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Decarceration and community re-entry in the COVID-19 era

Carlos Franco-Paredes, Nazgol Ghandnoosh*, Hassan Latif, Martin Krsak, Andres F Henao-Martinez, Megan Robins, Lilian Vargas Barahona, Eric M Poeschla*

Jails and prisons are exceptionally susceptible to viral outbreaks, such as severe acute respiratory syndrome coronavirus 2. The USA has extremely high rates of incarceration and COVID-19 is causing an urgent health crisis in correctional facilities and detention centres. Epidemics happening in prisons are compounding the elevated risks that COVID-19 poses to people of colour, older people, and those with comorbidities. Intersectoral community re-entry efforts in the USA and other countries have shown that releasing people from correctional facilities as a pandemic-era public health intervention is safe and can support both public safety and community rebuilding. Therefore, substantial decarceration in the USA should be initiated. A point of focus for such efforts is that many people in prison are serving excessively long sentences and pose acceptable safety risks for release. Properly managed, correctional depopulation will prevent considerable COVID-19 morbidity and mortality and reduce prevailing socioeconomic and health inequities.

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For a Spanish translation of the abstract see **Online** for appendix

*Joint first authors

Department of Medicine, Division of Infectious Diseases, University of Colorado School of Medicine, Aurora, CO, USA (C Franco-Paredes MD, M Krsak MD, A F Henao-Martinez MD, M Robins BA, L Vargas Barahona MD, E M Poeschla MD)**; Hospital Infantil de México, Federico Gomez, México City, México** (C Franco-Paredes)**; The Sentencing Project, Washington, DC, USA** (N Ghandnoosh PhD)**; and Second Chance Center, Aurora, CO, USA** (H Latif)

Correspondence to: Dr Carlos Franco-Paredes, Department of Medicine, University of Colorado School of Medicine, Aurora, CO 80045, USA **carlos.franco-paredes@cuanschutz.edu**

Introduction

In the USA, mass incarceration has become a crucial determinant of social inequity and a source of multi-generational despair.[1–6] The prison boom since the mid-1970s has disproportionately affected people of colour and has become a social force that rivals the education system and labour market influencing numerous communities in the USA.[3] The overall prison and jail populations increased from almost 400 000 individuals in 1975 to a peak of 2·3 million individuals by 2008.[7] Before the COVID-19 pandemic, jails and prisons in the USA held nearly a quarter of the global incarcerated population.[1] Moreover, correctional facilities are just one component of the vast US justice system. The system's reach is massive given the fact that 600 000 individuals are released from state and federal prisons each year, with more than 4 million people on probation or other forms of community supervision.[3,4] Incarceration levels that produce diminishing returns to public safety and could be a source of net societal harm emerged from public policies, some racially motivated, that were put in place over the past three decades since 1970s, by politicians eager to show that they were enforcing a strict criminal justice system.[3,8–9]

The evidence suggesting that mass incarceration has ensured public safety is poor.[8–9] Many countries worldwide had high crime rates in the 1970s that fell substantially after the 1990s.[9–11] The USA substantially increased national incarceration rates during the period of high crime and the subsequent fall.[11–12] Politicians have repeatedly promoted a so-called war on drugs, which focuses on restricting drug supply instead of tackling the roots of substance use disorder[3]—ie, poverty and racial discrimination, loss of many well paying jobs with stable health benefits, insufficient educational opportunities, and low access to mental health care and effective drug treatment.[1,4,12] The social and economic costs of relying on disproportionate incarceration and the failure to address the core causes of crime have transformed correctional institutions into counter-productive facilities that deepen racial inequities.[13–14] Compared with other high-income countries, harsher sentencing in the US judicial system condemns generations of people to diminished lives.[12] Draconian sentencing, congressional constraints on judicial discretion in sentencing, measures such as the so-called three strikes law, and harsher punishments for crack cocaine crimes but not powdered cocaine crimes were all factors that have contributed to the USA having a high number of people, particularly people of colour, in prisons and jails.[12–13] Mass incarceration has led to more than 2 million children in the USA having a parent incarcerated.[3,14–15] Many of these children live in low-income neighbourhoods, have lost siblings to violence, and experience food and housing insecurity.[15] These compounded disadvantages place children at high psychiatric, legal, social, and financial risk, including being at an amplified risk for future imprisonment.[14–15] Most states in the USA have modestly downsized their prisons since reaching their peak population levels, but the number of people incarcerated in the USA remains several times higher (670 people per 100 000 residents) than that of other high-income countries (eg, 94 per 100 000 in Germany and 45 per 100 000 in Japan).[7,10–11]

