COVID-19, Incarceration, and the Criminal Legal System

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SUMMARY. America’s status as the world’s leading jailor is a key factor rendering it especially vulnerable to the COVID-19 pandemic. Contact with the criminal legal system is a documented driver of health harms on both individual and community levels, with disproportionate impact on people of color. COVID-19 magnified the deleterious public health impact of policing, prisons, community supervision, and other elements of the criminal legal apparatus. On the structural level, decades of lavish spending on the United States’ vast system of control and punishment has crowded out investments in public health prevention and social support infrastructure, making the nation uniquely ill-prepared to weather the COVID-19 disaster. In a tragic illustration of politics trumping science, elected officials and correctional administrators ignored calls to make rapid depopulation of correctional facilities a core component of the U.S. COVID-19 response. The number of people released remains devastatingly small, while crowded, unsanitary, and inhumane conditions persist in many facilities. Predictably, this resulted in explosive outbreaks of COVID-19 behind bars, among correctional personnel, and in surrounding communities. But it is not too late: states and the federal government can still take immediate action to protect those who remain incarcerated; chief among these steps are (1) depopulating correctional facilities to reduce the number of people held in congregate settings and (2) prioritizing people incarcerated and correctional staff for vaccine distribution. When it has occurred, depopulation of correctional settings is rarely paired with meaningful efforts to connect reentering individuals to vital supports. Community supervision systems largely failed to relax onerous probation/parole requirements. In many jurisdictions, police have taken on enforcement of physical distancing and other public health orders; a sharply disproportionate burden of which has fallen on Black, Indigenous, and other people of color. The crisis in American policing has been especially on display when misinformation-fueled protests against pandemic controls like masks and restaurant closures receive tacit — or express — support from law enforcement while protests against brutality have been met with violence. This Chapter discusses how the U.S. criminal legal system continues to shape its COVID-19 response. It (1) explains how the criminal legal system continues to exacerbate the ongoing public health emergency, and (2) focuses on ways in which the incoming Biden–Harris Administration can begin to undo the damage wrought by the outgoing federal administration through neglect and missteps. For more information on COVID-19, incarceration, and the criminal legal system, please see Chapter 31 in Assessing Legal Responses to COVID-19: Volume I.

Introduction

Our first Chapter began with a breakdown of why the criminal legal system was a public health crisis before COVID-19. The United States leads the world in the number of people it incarcerates and oversees through its criminal legal system; in this vast regime of control and punishment, people of color are grossly overrepresented. Moreover, mental health, addiction, and poverty play an overwhelming role in a person’s chances of incarceration. Thus, structural racism and economic inequality, combined with overcriminalization and disinvestment in health and social supports, has resulted in more than three million people behind bars and more than 6.5 million people living under correctional supervision—including probation and parole—comprising 6% of the adult population (Macmadu et al., 2020). This vast criminal legal system has also diverted investments in public health prevention and social support infrastructure, aggravating the vulnerability of many to criminal legal contact.

The Criminal Legal System in the Context of COVID-19

Even before the world understood the magnitude of the catastrophe COVID-19 would wreak on our society, economy, and population, the United States was in the midst of a separate crisis...
of over-incarceration. As public health experts noted in a letter to incoming Biden–Harris COVID-19 Advisory Board members, despite nationwide crime rates falling for decades, the incarcerated population expanded 300% between 1980 and 2008 and declined by just 8% since 2008 (Franco-Paredes, 2020). Black, Indigenous, and other people of color continue to be overrepresented in the criminal legal system, and the aging population in correctional facilities further contributes to the risk COVID-19 presents to people incarcerated.

One important factor undercutting health care in correctional facilities is the prohibition on Medicare or Medicaid reimbursement for correctional health services. This exclusion — referred to as the "inmate exception" — contributes to significant under-resourcing and has produced an isolated correctional medical system that does not have to meet accreditation or other quality control mandates (Fiscella et al., 2017). The inmate exception contributes both to declines in overall health of incarcerated persons, as well as shields jails and prisons from broader regulatory and norm-setting forces that could, for example, encourage facilities to implement COVID-19-related policies to curb the spread of infection behind bars and upon release (Fiscella et al., 2020).

