outbreaks in prisons/jails and Immigration and Customs Enforcement (ICE) detention centers‡	Carceral settings including jails/prisons/immigration detention centers Staff, inmates, and detained individuals	Inmates in prisons and jails with high prevalence of underlying chronic diseases	Conglomerate populations in overcrowded jails and prisons

* Individuals older than 65 years show reduced responses to vaccines and infectious diseases, including influenza.[12,15]

† From February 27 to March 25, there were approximately 140 nursing homes and long-term care facilities affected with COVID-19 cases.[13] According to recent estimates, as of April 17, 2020, there are more than 2,500 nursing homes and long-term care facilities with reported cases.[14]

‡ According to the Bureau of Federal Prisons, by April 14 there were 446 cases among inmates and 248 cases among staff in 42 facilities, and 11 Residential Reentry Centers (RRCs). However, by April 9, 2020, there were 495 cases among inmates, 309 cases among staff, and 22 deaths distributed in 45 facilities, and 19 RRCs.[22] When combining prisons and jails in all states, there are at least 1,324 confirmed cases of COVID-19 tied to prisons and jails, with at least 32 deaths.[23]

Solis J, Franco-Paredes C, Krsak M, Henao-Martinez AF, Zimmer SM. Am J Trop Med Hyg 2020



Prison COVID-19 Project

Incarcerated with COVID-19:

317,500 cases
1881

Correctional officers with COVID-19:

72,183 cases
101 deaths

State of Colorado DOC
7,252 cases (17,800 individuals)
25 deaths

Dolovich S, et al. JAMA 2020; 324(6): 602-3;
Franco-Paredes C, Ghandhoosh N, et al. Lancet Infect Dis 2020;

The COVID-19 Epidemiologic Death Row

- 1881 deaths by COVID-19 in 9 months (COVID Prison Project)
- 1526 deaths by execution in 44 years (Death Penalty Information Center)

The social roots of both types of death are related

https://blogs.bmj.com/medical-humanities/2020/11/02/imprisoned-on-the-covid-19-death-row/

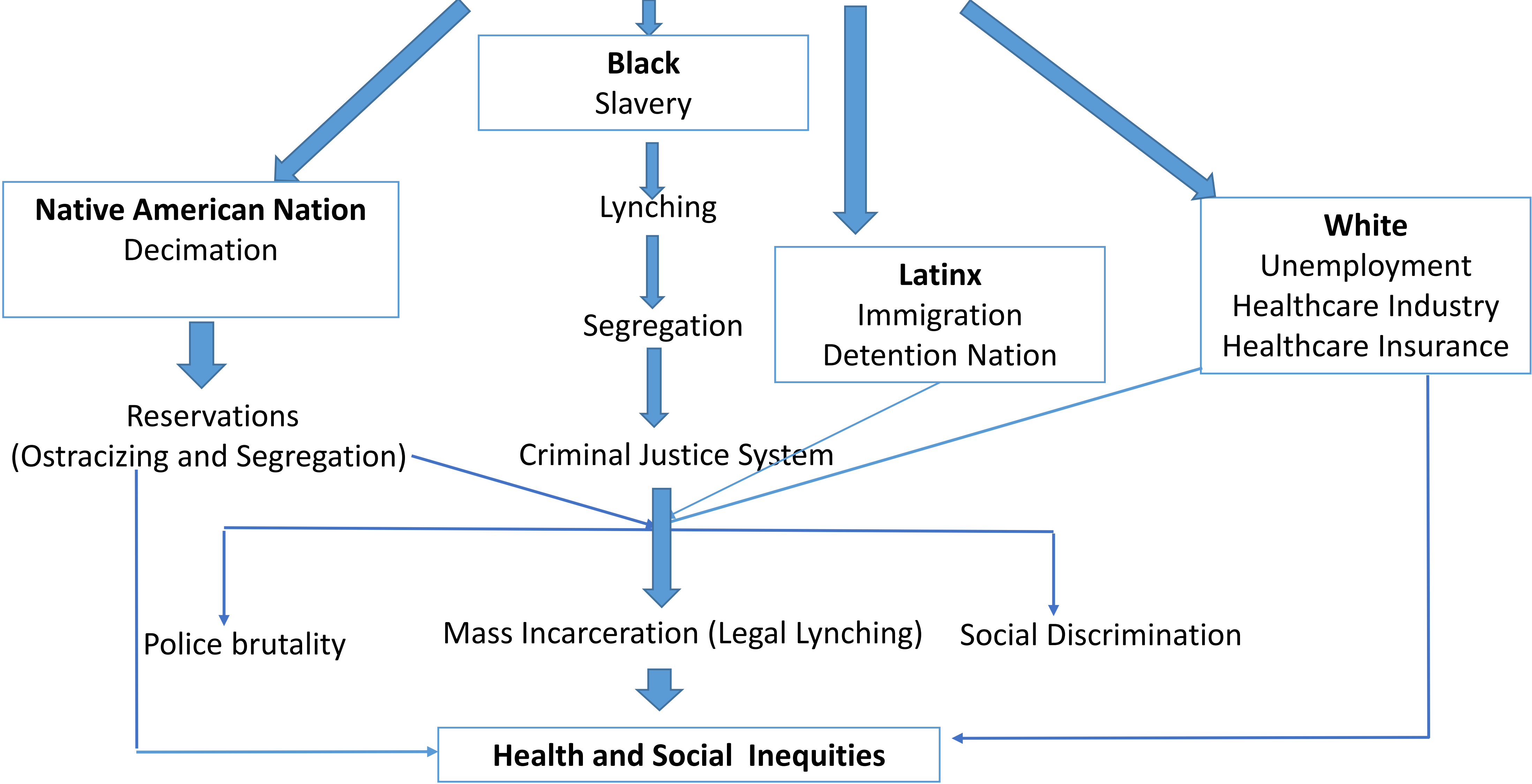
The structural racism in the criminal justice system affects health through different pathways