Inequities in the US criminal justice system stem from enduring the systemic effect of racial oppression, police force militarisation and assignment over-reach, police brutality, and a large and dysfunctional community supervision structure.[2–4,16] The problems that incarcerated people experience inside correctional facilities are extensions of underlying societal and economic inequities that predisposed them to become incarcerated.[1,17,18] Imprisonment also widens underlying health disparities and reduces the lifespan of large sectors of the population because of economic injustice, inadequate medical care, psychosocial trauma, and residential segregation.[19,20] The biological expression of these racial injustices include so-called deaths of despair[21–23] (ie, premature deaths due to suicide, drug overdose, and alcoholic liver disease) and having an increased risk of cardiovascular disease, chronic kidney disease, chronic liver disease, accelerated ageing, and acquisition of particular infections.[19,22,24]

	Before COVID-19 pandemic	During COVID-19 pandemic*
State prisons	1 260 393 (Dec 31, 2019)†	1 207 710 (May 1, 2020)†
Jails	738 400 (Dec 31, 2018)‡	575 952 (July 22, 2020)‡§
Federal prisons	175 315 (March 5, 2020)¶	156 968 (Aug 13, 2020)¶
Immigration detention (ie, ICE)	37 888 (March 20, 2020)‖	21 118 (Aug 8, 2020)‖
Total	2 211 996	1 961 748

ICE=Immigration and Customs Enforcement. *Population reductions in jails, prisons, and ICE detention centres might represent a combination of early releases and reduced intake in response to the COVID-19 pandemic. †Data from Vera Institute of Justice[48] and our additional data file. There are insufficient data on the prison populations in the states of Illinois, Maryland, Minnesota, New Mexico, and Virginia. A similar analysis by The Marshall Project[49] found that state prisons downsized from 1 130 457 to 1 046 370 people between March, 2020, and mid-June, 2020. This estimate excluded the prison populations in Maryland and Alaska and only included the sentenced populations in states with unified prison and jail facilities. ‡Data from US Bureau of Justice Statistics.[50] §Estimate based on a median 22% reduction in sample population of jails between Jan 1, 2020, and July 22, 2020, analysed by Prison Policy Initiative on the basis of data collected by NYU Public Safety Lab[46] and Prison Policy Initiative;[51] the Vera Institute of Justice found that the number of people in US jails fell by a quarter from mid-March, 2020, to the beginning of June, 2020.[52] ¶Data from US Federal Bureau of Prisons;[53] the Aug 13, 2020, total includes 7932 individuals on home confinement, which is an increase of 5283 since March 5, 2020. ‖Data from ICE Guidance on COVID-19.[54]

Table: **Number of people in state and federal prisons, jails, and immigration detention in the USA before and during the COVID-19 pandemic**

COVID-19 disproportionately affects African Americans, Latinx, and Native Americans[17,18,25,26] because of contributing factors such as having service jobs that require face-to-face contact, living in crowded housing, and use of public transportation.[26] The pandemic is intersecting with a dysfunctional justice system and has confirmed once again, eight centuries on from the Black Death,[27–30] how epidemics reveal underlying social inequities that produce illness.[20,29] The regular movement in and out of correctional facilities also presents a problem during a pandemic.[31–33] The movement of people between correctional facilities and the broader community and the close contact between people who are incarcerated and correctional staff means there is a continuous threat of introduction or reintroduction of severe acute respiratory coronavirus 2 (SARS-CoV-2).[18,32] Incarcerated people have an increased prevalence of tuberculosis, HIV, hepatitis B, hepatitis C, and syphilis.[34,35] Jails, prisons, and detention centres represent conducive environments for the spread of respiratory infections such as influenza and tuberculosis.[4,34,35] Because SARS-CoV-2 is a highly transmissible respiratory virus that can be transmitted by asymptomatic people, the risk of outbreaks in correctional facilities is high.[31] Similar to the events of the 1918–19 influenza pandemic,[33] the structural vulnerabilities of people in prison are being shown in 2020 in the San Quentin State Prison (San Quentin, CA, USA), where a COVID-19 outbreak has escalated to a third of imprisoned people and staff testing positive.[36] In custodial settings, the rate of COVID-19 infection could reach up to 50% or more and many individuals have asymptomatic infections.[18,37–40] Overcrowding, poor sanitation, insufficient environmental disinfection, non-functioning ventilation systems, bureaucracies that are unable to do rapid COVID-19 testing or case tracking, and inadequate provision of medical services compound the risk of COVID-19 transmission in jails and prisons.[18,31,40]

