



Addressing the Public Health Crisis of U.S. Carceral Facilities: An Integrated and Equitable Approach

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The SARS-CoV-2 virus and resultant coronavirus disease (COVID-19) have caused unprecedented suffering among incarcerated individuals since the beginning of the pandemic. While many believe that widespread vaccination in jails, prisons, and other carceral settings will solve the problem, this perspective underestimates the severity of the situation and mischaracterizes its driver. Vaccines are a necessary but insufficient component to what should be a comprehensive, immediate, and ethical response to COVID-19 in carceral settings across the United States. Vaccination alone cannot address the broader public health crisis of mass incarceration, which **threatens the health** and **shortens the lifespan of those held within jails**, prisons, and detention centers. Instead, a robust, integrated, and ethical public health response to mitigate COVID-19 and other brutal conditions within carceral facilities could provide a foundation for better health care access not only in prisons but also for state and national populations in general. Below, we identify three interrelated problems: (1) noncompliance with epidemiological and public health demands, notably a failure to decarcerate in response to COVID-19; (2) the criminal legal system's isolation from public health oversight and accountability; and (3) the problematic and inequitable distribution of vaccines to incarcerated individuals. We then propose necessary principled measures that federal, state, and local policymakers should take to address the devastating impact that COVID-19 continues to have on incarcerated individuals and their communities.¹

I. THE STATE OF THE PROBLEM

Currently, the public health crisis inside carceral facilities is plagued by at least three interconnected problems. **First, the past year has made clear that carceral facilities are overwhelmingly unresponsive to epidemiological**

needs and public health demands. Due to problems with testing, data transparency, and oversight, at least **626,000 incarcerated people nationwide have tested positive for COVID-19**. This number is likely a gross undercount. These system deficiencies have led to serious health complications and a **disproportionately high number of deaths**. They have resulted in a **disproportionate impact on Black and Latinx individuals**, a product of the structural racism inherent to the criminal legal system and persistent racial and ethnic disparities in incarceration and sentencing. These deficiencies have implications for the wider public's health, leading to, for example, the **spread of COVID-19 in the community**. According to **one study**, the churn of people through Cook County Jail was associated with around 16 percent of documented COVID-19 cases in Chicago and the rest of Illinois as of April 19, 2020. This finding suggests that carceral settings are epicenters of COVID-19 spread throughout the nation's wider communities.²

As a whole, carceral systems at the state and federal levels have failed to formulate a cohesive and democratically accountable public health policy and infrastructure to combat the rapid spread of COVID-19.³ **Notably, carceral facilities have failed to substantially reduce their prison populations** (commonly referred to as **decarceration**)—a policy step which, when taken alongside regular testing and tracing, is **perhaps the most powerful and life-sustaining tool at the disposal of state officials**. This is especially the case in federal and state prisons. As COVID-19 began spreading through federal prisons during the early months of the pandemic, wardens **rejected** over 98 percent of applications for compassionate release. This finding **accords** with historical trends of neglect toward medically vulnerable incarcerated individuals. States have also failed to decarcerate: While jails experienced a 31 percent median reduction in their populations during the early months of the pandemic, **the typical state prison system**

¹ This brief is developed in the consultation of leading scholars, practitioners, clinicians, and policymakers regarding the policy changes that stand to be most critical to the health and wellbeing of currently and formerly incarcerated people. For a comprehensive vision of how to transform the criminal legal system, please go to **JustLeadershipUSA's 2021-2024 Roadmap** which provides immediate, mid-term, and long-term recommendations for change.

² Incarceration also affects general societal health because people often experience high rates of insecure housing after jail or prison. People who are formerly incarcerated are **almost ten times more likely** to experience homelessness. This vulnerability matters because, as we have seen in New York City, the COVID-19 mortality rate for people who are homeless and in shelters is **49 percent higher** than that of the general New York City population.

³ The lack of consistent data reporting and assessments coming out of jails, prisons, and detention centers has undercut the ability of policymakers, researchers, and communities to respond to the COVID-19 crisis in these facilities. This lack of transparency has also deprived many incarcerated individuals of their constitutional right to legal representation.

reduced its prison population by no more than 5 percent. Efforts have slowed, if not reversed, in recent months. These trends are alarming given **40 percent of incarcerated people in the U.S. have a preexisting condition**. As the #ReleasesNow testimonials from incarcerated people at San Quentin State Prison make painfully clear, the public health crisis in often-overcrowded prison facilities is nothing short of a state of emergency. **Decarceration is thus a clear and necessary public health measure to mitigate COVID-19 in carceral facilities.**

