Ten Urgent Priorities Based on Lessons Learned from Over a Half Million Known COVID-19 Cases in U.S. Prisons

ABSTRACT
COVID-19 infections are ravaging US prisons. Prison residents and staff must be prioritized for vaccination, but a rapidly mutating virus and high rates of continued spread require an urgent, coordinated public health response. Based on knowledge accumulated from the pandemic thus far, we identify 10 pressing public health priorities for responding to COVID-19 in prisons: (1) accelerate population reduction coupled with community reentry support; (2) improve prison ventilation systems; (3) ensure appropriate mask use; (4) limit transfers between facilities; (5) strengthen partnerships between public health departments and prison leadership; (6) introduce or maintain effective occupational health programs; (7) ensure access to advance care planning processes for incarcerated patients and delineation of patient healthcare rights; (8) strengthen partnerships between prison leadership and incarcerated people; (9) provide emergency mental health support for prison residents and staff; and (10) commit to public accountability and transparency. Dedicated prison leaders cannot accomplish these public health priorities alone. We must mobilize prison leaders, staff, and residents, public health departments, community advocates, and policymakers to work together to address the pandemic’s outsized impact in US prisons.
The 1918 Spanish flu demonstrated the calamitous consequences a highly transmissible respiratory pathogen can have in overcrowded prisons, jails, juvenile detention centers, and immigration detention centers (herein referred to as “prisons”). Yet when the COVID-19 pandemic arrived in early 2020, the US had experienced five decades of growth in imprisonment rates. Approximately 2.3 million people were incarcerated (seven times the number held in 1972) across the nation’s 7,000 facilities, with many prisons populated well above 100% capacity. Intersecting risks related to poverty, racial inequity, and overcrowding and high infection transmissibility of COVID-19, make residents and staff particularly vulnerable to COVID-19. As the pandemic has raged in US prisons, lessons have emerged that can inform a life-saving public health response.

**Toll of COVID-19 in US Prisons**

Over the six months following publication of our July 2020 article, “Prisons: Amplifiers of the COVID-19 Pandemic Hiding in Plain Sight,” the pandemic has taken a devastating toll on people who live or work in US prisons. Confirmed cases continue to rise at a breathtaking rate, affecting prison residents, staff, their families and communities, and challenging the capacity of local healthcare systems. In January 2021, ten months since the US reported its first death of an incarcerated patient, over 510,000 cases of COVID-19 had been reported in prisons, more than double the number reported only two months earlier. COVID-19 has claimed the lives of at least 2,200 US prison residents and staff. In the few states that publicly report cases among youth in juvenile detention centers, at least 3,360 cases have been confirmed. The majority of the US’s largest outbreaks have occurred in prisons. Now, nearly one year into the COVID-19 pandemic, it is imperative that we integrate lessons learned from the responses and calls to action.
into strategic steps to protect prison residents and staff.

**Urgent Priorities**

National COVID-19 guidelines issued by the Centers for Disease Control and Prevention (CDC) have provided some guidance to prison leadership during the pandemic. However, system discoordination and variation between prisons by prison type, population size, population health status, degree of overcrowding, and quality of facility infrastructure (many buildings are archaic) have resulted in jurisdictions and facilities using “trial by error” approaches with varying degrees of success. With the recent availability of vaccines, health experts have called for prison residents and staff to receive priority vaccination. However, viral mutations, lags in vaccine distribution, and vaccine hesitancy will mean that COVID-19 mitigation techniques will be required for months, and likely years, to come. To supplement prompt vaccine education and delivery to staff and residents, we summarize ten key public health priorities needed to respond to COVID-19 in prisons:

1. **Accelerate population reduction coupled with community reentry support to make more space for physical distancing, and areas for quarantine and medical isolation**

Many jurisdictions, especially early in the pandemic, enacted decarceration strategies to enhance the ability of residents and staff to comply with physical distancing measures to prevent COVID-19 spread. The National Academy of Sciences declared decarceration the most important public health strategy to minimize the devastating impact of COVID-19 in prisons. Decarceration can be achieved through a variety of mechanisms, including commutation/release, furlough, or home
confinement. Yet, between January and August 2020, population size in post-conviction state
prisons decreased by only 4%\textsuperscript{9}, a small reduction insufficient for achieving community-standard
guidelines for physical distancing. A decarceration strategy, informed by public health
professionals and prison leaders, is also needed to ensure sufficient quarantine and medical
isolation rooms are available for outbreaks.\textsuperscript{10} To drive decarceration, prison health professionals
can advocate for patients’ health needs; public health practitioners can promulgate decarceration
policy and alternatives to incarceration to prevent new incarceration; and, when necessary,
healthcare professionals can serve as medical experts in litigation to improve prison conditions
or achieve decarceration. Academic and community clinicians can advise on prognostication and
medical documentation for courts to guide decarceration efforts.\textsuperscript{11, 12}