Decarceration in response to the COVID-19 pandemic

People of colour make up nearly two-thirds (63%) of the incarcerated population.[41] African American people make up a third (33%) of the incarcerated population, compared with 13% of the general population.[41,42] According to the UCLA COVID-19 Behind Bars Data Project, by Aug 24, 2020, there was an estimated 113 664 COVID-19 cases and 887 related deaths among incarcerated people in the USA.[39,43] Since early April, 2020, the 15 largest known clusters of COVID-19 cases in the USA have occurred in prisons and jails.[37] These data and other relevant data collection projects[38,44,45] that report similar estimates have important limitations because of substantial under-testing and under-reporting by correctional facilities during this pandemic.[36,40,46] In response to the growing number of COVID-19 outbreaks in these facilities, public health experts, civil rights attorneys, and advocacy groups have made urgent appeals for prison depopulation.[32,47] Many jurisdictions have restricted the admission and accelerated the release of individuals in pre-trial detention or people convicted of non-violent offences in jails and prisons and reduced the population in immigration detention centres. This activity has reduced the overall incarcerated and detained population in the USA by approximately 11% during the pandemic (table).[46,48–54] Experts in correctional health and human rights have argued that these decarceration levels are insufficient and raised concerns that pandemic responses could be exacerbating racial disparities.[32,47] For example, in Illinois and Connecticut, decarceration of White people has been substantially higher than that of African Americans during the COVID-19 pandemic.[55,56]

Depopulation of correctional facilities has been inadequate, whether considered with the COVID-19 pandemic or with the dismaying long-term trends.[51,52,57,58] The population of people in prisons in the USA grew from approximately 196 000 people in 1972 to over 1·5 million in 2009, an increase of more than 700%.[3,58,59] Although nationwide crime rates fell by half in the 1990s, the prison population was only reduced by 9% between 2009 and 2018.[59] The level of decarceration before the pandemic was already incommensurate with the nationwide crime drop[56,59] and what has occurred since is not adequate to the urgency of the COVID-19 public health crisis.[18,49] The growing number of COVID-19 related deaths in jails and prisons[39] highlights the inability of incarcerated people to shield from the effect of this pandemic inside crowded and unsanitary environments where physical distancing is unattainable and they are unable to seek timely and adequate medical care.[6,31,60]

People older than 55 years, who are incarcerated, are especially at risk of severe COVID-19 and they often pose little public safety risk.[58,59] Yet, political leaders have often neglected this population in prison depopulation efforts. One in seven people in state and federal prisons in the USA is serving a life sentence, including life with or

without parole and virtual life sentences (ie, 50 years or longer).[58] Many of these individuals have served decades in prison for violent crimes committed as young adults and, when released, they have some of the lowest re-offence rates.[58,59] However, the focus of politics on high-profile recidivist cases has often surpassed health and evidence-based criminological data that support release of older people after long sentences have been served.[58] The numerous outbreaks of COVID-19 among people who are incarcerated show that the USA does not embrace scientific evidence that supports the depopulation of correctional facilities to mitigate the spread of the virus[60] and criminological evidence that suggests this policy would not harm public safety.[18,32,55–59]

Protecting the incarcerated against COVID-19

Considering the restricted agency of people who are incarcerated, the government has a fundamental obligation to care for this population. Protecting people residing in correctional facilities during the COVID-19 pandemic and in regular times is a constitutional mandate and should be a public health priority.[47] Imprisonment for the purpose of justice or public safety reasons should not preclude the need to uphold the highest attainable standards of protection for people who are incarcerated. Federal guidance on COVID-19 for correctional facilities has had an inadequate effect in protecting individuals who are susceptible to SARS-CoV-2 by not recommending a substantial population reduction in jails and prisons as a crucial intervention.[61] These recommendations have focused mainly on mitigating interventions (eg, infection prevention and physical distancing), which has proven insufficient to interrupt transmission in correctional settings as the number of cases and deaths continue to increase.[37–39] Prison crowding in the USA is widespread and prevents physical distancing.[60] Compliance with COVID-19 infection prevention protocols in these environments is extremely challenging and often impossible.[18,31] Without a substantial decrease in population density, effective physical distancing to protect individuals at high risk of severe COVID-19 cannot occur.[60] For example, Iran released more than 70000 people from prison at the peak of their epidemic, reducing the overall effect of COVID-19.[31] By contrast, jails and prisons in the USA have not depopulated at the same scale as other countries.[46–49,51,52] Additionally, amid this exponential increase in cases and the case-fatality rate among incarcerated people,[39] current federal guidance continues to withhold expanded testing approaches that could provide invaluable guidance for population management strategies inside correctional facilities.[28]

