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DECARCERATING CORRECTIONAL FACILITIES DURING COVID-19

Advancing Health, Equity, and Safety

Committee on the Best Practices for Implementing Decarceration as a
Strategy to Mitigate the Spread of COVID-19 in Correctional Facilities

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Committee on Law and Justice

Division of Behavioral and Social Sciences and Education

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This Consensus Study Report was reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise. The purpose of this independent review is to provide candid and critical comments that will assist the National Academies of Sciences, Engineering, and Medicine in making each published report as sound as possible and to ensure that it meets the institutional standards for quality, objectivity, evidence, and responsiveness to the study charge. The review comments and draft manuscript remain confidential to protect the integrity of the deliberative process.

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Although the reviewers listed above provided many constructive comments and suggestions, they were not asked to endorse the conclusions or recommendations of this report nor did they see the final draft before its release. The review of this report was overseen by John V. Pepper, Department of Economics, University of Virginia and Philip J. Cook, Sanford School of Public Policy, Duke University. They were responsible for making certain that an independent examination of this report was carried out in accordance with the standards of the National Academies and that all review comments were carefully considered. Responsibility for the final content rests entirely with the authoring committee and the National Academies.

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Summary¹

CCOVID-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. The COVID-19–related death rate in the prison population was three times higher than in the U.S. population, adjusting for age and sex. Because of the large racial and ethnic disparity in incarceration, the penal system has likely contributed to inequality in infections. 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 are associated with community infection rates.

In this context, Arnold Ventures and the Robert Wood Johnson Foundation asked the National Academies of Sciences, Engineering, and Medicine to form an ad hoc committee to offer guidance on efforts to decarcerate, or reduce the incarcerated population, as a response to the COVID-19 pandemic. The committee—comprising experts in corrections, correctional health, economics, epidemiology, law, medicine, public health, public policy, and criminology and sociology—examined best practices for implementing decarceration and the conditions that support safe and successful reentry of those decarcerated.

¹This summary does not include references. Citations to support the text and conclusions herein are provided in the body of the report.

COVID-19 AND CORRECTIONAL FACILITIES

The conditions and characteristics of correctional facilities—overcrowded with rapid population turnover, often in old and poorly ventilated structures, a spatially concentrated pattern of releases and admissions in low-income communities of color, and a health care system that is siloed from community public health—accelerates transmission of the novel coronavirus (SARS-CoV-2) responsible for COVID-19. Such conditions increase the risk of contact with the virus for incarcerated people, correctional staff, and their families and others in their communities. Relative to the general public, moreover, incarcerated individuals have a higher prevalence of chronic health conditions, such as asthma, hypertension, and cardiovascular disease, making them susceptible to complications if they become infected. Indeed, according to data available for this report, cumulative COVID-19 case rates among incarcerated people and correctional staff have grown steadily higher than case rates in the general population since March 2020.

A growing body of research on the transmission of the novel coronavirus and epidemiological models of the spread of infectious diseases help explain why prisons and jails have become hotspots for COVID-19; the research also points to strategies for mitigating the spread of the disease. Decarceration from correctional facilities is one such strategy. By creating smaller populations within correctional institutions, other mitigation strategies are easier to implement. Physical distancing, diagnostic testing, and the ability to quarantine and medically isolate the incarcerated population that remains are all assisted by low prison and jail populations and slack capacity. To achieve population reduction, the committee viewed decarceration as consisting of both diversion from incarceration prior to admission and reduction of the incarcerated population through accelerated release from jails, prisons, and detention centers.

From its review of the evidence, the committee concluded that decarceration is an appropriate and necessary mitigation strategy to include in the COVID-19 response in correctional facilities and would reduce risks of exposure to and transmission of the disease within correctional facilities, thus improving the safety of incarcerated and detained people and correctional staff.

CONSIDERATIONS FOR DECARCERATION AND REENTRY

The current public health emergency necessitates a broad conception of public safety that includes the threats to life and health posed by the virus. In its study, the committee considered both public safety and public health. It reviewed large bodies of research on recidivism and the inca-

pacitation effects of incarceration on crime, and it examined correctional health, reentry supports, and the health effects of incarceration on individuals and their families and communities. The committee also considered how decarceration might affect racial equity given disproportionate rates of incarceration and consequences in Black, Hispanic, and Native American communities.

Research on recidivism suggests that correctional authorities could decarcerate in a manner that would pose relatively little risk to public safety. Research on reentry and health care for justice-involved people finds that access to community health care and housing support are important complements to decarceration, helping to promote public health and safety. In light of racial and ethnic disparities in COVID-19 infection rates as well as socioeconomic vulnerabilities emerging as the pandemic evolves, any efforts to decarcerate will need to consider not only those individuals released from correctional facilities but also the families and home communities to which they return. Appropriate planning for reentry and the provision of supports, especially during the first few weeks following release, can help mitigate public health and public safety risks and also the racial inequities that exist and are widening.

Some jurisdictions have taken steps to decarcerate their prisons and jails since the onset of the pandemic. But the reductions in incarceration that have occurred appear to have resulted mainly from declines in arrests, jail bookings, and prison admissions because of temporary closures of state and local courts rather than proactive efforts to decarcerate prisons and jails. Despite the desirability of decarceration from the perspective of public health and its feasibility from the viewpoint of public safety, the committee found that there is too little scope in current law for accelerating releases for public health reasons. Indeed, medical or health criteria for release, even in pandemic emergencies, are largely nonexistent at the state level and highly circumscribed in the federal system.

GUIDANCE FOR DEPOPULATING CORRECTIONAL FACILITIES

In formulating its recommendations for taking action on these issues, the committee recognized that decarceration is a process, not a one-time action. Successful decarceration will depend on existing partnerships and new collaborations. And it will require a range of decisions, actions, and programs, not just from the criminal justice system but also in domains of social policy including health care, housing, and income support. Decarceration efforts will vary by state and jurisdiction, reflecting the state of viral transmission within a correctional facility and the surrounding community and the complement of housing, health care, income supports necessary and available at the time.

The committee recognizes that some actions will be immediately feasible, while others will take longer to implement. Because the duration of the current crisis is unpredictable, the recommendations offered herein address both immediate demands for preventing and controlling COVID-19 transmission in correctional facilities and steps that can be taken to foster preparedness for the next outbreak, pandemic, or public health emergency.

Guiding Principles for Decarceration

Informed by research and epidemiological data, the committee outlined the following principles to be considered in developing strategies for depopulating correctional facilities:

- **Maximization of net benefits,**
- **Equal regard and fairness with view to mitigation of health and racial inequities, and**
- **Transparency to support evidence-based decision making.**

Together, the principles encourage decision makers releasing incarcerated individuals to do so through a lens of racial equity, meaning that all people have the opportunity to be released safely back to their families and communities.

Diversion: Immediate Actions

The committee's review of the evidence revealed the fundamental importance of reducing prison and jail populations as a public health strategy that will ultimately enhance community safety. Accordingly, the committee outlines steps for decarcerating through diversion. During public health crises, there are few compelling public safety reasons to hold many people in custody. While there may often be risks of criminal behavior in the future, evidence suggests those risks are relatively low for many individuals, especially in pretrial detention.

Recommendation 1: Federal, state, and local officials should exercise their discretion across a variety of domains to divert individuals from incarceration, including

- (a) law enforcement's issuance of citations in lieu of making arrests;
- (b) judges' and prosecutors' adherence to a strong presumption against pretrial detention, and release on own recognizance as a default option, to be overridden only when strong evidence indicates that release would be at odds with public safety or court appearance;

- (c) legislatures', prosecutors', and courts' elimination of the use of incarceration for failure to pay fines and fees and prioritization of noncustodial penalties for misdemeanors, probation and parole violations, and other nonserious conduct to the extent possible; and
- (d) local officials' elimination or significant reduction in the use of bail.

Release: Immediate and Medium-Term Actions

While efforts to divert individuals from incarceration will stem the flow of people into jails and, ultimately, prisons, for individuals already incarcerated, additional mechanisms will be needed to reduce health risks. The committee acknowledges that release efforts often require greater political will and more time to implement than diversion efforts. However, consideration of health equity prompts a deeper look at these incarcerated individuals, especially those in prisons who tend to be at greater risk for COVID-19 due to their age, the presence of chronic health conditions, and the length of potential exposure given their typically longer sentences.

The necessary extent of depopulation will vary by facility. The need for and timing of various decarceration strategies will require consideration of factors such as overcrowding, the physical design and conditions of facilities, population turnover, health care capacity, and case positivity rates (or reproduction ratio) among the incarcerated population and surrounding community. A number of officials have authority to impact release efforts throughout correctional systems at the federal, state, and local levels.

Recommendation 2: Correctional officials in conjunction with public health authorities should take steps to assess the optimal population level of their facilities to adhere to public health guidelines during the pandemic, considering factors such as overcrowding, the physical design and conditions of their facilities, population turnover, health care capacity, and the health of the incarcerated population.

Recommendation 3: To the extent that the current population level in a facility is higher than the optimal population level for adhering to public health guidelines, correctional officials should identify candidates for release from prison and jail in a fair and equitable manner and engage other officials outside the correctional system as necessary to expedite decarceration to the optimal level. Individuals assessed as medically vulnerable, nearing sentence completion, or of low risk to commit serious crime are likely to be suitable candidates for release during a public health crisis.

Recommendation 4: Given the extreme medical vulnerability of some incarcerated people to COVID-19, federal and state policy makers should revise compassionate release policies to account for petitioners' medical condition, age, functional or cognitive impairment, or family circumstances. Because of the severity of the health risks, such applications should be reviewable by the courts or some other decision maker external to the standard parole process and should allow scope for representation by counsel in the process on behalf of petitioners.

Reentry: Immediate and Medium-Term Actions

Research indicates that when a person leaves a correctional facility, the most urgent needs for material well-being are housing, health care, and income support. The committee therefore recognizes that these are important complements to any efforts to decarcerate and recommends that correctional officials, in collaboration with public officials and community-based programs, develop individualized reentry plans incorporating a bundle of services that encompass housing, health care, and income supports. The development of these plans should include efforts to identify systemic barriers to accessing public benefits and maintaining continuity of benefits and to support enrollment in benefits for individuals returning from incarceration across each of these domains. Public officials should also employ measures to avoid creating additional COVID-19–related health risks to the families and communities to which incarcerated individuals are returning, including offering testing prior to release, a place to quarantine in the community, and examination of parole and probation policies and procedures.

Recommendation 5: When releasing individuals from prisons and jails, correctional officials, in collaboration with other public officials and community-based programs, should develop individualized reentry plans incorporating a bundle of services encompassing health care, housing, and income supports to address individual and family needs as an important complement to decarceration efforts. Incarcerated individuals should be eligible and approved for such services at least 30 days prior to release when possible.

- (a) Federal, state, and local authorities should identify resources for providing housing as required by incarcerated individuals for safe discharge including space for quarantining in the community. Local housing authorities should limit restrictions on housing eligibility based on criminal history to those required by the U.S. Department of Housing and Urban Development and limit restrictions on tenants adding returning household members. Federal, state, and local authorities should explore

- opportunities to offer financial support to families that provide housing to incarcerated individuals upon release. Correctional officials should take steps to facilitate enrollment in appropriate housing programs and services prior to release where necessary, and a lack of housing in the community should not be grounds for continuing incarceration.
- (b) State and local officials should identify barriers to access public benefits for individuals returning from incarceration; work to maintain continuity of benefits; and support enrollment in benefits for income and basic needs, including access to the Supplemental Nutrition Assistance Program, Medicaid, Medicare, and Supplemental Security Income.
 - (c) Community health systems should facilitate health care access for people just released from correctional systems by removing requirements for government identification at the first visit, prioritizing the urgency of in-person first appointments immediately prior to release, and easing restrictions on video visits to improve engagement in primary care, substance use, and mental health treatment. The federal government, through the Centers for Medicare & Medicaid Services, Substance Abuse and Mental Health Services Administration, and the U.S. Drug Enforcement Administration, should extend and expand upon guidance that has permitted flexibility in the use of telemedicine for primary care and substance use treatment.

Recommendation 6: Correctional officials in coordination with local public health authorities should implement measures to avoid creating additional COVID-19–related health risks for families and communities. These measures should include providing COVID-19 testing prior to release and facilitating quarantining as necessary. When newly released individuals lack a place to quarantine, local officials should take steps to provide them with a safe place in the community to quarantine for 14 days before returning to their families, as well as publicly support and coordinate with community officials to ensure access to and retention of housing for returning individuals and their families.

Recommendation 7: Parole and probation departments should examine their policies and procedures and take quick action where needed to reduce the impact of community supervision on the spread of COVID-19. Such action should include administratively eliminating or greatly limiting revocation for technical violations, replacing in-person office visits wherever possible with noncontact means of collecting supervision reports, and removing conditions on parole or probation that require

an individual to apply for or obtain work. Courts and paroling authorities should limit the application of probation and parole to those who absolutely need community supervision and reduce the terms of probation and parole to only as long as necessary to achieve the goals of supervision.

Recommendation 8: States should remove barriers to eligibility for Medicaid to ensure that incarcerated and previously incarcerated individuals have access to COVID-19 tests and related services and transitional health care needs:

- (a) Exercise the optional eligibility provided in the Families First Coronavirus Response Act to provide Medicaid coverage for COVID-19 testing and related services to individuals who are uninsured;
- (b) Allow Medicaid payment for medical services furnished to an incarcerated individual during the 30-day period prior to that individual's release;
- (c) As long as statutes preclude Medicaid reimbursement for incarcerated individuals, states should 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; and when they do so, the Centers for Medicare & Medicaid Services should take steps to facilitate the speedy review of and decision on such waivers; and
- (d) Enroll individuals eligible for Medicaid during incarceration, prior to their release.

Improving Preparedness

Past research on pandemic management in correctional facilities suggests that preparedness planning is critical to management of future COVID-19 outbreaks and other public health emergencies. Preparedness planning involves public health experts and correctional officials and the creation of plans for safely diverting and releasing people from custody during a public health crisis. The goal of this work would be to weigh medical criteria and public health considerations against criminal justice purposes to develop community standards for safely diverting and releasing people from custody during public health emergencies and improve the preparedness of correctional systems.

Data Needs and Research Recommendations

There is a lack of consistently defined, publicly available data on COVID-19 testing, infection rates, hospitalizations, and deaths in prisons and jails, largely due to the isolation of the correctional health system from the nation's larger public health infrastructure. This lack of data also obscures racial disparities in COVID-19 testing, treatment, and outcomes in corrections. Without systematically collected data and research and evaluation of decarceration efforts, it is difficult to improve on evidence-based guidance about how to mitigate and prevent SARS-CoV-2 transmission and to integrate efforts within correctional facilities into the nation's collective public health mission during the pandemic. As a result, several fundamental research questions have gone unstudied. The committee formulated two recommendations specific to data needs and research. These recommendations highlight the need for data standardization and transparent reporting across jurisdictions, as well as monitoring and evaluation research on the causal relationship between incarceration and community health and the effectiveness of decarceration strategies.

Recommendation 9: All correctional facilities (including jails, state and federal prisons, detention centers of the U.S. Immigration and Customs Enforcement, and juvenile facilities) should report daily standardized, aggregated data on COVID-19 incidence, testing rates, hospitalizations, mortality, and all-cause-mortality among incarcerated people and staff by age, gender, and race/ethnicity to public health officials as directed and via a public-facing website or dashboard. All correctional facilities should also report daily standardized, aggregated data on decarceration efforts (especially releases) by age, gender, and race/ethnicity via a public-facing website or dashboard.

Recommendation 10: State and federal research infrastructures should invest in the monitoring and evaluation of the changes in operations and targeted COVID-19 release mechanisms in correctional facilities to document the impact of such efforts on correctional health, public safety, public health, and racial equity. The research undertaken to systematically monitor and evaluate decarceration efforts should facilitate transparency and evidence-based decision making in criminal justice. Researchers and funders should support a fully formed research program on the implications of incarceration for the transmission of infectious disease that extends beyond the adult criminal justice system to include juvenile incarceration, immigration detention, and other forms of detention. Furthermore, research should aim to examine the mutual

influence of community and correctional facility on the transmission of disease, including the influence of community health conditions on the prevalence of infection and virus transmission inside correctional facilities and the influence of correctional facilities on associated communities.

CONCLUSION

Decarceration in the service of public health will require sustained engagement among public officials and correctional and health leaders at the federal, state, and local levels as well as actors within community health and social services systems. In the perspective of this report, public safety encompasses good public health. Institutions for incarceration have been the sites of numerous outbreaks of infection and in this sense have posed a threat to public safety. Good health and safety in the pandemic era will require reducing incarceration and supporting the communities whose incarceration rates are highest.

1

Introduction

COVID-19 infection rates and the resultant morbidity and mortality of people who are incarcerated are disproportionately higher than those of the general population. According to the best available evidence, by August 2020 COVID-19 cumulative case rates among incarcerated people were nearly five times higher than the rates in the general population. In addition, the COVID-19–related death rate in the prison population was three times higher than in the U.S. population, adjusting for age and sex (Saloner et al., 2020). Overcrowding and the physical environment in many facilities, coupled with high levels of admissions and releases, make physical distancing and other prevention strategies difficult if not impossible to implement in correctional facilities. Moreover, the medical vulnerabilities of the incarcerated population create acute health risks in prisons and jails. Indeed, the conditions in correctional facilities have fueled epidemics of the past three decades (Beaudry et al., 2020; Hammett, Harmon, and Rhodes, 2002; Institute of Medicine, 2007; NRC, 1993, 2014) and now are posing a new public health threat during the COVID-19 pandemic.

Correctional facilities also are not as isolated as they may appear to be. What affects incarcerated people also affects correctional staff, the families of those incarcerated, and the local communities in which the facilities are located. Movement within jails and prisons; transitions among penal facilities, courts, and medical providers; and the daily staff inflow and outflow to and from local communities further challenge public health efforts to contain viral transmission and undertake public health efforts. Given racial and ethnic disparities in incarceration in the United States and their impacts

on the health of incarcerated individuals, their families, and communities¹ (NASEM, 2018, 2020b; NRC, 2014), prisons and jails may be contributing to higher prevalence of COVID-19 cases in predominantly Black and Hispanic communities relative to White communities (Gross et al., 2020; Webb Hooper, Nápoles, and Pérez-Stable, 2020).²

For months, federal, state, and local policy makers have faced the challenge of protecting people who work and live within the penal system and maintaining public health and safety. Correctional leaders have been responding to state and local directives, often with insufficient resources and guidance to fight the new pandemic. Furthermore, correctional health care systems have been historically administered outside of the mainstream public health infrastructure (Macmadu and Rich, 2015; NRC, 2014; Schwartz, 2008; Wachino, 2020). Unlike nursing homes, which were also a source of outbreaks, health care in prisons and jails is not overseen by an independent quality commission nor integrated with community health systems. As a result, correctional health services have often been left out of the epidemic preparedness planning undertaken at the local, state, and federal levels.³

There is no one solution to mitigating the spread of the novel coronavirus in correctional facilities and surrounding communities. Multiple steps, strategies, and reevaluations are required, especially in the context of evolving science and experience. Decarceration is one strategy, taken in parallel with other steps to create space and distancing and advance cleaning and health monitoring procedures within correctional facilities. During the pandemic, multiple decarceration efforts across jails, prisons, and detention centers have been undertaken, leading to an approximately 11 percent reduction in incarcerated populations. This report examines the strategy of decarceration—the challenges and opportunities of reducing the numbers of people in jails, prisons, and similar facilities—to mitigate COVID-19 transmission.

STUDY CHARGE AND SCOPE

In response to the need for advice on effectively decarcerating correctional systems, the Committee on Law and Justice of the National

¹We note that the rate of incarceration for Black women has declined since 2002 and is currently similar to that for White women (Myers, Sabol, and Xu, 2018). However, the rate of incarceration for Black men remains disproportionately high compared with White men.

²The limited data that are available also show health disparities during the COVID-19 pandemic among American Indian, Alaska Native, and Pacific Islander populations (Webb Hooper, Nápoles, and Pérez-Stable, 2020).

³The National Commission on Correctional Health Care encourages correctional health providers to reach out to state and local health departments since they may not include correctional health in their planning or communications: see <https://www.ncchc.org/COVID-Resources>.

Academies of Sciences, Engineering, and Medicine, in collaboration with the National Academies' Societal Experts Action Network, convened an expert ad hoc committee to examine evidence-based practices, equity issues, and the necessary community supports and services for decarceration and reentry.

The Committee on Best Practices for Implementing Decarceration as a Strategy to Mitigate the Spread of COVID-19 in Correctional Facilities was assembled to carry out this study and produce this consensus report on a rapid timeline to meet the pressing demand for guidance. The committee included experts in the areas of corrections, correctional health, economics, epidemiology, law, medicine, public health, public policy, and criminology and sociology. Arnold Ventures and the Robert Wood Johnson Foundation provided support for the study, and they asked the committee to examine best practices for implementing decarceration as a response to the pandemic and to take stock of the release mechanisms and the conditions (e.g., access to health care and adequate housing) that support successful reentry. See Box 1-1 for the committee's formal statement of task.

In undertaking its charge, the committee interpreted "decarceration efforts" broadly to include efforts both to accelerate release from prisons and jails and to divert people from entering incarceration in the first place.⁴ It also viewed community supports as including resources and services for previously incarcerated individuals, their families, and their communities necessary to reduce risks of infection and promote well-being.

BOX 1-1 **Statement of Task**

The National Academies of Sciences, Engineering, and Medicine will convene an ad hoc committee that will provide advice to policymakers, correctional officials, and public health officials on best practices for mitigating the spread of COVID-19 in correctional facilities through large-scale release and decarceration efforts. The short consensus report will consider the following questions:

- How can correctional facilities apply evidence-based practices to large-scale release and decarceration, while paying attention to equity issues?
- What community supports are needed to ensure successful reentry for released individuals and the community?

The committee will issue a report with findings and recommendations at the end of the study.

⁴See the Bureau of Justice Statistics for a flowchart of events in the criminal justice system at <https://www.bjs.gov/content/largechart.cfm>.

The committee recognized that decarceration is one of many strategies that will be used to protect people living and working in correctional facilities. Other measures include physical distancing, intensified cleaning, requirements for face coverings and personal protective equipment, single celling, cohorting,⁵ regular symptom screenings, contact tracing, and implementation of testing protocols among staff and incarcerated persons for SARS-CoV-2, the virus that causes COVID-19. Reducing the incarcerated population can facilitate these many strategies and the provision of medical care (Cloud et al., 2020). In addition, the positive effects of decarceration on reducing transmission of the virus may extend beyond correctional facilities, enhancing the safety not only of incarcerated people but also of correctional staff and others in the surrounding communities. Given our charge, the committee does not offer advice on the many measures employed for virus mitigation inside facilities, but we affirm their importance and view decarceration as an effort to support these other strategies (see Chapter 5).

This report focuses on prisons and jails in federal, state, and local jurisdictions, but the committee also examined data and literature on detention centers under the authority of U.S. Immigration and Customs Enforcement (ICE). As is the case in jails and prisons, ICE detention facilities have long been vulnerable to infectious disease outbreaks, even for diseases with effective prevention and management strategies (Erfani et al., 2020; Meyer et al., 2020).⁶ During the COVID-19 pandemic, ICE facilities are experiencing outbreaks similar to those in jails and prisons. While data are far from complete, more than 5,000 people tested positive for COVID-19 while in ICE custody from February to August 2020 (ICE, 2020).⁷ While correctional and immigration detention settings differ in many respects, they can share similar conditions—overcrowding, poor sanitary conditions, inadequate

⁵In guidance from the U.S. Centers for Disease Control and Prevention, “cohorting refers to the practice of isolating multiple individuals... or quarantining [them] together as a group” (CDC, 2020).

⁶Several studies point to the transmission of diseases in ICE facilities. A survey of adults detained within a California ICE facility found that 12 percent were susceptible to varicella (chickenpox) during 2014 and 2015, a case rate six times higher than that in the comparable U.S. population of adults at the time (Varan et al., 2018). Similarly, between 2018 and 2019, there were nearly 900 confirmed and probable cases of mumps among adults in ICE detention facilities (Kuehn, 2019). A privately operated ICE facility in Arizona detected 32 cases of measles in 23 detained individuals and 9 staff in the course of a single month in 2016 (Venkat et al., 2019). A retrospective analysis of health reports for individuals detained in 2005 documented a culture-confirmed case rate of tuberculosis (TB) that was 2.5 times higher than that among foreign-born U.S. adults not detained (Schneider and Lobato, 2007). Another study of 327 individuals with confirmed pulmonary TB inside detention facilities found that nearly 80 percent were asymptomatic at the time of diagnosis (Boardman et al., 2020).

⁷See ICE data reporting at <https://www.ice.gov/coronavirus#main-content>.

public health practices—that place both settings at increased risk of continuing to be hotspots for the COVID-19 pandemic. Because risks to public safety due to criminal behavior are low (NASEM, 2015), the federal government needs to also consider immediate strategies to mitigate the spread of COVID-19 in these centers, including decarceration.

The committee chose not to specifically examine juvenile detention centers, recognizing that the committee did not have strong expertise on the juvenile justice system, which operates very differently than adult corrections, and that the science on SARS-CoV-2 transmission among youth continues to be evolving rapidly. However, we acknowledge that many of the concerns expressed in this report about virus transmission in facilities where physical distancing, isolation, and quarantine are difficult and where people enter and exit regularly can apply to juvenile detention centers.⁸

WHAT IS DECARCERATION?

Decarceration is the process of reducing the number of people in correctional facilities by releasing those currently incarcerated and by diverting those who might otherwise be incarcerated. This process involves strategies for ending custodial sentences for those who are incarcerated as well as minimizing arrests, court appearances, and parole and probation revocations for those still in the community.⁹

Decarceration is not new. In many states, policy makers have tried to reduce prison and jail populations out of concern for the financial and social costs of incarceration, and the rate of incarceration in the United States started to decline in 2009 (NRC, 2014). Although there is consistent evidence that imprisonment has some crime-reducing effect (NRC, 2014, see Chapter 5), a number of states have been able to reduce their prison populations without increasing serious crime (e.g., Bird, Goss, and Nguyen, 2019).

Other epidemics (Beaudry et al., 2020) and early experiences with the COVID-19 pandemic have shown the importance of depopulating congregate living and working areas, particularly high-risk settings like correctional facilities. Since many of the jails, prisons, and detention centers in the United States are overcrowded (Carson, 2020), and physical conditions of incarceration can spread infection, decarceration can protect

⁸On September 30, 2020, the Sentencing Project reported COVID-19 infections among more than 1,800 incarcerated youth and more than 2,500 staff working in facilities in the juvenile justice system: see <https://www.sentencingproject.org/publications/youth-justice-under-the-coronavirus-linking-public-health-protections-with-the-movement-for-youth-decarceration>.

⁹In March 2020, for example, the United Nations High Commissioner for Human Rights urged governments to address the needs of those confined and working in place of detention, encouraging them to act quickly to reduce the numbers of people detained: see <https://news.un.org/en/story/2020/03/1060252>.

medically vulnerable incarcerated people and staff and “flatten the curve” of virus transmission both within correctional facilities and in the broader community.

Indeed, efforts to decarcerate are already under way across a number of jurisdictions during the pandemic. Prisons and jails experienced declines in total population (approximately 11 percent of the incarcerated population) in the first half of 2020 (Franco-Paredes et al., 2020; Jail Data Initiative, 2020). These efforts have included releasing individuals who are close to their release date or considered low risks to public safety. Other strategies include changes to custodial sentencing decisions and intake processes. Some localities have reduced jail admissions by opting for citations instead of arrest or by vacating warrants for unpaid court fines.¹⁰

As detailed in Chapter 3, these reductions appear to be mainly the result of declines in arrests, jail bookings, and prison admissions related to lockdowns and the closure of state and local courts. The releases among sentenced jail and prison populations that have occurred have, for the most part, occurred on a case-by-case basis and have been procedurally slow and not well suited to crisis situations.

The various stakeholders—governors, legislators, criminal justice and public health officials, community leaders, and health system and housing and safety net organizations—will have to coordinate their efforts as they consider policy options to safely reduce incarceration, including community supervision, sentencing, and sanctions; jail and prison release mechanisms; reentry strategies; and community reintegration. Coordination is necessary because the challenge of decarceration is not confined to penal facilities. Rather, it also encompasses the provision of health care, housing, and financial supports to the formerly incarcerated and the families who support them, and developing policies and institutional structures that keep communities safe and healthy during the pandemic.

MAGNIFIED INEQUITY IN THE COVID-19 PANDEMIC

The committee recognizes that several previous reports of the National Academies (Institute of Medicine and National Research Council, 2013; NASEM, 2018, 2020b; NRC, 2013, 2014) have documented and reflected on health and racial/ethnic disparities related to the criminal justice system. *The Growth of Incarceration in the United States: Exploring Causes and Consequences* (NRC, 2014, pp. 2, 5) explains the following:

¹⁰See more information and discussion on the efforts—both in and out of courts and corrections—to decrease jail and prison populations in Chapter 3 of this report as well as through the UCLA Law Covid-19 Behind Bars Data Project available at <https://law.ucla.edu/academics/centers/criminal-justice-program/ucla-covid-19-behind-bars-data-project>.

Those who are incarcerated in U.S. prisons come largely from the most disadvantaged segments of the population. They comprise mainly minority men under age 40, poorly educated, and often carrying additional deficits of drug and alcohol addiction, mental and physical illness, and a lack of work preparation or experience. Their criminal responsibility is real, but it is embedded in a context of social and economic disadvantage... Racial disparities in incarceration have tended to differentiate the life chances and civic participation of blacks, in particular, from those of most other Americans... Incarceration is associated with overlapping afflictions of substance use, mental illness, and [higher] risk for infectious diseases (HIV, viral hepatitis, sexually transmitted diseases, and others) [than the general population]. This situation creates an enormous challenge for the provision of health care for [incarcerated persons], although it also provides opportunities for screening, diagnosis, treatment, and linkage to treatment after release.

The COVID-19 pandemic has in general exposed and exacerbated long-standing health inequities in the United States (NASEM, 2017) that have resulted in socioeconomically disadvantaged people and people of color—notably Black and Hispanic populations—facing disproportionate risks of infection, severe morbidity, and death (Gross et al., 2020).