- Mass incarceration (hyperincarceration) contributes to racial health disparities in the USA across a range of outcomes because of its direct and indirect consequences for health, and the disproportionate concentration of incarceration among black communities

- Individuals who experience incarceration at any point in their life are disproportionately in poor health both before, during, and after their incarceration

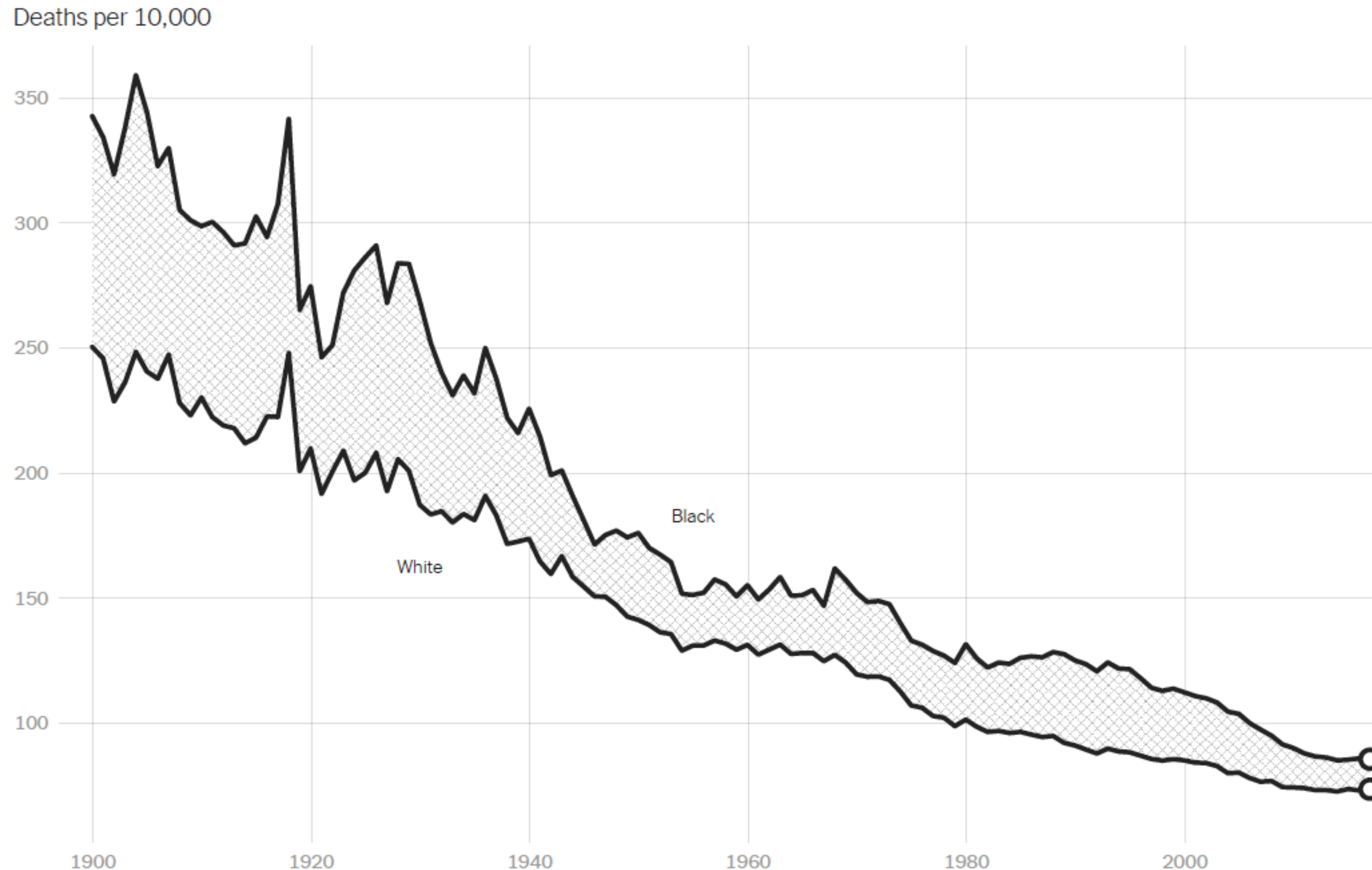
- High incarceration prevalence also compromises community health, with the strongest evidence implicating community-level increased incidence of HIV