Second, the criminal legal system's isolation from broader public health oversight and accountability systems has enabled carceral control to supplant the public health imperatives and best practices needed to protect vulnerable individuals from COVID-19. This sequestration of carceral health care from wider public health is by design. It tracks with the institutional logic that separates and excludes those deemed offenders from the embrace of community and public provision. When Congress passed Medicare and Medicaid into law in 1965, it prevented the programs from paying for health care in jails or prisons through the **Medicaid Inmate Exclusion Policy (MIEP)**. Section 1905(a) of the Social Security Act prohibits payment of any federal Medicaid matching funds for use of services for inmates of public institutions (e.g., jails, prisons, detention centers) except when they become patients in separate medical facilities. Currently, **19 states terminate Medicaid coverage completely when a person becomes incarcerated; the remaining states suspend coverage**. This creates costly additional barriers to and gaps in medical access for people upon release from prison. (This policy applies to those incarcerated in both **adult carceral facilities and juvenile detention facilities**). Even progressive health care proposals like **Medicare For All** carry over the MIEP.

By carving out incarcerated people and non-incarcerated detainees from public health programs, the government also allows inadequate health access to pervade our nation's jails and prisons. Because the MIEP exempts jails and prisons from the federal mandate that organizations participating in Medicare and Medicaid maintain minimum health standards, carceral facilities are **shielded from accountability and public health oversight and thus allowed to maintain poor health standards**. The constitutional standard that prisons go beyond "deliberate indifference to serious medical need" establishes an exceptionally low bar that many jails and prisons still **struggle and often fail to meet**. Since the vast majority of incarcerated people have **a current medical health problem**, carceral facilities must be woven into the formal public health apparatus.

Third, while carceral facilities continue to face high rates of COVID-19 infection and mortality, vaccine distribution efforts at the state level have remained slow and plagued with ethical infractions. Most critically, **most states have not included incarcerated individuals in their highest priority groups for vaccination**, even though incarcerated people are among the most medically vulnerable in the country. Consequently, as of the publication of this brief, **one out of every**

five people in prisons has tested positive for COVID-19, and the rate of infection in prisons is four times the rate in the general population. In state prisons, **one in three** incarcerated people is known to have had the virus. In light of these challenges, state courts have begun to weigh in. A New York Supreme Court judge **recently ruled that the state's incarcerated population has been arbitrarily excluded from the state's vaccine rollout** and that New York state must immediately offer the vaccine to prisoners. This was "an abuse of discretion," said the judge, who emphasized that state officials "irrationally distinguished between incarcerated people and people living in every other type of adult congregate facility, at great risk to incarcerated people's lives during this pandemic."

Even in states where incarcerated populations are in high priority vaccination groups, vaccination rollout has operated with little regard to fundamental ethical principles of autonomy and dignity. For example, although the California Department of Corrections and Rehabilitation (CDCR) has now vaccinated a large portion of its nearly 100,000-person incarcerated population, problems continue: "**Reports from incarcerated people in prisons across CDCR has highlighted inadequacies in vaccine rollout such as: incorrect doses, different first and second vaccines, and ignoring incarcerated people's health needs around reactions post-vaccination.**" Moreover, CDCR has still not stopped transfers between facilities. This is despite the fact that its handling of prison transfers resulted in massive outbreaks that the state Office of the Inspector General **described in February 2021** as "deeply flawed and [as having] risked the health and lives of thousands of incarcerated persons and staff." Moreover, **incarcerated people in some prisons have reported or feared severe reactions after the first dose of the vaccine**. This has severely diminished trust. Many have refused the critical second dose out of fears that facilities are not safely managing distribution. These reports from California accord with other recent reports that incarcerated individuals are deeply wary of receiving the **vaccine in prison**, a skepticism rooted in **mismanagement, neglect, and the long history of medical experimentation and trauma-inducing punitive practices** that have occurred in U.S. correctional facilities.

II. THE SOLUTION

In addition to decarceration as a main priority, place the health of incarcerated people under the oversight and accountability systems of public health institutions, and make basic health services accessible to those who are directly impacted by incarceration. These alarming patterns call for state and federal public health systems to integrate incarcerated individuals and their loved ones within existing systems of health care prevention, promotion, and education. The advent of the COVID-19 pandemic can serve as an important moment to align the health crisis in carceral facilities with public health imperatives. This effort must begin with integrative policies that repudiate the false dichotomy between "correctional health" and population health.

ARGUMENT SUMMARY

COVID-19 has magnified the persistent public health crises and racial inequities that are inherent to mass incarceration and most clearly laid bare in the nation's jails and prison. An important source of these crises is the carving out of those within jails and prisons from the U.S. safety net (Medicare, Medicaid, etc.). Legislators and policymakers made a grave error with this decision, the repercussions of which we live with to this day.