These groups are at increased risk of infection since they are disproportionately represented in high-risk settings (e.g., front-line work, prisons and jails, homeless shelters, overcrowded housing) (Rogers et al., 2020). This risk of infection is coupled with increased risk of complications once infected due to a higher prevalence of underlying health conditions—conditions that are often undertreated because of structural disadvantages (e.g., limited access to health care), as well as discrimination within health systems (Darity, 2003; NASEM, 2017, 2020a; NRC, 2014). Beyond these health issues, the economic crisis brought on by the pandemic also disproportionately impacts communities considered to be more racially and ethnically diverse than predominantly White communities (Adhikari et al., 2020; Cowger et al., 2020).¹¹

¹¹These health disparities are exacerbated by corresponding racial, ethnic, and economic disparities in rates of incarceration, with a variety of broader effects (NRC, 2014). Having a prison record is associated with an elevated risk of negative health outcomes across the life course (Esposito et al., 2017; Massoglia, 2008; Schnittkner and John, 2007). Sixty-three percent of Black Americans and 45 percent of Americans overall have had an immediate family member incarcerated (Enns et al., 2019). Families of incarcerated people also tend to suffer negative physical and mental health outcomes as a result of their loved one's incarceration (Davis and Schlafer, 2017; Dube, Anda, and Felitti, 2001; Gaston, 2016; Heard-Garris et al., 2018; Lee, Fang, and Luo, 2013; Roettger and Boardman, 2012; Swisher and Roettger, 2012; White, Cordie-Garcia, and Fuller-Thompson, 2016; Wildeman, Schnittkner, and Turney, 2012). Incarceration not only affects the health of incarcerated populations but also contributes to the breakdown of educational opportunities, family structures, economic mobility, housing options, and neighborhood cohesion, especially in low-income communities of color (NRC, 2014). In this sense, incarceration is part of a community ecology that shapes more proximate social determinates of health (Cloud, Parsons, and Delany-Brumsey, 2014; NASEM, 2018).

Decarceration is a strategy for reducing viral transmission in correctional settings, but it needs to be executed with an eye toward reducing these existing inequalities and in ways that do not increase risks to the health and well-being of already vulnerable families and communities. Health equity will therefore be an important goal in decarceration efforts. In this report, health equity encompasses the fair opportunity for all members of the population to be as healthy as possible. According to framing by the Robert Wood Johnson Foundation, such opportunity “...requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care” (Braveman et al., 2017, p. 2).

APPROACH TO THIS STUDY

During the course of this study, the committee met virtually five times over a 5-week period. In addition to deliberating on the available scientific literature and evolving information related to correctional settings and the COVID-19 pandemic, the committee heard a presentation from the sponsor and received a commissioned paper from the COVID Prison Project, documenting COVID-19–related data in correctional facilities.¹² Two conference calls were also held to hear from both correctional officials and groups representing currently and formerly incarcerated persons to learn about their concerns, challenges, and perspectives on the pandemic and mitigation strategies in place. To supplement its own expertise, the committee also drew on the presentations and discussions in two public webinars hosted by the National Academies’ Societal Experts Action Network (see Chapter 5):

- The first webinar, “Preventing the Spread of COVID-19 in Correctional Facilities,” held August 20, 2020, examined emerging practices for preventing new cases in jails and prisons. Highlighted strategies included wastewater surveillance, testing and contract tracing in correctional facilities, best practices for decarceration, and preparations for vaccine distribution. Speakers were Annette Chambers-Smith, Ohio Department of Corrections; Sara Smith Kariko, Washington State Department of Corrections; Lisa Puglisi, Yale School of Medicine; and Homer Venters, former chief medical officer of the New York City Correctional Health Services.
- The second webinar, “Health Care and Health Care Financing for COVID-19 in Correctional Facilities,” held August 26, 2020, examined how correctional facilities are managing health care during

¹²See <https://covidprisonproject.com>.

COVID-19 and strategies for financing COVID-19–related health care. Topics discussed included sick call and long-term care for COVID-19 patients; protection of medically vulnerable people in correctional facilities, including medical isolation; and opportunities for expansion of Medicaid coverage for correctional populations. Speakers included Jennifer Clarke, Rhode Island Department of Corrections; Vikki Wachino, Community Oriented Correctional Health Services; Brie Williams, University of California, San Francisco; and Tyler Winkelman, Hennepin County and University of Minnesota.

In preparing this report, the committee drew on its own expertise—years of studying and working with the criminal justice system and correctional health care—and studied a burgeoning research literature on the pandemic and incarceration, and it also examined newly collected data on the COVID-19 pandemic in correctional settings and on decarceration efforts. Given the timeline for producing this report, however, an exhaustive review of all available guidance documents for jails, prisons, and other detention facilities was not feasible. The committee is aware that numerous resources, including those from the U.S. Centers for Disease Control and Prevention, the World Health Organization, the Council on Criminal Justice, and a number of state departments of corrections, offer guidance and recommendations for correctional facilities. Where appropriate, this report looks at how guidance from these other documents fits with the committee’s conclusions and recommendations.

REPORT PURPOSE AND AUDIENCES

This report is intended primarily to provide guidance to policy makers, correctional officials, correctional and community health providers, and public health officials at the federal, state, and local levels. It should also be useful to others who offer input and advice to these decision makers and to researchers continuing to study correctional settings and the effects of the COVID-19 pandemic. The committee recognizes that readers will be concerned with weighing issues of health risks and equity alongside priorities for rehabilitation, reentry, and public safety. Public safety and public health, however, depend closely on each other and any strategy that works at the intersection of these domains should aim to strengthen both.

As the COVID-19 crisis escalated in prisons and jails around the country in March and April of 2020, criminal justice policy makers and public health officials often worked quickly and vigorously with few resources or guidance. Acknowledging these efforts and drawing on the lessons of this

experience, the committee offers this report to help decision makers further reduce jail and prison populations during the current outbreak.

ORGANIZATION OF THE REPORT

Following this introduction, Chapter 2 provides context on the criminal justice system, specifically how five factors augment the transmission of COVID-19: (1) correctional population turnover; (2) overcrowding in old, poorly ventilated facilities; (3) admission to and release from low-income and predominantly Black and Hispanic neighborhoods; (4) chronic health conditions that increase risk for COVID-19 morbidity; and (5) the state of correctional health care, which is siloed from the public health infrastructure. The chapter describes the pandemic in correctional systems and what is known about its impact on incarcerated people, staff, and surrounding communities and illustrates how decarceration may facilitate decreasing infection within correctional systems and surrounding communities.

Chapter 3 expands on decarceration as a way to mitigate viral transmission and COVID-19 complications. It examines multiple ways to approach decarceration, outlines important considerations, identifies best practices, and provides new data on current decarceration efforts in prisons and jails.

Chapter 4 focuses on reentry and the community supports in such areas as health care and housing that need to be in place to complement decarceration.

Chapter 5 provides background on a number of strategies undertaken or considered to reduce the spread of the virus in correctional settings and offers concrete recommendations for supporting decarceration strategies.

Finally, Appendix A provides a detailed discussion of research on recidivism, and Appendix B provides biographical sketches of committee members and study staff.

2

Correctional Facilities and COVID-19: Context and Framing

This chapter provides the conceptual and empirical context that guided the committee's analysis of how decarceration and enhanced reentry planning and service provision can contribute to a comprehensive COVID-19 mitigation strategy. It begins with a basic description of disease dynamics and then considers how the conditions and operations of the U.S. correctional system are likely to amplify the spread of COVID-19, both within correctional facilities and in surrounding communities. It then draws on emerging data and analysis to describe the scope of the COVID-19 outbreak in U.S. prisons and jails and discusses the data limitations that challenge research efforts necessary to inform ongoing pandemic and public health responses.

THE BASIC EPIDEMIOLOGY OF COVID-19

Epidemiologists study the spread of infectious diseases by dividing the population into distinct categories (or compartments) defined by the progression of a disease and then examining the process by which individuals move between these compartments. In the susceptible-exposed-infected-recovered (SEIR) model presented by Anderson and May (1991), all members of a closed population are in one of four compartments: susceptible to infection (S), exposed to infection but not yet infected (E), infected-infectious (I), or recovered (R). Movement between these compartments depends on the transmission rate (a factor that depends on the nature of the pathogen and the social and institutional structures that shape human interaction, as well as human behavior), the length of time to recovery, and the likelihood that the exposed become infected and the time profile of this process.

As a disease outbreak progresses, the pace and volume of new infections change as the susceptible population shrinks when greater proportions of the population move into the recovered compartment and the susceptible population is reduced through vaccination.

In studying the impact of an infectious disease outbreak, researchers often focus on two key measures and the factors that influence them: the basic and effective reproduction ratio. The basic reproduction ratio, called R_0 , measures the number of new infections transmitted by an initial infected person. R_0 is higher when the infection rate is higher (an individual transmits a large number of new infections each day) and lower when the recovery rate is faster (i.e., individuals recover quickly from the disease). When R_0 is greater than 1, infection will spread; when it is less than 1, outbreaks will quickly die out (Anderson and May, 1991).

The second summary measure is the effective reproduction ratio, or R_e , which is the number of new infections that result from a new infection at a given point in time after the initial infection. R_e depends on R_0 , but also on the proportion of the population that remains susceptible. As the susceptible proportion shrinks, R_e will decline as there are fewer and fewer susceptible individuals that can be infected (Anderson and May, 1991).

While understanding of how SARS-CoV-2 spreads from person to person is evolving, a major route of spread is through respiratory droplets between persons in close proximity to one another (within 6 feet). Moreover, virus-laden aerosols of smaller particles may also cause infection, especially in closed quarters with poor ventilation, where the aerosols can remain in the air and circulate through a closed environment for some time (Klompas, Baker, and Rhee, 2020). Although less likely, transmission of the virus can also occur when contact with contaminated surfaces is followed by contact with the eyes, nose, or mouth. When exposure to the virus causes an infection, it is often followed by a latent period of approximately 5 days but can be as long as 14 days, at which point symptomatic patients begin to present with respiratory and a variety of other physical problems. Asymptomatic infections are not uncommon. Patients are likely at highest risk of spreading the illness before symptoms develop and early in the course of their illness (Joost Wiersinga et al., 2020).

This understanding of COVID-19 informs what has become the standard protocol for minimizing the spread of disease: physical distancing of at least 6 feet; mask wearing; regular hand washing; restricted use of congregate settings, particularly indoors; diagnostic testing of symptomatic and asymptomatic individuals; quarantine for 14 days following contact with an infected person; and contact tracing for infected patients.¹

¹See, for example, steps posted at U.S. Centers for Disease Control and Prevention at <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/index.html> [updated September 11, 2020].

THE CORRECTIONAL SYSTEM AS AN AMPLIFIER OF COVID-19 SPREAD

The adult correctional system includes state and federal prisons, incarcerating 1.47 million men and women in 2018, and local jails that held another 738,000 (Maruschak and Minton, 2020). In 2019, an additional 56,000 people were in immigration detention facilities as a result of either apprehension at the border by U.S. Customs and Border Protection officers or arrests occurring within the United States by U.S. Immigration and Customs Enforcement (ICE) officers (ICE, 2020). According to the most recent data, the adult incarcerated population is held in 2,005 state and federal prisons and 3,163 jail facilities. Prisons employ a total staff of about 480,000, while jails employ another 205,000. The penal system thus includes around 3 million people, counting the incarcerated population and staff, distributed across more than 5,000 facilities.²

Five features of the penal system are particularly important for public health and the transmission of the novel coronavirus. First, the high rate of incarceration has created high rates of admission and release. Second, rapid growth in prison and jail populations has contributed to overcrowding in facilities that are often old and poorly ventilated, with great variation in the physical plant of facilities including use of congregate spaces. Third, admission to and release from incarceration are spatially concentrated in low-income, predominantly Black and Hispanic neighborhoods. Fourth, in addition to their socioeconomic disadvantage, people at greatest risk of incarceration are also in poor health, burdened disproportionately by chronic health conditions. Finally, the correctional health care system is largely siloed from public health and emergency preparedness planning and not resourced to manage pandemic outbreaks. Box 2-1 describes how these five features may have contributed to a COVID-19 outbreak at San Quentin Prison in California.

Admissions to and Releases from Incarceration

Patterns of admission and release are strikingly different for prisons and jails. Prisons are state and federal facilities incarcerating men and women who have been convicted of felony offenses and are typically sen-

²Facility counts are from the Bureau of Justice Statistics (BJS) and its census of state and federal adult correctional facilities (latest data available for 2012) and the census of jails (latest data available for 2013). Data on employment in state and federal prisons are from the BJS justice expenditure and employment extracts (latest data available for 2016) and the Bureau of Prisons; see https://www.bop.gov/about/statistics/statistics_staff_ethnicity_race.jsp. Data on jail employment are taken from staff counts of the BJS census of jails (latest data available for 2013).

BOX 2-1

COVID-19 Outbreak at California State Prison, San Quentin

In the California correctional system, an initial outbreak occurred within the California Institute for Men in late April through May 2020. This outbreak emerged before extensive testing of those incarcerated and staff had commenced and even before many of the mitigation measures now in place across the state system had been implemented. In late May, a number of individuals were transferred from this prison to other facilities of similar prison population, San Quentin and Corcoran. It was later discovered that some of those transferred tested positive for COVID-19 (McCoy et al., 2020). This created a large outbreak at San Quentin (1,635 active cases in early July) but had a more limited effect at Corcoran (< 150 cases in early July). It has been suggested that the facility design of Corcoran contributed to the relatively more successful control of virus transmission. In San Quentin, however, the facility was overcrowded with a number of communal spaces.

As cases appeared and concerns grew, a group of medical experts from the University of California, San Francisco and the University of California, Berkeley was asked to visit San Quentin in mid-June. They identified a number of conditions that contributed to the outbreak (McCoy et al., 2020):

- There simply do not appear to be sufficient on-the-ground [medical] staff who are not working from home (p. 2).
- There are currently 3,547 people in total incarcerated at San Quentin, approximately 1,400 of whom have at least one COVID-19 risk factor (as do many, unknown, staff members) (p. 3).
- Given the unique architecture and age of San Quentin (built in the mid-1800s and early 1900s), there is exceedingly poor ventilation, extraordinarily close living quarters, and inadequate sanitation (p. 3).
- There is an immediate need to clean and turn on all fan and HVAC systems (e.g., North Block, Gymnasium, Dorms) in order to maximize air exchange and ventilation as soon as possible (p. 4).
- A massive outbreak at San Quentin will significantly and quickly overwhelm the availability of these 106 Adjustment Center cells, and there will quickly be nowhere for infectious cases to be moved (p. 6).

In response to the escalating cases and the lack of space, the prison installed tents for medical stations to care for and isolate those who became infected.^a The large outbreak at San Quentin became an example of how quickly the virus can spread in the adverse conditions of correctional settings (Maxmen, 2020; Williams and Griesbach, 2020). By the end of the outbreak in August 2020, about two-thirds of those incarcerated had tested positive for the coronavirus and 28 people had died.

^aSee <https://www.cdcr.ca.gov/covid19/san-quentin-state-prison-response>.

SOURCE: Description and data drawn from information in *Plata v. Newsom*, Case No. 01-1351 JST, United States District Court, Northern District of California, Oakland Division, and the California Department of Corrections and Rehabilitation population COVID-19 tracker at <https://www.cdcr.ca.gov/covid19/population-status-tracking/>.

tenced to incarceration for 1 year or longer. The average length of stay in state prisons is 2.6 years (Kaeble and Cowhig, 2018). Each year, prisons admit and release about 600,000 people. In 2018, 72 percent of all those admitted to prison had been convicted of new crimes, while 28 percent had not come from court but had been sent to prison for violating the conditions of probation or parole (Carson, 2020).

For local jails, roughly two-thirds of their populations are defendants who have not been sentenced and are awaiting court action. The remaining one-third have been convicted and received short sentences, typically less than 1 year of incarceration. About 63 percent of individuals in jail are held for a felony offense and 37 percent for a misdemeanor (Zeng, 2020). Jail stays are relatively brief, an average of about 28 days and as short as 2–3 days in some jurisdictions (Cunniff, 2002). Short jail stays produce very high rates of admission and release. A total of 10.7 million people were admitted to jails in 2018 (Zeng, 2020).

In the early phase of the pandemic, the virus spread “outside in” from the community into the facility from people who were newly admitted, staff, or visitors. Because of high rates of admission, 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.³ As noted above, jail stays are usually very short, with many people moving in and out in a matter of days, often making quarantine infeasible. Even testing may not be practical in many cases, given the lag time on many COVID-19 tests. Jails in urban areas, too, often lack outdoor space for recreation, so that many more people are interacting in close quarters before release back to their communities.

In federal immigration detention facilities, high rates of infection are also associated with high rates of admission. In fiscal year 2019, the number of new book-ins (defined as the first time a person is taken into custody by ICE, and most akin to admissions in other correctional systems) was 510,854, up from 396,448 in the previous fiscal year. The average length of stay in an immigrant detention facility in fiscal year 2019 was 34.3 days and was substantially higher for individuals arrested internally by ICE (54.5 days) relative to those apprehended at the border (26.6 days) (ICE, 2019).

While yearly prison admissions are fewer than those to jails and the average length of stay is longer (2.6 years; median time served was 1.3 years) (Carson, 2020; Kaeble, 2018), movement within and between prison facilities is still concerning under pandemic conditions. Movement throughout all correctional facilities is common as staff and incarcerated people move in and out of housing, dining, recreation, and programming areas.

³The SEIR model discussed above by Anderson and May (1991) does not account for high throughput.

The rounds of staff, visitors, and incarcerated people can become a means for spreading the virus throughout a facility and between facilities. Once introduced into a correctional facility, the virus finds an environment in which staff and incarcerated people work and live in close quarters and are frequently inside for long periods each day. Some prisons and jails have responded by locking down and restricting movement. If people cannot interact with others outside their cells or dorms, then even if the virus does appear in one place in a facility, it will be contained in that unit and not spread to other parts of the prison or jail. Yet these measures may still fail where staff move around, bringing meals, medications, and other necessities to those who are locked in.

Overcrowding and Physical Plant of Facilities

Overcrowding is often measured by the ratio of incarcerated population in a facility to a measure of the facility's capacity. Capacity can be measured in different ways according, for example, to the design of the prison or its operational use. Typically, higher rates of infection have been found in overcrowded facilities whose population exceeds capacity (see Chapter 3).

Each year the Bureau of Justice Statistics (BJS) reports year-end prison populations, by state, relative to three measures of prison capacity. At the highest measure of capacity, 12 states and the federal system were overcrowded in the sense that population exceeded capacity. Because the BJS figures are provided at the state level, even states that are rated under capacity may have some overcrowded prisons. Using the lowest measure of capacity, 25 states and the federal system were overcrowded. Between 26 and 44 percent of people incarcerated were held in an overcrowded jurisdiction.⁴

Applying similar measures to jails, the average daily incarcerated population exceeds capacity in all but two states, Virginia and West Virginia (Minton and Zeng, 2015). Data on jail overcrowding is available at the facility level from the BJS Census of Jails. The latest census in 2013 contained information on 2,931 facilities, covering most jails and temporary detention centers in the country. According to these data, 17 percent of jails reported average daily populations in excess of rated capacity. Roughly 31 percent of people incarcerated in jails are housed in overcrowded facilities.

Overcrowding presents a significant challenge to preventing and mitigating viral spread. Overcrowding may impede the flexibility that correc-

⁴Note that even in systems where the total population falls short of design capacity, there may be crowding in specific facilities. For example, California's correctional reforms greatly reduced overcrowding in lower-security institutions but had much smaller effects on higher-security facilities.

tional health care leaders need to quickly move large numbers of residents into quarantine units in response to possible COVID-19 exposures or create medical isolation units once individuals are likely exposed or sick. With overcrowding, people who are infected are often relegated to the same housing units as those who are not infected, possibly sustaining the risk of further transmission (Cloud et al., 2020).

Double or triple bunks in dormitory-style units are common in overcrowded facilities. Such units make greater use of a fixed number of sinks, toilets, and showers or congregate areas where people gather, increasing the risks of transmission. Double ceilinging has also become common, particularly for facilities built in the 1980s and 1990s that were designed with cells for single occupancy. With as little as 20 square feet of free floor space in a cell (subtracting space for bedding, sink, and toilet) for two occupants, physical distancing is impossible.

Overcrowding not only impedes physical distancing but also makes it difficult to keep surfaces properly clean and disinfected. In some cases—as with bathrooms in crowded dorms—the number of people alone obstructs such efforts. In addition, distribution of the cleansers and other products required to keep surfaces clean is often limited. Likewise, a lack of soap, hand sanitizer (which, because of its high alcohol content, is contraband in many facilities), and even clean towels can thwart efforts at adequate hand hygiene. Moreover, correctional leaders also expressed concerns about the age of facilities, with attendant poor ventilation.

Spatial Concentration

Admissions to and releases from prisons and jails tend to be concentrated in low-income communities of color (Clear et al., 2003; Sampson, 2012; Simes, 2018b). For example, Sampson and Loeffler (2010) analyze the spatial pattern of prison incarceration in the city of Chicago and find the highest rates of incarceration in neighborhoods with the highest rates of concentrated disadvantage, measured by the local-area level of poverty, unemployment, welfare receipt, and single parenthood. The close association between incarceration and socioeconomic disadvantage persists even after accounting for neighborhood crime rates. Simes (2018b) analyzes statewide imprisonment data in Massachusetts and finds a similar concentration of incarceration in Black neighborhoods with high levels of poverty. She also finds significant pockets of incarceration outside of major urban areas, in small towns. This latter finding is consistent with other recent reports of rising jail populations in small towns and rural areas (Vera Institute of Justice, 2017).

The spatial concentration of incarceration 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 disadvantaged communities that are themselves struggling to respond to COVID-19 without adequate health care and social support. Previous research has examined such disease transmission from incarceration to community and found high rates of sexually transmitted diseases and mortality in local communities with high incarceration rates (Kajeepta et al., 2020; Nowotny et al., 2020). One recent study has linked jail incarceration to COVID-19 case rates at the ZIP Code level in Chicago and across Illinois more broadly (Reinhart and Chen, 2020).

Correctional staff also provide a path for community transmission. In rural communities where many residents work in a local prison, the mechanisms for transmission from incarceration to community may be similar to those for incarcerated people who are cycling through local jails. As noted, staff move throughout a facility while at work, and they then return each day to their households and communities, potentially bringing the virus with them. With staff shortages due to illness, leaves, and vacancies, it can be difficult to implement consistent staff assignments that limit movement throughout the facility as advised by the U.S. Centers for Disease Control and Prevention (CDC) (CDC, 2020; CLA, 2020).

Health of Individuals in Prisons and Jails

Socioeconomic disadvantage, often compounded by life histories of substance use and untreated illness, form the social context for the poor health of the incarcerated population. Incarcerated people contend with high levels of chronic disease (Massoglia and Remster, 2019; Wildeman and Wang, 2017; Wildeman, Schnittker, and Turney, 2012): see Table 2-1. After controlling for other risk factors, incarcerated people have been found to have higher rates of many chronic conditions than the general population—including hypertension, asthma (Binswanger, Krueger, and Steiner, 2009; Maruschak, Berzofsky, and Unangst, 2016), and certain types of cancer (Binswanger, Krueger, and Steiner, 2009)—all of which are risk factors for COVID-19. Another risk factor is pregnancy: recent guidance from the CDC suggests that pregnant people might be at an increased risk of severe illness from COVID-19 compared to non-pregnant people.⁵ While systematic data are not available, Surfin and colleagues examined admissions to a geographically diverse sample of 22 state prison systems and the Federal Bureau of Prisons between 2016 and 2017 and found that an estimated 1,396 pregnant individuals were admitted (Surfin et al., 2019). An analysis of female admissions to a sample of six jails found that 1,622 individuals, or approximately 3 percent of all women admitted to the jails,

⁵See <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/pregnancy-breast-feeding.html>.

TABLE 2-1 Percentage of People Incarcerated in Prisons and Jails Who Have Ever Had a Chronic Condition, by Chronic Condition, 2011–2012

Chronic Condition	Prison Population (%)	General Population (%) ^a	Jail Population (%)	General Population (%) ^b
Cancer	3.5	-	3.6	-
High Blood Pressure/ Hypertension	30.2	18.1	26.3	-
Stroke-related Problems	1.8	0.7	2.3	13.9
Diabetes/High Blood Sugar	9	6.5	7.2	4.5
Heart-related Problems	9.8	2.9	10.4	1.9
Kidney-related Problems	6.1	-	6.7	-
Asthma	14.9	10.2	20.1	11.4

^aGeneral population estimates were standardized to match the prison population by age, sex, race, and Hispanic origin.

^bGeneral population estimates were standardized to match the jail population by age, sex, race, and Hispanic origin.

SOURCE: Adapted from Maruschak, Berzofsky, and Unangst (2016, pp. 3–4).

were pregnant (Surfin et al., 2020). Extrapolating this rate to the national female jail population, the authors conclude that as many as 55,000 pregnant individuals are admitted to jails annually (Surfin et al., 2020).

A recent study of COVID-19 patients at two Michigan hospitals illustrated the additional vulnerability of those entering from the prisons compared with those from the general public (Altibi et al., 2020). This study examined clinical outcomes and mortality among 706 COVID-19 patients (108 of them were from local prisons) from March 10 to May 10, 2020. Compared to the patients from the general public, they were more likely to arrive at the hospital with severe symptoms and markers of infection, such as tachypnea, hypoxemia, and elevated inflammatory markers. The higher clinical severity among incarcerated people could reflect late reporting of symptoms or a higher threshold for or difficulties referring COVID-19 patients from a correctional facility to the hospital than that from the community. Either way, these data indicate unique issues for managing COVID-19 in correctional facilities. Furthermore, compared with the patients from the general public, larger percentages of incarcerated individuals were admitted to the intensive care unit (27% vs. 19%), required vasopressors (24% vs. 10%), and required intubation (25% vs. 15%). The incarcerated individuals

were also at approximately twice the risk of death than other patients. In this study sample, the incarcerated individuals “were younger in age, predominantly males, and had higher prevalence of chronic obstructive pulmonary disease, diabetes mellitus, underlying malignancies, and [greater comorbidity burden]” (Altibi et al., 2020, p. 13).

The aging of the incarcerated population further increases the risk of COVID-19 complications in prisons and jails. Elderly people are a relatively small fraction of the incarcerated population but because of the increase in the length of stay in prison, their proportion has grown in the period of the prison boom. From 1993 to 2013, the proportion of the population over age 55 has grown from 3.1 to 9.9 percent (Carson and Sabol, 2016). Figure 2-1 compares the age distribution of the 2018 prison population to the U.S. general population in the 2010 census. By 2018, 13 percent of men in prison and 8 percent of women were over age 55.

There is also evidence of aging in the jail population. From 1996 to 2008, the number of people incarcerated in jail aged 55 or older increased by 278 percent, compared with a 53 percent increase in the overall jail population (Beck and Berzofsky, 2010; Darrell and Beck, 1997; Greene et

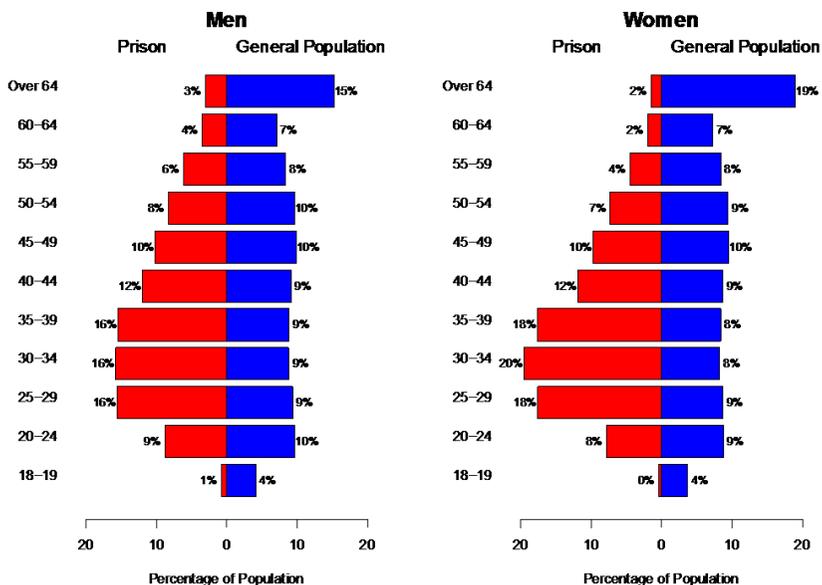


FIGURE 2-1 Age distribution of males and females held in state prisons in 2018 compared with the U.S. general population.

SOURCE: Data from Bureau of Justice Statistics (Carson, 2018) and 2018 population estimates from the U.S. Census Bureau.

al., 2018). An estimated 500,000 older adults are arrested and pass through jails each year (Snyder, 2012).

Correctional Health Care

All states have a constitutional obligation to provide adequate health care to incarcerated people. Regardless of size, facilities must provide means for incarcerated individuals to request medical care and be able to respond to emergencies (Rold, 2008). The nature of correctional health, and the extent to which medical care is provided on-site within the facility or off-site in the community, varies across facilities and correctional systems (NRC, 2014; Redemske, 2018). Since correctional health services fall outside of the public health infrastructure and few systems have voluntarily chosen to be accredited by existing bodies (e.g., National Commission on Correctional Health Care), the state and quality of care in correctional facilities across the nation is difficult to monitor (NRC, 2014; Rich, Allen, and Williams, 2015).

Most state prison systems handle routine medical and mental health services within the correctional facilities, and many also provide care for chronic conditions on site. Jails, which have smaller budgets and range in size, either directly employ medical staff, contract with an outside agency to provide on-site services, or partner with local public health professionals. However, incarcerated individuals are usually transported to community hospitals for emergency or specialized care (Chari et al., 2016). When incarcerated individuals are sent to local hospitals for medical care, they are accompanied by a corrections officer for security purposes (Smith, 2016).

Before the added health care demands of the pandemic, correctional health care services faced financial challenges. Recent figures indicated that health care costs accounted for up to 20 percent of correctional system budgets (Huh et al., 2017; Sridhar, Cornish, and Fazel, 2018), although per person spending varies dramatically across states. In addition to finances, other issues, such as security protocols, overcrowding, and workforce understaffing, can further limit the level of health care that a correctional system is able to provide. Delivery of care can be affected and at times constrained by security protocols (Redemske, 2018), and prison and jail overcrowding often overwhelms limited health care resources (for California, see *Brown v. Plata* 2010; Venters, 2019). Nonetheless, correctional health care often provides much needed medical attention to those who have been unable to seek care in their communities (NRC, 2014; Rich, Allen, and Williams, 2015).