Rapid decarceration must go hand-in-hand with adequate reentry support and planning.\textsuperscript{12, 13}
Before the COVID-19 pandemic began, the risk of death among formerly incarcerated
individuals within two weeks of release was 12.7 times higher than for other state residents.\textsuperscript{14}
During the pandemic, mortality risk is further heightened as discharges may be rushed,
community resources limited, and community COVID-19 transmission may occur. Roadmaps
for emergency discharge planning during the pandemic have been developed.\textsuperscript{2, 12} Priorities
include educating people leaving prisons about COVID-19, activating public health insurance
benefits for eligible individuals, and ensuring linkages to community health services.\textsuperscript{9, 12} We
recommend prioritizing addiction treatment and taking advantage of prescribing flexibilities
during the pandemic, such as using televisits for prescribing treatment for opioid use disorder.
Assistance with accessing community resources, such as food stamps, housing, and crisis support
to prevent drug overdose, suicide, or recidivism, is also crucial.\textsuperscript{12} While decarceration should be
prioritized in the pandemic, it is equally important to bolster reentry supports in order to prevent
COVID-19 transmission, serious adverse health outcomes, and recidivism.

(2) Improve ventilation in housing units and common spaces

In many prisons, residents share a small (~4-by-10-foot) cell, oftentimes with a barred door,
leaving few options to achieve the physical distance recommended for the general public.
Further, even single cells with solid doors can function like a shared dorm if heating, ventilation,
and air conditioning (HVAC) units are not up to code. Many residents actively participate in
limiting the spread of COVID-19 through cleaning and disinfection efforts. However, given the
importance of preventing aerosol transmission of COVID-19, sweeping structural measures in
many facilities are urgently needed to maximize ventilation with outdoor air and upgrade HVAC
system filters to MERV 13 air filters or to the highest MERV-rated filter that the HVAC system
can allow.\textsuperscript{15} Such measures are of particular importance in cells designated for medical isolation
or quarantine. To halt COVID-19 spread, HVAC systems should be upgraded to hospital-level
quality to ensure that residents and staff are not breathing inadequately filtered air.

(3) Ensure appropriate mask use among staff and residents

Though mask-wearing has become politicized, proper mask use must be non-negotiable in
prisons since it can prevent COVID-19 transmissibility by greater than 70%.\textsuperscript{16} Depending on
degree of spread in facilities and HVAC system adequacy, many prisons are opting for KN95 or
N95 mask use. Masks should be worn properly at all times by staff, including in breakrooms
unless staff are alone, and removed only for eating and drinking. For residents, mask wearing at
all times is infeasible (e.g., when eating, bathing, or sleeping). Inability to adhere to universal
Simultaneously, encouraging masking-wearing in prisons via public health education about mask use importance and fit, consistent guidelines, incentivization efforts, and, if needed, reasonable disciplinary action for staff and residents who refuse masks are needed so that proper mask use becomes an expected and explicit norm.\(^{17}\)

**4) Limit transfers between facilities**

Prison-to-prison transfers (and facility-to-facility within prisons) have led to numerous COVID-19 outbreaks. Between June and August 2020, San Quentin California State Prison, which held 3,362 people and was at 109% design capacity in mid-July,\(^ {18}\) had one of the largest outbreak clusters of COVID-19 in the US at the time, with confirmed cases in at least 2 out of 3 residents, and 28 resident deaths.\(^ {19}\) The outbreak began when 121 patients from another state facility with an outbreak were transferred to the COVID-naïve San Quentin facility.\(^ {19}\) Data across facilities indicate that transfers should stop, with few being absolutely necessary.\(^ {20}\) Prison medical staff should be consulted on transfer decisions and protocols. Transfers should be accompanied by rigorous testing strategies, use of personal protective equipment during transfer, screening protocols, and 14-day quarantine.

