

# Impact of COVID-19 on Persons in Correctional Facilities – A Commentary

David Wyatt Seal, PhD, FAAHB

**Objective:** People who work in or who are confined to correctional facilities are at high risk for exposure to COVID-19. In this paper, I describe the at-risk populations in correctional facilities and identify mechanisms for reducing or minimizing rates of COVID-19 transmission. **Methods:** Risk reduction involves careful situational analysis and adaptation of communicable disease control procedures. **Results:** Prevention, identification and quarantine, and treatment are 3 steps that can reduce and minimize risk of infection to correctional facility workers and incarcerated individuals. **Conclusions:** Incarcerated individuals are particularly vulnerable to COVID-19 exposure, infection, and disease consequences due to their high incidence of chronic disease and poor health in general, as well as the conditions of confinement. Humane and immediate steps to prevent, diagnose, and treat COVID-19 among individuals in correctional settings are needed.

**Key words:** Coronavirus; COVID-19; correctional facilities; prisons; incarcerated populations; communicable disease control  
*Health Behav Policy Rev.*™ 2020;7(2):161-164

DOI: <https://doi.org/10.14485/HBPR.7.2.9>

Approximately 1.5 million people were incarcerated in the United States at the end of 2017.<sup>1</sup> Of these individuals, about 81,000 people were incarcerated in local jails and over 121,000 in private prisons. The rate of incarceration per 100,000 people was nearly 6 and 3 times higher among Blacks and Latinos, respectively, than among Whites. The vast majority (92.5%) were men. People over 50 comprise about 20% of individuals incarcerated in a state or federal correctional facility. Among people 65+ years of age, black men were 4.5 times more likely to be imprisoned than their white counterparts.

## Health Status of Incarcerated Populations

Compared to the general community, a higher percentage of people who are incarcerated have ever experienced an infectious disease (eg, HCV, HIV, STIs, TB) or chronic disease (eg, asthma, cancer, cardiovascular disease, cirrhosis of the liver diabetes).<sup>2</sup> Some authorities estimate that over 40% of people incarcerated in state and federal prisons or jails have

a current chronic medical condition – over 50% lifetime.<sup>2</sup> About one-fourth report multiple chronic conditions.<sup>2</sup> Women are more likely than men to report ever having an infectious or chronic condition.<sup>2</sup> Whites are slightly more likely to report ever experiencing a chronic disease than Blacks or Latinos.<sup>2</sup> Older people (50+ years) are about 3 times as likely to ever report an infectious or chronic disease than younger people in the correctional system.<sup>2</sup>

Community lifestyle factors through the decades also impact the health of people who become incarcerated, including homelessness, lack of health insurance, lack of access to medical and mental healthcare, obesity, sexual risk behavior, smoking behavior, substance misuse, and injection drug use.<sup>3-5</sup> Moreover, incarcerated individuals consistently report health declines during incarceration.<sup>6,7</sup> People who are incarcerated often lack access to healthy lifestyle options such as nutritious foods and exercise and have limited access to healthcare services and other needed resources during incarceration.<sup>7</sup>

*David Wyatt Seal, Professor, Department of Global Community and Behavioral Sciences, Tulane University School of Public Health and Tropical Medicine, New Orleans, LA.*  
Correspondence Dr Seal; [dseal@tulane.edu](mailto:dseal@tulane.edu)

Despite the documented rates of infectious and chronic disease among correctional facility populations, the operational structure of correctional facilities can create barriers to healthcare access.<sup>8</sup> Indeed, research suggests many incarcerated people with chronic mental or physical conditions do not receive needed medical care and medications.<sup>9,10</sup> Correctional facilities, especially jails and smaller prisons, may be understaffed or lack the specialized medical expertise needed to treat serious chronic diseases. Other factors impeding timely access to medical care in incarcerated settings can include mandatory co-pays, mistakes or delays in obtaining needed medications, and the transitory nature of jail and prison systems.<sup>11</sup> Transitional healthcare as people return to the community from incarceration can disrupt medical care and medication access even further.<sup>12-14</sup>

### **Potential Threat of COVID-19 to Correctional Populations**

People who are confined to or who work in correctional settings are at elevated risk for exposure to COVID-19.<sup>16</sup> There are many factors that increase the risk that COVID-19 will be introduced to a correctional facility. Entry of multiple shifts of staff members into the facility on a daily basis, transfers of incarcerated people between facilities and systems to court appearances and to outside medical appointments, and visits from family members, legal representatives, and other persons in the community elevate individual risk.<sup>15</sup> Furthermore, both staff members and newly incarcerated persons come from a wide range of geographical venues increasing the likelihood of introducing COVID-19. Similarly, a person may be housed in multiple facilities while moving through the judicial system (eg, overnight jail to short-term detention center to long-term prison facility while passing through court system buildings and security transport).