During the COVID-19 pandemic, correctional health care providers have been asked to do even more—screening incarcerated persons and staff, administering tests on a regular basis, and responding quickly and safely to those with symptoms. While correctional health care tends to have access to emergency medical equipment to treat a few patients in

respiratory distress, widespread outbreaks can overwhelm the resources available in a facility. Facilities may lack enough emergency medical supplies to treat large numbers of incarcerated people, and understaffing complicates the ability to care for people in corrections as well as to transport them to outside hospitals for more intensive care (Williams et al., 2020). Moreover, some correctional systems rely on outside vendors or community health systems for SARS-CoV-2 diagnostic testing, and incarcerated people are not prioritized. Some facilities do not have sufficient budgetary resources needed for additional testing equipment or personal protective equipment. Many correctional health systems rely on paper medical records, which slows identification of those who are at high medical risk for COVID-19 (Goldstein, 2014; Williams et al., 2020). Furthermore, copayments required to seek medical care may deter some incarcerated people from reporting symptoms (Montoya-Barthelemy et al., 2020; Wyant and Harner, 2018).

The net result of these dynamics is that while correctional facilities are in a position to provide medical care to those incarcerated there are many challenges to doing so, even under normal operations. When COVID-19 outbreaks occur, many correctional facilities will likely turn to community-based health resources and hospitals for assistance and treatment of those infected, which in turn will further stress these community health systems during the pandemic.

THE SCOPE OF THE OUTBREAK

To accurately describe the full extent of the COVID-19 pandemic in correctional facilities is difficult given the large variability in testing practices, testing rates, and data reporting and transparency across the country. Comprehensive data on testing rates have not been available, and testing rates in both correctional facilities and the overall population have been uneven, with some facilities early in the pandemic testing no one or only symptomatic persons. For instance, testing rates can only be calculated for states that provide data relevant to the number of people tested, and only a handful of states provide such data. Other states only give data on the total number of tests completed, and others do not provide enough detail to interpret their testing numbers. The reporting of testing data has not been standardized, and testing efforts have been uneven, with some states engaging in robust mass testing and others testing very little. Community testing practices and data reporting were also variable, making comparisons all the more challenging.

The data we present here are from the COVID Prison Project (CPP), which scraped public-facing websites of correctional facilities for data on 53 prison systems (50 states, Puerto Rico, the Federal Bureau of Prisons, and ICE) and select jails with regular reporting. Research staff at CPP con-

firmed the quality of the data and their interpretation, and tracked how reporting changed daily. CPP relied on officially reported data from correctional systems, which may be subject to inaccuracies and reporting delays.

With these caveats, higher transmission rates in prison appear to be reflected in the COVID-19 case rates among incarcerated people and staff compared to the general population: see Figure 2-2. (The case rate is the number of people testing positive for the SARS-CoV-2 virus that causes COVID-19 divided by the total population in question, such as the prison population, the staff population, or the general population.) At the end of April 2020, people incarcerated in prisons and prison staff had similar case rates. During the first week of May, as testing increased after multiple outbreaks, case rates among people incarcerated in prisons began to grow at much higher rates relative to staff. While we are unable to appropriately adjust for testing in prison and in the community with the available data, the cumulative case rate among incarcerated persons was about five times higher than in the general population by the end of August 2020, and the rate for staff was about three times higher. Similar incarceration-community differences have also been reported for Massachusetts and at the national level (Jiménez et al., 2020; Saloner et al., 2020).

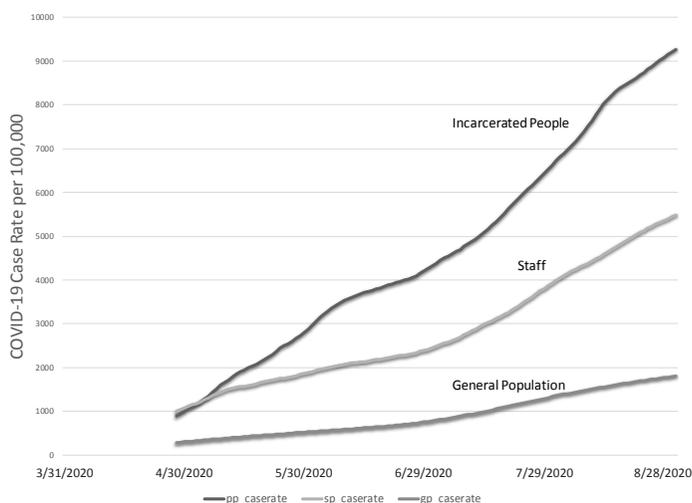


FIGURE 2-2 COVID-19 case rate by August 31, 2020, for incarcerated populations of state and federal prisons and their staff in comparison with the general population, 7-day moving average.

NOTES: Case rates: pp, incarcerated people; sp, staff; gp, general population. Testing capabilities and frequency vary across states and facilities.

SOURCE: Data from COVID Prison Project (2020).

As of August 31, 2020, there is large variation in case rates across state jurisdictions: see Figure 2-3 and Table 2-2.⁶ Compared to a national case rate in the general population of under 2 percent, the highest COVID-19

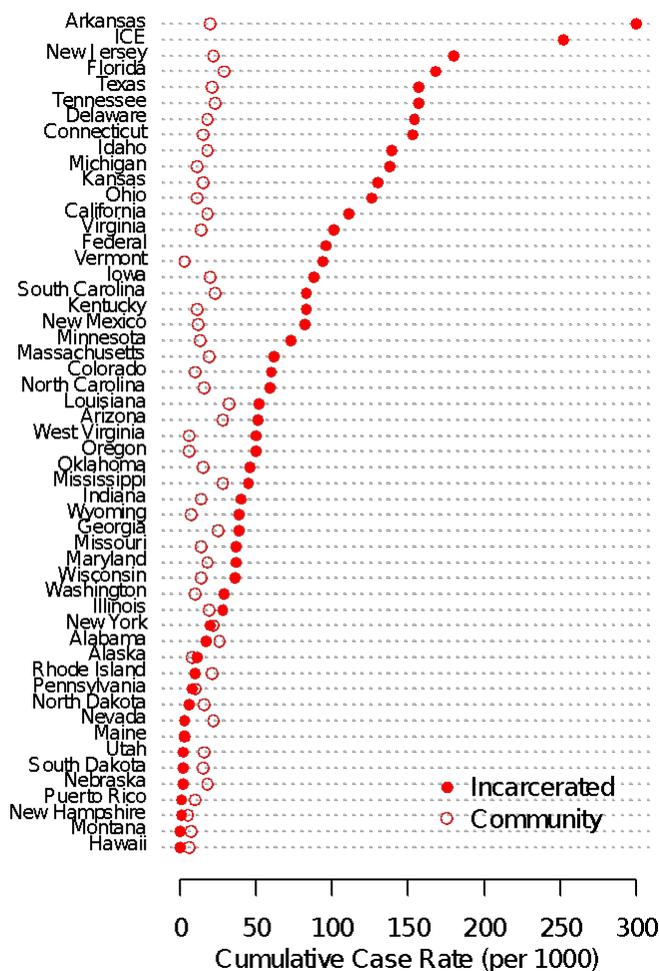


FIGURE 2-3 Cumulative COVID-19 case rates by August 31, 2020, in state and federal prisons and ICE detention, compared with cumulative COVID-19 case rates in the general population, by state.

NOTE: Testing capabilities and frequency vary across states and facilities.

SOURCE: Data from COVID Prison Project (2020).

⁶For the state data, we examined whether the cumulative rate was related to the extent of testing, but the correlation between the case rate and the testing rate was not significant and only modestly positive, $r = 0.26$.

case rate in prisons was found in Arkansas, where 30 percent of the prison population tested positive. During this time, Arkansas used molecular testing for COVID-19 and underwent mass testing in facilities that were in outbreak status. Another seven states reported case rates of around 15 percent or higher. A few state correctional systems (Alaska, Hawaii, Montana, Nebraska, Nevada, Maine, and Vermont) kept infection levels below 10 per 100,000. Among larger states, only Pennsylvania kept infection at a similarly low level. Pennsylvania used molecular testing for COVID-19 and has also engaged in mass testing across many facilities. Like the national figures, we have not adjusted for differences in testing between prison and community at the state level. Improving the quality and availability of data on COVID-19 testing and cases, as well as information on facilities' mitigation strategies, is a significant research priority for understanding the different outcomes across correctional facilities during the pandemic.

TABLE 2-2 COVID-19 Cumulative Prevalence, Test Positivity Rate, and Mortality Rate of Incarcerated People, by State and Federal Jurisdiction, as of August 31, 2020

Jurisdiction	Cumulative Prevalence (per 1,000)	Test Positivity Rate (%)	Mortality Rate (per 10,000)	Case Fatality Rate (%)
BOP	96	24.99	9	0.96
ICE	252	20.01	2	0.09
Alabama	17	21.56	10	5.85
Alaska	11	1.06	-	-
Arizona	51	9.55	7	1.35
Arkansas	300	32.17	-	-
California	111	12.20	6	0.54
Colorado	60	3.02	2	0.34
Connecticut	153	-	7	0.47
Delaware	154	-	29	1.89
Florida	168	19.77	10	0.57
Georgia	39	-	11	2.76
Hawaii	0	1.06	0	0.00
Idaho	139	19.96	2	0.16
Illinois	28	-	4	1.44
Indiana	40	26.19	8	2.06
Iowa	88	6.78	4	0.46
Kansas	130	-	4	0.28

continued

TABLE 2-2 Continued

Jurisdiction	Cumulative Prevalence (per 1,000)	Test Positivity Rate (%)	Mortality Rate (per 10,000)	Case Fatality Rate (%)
Kentucky	83	-	11	1.37
Louisiana	52	29.37	8	1.51
Maine	3	0.29	-	-
Maryland	37	3.53	4	1.01
Massachusetts	62	5.00	11	1.85
Michigan	138	13.59	19	1.35
Minnesota	73	1.62	3	0.36
Mississippi	45	34.97	1	0.19
Missouri	37	3.52	0	0.11
Montana	0	0.09	-	-
Nebraska	2	1.15	-	-
Nevada	3	-	-	-
New Hampshire	1	1.32	-	-
New Jersey	180	23.06	30	1.66
New Mexico	82	4.32	6	0.78
New York	20	8.83	5	2.25
North Carolina	59	5.61	3	0.54
North Dakota	6	-	0	0.00
Ohio	126	23.53	19	1.53
Oklahoma	46	8.17	-	-
Oregon	50	19.43	3	0.70
Pennsylvania	8	2.76	3	3.61
Puerto Rico	1	-	1	14.29
Rhode Island	10	1.37	-	-
South Carolina	83	-	2	0.27
South Dakota	2	2.58	0	0.00
Tennessee	157	13.99	4	0.26
Texas	157	10.64	14	0.87
Utah	2	1.14	0	0.00
Vermont	94	8.10	-	-
Virginia	101	-	5	0.52
Washington	29	9.99	1	0.45
West Virginia	50	4.33	0	0.00
Wisconsin	36	2.50	-	-
Wyoming	39	3.30	-	-

NOTES: BOP, Federal Bureau of Prisons; ICE, U.S. Immigration and Customs Enforcement. Testing capabilities and frequency vary across states and facilities.

SOURCE: Data from COVID Prison Project (2020).

Similar data on the crude case rates of COVID-19 infection among prison staff are available for nearly all states: see Table 2-3. States with high rates of COVID-19 infection among the incarcerated population have tended to have high rates of COVID-19 infection among staff; this includes jurisdictions such as Texas, New Jersey, and Florida. Across all 50 jurisdictions for which data are available (including Puerto Rico, the federal system, and ICE detention), the staff infection rate correlates at $r = 0.5$ with the infection rate for the incarcerated population. By this measure, the health of prison staff is closely related to the well-being of the incarcerated population (COVID Prison Project, 2020).

TABLE 2-3 COVID-19 Cumulative Prevalence and Mortality Rate for Correctional Staff by State and Federal Jurisdiction, as of August 31, 2020

Jurisdiction	Cumulative Prevalence (Per 1,000)	Mortality Rate (Per 10,000)
BOP	41	0
ICE	-	-
Alabama	103	6
Alaska	0	-
Arizona	71	-
Arkansas	86	-
California	47	2
Colorado	21	-
Connecticut	63	-
Delaware	80	-
Florida	101	-
Georgia	85	2
Hawaii	-	-
Idaho	46	-
Illinois	51	-
Indiana	63	3
Iowa	43	-
Kansas	53	8
Kentucky	52	3
Louisiana	102	13

continued

TABLE 2-3 Continued

Jurisdiction	Cumulative Prevalence (Per 1,000)	Mortality Rate (Per 10,000)
Maine	0	-
Maryland	54	1
Massachusetts	21	-
Michigan	34	2
Minnesota	26	0
Mississippi	40	-
Missouri	27	0
Montana	2	-
Nebraska	26	-
Nevada	40	4
New Hampshire	8	-
New Jersey	122	-
New Mexico	2	0
New York	69	3
North Carolina	4	1
North Dakota	28	0
Ohio	86	4
Oklahoma	29	-
Oregon	42	-
Pennsylvania	16	1
Puerto Rico	4	-
Rhode Island	16	-
South Carolina	77	2
South Dakota	12	0
Tennessee	55	2
Texas	147	7
Utah	2	-
Vermont	21	-
Virginia	7	-
Washington	97	7
West Virginia	20	0
Wisconsin	18	-
Wyoming	20	-

NOTES: BOP, Federal Bureau of Prisons; ICE, U.S. Immigration and Customs Enforcement. Testing capabilities and frequency vary across states and facilities.

SOURCE: Data from COVID Prison Project, 2020.

Data on COVID-19 infections in jails are more limited than the comparable data for prisons. Each individual jail has made its own decisions about whether to test for COVID-19 and the collection and reporting of data on COVID-19 testing, infection rates, and deaths. Data on county and jail cumulative case rates are reported by CPP. From the limited information on cases in 41 jails, there is a correlation between the size of the jail population and the COVID-19 case rate per 1,000 ($r = 0.41$, $p = 0.008$). The five largest jails in the CPP dataset are in Los Angeles County, Harris County, Dallas County, Cook County, and Maricopa County. Each of these large jails has a higher reported case rate relative to the surrounding county, although this difference varies from 7 to 343 per 1,000. Overall, data from the available jails show a similar pattern to prisons, where COVID-19 crude case rates are often higher than in the surrounding county (see Figure 2-4).



FIGURE 2-4 COVID-19 cumulative case rate in selected county jails compared with county cumulative case rates.

NOTE: Testing capabilities and frequency vary across counties and facilities.

SOURCE: Data from COVID Prison Project (2020).

Data on COVID-19 infection in ICE facilities are also reported less consistently relative to prison data. Based on available data, there appears to be a high level of COVID-19 infection in ICE facilities. The cumulative case rate indicates that nearly a quarter of all immigration detainees had tested positive as of August 31, 2020. This case rate is more than three times higher than the average case rate in state prison systems.

Another indicator of the extent of the pandemic in correctional facilities is given by the death rate. The adjusted COVID-19–related death rate in the prison population was three times higher than would be expected if the age and sex distributions of the U.S. and prison populations were equal (Saloner et al., 2020). By the end of September 2020, there were 1,170 reported deaths among people in prison or ICE detention as a result of COVID-19 and 83 reported COVID-19–related deaths among prison staff across 19 prison systems (COVID Prison Project, 2020; UCLA Law COVID Behind Bars Data Project⁷). The highest staff mortality rate has been reported by Louisiana, although Texas has reported the highest number of deaths. However, there is much unknown about deaths among staff and incarcerated people. Most states do not report demographic information, the circumstances that led to death, or where the death occurred. For instance, when someone dies in the hospital versus in the correctional facility, it is unclear how this death is counted. In addition, there are no available data tracking the number of excess deaths that could be attributed to avoiding care within correctional facilities.

Notably, there is also no systematic collection of data on racial and ethnic differences in the COVID-19 case rates, testing, or deaths in jails and prisons and among released cohorts. Only four states—Vermont, Tennessee, Massachusetts, and Washington—are proactively reporting any demographic data on their COVID-19 testing or case counts among incarcerated people. As COVID-19 cases among incarcerated people continue to climb, racial and ethnic differences in disease prevalence remain unclear (see, e.g., Guo, 2020). See Chapter 5 for a detailed discussion of data and research needs.

Given the movement of those incarcerated as well as staff between correctional facilities and local communities, the committee believes the COVID-19 risk in communities may be tied to the COVID-19 risk in correctional facilities. Drawing from past research on transmission of infectious diseases, transmission from correctional facilities may be spatially concentrated in the small number of communities from which prison and jail populations are disproportionately drawn (Ndeffo-Mbah et al., 2018). Few studies have examined COVID-19 disease transmission dynamics be-

⁷See <https://law.ucla.edu/academics/centers/criminal-justice-program/ucla-covid-19-behind-bars-data-project>.

tween communities and correctional facilities, although one paper on a Cook County Jail in Chicago, Illinois, reports that jail population churn was a significant predictor of COVID-19 cases at the ZIP Code level, accounting for 55 percent of the variance across ZIP Codes in Chicago and 37 percent of the variance in all of Illinois. Moreover, jail population turnover was the most significant predictor of variance in COVID-19 infection, exceeding race, poverty, public transit use, and population density (Reinhart and Chen, 2020).

Although the data limitations are formidable, the available figures reported by public health authorities and penal facilities have three main implications: (1) there is great heterogeneity in COVID-19 case rates across states; (2) in some jurisdictions, the extent of infection among the incarcerated population appears to be significantly greater than that in the community; and (3) better data on testing and methods are needed in order to accurately monitor the relative risk of incarcerated populations compared with the general population.

MITIGATING TRANSMISSION IN CORRECTIONAL FACILITIES

There have to date been very few studies on how to best mitigate COVID-19 transmission in correctional facilities, although a number of papers have examined similar settings, such as homeless shelters, or how prisons have managed highly infectious respiratory diseases in the past (Beaudry et al., 2020; Mosites et al., 2020). A recent systematic review (Beaudry et al., 2020) identifies nine main themes for managing past infectious disease outbreaks in correctional settings, which are relevant to the COVID-19 pandemic: multi-agency collaboration, health communication, screening for contagious diseases, isolation and quarantine, contact tracing, immunization programs, surveillance, prison-specific guidelines, and population restriction. We discuss some these strategies in greater detail in Chapter 5. The review also identifies depopulation as an important strategy (part of population restriction) to be considered as part of pandemic management.

In one of the few studies of a COVID-19 outbreak in a penal facility, Malloy and colleagues (2020) analyze data from a large urban jail system to estimate the effect of certain mitigation strategies in reducing COVID-19 transmission during an ongoing outbreak. The authors draw upon data provided by the jail during a large outbreak on the infection rates of incarcerated people and staff, as well as drawing point-estimate ranges of parameters from extant research (Puglisi et al., 2020). Using a calibrated SEIR model (see above), they estimate R_e at this particular local facility during four phases coinciding with differences in facility policy. These phases included (1) the start of the pandemic, (2) a period following a reduction in the jail popula-

tion following a decline in admissions, (3) a period following the greater use of single-celling to house incarcerated people, and (4) a period after the jail began to implement testing for asymptomatic infection. During phase 2 (days 12–17), the jail population started to decrease by 1.41 percent each day through a combination of measures that included a marked decrease in new detentions given changes in the court and judicial system procedures and large community organized bail payments. During phase 3 (days 18–36), the jail began increasing the portion of the population in single-occupancy cells from 26 percent on day 18 to 54 percent on day 36; and during phase 4, asymptomatic testing began and 18 percent of the reported daily incidence of positive COVID-19 tests among the incarcerated population was asymptomatic.

The authors estimate that between the start of the pandemic and the final period corresponding to the implementation of the four policy options, in addition to CDC recommendations that included masking, staff training, and sanitary procedures, R_e declined from the high level of 8.23 to only 0.45. Depopulation enabled the jail to move nearly 70 percent of residents in single cells, rather than the 5 percent at the beginning of the outbreak, which reduced infections and hospitalizations by more than 60 percent. Another observational study of Massachusetts jails and prisons supports that depopulation is associated with lower facility case rates and found that facilities with smaller reductions in incarcerated populations demonstrated higher rates of confirmed cases (Jiménez et al., 2020).

Recent research has also explored how correctional facility characteristics, specifically facility capacity and staffing, influence COVID-19 transmission and deaths. Vest and colleagues used data from 103 state prisons of the Texas Department of Corrections to identify “latent class profiles,” or groups of facilities which are similar based on the outcomes of incarcerated resident COVID-19 cases, staff COVID-19 cases, and incarcerated resident COVID-19 deaths. Three distinct groups of Texas prisons were identified: a low outbreak profile, a high outbreak profile, and a high death profile. Low outbreak prisons were, on average, at 85 percent of capacity, while the high death and high outbreak profiles averaged 94 percent and 102 percent capacity, respectively. In addition, the current number of employees significantly predicted membership in the high outbreak and high death profiles compared to the low outbreak profile. Age of operation for a prison was no different among the three profiles. Vest et al. (2020) conclude that housing persons at 85 percent of prison capacity may reduce the risk of infection and death related to COVID-19.

While limited in scope, these studies suggest that decarceration may facilitate other important prevention and mitigation strategies, especially single-celling, and cohorting, where confirmed COVID-19 cases are housed together and isolated. The legal, epidemiological, and ethical arguments for decarceration are described in Box 2-2.

BOX 2-2**Ethical, Epidemiological, and Legal Arguments
for Virus Mitigation through Decarceration**

Strassle and Berkman (2020, p. 3) point out that “ethical, epidemiological, and legal arguments all point to a need for an immediate reduction in the incarcerated population”:

- **Ethical arguments**—As a matter of supporting every individual’s right to health, governments have an ethical responsibility “to protect individuals who have been deprived of the liberty to protect themselves” (Strassle and Berkman, 2020, p. 4). Furthermore, many societies have a strong sense of duty to protect their most vulnerable populations in a public health crisis (World Health Organization, 2017).
- **Epidemiological and public health arguments**—Penal conditions and the vulnerabilities of incarcerated people have important implications for public health. The high rates of admission and release and overcrowding in facilities that are often inadequately ventilated exacerbate virus transmission. Incarcerated people are in relatively poor health, disproportionately burdened by chronic conditions, and more susceptible to severe complications if infected. Furthermore, admissions and releases from jails and prisons are spatially concentrated in low-income communities of color that are often vulnerable to health risks. Reducing the spread of the virus among incarcerated populations and associated communities will help preserve limited health care resources in both settings.
- **Legal arguments**—There is “legal precedent which suggests that incarcerated people have a right to protection from infectious diseases” (Strassle and Berkman, 2020, p. 4). Continued incarceration during a pandemic will expose people sentenced only to the deprivation of liberty to a heightened risk of dying prematurely. There is a strong constitutional imperative to take steps to reduce this risk. Both the Eighth Amendment prohibition on cruel and unusual punishment and the Due Process Clause forbid state officials from incarcerating people “in unsafe conditions” (*Youngberg v. Romeo*, 457 U.S. 307 [1982]). Indeed, the Constitution imposes an affirmative duty on corrections officials to ensure the health and safety of the people society incarcerates (*Farmer v. Brennan*, 511 U.S. 825, 832-33 [1994]). This duty arises “from the limitation which [the State] has imposed on [the detained individual’s] freedom to act on his own behalf” (*DeShaney v. Winnebago County Department of Social Services*, 489 U.S. 189 [1989]). As Chief Justice Rehnquist explained in *DeShaney v. Winnebago County*, “when the State takes a person into its custody and holds him

continued

BOX 2-2 Continued

there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being” (*DeShaney v. Winnebago County Department of Social Services*, 489 U.S. 189 [1989]). The state’s obligation, in other words, arises from the total dependence of those incarcerated on prison officials, a function of the government’s own decision to incarcerate people under conditions depriving them of the capacity to protect themselves (Dolovich, 2019, p. 138). If people are exposed to danger while they are in custody, the state must provide for their safety, since “if the authorities fail to do so, th[is] need will not be met” (*Estelle v. Gamble*, 429 U.S. 97 [1976]).

Failing to take available steps to protect people in custody from the threat of COVID-19, especially those at highest risk of complications from the virus, “may actually produce physical torture or a lingering death, the evils of most immediate concern to the drafters of the [Bill of Rights]” (*Estelle v. Gamble*, 429 U.S. 97 [1976]).

CONCLUSION

This chapter has reviewed five features of the correctional system that limit the ability of jails and prisons to protect those incarcerated and correctional staff during the pandemic and likely amplify virus transmission within these settings and to local communities. These features include high rates of admissions and releases (particularly in jails), overcrowding (particularly in older facilities), the spatial concentration of incarceration predominantly in low-income communities of color, the health vulnerabilities of the incarcerated population, and the underresourced correctional health system. While the data from jails, prisons, and other facilities are far from complete, the available information points to cumulative COVID-19 cases and mortality rates among incarcerated people that are significantly higher than in the general population.

Prison and jail staff also have experienced substantially higher rates of COVID-19 infection relative to surrounding communities. These rates coupled with the current conditions of most correctional facilities create significant demands on correctional staff and correctional and community health resources. Emerging research suggests that decarceration can be an effective strategy for mitigating transmission inside correctional facilities. Decarceration is likely to reduce the impacts of overcrowding, facilitate other mitigation strategies (e.g., physical distancing, quarantines), and reduce demands on limited health care resources. The next chapter reviews existing legal mechanisms for decarceration and efforts made by jurisdictions to depopulate jails and prisons during the pandemic.

3

Considerations for Decarceration

A selective draw-down of correctional populations raises the obvious question of which individuals should be either released or diverted from prisons and jails and what criteria should be used to make those decisions. The COVID-19 pandemic illustrates that the harms of incarceration also include diminished public health. At the same time, there are cases of incarceration where the immediate impact on public safety may be small to negligible—such as those incarcerated due to failure to pay small amounts of bail, due to a technical or parole revocation, or imprisonment of the elderly or medically compromised—even as continued incarceration exposes the incarcerated person to a heightened risk of COVID-19–related sickness and death.

In order to reconcile public safety and public health considerations, in this chapter the committee argues that, in light of the current public health crisis, a more inclusive assessment of the impacts of incarceration on society is needed. To this end, the chapter first reviews research on recidivism and the effects of incapacitation through incarceration on crime. It then outlines legal mechanisms for decarceration, through diversion and release. Finally, the chapter reviews efforts made by prisons and jails to depopulate since the start of the pandemic, cataloguing an inability to meet the crisis brought on by the COVID-19 pandemic.

BALANCING PUBLIC SAFETY AND PUBLIC HEALTH

There are several candidate criteria for identifying which individuals should be released or diverted. One might prioritize releasing and divert-

ing incarcerated individuals for whom the risk of death and serious illness associated with contracting COVID-19 is relatively high. While a small proportion of incarcerated individuals are in the high-risk age range,¹ incarcerated individuals in the nation's prisons and jails are less healthy on average than the general population, with a high age-adjusted prevalence of conditions that elevate the COVID-19 mortality risk, such as asthma, diabetes, and cardiovascular disease (Skarupski et al., 2018; see also Chapter 2). Moreover, there is evidence of premature aging of people living in prisons and jails and of the early onset of age-related cognitive impairment and other age-related health problems (Ahalt et al., 2018; Greene et al., 2018). Hence, despite the younger average age of the incarcerated population, the high prevalence of comorbid conditions that are likely to enhance the risk of serious COVID-19–related complications implies that age-based infection mortality rates for people living in prisons and jails may differ from those of the general public. To the extent that correctional administrators prioritize reducing mortality and health equity within institutions, such preexisting conditions that increase vulnerability may provide key considerations.

Beyond health conditions, correctional authorities will certainly be concerned with the impact on public safety of reducing their institutional populations. Research on recidivism reveals that a large proportion of individuals released from prison² are subsequently rearrested, with many being returned to prison custody. A substantial portion of these arrests and returns to custody are for technical violations and relatively less serious offenses (Alper, Durose, and Markman, 2018; Carson, 2020). In some instances, however, individuals released from prison subsequently commit serious offenses. This is also true in some instances when individuals are released from jail either due to time served or a pretrial release.

Overall, there is great heterogeneity among incarcerated people and their likelihood of future serious offending, and there have been recent reductions in correctional populations in the United States that have not caused a measurable increase in serious violent crime (see below and Appendix A). Moreover, steps can be taken to reduce recidivism risks through reentry planning and the provision of supports, especially during the first few weeks following release, when both the recidivism risk and the mortality risk are particularly high. Appendix A provides a detailed discussion of

¹Carson and Sabol (2016) document that while the U.S. prison population has aged since 1993, the proportion over 65 years of age is relatively small. Specifically, the authors estimate that 2.2 percent of people prison in 2013 were over age 65. For comparison, roughly 16 percent of the U.S. population is 65 or older.

²Much of the research exploring recidivism focuses on individuals sentenced to prison. Most individual admitted to jail are not ultimately sentenced to prison, with a large percentage of them released within a few days of booking and prior to the adjudication of their cases.

what is known about the recidivism rates of incarcerated individuals from national studies: the evidence indicates that correctional authorities can use information at hand to identify individuals at high risk of recidivism and potential factors that might mitigate that risk through supportive reentry planning. This section briefly discusses the predictability of recidivism rates and key implications of that literature for the current pandemic.

Predictability of Recidivism

The likelihood of recidivism varies greatly among people who are incarcerated. Moreover, recidivism risk changes over the life course. For example, one of the strongest empirical regularities in criminology is the large reduction in the likelihood of criminal justice involvement with age, even among individuals with lengthy criminal histories (Gottfredson and Hirschi, 1990; Laub and Sampson, 2003). Moreover, recidivism risk varies considerably with time since release, being particularly high in the first few weeks following release (as is also the case for health outcomes, including drug overdoses and death) and declining thereafter.

A report by the National Research Council (NRC, 2008) summarizes the factors correlated with the likelihood of subsequent criminal justice involvement after release from incarceration. Many of these factors are static, in that they are part of someone's past and cannot be altered, while other factors are dynamic in that they can change and can decrease the risk of recidivism by careful reentry planning and service provision. Among the static factors, individuals released from their first term of incarceration have lower recidivism rates, as do individuals with less lengthy criminal histories and individuals who are older. The content of one's criminal history—the current conviction offense as well as what one has been convicted of in the past—also has some predictive power. With respect to dynamic factors, they include substance use disorders, extreme material deprivation, homelessness, and antisocial thoughts and beliefs. Since these factors are changeable, such services as income support, housing assistance, substance use treatment, and cognitive-behavioral therapy can lower the recidivism risk for many and are particularly important during the transition period within the first few months of release (NRC, 2008). For released people with severe mental illness, planning for continuity in mental health care is also likely to be important for avoiding adverse outcomes upon release (see, e.g., Theurer and Lovell, 2008).