The eighth amendment of the US Constitution clearly guarantees freedom from cruel and unusual punishments; however, the illness and deaths caused by COVID-19 in prisons show inherent cruelties within the correctional systems of the USA.[47] A swift and coordinated response by the federal government, US states, and local authorities to reduce the transmission inside these facilities could have prevented the more than 880 deaths due to COVID-19 in correctional facilities.[39] Neglecting the legal mandate to protect people who are incarcerated during the COVID-19 pandemic represents an unfair social arrangement that causes health inequity[20] by impairing their ability to shield from the pandemic.[18] Civil rights attorneys and public health leaders have recently highlighted how decarceration is the most effective intervention to protect people who are medically susceptible and are incarcerated.[47,62] Reducing population density in correctional facilities could lead to more effective physical distancing interventions and infection prevention protocols being implemented.[18,60]

Community re-entry and COVID-19

People who were previously imprisoned often have individual, familial, and community disruptions resulting from mass incarceration and they can endure structural violence (ie, social structures that impair human life by lowering the degree to which someone is able to meet their basic needs), during their re-entry and reintegration process, which amplifies a cycle of social injustice.[63,64] After exiting correctional facilities, individuals face many challenges—eg, reduced employment opportunities, housing and food insecurity, discrimination and stigma, lowered wages, and an inability to reconstruct their identities, exercise their agency, and build enough dignity to avoid reincarceration.[3,63,64] Before the COVID-19 pandemic, approximately 600 000 people left federal and state prisons every year and 5 million people went through the jailing system while waiting to resolve their case or for sentences of less than 1 year.[3,63] Therefore, there is a risk that prison and jail releases will fuel the pandemic in communities.[65] Guidelines from the Centers for Disease Control and Prevention have provided insufficient testing guidance during release planning efforts by recommending only symptom screening and temperature checks at the time of release.[66] Reintroduction of COVID-19 into the larger community by released individuals occurred during the coronavirus outbreak in Cook County Jail (Chicago, IL, USA).[65] Therefore, decarceration during this COVID-19 pandemic will benefit from a different strategy to the current one of re-entry support approaches that involve less person-to-person contact and avoidance of group activities, which are crucial components of adaptation during the initial phase of reintegration.[67,68] Population management strategies must consider viral screening and instituting quarantine and isolation protocols when needed, particularly in halfway houses or other dormitory-style living environments.[68] Community re-entry is further complicated by the unprecedented levels of unemployment and economic downturn caused by the COVID-19 pandemic.[69] These challenges call for substantial investments that support re-entry including the provision of stable housing, ensuring food security and access to medical care through enrolment in Medicaid (particularly relevant for

***Panel:* Community re-entry and reintegration policies in the COVID-19 era**

Enhancing public health
- Re-entry support approaches that involve less person-to-person contact
- Avoidance of group activities
- Education of preventive interventions
- Hygiene and disinfection strategies
- Viral screening and instituting quarantine and isolation protocols when indicated, particularly at halfway houses or other dormitory-style living environments

Removing structural vulnerabilities
- Stable housing
- Food security
- Access to other public services
- Expanding job opportunities
- High-quality early education
- Enhancing residential mobility

Reducing health inequities
- Access to quality medical care
- Enrolment (or re-enrolment) in Medicaid, including individuals with pre-existing conditions
- Increase access to mental health services
- Effective treatment for substance use disorder

Permanent reductions in jail and prison populations
- Reduce incarceration to levels of other industrialised countries

individuals with pre-existing conditions), and enabling access to other public services.[67]