Once introduced into a correctional facility, the probability of rapid spread among workers and incarcerated individuals is high. People who work in or who are confined to correctional facilities also face higher risk of disease severity and mortality. Most correctional facilities are overcrowded and people are in close proximity to one another. Incarcerated people share common areas (eg, dining, toilet, shower, and recreational facilities) that present

challenges to the maintenance of sanitization and necessary hygiene. Unlike stores and other commercial establishments that can close down to become sanitized or disinfected, correctional facilities are 24-hour operations. Moreover, recommended preventive measures (eg, use of alcohol-based hand sanitizer, cleaning disinfectants) may not be readily available in correctional facilities. Even regular access to soap, hot water, and paper towels may be restricted for security reasons.

Furthermore, incarcerated people may not have adequate access to educational materials and current updates about COVID-19. They may be hesitant to report minor symptoms or seek medical care due a lack of financial resources for co-pays or fear of being isolated. Relatedly, correctional facilities do not have the ability to allow most staff members to work at home, nor can work shifts be staggered because prisons operate around the clock. Correctional staff members, who are often poorly paid, may not have sufficient resources to stay at home should they have minor symptoms. Many correctional facilities have limited or no capacity to isolate or quarantine people who have been exposed to COVID-19 or who are known to be infected. For facilities with limited medical personnel, healthcare practitioners quickly can be overwhelmed with patient care should an outbreak occur.

### **Strategies to Address the Threat of COVID-19 in Correctional Settings**

A comprehensive strategy to address the threat of COVID-19 in correctional settings must include 3 coordinated components – *prevention, identification and quarantine, and treatment.*

Step 1 is **prevention**. Given the perpetual overcrowded conditions of most correctional facilities, an immediate and substantial reduction in the number of people who are confined would help reduce the introduction and spread of infection. Correctional systems should take immediate steps for the mass release of incarcerated people who are unlikely to commit serious crimes if released, including people over 50, people with chronic or other serious medical conditions making them vulnerable to COVID-19 morbidity and mortality, and people who are incarcerated for non-violent crimes (eg, drug use or possession of drugs). This action would have the immediate effect of creating significantly

less crowding, thereby enabling the prevention and control of COVID-19 within correctional facilities.

In conjunction with mass release of low-risk and vulnerable individuals, law enforcement officials need to suspend incarceration of people arrested for minor non-violent crimes and misdemeanors. Instead, alternatives such as citations and court appearance mandates could be issued. Thus, people could wait at home for their court hearing rather than wait in a correctional facility. Similar recommendations are made for people who commit minor parole or probation violations. Relatedly, judges should increase the use of fines, mandated community service, probation assignment, and court-ordered participation in diversion or treatment programs instead of pronouncing sentences requiring incarceration.

Beyond significant reductions in prison crowding, there are many other preventive steps that can be taken by corrections personnel. Facilities should restrict entry by all non-corrections personnel. However, lawyers, and advocates should be allowed private videocalls with their clients during regularly scheduled visitation hours. Furthermore, contact with outside family and friends should be increased to help incarcerated people stay socially connected. This can be enhanced by indefinitely waiving telephone charges (perhaps setting maximum caps).

Within a facility, steps should be taken to optimize space utilization and restrict movement to increase physical space among individuals. If possible, housing no more than one person in a cell or holding area is desirable. If doing this is impractical, facilities could rearrange space to provide people with as much physical distance as possible. In larger holding or waiting areas, people could be required to sit apart from one another. Additionally, there could be staggered use of shared areas, thereby allowing only a limited number of people to use a common area at a time, while also enforcing time allocations. Where physical spacing cannot be accommodated (eg, group sessions), facilities may consider suspending all non-essential groups. Finally, increased sanitization of facilities several times a day or when common areas are not in use can serve as a preventive measure. In conjunction with these actions, facilities could increase access to hand sanitizer dispensers with free access on units and in common areas along with provision of soap and towels when people are confined to their cell.

Step 2 is early *identification and quarantine* of people who might have been infected with COVID-19. This requires temporarily using a non-medical area for isolation purposes. For people requesting or needing medical care, facilities could have medical stations within each unit to perform recommended temperature and symptom screening before moving people to the medical unit. Similarly, all new intakes into the facility should be screened prior to transfer to a unit or holding area.

Step 3 is *treatment* of people who are confirmed to be infected with COVID-19. Depending on the capacity of the correctional facility, this may require hospitalization or transfer to another medical center. Correctional leadership should have a clear and coordinated plan with community medical sites for the secure transfer of people warranting outside medical care.