Another line of research relevant for jail depopulation in the context of the pandemic finds, in different ways, that pretrial detention is often poorly calibrated to the risk to public safety. Research on risk assessment finds that it is possible to release some groups of the jail population with no effect on later arrests or failure to appear in court. For example, analyzing New York court

data, Kleinberg and colleagues (2018) report that 41 percent of the pretrial detention population could be released with no increase in crime. Indeed, risk instruments have been used in an effort to reduce pretrial populations (Viljoen et al., 2019). Research on racial disparity point to relatively high rates of incarceration among Black (and low-income) defendants, which may in part be due to an inability to pay bail (Demuth, 2003; Schlesinger, 2005; Wooldredge et al., 2015), and racial bias in detention decisions (Arnold, Dobbie, and Yang, 2018; Spohn, 2009). The findings suggest that Black defendants are often over-incarcerated relative to their risk to public safety, and they could be released with no greater risk than similar White defendants. Research exploiting the random assignment of judges, along with other natural experiments, finds that pretrial detention for low-level offenses is often causally related to continuing criminal justice involvement. Studies find that pretrial detention is associated with criminal conviction, longer sentences, and imprisonment (Dobbie, Goldin, and Yang, 2018; Heaton, Mayson, and Stevenson, 2017; Stevenson, 2018), and related work finds that pretrial detainees are more likely to later be rearrested (Leslie and Pope, 2017). Under pandemic conditions, ongoing court involvement and incarceration is associated with greater exposure to infection. Taken together, evidence for the overuse of pretrial incarceration for low-risk defendants and extra-legal disparities by race and economic status suggest that reductions in the jail population are possible with little negative effect on crime.

An issue particularly relevant to criteria for decarceration during COVID-19 is that individuals who are at high-risk for COVID-related complications and mortality due to advanced age and comorbid health conditions tend to be serving long prison sentences for a serious violent offense. Releasing individuals convicted of serious violent offenses is often politically fraught. Such releases may be viewed as undermining the retributive purpose of the sentence and may turn public opinion against policy makers in cases of reoffending. Hence, policy reform discussions and even policy design often exclude individuals convicted of violent offenses from consideration, regardless of objective assessment of the risk posed by such individuals.

This exclusion in the policy reform discussions poses specific challenges to release policies that prioritize individuals at high medical risk during COVID-19. Research on how recidivism varies by conviction can inform this discussion. Prescott, Pyle, and Starr (2020) review research on recidivism rates for individuals convicted of violent crimes and how they compare to people convicted of nonviolent crimes. The authors also present new analysis of data from the National Corrections Reporting Program (NCRP). The review of past research generally finds individuals in prison convicted of violent offenses, including those convicted of murder, consistently have lower recidivism rates relative to individuals convicted of

nonviolent offenses. In their analysis of NCRP data, the authors find that individuals convicted of murder are somewhat more likely to be returned to prison custody for a new murder relative to otherwise comparable releases, though the recidivism rate for this crime for all individuals is low. Interestingly, the authors find that people convicted of violent offenses have lower overall recidivism rates for all age groups compared with individuals convicted of nonviolent offenses, though the recidivism rates are particularly lower for people 55 and over.

Research also indicates that the prison population in some states can be drawn down quickly by limiting returns to custody for technical parole violations. The 2011 experience in California can prove instructive in this regard. Reforms to parole practice caused a sharp and permanent decline in prison admissions, from roughly 2,200 a week to roughly 500 a week. Interestingly, releases, which also hovered at around 2,200 a week prior to the reform, also dropped to match the lower level of weekly admissions, although with a lag (Lofstrom and Raphael, 2016). The effect of the permanent and sharp decline in admissions together with the lagged alignment of releases was a decline in the prison population by nearly one-fifth and much smaller flows of individuals into and out of the state's prisons. There is no evidence of an impact of this change on violent crime, although there is some evidence of a relatively small effect on property crime (Lofstrom and Raphael, 2016).

Sustained declines in crime and incarceration have been observed in other cities and states over the past two decades. In New York City, the incarceration rate declined by 55 percent from 1996 to 2014 while violent crime fell in this period 54 percent (Greene and Schiraldi, 2016). Similar trends can be seen in Michigan, where the prison population declined by 20 percent from 2006 to 2016, with corresponding declines in both violent (-19%) and property (-41%) crimes (Schrantz, DeBor, and Mauer, 2018). Connecticut, Mississippi, New York, New Jersey, Rhode Island, and South Carolina achieved similar prison population reductions and also experienced falls in crime rates (Mauer and Ghandnoosh, 2015; Schrantz, DeBor, and Mauer, 2018). Although causality is difficult to disentangle, these states' experiences suggest that incarceration can be reduced without necessarily increasing crime.

Implications of Recidivism Evidence for Responding to COVID-19

Recidivism research suggests that there is substantial heterogeneity among incarcerated people and that correctional authorities could decarcerate in a number of ways that would minimize public safety risk if given the flexibility to do so. Such flexibility could include diverting from jail, releasing incarcerated people most at risk for COVID-19 complications

and mortality, and limiting return to custody for technical parole and probation violations. Like release, diversion based on considerations of future offending will inevitably result in cases of individuals who are released committing new crimes, as well as cases where individuals who would not reoffend are either not diverted or not released. That there is harm in both directions is often a point that is lost in public discussions of public safety. In the context of a public health crisis and the need to create the capacity to implement physical distancing protocols and not overwhelm correctional medical facilities, correctional authorities will need to use all the available information to devise population reduction strategies across jails and prisons that minimize the likely impacts on crime rates.

PRISON AND JAIL DEPOPULATION IN 2020

Prisons, jails, and immigration detention facilities have all experienced declines in population during the COVID-19 pandemic. A national overview of the decline in incarceration since the onset of the pandemic is provided by Franco-Paredes and colleagues (2020). Based on their own compilation and data from the Vera Institute of Justice, they find that the incarcerated population declined by about 250,000 from the pre-pandemic period to July/August 2020, a decline of more than 10 percent of the total incarcerated population. Jails contributed nearly two-thirds to the total decline in incarceration, and jail populations fell by more than 20 percent. State prisons also registered population decline, but of less than 5 percent³ (see Table 3-1).

There are two ways to reduce the population of jails and prisons: by diverting from custody people who would otherwise be incarcerated and by releasing those already incarcerated. Since the start of the pandemic, public officials across the country have pursued both strategies. This section outlines some of the approaches that have been used to reduce the number of people in custody in both prisons and jails through diversion and release efforts. The discussion here represents only a sampling of the efforts under way; given the many initiatives being undertaken in real time at the federal, state, and local levels, it is impossible to be comprehensive. The aim of this review is twofold: to emphasize the range of pathways to decarceration

³The committee notes, however, that total declines in system-wide populations by themselves may contribute little to mitigating the spread of the virus. For example, if the state of Pennsylvania incarcerated 100,000 people in January 2020 and released 20,000 in March 2020, the incarcerated population in Pennsylvania would have declined by 20 percent. However, if the state achieved that population decline by closing two facilities that housed 10,000 individuals each and did nothing to affect the population size of the remaining facilities in its system, the remaining incarcerated individuals would remain at the same risk as they were prior to the 20 percent reduction, if nothing else was changed.

TABLE 3-1 Reductions in Incarcerated Populations from the Pre-Pandemic Period to mid-2020

Jurisdiction	Period	Pre-Pandemic	In Pandemic	Population Decline	Percent Decline
State Prisons	Dec. 31, 2019–May 1, 2020	1,260,393	1,207,710	52,683	4.2
Federal Prisons	March 5, 2020–August 13, 2020	175,315	156,968	18,347	10.5
Jails	Dec. 31, 2018–July 22, 2020	738,400	575,952	162,448	22.0
Immigration (ICE)	March 20, 2020–Aug. 8, 2020	37,888	21,118	16,770	44.3
Total		2,211,996	1,961,748	250,248	11.3

NOTE: ICE, U.S. Immigration and Customs Enforcement.

SOURCE: Adapted from Franco-Paredes et al. (2020, p. 2). Reprinted from *The Lancet*, September 29, 2020, Franco-Paredes et al., Decarceration and community re-entry in the COVID-19 era, p. 2, 2020, with permission from Elsevier.

and to identify obstacles that may prevent officials from undertaking more far-reaching decarceration efforts.

Despite the constraints of current law and criminal justice policy, prisons and jails across the country experienced population declines as the pandemic spread. The COVID-19 crisis in correctional facilities was acute, but these population reductions likely improved the health environments inside penal facilities. How large were they, and how were they achieved?

Diversification from Jail

In early 2020, as the risk of viral spread in crowded facilities became clear, local officials around the country took steps to reduce the number of people housed in and churning through their jails.⁴ In East Baton Rouge, Louisiana, and Fort Worth, Texas, for example, law enforcement officers stopped arresting people for most misdemeanors and, instead, issued citations for low-level offenses (D'Angelo, 2020; Skene, 2020). In Racine County, Wisconsin, the sheriff's office restricted admission to the jail to

⁴During this same period, some state prison systems also halted or limited intake (e.g., Wisconsin; see https://madison.com/wsj/news/local/crime-and-courts/wisconsin-gov-tony-overs-halting-prison-admissions-to-prevent-covid/article_032e01f1-931c-5347-9e96-b9dd2894248a.html). But because the people affected were bound for state prison, these efforts merely created a backlog in county jails. It is therefore only diversionary efforts at the local level, which prevent the intake of new arrivals into jails, that would reduce population density in carceral facilities as a whole.

those individuals suspected of violent crimes (Mauk, 2020). In Maine, the chiefs of the state's superior and district courts issued an order vacating more than 12,000 outstanding warrants for failure to appear or any unpaid fines or fees (State of Maine, 2020), and in South Carolina, the state supreme court directed courts not to issue bench warrants for failure to appear and to release without bond anyone charged with a noncapital crime (Chief Justice Beatty, 2020).

While fine-grained correctional data for the first 8 months of 2020 are not systematically available, several new data collection efforts help illuminate recent trends. The Jail Data Initiative (JDI) at New York University's Public Safety Lab has collected publicly available jail counts each day at the county level by scraping public databases. As of September 2020, the data file included populations in 1,034 jails across the country. Several large jurisdictions, such as New York City, Los Angeles County, and Cook County, Illinois, are missing from the data collection in the critical period through the first half of 2020. Despite these limitations, the data provide a broad overview of jail trends in the first months of the pandemic.

Using these data, the committee examined jail populations in all counties for which data had been reported as of March 15, 2020, and July 31, 2020—a total of 553 local jurisdictions. These counties accounted for 145,000 incarcerated people, about 19 percent of the midyear jail population in 2019. Figure 3-1 shows the jail population plotted on the log scale on July 31 against that on March 15. Almost 88 percent of the jails in the database recorded declines in population during this period, falling below the 45-degree line. Declines in the jail population were recorded in both small and large facilities, with the reduction in population averaging 22 percent in the 4 months from March to July. Information on large jurisdictions not included in the database also shows similar population reductions at jails in New York City; Cook County, Illinois; and Los Angeles County.

The JDI database offers few clues as to why the jail population fell so much in such a short period, but information from the much smaller sample of the Safety and Justice Challenge (SJC) at the MacArthur Foundation provides useful detail.⁵ In the 26 jurisdictions reporting data, the jail population declined by 27 percent on average from February to June 2020. The SJC data also record bookings into jail that result from police arrests, not from any diversion from incarceration at court. Figure 3-2 plots the log decline in the number of bookings against the log decline in the jail population. The close relationship between the decline in bookings and the decline in the jail population suggests that depopulation in those sites was not substantially the result of specific efforts by the courts to divert defendants from jail un-

⁵SJC is a jail reform project working in local jurisdictions and collecting detailed data on jail population dynamics.

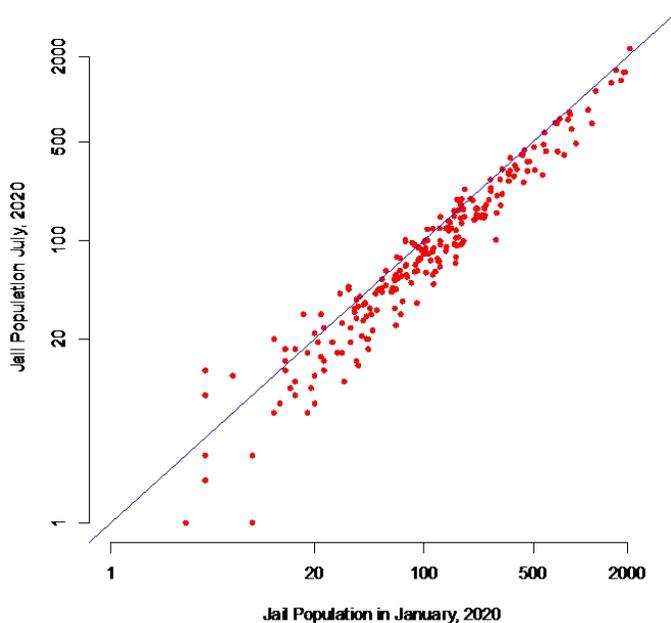


FIGURE 3-1 Jail populations in January and July 2020, 553 jail facilities.
SOURCE: Data from Jail Data Initiative (2020).

der pandemic conditions. Instead, under the stay-at-home guidance widely adopted across the counties, both criminal activity and arrests by police slowed significantly, and the caseloads in the courts were greatly reduced.

The SJC sites in the study adopted measures in the areas of policing, case processing, pretrial release, and probation that aimed to reduce COVID-19 exposure in the initial stages of the criminal justice system. Police in the SJC sites broadly attempted to resolve situations in the field without making arrests. This involved making increased use of citations and suspending arrests for traffic and misdemeanor warrants. Many counties released defendants facing nonviolent charges on a bond or to pretrial supervision. In around half the counties, parole and probation offices relaxed incarceration for technical violations. Still, some efforts to ease court activity tended to reverse the move to jail depopulation. Trials and hearings were widely postponed. As a result, lengths of stay in jail tended to increase for those already incarcerated. Indeed, lengths of stay in jail increased in more than half of the SJC sites, suggesting that defendants awaiting trial before the onset of the pandemic remained incarcerated as activity in the criminal courts slowed.

These examples suggest that law enforcement officers have played an important role in reducing jail admissions, but other actors can also con-

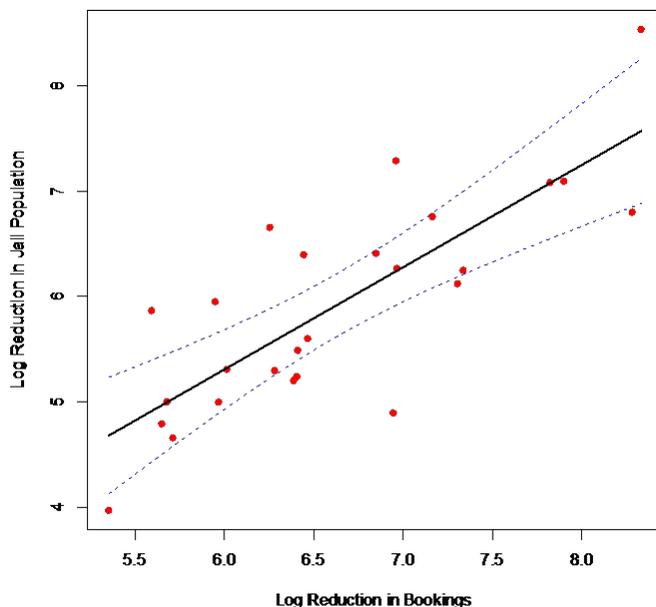


FIGURE 3-2 Declines in jail bookings and in the jail population from February to June 2020, log scale, includes 26 sites from the MacArthur Foundation's Safety and Justice Challenge (<http://www.safetyandjusticechallenge.org/>).

NOTE: The regression line summarizes the relationship.

SOURCE: Data from MacArthur Foundation (2020).

tribute to diversion. Prosecutors could also decide to decline to seek pretrial detention in all but the most serious cases. Law enforcement officers might thus be deterred from arresting people they might otherwise have brought into jail. Judges, too, could exercise their discretion to refrain from ordering the pretrial detention of people who come before them. Judges could curtail the use of bail and increase the number of defendants released on their own recognizance. In sentencing, judges could also use noncustodial sanctions for probation violations and misdemeanor offenses.⁶

Release

The picture with respect to releases is more complicated. Here, the difference between jails and prisons matters greatly. As noted in Chapter 2, these institutions house different populations. Jails are waystations, most often housing people who are awaiting trial, are awaiting sentencing,

⁶In cases where people have not been incarcerated prior to their hearings, these actions serve the goal of diversion rather than release.

have committed probation violations, or are serving short sentences for misdemeanors.⁷ By contrast, prisons are places where people go to stay: they house people serving sentences for felonies, which are crimes that carry sentences of more than 1 year in prison. The discussion below turns first to available levers for releasing people from jail and then to mechanisms for releasing people from prisons. As detailed below, prisons face the strongest legal and political pressures to retain people in custody and, as a result, obstacles to meaningful decarceration for prisons are greatest. Indeed, there is little evidence that release efforts have occurred on a large scale since the pandemic's inception. Of those releases that have occurred, little demographic data as to the race and ethnicity of releasees are available. Without attention to racial equity, experts in correctional health have raised concerns that pandemic responses could exacerbate racial disparities (see Chapter 5). For example, Illinois and Connecticut provide some of the only available data and preliminary reports that find that decarceration of Whites has been substantially higher than that of Blacks during the COVID-19 pandemic (Franco-Paredes et al., 2020; Hoerner and Ballesteros, 2020; Lyons, 2020).

Jails

During the first months of the pandemic, some public officials acted to depopulate their local jails. In San Francisco, for example, the district attorney ordered prosecutors not to oppose motions to release people facing misdemeanor charges or felony drug charges absent evidence that they posed a public safety threat (BondGraham, 2020). In Los Angeles, the sheriff ordered the release of 1,700 people who had been sentenced to jail time for nonviolent offenses and had less than 30 days left to serve (Carissimo, 2020). And in New York City, the mayor ordered the release of 300 elderly, medically compromised individuals from Rikers Island (Budryk, 2020). In several cases, similar releases from county jails were the product of collaborative efforts among various officials.⁸ Higher state courts may also direct

⁷Jails may also house people on immigration holds. Reductions in this subset of the jail population would depend on actions by the U.S. Immigration and Customs Enforcement (ICE) or by the municipal agencies that act in concert with ICE.

⁸In Washington County, Arkansas, local jail officials pursued collaborative strategies to reduce their jail populations, working with local prosecutors and circuit judges to release approximately 150 people on home monitoring and seeking (and receiving) state approval to release 33 people serving 90-day sentences on technical parole violations (Sissom, 2020). In New Jersey, following mediation involving the Office of the Attorney General, the County Prosecutors Association, the Office of the Public Defender, and the American Civil Liberties Union of New Jersey, the state's supreme court ordered the release of anyone serving time in jail as a condition of probation, on a probation violation, pursuant to a municipal court conviction, or for a misdemeanor (Supreme Court of New Jersey, 2020).

trial courts to noncustodial sentences, and district attorneys may choose to endorse them rather than advocating for bond requirements or custodial sentences. Sheriffs often have legal authority to release people from pretrial detention or to release, prior to the expiration of their sentences, people who are serving short sentences for misdemeanor offenses. Depending on the jurisdiction, mayors, too, may have the authority to release people from incarceration.

Prisons

Several officials possess legal authority to release people serving prison time. Many governors (or, in the case of the federal system, the President) can use their pardon or commutation power to reduce judicially imposed sentences.⁹ Parole boards, often acting in concert with departments of corrections, can grant parole or issue medical furloughs.¹⁰ Courts can order releases as remediation for constitutional violations, and in the federal system, can entertain and grant petitions for compassionate release brought by people in the custody of the Federal Bureau of Prisons (BOP). In addition, legislatures can exercise their inherent authority to revise prison sentences imposed pursuant to the state's sentencing laws.

Available data on imprisonment show a trend toward declining incarceration of approximately 4 percent in state prisons and roughly 10 percent in federal prisons (Franco-Paredes et al., 2020). Because the numbers of new bookings into jail and new cases at court slowed dramatically, particularly as the pandemic spread rapidly in March and April 2020, it appears likely that prison admissions during this period also slowed significantly. The data suggest that prisons were receiving significantly fewer new commitments from courts in this period. Although this appears to be a likely explanation, research is needed to explain prison depopulation when more complete data become available.

⁹In California, for example, the governor accelerated by up to 60 days the releases of 3,500 people who had already been found suitable for parole but were awaiting expiration of the statutory waiting period (St. John, 2020). Similarly, in Kentucky, the governor commuted the sentences of more than 900 people serving prison sentences for nonviolent, nonsexual crimes (Planalp, 2020). And in Pennsylvania, the governor used his reprieve power to accelerate the releases of more than 400 people with medical conditions that put them at high risk of complications from the virus (Commonwealth of Pennsylvania Office of the Governor, 2020).

¹⁰In North Dakota, for example, the state's parole board held a special session at the outbreak of the pandemic and granted early parole release to 120 individuals (Baumgarten, 2020; Martin, 2020). In early June, the Arkansas Board of Corrections certified more than 1,200 people as eligible for parole consideration. As of early July, 730 people had been released from Arkansas prisons, leaving that state's prison system roughly at capacity for the first time since 2007 (Arkansas Department of Correction, 2020).

Anecdotal reports from correctional leaders suggest that state prison systems tried to reduce populations through parole release, compassionate release, and home monitoring, but there is little evidence that these efforts occurred on a large scale. Barriers to implementing these release mechanisms likely stem from the fact that everyone in prison has been sentenced to a custodial term following a criminal conviction, and few legal mechanisms are available for releasing people from imprisonment. Moreover, those mechanisms that are available follow a penological model that creates a strong presumption against release prior to the expiration of a sentence. As a consequence, the percentage of people released from prison in the wake of the COVID-19 pandemic has been considerably lower than the percentage released from jails.

Barriers to Exercising Discretionary Release Powers

In April 2020, Attorney General William Barr issued a memorandum directing BOP officials to prioritize the use of home confinement, to release, “where appropriate,” those individuals who both are vulnerable to COVID-19 and pose a low public safety threat (Office of the Attorney General, 2020). According to BOP, more than 7,600 people have been released under this guidance since this memorandum was issued (BOP, 2020).¹¹

While some states have taken steps to reduce their prison populations, as described above, the overall effect has been relatively small. Governors and parole boards appear to be hampered in taking such steps by several factors: processes not designed for exigent circumstances; concern about risks to public safety, understood largely in terms of crime prevention; and concerns about public reactions and backlash. As a consequence, review of release petitions at all levels is slow and painstaking, and such factors as the original offense of conviction remain highly salient, even for people who have been incarcerated for decades and are now elderly or physically infirm and thus pose little risk of recidivism.

The power to grant compassionate release is even more limited. In 2018, Families Against Mandatory Minimums (FAMM) conducted a comprehensive review of all state compassionate release regimes. It found that, although “49 states plus the District of Columbia provide one or more forms of compassionate release,” these regimes are rarely used. The

¹¹According to Prescott, Pyle, and Starr (2020), “on March 26, Attorney General William Barr issued a memo urging federal prisons to transfer older and medically vulnerable prisoners to home confinement—but it was limited to those with nonviolent offenses who were deemed low-risk.” The authors note that by April 3, 2020, only 552 incarcerated people had been released, out of approximately 175,000 people living in BOP facilities. A subsequent April 2020 memo made the requirements more flexible and more people were released.

FAMM report identifies several obstacles to the granting of compassionate release petitions, including “strict or vague eligibility requirements; categorical exclusions; missing or contrary guidance; complex and time-consuming review processes; and unrealistic time frames” (Price, 2018). To be eligible in Mississippi, for example, the petitioner must be “bedridden.” Georgia requires showing that people are “entirely incapacitated” and “reasonably expected” to die within 1 year. In California, “medical parole” is restricted to those people who are “permanently medically incapacitated, unable to perform activities of daily living,” and who “require constant care.” In Kansas, a person must be projected to die within 30 days. In many states, even people whose medical conditions fall within the ambit of the regulations may still be denied on the basis of their crimes or unless they have served a minimum term. Procedures are often unclear and time-consuming for incarcerated people in terminally poor health. In states where the final decision is made by the parole board, a body typically focused on punishment and evidence of rehabilitation and not on the needs or vulnerabilities of those seeking release, a decision to grant compassionate release is rare. Together, these features explain why compassionate release has historically been so rarely granted and why it has not proved a meaningful channel for release from state prisons during the pandemic.

Federal prisons have taken a different path with compassionate release since the onset of the pandemic. The majority of petitions for compassionate release filed by federal prisoners have been denied, but a non-negligible number—approximately 1,495—have been granted. The reason for this relatively broader use of compassionate release is the greater scope for advocacy the federal system allows on behalf of vulnerable individuals in federal custody. In the vast majority of states, parole boards make compassionate release decisions, but in the federal system these decisions are made by federal courts. Prior to passage of the First Step Act of 2018, only the BOP director could petition the court to reduce a prison sentence for reasons of age, medical condition, family circumstance, or some other “extraordinary or compelling reason,”¹² as long as the director had determined that the individual seeking release was “not a danger to the safety of any other person or to the community.” While the First Step Act did not change the factors a court considers, it granted those seeking release the right to bring the matter to court themselves. Petitioners must still first file a request with the warden in their facility, but if BOP does not bring a motion for release to the federal courts within

¹² 18 USC § 3582(c)(1)(A); United States Sentencing Guidelines Manual § 1B1.13.

30 days, petitioners can now file such a motion themselves.¹³ This procedural change has brought the increased use of compassionate release. In the year prior to passage of the First Step Act, the federal courts granted only 24 motions for compassionate release; in the year after passage, that number was 145.

Despite the increase in motions for compassionate release, the court's criteria for assessing such a petition are unchanged. Whether a motion is brought by the BOP director or the person seeking release, the court must take account of the sentencing factors listed in the law (18 USC § 3553), which include “the nature and circumstances of the offense and the history... of the defendant,” as well as the various purposes of punishment, including the need “to reflect the seriousness of the offense, to promote respect for the law, and to provide just punishment for the offense”; to “afford adequate deterrence to criminal conduct”; and to “protect the public from further crimes of the defendant.”¹⁴ These factors are the same considerations federal courts use when sentencing people convicted of crimes. Because federal courts are statutorily obliged to consider them when entertaining a compassionate release petition, these factors continue to narrow the possibility of prison release regardless of how much time a person may have already served or however strong the public health grounds for release. Box 3-1 further describes the role of federal courts in releases.

In sum, there is evidence of a decline in incarceration in the first half of 2020, though this appears to be largely due to declines in crime, arrests, and court processing rather than deliberate efforts at depopulation in response to the pandemic. While prison and jail populations fell, there is also evidence of an increase in incarceration in the period from June 2020 to the time of this writing in October 2020, as cities and courts begin to reopen. Figures are incomplete and highly preliminary, but the data scraping effort at JDI reports rising incarceration in the 348 jails they have been tracking since March 2020. For those 348 jails, they find the total population was at a minimum for 2020 on May 2, at 57,305. By October 4, the population had increased to 70,350.¹⁵ The increase in incarceration combined with high rates of daily new infections underscores the continuing need for mechanisms for decarceration in support of public health.

¹³ 18 USC § 3582(c)(1)(A).

¹⁴ The statute also lists as relevant the need “to provide the defendant with needed educational or vocational training, medical care, or other correctional treatment in the most effective manner” (18 USC § 3553).

¹⁵ See <https://publicsafetylab.org/jail-data-initiative>.

BOX 3-1 Releases and the Federal Courts

The federal courts first began entertaining constitutional challenges to prison conditions in the 1970s. Over the ensuing decades, when prison conditions were found to be unconstitutional and no other form of relief was available to remedy the violation, courts nationwide ordered population reductions. Over the past decades, however, the scope of federal court authority has narrowed as a result of congressional action and Supreme Court directives. As a consequence, very few incarcerated people have been released from prison pursuant to federal court order in response to COVID-19–related health concerns.

Since the start of the pandemic, prisoners' advocates have petitioned federal courts around the country for the release of their clients in federal and state prisons. In most cases, they have lost, if not at trial then on appeal. To date, only two cases, *Martinez-Brooks v. Easter* and *Torres v. Milusnic*, have yielded releases. Each involved a single federal facility—the federal correctional facility in Danbury, Connecticut (*Martinez-Brooks*), and one in Lompoc, California (*Torres*). And in each case, to date, very few people have been released pursuant to these court orders: 119 from Danbury and 30 from Lompoc. Otherwise, the courts have uniformly rejected plaintiffs' suits.

The passage of the Prison Litigation Reform Act in 1996 has also limited the authority of the federal courts to grant prisoner release orders as a remedy for unconstitutional prison conditions. Under 18 USC § 3626(a)(3), any such orders may be issued only by a three-judge panel, and no federal court may grant a motion to create such a panel unless that court “has previously entered an order for less intrusive relief that has failed to remedy” the constitutional violation, and the defendant “has had a reasonable amount of time to comply” with previous orders. This provision was meant to slow the process, to limit the power of the courts to order releases, and to build in time for prison officials to find alternative ways of correcting any constitutional violation. In some cases, including in *Martinez-Brooks v. Easter* and *Torres v. Milusnic*, plaintiffs manage to avoid the constraints of this provision by successfully arguing that habeas corpus was the more appropriate procedural vehicle. Most of the time, this only meant that the plaintiffs lost on other grounds.

But for those not focused on the intricacies of legal analysis, it is the bigger picture that matters. Aside from two cases, in which liability rested on defendants' failure to implement Federal Bureau of Prisons (BOP) directives issued in response to COVID-19, the federal courts have proved an inadequate mechanism to effectuate large-scale releases in light of the COVID-19 pandemic.

CONCLUSION

Available data on changes in the incarcerated population since the onset to the pandemic show that total prison populations have declined by roughly 5 percent nationwide and total jail populations have declined by roughly 20

percent. While noteworthy, diversion efforts have largely been the results of decreases in criminal activity, arrests by law enforcement, and court processing. Releases have generally been procedurally slow (due to requirements to consider individual circumstances on a case-by-case basis) and not well-suited for addressing crisis conditions. Reports of continued outbreaks in correctional facilities across the country suggest additional efforts are needed, specifically on a system and facility-by-facility basis.

Furthermore, the committee's review of research on recidivism and legal analysis of diversion and jail and prison release have two main implications. First, it is possible to reduce incarceration significantly without a large increase in crime. Prior to the pandemic, New York, New Jersey, Massachusetts, and Connecticut sustained large reductions in prison populations, while crime rates in those states fell or remained at historically low levels. Perhaps the most relevant example is provided by California, where the policy of realignment adopted in response to court order to bring down the state's prison population reduced the number of people in prison rapidly by about one-third, with no measurable effect on violent crime.