If we are to build back better in the wake of COVID-19, stakeholders at the local, state, and federal levels—notably the Biden Administration—should work to change the state's relationship to those who are directly impacted by incarceration. This change reflects a transition in the administration of justice from a principle of alienation and separation to a principle of association, an approach now considered by experts to be an international best practice. This policy transition should occur along two parallel tracks: (1) decarceration to enable those in prison to return to their families and communities; and (2) creation of key policies and federal incentives that fully incorporate those impacted by incarceration and felony conviction into the social safety net. The active pursuit of both aims is an ethical and public health necessity, in addition to being an imperative of antiracism.

In what follows, we outline some essential short- and long-term steps, and key executive and other policy levers that can be mobilized to make them happen.

We also emphasize that such steps should be informed by the expertise and guidance of those who have been directly impacted by the criminal legal system. Directly impacted individuals should be at every decision-making table. This representation is invaluable to equitable policy development and implementation. We urge stakeholders and policymakers to read and implement JustLeadershipUSA's (JLUSA) comprehensive [2021-2024 Roadmap](#) for transforming the administration of justice in America. This [roadmap](#) is the first of its kind. It is informed by the expertise of directly impacted people and JLUSA's nationwide network of grassroots organizations, and it includes both immediate executive actions and mid- and long-term legislative recommendations to guide federal actors toward a fairer, more humane, and just criminal legal system that will lead to an end to mass incarceration.

III. NECESSARY NEXT STEPS: SHORT-TERM AND LONG-TERM

VACCINE DISTRIBUTION MUST ACCOMPANY WIDESPREAD AND COMPREHENSIVE DECARCERATION

- Research has shown that [decarceration](#) is safe and is not associated with increases in recidivism. Decarceration strategies include widespread releases of individuals who do not pose risks to public safety, enhanced use of home confinement, and abolishing the use of pre-trial detention of individuals who cannot afford bail.
- Research shows that [decarceration efforts](#) and compliance with CDC guidelines (e.g., testing, washing hands) are very effective strategies to reduce COVID-19 transmission in carceral facilities.
- Even a very effective vaccine will not work optimally in congregate, high-spread settings in carceral facilities.⁴ This fact holdstrue as new variants have begun developing in carceral facilities and will continue to be more likely to develop in these settings.
- Because of persistent and historic abuses of incarcerated individuals in medical research, consent to vaccination will remain uncertain and an ethical quandary. As an example, the sheriff of Middlesex County, MA, surveyed 400 incarcerated individuals about their willingness to receive a COVID-19 vaccine, finding that 60 percent would refuse even if they could receive it at no cost.

PUBLIC HEALTH DEPARTMENTS AT ALL LEVELS OF GOVERNMENT MUST PLAY A ROLE IN OVERSIGHT AND ACCOUNTABILITY. CORRECTIONS DEPARTMENTS SHOULD NO LONGER CONTROL THE ADMINISTRATION OF HEALTH AND MENTAL HEALTH CARE OF INCARCERATED INDIVIDUALS

- A reorientation of the state is necessary. The system currently operates on a principle of alienation and separation. It needs to change to a system based on a principle of association – individuals involved in the criminal legal system require more community connections and support.
- This principle of association requires that individuals with lived experience are integrated into policy-making frameworks at all levels of government. Only through integrative and comprehensive conversations will needs be met and policies reoriented.
- Despite numbers of COVID-19 cases in carceral facilities, several states have already [begun](#) rolling back suspensions of health care co-pays. During the pandemic and after,

⁴ As Paltiel, Schwartz, Zheng, and Walensky explain, “even a vaccine with seemingly adequate efficacy, pace, and coverage may be insufficient to alter the fundamental population dynamics that produce high disease prevalence.”

disincentives to receive health care in carceral settings must be eliminated.

- The billions of dollars made available to state and local jurisdictions through American Rescue Plan Act to build out their public health systems could also be used to support the provision of health workers in correctional facilities.
- Sheriffs and wardens have immense decision-making influence over the health care access and experience among incarcerated people. Their position opposes the principles of equitable access, since these correctional authorities do not have public health expertise and are chiefly responsible for maintaining order within facilities. This exemplifies how correctional power takes structural precedence over the equitable provision of healthcare and health access for incarcerated populations.