Disparities in COVID-19 Rates in Jails and Prisons

We now know that the rate of COVID-19 infections is four times the national rate and the mortality rate in correctional facilities is double that of the general population (Franco-Paredes, 2020). These figures are more troubling when broken down by state: More than 40% of people incarcerated in Arkansas, Kansas, and South Dakota were infected, and death rates in Arkansas, Delaware, Ohio, Oklahoma, and Oregon were more than seven times higher than that of the general population (Schnepel, 2020).

One report found that around 12 of every 100 individuals in state and federal prisons had recovered from or was currently infected with COVID-19 as of mid-November 2020 (Brennan Center, 2020). The raw numbers are staggering: Of the more than 330,000 people known to have tested positive behind bars, 1,868 perished (The COVID Prison Project, 2021). Moreover, those who are incarcerated have higher rates of acute and chronic health conditions than the general population, including HIV and other infectious diseases, mental health conditions, and other comorbidities — e.g., hypertension, diabetes, and asthma — directly linked to severe COVID-19-related illness and death (APHA, 2020).

The racial gradient, as surmised from limited data, is devastating, as disparities in incarceration are reflected in infection rates. Indeed, one study found that infection rates and suspected infection rates for Black Americans behind bars were anywhere from two to four times that of white individuals (Nelson & Kaminsky, 2020). Coupled with higher rates of preexisting conditions and other comorbidities, COVID-19 presents an even greater risk to people of color in both communities and the criminal legal system.

We previously outlined why correctional facilities are structurally prone to be hotspots for disease transmission. These factors include widespread overcrowding, lack of basic sanitation, substandard health care, and many other issues symptomatic of abuse and neglect of people behind bars. Moreover, confined conditions, high turnover rates, and underinvestment in resources for infection control exacerbate transmission risks in correctional facilities (Macmadu et al., 2020).

The continued lack of consistent and frequent testing, basic sanitization and hygiene products, and facility space to enable quarantining further contributes to rampant infections. Such settings led to more than 40 of the 50 largest clustered outbreaks, or "hotspots," occurring in jails and prisons (Macmadu et al., 2020). Indeed, more than 800 hotspots were in correctional facilities as of mid-November 2020, and nearly 15% of the facilities had more than 500 cases (Schnepel, 2020). Prisons and jails have long been known to be porous with respect to their surrounding communities, and COVID-19 easily breaks in and out of their walls. A prime example is Cook County Jail in Chicago, where nearly 16% of all COVID-19 cases in the state were linked to an outbreak in the facility (Macmadu et al., 2020). Importantly, those incarcerated are not the only people at greater risk in the criminal legal system: As of January 8, 2021, a little more than 77,000 correctional staff tested positive and 113 have died (The COVID Prison Project, 2021).

The overincarceration crisis has therefore — predictably — amplified the COVID-19 crisis. The dismal health status of its enormous correctional population and the failure to provide adequate reentry supports help explain the link between the United States’ status as the world’s leading jailer and its position at the bottom of public health rankings among peer nations. In addition to the racial justice, fiscal stewardship, and other reform imperatives, public health data demonstrating individual and community detriment from incarceration helped amplify calls for reform; however, aside from marginal sentencing reform, these calls went largely unheeded. With few exceptions, federal, state, and local governments have failed to implement meaningful policies to combat the rising number of cases behind bars.

Federal and State Failures to Depopulate Prisons and Jails

Despite the dire pre-pandemic environment and a vast body of evidence showing the particular risks correctional facilities posed to COVID-19 transmission, early calls to depopulate correctional institutions went largely unheeded. Depopulating, or “decarceration,” refers to both reducing the number of people behind bars by both releasing individuals before their sentence is entirely served, and diverting individuals who would be incarcerated (NASEM, 2020). As to the latter, diversion strategies include reducing the number of arrests, eliminating cash bail and otherwise reducing pre-trial detention, and relaxing parole and probation conditions to ensure individuals remain in their communities.