**5) Strengthen partnerships between public health departments and prison leadership**

The COVID-19 pandemic has brought to the fore the importance of agile coordination between prison leadership and public health departments. Many local public health departments have been in near-constant communication with area prisons to coordinate testing. Yet, many states have tested less than 10% of their prison populations while others have not made testing results
public, obscuring the true scope of the pandemic within prisons and hampering community health system responses. During the pandemic, prison health should be an active concern of public health departments, especially regarding ensuring rapid testing, data transparency, vaccination distribution, emergency workforce replacement for healthcare staff sick days, coordination of hospital transfers, and emergency access to Medicaid and housing when needed for people released to the community. Such partnerships can turn their attention post-pandemic to optimizing future preparedness and addressing health disparities plaguing residents of the justice system.

(6) Introduce or maintain thoughtful occupational health programs

When the pandemic began, many prison occupational health programs were unequipped to respond to a health crisis of such magnitude. Prison medical directors were called upon to protect the health of prison residents and staff (essentially doubling patient care responsibilities). Questions regarding staff exposures, symptom monitoring, testing, and guidance regarding return to work or mask-wearing needed to be made quickly, with insufficient infrastructure support. Many prison medical leaders have also been tasked with vaccine education and delivery for prison staff. Funding to bolster prison occupational health programs is crucial. At a minimum, prison occupational health programs should include ensuring that prison staff have access to adequate personal protective equipment (PPE) as well as sick days and free or affordable health services, encouraging staff to report symptoms and stay home when sick or exposed.

(7) Ensure access to advance care planning processes for incarcerated patients and delineation of healthcare rights
Older adults and/or people with significant medical conditions—i.e., those with highest risk of severe COVID-19—comprise a growing proportion of the US prison population. The pandemic has reinforced the importance of access to advance care planning for incarcerated patients, especially for older adults and people with serious illness. Such advance care planning processes should include clear, in-depth conversations with a primary healthcare professional to clarify patients’ healthcare wishes and to guide them in the selection of a medical proxy decisionmaker in case of future need.

The pandemic has also demonstrated the importance of community hospital healthcare professionals understanding the rights of hospitalized incarcerated patients. For example, confusion exists among hospitalists about whether and when hospitalized incarcerated patients can communicate or visit with loved ones. Guidelines exist for community healthcare professionals to clarify the tenets of ethical care for incarcerated patients. Structured partnership and clear communication between prison leaders, prison healthcare professionals, and community hospital administrators is needed to ensure that: adequate advance care plans can be accessed upon hospital transfer, are systematically communicated with community healthcare professionals upon hospitalization, and that protocols and procedures to ensure access to family and loved ones are in place for incarcerated patients hospitalized with COVID-19. Moreover, many national standards limit or prohibit the use of shackles for pregnant women in custody who are in labor in community hospitals. The pandemic has made clear the vital need for medical professionals to enact similar limits on the use of shackles for people who are dying or seriously ill in community hospitals.
Strengthen partnerships between prison leadership and incarcerated people

Partnerships forged between prison residents and prison leaders can be key to safeguarding health in a prison, especially during a pandemic. At a minimum, recognition by prison administrators of failures to treat residents and families with respect is a necessary component of quality medical care, as is proper representation of patients’ voices, acknowledgment of power imbalances, and identification of shared health-related goals. Collective practices, such as the meaningful use of ideas generated in “inmate advisory councils” and family councils can help shift prison culture towards productive partnerships. Residents are living with constant fear of COVID-19 and it is imperative that prison and medical leadership engage in meaningful dialogue with residents and families to elicit ideas that can improve day-to-day life and the physical and mental health of residents.

Provide emergency mental health support for prison residents and staff

With higher rates of mental health challenges and substance use disorders compared to the general US population, prison residents and staff, who are already over-burdened by traumatic experiences, many are suffering the exhausting effects of enduring the pandemic in prisons. Prison staff are putting themselves, their households, and their communities at risk, which further exacerbates the stress of working in prisons. In response to the constant stress and fear associated with living and working in infection hotbeds, emergency mental health support services for residents and staff are needed. Expanded telehealth mental health visits and heightened surveillance for suicidality should be deployed. Community mental health agencies can also assist. While the acknowledgement of ongoing stress and provision of online resources are a
start, our consultation with experts suggests that a prompt and proactive trauma-informed response is needed.