HEALTH DEPARTMENTS AND AGENCIES SHOULD BRING THEIR RESOURCES AND EXPERTISE TO THE VACCINATION ROLLOUTS IN CARCERAL FACILITIES

- Vaccination efforts at the federal and state levels should create linkages between carceral facilities and public health agencies. A useful model here is the [Transitions Clinic program](#) and network, a consortium of over 40 primary care clinics nationwide that serves the health and social needs of individuals recently released from incarceration. These clinics are staffed with health workers with lived experience of incarceration who act as vaccination education resources within their communities and for people leaving incarceration.

CULTURALLY COMPETENT HEALTH CARE WORKERS FROM OUTSIDE HEALTH DEPARTMENTS AND AGENCIES, NOTABLY COMMUNITY HEALTH WORKERS, SHOULD SERVE AS “CREDIBLE MESSENGERS” TO CARRY OUT THE HEALTH EDUCATION AND VACCINATION EFFORTS IN PRISONS AND JAILS.

- State and local health departments and clinics should directly operate vaccination processes within carceral facilities (e.g., by means of pop-ups), including education, confidential consults, and actual vaccination of incarcerated people. Doing so ensures compliance with public health standards and protection of confidential health information, preventing such information from being communicated to non-health officials and/or used as a means of coercion. To do this, time is a major factor; medical staff need time and availability to consult with incarcerated patients.
- These entities should work with **credible messengers**—that is, formerly incarcerated individuals and the loved ones of those directly impacted by the criminal legal system—to provide education and distribution of vaccines to the community. This proposal reinforces the need for ethical and engaged vaccine education in marginalized communities. It also fosters democratic relationships between directly impacted individuals and public health systems, which is a dire need across the nation’s communities.

■ Strong evidence supports this approach. A recent [survey of The Marshall Project](#) found that although there was extensive interest in the vaccine among incarcerated people, the lack of vaccine education and history of medical abuse and neglect created barriers to vaccination. Most incarcerated people “said they’d get vaccinated if their questions were answered, if their friends and family said it was safe, or after guards received their immunizations first.” However, the article continued: “many incarcerated people don’t know enough about the vaccine to decide whether to take it, the survey showed. Many of the respondents raised basic questions about the vaccine: What are the long-term side effects? If I have had the virus, do I still need to be vaccinated? Can you still get COVID-19 after receiving the shots?” Sending credible public health messengers (who are unaffiliated with correctional facilities) into jails and prisons may address these problems.

POLICYMAKERS, HEALTH EXPERTS, AND ADVOCATES MUST INTEGRATE EQUITABLE AND INCLUSIVE HEALTH FRAMEWORKS INTO ONE COHERENT SET OF GUIDING PRINCIPLES.

- Carceral systems must defer to public health agencies in navigating the vaccination process. In so doing, they must avoid coercive prosecutorial and punitive practices to increase vaccine uptake. This issue goes hand-in-hand with the need for public health systems to properly prioritize and oversee the health and wellbeing of people in jails and prisons.
- In particular, public health agencies have an obligation to preserve and respect the decision-making capacity and dignity of incarcerated individuals.
- As things stand, departments of corrections and sheriffs’ offices have too much power and discretion over the provision of health and mental health care in jails, prisons, and other detention facilities. Introducing Medicaid and other public health programs will decrease instances of health and mental health care deprivations. It will also advance the need for accountable, evidence-based care.
- Governments at all levels must inform the public about the progress of vaccination efforts in carceral facilities by means of easily accessible data and constant communications. This will increase transparency and make vaccine distribution receptive and sensitive to input from both experts and concerned communities.
- The Department of Justice (DOJ) should establish national standards, mandates, and incentives for data collection and reporting on matters of health conditions and services in jails, prisons, and detention centers.
- As the Bureau of Justice Statistic’s [Mortality in Correctional Institutions \(MCI\)](#) reporting program shows, this level of data collection is feasible—it simply needs to be mandated and built upon.
- The Departments of Health and Human Services (HHS)

and Justice (DOJ) should work together to facilitate the involvement of other public health agencies (e.g., [creating avenues with the Department of Veterans Affairs to ensure access to established benefits for incarcerated veterans](#)).

- Community health and mental health care providers should not always have to report their patients to law enforcement or other government agencies when these patients are both parents and substance users. Mandatory reporting schemes both criminalize and marginalize individuals who use substances while increasing the risk of separating children from their parents. Substance use alone with no concern for child abuse or neglect should not trigger mandatory reporting.

CREATE ROBUST POLICIES, PROCESSES, AND DISCOURSES CONCERNING HEALTH ACCESS FOR INCARCERATED PEOPLE AND PEOPLE TRANSITIONING OUT OF CARCERAL FACILITIES.