During the pandemic, multiple decarceration efforts across jails, prisons, and detention centers have been undertaken, leading to an approximately 11% reduction in incarcerated populations — a drop in the bucket considering the systemic overcrowding in
correctional facilities and despite the fact that decarceration provides positive effects both for those behind bars and for people living in surrounding communities (NASEM, 2020).

**Federal response.** The federal response was largely characterized by confusing, often changing, guidelines for COVID-19 protocols and compassionate release for those most vulnerable to the virus. One study found that, while 10,840 federal prisoners applied for compassionate release in the first three months of the pandemic, wardens approved only 156 of those petitions, or less than 2% (Brennan Center, 2020).

Even more disturbing is the COVID-19 outbreak linked to an acceleration of federal executions by the Trump Administration over the summer when a federal Bureau of Prisons (BOP) staff member who was involved in the first execution tested positive for the virus; nevertheless, BOP neither tested everyone in the facility nor required staff to quarantine for a full two weeks, instead allowing staff to return to work after 10 days without retesting (Brennan Center, 2020).

**State responses.** Some states and local governments are doing slightly better with efforts to decarcerate, but by and large have failed to decarcerate at a meaningful pace even as infection rates grow (Brennan Center, 2020). New Jersey has been held up as a model for other states, expecting to reduce the state’s prison population by almost 35% by March 2021 based on a recently enacted law crediting individuals with early-release credits for time served during the pandemic (Tully, 2020).

The District of Columbia enacted a similar law that both retroactively awarded good time credit for those who had served at least 20 years and enabled such individuals to cite age, health, or other ‘extraordinary and compelling circumstances’ as justification for early release — unfortunately, judges have rejected around 68% of such requests (Marimow, 2020).

Importantly, neither federal nor state governments are prioritizing the release of individuals particularly vulnerable to COVID-19. In California, only 62 of the 6,500 eligible individuals were released solely due to their medical conditions; the rest of the more than 7,500 people released had less than a year to serve on their sentences (Lyons, 2020).

**Key Agenda Items**

We previously focused on the structural components of the criminal legal system that led to the current COVID-19 crisis in carceral facilities. In this updated version of the Chapter, we take advantage of the opportunity presented by an incoming federal administration to outline actions that can address the ongoing pandemic following the disastrous failures of their predecessors.

**Decarceration is Imperative to Slowing the Spread of COVID-19**

As previously discussed, public health experts and criminal justice advocates have issued increasingly urgent calls for the United States to ramp up decarceration. It is not too late to embrace decarceration as both a public health and moral imperative. Resistance to decarceration is largely due to fears that releasing people present a threat to public safety, a false narrative that perpetuates irrational and outdated fears of those who are incarcerated. This, despite the fact that there exists abundant criminological evidence that releasing many incarcerated people would not pose a threat to public safety (Franco-Paredes, 2020). Examples of states that simultaneously reduced prison populations and saw crime rates decrease include California, Michigan, New Jersey, New York, and Texas (APHA, 2020).

Decarceration is the most effective way to ensure fewer people are infected behind bars, but simply releasing individuals from incarceration will not curb new infections if not paired with meaningful reentry supports. Reentry planning is essential to breaking the cycle of interaction with the criminal legal system. This includes discharge planning similar to hospitals and “warm hand-offs” (transporting person directly to services that increase positive outcomes). COVID-19 poses additional challenges: during the pandemic, reentry must not only be managed remotely, but also unequivocally include housing, transportation, and financial assistance, as well as community interventions to ensure the cycle of incarceration is broken. Such interventions should also include specialized, potentially remote, community supervision (i.e., for people with substance use disorder (SUD)); continued treatment of physical (including COVID-19) and mental health conditions; and expanded access to services. Moreover, and as discussed in our previous Chapter, releases must be sensitive to the barriers to reentry that are specifically exacerbated by COVID-19.

It bears repeating that Black, Indigenous, and other people of color are disproportionately represented in prison and jail populations. Because of this, corrections facilities and policy makers alike must ensure that pandemic-related decarceration is not racially imbalanced by, for example, taking into account the heightened risk COVID-19 presents to people of color. Corrections facilities must also immediately begin tracking and reporting data on infections and deaths, including racial and ethnic markers, if they are not doing so already.