Second, despite the feasibility of decarceration from the viewpoint of public safety and its desirability from the perspective of public health, there is too little scope in current law for accelerating releases for public health reasons. Indeed, medical or health criteria for release, even in pandemic emergencies, are largely nonexistent at the state level and highly circumscribed in the federal system. For correctional officials to implement decarceration, steps can be taken to mitigate public safety and public health risks through reentry planning and the provision of supports, including testing upon release, which is the focus of the next chapter.

4

Community Systems for Decarceration

The COVID-19 pandemic has exacerbated the challenges faced by individuals reentering the community and the communities and families of formerly incarcerated individuals. Because incarcerated people are disproportionately from communities most affected by the COVID-19 pandemic, it is important to think of reentry and community safety as not only focused on individuals released from prison or jail but also concerned with the communities to which they will return. This chapter discusses discharge planning and how correctional systems can be supported by community health care and payment structures, housing, and other income support systems.

These community and social supports are important complements to decarceration efforts. Recognizing that communities are grappling with varying levels of viral transmission as well as potential resource limitations, this chapter highlights a number of community support services that can be leveraged to support individuals who return home. Reentry during the pandemic will require a unique set of discharge plans, including testing and quarantining individuals prior to release, as well as supports and resources from community health care and housing systems. Absent these considerations, efforts to decarcerate during the COVID-19 pandemic will fall short of their fullest potential to protect public health.

DISCHARGE PLANNING

Most prisons have a basic form of discharge planning services, which may include a limited supply of medications postrelease (< 30 days) and

questions about where a person will live following release. A few systems also provide referral to primary and specialty care, such as substance use treatment in the community (Mallik-Kane, 2005; Visher and Mallik-Kane, 2007). Jails less commonly have a formalized discharge planning system focused on housing or health concerns given the shorter lengths of incarceration and unknown date of release. Individuals can be released from court or in the middle of the night—without their belongings, medications, medical records, or referrals to community health care. Whether being released from prison or jail, people are rarely provided their medical records and, even in these circumstances, must pay for their records (Puglisi, Calderon, and Wang, 2017).

Discharge planning in correctional systems is often siloed from the community health system. A study of the Texas Department of Corrections shows that when the correctional system provided people with a prescription for antiretroviral medications at release, that initial prescription was filled by only 5.4 percent of individuals within 10 days of release (95% confidence interval [CI] = 4.5%–6.5%) and by only 30.0 percent of individuals within 60 days of release (95% CI = 28.1%–32.0%) (Baillargeon et al., 2009). Absent intentional coordination and linkages to the community health system, providing prescriptions alone did not ensure that formerly incarcerated individuals could engage with and access the needed care upon release. Many formerly incarcerated people have never navigated or received treatment from community-based health systems or may have little experience using a pharmacy or health insurance. One reason is that roughly 40 percent of individuals are newly diagnosed with a chronic health condition, including such conditions as HIV, while incarcerated (Shavit et al., 2017). People first learn how to manage chronic conditions within the rules and structures of jails and prisons, where they rely on correctional officers and health professionals to administer medications and check for daily adherence (Thomas et al., 2016).

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. First, given the high risk of transmission of the virus in prisons and jails, reentry planning will need to consider COVID-19 testing. Testing prior to discharge with timely return of results would reduce the risk of exposing others to the virus. Moreover, given false negatives and real-world implementation difficulties encountered with COVID-19 testing, a synergistic strategy would be to also provide individuals returning to congregate or crowded settings a place in the community to complete a 14-day quarantine in a safer environment, such as a subsidized hotel room (see Chapter 5). Continuing community transmis-

sion of COVID-19 also makes it important that people released from jail or prison are discharged with robust education about the disease and a connection to community-based health services, especially if they have a chronic health condition or have residual symptoms from COVID-19.

COVID-19 has placed significant strains on outpatient and inpatient services in community settings. Many primary care and behavioral health care providers have put a temporary halt on new appointments during the pandemic and are providing care only through telemedicine. Some correctional systems have started to distribute telephones with video capacity prior to release or even facilitate “warm handoffs” through video conferencing to improve access to health care for soon-to-be-released individuals (e.g., Connecticut Department of Corrections). Providing an adequate supply of medications as well as a link to primary care is important prior to release, as engagement in primary care has been shown to reduce reliance on emergency departments for ambulatory care needs (see Chapter 5). Prior to the pandemic, some prisons and jails were piloting programs designed to educate people on how to manage their chronic diseases in the community, including obtaining medication refills and using insulin for the first time (Reagan, Walsh, and Shelton, 2016). Continuing such programs may reduce unnecessary use of the community system during the pandemic.

Health Insurance Coverage

Without health insurance, obtaining primary care and substance use and mental health treatment immediately following release can be difficult. There are a number of opportunities within federal health insurance programs, including Medicaid, Medicare, and the Veterans Health Administration, for easing the transition from correctional to community health care, which is especially important during the pandemic. We focus on Medicaid, a state–federal health care program that covers low-income adults and acts as the primary mechanism for health insurance coverage of those directly impacted by incarceration. Importantly, Medicaid covers mental health and substance use treatment and services, including intensive case management, rehabilitation, and support services, which are heavily used among individuals recently released from correctional systems. Enrollment in Medicaid prior to release is associated with increased engagement in treatment among people with serious mental illnesses (Morrissey, Domino, and Cuddeback, 2016).

Beyond increased access to health care, Medicaid coverage may also affect crime, rearrest, and costly reincarceration. He and Barkowski (2020) recently found Medicaid expansion under the Patient Protection and Affordable Care Act (ACA) to be negatively correlated with numerous types of crime, such that states with expanded coverage reported decreas-

ing levels of crime (including homicide) compared with states that did not expand coverage. Evidence also suggests that Medicaid expansion reduces recidivism for certain violent and public-order crimes (Aslim et al., 2020). Together, these findings suggest that losing or never gaining Medicaid coverage harms not only individuals involved in the criminal justice system but also their home communities.

Roughly two-thirds of the local jail population being held prior to trial who have not been convicted of a crime lose their Medicaid health benefits or are ineligible for Medicaid coverage (CMS, 2016) because of the Medicaid Inmate Exclusion Policy: under the Social Security Act (1905(a)(A)), that exclusion prohibits use of federal funds and services, including Medicaid, for medical care provided to “inmates of a public institution.”¹ The law does not differentiate between individuals who have been convicted of a crime and those incarcerated prior to conviction. This means that individuals who can afford to “bail out” will remain covered by federal health care benefits, but poor defendants who are jailed for failing to pay bail may face a gap in health care coverage when released until they are able to reenroll for state health benefits. A joint report of the National Association of Counties and the National Sheriff’s Association, “Addressing the Federal Medicaid Inmate Exclusion Policy,” indicates that these interruptions result in poor care transitions, disruptions in treatment for chronic mental health and medical conditions (e.g., hepatitis C treatment or cancer care), limited exchange of health care information, and significant costs to county taxpayers.²

In accordance with Medicaid administrative rules, states could immediately institute a number of programs or policy changes which promote transition of health care during the COVID-19 pandemic, especially facilitating access to prescription medications, primary care, substance use and mental health treatment, and, in some instances, cover the costs of SARS-CoV-2 testing and related health needs prior to release; see Box 4-1 and Chapter 5.

Termination versus Suspension upon Incarceration

Under Medicaid administrative rules, states can choose to follow the rules promulgated by the Social Security Administration and suspend (rather than terminate) Medicaid benefits when a person is incarcerated. Payments for a person whose benefits have been suspended are meant to

¹Federal law prohibits states from using federal Medicaid matching funds for health services provided to adults and juveniles in public institutions except when the person is admitted to an off-site hospital or other qualifying facility for at least 24 hours (Social Security Act § 1905(a)(30)(A)). This limitation in federal payment is called the “inmate coverage exclusion” (MACPAC, 2018).

²See <https://www.naco.org/resources/featured/naco-nsa-joint-task-force-report-addressing-federal-medicaid-inmate-exclusion-policy>.

BOX 4-1

Medicaid Reform during the COVID-19 Pandemic

Expanded Medicaid Coverage under the Families First Coronavirus Response Act

In states that have not expanded Medicaid under the Affordable Care Act (ACA), the state can provide Medicaid coverage for COVID-19 testing and related services to individuals who are uninsured if the state takes up the optional eligibility group provided in the Families First Coronavirus Response Act (FFCRA) of 2020. This pathway allows low-income adults in non-expansion states, including adults who are incarcerated, to apply for Medicaid and enroll once they have been released.

State Waivers to the Medicaid Inmate Exclusion Policy

Two types of federal waivers could be used to expand Medicaid coverage or support access to covered services for incarcerated individuals during the COVID-19 crisis: Section 1115 and 1135 waivers. However, the Centers for Medicare & Medicaid Services (CMS) has not yet approved either flexibility mechanism to facilitate coverage for incarcerated individuals.

- *Section 1115 Waivers.* Section 1115 of the Social Security Act (SSA) allows CMS to waive certain federal requirements for states to conduct demonstrations that promote the objectives of the Medicaid program. According to the Kaiser Family Foundation (KFF) (2020a), some states are currently seeking such waivers to expand the scope of services that may be eligible for federal financial participation when provided to incarcerated people during the COVID-19 emergency (e.g., allowing federal financial participation for COVID-19 testing or outpatient treatment, not just inpatient care).
- *Section 1135 Waivers:* Section 1135 of the SSA allows the Department of Health and Human Services (HHS) to waive certain federal requirements during a federally declared emergency. These waivers have been essential to states during the COVID-19 emergency, allowing them to waive various prior authorization, provider enrollment, conditions of participation, and reporting requirements, among others. Section 1135 waivers cannot be used to expand the covered services allowable under a program—and thus could not be used to change which services are eligible for federal financial participation under Medicaid’s inmate exclusion. However, 1135 waivers could help support access to inpatient services for the treatment of COVID-19 by making it easier for facilities to qualify for the *inpatient exception* to Medicaid’s inmate exclusion. That is, 1135 waivers could be used to expand *where* incarcerated individuals can receive Medicaid-covered inpatient services (e.g., by allowing federal financial participation for services furnished in facilities that serve only justice-involved populations, which is normally not allowable). According to KFF (2020a), “This could help ensure care for people involved in the justice system while minimizing burdens on local hospitals serving the broader community and reduce correctional staff needs by eliminating requirements for one-to-one staff management requirements that are otherwise required for individuals in an inpatient setting” (see also Mistak, n.d.).

resume automatically after the individual is released from jail or prison, as long as the Social Security Administration is informed of the release and the person completes a standard form demonstrating that his or her income continues to meet Medicaid eligibility requirements, though this “automatic” process may take months. States that suspend (rather than terminate) Medicaid facilitate timely reactivation of Medicaid following release (Rosen et al., 2014). Suspension also has been shown to have financial benefits, as states can be reimbursed for inpatient medical services for incarcerated individuals enrolled in Medicaid. Numerous states, including Arkansas, Colorado, and Michigan, have reported cost savings through this mechanism, ranging from \$3 million to \$19 million per year.

Nine states terminate incarcerated individuals’ health benefits (KFF, 2020b), leaving the majority of released individuals in those states without health care coverage upon release and susceptible to poor health outcomes and recidivism during a particularly vulnerable transition period. Federal action is not necessary for states to change their termination policies. States currently have the authority to suspend, rather than terminate, a person’s Medicaid and Medicare enrollment during incarceration. States could change their policies at any point to expedite enrollment during the COVID-19 crisis, and such a change would be particularly helpful in states that are accelerating the release of medically vulnerable individuals in response to the pandemic.

Medicaid Enrollment during Incarceration

While the Medicaid Inmate Exclusion Policy prevents the use of federal Medicaid funds to cover care for individuals who are incarcerated, it does not explicitly limit individuals from being enrolled in Medicaid during incarceration (MACPAC, 2018). Prison and jail systems have attempted to ease the transition for newly released individuals by allowing them to apply for Medicaid (and also Medicare as appropriate) prior to release. According to an inventory conducted by the Center for Mental Health and Addiction Policy Research at The Johns Hopkins University, as of January 2015, 64 programs across 21 states had sought to enroll individuals living in correctional settings in Medicaid (Bandara et al., 2015). Evidence on these programs suggests some best practices for facilitating the enrollment process, including training correctional staff to serve as navigators to help incarcerated people complete applications, creating plans for direct handoffs from correctional health care providers to community health care providers following release, and providing individuals with information about Medicaid and community-based systems of care prior to their release (Ryan et al., 2016). Health insurance navigators in Maricopa County, Arizona, for example, provided education and enrollment assistance to more

than 1,000 individuals with complex health needs and serious mental illness who were eligible for release. In Massachusetts, with implementation of the MassHealth/Department of Corrections Prison Reintegration Pilot Program, more than 70 percent of individuals released from the state's prisons in fiscal year 2015 had submitted a Medicaid application, and more than 75 percent of submitted applications had been approved. In Ohio, a partnership between the state's Medicaid agency and the Department of Rehabilitation and Correction enrolled more than 700 individuals in Medicaid managed care plans within 90 days of their scheduled release (Beck, 2020; Ryan et al., 2016).

Even for the 12 states that have not expanded Medicaid under the ACA (approximately 730,000 individuals in jails and prisons and nearly 1.5 million on parole or probation),³ the state can provide Medicaid coverage for COVID-19 testing and related services to individuals who are uninsured if the state takes up the optional eligibility group provided in the Families First Coronavirus Response Act (FFCRA) of 2020. This pathway allows low-income adults in non-expansion states, including adults who are incarcerated, to apply for Medicaid and enroll. While the inmate exclusion provision would continue to apply (and thus make this limited eligibility option mostly irrelevant with respect to Medicaid payment during a person's incarceration), this pathway would be helpful once incarcerated individuals had been released, accelerating and easing their access to Medicaid coverage.

HEALTH CARE

While health insurance is critical during the pandemic for people to access COVID-19 screening and testing, chronic disease management, and substance and mental health treatment, it is important to note that Medicaid coverage is not a panacea for improving health care access. Howell and colleagues (2020), Olfson and colleagues (2018), and Saloner and colleagues (2016) all found that among nationally representative samples of low-income individuals, Medicaid expansion corresponded with increased insurance coverage but failed to increase access to substance use or mental health treatment (Olfson et al., 2018; Saloner et al., 2016). Many of the treatment facilities that would be most used by formerly incarcerated people, including those providing substance use and mental health services, do not accept Medicaid, leaving patients at high risk of poor outcomes and recidivism (Grogan et al., 2016). People recently released from correctional facilities are less likely to have a primary care provider or mental health care provider and to have high levels of preventable hospital admissions

³See <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>.

(American Academy of Family Physicians, n.d.) compared with the general population. An audit study conducted in British Columbia with universal health insurance found that recently incarcerated people were half as likely to be offered an appointment in primary care compared with those not recently incarcerated (Fahmy et al., 2018).

Active engagement of people just released from correctional facilities into the community health care system is an important complement of successful decarceration and efforts to flatten the curve during the COVID-19 pandemic. Health systems will need to rely on proven strategies to maximize access to and engagement in primary care and mental health and substance use treatment (Kouyoumdjian et al., 2015; Spaulding et al., 2018; Wohl et al., 2017). Evidence shows that practices tailored to the needs of newly released individuals can improve their retention in primary care, reduce preventable hospitalization, and lessen future contact with the criminal justice system. For example, a randomized controlled trial in Los Angeles has shown that peer navigation started while individuals are incarcerated and maintained following release is effective in improving engagement in HIV care and sustained viral load suppression. The LA LINK model is a peer navigator intervention in which participants share common experiences such as prior incarceration, living with HIV, or prior substance use disorder (Cunningham et al., 2018).

Another evidence-based intervention to engage recently released individuals in primary care is the Transitions Clinic Network (TCN), a national consortium of more than 40 primary care centers that serves the primary health care needs of individuals returning from incarceration (Shavit et al., 2017). TCN programs include interdisciplinary primary care teams with community health workers with personal histories of incarceration. In a randomized controlled trial, participants in the TCN program in San Francisco had 51 percent fewer visits to the emergency department in a year compared with those who were assigned to receive expedited primary care in safety net systems (Wang et al., 2012). TCN participation also impacts future criminal justice contact, specifically being associated with lower rates of returning to prison for a parole or probation technical violation and fewer incarceration days compared with the control group (Wang et al., 2019). During the COVID-19 pandemic, TCN programs in California, Connecticut, and North Carolina created statewide hotlines to facilitate collaborations with state prison systems and local jails and community health care systems so that people released from incarceration could receive a “bundle” of services that include expedited primary care appointments, as well as in some locations phones prior to their release, and connections to rapid rehousing.⁴

⁴See <https://transitionsclinic.org/> and <https://cceh.org/wp-content/uploads/2020/04/DOC-Re-entry-Housing-Assistance-Program.pdf>.

In addition, access to primary care, substance use treatment, and mental health care during the pandemic may be facilitated by giving patients access to telephones with video capabilities. During COVID-19, federal agencies issued new guidance about the use of telemedicine for health care delivery. The Centers for Medicare & Medicaid Services temporarily waived restrictions, allowing Medicare and Medicaid to cover additional telehealth services.⁵ And the Substance Abuse and Mental Health Services Administration and the U.S. Drug Enforcement Agency issued new guidance for opioid treatment programs, indicating these programs could prescribe buprenorphine via telehealth and liberalized the number of days of take-home medications for methadone, reducing in-person visits.⁶

Video communication is associated with higher patient understanding and satisfaction compared with telephone communication (Nouri et al., 2020). This is particularly important to consider in primary care and substance use and mental health treatment—where ongoing relationships and clear communication are essential to successful disease management. In some health systems, however, patient portal enrollment is a requirement for video visits. Because it is well documented that vulnerable populations are less likely to use patient portals, health care practices could remove requirements that patients enroll in patient portals prior to scheduling video visits (Grossman et al., 2019). Finally, because video communication can be challenging among populations with limited digital access or digital literacy (the ability to use and understand information from digital devices) (Khoong et al., 2020; Manganello et al., 2017), prioritizing populations just released from correctional facilities for in-person primary care visits, when possible, may improve access and engagement immediately postrelease.

HOUSING

Stable housing is important for facilitating the safe return of an incarcerated individual back into the community. Sirois (2019, p. 842) reports that “as many as 20 percent of men and women who leave prison are homeless after release.” Homelessness is associated with increased recidivism, poor health outcomes (Brown et al., 2017; Garibaldi, Conde-Martel, and O’Toole, 2005), increased use of acute health care (Fazel, Geddes, and Kushel, 2014; Hwang and Henderson, 2010; Hwang, Lee, and Kong, 2018; Raven et al., 2016), and mortality (Aldridge et al., 2018; Morrison, 2009; Roncarati et al., 2018).

During the pandemic, homelessness has also been shown to increase the risk of acquiring (and transmitting) SARS-CoV-2 (Baggett et al., 2020;

⁵See <https://www.medicare.gov/medicaid/benefits/telemed/index.html>.

⁶See <https://www.samhsa.gov/coronavirus>.

Mosites et al., 2020; Perri, Dosani, and Hwang, 2020; Tsai and Wilson, 2020). Congregate shelters, where a large proportion of people experiencing homelessness live, have been sites of major outbreaks of COVID-19, with infection rates similar to those seen in prisons and jails (Baggett et al., 2020; Hawks, Woolhandler, and McCormick, 2020; Imbert et al., 2020; Mosites et al., 2020). Adults experiencing homelessness often are unsheltered, have minimal access to hygiene facilities, are exposed to harsh natural conditions, and experience a high prevalence of food insecurity (Kuhn et al., 2020), and the COVID-19 pandemic has exacerbated these already poor conditions. To decrease the transmission of COVID-19, many homeless shelters have limited their capacity by exiting individuals to hotels or unsheltered settings and ceasing new entries, thereby adding to the numbers of individuals experiencing unsheltered homelessness. By some estimates, moreover, pandemic-related economic disruptions could increase homelessness by 40 to 45 percent over the next year (Community Solutions, 2020) as eviction moratoriums end (Community Solutions, 2020; Corinth, 2017). Essential to decarceration efforts is ensuring that they do not contribute to increases in homelessness.

There are many avenues to ensuring that returning people have access to housing, including efforts focused directly on the released individual, on families and social supports, and on modifications to the housing system writ large (Reentry and Housing Coalition, n.d.). These proven strategies, with the goal of minimizing homelessness, can complement decarceration efforts. It is important to reduce the potential for returning individuals or their family members and social supports to be placed at high risk of acquiring COVID-19 through community transmission when they return, and ensure that housing is not an impediment to the success of decarceration (see, e.g., Williams and Bertsch, 2020).

Returning Individuals

There are several options for reducing the chances that returning individuals will face homelessness. Individuals who were homeless upon entry into prison or jail and have no other housing option upon release are eligible for funding and programs designed for people experiencing homelessness. Those who met criteria for chronic homelessness before entering prison or jail—1 year of homelessness or four or more episodes in the prior 3 years that lasted a total of 1 year and a disabling diagnosis (HUD, 2015) and who would become homeless upon exit—qualify for permanent supportive housing (USICH, 2016). Permanent supportive housing or subsidized housing with associated voluntary supportive services has been shown effective in housing individuals with disabling diagnoses (Caton, Wilkins, and Anderson, 2007; Raven, Niedzwiecki, and Kushel, 2020). It is most

effective when used with a “housing first” approach, meaning that there are no preconditions for engagement with services prior to housing entry (Gulcur et al., 2003; Raven, Niedzwiecki, and Kushel, 2020). Permanent supportive housing can be scattered site (i.e., rental units with voluntary services attached) or project based (i.e., a building devoted to multiple units). It has been shown to enable the achievement of housing stability and decrease reliance on institutional care in numerous settings, including those with histories of involvement in the criminal justice system (Aidala et al., 2014; Stergiopoulos et al., 2015).

Permanent supportive housing is funded through a variety of mechanisms. Health-related support services as well as some housing-related services (i.e., housing transition, tenancy support) can be paid for by Medicaid (KFF, 2017), increasing the urgency of obtaining Medicaid eligibility prior to discharge. The housing subsidies can be provided through federal housing choice vouchers or state or local subsidies. The Veterans Affairs (VA) system provides permanent supportive housing for veterans through the U.S. Department of Housing and Urban Development (HUD-VA) Supportive Housing program, whereby HUD funds vouchers for housing and the VA system provides supports. While resources are limited, recent expansion of Emergency Services Grant funding through the Coronavirus Aid, Relief, and Economic Security (CARES) Act could present an opportunity to expand such programs (PDOCE, 2020).

For individuals who meet criteria for homelessness but not chronic homelessness, rapid rehousing is another strategy for providing housing. Rapid rehousing provides housing assistance and supportive services for up to 24 months (National Alliance to End Homelessness, n.d.; USICH, 2018), with the aim of assisting individuals in stabilizing their income so they can afford to continue the housing after the subsidy ends (HUD, 2013).

To access either permanent supportive housing or rapid rehousing, individuals must be engaged with the coordinated entry process for people experiencing homelessness. Coordinated entry programs are managed by the homeless continuum of care in the area where an individual will be discharged to (HUD, 2020). Long wait lists for access to either housing service could create barriers to reentry, particularly in the setting of the COVID-19 crisis, but increased coordination between correctional discharge planning and homeless continuum of care can improve the likelihood of successful discharge.

Family and Social Supports

Many people return from incarceration to live with families and friends, and they may be returning to families and communities facing unprecedented economic strain, perhaps with family members fearing or facing

eviction. In one study, 44 percent of Black renters and 41 percent of Hispanic renters reported having no or slight confidence that they could make their next month's rent in early June, compared with 21 percent of White renters (Greene, 2020; U.S. Census Bureau, 2020). Thus, even those who are decarcerated to housing (i.e., to live with family or friends) may lose that housing because of pandemic-related economic pressures, especially given the overrepresentation of Black and Hispanic individuals among the incarcerated. In response to the threats to housing security, the U.S. Centers for Disease Control and Prevention and the U.S. Department of Health and Human Services issued an emergency nationwide eviction moratorium in September to last through December 31, 2020. Another policy remedy is to offer monetary incentives to families for housing released individuals, as was done by New York City on a trial basis for relatives of homeless families in 2016 (Fermino, 2016). Programs could use the model of the Kinship Guardianship Assistance Payment Program, which provides financial assistance for relatives who become guardians for children exiting the child welfare system.

Even those families or friends not experiencing financial strain face additional barriers to supporting returning individuals. For example, families that rent housing, with or without subsidies, face limits on hosting family members. Families living in subsidized housing face strict limits on having nonleaseholders stay in their home—no more than 14 days in a row and 21 days in a year. To avoid this limit, householders would have to add individuals returning from prison or jail to their lease, but they may face numerous barriers to doing so. While HUD sets narrow limitations on this practice (i.e., excluding anyone from the property who has manufactured methamphetamine or has been convicted of a federal sex offense), local housing authorities have wide latitude to expand these exclusions, and many do so (24 C.F.R. § 960, 1995).

While many people exiting incarceration “live in the shadows,” staying with family without official permission, there are successful models for overcoming these housing restrictions. Since 2011, HUD has encouraged public housing authorities to create opportunities and reduce barriers for people with criminal records to live in Public Housing Authority- or Housing Choice-funded housing (Vera Institute of Justice, 2015). In 2016, HUD created the “It Starts with Housing” program to expedite public housing opportunities for individuals leaving correctional facilities. Demonstration projects included those that focused on family reunification and those that provided housing for high-risk individuals exiting without housing (Ramírez, 2016). The former projects were less resource intensive (Ramírez, 2016).

An example is the Family Reentry Pilot Project, implemented through a partnership among the New York City Housing Authority, the Vera Institute on Justice, the Corporation for Supportive Housing, and the New York

City Department of Homeless Services. In this project, individuals exiting prison or jail could join their families in public housing with temporary permission to do so and receive case management services from affiliated nonprofits (New York City Housing Authority, 2014). After program completion, individuals could either be added to the lease officially or allowed to stay in an unofficial capacity (New York City Housing Authority, 2014). This and similar models offer a roadmap for fostering the ability of families to assist in decarceration efforts without threatening the housing of the host household.

Individuals who rent on the private market also face challenges should they wish to house people just released from correctional facilities. Many leases specify the number and nature of visitors, and nonleaseholders are not allowed to stay permanently. Therefore, having a nonleaseholder stay in the home could constitute a lease violation, which in turn could threaten the stability of a household that in many cases could already be concerned about eviction. Generally, property owners are granted discretion in deciding who can be a renter and could use convictions to disallow an individual from being added to a lease. In 2016, HUD warned private landlords that discrimination on the basis of criminal history could violate fair housing laws (HUD, 2016); similar guidance could be issued again.

EMPLOYMENT AND INCOME SUPPORTS

Regular income generated through employment or government programs can help formerly incarcerated individuals meet basic health and housing needs. Employment income, in particular, can also help those with incarceration histories build pride, social status, and daily routine (Sullivan, 1989; Western, 2018), which can further assist them in socially reintegrating with family and community. The economic downturn brought on by the COVID-19 pandemic poses particular challenges for individuals who may be decarcerated during this period and require special considerations for social support systems related to employment, income support, and food security.

Employment

Although researchers often point to employment as the most important path to social and economic stability after incarceration (Sampson and Laub, 1993; Sullivan, 1989; Western, 2006), job seeking during the pandemic faces at least two obstacles. First, the employment crisis that has accompanied the broad shutdown of businesses has fueled unemployment among the recently incarcerated. Second, the low-wage jobs, often in service industries, filled by formerly incarcerated workers are currently treated as

“essential” and uncovered by the protections of a work-from-home schedule. If those released during the pandemic are more likely to be older or to have serious health problems, the “essential” employment that is available to them may carry significant COVID-19 risks.

Two employment-related benefits can be seen as particularly important for the economic well-being of low-income workers: the Earned Income Tax Credit (EITC) and unemployment insurance. The EITC could provide an important source of income support for people who have some earned income; however, researchers observe that its antipoverty effects are reduced by the very low level of benefits for single tax filers without children (Hoynes, 2019). Thus, while the EITC is now among the largest federal antipoverty programs, its benefits are small for the formerly incarcerated, who are often unmarried and living separately from their children. Unemployment insurance has not been a major source of support for recently incarcerated job seekers because few have a full-time employment history that enables the payment of those benefits. However, the CARES Act of 2020 expanded unemployment insurance to independent contractors and part-time workers who would normally be ineligible. The act also created Pandemic Unemployment Assistance for workers who have lost jobs because of the pandemic and for those caring for household or family members with COVID-19. Expanding the EITC to single filers and continuing expanded unemployment assistance could help provide economic stability for those who are diverted or released from incarceration.

Income Support

For released individuals who cannot find work, ensuring access to income support will be important for maintaining housing stability, food security, and safety as well as preventing reincarceration. This may be particularly relevant in the face of the widespread unemployment seen during the pandemic. Given the poor health and the high rate of disability among incarcerated men and women, Social Security Disability Income (SSDI) or Supplemental Security Income (SSI) may be important sources of income support, though SSDI and SSI applications can both be onerous. SSI is more readily available to people released from incarceration. As a social insurance program, SSDI requires a history of contribution to the program, whereas SSI is a needs-based program pegged to poverty status. SSDI benefits are more generous on average, but survey data indicate greater SSI income among formerly incarcerated respondents (Bryan, 2018). In both cases, successful application can take many months and access to correctional system medical records is needed to document a qualifying disability successfully, but obtaining such access can cause delays, especially during the pandemic.

There is no suspension of SSI benefits for brief periods of incarceration, less than 1 month, and benefit reinstatement is automatic for those incarcerated up to 1 year. For incarceration longer than 1 year, however, SSI benefits are not automatically reinstated. In contrast, SSDI benefits are automatically reinstated, and if the benefits were terminated prior to release individuals can apply for reinstatement. Individuals may meet criteria for SSI or SSDI because of disabilities identified, acquired, or exacerbated during incarceration. In such cases, applicants who were not eligible for SSI when they entered prison or jail may seek those benefits upon release.

Some institutions have prerelease agreements with Social Security offices that allow the application process to start several months prior to discharge. The SOAR (SSI/SSDI Outreach, Access, and Recovery) program has been shown to increase the success of obtaining SSI and SSDI benefits (Dennis et al., 2011). SOAR is designed to increase access to SSI/SSDI for people who are experiencing or at high risk of homelessness and have a mental health or substance use disability. When implemented in jails and prisons, it has achieved this aim (Lupfer and Ware, 2019; Ware, 2019). While there is no dedicated federal funding for SOAR programs, these programs exist in all 50 states through a variety of mechanisms, including collaboration with criminal justice institutions.