- **Expand Medicaid to directly impacted people.** In Medicaid, the United States already has a flagship public health care system for financing care for vulnerable populations. This can and should be expanded to include those in prison. These individuals are among the most vulnerable populations in the nation. Medicaid expansion to system impacted people offers potential [savings](#) to states while also connecting people to perhaps one of the most vital sources of health care coverage in the nation.
- **Expand and Specify the Medicaid Reentry Act.** An amendment to the Title XIX of the Social Security Act ([H.R. 955](#) and [S.285](#)), which would make Medicaid available one month (30 days) before a person is released from prison, was introduced to Congress in February 2021 but as of yet has not successfully proceeded to legislation. While this policy is insufficient to address the deep and broad circumstances faced by those who are currently incarcerated, it can play a key role in connecting those who are near release from prison to life-saving and -sustaining public health resources. The Biden administration should work with Congress to help move this through committee and into law. This would strengthen and improve the life outcomes and chances of those released from prison.
- H.R. 955 (formerly drafted under the Medicaid Reentry Act) also [enables](#) access during pre-and post-release to services for individuals impacted by COVID-19 and other complex health conditions, including substance use and mental health conditions.
- H.R. 955 could be joined with executive level incentives to states to launch initiatives that systematically bring community providers to prison facilities and enroll individuals transitioning out of prison into various kinds of coverage and state programs.
- **Finally, H.R. 955 (formerly the Medicaid Reentry Act) should be made actionable and specific to the problems of implementation.** Currently, this legislation is only three lines

long. In order to be actionable, it should be more detailed, so it can attend to problems of oversight and implementation. For example, many people are held in pretrial detention for indeterminate amounts of time, without knowledge of time of release. Moreover, if a Medicaid Reentry Act passed as it is written now, there may be a tendency among jails and prisons to withhold health care until the last 30 days so that care will be covered by Medicaid. Such problems raise critical problems of equity and access and should be addressed in the design of legislation and/or program regulations.

EXPAND THE PUBLIC HEALTH SERVICE CORPS TO FORMERLY INCARCERATED PEOPLE.

- **Policymakers should encourage the formation of medical-legal partnerships and transitions clinics.** Both institutional models are key for not only caring for individuals who are exiting the criminal legal system and reintegrating society, but also linking them with social supports (e.g., identification services, housing, immigration supports.) [Given that drug-related deaths are most prevalent within two weeks of release](#), these types of services are necessary and urgent. The substance use treatment [program](#) initiated in the Rhode Island Department of Corrections offers one valuable model for other states.
- **Engage and direct the Centers for Medicaid and Medicare Services (CMS) to interpret the statute for 1115 waivers broadly, allowing states flexibility in enabling Medicaid and other public health programs to penetrate carceral facilities.** “Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program.” CMS should allow states to leverage 1115 waivers to circumvent the MIEP and enable Medicaid to provide, oversee, and manage health and mental health service delivery in carceral facilities, for instance by [including the behavioral health of incarcerated people as well as the health care transitions of incarcerated people in the weeks and months prior to coming back to their communities](#).
- There is a need to change the term we use for the transition from prison to life outside of prison. The term “reentry” is indifferent to the social, racial, and economic inequities that make particular groups vulnerable to incarceration in the first place and that tend to define their lives even after prison. Local, state, and federal actors can be leaders in changing the public conversation around formerly incarcerated people by changing rhetoric from a language of “reentry” to a language of “community embrace” instead. Given that [1 in 2 Americans has a close family member who has been to jail or prison](#), the latter term is more reflective of what many American families want for their loved ones who are returning home from prison.

EXPLORE THE POTENTIAL OF FEDERALLY QUALIFIED HEALTH CARE CENTERS AS A WAY TO AMELIORATE PARTICULARLY DISTRESSING HEALTH CONDITIONS IN CARCERAL FACILITIES.

- It should be noted that while 1115 waivers are one policy possibility, they require lengthy applications and demand that states be especially motivated to improve their health systems. **Federally Qualified Health Care Centers (FQHCs)** work on a different model by utilizing a unique payment structure under Medicaid: they receive an allotment or enhanced payment rather than a service fee, operating with the understanding that the patients and problems of their patients are specific and particularly high-need. There is a network of FQHCs that operates in underserved areas.

- Alongside the primary goal of decarceration, a network of community-based FQHCs could play a critical role in jails and prisons to better deliver a community standard of care. FQHCs also provide medical-legal supports which could provide incarcerated people with an important avenue for support and access. That said, FQHCs are not the best solution to the problem of health access in jails and prisons. The best response to that problem remains decarceration so that people can receive the care they require in the general community.

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