**Strategies to Protect Those Who Remain Behind Bars**

We recognize that, while not every person behind bars will be eligible for early release even under the most liberal federal and state policies, correctional facilities must take meaningful action to ensure those who remain behind bars are protected from COVID-19 to the greatest extent possible.

First, this means significant investment in enhanced sanitation measures. One study found that there continues to be “shortage[s] of cleaning supplies, wipes, hand sanitizer, and even disposable covers for thermometers, and this interfered with [corrections staff] ability to conduct temperature screening among inmates” (Nelson & Kaminsky, 2020). Greater access to personal protective equipment (PPE), including masks, is imperative.

Second, there must be more frequent and robust control measures for stemming the spread of COVID-19. This includes testing of both people incarcerated and correctional staff, as well as contact-tracing. Moreover, correctional facilities must enable
more effective social distancing and quarantining capacity. Social distancing and quarantining is impossible while correctional populations remain as high as they are — this is why decarceration is so important. Absent significant reductions in the incarcerated population, however, correctional facilities must immediately institute regular testing. Those who test positive must be provided ethical quarantine spaces and their contacts traced to ensure facilities know exactly who is at further risk of contracting the virus.

Third, Congress should eliminate the inmate exception preventing Medicare and Medicaid dollars from being spent in correctional facilities. The prohibition prevents good health care in general for people incarcerated, but also prevents spending on COVID-19-related health care in the criminal legal system. Poverty is a key indicator of whether a person comes into contact with the criminal legal system, and the ban on granting those behind bars coverage under the nation’s health care program for the economically disadvantaged is counterproductive and contrary to the programs’ stated missions.

Lastly, and perhaps most controversially, governments must prioritize corrections staff and those incarcerated for vaccine distribution along with health care workers and other people who live in congregate settings. People behind bars should be at the front of the line precisely for the reasons detailed above. Simply put, preventing infections behind bars benefits both those inside and outside of correctional facilities. Prisons and jails are vectors for viral spread because those incarcerated cannot adequately engage in social distancing, have little access to masks and other PPE, and are exposed to countless individuals that come in and out of facilities, including staff and visitors. Despite these clear facts, governors and members of the community are hesitant to make vaccine distribution in correctional facilities a priority — this reticence will cost lives, both behind bars and in the surrounding communities.

Structural and Administrative Steps to Address the Incarceration Crisis

Finally, as previously described, the pandemic provides federal, state, and local governments the opportunity to begin to address the overincarceration crisis. This means governments should immediately begin investing in communities and alternatives to the criminal legal system, which should include access to basic resources like education, jobs, and housing, as well as affordable and accessible health care — including mental health care and substance use disorder treatment — to ensure vulnerable individuals are not funneled into the criminal legal system (APHA, 2020). Front-end solutions reduce the number of people who are ultimately incarcerated for crimes often associated with poverty, mental health conditions, and SUD. A renewed focus on racial equity could reduce racial disparities in the criminal legal system.

Similarly, governments must stop practices like pre-trial detention and cash bail that further bloat the criminal legal system and contribute to disease transmission. Changes to policing and releases from correctional facilities are estimated to prevent 23,000 COVID-19 infections among people incarcerated and 76,000 infections in surrounding communities (APHA, 2020).

In the context of decarceration, correctional facilities should move those with mental health conditions and SUD from locked facilities to community-based treatment, employing community-based interventions (see the Sequential Intercept Model section in Chapter 31 of Volume I). Legislatures must actively work to decriminalize sex work, substance use, homelessness, and other “quality of life” charges (APHA, 2020). Legislatures could also broaden public health officials’ authority over correctional facilities to minimize the public health harms posed by these facilities both in the context of COVID-19 and beyond (APHA, 2020).