Wildeman C, Wang EA. Lancet. 2017;389(10077):1464-1474.



The Structures of Oppression in the United States
Black
Slavery
Lynching
Segregation
Criminal Justice System
Native American Nation
Decimation
Reservations
(Ostracizing and Segregation)
Latinx
Immigration
Detention Nation
White
Unemployment
Healthcare Industry
Healthcare Insurance
Police brutality
Mass Incarceration (Legal Lynching)
Social Discrimination
Health and Social Inequities

Structural Racism it’s the most important way through which racism affects health



- **Racial inequities** in health originate from stable racialized social structures that determine differential access to risks, opportunities, and resources that drive health

Wrigley-Field E. Proc Natl Acad Sci 2020; 117(36): 21854-56

Correctional Facilities as Amplifiers of COVID-19 transmission

- Approximately 13% transmission from Cook County Jail **(Reinhart E. Health Affairs June 2020)**
- COVID-19 caseloads grew more quickly over the summer of 2020 in nonmetro counties with more people incarcerated.
- COVID-19 caseloads grew *much* more quickly over the summer of 2020 among counties in multicounty economic areas with more people incarcerated.
- Mass incarceration added to COVID-19 caseloads in multicounty economic areas and states
- Nationally, this impact reached a tragic scale: Mass incarceration added more than a half million cases in just three months

Gregory Hooks, Wendy Sawyer, Prison Policy Initiative, December 2020

	Before COVID-19 pandemic	During COVID-19 pandemic*
State prisons	1260393 (Dec 31, 2019)†	1207710 (May 1, 2020)†
Jails	738400 (Dec 31, 2018)‡	575952 (July 22, 2020)‡§
Federal prisons	175315 (March 5, 2020)¶	156968 (Aug 13, 2020)¶
Immigration detention (ie, ICE)	37888 (March 20, 2020)‖	21118 (Aug 8, 2020)‖
Total	2211996	1961748

ICE=Immigration and Customs Enforcement. *Population reductions in jails, prisons, and ICE detention centres might represent a combination of early releases and reduced intake in response to the COVID-19 pandemic. †Data from Vera Institute of Justice[48] and our additional data file. There are insufficient data on the prison populations in the states of Illinois, Maryland, Minnesota, New Mexico, and Virginia. A similar analysis by The Marshall Project[49] found that state prisons downsized from 1130457 to 1046370 people between March, 2020, and mid-June, 2020. This estimate excluded the prison populations in Maryland and Alaska and only included the sentenced populations in states with unified prison and jail facilities. ‡Data from US Bureau of Justice Statistics.[50] §Estimate based on a median 22% reduction in sample population of jails between Jan 1, 2020, and July 22, 2020, analysed by Prison Policy Initiative on the basis of data collected by NYU Public Safety Lab[46] and Prison Policy Initiative;[51] the Vera Institute of Justice found that the number of people in US jails fell by a quarter from mid-March, 2020, to the beginning of June, 2020.[52] ¶Data from US Federal Bureau of Prisons;[53] the Aug 13, 2020, total includes 7932 individuals on home confinement, which is an increase of 5283 since March 5, 2020. ‖Data from ICE Guidance on COVID-19.[54]

***Table:* Number of people in state and federal prisons, jails, and immigration detention in the USA before and during the COVID-19 pandemic**

11% population reduction – Correctional facilities and immigration detention centers

Franco-Paredes C, Ghandhoosh N, Lancet Infect 2020

Mr. R.

