

COVID-19 IN U.S. PRISONS: A COMPARATIVE ANALYSIS OF
PUBLIC HEALTH INTERVENTIONS ACROSS STATES

by

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Covid-19 in U.S. Prisons: A Comparative Analysis of Public Health Interventions Across States

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Adults in U.S. custody suffered from disproportionately high rates of Covid-19 infection and death. This was in part due to a lack of public health interventions within corrections, and in part due to the state of mass incarceration. This thesis begins by describing the reality of Covid-19 in U.S prisons, ultimately narrowing in on three diverse prison systems and the Federal Bureau of Prisons. Case study methodology is utilized to describe the steps taken and not taken by various corrections departments to mitigate the spread of Covid-19 for the purposes of comparison. Through comparative analysis, this thesis seeks to determine best practices for mitigating communicable disease in carceral settings and ultimately offer recommendations for policy makers to consider before the next public health emergency.

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Table of Contents

Background	7
Chapter 1: Oregon Case Study	16
Interventions and Strategy	20
Chapter 2: Texas Case Study	29
Interventions and Strategy	33
Chapter 3: New Jersey Case Study	41
Interventions and Strategy	45
Chapter 4: Federal Bureau of Prisons Case Study	51
Interventions and Strategy	54
Chapter 5: Case Study Analysis	60
Policy Recommendations	67
Bibliography	70

List of Figures

Figure 1: Prison Admissions In Oregon Over Time	22
Figure 2: Prison Releases In Oregon Over Time	23
Figure 3: Incarceration Rates Per 100k over time in Texas and the U.S.	30
Figure 4: New Jersey Department of Corrections Visitation Policy	46
Figure 5: Federal Bureau of Prisons Population Totals Over Time	51
Figure 6: Federal Bureau of Prisons Covid-19 Operational Risk Levels	54

List of Tables

Table 1: Key Prevention Measures by Case Study	60
Table 2: Covid-19 Outcomes by System as a Flat Rate and Ratio	62

Background

The Covid-19 infection rate among the general population in the U.S. fluctuated significantly from March of 2020 through December of 2021. According to the CDC, the infection rate peaked in January of 2021 with a new case count over 280 thousand. Cases spiked again in December of 2021, reaching a height of 446k new cases reported. The rate of infection among nationwide prison populations consistently outpaces that of the general population. As of September 2021, the rate of infection is estimated to be 5.5 times higher in prison populations than the general public (Lemasters et al., 2022). Disparate infection rates compounded by the diminished health profile of incarcerated populations generally lead to similarly accelerated mortality rates. By November 13 2020, state and federal prisons had reported 1,412 Covid-19 deaths of incarcerated people. Fifty-one percent of Covid-19 deaths until this point had been in excess of the number expected based on the mortality rates of demographically similar but non-incarcerated populations. The 721 excess deaths should be considered avoidable, as they would not incur if the individual had not been incarcerated (Schnepel, 2020).

The relative population size and close confinement in carceral settings fosters widespread and efficient disease transmission. Carceral institutions have a historical reputation as “petri dishes” for infectious disease that precedes Covid-19. Rapid transmission of infectious diseases such as influenza, tuberculosis, and HIV are well documented. For example, records from an influenza outbreak in San Quentin Prison in California dated back to 1918 demonstrate similarly rapid transmission once the infection penetrated the facility. According to these records, the virus first entered San Quentin on April 13th through an infected individual transferred from county jail. By April 23rd, more than half of the 1,900 AIC’s at San Quentin were infected with the

virus. Influenza ravaged San Quentin twice more; the second epidemic in October, and the third in late November (Stanley, 1919). In terms of Covid-19, rapid rates of transmission are reflected in the fact that carceral facilities represented 19 of the top 20 Covid-19 “hot spots” nationally as of August 2020.

With the exception of facilities operated by the Federal Bureau of Prisons which are located throughout the country, state level corrections departments are the primary arbiters of health-related policies and interventions. States with regional and political differences applied different strategies for mitigating the virus accompanied by various levels of enforcement. Certain state policies proved more effective than others, leading to drastically different infection rates and health outcomes by state. Some variation occurs within states and between institutions, however the bulk of the disparity occurs at the state-level. The heterogeneity across states provides an opportunity for policy makers to learn from the response to Covid-19 and develop best practices for mitigating harm to the human health of incarcerated populations amidst public health crises and pandemics.