(10) Commit to public accountability and transparency

Many prisons have made great efforts to adhere to emerging CDC recommendations regarding COVID-19 in prisons. The National Commission of Correctional Health Care also provided early guidance on standards of care related to COVID-19; however, accreditation with the Commission is voluntary and most US prisons are not accredited. Residents, family members, advocates, and attorneys have voiced concerns about variation in practice across prisons and lack of transparency regarding COVID-19 infection control measures in US prisons. In particular, the lack of information available about COVID-19 prevention and care approaches in immigration detention centers underscores the urgent need for improved transparency from these agencies.

Some prisons and related government agencies published early tracking of COVID-19 testing and policies. These positive outliers demonstrate that increased transparency and accountability in maintaining standards of care during the pandemic is possible. Such data can be used by researchers and public health departments to measure the pandemic’s scope and guide resource allocation to optimize a coordinated, data-driven response. Experiences to date suggest that government mandates through legislation are worth pursuing in order to ensure timely and accurate reporting about COVID-19 in prisons.

CONCLUSIONS

The COVID-19 pandemic in prisons has created an infectious disease crisis in the setting of what was already a public health travesty—mass incarceration. As the public health community battles 10
the pandemic and prepares for future waves of COVID-19 resurgence, addressing the poverty, racial inequality, and historical oppression that fuel mass incarceration will be crucial. If public health lessons learned from the pandemic in prisons are properly applied, COVID-19 can be an impetus to promulgate overdue justice reform and interventions that promote health equity. As the world awaits widespread distribution of vaccines and more effective anti-viral therapies, the public health community has a vital role to play in creating the conditions that best protect the human rights and health of prison residents and staff in all types of prison settings. Many of these lessons could have been learned after the 1918 Spanish Flu. We must not squander the lessons learned now from the COVID-19 pandemic of 2020.

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REFERENCES


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<th>Lesson</th>
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| 1) Accelerate population reduction coupled with community reentry support to make space for physical distancing, and areas for quarantine and medical isolation | • Pursue evidence-based decarceration strategies informed by public health professionals and prison leaders and prevent new incarceration by promoting alternatives to incarceration  
• Bolster reentry supports by educating people leaving prisons about COVID-19, ensuring access to health insurance, and promoting linkages to community and social services |
| 2) Improve ventilation in housing units and common spaces               | • Maximize ventilation with outdoor air  
• Ensure air ventilation systems meet standards to prevent the spread of COVID-19 in housing units and common spaces and that MERV 13 or higher air filters are used (or the highest MERV-rated filter that the HVAC systems can allow)  
• Ensure that medical isolation units and quarantine cells are available, when needed, to prevent the spread of COVID-19 |
| 3) Ensure appropriate mask use among staff and residents               | • Ensure access to masks for residents and staff  
• Ensure universal mask use with proper fit is non-negotiable  
• Provide health education about mask importance, use, and fit |
| 4) Limit transfers between facilities                                  | • Avoid transfers between facilities  
• If a transfer must take place, allow medical staff involvement in transfer policies, use PPE, and ensure screening protocols are in place (i.e., that the resident being transferred does not have COVID-19 or COVID-19 exposure after test administration), and require a 14-day quarantine |
| 5) Strengthen partnerships between public health departments and prison leadership | • Encourage frequent, regular meetings between prison and public health leaders to manage COVID-19  
• Develop and implement coordinated pandemic preparedness plans for current and future waves |
| 6) Introduce or maintain thoughtful occupational health programs       | • Promote occupational health programs that are accessible to prison staff by bolstering funding, ensuring access to PPE, affordability for staff, and applying a non-punitive approach  
• Promote culture of health among prison staff that encourages symptom reporting and behaviors informed by health evidence to prevent COVID-19 transmission |
| 7) Ensure access to advance care planning processes for incarcerated patients and delineation of healthcare rights | • Ensure that advance care planning processes are developed and accessible for residents  
• Ensure that hospitals caring for residents of prisons are aware of advance care plans and know patient rights |
| 8) Strengthen partnerships between prison leadership and incarcerated people | • Encourage a culture and infrastructure to support partnership with prison residents in responding to COVID-19 |
| 9) Provide emergency                                                  | • Recognize that COVID-19 in prisons is a significant source of |
| mental health support for prison residents and staff | stress and psychological trauma  
- Provide trauma-informed mental health support, including via expanded telehealth mental health visits, and deploy heightened surveillance for suicidality |
| 10) Commit to public accountability and transparency |  
- Mandate data reporting on COVID-19 prison cases  
- Publicly report procedures for combatting COVID-19  
- Promptly conduct outreach to affected families |