Food Insecurity

Food insecurity is defined by the U.S. Department of Agriculture as having limited access to adequate food (Coleman-Jensen et al., 2017; Ma et al., 2016). In 2019, approximately 13.7 million households (10.5% of all U.S. households) were food insecure at some point during the year (Economic Research Service, 2020). Early estimates of the effect of COVID-19 on food insecurity suggest that nearly one in four (23%) U.S. households were experiencing food insecurity as of April 2020 (Schanzenbach and Pitts, 2020). Food insecurity is associated with wide-ranging consequences for nutrition, health, and development (Seligman and Schilling, 2010) and significantly greater health care utilization, including emergency department visits and inpatient admissions (Berkowitz et al., 2018). Research clearly suggests that Supplemental Nutrition Assistance Program (SNAP) benefits reduce health care costs (Berkowitz, Seligman, and Basu, 2017).

Food insecurity is particularly common and severe for those released from incarceration, intersecting with the challenges of housing, family support, and poverty. Research by Western and colleagues (2015) has revealed that formerly incarcerated individuals in Boston experienced a number of stressors and hardships during reintegration and often lacked the ability to meet basic needs, including food and housing (Western et al., 2015). Using

data from the National Longitudinal Study of Adolescent to Adult Health, Testa and Jackson (2019) found that people with a history of incarceration have an increased likelihood of experiencing food insecurity, mediated in part by household income, depressive symptoms, and social isolation (Testa and Jackson, 2019). And a small study on food insecurity among people recently released from prisons in Texas, Connecticut, and California found that hunger (going 24 hours without food) was associated with increased HIV risk behaviors (Wang et al., 2013), including exchanging sex for money. Furthermore, hunger was worse among those living in states that limit SNAP benefits based on a criminal record.

In 1996, the U.S. Congress enacted a ban on eligibility for food stamps and other federal programs for people convicted of drug felonies as part of the Personal Responsibility and Work Opportunity Reconciliation Act (Mauer and McCalmont, 2013). Currently, only one state (South Carolina) has retained the full lifetime ban, but 24 states retain a partial ban, while 25 states and the District of Columbia enforce no ban (Government Accountability Office, 2005). Programs such as SNAP have been shown to significantly reduce poverty (NASEM, 2019), and they are also significantly associated with reduced recidivism among the formerly incarcerated (Yang, 2017). Given high rates of food insecurity and its strong association with increased health care utilization following release, enrolling individuals in SNAP prior to release from a correctional facility and eliminating this ban may reduce unnecessary use of the health care system during COVID-19 outbreaks.

CONCLUSION

Many of the challenges for meeting basic needs that individuals returning to the community confronted before the pandemic have been exacerbated during the COVID-19 period. The conditions to which individuals return home vary across communities and depend not only on the rates of community viral transmission but also on the available resources and supports for health care, housing, and income. Reentry planning will need to balance these considerations, as well as testing prior to release, the ability to quarantine in the community, and a complement of health care, housing, and income supports, as they are available; they are all important complements to decarceration efforts to maximize individual, family, and community health and safety. Decarceration will be most successful if correctional system leaders collaborate with community health care and social safety net systems to provide support to this population and eliminate barriers to existing resources and programs, including Medicaid, housing programs, and SNAP, which collectively can help mitigate both public health and public safety risks. We turn to these considerations in detail in the next chapter.

5

Guidance for Depopulating Correctional Facilities

Correctional facilities have been the sites of COVID-19 outbreaks across the country. Many of America's correctional facilities are overcrowded, and their physical designs and conditions prevent appropriate distancing and ventilation, making them high-risk environments for virus transmission. Incarcerated people once infected are three times more likely to die from COVID-19 than the general population (Saloner et al., 2020). Furthermore, outbreaks in correctional facilities are not isolated from the communities in which they are located. Researchers have found high rates of infection among correctional staff and associations between community rates of infection and incarceration rates (Reinhart and Chen, 2020; see Chapter 2). Mitigating and ultimately ending the pandemic will require public health efforts on many fronts, among which will be mitigating the spread of the virus in correctional facilities.

This chapter provides guidance for policy makers and other decision makers at the federal, state, and local levels for depopulating correctional facilities. The chapter summarizes the committee's findings in the previous chapters and highlights its conclusions and recommendations. The committee recognizes that some actions are immediately feasible (indeed, many are already under way in some jurisdictions), while others will take longer to implement. We offer recommendations that address immediate demands for preventing and controlling COVID-19 transmission in correctional facilities, as well as recommendations that foster preparedness for the next pandemic or emergency. Our assessment is based on the best available information and scientific evidence at this time, and we conclude with recommendations for critical data collection and research to build on this evidence base.

The preceding chapters have provided background in three ways: (1) laying out evidence on pre-pandemic conditions in prisons, jails, and U.S. Immigration and Customs Enforcement (ICE) detention centers, as well as the characteristics of incarcerated persons and their families and communities that have contributed to the spread of the novel coronavirus; (2) summarizing scholarship on COVID-19 and correctional facilities and assembling and analyzing data on COVID-19 infection in incarcerated people and staff and decarceration trends; and (3) describing prior scholarship on recidivism and evidence-based reentry supports, detailing the challenges and opportunities for responding effectively to the pandemic in the current context.

MITIGATING THE SPREAD OF THE VIRUS

The public health response to the COVID-19 pandemic in correctional facilities has been aimed at suppressing transmission of the virus to limit complications from the disease; to save as many lives as possible; and to preserve limited health care resources, including ventilators and personal protective equipment. The U.S. Centers for Disease Control and Prevention (CDC) issued guidance for correctional and detention settings twice during the pandemic (see Box 5-1 for the most recent guidance). Correctional administrators around the country have had to adapt these guidelines for the specific needs and challenges in their facilities.

Much of the CDC advice focuses on creating space between individuals; intensifying cleaning practices; and identifying, containing, and treating those infected within the operations of correctional facilities. CDC guidance encourages correctional officials to coordinate with law enforcement and court officials to identify ways to limit overcrowding (CDC, 2020), but it does not provide specifics about how best to reduce the population. Our review of the evidence indicates that relieving population pressures in jails, prisons, and detention centers greatly facilitates adherence to CDC guidelines, controlling COVID-19 outbreaks, and reducing health risks, particularly for medically vulnerable people (AMEND, 2020; Williams et al., 2020). Smaller populations make it easier for correctional officials to place individuals in single cells, have sufficient resources for testing, and safely quarantine individuals after exposure to an infected person.

The following sections summarize what the committee was able to learn during this brief study about efforts to mitigate the spread of the virus in correctional facilities, notably through its collective experience and the two webinars held in August 2020 (see Chapter 1). While some correctional, health, and legal authorities have responded creatively and vigorously to the pandemic, correctional facilities continue to experience large cluster outbreaks. Many correctional administrators still confront

BOX 5-1
Topics of the CDC's Recommendations Related to COVID-19 for Correctional and Detention Settings

- Operational and communications preparations for COVID-19
- Enhanced cleaning/disinfecting and hygiene practices
- Social distancing strategies to increase space between individuals in the facility
- Strategies to limit transmission from visitors
- Infection control, including recommended personal protective equipment (PPE) and potential alternatives during PPE shortages
- Verbal screening and temperature check protocols for incoming incarcerated/detained individuals, staff, and visitors
- Testing considerations for SARS-CoV-2 (the virus responsible for COVID-19)
- Medical isolation of individuals with confirmed and suspected COVID-19 and quarantine of close contacts, including considerations for cohorting when individual spaces are limited
- Health care evaluation for individuals with suspected COVID-19
- Clinical care for individuals with confirmed and suspected COVID-19
- Considerations for people who are at increased risk for severe illness from COVID-19

SOURCE: CDC Guidance for Correctional & Detention Facilities (updated July 22, 2020) (CDC, 2020).

pressing needs to reduce the numbers of confined people, especially those at high risk for infection and complications.

**Attention to COVID-19 Prevention and Control
among Incarcerated Individuals**

Following CDC and other official guidance and through informal sharing of lessons between correctional leaders, facilities have adopted a range of approaches to prevent and mitigate SARS-CoV-2 transmission. These include population management (quarantines, medical isolation, cohorting, and single celling), surveillance, screening and testing for SARS-CoV-2 infection, contact tracing, and expanded communication efforts to keep incarcerated individuals and their families informed (e.g., see Box 5-2 for strategies undertaken by the Pennsylvania Department of Corrections).

Quarantines, Medical Isolation, Cohorting, and Single Celling

Quarantine, medical isolation, cohorting, and single celling are related protocols for separating COVID-19 cases from susceptible persons within

BOX 5-2**Timeline of Pandemic Response and Depopulation Efforts of Pennsylvania Department of Corrections**

March 13, 2020

- Cancelled visits at all state correctional institutions
- Started working on advanced cleaning and hygiene and new forms of engagement
- Began enhanced screening (taking temperatures and asking a series of questions) of all staff, vendors, and contracted providers, including contracted chaplains

March 23, 2020

- Changed reception of newly sentenced people and those who violated the conditions of their parole to only one facility with quarantine period
- Increased the medical staff and medical supplies at this reception facility
- Initiated steps to reduce the incarcerated population (e.g., working with the parole board to maximize releases, expediting the release process for anyone with a pending home plan)

March 29, 2020

- First incarcerated person with a positive test for COVID-19
- Implemented a statewide quarantine of incarcerated people
- Incarcerated individuals ate in their cells but were allowed out-of-cell time for video visits, phone calls, and access to the law library, as well as provided with in-cell programming

a facility. Quarantines involve separating individuals who are exposed to or expected to have an infectious disease from others in the facility until their disease status is known. In the case of COVID-19 in correctional facilities, the CDC recommends that individuals be quarantined for 14 days in individual cells (CDC, 2020).

Medical isolation is the practice of separating individuals with confirmed COVID-19 cases from the uninfected population until they are no longer contagious (Williams, 2020). Medical isolation is distinct from solitary confinement¹ (CDC, 2020). Given the negative impacts of solitary confinement (NRC, 2014), steps need to be taken to ensure the maintenance of contact with other people, including family, in cases of medical isolation. Although many facilities have suspended in-person visits to minimize viral transmission, some have implemented free virtual visiting programs and phone calls to encourage social contact. When the protocols of solitary

¹The CDC guidance refers to this as “punitive isolation” (CDC, 2020).

April 10, 2020

- Governor's order^a for temporary program to reprove sentences of incarcerated people in state prisons who have been identified as being nonviolent and who otherwise would be eligible for release within the next 9 months or who are considered at high risk for complications of coronavirus and are within 12 months of their release—approximately 1,500 to 1,800 incarcerated people would be eligible

May 26, 2020

- Began reopening process^b for state prisons—following governor's reopening plan for state, as counties advance through phases, prisons within those counties will gradually increase the "cohort size" or number of incarcerated people allowed out of cells at one time
- Both staff and incarcerated people required to wear masks
- Employee enhanced screening continued and contact visits remain suspended through all levels until the entire state is in phase "green"—video visits remain an option
- A COVID testing strategy initiated that includes (in part) testing of all transfers, all individuals who are to be released, and all new commitments from county jails

SOURCES: Excerpts from news archive available from <https://www.cor.pa.gov/Pages/COVID-19.aspx> and <https://www.media.pa.gov/Pages/Corrections.aspx>.

^aGovernor Order available at <https://www.governor.pa.gov/wp-content/uploads/2020/04/20200410-GOV-DOC-reprieve-release-order-COVID-19.pdf>.

^bDemobilization plan available at <https://www.cor.pa.gov/Documents/PA-DOC-COVID-Demobilization-Plan.pdf>.

confinement are used for quarantines or medical isolation, individuals may mask or disguise coronavirus symptoms for fear of being sent to solitary confinement, which could lead to more extensive outbreaks (Cloud et al., 2020; Williams, 2020).

People with confirmed COVID-19 cases can be grouped together and isolated to prevent transmission to other people and parts of the prison or jail. This practice is known as cohorting (CDC, 2020). Cohorting individuals with confirmed COVID-19 allows correctional facilities to separate people with COVID-19 from the general population without isolating them entirely. Some correctional facilities have adopted other small groupings or cohorts in order to reduce person-to-person contacts and movement within facilities.² Assigning people to cohorts has thus served

²For example, in the Pennsylvania Department of Corrections, the size of cohorts has ranged from 2 to 50 individuals depending on the prevalence of COVID-19 in a facility (see demobilization chart at <https://www.cor.pa.gov/Documents/PA-DOC-COVID-Demobilization-Plan.pdf>).

multiple purposes during the pandemic. Cohorts often share housing units and bathroom facilities and, depending on the level of virus transmission within a facility, meals, programming, and work assignments. Furthermore, correctional staff can be assigned to a single cohort, reducing the mixing of correctional staff with many different incarcerated people.

In some state prison systems, disused facilities or housing units were reopened in order to quarantine and/or medically isolate incarcerated people. In others, reducing the incarcerated population through prison releases and jail suspensions enabled the reconfiguration of units within facilities to support quarantines and isolation (CLA, 2020).

Surveillance and Screening and Testing for COVID-19

In response to COVID-19, correctional facilities have developed screening and testing procedures for staff and incarcerated individuals that have evolved throughout the pandemic. Facilities have used a range of diagnostic tests³ and have implemented mass,⁴ targeted, and prevalence⁵ testing strategies (CLA, 2020; Hagan et al., 2020).

Testing incarcerated individuals for COVID-19 proved to be a challenge for many facilities. Testing supplies were often limited and slow to arrive at correctional facilities, or sometimes rendered useless for controlling COVID-19 by the length of time required for laboratories to return

³Coronavirus tests fall into two primary categories: molecular or antigen (Food and Drug Administration, 2020). Molecular tests are used to diagnose an active coronavirus infection, and results for most molecular tests can take up to 1 week. Antigen tests can also be used to diagnose an active coronavirus infection, but they are more likely to produce false negatives than molecular tests. Antigen test results can be available within 1 hour. Rapid tests can be either molecular or antigen tests. These tests can be analyzed in a clinic or doctor's office, potentially providing a result within minutes.

⁴Mass testing usually refers to the practice of testing an entire population or group for coronavirus infection, whether or not they display symptoms. The goal of mass testing is to find asymptomatic or presymptomatic individuals with active infections (Raffle, Pollock, and Harding-Edgar, 2020). These individuals can then be isolated and their contacts can be traced to identify other potential cases. False negative and false positive test results are a concern in all coronavirus testing, and mass testing produces both false negatives and false positives in greater numbers (Raffle, Pollock, and Harding-Edgar, 2020), which carries the potential for missed cases and unnecessary isolation (Manrai and Mandl, 2020).

⁵Prevalence testing entails testing a random sample of a population to determine the prevalence of an illness at a given point in time. Prevalence testing can provide corrections officials with useful information about viral spread in their facilities but does not identify all active COVID-19 infections. Targeted testing programs reserve tests only for those with either convincing symptoms, likely exposure to COVID-19, or risk factors for severe illness. Some have argued that incarcerated individuals and correctional staff should be priority targets for testing, given that they live and work in crowded conditions (Huerto, Goold, and Newton, 2020).

results (CLA, 2020). Accordingly, some correctional systems adopted alternative testing and surveillance approaches. The Ohio Department of Corrections (DOC), for example, supplements their surveillance by testing wastewater for the presence of the SARS-CoV-2 virus as an early warning system. In partnership with the U.S. Environmental Protection Agency and the Ohio State University, the Ohio DOC conducts regular wastewater tests of facilities (Chambers-Smith, 2020). The regular tests can identify likely outbreaks before they happen, giving correctional officials 5–7 days to prepare supplies, implement restrictive protocols, and marshal resources to the affected facility. The Ohio DOC also developed a contact tracing plan based on an incarcerated person’s movement through and within the system (Chambers-Smith, 2020); the Ohio DOC used surveys and facility-based cameras to identify people who were exposed to the infected person. Incarcerated individuals were tested on entry to a facility, when transferred between facilities, and after interaction with people in external facilities (e.g., after receiving health care services outside of their home facility) (Chambers-Smith, 2020). This testing plan allowed the Ohio DOC to identify more cases than had been revealed by mass testing or contact tracing.

Communication with Incarcerated Individuals and Their Families

Correctional leaders in some systems have used frequent communication with incarcerated individuals and correctional staff to encourage compliance with COVID-19 protective measures. The Correctional Leaders Association recommends “overcommunication” between corrections leaders and incarcerated individuals, with regular explanations of operational changes as they happen (CLA, 2020). Clearly communicating that changes to programming, movement, or visitation are occurring for the safety of incarcerated individuals, rather than punishment, is important for encouraging cooperation (CLA, 2020). One correctional official described to the committee their provision of opportunities for comfort and entertainment including setting up coffee and tea stations and providing board games and puzzles in quarantine units. Other facilities provided free access to cable television and tablets to use for education or entertainment (CLA, 2020), and free video visit programs to replace in-person visitation.

Some correctional leaders have also endeavored to communicate with the families and loved ones of incarcerated individuals about the status of COVID-19 infection within corrections and any adjustments to operations within correctional facilities. Several departments of corrections have shared information about COVID-19 within facilities with the public. The Pennsylvania DOC, for example, maintains a dashboard on its website with key coronavirus metrics for each correctional facility. The

website also includes information on facilities' prevention and mitigation plans. Other state departments of corrections also maintain similar webpages.

Attention to Prevention among Correctional Facilities Staff

The most recent CDC guidance details protections for correctional staff (CDC, 2020), and public health experts emphasize the central importance of the occupational health of correctional staff to mitigating COVID-19 in correctional facilities (Sears et al., 2020). Like other first-line responders, correctional facility staff are essential workers and must report to work even during emergency lockdowns. They may either bring COVID-19 into the facility or acquire it at work and transmit it to their families and communities. Some correctional systems have worked to include staff in mitigation plans and make the development of these plans transparent (CLA, 2020), but balancing the safety and protection of staff while maintaining safe management of a facility is challenging. Many correctional facilities lack telework options and capability, face preexisting staff shortages that are compounded by absenteeism during the pandemic, and have limited employer-provided child care options and resources to cover new or existing staff without available paid leave.

Nonetheless, correctional administrators across the country have developed collaborations to implement practices for preventing and mitigating COVID-19 among facility staff. The committee is aware of many of these practices, including hiring community supervision officers and previous employees to address current staff shortages, streamlining onboarding processes, and providing incentives to work in high-risk areas; supporting telework where appropriate; allowing the use of administrative leave and providing paid sick leave for 14 days; promoting staff wellness by providing masks, hand hygiene stations, and resources for health and stress management; holding virtual town halls to address staff concerns; conducting on-site testing; and arranging alternative housing in hotels for staff members who self-report being exposed to COVID-19 and want to protect their families (CLA, 2020).

GUIDING PRINCIPLES OF EQUITY AND TRANSPARENCY

The COVID-19 pandemic in the correctional system follows the contours of racial and economic inequality, confronts decisions between the financial cost of mitigation and public health, and requires high-quality data for informed decision making. The committee thus adopted the following principles to consider in developing strategies for depopulating correctional facilities.

- **Maximization of net benefits**—Under this principle, decarceration plans will aim strategically to reduce mortality and morbidity caused by the transmission of COVID-19 among incarcerated and detained people, correctional staff, and the local communities in which they are located. In addition, planning will reflect consideration of improvements of conditions of confinement and services for those who must remain incarcerated, as well as potential public safety and fiscal costs.
- **Equal regard and fairness with view to mitigation of health and racial inequities**—The principle of equal regard recognizes the equal worth and value of all people, protecting them from discrimination, when determining fair approaches to limiting the use of custody and releasing individuals from correctional facilities. This principle requires that decarceration strategies be implemented in ways that do not raise risks to the health and well-being of already vulnerable individuals, families, and communities, and it also acknowledges how institutions and structures continue to increase the risk of incarcerated people for poor health outcomes, especially for Black and low-income people. Reducing COVID-19 transmission will require new partnerships across systems (housing, health care, social service, and correctional systems) and the removal of institutional and legal barriers that prevent incarcerated people from accessing food, health care, housing, and income supports following release. Achieving health equity means ensuring the fair and just opportunity to be as healthy as possible for all members of society, including those previously incarcerated. While health and safety priorities will have to be considered, the principle of fairness requires impartiality and the engagement and participation of affected groups in establishing criteria for decarceration.
- **Transparency to support evidence-based decision making**—A key issue for this principle is the use of health evidence to inform decisions about diversion and release. Health evidence typically has little role in criminal justice decision making, but public health emergencies necessitate a broad conception of public safety, one that encompasses the threats to life and health posed by virulent disease. The principle of transparency demands data on COVID-19 infection and complications from facilities and disclosure of the criteria and priorities that will determine people's chances of future detention and/or release, as well as how decarceration strategies are to be implemented and whether certain populations will benefit more than others. Decisions in decarceration planning can be affirmed if they are supported by regular review of available data

and information and informed by feedback from collaborators and stakeholders, including public health professionals and currently incarcerated individuals.

TAKING ACTION: THE COMMITTEE'S CONCLUSIONS AND RECOMMENDATIONS

Throughout this report, the committee has argued that incarcerated people and their families and correctional staff are particularly vulnerable to infection and severe illness from COVID-19. Standard prevention and infection control strategies within correctional facilities are important but can be difficult to implement, especially if facilities are overcrowded or unable to implement CDC guidance to maximize physical distancing and other mitigation strategies. Our first eight recommendations are based on one of our two key conclusions.

Conclusion 1: Decarceration is an appropriate and necessary mitigation strategy to include in the COVID-19 response in correctional facilities. Decarceration—consisting of both diversion from incarceration and reduction of the incarcerated population through accelerated release from jails, prisons, and detention centers—will facilitate other mitigation strategies in correctional facilities designed to prevent exposure to and transmission of disease among those who remain.

Decarceration is a process, not a one-time action, and will vary by state and jurisdiction, adjusting as needed for the state of viral transmission within a correctional facility and the surrounding community and the complement of housing, health care, and income supports necessary and available at the time. Safe and equitable decarceration will require a mix of policy and practice decisions among federal, state, and local officials and will require actions to reduce the number of people detained and to release incarcerated individuals from correctional facilities. It will require policies and actions to ensure adequate health care and social supports for released individuals and their families.

While the committee presents actions that may be taken in the short term to address immediate concerns, the committee also offers recommendations for preparedness for future outbreaks and pandemics, which are of key concern to decision makers and correctional leaders. Because forecasting the time frame in which the current crisis may end is highly speculative, the committee suggests actions and planning in the short term that can help with preparedness for future COVID-19 outbreaks and the next pandemic or emergency. Monitoring the progress of decarceration efforts, including regular assessments of the state of the pandemic and needs of those released

as well as those still incarcerated, will help jurisdictions make adjustments as necessary and build foundations for emergency planning during and post pandemic.

Diversion: Immediate Considerations

The committee urges all public officials with the legal authority to exercise their discretion to divert individuals from incarceration. During public health crises, there are few compelling public safety reasons to hold many people in custody. While there may often be risks of criminal behavior in the future, for many individuals, especially those held in pretrial detention, evidence suggests these risks are relatively low (see Chapter 3). The risks of crime and of viral transmission in correctional facilities both threaten community safety, and both need to be weighed in decisions to decarcerate.

As noted in Chapter 3, some jurisdictions have taken steps to decarcerate their correctional facilities through diversion. Decreases in incarcerated populations that have occurred since the onset of the pandemic are predominantly the result of declines in new entrants due to decreased arrests and fewer bookings because of lockdowns and the closure of state and local courts. As stay-at-home restrictions have been lifted and as courts have begun to resume normal operations, the number of new entrants into jails has begun to increase despite the continued public health risk. When incarceration seriously threatens a person's health (see, e.g., Skarupski et al., 2018), incarceration for noncriminal behavior or minor charges is to be avoided. Misdemeanors, technical violations of probation and parole, and nonpayment of bail are all cases appropriate for diversion in a public health emergency. The use of discretion for diversion in this way may be especially relevant to jail incarceration and in many cases could be implemented immediately without formal changes in policy or new commitments of resources.

Recommendation 1: Federal, state, and local officials should exercise their discretion across a variety of domains to divert individuals from incarceration, including

- (a) law enforcement's issuance of citations in lieu of making arrests;
- (b) judges' and prosecutors' adherence to a strong presumption against pretrial detention, and release on own recognizance as a default option, to be overridden only when strong evidence indicates that release would be at odds with public safety or court appearance;
- (c) legislatures', prosecutors', and courts' elimination of the use of incarceration for failure to pay fines and fees and

- prioritization of noncustodial penalties for misdemeanors, probation and parole violations, and other nonserious conduct to the extent possible; and
- (d) local officials' elimination of or significant reduction in the use of bail.

Release: Immediate and Medium-Term Actions

While efforts to divert individuals from incarceration will stem the flow of people into jails and, ultimately, prisons, additional mechanisms will be needed to reduce the public health risks confronted by individuals already incarcerated. The committee acknowledges that release efforts often require greater political will and more time to implement than diversion efforts. However, consideration of health equity prompts a deeper look at incarcerated individuals, especially those in prisons, who tend to be at greater risk for COVID-19 due to their age, the presence of chronic health conditions, and the length of potential exposure given their typically longer sentences. While the total prison population across the country has declined by roughly 5 percent since the onset of the pandemic (Franco-Paredes et al., 2020; see also Chapter 3), the 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 (see Chapter 3).

Moreover, the necessary extent of depopulation will vary by facility.⁶ The need and timing for various decarceration strategies will require consideration of factors such as overcrowding, the physical design and conditions of facilities, population turnover, and case positivity rates (or reproduction ratio) among the incarcerated population and surrounding community.

Past research on recidivism indicates that correctional authorities have opportunities to decarcerate in a manner that minimizes risk to public safety if given the flexibility to do so, as there are alternatives to incarceration and community supports that can reduce the risks of further criminal behavior. While prison release policies often focus on

⁶As noted in Chapter 3, total declines in system-wide populations by themselves may contribute little to mitigating the spread of the virus. For example, if the state of Pennsylvania incarcerated 100,000 people in January 2020 and released 20,000 in March 2020, the incarcerated population in Pennsylvania would have declined by 20 percent. However, if the state achieved that population decline by closing two facilities that housed 10,000 individuals each and did nothing to affect the population size of the remaining facilities in its system, the remaining incarcerated individuals would remain at the same risk as they were prior to the 20 percent reduction, if nothing else changed.

those convicted of nonviolent offenses, consideration of decarceration for individuals serving violent convictions is also warranted. Generally speaking, older incarcerated persons serving long prison sentences tend to be serving time for a serious violent conviction and these individuals are often those that are at high-risk for COVID-related complications and mortality due to advanced age and comorbid health conditions. Prescott, Pyle, and Starr (2020) find those convicted of violent crimes consistently have lower recidivism rates relative to individuals convicted of nonviolent crimes. Interestingly, the authors find that individuals convicted of violent offenses have lower overall recidivism rates for all age groups, though the recidivism rates are particularly lower for incarcerated people 55 and over (see Chapter 3).

Recommendation 2: Correctional officials in conjunction with public health authorities should take steps to assess the optimal population level of their facilities to adhere to public health guidelines during the pandemic, considering factors such as overcrowding, the physical design and conditions of their facilities, population turnover, health care capacity, and the health of the incarcerated population.

Recommendation 3: To the extent that the current population level in a facility is higher than the optimal population level for adhering to public health guidelines, correctional officials should identify candidates for release from prison and jail in a fair and equitable manner and engage other officials outside the correctional system as necessary to expedite decarceration to the optimal level. Individuals assessed as medically vulnerable, nearing sentence completion, or of low risk to commit serious crime are likely to be suitable candidates for release during a public health crisis.

Compassionate release—intended to reduce sentences and release incarcerated people for compelling reasons, usually related to medical and family circumstances—would in theory be appropriate during the pandemic. However, the committee’s review of state policies revealed substantial barriers to using compassionate release policies to shorten sentences when incarcerated people are facing significant risks to health, including death, hampering the ability of jurisdictions to undertake large-scale releases. When considering petitions for compassionate release, decision makers, such as judges and parole boards, should emphasize health criteria and age as well as the evolving environment of health risks during the pandemic, embracing evidence-based principles by adopting medical eligibility criteria that reflect current medical knowledge about how people commonly experience serious illness and die (Prost and Williams, 2020; Williams et al., 2011). Release

decisions relying substantially on the petitioner's original crime will tend to overlook the medical criteria that should gain greater weight in a public health emergency.

In terms of procedure, states could consider revising compassionate release policies in ways that accord with changes in the federal approach to compassionate release resulting from enactment of the First Step Act. Previously courts could consider only compassionate release petitions brought by the director of the Federal Bureau of Prisons (BOP). Petitioners could file their compassionate release petitions and wait while their requests underwent multiple levels of BOP review, any one of which could result in a denial. Under the First Step Act, if petitioners receive no response to their petition within 30 days, they have the right to bring their own petition to the federal court. This shift not only speeds up the process but also allows for advocates to represent petitioners' interests.

Recommendation 4: Given the extreme medical vulnerability of some incarcerated people to COVID-19, federal and state policy makers should revise compassionate release policies to account for petitioners' medical condition, age, functional or cognitive impairment, or family circumstances. Because of the severity of the health risks, such applications should be reviewable by the courts or some other decision maker external to the standard parole process and should allow scope for representation by counsel in the process on behalf of petitioners.

Reentry and Safe Return into Communities: Immediate and Medium-Term Actions

Engaging community systems to support successful reentry will be an important complement to any release efforts made in response to the COVID-19 pandemic. Research indicates that when a person leaves a correctional facility, the most urgent needs for material well-being include housing, health care, and income supports (Western, 2018). Steps taken through reentry planning and the provision of these supports, especially during the first few weeks following release, can help mitigate viral transmission, personal health, public health, and recidivism risks.

The committee recognizes that many of its recommendations for ensuring safe return to communities will have financial and budgetary implications for federal, state, and local governments, and especially correctional, housing, and health care systems. For this reason, the committee urges these actors to fully utilize existing funds and programs, ensure eligibility and enrollment of released people into existing social safety net programs, and prioritize this population in consideration for COVID-19 relief funds.

Supporting Individuals Who Return to Their Communities

The quick release of incarcerated people, particularly those with chronic health conditions or mental illnesses, will require clear plans for continuation of medical care and information about how to protect themselves and their families from COVID-19. Prior to release, people need to receive adequate information and education on the release process, along with clear recommendations and connections to assistance programs and services that meet their specific needs (Beaudry et al., 2020). They and family advocates need to have the opportunity to meet with discharge planners or other social service providers to review discharge plans and community referrals, ask questions, and seek additional guidance as needed. Such information needs to be communicated at appropriate reading levels.

