

DECARCERATING DURING COVID-19

Highlights for Public Health Officials

The National Academies of Sciences, Engineering, and Medicine, with support from Arnold Ventures and the Robert Wood Johnson Foundation, was asked to form an ad hoc committee to offer guidance on mitigating the spread of the novel coronavirus in correctional facilities and summarize findings on large-scale release and decarceration efforts. The committee comprised experts in corrections, correctional health, economics, epidemiology, law, medicine, public health, public policy, and criminology and sociology.

In its report *Decarcerating Correctional Facilities during COVID-19: Advancing Health, Equity, and Safety*, the committee concludes that decarceration is an appropriate and necessary mitigation strategy to include in the COVID-19 response. The current crisis necessitates a broader view of public safety, one that encompasses public health decisions. Despite being a source for numerous outbreaks, both for COVID-19 and other respiratory diseases, correctional facilities have not consistently been included in pandemic planning or guidance.

COVID-19 infection rates in correctional facilities and the resulting morbidity and mortality are disproportionately higher than the general population. By August 2020, COVID-19 cumulative case rates among incarcerated people were nearly five times higher than in the general population and the rates among correctional staff were three times higher. And because correctional facilities are not isolated settings—incarcerated individuals move between facility and community and staff return home at night—the outbreaks in correctional facilities have been associated with community infection rates.

In the early phase of the pandemic, the virus spread “outside in” from the community into facilities from people who were newly admitted, staff, or visitors. The ongoing appearance of newly susceptible entrants to prisons and jails, in particular, can sustain outbreaks beyond the usual life cycle of a disease in a closed population. Incarcerated people have been found to have higher rates of many chronic conditions than the general population—including hypertension, asthma, and certain types of cancer—all of which are risk factors for complications with COVID-19.

Further, the spatial concentration of incarceration, in low-income and predominantly Black and Hispanic neighborhoods, suggests that disease may also flow from “inside out.” In this case, people who are exposed to SARS-CoV-2 in correctional facilities are returning to communities



that are themselves struggling to respond to COVID-19 many without adequate health care and social support.

Decarceration is a strategy aimed to reduce mortality and morbidity caused by the transmission of COVID-19 among incarcerated people, correctional staff, and the local communities in which correctional facilities are located. When done well (with appropriate collaboration between corrections and community supports), decarceration can reduce health risks for medically vulnerable populations and reduce demand on healthcare resources. Health equity—the opportunity for all members of the population to be as healthy as possible—will be an important goal in decarceration efforts.

The report advises public health officials at the local, state, and federal levels to consider the following:

- Mechanisms for adequate COVID-19 testing within correctional settings, prior to release
- Importance of reducing populations in confined correctional settings and safe mechanisms for release that avoid creating additional COVID-19-related health risks for families and communities
- Adequate healthcare supports to improve access to health care and ensure engagement between correctional and community health services and reduce preventable hospitalizations and recidivism

Existing legal mechanisms for release are slow (due to requirements to consider individual circumstances on a case-by-case basis) and not well suited in a public health crises, though a number of actors hold the authority to act, including correctional officials, parole boards, and governors, among others. Past research on recidivism indicates that correctional officials have opportunities to decarcerate in a manner that minimizes risk to public safety if given the flexibility to do so. Recidivism risks can be reduced through thorough reentry planning and the provision of supports, notably assistance with healthcare, housing, and income.

The report finds that relieving population pressures in jails, prisons, and detention centers greatly facilitates adherence to Centers for Disease Control and Prevention (CDC) guidelines, reducing health risks, particularly for medically vulnerable people. Smaller populations enable room to place individuals in single cells, sufficient resources for regular testing, and ways to safely quarantine individuals after exposure to an infected person. Creating smaller populations within correctional settings requires releasing some individuals.

Effective discharge planning during the COVID-19 pandemic requires additional considerations of a person's risk of acquiring or transmitting SARS CoV-2 and how this intersects with their access to community health care, noncongregate housing, and food and basic needs, especially when community rates of COVID-19 are high. Testing prior to discharge with timely return of results would reduce the risk of exposing others to the virus. Moreover, a synergistic strategy would provide individuals returning to congregate or crowded settings a place in the community to complete an appropriate quarantine in a safer environment, such as a subsidized hotel room.

Ongoing transmission of the virus also makes it important that people released from jail or prison are discharged with information about the disease, a connection to community-based health services, and a 90-day supply of any medications. During the crisis, to soften known

impediments to health care access, community health systems should accept new patients without government identification and relax restrictions for the need to connect first to an electronic health record portal prior to virtual health visits.

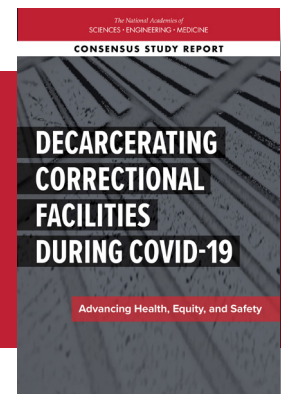
Underinsurance or lack of insurance is quite common among incarcerated and previously incarcerated individuals. In some jurisdictions, Medicaid/Medicare coverage has been terminated instead of suspended when someone is incarcerated. During the pandemic, discharge planning should include a process for expediting enrollment or re-enrollment in Medicaid or Medicare. Activating Medicaid in the 30 days prior to release would not only create a path for paying for COVID-19 testing prior to release, but also facilitate connections to a primary care provider, substance use and mental health treatment and outpatient medications. Specifically, states can improve individuals' access to Medicaid by:

- providing assistance to enroll individuals eligible for Medicaid during incarceration, prior to their release
- exercising the optional eligibility provided in the Families First Coronavirus Response Act; and
- opt to suspend, not terminate, Medicaid eligibility when an individual is incarcerated and exercise their authorities to apply for section 1115 and 1135 waivers of the Social Security Act to expand Medicaid coverage or support access to covered services for incarcerated individuals during the COVID-19 crisis [*When states do so, the Centers for Medicare & Medicaid Services (CMS) should take steps to facilitate the speedy review of and decision on such waivers*].

Decarcerating Correctional Facilities during COVID-19: Advancing Health, Equity, and Safety

Available:

<https://www.nap.edu/25945>



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