- R. is a 19 year old male. He is currently incarcerated at one of the county jails in Maryland. During an interview as part of a jail inspection to document conditions in this jail during a COVID-19 outbreak, he shared with me that “mass incarceration of black people is something that started 400 years ago in the form of slavery”
- His oldest brother was killed in a drive-by shooting and prior to incarceration, he lived with his mother and his little brother, who is handicapped. He is currently incarcerated because of parole violation from a previous incarceration for shop-lifting at a gas-station. He has spent many months in jail because he could not afford bail

Mr. R.

- R. wants to go to college after his release and he wants to support his mother and take care of his little brother

- What are the chances that R. will be successful in achieving these goals

In the Outside:
Community Reentry and Reintegration – Health Inequities and Inequalities

- High risk of dying the first 2 weeks after release
- Transition of care clinics
- Linkage to care – addiction/mental health
- Social workers/navigators

Panel: **Community re-entry and reintegration policies in the COVID-19 era**

Enhancing public health

- Re-entry support approaches that involve less person-to-person contact
- Avoidance of group activities
- Education of preventive interventions
- Hygiene and disinfection strategies
- Viral screening and instituting quarantine and isolation protocols when indicated, particularly at halfway houses or other dormitory-style living environments

Removing structural vulnerabilities

- Stable housing
- Food security
- Access to other public services
- Expanding job opportunities
- High-quality early education
- Enhancing residential mobility

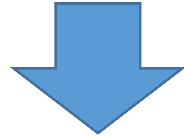
Reducing health inequities

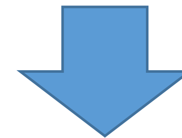
- Access to quality medical care
- Enrolment (or re-enrolment) in Medicaid, including individuals with pre-existing conditions
- Increase access to mental health services
- Effective treatment for substance use disorder

Permanent reductions in jail and prison populations

- Reduce incarceration to levels of other industrialised countries

Healthcare's Role





The traditional model:

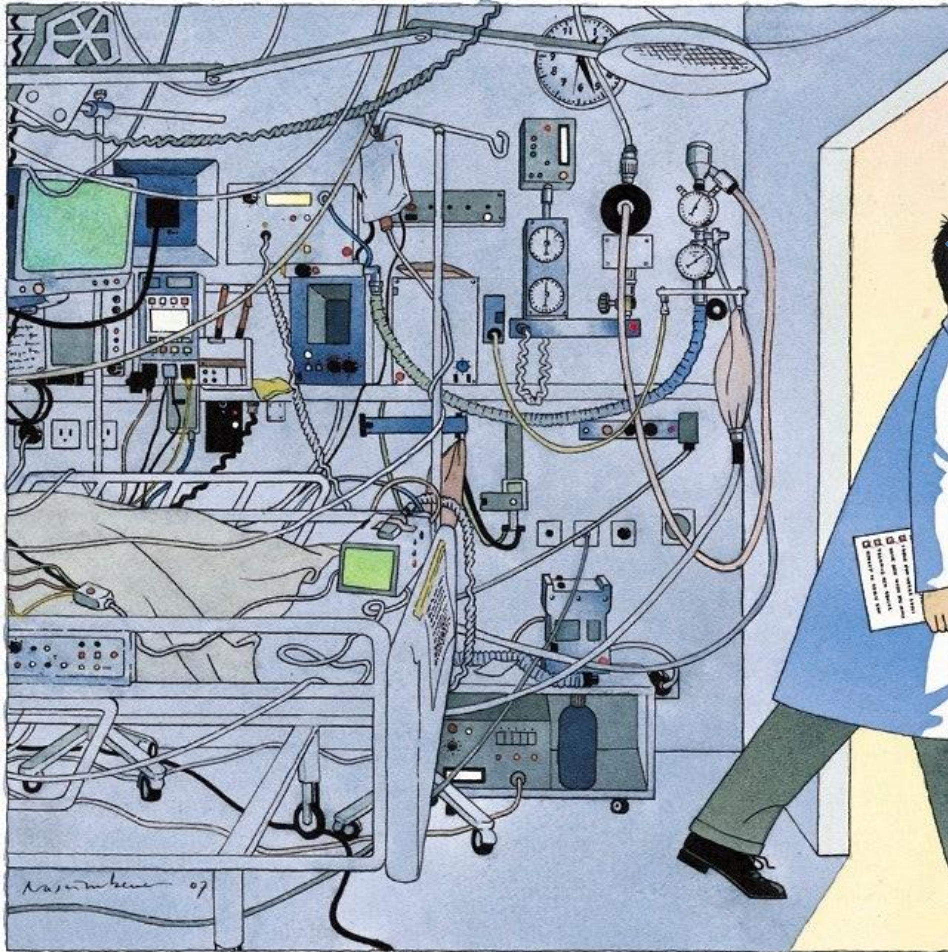
Caring for Illness

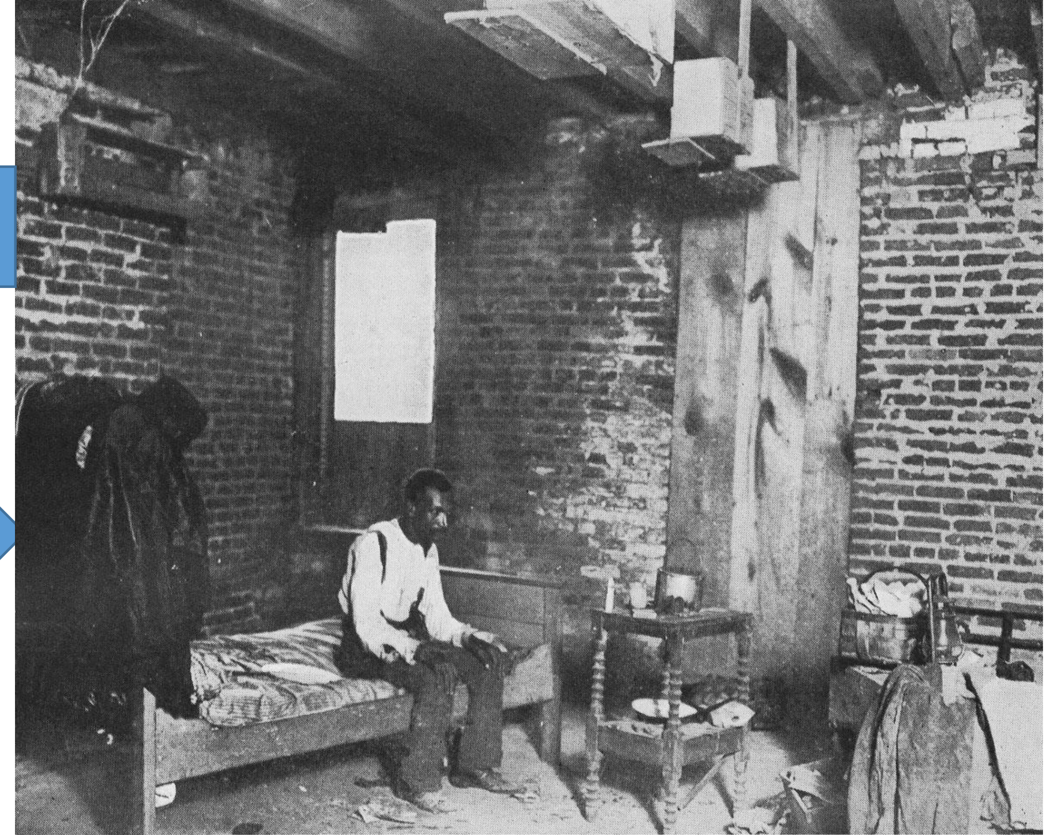
Expand the role into demanding and supporting societal reform:

- Improving social conditions
- Countering inequities
- Fighting against structural racism

Berwick DM. JAMA 2020;324(3)

Clinical medicine is an incomplete endeavor if we don't pay attention to societal forces





Dying Consumptive in a Tenement Room Entirely Below the Street Level and Entered Through a Trap-Door in the Sidewalk. The Tenement Needs Inspection; the Consumptive, Instruction and Assistance.

Health care professionals must be leaders of societal change and workers of justice

The Wish List

- Reducing Mass Incarceration
  - End War on Drugs
  - Inhumane policing
  - Reducing Structural Racism
    - Residential Racial Segregation
    - Harsh Sentencing of Minorities compared to Whites
  - Shifting funds from DOC/Jails to build community safety by improving social capital
  - Closure of Immigration Detention Centers