Finally, governments should urge and, in some cases, order correctional facilities to immediately implement policies and operating procedures to promote COVID-19-safe release. This necessarily includes better data tracking of active infections, deaths, and contact tracing but extends to ramping up post-release supports for those reentering. Moreover, facilities must have appropriate administrative capacity to ensure people do not die behind bars because staff cannot coordinate timely release.
Recommendations for Action

**Federal government:**

In addition to the recommendations detailed in our first Chapter, many of which have not been implemented across the board or at all, the federal government should implement the following recommendations:

- The Centers for Disease Control and Prevention (CDC) should explicitly recognize and include decarceration and expanded access to health care for incarcerated and recently released individuals as necessary guidance for federal, state, and local officials. Although a flurry of recent executive orders discussed the need for decarceration (e.g., Executive Order 14006, which directs Executive Branch agencies to end contracts with privately operated criminal detention facilities to decrease incarceration levels) ending contracts with for-profit facilities does nothing to reduce the number of people incarcerated today.

- Department of Justice leaders should utilize existing authorities, such as compassionate release and home confinement, to expedite the immediate release or transfer of elderly and medically vulnerable people out of the Bureau of Prisons (BOP). In accordance with recent Executive Orders directing executive agencies to implement policies that enhance racial equity, the Executive Branch should direct BOP to ensure that pandemic-related decarceration is not racially imbalanced.

- Congress and the Executive Branch should support COVID-19 relief funding for state, local, and Tribal criminal legal systems to incentivize a significant reduction of incarcerated populations and to assist reentry and community-based organizations to respond to COVID-19.

- The Executive Branch should direct the Attorney General to minimize arrests, decline to seek detention of individuals at their initial appearance in court, and consent to the release of those already detained, absent clear and convincing evidence that the person poses a specific threat of violence to a specific person.

- BOP should implement universal and regularly repeated testing for all correctional staff and people incarcerated. Executive Order 13996 addresses this recommendation but must be fully implemented to ensure people incarcerated and working in federal correctional facilities are tested and should go further in prioritizing these populations – those incarcerated and correctional staff – in vaccine distribution.

- Congress should pass the COVID-19 in Corrections Data Transparency Act, which requires the BOP, U.S. Marshals Service, and state and local correctional agencies to report disaggregated data to the CDC on the effects of COVID-19 in their facilities, including any racially or ethnically disparate impacts. Executive Orders 13994 and 13995 address expanding data collection, but a federal law passed by Congress to this end would better ensure COVID-19 data reporting on the state and local level.

- Congress should pass legislation using the power of the purse to incentivize states to decarcerate and provide vaccines to people behind bars, and legislation repealing the inmate exception for Medicare and Medicaid.

**State governments:**

In addition to the recommendations detailed in our first Chapter, many of which have not been implemented across the board or at all, state governments should implement the following recommendations:

- State prosecutors, by exercising their prosecutorial discretion, and law makers, by implementing sensible legislation, should stop practices like pre-trial detention and cash bail that further bloat the criminal legal system, as well as work to enact legislation decriminalizing sex work, substance use, housing insecurity and homelessness, and other "quality of life" charges.

- Legislators should require prisons and jails to implement policies to address COVID-19 behind bars, and to frequently report data on infections, deaths, and releases that include demographics.

- Legislators, governors, and public health departments should prioritize people behind bars and correctional staff for vaccine distributions and greatly expand compassionate release programs for the medically vulnerable.

- State prosecutors and governors should not stand in the way of requests for early release or oppose recommendations for release made by parole boards.
Recommendations continued, local governments:

In addition to the recommendations detailed in our first Chapter, many of which have not been implemented across the board or at all, local governments should implement the following recommendations:

- Local prosecutors, by exercising their prosecutorial discretion, and law makers, by implementing sensible legislation, should stop practices like pre-trial detention and cash bail that further bloat the criminal legal system, as well as work to enact legislation decriminalizing sex work, substance use, housing insecurity and homelessness, and other “quality of life” charges.

- Legislators should require prisons and jails to implement policies to address COVID-19 behind bars, and to frequently report data on infections, deaths, and releases that include demographics.

- Legislators and public health departments should prioritize people behind bars and correctional officers for vaccine distributions and greatly expand compassionate release programs for the medically vulnerable.

About the Authors

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References