Housing, health care, and income supports, including provision for such basic needs as food, a telephone, and government identification, are important components of a discharge plan. Table 5-1 lists strategies that can be considered during discharge planning to ensure that supports and services are in place prior to reentry.

Obtaining these supports during the COVID-19 pandemic will vary by community. Community organizations may be closed or working remotely, which limits their ability to provide basic needs. In this context, telephone access is a priority, as it is critical to connecting with health care (Mann et al., 2020) and other social services (Western, 2006; Western et al., 2015). Incarcerated people being released need to therefore be given phones, preferably with video capacity, through a prepaid cell phone service or expedited referral to the Federal Communications Commission's lifeline service. Likewise, as food systems are interrupted during the pandemic (Raifman, Bor, and Venkataramani, 2020), it will be important to facilitate the ability of those being released to obtain Supplemental Nutrition Assistance Program (SNAP) benefits prior to release, and states can expand their use of disaster SNAP benefits (Benfer and Wiley, 2020).

Given the high rates of COVID-19 among nonsheltered individuals (Baggett et al., 2020; Mosites et al., 2020), being released to homelessness during the COVID-19 pandemic is not in the interests of public health (Howell et al., 2020). Since many shelter systems are closed during community COVID-19 outbreaks, housing and medical discharge plans may need to be coordinated among housing, health care, and correctional systems to facilitate smooth and safe discharge plans, especially for the most medically vulnerable. As with past outbreaks of infectious disease in correctional facilities, multiagency collaboration is an integral part of managing release during the time of COVID-19 (Beaudry et al., 2020; CDSS, 2020) and critical to ensure racial equity. Families of Black, Hispanic, and Native American individuals tend to face more impediments and threats to safety than

TABLE 5-1 Strategies for Ensuring the Availability of a Bundle of Supports and Services for Reentry

Domain	General Postdischarge Concerns	COVID-19–Specific Concerns
Housing	<ul style="list-style-type: none"> Limited access to housing; high risk for homelessness 	<ul style="list-style-type: none"> Shortage of reliable and safe noncongregate housing Families live in housing and neighborhoods at high risk if infected
Food Security	<ul style="list-style-type: none"> Limited access to public assistance and SNAP benefits 	<ul style="list-style-type: none"> Interruption of normal food supply chains; difficulty obtaining government IDs
Income	<ul style="list-style-type: none"> Extreme poverty Income instability 	<ul style="list-style-type: none"> Economic recession, high unemployment Difficulty enrolling in SSI Limited eligibility for social insurance programs like unemployment insurance, SSDI
Health Care Access	<ul style="list-style-type: none"> Gaps in primary care and substance use and mental health treatment, high utilization of emergency care, discrimination; many have never used the community health system 	<ul style="list-style-type: none"> Limited outpatient and inpatient capacity; transition to telemedicine services; limitations on or cessation of new patient visits
Health Insurance	<ul style="list-style-type: none"> Underinsurance or lack of insurance common among release individuals Medicaid/Medicare coverage is terminated instead of suspended 	<ul style="list-style-type: none"> Difficulty obtaining government IDs

NOTES: DEA, Drug Enforcement Agency; SAMHSA, Substance Abuse and Mental Health Services Administration; SNAP, Supplemental Nutrition Assistance Program; SSDI, Supplemental Security Disability Insurance; SSI, Supplemental Security Income.

SOURCE: Adapted from Howell et al. (2020).

 Strategies

- Perform COVID-19 tests on individuals prior to release
 - Expand access to noncongregate transitional housing, rapid rehousing, and permanent supportive housing programs
 - Eliminate bans on housing assistance and tenancy in public housing based on criminal record
 - Facilitate SNAP enrollment prerelease
 - Eliminate work requirements and bans on public assistance based on criminal record
- Provide financial support at the time of release to the individual/family
 - Program enrollment prior to release as part of discharge planning
 - Obtain ID to assist in enrollment in income support programs and benefit receipt
- Ensure all people have access to a phone appropriate for telemedicine
 - Provide timely primary care
 - Arrange for coordination between correctional and community health
 - Arrange for effective transfer of health records
 - Provide a 90-day supply of medication
 - Expand funding and capacity to enhance primary care based transitional services, including peer/community health workers
 - Maintain SAMHSA and DEA measures to increase access to buprenorphine and methadone and further deregulation
- Facilitate expedited Medicaid/Medicare enrollment
 - Facilitate use of Medicaid waivers 1115 and 1135
 - Allow Medicaid payment for medical services furnished to an incarcerated individual during the 30-day period prior to the individual's release
 - Eliminate termination of Medicaid upon incarceration
-

White families offering housing to previously incarcerated family members (Simes, 2018a; Western, Braga, and Kohl, 2017). They are more likely to live in publicly subsidized housing, to face severe housing cost burdens, to live in overcrowded housing, and to fear eviction (National Low Income Housing Coalition, 2019). These factors all pose barriers to hosting a re-entering individual and may magnify inequities if prisons and jails make decisions about whom to release based on the availability of housing and social networks.

The economic downturn brought on by the COVID-19 pandemic poses particular challenges for individuals who may be decarcerated during this period and require special considerations for social support systems related to employment, income support, and food security. Income support typically relies on the major federal antipoverty and social insurance programs, such as SNAP, Supplemental Security Income, and Social Security Disability Insurance, as well as unemployment insurance.

Access to community health care services can be challenging during COVID-19. In communities with high rates of transmission, some community health care systems are not taking new patients, and many are only conducting telemedicine visits. Especially in the midst of community outbreaks and particularly in rural areas where there is limited community outpatient and inpatient capacity, correctional facilities will need to ensure that all people reenter the community with guidance on how to access primary care and with at least a 90-day supply of their medications, which is a standard refill supply in the community (CMS, 2020).⁷ People just released from correctional systems often do not know how to make health care appointments, obtain their medications, or get a referral to access specialist care. Correctional facilities can also facilitate “warm handoffs” to community health care systems, including substance use and mental health providers (Freudenberg et al., 2005; Richie, Freudenberg, and Page, 2001), where possible, using video technologies.

Community health care systems need to screen new patients for recent release from a correctional system and provide, where possible, in-person appointments for those newly released given their propensity for poor health outcomes. When in-person visits are not possible, using telemedicine (as opposed to telephone visits) can improve patient engagement in primary care following release so additional efforts need to be made so that patients

⁷Primary care providers can play a key role in ensuring a health-promoting transition by checking to see whether patients have obtained their medications and know how to use them and have a telephone for future telemedicine visits and can attend to any urgent issues, including risk for postrelease relapse (Binswanger et al., 2013).

have phones with video capabilities and are not required to register for the health system patient portal prior to the visit.⁸

Recommendation 5: When releasing individuals from prisons and jails, correctional officials, in collaboration with other public officials and community-based programs, should develop individualized reentry plans incorporating a bundle of services encompassing health care, housing, and income supports to address individual and family needs as an important complement to decarceration efforts. Incarcerated individuals should be eligible and approved for such services at least 30 days prior to release when possible.

- (a) Federal, state, and local authorities should identify resources for providing housing as required by incarcerated individuals for safe discharge including space for quarantining in the community. Local housing authorities should limit restrictions on housing eligibility based on criminal history to those required by the U.S. Department of Housing and Urban Development and limit restrictions on tenants adding returning household members. Federal, state, and local authorities should explore opportunities to offer financial support to families that provide housing to incarcerated individuals upon release. Correctional officials should take steps to facilitate enrollment in appropriate housing programs and services prior to release where necessary, and a lack of housing in the community should not be grounds for continuing incarceration.
- (b) State and local officials should identify barriers to access public benefits for individuals returning from incarceration; work to maintain continuity of benefits; and support enrollment in benefits for income and basic needs, including access to the Supplemental Nutrition Assistance Program, Medicaid, Medicare, and Supplemental Security Income.
- (c) Community health systems should facilitate health care access for people just released from correctional systems by removing requirements for government identification at the first visit, prioritizing the urgency of in-person first appointments immediately prior to release, and easing restrictions on video visits to improve engagement in primary care, substance use, and

⁸Compared with telephone communication, video communication is associated with greater patient understanding, which is particularly important for newly released people given the essential role of trusting relationships and clear communication in primary and successful chronic disease management (Lion et al., 2015; Nouri et al., 2020).

mental health treatment. The federal government, through the Centers for Medicare & Medicaid Services, Substance Abuse and Mental Health Services Administration, and the U.S. Drug Enforcement Administration, should extend and expand upon guidance that has permitted flexibility in the use of telemedicine for primary care and substance use treatment.

Supporting Families and Communities

In implementing decarceration strategies, it is important to design reentry in a way that does not increase risk to families and communities. Many of the families and communities associated with incarcerated individuals are vulnerable to health risks, food and housing insecurities, and other forms of socioeconomic disadvantage because of the many existing institutional and structural barriers. Those challenges and needs have been exacerbated in the wake of COVID-19.

To reduce risk of COVID-19 to families and communities, testing prior to discharge with timely return of results would reduce the risk of exposing others to the virus. Given the false negatives and real-world implementation difficulties encountered with COVID-19 testing, a synergistic strategy would be to also provide individuals returning to congregate or crowded settings a place in the community to complete a 14-day quarantine in a safer environment, such as a subsidized hotel room. Providing 14 days of quarantine upon release could protect families and home communities. Individuals with a COVID-19 diagnosis, symptoms consistent with COVID-19, or exposure to a person with a confirmed or suspected COVID-19 diagnosis will need to be provided with appropriate accommodations for isolation. This strategy has been used for homeless individuals exposed to other infected individuals and to household members living in crowded housing (CDSS, 2020)⁹; implementation of this strategy would encompass people returning to shelters, halfway houses, and family homes.

⁹Many jurisdictions, concerned about the possibility of COVID-19 transmission in shelters, have created opportunities for those at high risk for COVID-19 infection (those who are older or have underlying health risks) to move to noncongregate shelters, such as unoccupied hotel rooms, trailers, or dorm rooms (CDSS, 2020). Relatedly, many have offered short-term stays in noncongregate shelters for those who have been exposed to or infected with COVID-19 but do not meet criteria for hospitalization (or for long-term noncongregate shelter) (CDSS, 2020). These projects were funded by a combination of funding, including Federal Emergency Management Agency (FEMA) disaster management funding, state and local funding, and funding from the Federal Emergency Services Grant program. While FEMA has provided up to 75 percent of funding for those who meet program entry criteria, the localities (or states) have needed to commit the money up front and apply for FEMA reimbursement (CDSS, 2020). Programs nationwide have found that the key to success includes providing appropriate staffing to support individuals staying in hotels. Program recipients have been provided a single-

Families of incarcerated people living in subsidized housing may face regulations that prevent adding nonleaseholders or people with certain convictions. Reentry plans need to consider family needs and may include provisions for assistance such as SNAP enrollment, public housing, and eviction protection (see the above discussion of supports for individuals).

Recommendation 6: Correctional officials in coordination with local public health authorities should implement measures to avoid creating additional COVID-19–related health risks for families and communities. These measures should include providing COVID-19 testing prior to release and facilitating quarantining as necessary. When newly released individuals lack a place to quarantine, local officials should take steps to provide them with a safe place in the community to quarantine for 14 days before returning to their families, as well as publicly support and coordinate with community officials to ensure access to and retention of housing for returning individuals and their families.

Helping families prepare for and overcome reentry challenges can promote the health and well-being of individuals being released and their families and decrease the likelihood of recidivism. Communication to families is critical and needs to include information about the scheduled release date, time, and coordination with other agencies; any exposure to COVID-19 infections; and available support services. Providing support to families may involve partnering with community-based organizations that offer housing resources, employment and educational opportunities, child care services, case management, and such activities as relationship and parenting classes and reentry support groups.

Many individuals are mandated to community supervision or transitional housing (halfway houses) upon release and directed to report to parole or probation officers. Existing requirements often place formerly incarcerated individuals and their parole and probations officers in situations that could increase the likelihood of infection. Public officials can examine their parole and probation policies and procedures and take quick action where needed to reduce the impact of community supervision on the spread of COVID-19, as examples in Chapter 3 demonstrate. The usual conditions of supervision, such as requirements to apply for or obtain work, can be particularly onerous under pandemic conditions, when housing is highly insecure, public transportation is challenging, and unem-

occupancy room, three meals a day, and supportive services. In California, there is also an effort to transition those in a Project Roomkey noncongregate shelter to permanent housing.

ployment is high. A coalition of community supervision executives have offered suggestions for minimizing health risks associated with probation and parole: revocation for technical violations should be greatly limited or eliminated, probation and parole should be applied only to those who absolutely need community supervision, terms of probation and parole should be reduced, office visits should be replaced wherever possible with noncontact means of collecting supervision reports, discontinuation of reporting altogether should be considered for low-risk individuals, and probation and parole staff should receive accurate and understandable training on health practices under COVID-19 (EXiT, 2020).

Recommendation 7: Parole and probation departments should examine their policies and procedures and take quick action where needed to reduce the impact of community supervision on the spread of COVID-19. Such action should include administratively eliminating or greatly limiting revocation for technical violations, replacing in-person office visits wherever possible with noncontact means of collecting supervision reports, and removing conditions on parole or probation that require an individual to apply for or obtain work. Courts and paroling authorities should limit the application of probation and parole to those who absolutely need community supervision and reduce the terms of probation and parole to only as long as necessary to achieve the goals of supervision.

Improving Access to Health Insurance upon Release

Access to health insurance or assistance with navigating health care benefits is important for successful reentry during COVID-19. As discussed in Chapter 4, there are many barriers to Medicaid eligibility for incarcerated and formerly incarcerated individuals. Discharge planning should include a process for expediting enrollment or reenrollment in Medicaid or Medicare for eligible individuals upon release, especially since many government offices are closed so that people cannot obtain the necessary documents for Medicaid and Medicare applications, such as a proper form of government identification, in a timely way. For people with Department of Veterans Affairs (VA) health benefits, correctional facilities can also facilitate “warm handoffs” to VA resources. Additionally, 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.

Recommendation 8: States should remove barriers to eligibility for Medicaid to ensure that incarcerated and previously incarcerated individuals have access to COVID-19 tests and related services and transitional health care needs:

- (a) Exercise the optional eligibility provided in the Families First Coronavirus Response Act to provide Medicaid coverage for COVID-19 testing and related services to individuals who are uninsured;
- (b) Allow Medicaid payment for medical services furnished to an incarcerated individual during the 30-day period prior to that individual's release;
- (c) As long as statutes preclude Medicaid reimbursement for incarcerated individuals, states should 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; and when they do so, the Centers for Medicare & Medicaid Services should take steps to facilitate the speedy review of and decision on such waivers; and
- (d) Enroll individuals eligible for Medicaid during incarceration, prior to their release.

Allowing Medicaid payment for an incarcerated individual during the 30-day period prior to that individual's release would provide a mechanism for COVID-19 testing and related services and ensure a smoother transition into primary care. There is evidence that tailoring health care practices to this population's needs by hiring peers or community health workers with past histories of incarceration can improve patient engagement in health care (Cunningham et al., 2018; Wang et al., 2008;) and reduce preventable hospitalization, also reducing future contact with the criminal justice system (Wang et al., 2019). Community health systems could be incentivized to tailor primary care practices through Medicaid financing or financing of federally qualified health centers by the Health Resources and Services Administration, creating smoother transitions for people being released from corrections during COVID-19 and also for the opioid epidemic and other public health emergencies.

Activating Medicaid coverage in the 30 days prior to a person's release would have the added effect of bringing oversight to correctional health care. It is well known that the quality of health care across correctional institutions varies greatly because of "a lack of uniform standards, the disconnect between correctional health care and that provided within the

community, and the variations in correctional health care providers and availability of treatments” (NRC, 2014, p. 213). While voluntary accreditation exists, there is no mandatory oversight of correctional health care as exists in the community setting that would permit identification of better- and worse-performing facilities or improvements in care delivery. Any preparedness strategy for the next COVID-19 outbreak or public health emergency will require improved integration of correctional facilities in the larger public health and health care system and especially during the transition back to the community.

PREPAREDNESS FOR FUTURE COVID-19 OUTBREAKS AND PANDEMICS

While the committee recognizes the need for urgent actions to incorporate decarceration as a tool to mitigate and prevent COVID-19 transmission in correctional facilities and the community, past literature of pandemic management in correctional facilities suggests that preparedness planning is critical to management of future COVID-19 outbreaks and other public health emergencies.

Evidence from the pandemic response in the past few months indicates that current efforts have been insufficient to reduce correctional populations in some facilities to a density that will enable those who remain incarcerated to practice adequate physical distancing or enable the release of those who are vulnerable to severe illness from COVID-19 or death. State and federal governments can take steps to improve the preparedness of correctional systems for future waves of the COVID-19 pandemic and subsequent pandemics or public health emergencies. As prison conditions and populations and the laws governing them are likely to change, existing state and federal public health agencies could provide an ongoing review of incarceration and release policies from a public health perspective and help ensure that the criminal justice system is prepared to respond appropriately to public health crises. These efforts could include the establishment of a planning and review group comprising public health experts, health care providers, and community representatives, including formerly incarcerated individuals, in collaboration with correctional officials and lawmakers, to review release policies from a public health perspective that weighs medical criteria and public health considerations with criminal justice system considerations. Such groups have been historically enacted to support governments and institutions by bringing together the appropriate balance of expertise to provide in-depth examination of particular issues and/or serve as an authoritative body between elected officials and the community to assist with public decision making.

Conclusion 2: Past research on pandemic management in correctional facilities suggests that preparedness planning is critical to management of future COVID-19 outbreaks and other public health emergencies. Preparedness planning involves public health experts and correctional officials and the creation of health plans for safely diverting and releasing people from custody during public health emergencies.

In the context of an emergency, a group convened by federal, state, or local government could also be empowered to implement decarceration strategies in accordance with public health preparedness plans. In their deliberations, the group would need to consider both the needs of incarcerated people and those of staff, who also face elevated risks of harm during a pandemic. Such a group could also serve to provide real-time review of health care delivery and prevention efforts in correctional facilities as the science evolved. The success of any such group would depend on the exposure to a wide variety of perspectives and on an accurate understanding of prevailing carceral conditions. Channels will therefore need to be created to provide incarcerated people with access to the group, and group members will need to be granted the authority to visit and tour all parts of any carceral facility whose practices are being considered.

DATA NEEDS AND RESEARCH RECOMMENDATIONS

Currently, the prison systems of all 50 states, Puerto Rico,¹⁰ and the BOP, are providing some data relevant to COVID-19 prevention efforts and cases in their facilities in public-facing websites. Almost all prison systems report case rates and hospitalization and mortality data; however, far fewer systems report testing rates (including type of tests, repeated testing of individuals), which confounds reporting of case rates among incarcerated people and staff, as well as data on hospitalization and mortality. Across systems, these data are updated at different intervals, and there are few reports on how data are collected or defined or how data parameters may have changed over time. The lack of data standardization across correctional systems further complicates assessments of COVID-19 incidence and outcomes and comparisons with local communities. Only three states, as of this writing, provide any information on race or ethnicity, which is essential to identify and address possible disparities in COVID-19 testing, cases, and deaths.

Far less is known about COVID-19 outcomes in the 3,200 jail systems across the country. A majority of jails are not reporting any COVID-19

¹⁰Data from other U.S. territories are currently lacking.

case rates, hospitalizations, or deaths, and systematic data about detention centers of ICE or juvenile facilities are unavailable. Also important to understanding COVID-19 in jails and calculating basic epidemiologic characteristics of COVID-19 outbreaks are the daily populations of jails with respect to new intakes and releases, which change significantly, especially in large urban jails.

It is critical that correctional systems standardize their data. If there are gaps in reporting, systems need to also explain why and when data reporting has changed. It is not surprising that since March 2020, as the pandemic and knowledge about it has evolved, systems have changed their data reporting. However, much reporting has changed in significant ways with little transparency and explanation for the changes. If facilities are no longer reporting data or the variables being reported have changed, a narrative explanation of these changes needs to be provided. Systems also need to include definitions of all data provided and report the data both at the aggregate state level and by facility. In addition to these organizing principles, Box 5-3 lists each data point that all systems need to routinely report.

Recommendation 9: All correctional facilities (including jails, state and federal prisons, detention centers of the U.S. Immigration and Customs Enforcement, and juvenile facilities) should report daily standardized, aggregated data on COVID-19 incidence, testing rates, hospitalizations, mortality, and all-cause-mortality among incarcerated people and staff by age, gender, and race/ethnicity to public health officials as directed and via a public-facing website or dashboard. All correctional facilities should also report daily standardized, aggregated data on decarceration efforts (especially releases) by age, gender, and race/ethnicity via a public-facing website or dashboard.

Although it may be difficult to eliminate the risk of transmission of COVID-19 from correctional facilities, the mitigation strategies recommended by the CDC, in combination with decarceration strategies described in this report, can improve the safety and health of residents and staff of these facilities and their families and communities. The limited evidence with which to judge the effectiveness of different strategies in relation to public health and public safety considerations makes decisions about these strategies challenging for jurisdictions.

Improvements in data collection, analyses and modeling of these data, and assembly of lessons learned will help meet these decision-making challenges. As indicated by the literature of the past few months reviewed for this report, researchers are using opportunities to conduct research in real time during the pandemic and provide scientific guidance as it becomes available. The committee encourages researchers to continue on this course; research

BOX 5-3**Data That Should Be Reported by Correctional Facilities**

COVID-19 Data: All data would include age, race, gender, and sex of individuals in each of these categories^a

- COVID-19 Risk: *Prevalence of COVID-19 risk factors*
- COVID-19 Testing: *Information relevant to the type of test used, number of people tested and retested, and number of tests administered^b*
- COVID-19 Cases: *Information on the number of new, active, and cumulative positive cases identified among incarcerated people and staff*
- COVID-19 Recovery: *Information on the number of recovered cases among incarcerated people and staff*
- COVID-19 Hospitalization: *Information on the number of incarcerated people and staff who have been and are currently hospitalized*
- COVID-19 Deaths: *Information on deaths from COVID-19 among incarcerated people and staff*
- All-Cause Deaths: *Information on deaths from other causes among incarcerated people and staff*
- Medical Isolation and Quarantine: *Information on the number of incarcerated people and staff in quarantine and medical isolation (including staff on sick leave)*

Demographic Data of Incarcerated Population: All data would include aggregate data on age, race, gender, and sex of individuals in each of these categories

- Daily Population: *Daily population of both incarcerated people and staff^c*
- Jail Status Counts: *Counts of jail population that distinguish between sentenced and unsentenced populations*

Decarceration Data: All data would include age, race, gender, and sex of individuals in each of these categories

- Releases: *Information on the number of people who have been released to mitigate COVID-19 risk by type of released (e.g., releases by facility, ordered by court or governor)*
- Requests: *Number of release requests and number granted*

^aIt is important to collect demographic data to identify and address inequities in testing, case identification, hospitalization, or mortality.

^bMany COVID-19 tests have obtained emergency authorization from the Food and Drug Administration. Research relevant to the reliability of these tests is ongoing, and once test specificity and sensitivity have been established, this information can be used to calculate true incidence more accurately. Additionally, as time passes and testing scales up in systems, it is important to differentiate among the number of tests administered, the number of people who have received a test, and how many people have been tested more than once.

^cDaily population data are necessary to calculate COVID-19-relevant rates. Without these population data, comparisons between systems and the general populations are impossible. These data also make it possible to calculate cumulative incidence over time.

on the efficacy of correctional facility-specific surveillance, prevention, and mitigation strategies is urgently needed. This research needs to include understanding if there are unique structural risk factors of correctional systems that place staff and incarcerated people at heightened risk for COVID-19 or whether there are unique health conditions that place incarcerated individuals at increased risk for serious illness from COVID-19. Research on the role of correctional facilities in contributing to virus transmission in communities will also advance understanding of opportunities to improve public health more generally. In addition, research on the effectiveness of mitigation strategies will help in preparing for the next outbreak in this pandemic or the next pandemic or public health emergency. Research in these areas needs to consider the relative effects of diversion strategies as compared with releases from jails and prisons. Such research also needs to take into consideration the circumstances in which people are released, as well as in the housing conditions, health systems, and communities to which they are released. In addition, this research needs to examine disparities and any differential effects by subgroups and whether mitigation strategies, including decarceration, augment racial disparities in corrections or COVID-19 outcomes in the communities in which they are located.

Recommendation 10: State and federal research infrastructures should invest in the monitoring and evaluation of the changes in operations and targeted COVID-19 release mechanisms in correctional facilities to document the impact of such efforts on correctional health, public safety, public health, and racial equity. The research undertaken to systematically monitor and evaluate decarceration efforts should facilitate transparency and evidence-based decision making in criminal justice. Researchers and funders should support a fully formed research program on the implications of incarceration for the transmission of infectious disease that extends beyond the adult criminal justice system to include juvenile incarceration, immigration detention, and other forms of detention. Furthermore, research should aim to examine the mutual influence of community and correctional facility on the transmission of disease, including the influence of community health conditions on the prevalence of infection and virus transmission inside correctional facilities and the influence of correctional facilities on surrounding communities.

CONCLUSION

In the perspective of this report, public safety encompasses good public health. Institutions for incarceration have hosted numerous outbreaks of infection and in this sense have posed a threat to public safety. Good health

and safety in the pandemic era will require reducing incarceration and supporting the communities whose incarceration rates are highest. Decarceration requires urgent and sustained engagement from correctional and health officials at federal, state, and local levels, as well as from those with oversight for community health systems and social services. The actions the nation takes now to prevent and mitigate COVID-19 will need to be measured and evaluated, as they represent an opportunity for learning to guide improvements to correctional health (and, by extension, to public health in vulnerable communities) and to the equitable and just use of incarceration.

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Appendix A

Recidivism, Incarceration, and Crime

This appendix reviews what is known about the recidivism rates of incarcerated individuals from national studies, evidence suggesting that correctional authorities can use information at hand to identify individuals at high risk of recidivism, and potential factors that might mitigate that risk through supportive reentry planning. The key implications of this literature for the current pandemic are discussed in Chapter 3.

OVERALL RECIDIVISM LEVELS

A very large body of research examines the likelihood of future interactions with the criminal justice system among those placed under correctional supervision in the community (e.g., those on probation or parole) or released from the custody of a state or federal prison or local jail. Recidivism is commonly measured using recorded incidents of future interactions with the criminal justice system, including being arrested, being arraigned for a new criminal charge, being convicted, and being placed in custody (often being returned to custody). Yet there is considerable debate regarding what is being measured using these official markers of criminal justice involvement. For example, people under community corrections supervision can be and often are arrested for behaviors that would not otherwise result in arrest, such as missing appointments, not reporting to a central authority, drinking or using drugs, leaving a specific county, and other such technical violations. Individuals on parole may be returned to prison custody with or without conviction for a new criminal offense, and in some states may be returned to custody directly by a parole

officer. In some instances, people arrested for new crimes may be returned to custody through parole revocation with no formal charging and adjudication for a new offense. Jurisdictions vary in the relative frequency with which people on parole are returned to custody for less serious violations. In jurisdictions with so-called swift-and-certain community corrections systems, brief returns to custody for minor infractions may routinely be used as a behavior management strategy. In other jurisdictions, returns to custody may be reserved for those who repeatedly violate terms of parole or engage in new crimes. Hence, it is often difficult to gauge whether cross-jurisdictional differences or changes over time in formal gauges of recidivism reflect actual changes in criminal behavior or differences in policies and practice. Arguably, a new conviction provides a less ambiguous gauge of subsequent criminal activity.

Overall, much of what is known about overall recidivism rates among released prison inmates comes from two national recidivism projects conducted by the Bureau of Justice Statistics (BJS). Langan and Levin (2002) report the results of an analysis of recidivism among individuals released from 15 state prisons in 1994. The study linked a random sample of releases from these states to criminal history records from the releasing states' criminal history repositories, as well as data from the cross-state repository maintained by the Federal Bureau of Investigation (the III database). The study found that within 3 years of release, nearly 70 percent of released individuals had been rearrested, roughly 47 percent convicted of a new crime, and 25 percent returned to prison with a new conviction. Among those released from prison, over half were returned without a new conviction. This result, however, likely reflects the outsized influence of California and the parole practice in place at the time, a factor explored in detail below. Langan and Levin (2002) also tabulate the proportion of all arrests for serious offenses committed by the people in this release cohort. While released individuals accounted for a relatively small percentage of all arrests for serious offenses, they conclude that the rate at which these formerly incarcerated individuals committed serious violent offenses was quite high relative to the general population.

Durose, Cooper, and Snyder (2014) and Alper, Durose, and Markman (2018) present comparable analyses of individuals released from prison in 2005. In these studies, the authors analyze people released from 30 state prison systems and measure recidivism outcomes over a 5-year period (the 2014 study) and a 9-year period (the 2018 study); the latter study focused solely on arrests. As with the 1994 release cohort (Langan and Levin, 2002), a large percentage of released inmates had been rearrested—nearly 67 percent within 3 years, 75 percent within 5 years, and 83 percent within 9 years. Within 5 years, 28 percent had been returned to prison because of

a conviction for a new offense, and 51 percent had been returned either for a new offense or for a parole violation without a new conviction, figures quite close to those from the 1994 study.

For at least one of the key recidivism outcomes—return to prison custody—the outcomes documented by these studies may paint an excessively negative picture of the reentry prospects of formerly incarcerated individuals. First, both studies rely on a subset of states, with California contributing the largest number of prison releases to the weighted recidivism estimates. To be specific, for the 1994 release cohort, California releases account for approximately 35 percent of the weighted analysis sample of releases, while for the 2005 release cohort, California accounts for nearly 26 percent of the weighted sample. Prior to a 2011 reform that limited returns to custody without a new conviction for individuals on parole, California had by far the highest rate of readmission from parole to its state prison system, for two reasons: (1) nearly all individuals released from prison in California were placed on parole, with a postrelease term of 5 years; and (2) California made heavy use of returns to custody for technical parole violations, with the returns often resulting in very short prison stays (Lofstrom, Raphael, and Grattet, 2014).

Figure A-1 illustrates how unusual California's practices were relative to the rest of the nation. The figure presents the number of prison admissions during calendar year 2010 that involved individuals on parole divided by the size of the parole population at the beginning of the year. States are ranked in the figure from highest to lowest values of this ratio. The value for California (0.68) is the highest in the nation, and is 24 percentage points higher than the value for the next-highest state (Connecticut, at 0.44). Moreover, 77 percent of the California admissions involved returns to custody without a new prison sentence.