## IMPLICATIONS FOR HEALTH BEHAVIOR OR POLICY

People who work in or who are confined to correctional facilities are at high risk for exposure to COVID-19. Incarcerated individuals are particularly vulnerable to COVID-19 exposure, infection, and disease consequences due to their high incidence of chronic disease and poor health in general, as well as the conditions of confinement. As a highly vulnerable population in a pandemic condition, humane and immediate steps to prevent, diagnose, and treat COVID-19 in correctional settings are needed to avoid further stigmatization and dehumanization of incarcerated individuals.

*Healthy People 2020* identifies incarceration as a social determinant of health.<sup>17</sup> Additional research is needed to enhance understanding of how to improve services for people and communities impacted by incarceration, thereby facilitating a better public health response to address incarceration as a social determinant of health. In the interim, the steps outlined above are an initial and practical response to the COVID-19 crisis affecting persons in correctional facilities.

### Human Subjects Approval Statement

As a commentary not involving original research with human subjects, the writing of this paper did not require Institutional Review Board examination.

## Conflict of Interest Disclosure Statement

The author declares no conflict of interest.

## References

1. Bronson J, Carson AE. *Prisoners in 2017*. Washington, DC: Bureau of Justice Statistics, NCJ 252159, Office of Justice Programs, US Department of Justice; 2019. Available at: <https://www.bjs.gov/content/pub/pdf/p17.pdf>. Accessed April 4, 2020.
2. Maruschak LM, Berzofsky M, Unangst J. *Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-2012*. Washington, DC: Bureau of Justice Statistics, NCJ 252159, Office of Justice Programs, US Department of Justice; 2016. Available at: <https://www.bjs.gov/content/pub/pdf/mpp.pdf>. Accessed April 4, 2020.
3. Seal DW, Belcher L, Morrow K, et al. A qualitative study of substance use and sexual behavior among 18-29 year-old men while incarcerated in the United States. *Health Educ Behav*. 2004;31(6):775-789.
4. Seal DW, Eldridge GD, Kacanek D, et al. A longitudinal, qualitative analysis of the context of substance use and sexual behavior among 18- to 29-year-old men following their release from prison. *Soc Sci Med*. 2007;65(11):2394-2406.
5. Seal DW, Margolis AD, Sosman J. HIV and STD risk behavior among 18-25 year-old men released from U.S. prisons: provider perspectives. *AIDS Behav*. 2003;7(2):131-141.
6. Loeb SJ, Steffensmeier D. Older inmates' pursuit of good health: a focus group study. *Res Gerontol Nurs*. 2011;4(3):185-194.
7. Loeb SJ, Abudagga A. Health-related research on older inmates: an integrative review. *Res Nurs Health*. 2006;29(6):556-565.
8. Magee CG, Hult JR, Turalba R, McMillan S. Preventive care for women in prison: a qualitative community health assessment of the Papanicolaou test and follow-up treatment at a California state women's prison. *Am J Public Health*. 2005;95(10):1712-1717.
9. Nowotny KM. Health care needs and service use among male prison inmates in the United States: a multi-level behavioral model of prison health service utilization. *Health Justice*. 2017;5(1):9. Available at: <https://doi.org/10.1186/s40352-017-0052-3>. Accessed April 4, 2020.
10. Wilper AP, Woolhandler S, Boyd JW, et al. The health and health care of U.S. prisoners: results of a nationwide survey. *Am J Public Health*. 2009;99(4):666-672.
11. Hatton DC, Kleffel D, Fisher A. Prisoner's perspectives of health problems and healthcare in a U.S. women's jail. *Women Health*. 2006;44(1):119-136.
12. Binswanger IA, Redmond N, Steiner JF, Hicks LS. Health disparities and the criminal justice system: an agenda for further research and action. *J Urban Health*. 2011;89(1):98-107.
13. Flanagan NA. Transitional health care for offenders being released from United States prisons. *Can J Nurs Res*. 2004;36(2):38-58.
14. Seal DW, Eldridge GD, Zack B, Sosman J. HIV testing and treatment with correctional populations: people, not prisoners. *J Health Care Poor Underserved*. 2010;21(3):977-985.
15. US Centers for Disease Control and Prevention (CDC). *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*. Atlanta, GA: National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases, CDC; 2020. Available at: <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>. Accessed April 4, 2020.
16. Matthew J, Akiyama MJ, Spaulding AC, Rich JD. Flattening the curve for incarcerated populations: Covid-19 in jails and prisons. *N Engl J Med*. 2020 Apr 2. doi: 10.1056/NEJMp2005687. [Epub ahead of print]
17. HealthyPeople.gov. Incarceration. Available at: <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/incarceration>. Accessed April 8, 2020.