

Health Departments Taking Action on Incarceration:

A Framework for
Advancing Health
Instead of Punishment
During COVID-19

JANUARY 2021

A Framework for Advancing **Health Instead of Punishment** During COVID-19



Doctors, families, and advocates gather to support decarceration during the COVID-19 outbreak at San Quentin State Prison.

Heavily policed communities — including Black people, Indigenous people, immigrants, people with disabilities, queer and trans people, people in poor neighborhoods, and sex workers — have long sounded the alarm that incarceration is a public health crisis. [Public health consensus and research on this has grown](#) in recent years, documenting how incarceration measurably harms individual, family, and community health. The far-reaching and long-lasting impacts include increased prevalence of chronic health conditions among those impacted — such as hypertension, diabetes, and arthritis — and decreases in life expectancy.

[The COVID-19 pandemic has added a layer of unprecedented threat and urgency](#) to this already chronic issue. Because of the characteristic overcrowding, medical neglect, and inadequate sanitation in the nation’s jails, prisons, and immigrant detention centers, [carceral facilities have become hot spots for COVID-19 outbreaks](#). The practices required to limit the spread of the virus — such as practicing physical distancing, wearing a mask, and minimizing indoor contact with others — are all impossible in carceral settings. It is therefore no surprise that carceral facilities regularly appear in the [top ten largest sources of COVID-19 infections nationally](#). Indeed, early estimates suggest that the case rate of COVID-19 in US prisons is [5.5 times higher](#) than in the US general population.

We know that there is no way for anyone to be safe and healthy inside a jail, prison, or immigrant detention center, especially during the COVID-19 pandemic. Because of this, mass releases of people from carceral facilities should be our priority as the primary prevention strategy. At the same time, we need to simultaneously employ harm reduction strategies to protect those who remain incarcerated.

Health departments can and must take action to curb the dual and overlapping threats of COVID-19 and incarceration. As we move toward collective action from a place of shared moral responsibility and sectoral power, we recognize that health departments and officials have varying amounts of formal jurisdiction over implementing the strategies outlined below.

However, jurisdiction and regulatory scope can change over time depending upon conditions and health crises. COVID-19 offers both impetus and opportunity to move public health work further “[upstream](#)” to address the policies, systems, and environments that create health— beyond solely individual-level health behaviors and health care. Moving upstream may require [developing a shared analysis](#) within health departments, [broadening regulatory scope](#), and/or [championing transformative change](#). Ultimately, divesting from systems of policing and punishment that harm individuals and communities and instead investing in institutions and systems that promote community well-being (like public health departments, public schools, affordable housing, and quality employment) is more

sustainable and will move us closer to health equity and collective liberation.

Based on our work nationally with community organizers on the frontlines of advancing racial justice, community safety, and health equity, we propose eight prevention and mitigation recommendations, and provide associated health evidence, for health departments to address the ongoing harms of incarceration during the COVID-19 pandemic and beyond. We conclude with action steps that health departments can concretely take to advance these recommendations.

1. Focus action toward mass decarceration

[Decarceration means releasing people from incarceration, providing them with the community-based resources they need to thrive, and protecting against cumbersome state supervision requirements.](#)

This is best approached through structural policy change rather than via individual case review to allow for maximum impact. This includes, but is not limited to, releasing everyone who is currently incarcerated on money bail, who is within 18 months of the end of their sentence, or who is eligible for parole. As these changes are proposed and implemented, officials must prioritize those who will be most vulnerable to serious complications or death if they become ill with COVID-19.

Based on existing data, we understand [mass decarceration to be an infection prevention strategy both for people who are incarcerated and for communities more broadly.](#) For example, one study found that [decreasing incarceration rates from just 3% to 2% of the general population reduces TB infections in prison by 44% and by 21% in the general population.](#) While TB has a higher rate of infection, we can reasonably conclude that we would see a similar effect for COVID-19. Further, recent statistical analyses have estimated that [mass incarceration added more than a half million COVID-19 cases nationally.](#)

2. Advocate against transfers between carceral facilities

A primary mechanism of COVID-19 transmission through jails, prisons, and immigrant detention centers is via the transfer of people between facilities. For example, the [COVID-19 outbreak at San Quentin State Prison](#) occurred when the California Department of Corrections and Rehabilitation transferred over 100 people from California Institute for Men, where there was an ongoing outbreak. Ending all transfers from one carceral facility to another in the midst of COVID-19, including [transfers from prisons or jails to Immigration and Customs Enforcement](#) (ICE), is urgently necessary to contain the virus.

3. Improve health care access for people who are incarcerated

Despite high rates of health concerns within carceral facilities, people who seek medical care while incarcerated struggle to receive the health care they need. The understaffing of medical professionals, lack of resources, inability to afford copays, and overall dehumanization of incarcerated people hinder receipt of quality care, [including for those who are incarcerated pretrial](#). Furthermore, corrections staff often ignore or deny incarcerated people's requests for medical care.

Health departments, or their parent agencies, typically either provide health care within carceral facilities or oversee contracts for the provision of health care via outside entities. During the pandemic, health departments must work to immediately strengthen and increase health care services, to ensure that people who are incarcerated receive the care they need. This includes releasing people to community-based clinical care. All people who have COVID-19 symptoms — whether incarcerated or not — deserve immediate access to testing, care, and the ability to protect themselves and others.

4. Prioritize incarcerated people in your jurisdiction's COVID-19 vaccine allocation

Congregate settings, such as long-term care facilities, are appropriately receiving priority in vaccine administration. Incarcerated people face particular and excessive risk due to the nature of their living environments: they are held in unsanitary and overcrowded conditions that are ripe for virus transmission and are provided inadequate health care.