It is imperative to improve health-care access and quality after incarceration because many people leaving jails and prisons have poor physical and mental health, including substance use disorders.[5,6,20,70,71] Insufficient health insurance within a dysfunctional system that links health insurance to employment leads to frequent use of emergency department services.[67,69] These medical morbidities prevent people who were formerly incarcerated from successfully reintegrating into the community.[23] Therefore, ensuring continuity of medical care at the time of community re-entry via transition clinics, health programmes (eg, mental health services), substance abuse services, and community-based services, reduces reincarceration and promotes health equity.[60,64,67] In the first 2 weeks of community re-entry, individuals are at an increased risk of death by suicide, drug overdose, cardiovascular disease, and accidental death.[23] For example, in the state of California, USA, a statewide committee of service providers has recommended several strategies to provide health care in transition clinics, link guidance by health departments for COVID-19 prevention and referral to care, and secure emergency housing after incarceration.[68]

Linking health equity in the COVID-19 era

The COVID-19 pandemic offers an invaluable opportunity to reshape collective thinking about structural racism, mass incarceration, and their social costs in the USA.[71,72] The preventive role of public health and the healing function of clinical medicine is inadequate without addressing structural forces that determine poor health, including unemployment, educational inequities, and hyperincarceration.[1] Medical professionals should confront prevailing health inequities, health-care access, and suboptimal medical care that result from structural racism in health-care organisations and academic medical centres.[71] In particular, the economically and socially harmful policy in the USA that ties health insurance to employment creates a fundamental web of inequity and, at the same time, constrains good job growth because employers must pay a substantial part of the insurance cost, which is a larger proportion of total costs for workers on lower salaries.[22,69] This deep structural problem in how the US health insurance is structured is extremely different to European systems.

Additionally, structural racism and police violence constitute the entry point to the criminal justice system and hyperincarceration. Medical professionals cannot turn away from the ongoing national debate about humane policing because mass incarceration is a major factor contributing to health inequities.[5,71,72] Police violence is one of the leading causes of death in young Black men between the ages of 20 years and 35 years in the USA[72]—eg, Elijah McClain, a 23-year-old unarmed African American man, died in August, 2019, while being arrested very near to our medical campus in Aurora, CO, USA. In fact, Black people and Native American people are at an increased risk of being killed by police compared with White men and women.[72] Therefore, maintaining the reductions in overall jail and prison populations during the COVID-19 pandemic and depopulating prisons and jails in the long-term is a major policy intervention that will promote social justice and health equity.[18,47,60] Evidence-based findings that show the lack of benefit and the broad range of harms caused by hyperincarceration[1,8,9] should lead to a rethinking of excessive imprisonment as a necessary component of public safety.[8] The socioeconomic crisis that the COVID-19 pandemic is causing and will continue to cause will further marginalise impoverished urban settings that could promote returning to pre-pandemic incarceration rates.[69]

Conclusion

There is no effective method to predict whether future epidemics and pandemics will affect marginalised groups (such as people who are incarcerated); however, there is an urgent need to minimise that vulnerability through social improvements that include permanent reductions in jail and prison populations[60] (panel). Some states in the USA, such as New York in 1999 and Connecticut in 2008, have cut their overall prison and jail

populations in half since reaching peak population levels.[73] Notably, during their periods of decarceration, these states have had less crime than the national average. However, these states still have high numbers of people who are incarcerated, especially involving people of colour, which are well above those of other countries and above what these states had before the era of mass incarceration.[73]

Public policies that invest in community development promote economic development that helps to interrupt the cycle of unemployment, incarceration, and health inequities.[20,22,24] Similarly, investments to increase access to mental health care and effective drug treatment would be more effective than relying on incarceration to address harmful drug use.[63,64,74] Investments in high-quality early childhood education and in promoting residential mobility to racially integrate neighbourhoods would be more effective than maintaining the current high levels of arrests and incarceration to tackle crime.[1,3,53] For the past five decades, many people in the USA have assumed that the criminal justice system and the availability of excess police force in their neighbourhoods are the most important determinants of public safety.[3,9,75] This perception is based on biased political rhetoric and media coverage. However, the COVID-19 pandemic and the Black Lives Matter movement have highlighted the inadequacy of returning to the pre-pandemic use of excessive incarceration policies that promote neither public safety nor justice.[69,76]

Every case of COVID-19 and every death had a definable trajectory that can be traced back to its social roots. The medical community should learn from the substantial effect of this pandemic on people of colour in the USA and advocate for confronting contemporary racial inequities, including ending police violence and hyperincarceration.

Contributors

CF-P and NG did the study design, data collection, data analysis, data interpretation, and writing of the initial and final manuscript. HL and MR did the data collection, editing of the final draft, and literature search. EMP, MK, LVB, MK, and AFH-M did the data analysis, literature search, and edited the final draft.

Declaration of interests

We declare no competing interests.

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