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Mitigation of COVID-19 and Other Infectious Diseases in Correctional Facilities

Robbie Dennis, a former inmate at the Louisiana State Penitentiary, lost at least 16 of his friends to COVID-19 within just a few months after the onset of the current pandemic (Sullivan & Shapiro 5). Although 16 deaths may not sound like a lot, this is 16 deaths in one correctional facility, with numbers likely to rise, and one would expect total numbers to reach the thousands if 16 people were to die in every correctional facility across the United States. Hence, this statistic and anecdote demonstrates the severity and urgency of the issue of COVID-19 and other infectious diseases in our correctional facilities and criminal justice system. Prisoners and detainees are particularly vulnerable to infectious diseases such as COVID-19, viral hepatitis, multidrug-resistant tuberculosis, MRSA, HIV/AIDS, and other sexually transmitted diseases due to “restricted movement, confined spaces, and limited medical care” according to Akiyama and his colleagues. Incarcerated individuals have been at an increased risk of infectious diseases long before the COVID-19 pandemic due to correctional conditions, but this situation was significantly exacerbated upon the onset of the pandemic. This problem continues to persist due to the mass incarceration policies being implemented in the United States for the last four decades. Unfortunately, this problem not only affects inmates, but also correctional staff and surrounding community members (Akiyama et al. 1). Therefore, uncontrolled infectious diseases in correctional facilities is a public health concern.

State and county departments of corrections and rehabilitation must mitigate this problem by decarcerating or releasing prisoners with guidance from federal government agencies including the United States Department of Justice Federal Bureau of Prisons and the United States Department of Health and Human Services Centers for Disease Control and Prevention if they want to avoid violating human rights. Prisons are inadequately equipped to meet the healthcare needs of elderly prisoners with declining health, and these prisoners pose minimum threat to public safety because they are incapacitated (Price 4). Furthermore, public safety and public health are inextricably linked, therefore it would be in the best interest of general public safety to avoid further deterioration of public health (Wang et al. 106). According to a study conducted by the Bureau of Justice Statistics, the federal prison system and at least 12 state prison systems have substantially exceeded capacity (Wang et al. 26). With approximately 655 out of every 100,000 Americans incarcerated, it is unreasonable to expect sufficient health and safety in our correctional facilities during a global pandemic, thus making human rights violations in the criminal justice system inevitable (Rubin 2). These statistics and pieces of information make it obvious that now is the time to act because more delays lead to many more lives lost in our correctional facilities. Although our war on crime and drugs must continue, we must not forget to prioritize our war against pathogens and make appropriate sacrifices, which includes using our ability to forgive or pardon, at least for those convicted of nonviolent misdemeanors, as well as those who are no longer physically capable of committing violent crimes. Government agencies at all levels, including federal, state, and county, must avoid violating human rights in correctional facilities by creating a tier-based set of criteria for compassionate release and pardon, taking into consideration medical conditions, physical ability to commit a violent crime, nonviolent behavior, and severity of prior crimes.

The Federal Bureau of Prisons and the Centers for Disease Control and Prevention should collaborate to establish guidelines for decarceration using compassionate release and legal pardon protocols during the pandemic, and mandate compliance by state and county governments through federal executive powers. This must be done to prevent human rights violations against our fellow Americans and can be achieved by establishing sets of criteria in tiers, with medical conditions being first priority, physical ability being second priority, and severity of crimes being third priority. These tiers and priorities are established based on intrinsic American and human values. Human lives are of utmost importance, which is why medical conditions should be first priority due to increased morbidity and mortality of people infected with COVID-19 that have underlying chronic health problems. Public safety, which is also directly related to human lives, is why physical ability comes in second priority. However, physical ability is not first priority because it is relatively less influential to clinical outcomes than prisoners having underlying health problems. Severity of crimes comes in third priority because although we should avoid putting people convicted of nonviolent misdemeanors at unnecessary risk, if they are healthy and young individuals, then they are still at less risk of death due to COVID-19 relative to their older and more medically problematic counterparts.

It is important to have guidelines established by both the public health and the public safety communities to ensure comprehensive guidelines for decarceration during this pandemic as well as future ones. This is because expert insights are needed to ultimately balance public health and public safety, and drawing from only one side of expertise inevitably makes this process fraught with disproportionate and counterproductive measures that do not effectively optimize the current correctional and public health crisis. For example, the public health community may want to release too many people, whereas the public safety community may want to release too little, or vice versa. It is also important to draw from both areas of expert knowledge because public health authorities may be more competent at identifying who would be eligible for compassionate release due to terminal illness or chronic health problems, whereas public safety authorities may be more qualified at identifying who should be forgiven, and how they should be monitored by their parole officers.

Given that underlying medical conditions and chronic health problems should be the first priority when creating tiers of criteria for compassionate release or at least home confinement, criteria for officially identifying high-risk inmates based on health conditions must be clarified to guarantee objective evaluations and ensure racial equity during the decarceration process. Chronic health conditions such as asthma as well as other types of chronic obstructive pulmonary diseases, hypertension, cardiovascular diseases, and diabetes mellitus all increase the risk of complications and death due to COVID-19 infection (Wang et al. 46). Therefore, inmates with these chronic health conditions should be higher up on the list of people to be considered for compassionate release. In essence, based on this information provided by the National Academies of Sciences, Engineering, and Medicine, COVID-19 appears to mainly affect the cardiovascular and respiratory systems of the body, which is why prisoners with problems in these physiological systems should be specifically included as the bedrock of medical criteria for compassionate release.