Additionally, [the physical toll of incarceration can accelerate aging and exacerbate chronic health conditions](#) among incarcerated people, both of which are risk factors for developing serious complications from COVID-19. Incarcerated people must be offered COVID-19 vaccines, as well as [accurate information on the risks and benefits](#), as early as possible to prevent unnecessary deaths.

5. Speak out against the use of solitary confinement units, including for those who test positive for COVID-19

Alongside the documented [deleterious mental health impacts](#) of solitary confinement, recent work shows that it has been found to contribute to a [24% increase in mortality](#) in the first year after release from incarceration, especially from suicide. Use of solitary confinement — a deadly type of confinement — to curb a deadly virus is both counterproductive and inhumane. Furthermore, fear of facing the extreme social isolation of solitary confinement may result in incarcerated people not disclosing symptoms or seeking treatment, which would worsen the spread of COVID-19.

6. Ensure COVID-19 testing is equitable in design and enforcement

Health departments must mandate, to the extent possible, COVID-19 testing for all staff and contractors every time they enter carceral facilities. This may require renegotiating union and service delivery contracts. Officials must also ensure that COVID-19 testing is readily and freely available for all incarcerated people. Incarcerated people must not be coerced into testing and instead must always be able to opt into or out of testing as frequently or infrequently as they choose.

People who are incarcerated are unfortunately forced to weigh the risk of retaliation (including solitary confinement if they test positive) and the risk of potential infection (including from exposure to new people in the process of receiving a test and from the facilities' poor hygiene practices during test administration) against access to testing.

7. Promote transparent, accessible, and regular reporting of COVID-19 testing, cases, and deaths in carceral facilities

There has been drastic and systemic undercounting and under-reporting of COVID-19 data in jails, prisons, and detention centers. For example, in [Alameda County, California, the Sheriff's Office has refused to offer universal testing at Santa Rita Jail even during its numerous COVID-19 outbreaks, which has led to a severe undercounting of cases](#). The Sheriff's Office also does not publicly provide data over time, opting to only provide current and aggregated statistics. Health departments have a unique role to play in ensuring that robust data on testing, cases, and deaths are available to the public and to decision-makers. This can include incorporating such data into existing data portals and being available to provide technical assistance to those using the data to make policy proposals.

8. Leverage the power of inspections to document abuses and neglect occurring inside carceral facilities

In many jurisdictions, the health department is responsible for yearly or bi-yearly inspections of jails, prisons, and immigrant detention centers. Inspections provide an opportunity for health workers to see behind the walls of carceral settings in a way that the general public cannot.

Health departments can leverage this power to expose the harmful conditions in jails, prisons, and immigrant detention centers and to hold their jurisdictions responsible for making changes to provide for the immediate needs of those who remain incarcerated as we pursue mass decarceration. During the COVID-19 pandemic, health departments can use this inspection authority to ensure that carceral facilities are following, at a minimum, the [Center for Disease Control \(CDC\) guidelines for preventing the spread of COVID-19](#) in these settings.

Across all strategies, action steps that health departments can take include:

Action Step	Resources
<p>Develop and deepen relationships with community organizers in your jurisdiction who are building power directly with people impacted by incarceration and who are leading local campaigns.</p>	<ul style="list-style-type: none"> • Find organizers in your area • Learn about health agency-organizer collaborations • Review case studies on: <ul style="list-style-type: none"> ◦ Sharing community power ◦ Building community alliances
<p>Use your public health platform to validate, amplify, and meet the needs of those directly impacted by incarceration.</p>	<ul style="list-style-type: none"> • Check out this Public Health Message Guide on Decarceration • Review case studies on: <ul style="list-style-type: none"> ◦ Changing the narrative ◦ Transformative leadership
<p>Strengthen the evidence base on how incarceration harms individual, family, and community health while protecting people’s privacy and sensitive health data.</p>	<ul style="list-style-type: none"> • Check out these data resources: <ul style="list-style-type: none"> ◦ SDOH Data source (pg 52) ◦ PPI Data Toolbox ◦ RWJF report (pg 30) ◦ AJPH Issue on Carceral Systems ◦ NYC SDOH Survey • Review case studies on: <ul style="list-style-type: none"> ◦ Mobilizing data
<p>Get clear on your legal and institutional authority within and outside the context of a state of emergency.</p>	<ul style="list-style-type: none"> • Adapt CDC guidance on COVID-19 in carceral settings for your local context • See resources on COVID-19 legal authorities of local governments from ChangeLab Solutions and Network for Public Health Law • Review case studies on: <ul style="list-style-type: none"> ◦ Working across government ◦ Broadening regulatory scope
<p>Build the consensus needed within your department to understand the public health crisis of incarceration, to advance strategic solutions, and to exercise your authority.</p>	<ul style="list-style-type: none"> • Check out the Washtenaw Plan Statement and the APHA Statement on Addressing Harms of the Carceral System • Review case studies on: <ul style="list-style-type: none"> ◦ Building organization capacity ◦ Prioritizing upstream policy ◦ Developing a shared analysis

Learn more about this issue

For more details about this issue, please visit our [Health Instead of Punishment Program page](#) or contact Amber Akemi Piatt, Health Instead of Punishment Program Director at amber@humanimpact.org.

For more information or to request technical assistance on ways health departments can address the harms of incarceration, please visit our [Capacity Building page](#) or contact Ana Tellez, Capacity Building Program Director at ana@humanimpact.org.

About Human Impact Partners



[Human Impact Partners \(HIP\)](#) transforms the field of public health to center equity and builds collective power with social justice movements.

All photos by Brooke Anderson, movementphotographer.com