While subsequent reports from the BJS cannot be used to construct a comparable figure post-2011, recidivism estimates published by the California Department of Corrections and Rehabilitation show a sharp decline in return-to-custody rates with the 2011 reforms. Figure A-2 reports several 3-year recidivism measures for individuals released from California state prisons during fiscal years 2002 through 2014. For 2002 through 2008, more than 61 percent of releases were returned to custody within 3 years. This rate begins to show a sharp decline in 2009 as the 3-year observation window for each subsequent cohort begins to overlap and then entirely overlaps with the post-2011 period, when parole practices had changed. By 2011, the 3-year return-to-custody rate had declined to below 25 percent. Declines in rearrest rates, as well as reconviction rates, can also be observed following this reform. While these recidivism outcomes can be attributed in part to change in the composition of each release cohort, a careful analysis

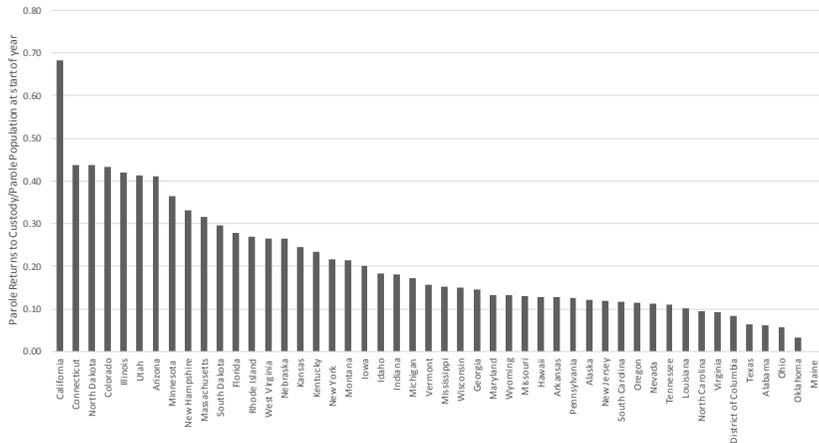


FIGURE A-1 Prison admissions of individuals on parole divided by the parole population at the start of the year, by state, 2010.

SOURCE: Data from Glaze and Bonczar (2011).

by Lofstrom, Raphael, and Grattet (2014) shows a sharp decline in returns to custody even after adjusting for individual characteristics.¹

Given the disproportionate contribution of California to the above widely cited release cohort studies, the sharp decline in California's return-to-custody rates, and the large drop in admissions in the state resulting from this reform, a comparable analysis of a post-2011 release cohort would likely reveal that the majority of released prison inmates do not return within 3 years.

Beyond the outsized influence of California, several researchers have raised concerns about the focus on release cohorts rather than on cohorts defined by people who have ever served time in prison. Rosenfeld (2008) points out that release cohorts defined by a specific time period (say, during a given calendar year) disproportionately comprise individuals who have been returned to prison and who will, in turn, be returned to prison in the future. For an entire year's worth of releases, there are indeed some individuals who will have been released and readmitted multiple times over the course of the year. Hence, the probability that a randomly chosen release over the course of a year will result in a return to custody is likely higher

¹Specifically, inmates released following the reform were older and more likely to be released from the first term in prison. Adjusting for these characteristics still reveals sharp declines in return-to-custody rates of a magnitude comparable to that observed in Figure 3-2 (in Chapter 3). In addition, Lofstrom, Raphael, and Grattet (2014) find little evidence of an offsetting increase in prosecution and a very small increase in the likelihood of a new criminal conviction among released inmates as a result of the reform.

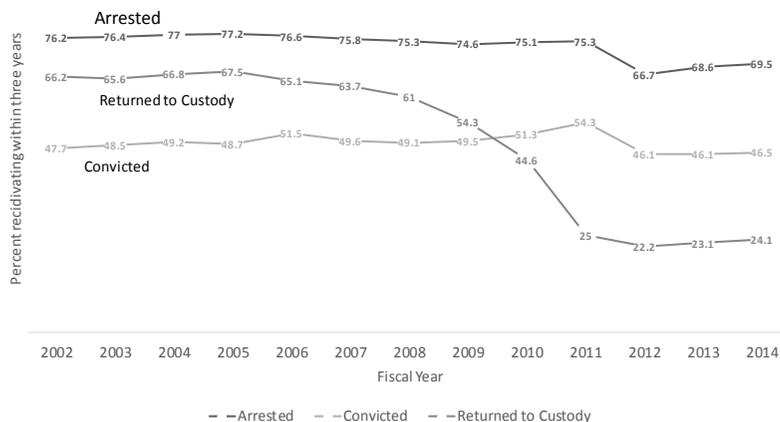


FIGURE A-2 Three-year recidivism indicators for prison inmates released from the California Department of Corrections and Rehabilitation.

SOURCE: Data from California Department of Corrections and Rehabilitation (2020). See <https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2020/01/Recidivism-Report-for-Offenders-Released-in-Fiscal-Year-2014-15.pdf>.

than the likelihood that someone who eventually serves a prison sentence will be returned for a second prison spell. Moreover, this observation may apply to other recidivism outcomes, such as arrests and convictions that do not result in a return to custody.

Rhodes and colleagues (2016) provide a recidivism analysis using annual release cohorts and data from the National Corrections Reporting Program for the years 2000 through 2014. The authors estimate recidivism in terms of both rearrest and return to custody for each annual release cohort during this period for observations of varying length. They present two sets of estimates: those in which each release receives equal weight in tabulating recidivism outcomes (what they refer to as the event-based sample) and those in which each release is inversely weighted by the number of times the individual in question was released during the year. For example, a release observation for someone released three times during a given calendar year would receive a weight of 1/3. Hence, the average of the releases of a person released more than once receives the same weight as the single release of someone released only once. For the 2000 cohort, the authors conclude that while 51 percent of releases would have resulted in return to prison custody over the subsequent 12 years, the individual-based analysis indicates that 33 percent of the unique individuals released over the course of the year would have been returned to prison over the same time period.

A careful reading of the methodology sections of two BJS analyses suggests that the approach of Rhodes and colleagues (2016) would yield

lower recidivism rates for at least the earlier study.² Both studies would certainly yield lower return-to-custody rates if they were implemented today, given that California would contribute proportionately fewer releases and would have much lower return-to-custody rates. Regardless, the change in policy in California, coupled with analysis focused on individuals rather than events, strongly indicates that a return to prison custody among those released is far from certain and that most who do prison time and are released, under current correctional practices, will not return to prison.

INCARCERATION RATES AND CRIME

Reducing prison population as a response to COVID-19 raises questions concerning whether such a change would cause an increase in crime rates. There is a large body of literature studying the relationship among incarceration levels, the risk of incarceration, and crime. While there is evidence that prisons incapacitate some individuals who would otherwise be criminally active, research also shows that such effects are heterogeneous across incarcerated people and that in societies that rely heavily on incarceration, the crime-prevention effects of incarceration for many are negligible (NRC, 2014). Moreover, recent reforms in California that have drawn down the combined prison and jail population by nearly a quarter over a relatively short time period have had little effect on crime rates.

Theoretically, incarceration may impact crime through several potential channels. First, incarcerating a criminally active person incapacitates that person, preventing the individual from committing new crimes within non-institutionalized society (though criminal offending may clearly still occur within institutions and this remains unmeasured in the research). The effects on crime of physically removing someone from society are likely to vary from person to person, often in predictable ways. Second, the threat of incarceration (or the severity of a sentence) may deter some individuals from committing a crime (a pathway referred to as general deterrence). If individuals consider the costs and benefits of their actions, stiffer sentences may increase costs above benefits and tip the decision-making scales away from committing a crime. Finally, serving a prison sentence may alter the future offending trajectories of former prison inmates. A prison spell may

²In relation to the two national release cohort studies, both had a complex sampling structure whereby they selected stratified random samples of releases from the included states, based on controlling by offense groupings. Langan and Levin (2002) appear to draw random samples of all releases from each controlling offense stratum, and thus must have sampled individuals who had been released more than once over the course of the year. In contrast, Alper, Durose, and Markman (2018) and the earlier study by Durose, Cooper, and Snyder (2014) indicate in their methods section that for individuals released more than once they select the first release.

reduce offending if the experience itself deters (a factor often referred to as “specific deterrence”). Alternatively, education and treatment services while incarcerated may have rehabilitative effects on those who pass through prison and reduce future offending as a result. On the other hand, a prison spell may erode connections to the workforce, lead to the erosion of marketable skills, and perhaps increase the likelihood of a future offense.

Beginning with incapacitation, there is a sizable body of research estimating the amount of officially recorded crime prevented by a year of detention. The methods employed by these studies range from surveys of prison inmates regarding past offending (reviewed in Spelman, 1994, 2000), state panel data analyses (Johnson and Raphael, 2012; Levitt, 1996; Liedke, Piehl, and Useem, 2006), studies that exploit sentencing reforms that either enhance (Vollaard, 2012) or reduce (Owens, 2009) sentences for admittedly criminally active people, to studies that evaluate the effects of sudden, discrete, and policy-induced changes in correctional populations (Barbarino and Mastrobuoni, 2014; Buonanno and Raphael, 2013; Lofstrom and Raphael, 2016). The general findings from this research are the following.

First, most analyses find average incapacitation effects associated with prison incarceration and to a lesser extent jail incarceration. Second, these incapacitation effects tend to be much higher in low incarceration settings. That is to say, the marginal effect on crime of a one-person increase in the incarceration rate tends to be much higher in countries with low incarceration rates or in periods of time in the United States when the incarceration rate was low, a pattern suggestive of diminishing crime-fighting returns to scale. For example, Lofstrom and Raphael (2016) find no impact on violent crime and a modest effect on property crime of a very large decline in California’s incarceration that resulted from the 2011 reform that greatly reduced the likelihood of a parole revocation. It is noteworthy that the decline in incarceration caused by realignment occurred in a state with a total incarceration rate (prison plus jail) that exceeded 700 per 100,000. By contrast, evaluation of a similarly sized prison decline that resulted from Italy’s 2006 collective clemency, reported in Buonanno and Raphael (2013), revealed considerably larger incapacitation effect. Italy’s total incarceration rate on the eve of the clemency was roughly one-seventh that of California’s. Interestingly, the study also found smaller effects of prison releases on crime rates in Italian provinces with relatively high incarceration rates, despite the generally low Italian incarceration rate (suggesting diminishing marginal crime fighting effects even in a low incarceration rate setting). Liedke, Piehl, and Useem (2006) find evidence in state panel data indicating that incapacitation effects in the United States diminish with the incarceration rate, as do Johnson and Raphael (2012). The first of these two studies (Liedke, Piehl, and Useem, 2006) finds that at suf-

ficiently high incarceration rates the marginal effects of incarceration on crime may turn positive (suggesting that a criminogenic effect may swamp incapacitation at some point). These findings suggest that incapacitation effects are inherently heterogeneous—for example, likely to be larger for the young than the old, likely to vary with prior criminal history, and likely to vary on average with the extensiveness with which a given society deploys incarceration in an attempt to control crime.

Beyond incapacitation, results from research on whether changes in sanction severity deter criminal offending tend to be mixed. Among the studies finding evidence of general deterrence, Drago, Galbiati, and Vertova (2009) find that individuals released from Italian prisons under the 2006 Italian Collective Clemency who faced larger sentence enhancements for re-offending tended to recidivate at a lower rate. Similarly, Helland and Tabarrok (2007) find that individuals facing the prospect of a sentence enhancement due to state three-strikes laws recidivate at relatively lower rates (though the effect of even a very severe sentence enhancement is relatively small). In contrast, research exploiting the discontinuous increase in sentencing severity at the age of majority tends to find little evidence of an impact of the stiffer sentencing on offending (see Hjalmarsson, 2009; Lee and McCrary, 2009; for a comparable analysis with contrary findings, see Levitt, 1998) as does much of the research on the deterrent effects of capital punishment (NRC, 1978, 2012). A thorough review of the deterrence effects of sanction severity concludes that general deterrence effects associated with stiffer penalties tend to be small (Nagin, 2013).

While this existing body of research is instructive, the recent experiences of California are particularly relevant to the question at hand, since the state enacted several policies that led to discrete and large declines in both prison and jail populations. California's incarceration rate on the eve of these reforms was quite close to the average for the nation and thus presents an abrupt change in incarceration rates for a high-incarceration rate system (a factor that the literature reviewed above that would suggest relatively small effects on crime from reducing the prison incarceration rate). By way of background, two broad factors converged to generate these policy changes. First, decades of litigation pertaining to conditions of confinement and the availability of health and mental health services in the state prison system culminated in a federal court order to reduce state prison overcrowding. Second, public opinion pertaining to sentencing severity and the use of incarceration in particular softened, resulting in several notable ballot measures aimed at undoing many of the stringent sentencing practices introduced in past decades.

To address the court order, California enacted broad corrections reform legislation under the banner of corrections realignment (passed in April

2011 and implemented on October 5, 2011).³ The legislation eliminated the practice of returning parolees to state prison custody for technical parole violations for all but a small set of the most serious offenders. The legislation also defined a group of nonserious, nonsexual, nonviolent offenders who serve their sentences in county jails. The act generated an immediate reduction in weekly prison admissions from roughly 2,100 per week to 600 per week and a steady, permanent decline in the prison population.

Regarding the change in public opinion, in recent years California voters passed several state ballot initiatives aimed at reducing the use of prison along both the intensive and extensive margins. In 2012, voters approved a ballot measure that narrowed the definition of felonies that would qualify for second- and third-strike sentence enhancements, limiting these felonies to serious and violent offenses (Proposition 36). More recently, voters passed a proposition that incentivizes prison inmates to engage in rehabilitative programming and refrain from institutional misconduct in exchange for shorter prison terms (Proposition 57 passed in November 2016).

The passage of Proposition 47 in November 2014, however, is perhaps one of the most far-reaching sentencing reforms passed by way of ballot initiative and had immediate impacts on the operations and practices of several different arms of the state's criminal justice system. Put simply, the proposition redefined a subset of "wobbler" offenses (offenses that can be charged as either a misdemeanor or felony) as straight misdemeanor of-

³The legislation was prompted by the state's need to reduce its prisoner population in the wake of *Brown v. Plata*, 563 U.S. 493 (2011), in which the U.S. Supreme Court upheld a population reduction order entered by a three-judge 9th Circuit panel against the California Department of Corrections and Rehabilitation (CDCR). *Plata* consolidated two decades-long federal class actions—*Plata* and *Coleman*—brought on behalf of people incarcerated in the California prisons. *Coleman* concerned the constitutionality of mental health care delivery in the state's prisons, and *Plata* challenged as unconstitutional the quality of the medical care. In both cases, federal district courts sided with the plaintiffs on the merits, finding that conditions in each context violated the Eighth Amendment prohibition on cruel and unusual punishment. After years of failure by the CDCR to remedy the constitutional violations found by the two courts, the cases were consolidated, and a three-judge panel was struck to consider whether a population reduction order was necessary. The three-judge panel sided with the plaintiffs on all counts, including a finding—required under 18 U.S.C.(a)(3)(E)—that prison overcrowding was the primary cause of the unconstitutional medical and mental health delivery in CDCR facilities and that no other less-intrusive relief would remedy the violation. The three-judge panel issued an order requiring the CDCR to reduce the population density of its facilities to 137.5 percent capacity (down from a high of roughly 200 percent capacity in 2006), and the U.S. Supreme Court upheld the order. The order left it up to the state to determine the best approach to achieving this reduction. Rather than releasing people from CDCR custody, Governor Brown instead spearheaded the passage of Assembly Bill 109 (referred to in the state as "corrections realignment") which shifted to the counties responsibility for those people convicted of the lowest level crimes (a group known as the "non-non-nons," for those convicted of nonserious, nonviolent, nonsexual offenses).

fenses. Regarding property offenses, the proposition redefined shoplifting, forgery, crimes involving insufficient funds, petty theft, and receiving stolen property offenses where the value of the property theft falls below \$950 as misdemeanors. The proposition also eliminated the offense of petty theft with a prior. Regarding drug offenses, a subset of possession offenses were redefined as misdemeanors. These new charging protocols apply to all new cases with the exception of instances where the individual in question has certain prior convictions. The proposition also included a provision for individuals currently serving sentences for reclassified offenses to file a resentencing petition, as well as a provision for those convicted in the past to file a petition to have the prior conviction reclassified as a misdemeanor (California Judicial Council, 2016).

The cumulative effects of these reforms have been a large reduction in the state's prison incarceration rate with slight overall reductions in the size of the jail population. Figure A-3 presents the prison incarceration rates for California and for the United States from the late 1970s through 2016. Both series exhibit pronounced increases during the last two decades of the 20th century. From the early 2000s on, however, there are notable departures with large relative decreases in California's incarceration rates post 2010.

Figure A-4 presents long-term trends for overall California violent and property crime rates. Similar to national trends, California's violent crime

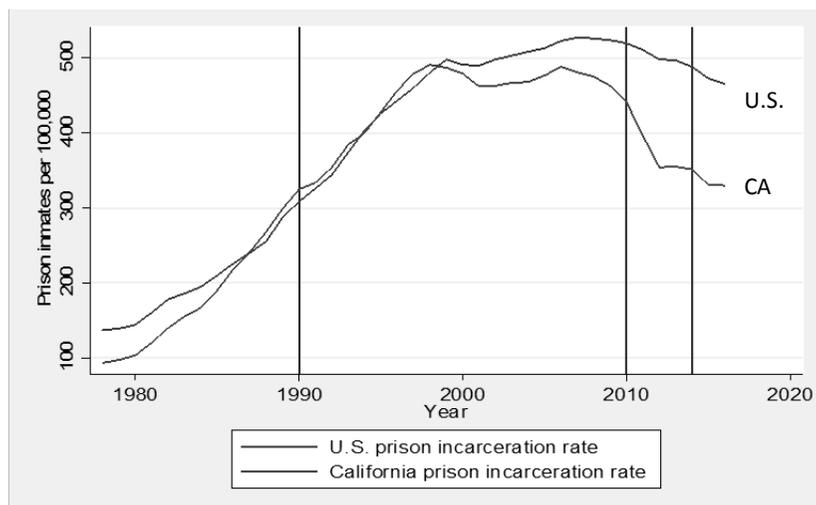


FIGURE A-3 Long-term trends for California and U.S. prison incarceration rates.

SOURCE: Data from California Department of Corrections and Rehabilitation and U.S. Bureau of Justice Statistics, Prison Population Counts (2020).

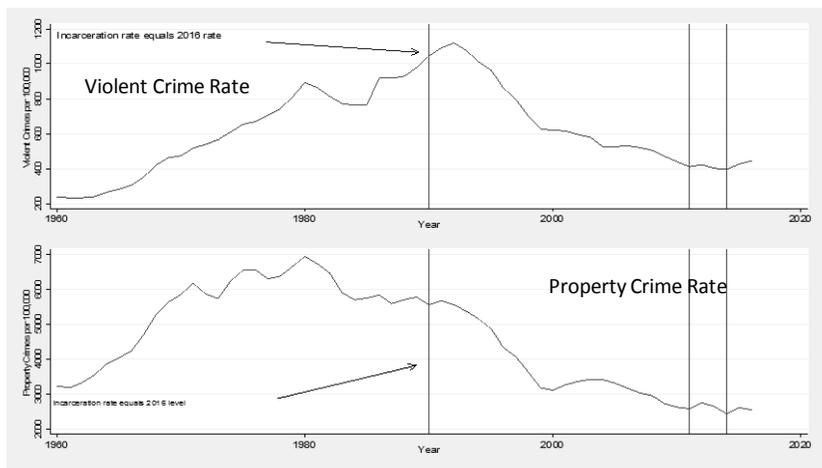


FIGURE A-4 Long-term trends for California violent and property crime rates.
SOURCE: Data from California Department of Corrections and Rehabilitation (2020).

rate peaks in the early 1990s before declining to current historical lows. While the historical peak for property crime occurs in the early 1980s, the largest declines in property crime occur post 1990, with the rate declining by roughly 50 percent over the subsequent 26 years. In both figures, the years 2010 (the last pre-realignment year) and 2014 (a year mostly preceding the implementation of Proposition 47) are marked with vertical lines. Notably, these reforms reduced the state's prison incarceration rate to early 1990s levels while crime rates have remained at historical lows. Lofstrom and Raphael (2016) present a thorough analysis of the 2011 reforms and find no evidence of an impact of the large reduction in the prison population on violent crime rates, but evidence of a small effect on part I property crime (auto theft). Bartos and Kubrin (2018) conduct a comparable analysis of the 2014 passage and implementation of Proposition 47 and similarly conclude that there is no evidence of an impact on violent crime and mixed though not statistically significant indicators of a small effect on larceny theft.

Overall, the research on these changes basically confirms what is visibly evident in the figures. Despite a sizable contraction in the overall incarcerated population in the state, crime rates remain at historically low levels. At face value, this suggests that it is certainly possible to reduce incarceration in a high incarceration setting without jeopardizing public safety.

Appendix B

Biographical Sketches of Committee Members and Staff

Emily A. Wang (*Co-chair*) is an associate professor in the Yale School of Medicine and directs the new SEICHE Center for Health and Justice. The SEICHE Center is a collaboration between the Yale School of Medicine and Yale Law School working to stimulate community transformation by identifying the legal, policy, and practice levers that can improve the health of individuals and communities impacted by mass incarceration. She leads the Health Justice Lab research program, which investigates how incarceration influences chronic health conditions, including cardiovascular disease, cancer, and opioid use disorder, and uses a participatory approach to study interventions that mitigate the impacts of incarceration. As an internist, she has cared for thousands of individuals with a history of incarceration and is co-founder of the Transitions Clinic Network, a consortium of 40 community health centers nationwide dedicated to caring for individuals recently released from correctional facilities by employing community health workers with histories of incarceration. She has an M.D. from Duke University and an M.A.S. from the University of California, San Francisco.

Bruce Western (*Co-chair*) is the Bryce professor of sociology and social justice and co-director of the Justice Lab at Columbia University. His research has examined the causes, scope, and consequences of the historic growth in U.S. prison populations. Current projects include a randomized experiment assessing the effects of criminal justice fines and fees on misdemeanor defendants in Oklahoma City and a field study of solitary confinement in Pennsylvania state prisons. He is also the principal investigator of the Square One Project that aims to reimagine the public policy response to

violence under conditions of poverty and racial inequality. He is the author of *Homeward: Life in the Year After Prison* and *Punishment and Inequality in America*. He is a member of the National Academy of Sciences and the American Academy of Arts and Sciences. He has been a Guggenheim fellow, a Russell Sage Foundation visiting scholar, and a fellow of the Radcliffe Institute of Advanced Study. He received a Ph.D. in sociology from the University of California, Los Angeles.

Emily P. Backes (*Study Director*) is a senior program officer for the Committee on Law and Justice and the Board on Children, Youth, and Families in the Division of Behavioral and Social Sciences and Education at the National Academies of Sciences, Engineering, and Medicine. In addition to her work on this study, she supports the Societal Experts Action Network, which links experts from the social and behavioral sciences to decision makers grappling with the challenges of the COVID-19 pandemic. In her nearly 10 years at the National Academies, she has directed studies and provided substantive analytical and editorial support to projects covering a range of topics, including adolescent development, financing early education, juvenile justice reform, policing, illicit markets, and science communication and literacy. She has an M.A. in history from the University of Missouri and a J.D. from the University of the District of Columbia.

Donald M. Berwick is cofounder, president emeritus, and senior fellow at the Institute for Healthcare Improvement. He also serves as lecturer in the Department of Health Care Policy at Harvard Medical School. Previously, he held the presidentially appointed position of administrator of the Centers for Medicare & Medicaid Services. A pediatrician by background, he has served as clinical professor of pediatrics and health care policy at the Harvard Medical School, professor of health policy and management at the Harvard School of Public Health, and as a member of the staff of Boston's Children's Hospital Medical Center, Massachusetts General Hospital, and the Brigham and Women's Hospital. He has also served as vice chair of the U.S. Preventive Services Task Force, the first "independent member" of the board of trustees of the American Hospital Association, and chair of the National Advisory Council of the Agency for Healthcare Research and Quality. He is an elected member of the American Philosophical Society, the American Academy of Arts and Sciences, and the National Academy of Medicine. He has an M.D. and an M.P.P.

Sharon Dolovich is a professor of law at University of California, Los Angeles (UCLA), School of Law and director of the UCLA Prison Law & Policy Program. She teaches courses on criminal law, the constitutional law of prisons, and other post-conviction topics, and her scholarship focuses on

the law, policy, and theory of prisons and punishment. She has been a visiting professor at New York University, Harvard University, and Georgetown University and a fellow at the Radcliffe Institute for Advanced Study. Previously, she served as deputy general counsel for the Los Angeles Citizens' Commission on Jail Violence. She is coauthor of *The New Criminal Justice Thinking*. She has a Ph.D. from Cambridge University and a J.D. from Harvard Law School. Since the start of the pandemic, she has spearheaded the UCLA Law Covid-19 Behind Bars Data Project.

DeAnna Hoskins is president of JustLeadershipUSA. She was formerly the senior policy advisor for corrections and reentry with the Department of Justice (DOJ). In this capacity, she represented DOJ's strategies and priorities and oversaw the Second Chance Act portfolio of grants, the National Reentry Resource Center, and residential substance abuse treatment programs. She had been designated as the interim deputy director of the Federal Reentry Interagency Council. She has experienced the reentry system from all perspectives as she is herself a previously incarcerated individual who has successfully transitioned back into the community, ultimately receiving a pardon. She holds an M.P.S. in criminal justice from the University of Cincinnati, a B.A. in social work, a clinical license as an addictions counselor, and a certification as an offender workforce development specialist.

Margot Kushel is a professor of medicine at University of California, San Francisco (UCSF), where she is the division chief and director of the Center for Vulnerable Populations and the director of the UCSF Benioff Homelessness and Housing Initiative. Her research focuses on reducing the burden of homelessness on health. She uses a variety of research methodologies with an aim toward informing the development of programs and policies to end homelessness through understanding the complex interactions between health and housing. She has a particular interest in homelessness in formerly incarcerated individuals, in older adults, and in medically complicated individuals. She maintains an active clinical practice as a general internist at Zuckerberg San Francisco General Hospital. She has an M.D. from the Yale School of Medicine and completed her residency and fellowship training at UCSF.

Hedwig Lee is a professor of sociology at Washington University, St. Louis. She holds a courtesy joint appointment at the George Warren Brown School of Social Work and is a faculty affiliate in the Department of Women, Gender, and Sexuality Studies. She is also an associate director of the university's Center for Race, Ethnicity & Equity. She currently serves on the research advisory board for the Vera Institute of Justice and on the board for the Interdisciplinary Association for Population Health Science. Her

recent work examines the impact of structurally rooted chronic stressors, such as mass incarceration, on health and health disparities. She has a Ph.D. in sociology from the University of North Carolina.

Steven Raphael is a professor of public policy at the University of California, Berkeley, and holds the James D. Marver Chair at the university's Goldman School of Public Policy. He is also the faculty director of the Institute for Research on Labor and Employment. His research focuses on the economics of low-wage labor markets, housing, and the economics of crime and corrections. His most recent research focuses on the social consequences of the large increases in U.S. incarceration rates and racial disparities in criminal justice outcomes. He also works on immigration policy, research questions pertaining to various aspects of racial inequality, the economics of labor unions, social insurance policies, homelessness, and low-income housing. Raphael is the author (with Michael Stoll) of *Why Are so Many Americans in Prison?* and *The New Scarlet Letter? Negotiating the U.S. Labor Market with a Criminal Record*. Raphael is research fellow at the National Bureau of Economic Research, the California Policy Lab, the University of Michigan National Poverty Center, the University of Chicago Crime Lab, IZA, Bonn Germany, and the Public Policy Institute of California. He has a Ph.D. in economics from the University of California, Berkeley.

Josiah “Jody” Rich is a professor of medicine and epidemiology at Brown University and a practicing infectious disease and addiction specialist providing care to patients at The Miriam Hospital and the Rhode Island Department of Corrections. He is the director and cofounder of The Center for Health and Justice Transformation at The Miriam Hospital and cofounder of the nationwide collaboration on HIV in corrections initiative through the Centers for AIDS Research. His primary areas of interest and expertise are in the overlap between infectious diseases and illicit substance use, the treatment and prevention of HIV infection, and the care and prevention of disease in addicted and incarcerated individuals. More recently he has focused on addressing the opioid overdose epidemic. He has served as an expert advisor to Rhode Island's Overdose Prevention and Intervention Task Force since its inception. He has an M.D. from the University of Massachusetts Medical School and an M.P.H. from the Harvard School of Public Health.

Julie Schuck is a program officer at the National Academies of Sciences, Engineering, and Medicine. She has provided analytical, administrative, and editorial support for many studies and workshops and served as a technical writer for many reports. Her projects have covered a wide range

of subjects, including law and justice issues, national security, STEM (science, technology, engineering, and mathematics) education, the science of human–system integration, workforce development, and the evaluations of several federal research programs. She has a B.S. in engineering physics from the University of California, San Diego, and an M.S. in education from Cornell University.

Dara Shefska is an associate program officer at the National Academies of Sciences, Engineering, and Medicine. She supported the Committee on the Neurobiological and Socio-behavioral Science of Adolescent Development and Its Applications, the Committee on Building an Agenda to Reduce the Number of Children in Poverty by Half in 10 Years, and the Committee on the Assessment of Health Outcomes by Birth Settings. Previously, she staffed the Roundtable on Obesity Solutions with the Food and Nutrition Board. In this role, she focused on publications, communications, and coordinating the Early Care and Education Innovation Collaborative. She was awarded the Health and Medicine Division’s Fineberg Impact Award for her efforts to increase the visibility of Roundtable workshops and publications. She is a graduate of McGill University and is currently pursuing a master’s degree at the University of Maryland School of Public Policy.

Stacey Smit is a senior program assistant at the National Academies of Sciences, Engineering, and Medicine, supporting consensus studies and forums for both the Board on Children, Youth, and Families and the Committee on Law and Justice. She has years of experience providing project management, administrative, and event planning support and has worked at various organizations in the area. Some of her previous studies include the Decadal Survey of Social and Behavioral Sciences for Applications to National Security; the Committee on the Use of Economic Evidence to Inform Investments in Children, Youth, and Families; the Committee on Supporting the Parents of Young Children; the Forum on Children’s Cognitive, Affective, and Behavioral Health; and the Committee on Increasing Capacity for Reducing Bullying and Its Impact on the Lifecourse of Youth Involved. She received her B.A. in sociology from the University of Maryland, College Park.

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