Obviously, implementation of decarceration guidelines provided by federal government agencies are bound to vary from state to state, because different states have different legislation (Price 4). Currently, there are no medical or geriatric parole laws or programs within the State of Illinois (Families Against Mandatory Minimums 1). The closest thing to compassionate release that the State of Illinois has is the Executive Clemency process, which gives the Governor of Illinois the authority to release eligible prisoners with serious medical conditions, though this rarely happens (Families Against Mandatory Minimums 1). Thus, the first legislative steps in the State of Illinois would need to be to pass a bill that requires a protocol which allows for home confinement or confinement to a medical facility for terminally ill or severely incapacitated prisoners that do not have a life sentence. Such decisions should be made by the medical director of the Illinois Department of Corrections. Unfortunately, early compassionate release for elderly, terminally ill, or severely incapacitated prisoners were neither included in The Neighborhood Safety Act of 2017 (Families Against Mandatory Minimums 3) nor in the SAFE-T Act of 2021 (Illinois General Assembly 476). Although legislating long-term medical and geriatric parole laws may be beneficial in the long-term, there is no time to waste during a pandemic because time wasted means lives lost. Due to these reasons, executive orders from the federal government may be necessary to reduce human rights violations within the Illinois Department of Corrections. If necessary, the Illinois Department of Corrections can satisfy such federal mandates by collaborating with the Illinois Department of Public Health and the Illinois State Police. If Springfield willingly fosters an interdisciplinary approach to establishing comprehensive and equitable sets of decarceration criteria and guidelines during the COVID-19 pandemic, they can save the lives of hundreds if not thousands of Illinoisans without compromising public safety across the state. Of course, this effort will presumably be led by the medical director of the Illinois Department of Corrections, however, insights from different professionals across agencies will ensure the most comprehensive and equitable criteria to be implemented in Illinois.

Indeed, critics may argue that decarceration would lead to more loss of life and property damage due to increases in crime rates and decreases in public safety. This is especially the case for government agencies at all levels, including federal, state, and county, because they are the entities that are ultimately responsible for both public health and safety. However, despite the ostensible legitimacy of the aforementioned concern, this can easily be solved by establishing guidelines for a tier system including factors like health conditions, physical ability to commit a crime, violence of prior crimes, et cetera, to ensure an optimal balance between public safety and public health.

A 2018 report from the nonprofit organization, Families Against Mandatory Minimums has indicated that elderly, terminally ill, and severely incapacitated prisoners pose little to no threat to public safety (Price 8). This essentially means that there is no point or justification for holding aging and dying prisoners who pose little to no threat to society and public safety. For example, someone convicted of a violent felony when they were 16 years old, and now they are 98 years old, have a form of chronic obstructive pulmonary disease, is wheelchair-bound, and has cataracts is probably not going to successfully commit a violent crime even if they want to because they are too functionally impaired to pose a risk to other people (Price 11). Furthermore, an article published in the *New England Journal of Medicine* indicates that many more lives are lost by refusing to release prisoners that are physically incapable of reoffending as well as those who are convicted of nonviolent misdemeanors based on studies conducted by various academic medical institutions including the Albert Einstein College of Medicine, Emory School of Medicine, and the Warren Alpert Medical School of Brown University (Akiyama et al. 3). As an overabundance of caution, such individuals can be subject to frequent monitoring by parole officers, completion of sentences in home confinement, or psychiatric hospitalization.

As of today, April 13, 2021, a total of 392,565 prisoners have been infected with COVID-19, thus resulting in a total of 2,516 deaths among incarcerated populations in about one year in the United States. A total of 108,264 correctional staff members have been infected with COVID-19, thus resulting in a total of 198 correctional staff member deaths during the pandemic nationally (The Marshall Project). Unless we want more incarcerated person and correctional staff blood on our hands, government agencies at all levels must act now. If mass decarceration is adopted during the COVID-19 pandemic, it will be viable to ensure reasonable levels of health and safety within our correctional facilities and facilitate the control of life-threatening infectious diseases like COVID-19, viral hepatitis, multidrug-resistant tuberculosis, MRSA, HIV/AIDS, other sexually transmitted diseases, et cetera. Compassion is a necessary component of this process and will not only prevent death among incarcerated individuals but also among correctional staff members. Federal and state correctional facilities must utilize the handbook containing instructions on decarceration titled *Decarcerating Correctional Facilities During COVID-19: Advancing Health, Equity, and Safety* for more thorough details apropos to next steps that should be taken, sets of criteria, and justifications for decarceration because it is essentially a step-by-step guide on how to balance public health and public safety reasonably well during a global pandemic. If administrators at the Louisiana State Penitentiary had read this book earlier, they may have been able to save the lives of 16 of Robbie Dennis’s friends, all of whom are now dead due to ignorance and negligence. If one Robbie Dennis lost 16 friends in prison during the COVID-19 pandemic, just imagine how many friends and fellow Americans have died in correctional facilities across the United States. Currently, there is sufficient data to compel our politicians and bureaucrats to change their current response to COVID-19 in the criminal justice system in order to ensure more humane treatment of incarcerated people and save lives (Prison Policy Initiative). We must act due to the sanctity of human life, and thousands of people like Robbie Dennis are depending on us to save their lives and the lives of their friends and loved ones.

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