Without adjusting for demographic characteristics, state and federal prisons reported positive Covid-19 cases at a rate 4 times greater than the general public (Schnepel, 2020). The 10 facilities with the highest cumulative case count not accounting for population size, are all state-run prisons located in California. Covid-19 infection rates vary drastically between federal facilities operated by the Bureau of Prisons (BOP). The cumulative Covid-19 case count for all 122 federally operated facilities is 46,820. The cumulative Covid-19 case count for all 1,677 state operated adult prisons is over 540 thousand (Covid Prison Project, n.d). According to a report from the Council on Criminal Justice (CCJ), the types of prisons reporting the greatest

number of COVID-19 cases are state operated facilities, prisons located in the south, and prisons with AIC populations over 1,000 (Schnepel, 2020).

On average, the Covid-19 mortality rate in state and federal prisons is 2 times greater than the general public. According to a report from the CCJ, “five states (AR, DE, OH, OK, and OR) have prison COVID-19 death rates more than seven times statewide... fourteen states (AK, CO, CT, HI, ME, MS, NV, NH, NY, ND, PA, UT, VT, and WA) had fewer prison deaths than expected” after adjusting for demographic characteristics (Schnepel, 2020).

The systems with the highest number of Covid-19 deaths are Texas (38 per 10 thousand), BOP, California, and Florida. The federal facilities with the highest number of Covid-19 deaths are located in Missouri (205 per 10 thousand), Massachusetts (139 per 10 thousand), and California (119 per 10 thousand). The CCJ report found that COVID-19 mortality rates were highest within large facilities, and prisons located in the Midwest (Schnepel, 2020). The only state not to report any Covid-19 deaths was Vermont. North Dakota and Maine each reported one Covid-19 death (UCLA Covid Behind Bars).

Introduction

The recency of Covid-19 has meant that existing literature on Covid-19 in carceral settings is limited. The bulk of the literature is centered on outcomes; analyzing data on infection, mortality, and vaccination rates among different justice-involved populations. There is consensus among researchers that infection rates in prisons consistently outpaced that of the general public, contributing to community transmission. The existing literature suggests that corrections departments across the country failed to meet their constitutional obligation to protect Adults in Custody (AIC’s) from the Covid-19 pandemic (Herring & Sharma, 2021).

Existing literature recognizes that incarcerated populations are uniquely vulnerable to Covid-19 in several ways. Incarcerated populations have a lower baseline health profile than the general public and are disproportionately likely to have comorbidities (Binswanger et al., 2009). Additionally, the close-confinement of large populations in carceral facilities lend well to the spread of communicable disease (Simpson & Butler, 2021). These vulnerabilities are reflected in the high number of excessive AIC deaths as a result of Covid-19. However, the health of people experiencing incarceration is often pushed to the side due to societal stigma (Franco-Paredes et al., 2020). Not only is this “pushing aside” a constitutional violation, it is rooted in structural violence.

This thesis begins with an overview of the national Covid-19 trends in U.S prisons with data provided by the UCLA “Covid Behind Bars” data project, The Covid Prison Project, The Marshall Project, and The Prison Policy Initiative. National trends represent “the big picture” of Covid-19 outcomes in U.S prisons. “The big picture” will gradually narrow in on the public health response in three characteristically diverse state prison systems and the Federal Bureau of Prisons (BOP). This thesis will employ case study methodology in order to develop a “complete” picture of the different approaches and identify causal relationships between interventions and outcomes.

One report from the National Commission on Covid-19 and Criminal Justice (2020), concludes with suggestions for future research on the topic. The report states, “Evaluating which public health responses within prison systems have been most effective is an important area for future research” (Schnepel, 2020). This is precisely the question this thesis will investigate. This

thesis will attempt to fill the policy level gap in the current knowledge base, providing best practices for future public health emergencies.

Research Questions

1. Which public health responses within Prisons are most effective at mitigating harm towards incarcerated populations during a public health crisis?¹
2. How do Covid-19 health outcomes vary by prison system and to what extent are they correlated with the institutional prevention strategy?

Significance

More research is needed on the management of Covid-19 in U.S. prisons for several reasons. The first of which relates to the scope of the problem. The U.S. is globally exceptional in its propensity of incarceration. As of 2022, the per capita rate of incarceration in the U.S was 573 per 100,000 residents. This incarceration rate translates to 1.9 million individuals, 1.1 million of which are held in state prisons. The U.S incarcerates 1 in 5 global prisoners despite comprising a mere 4.2% of the global population (Wagner & Sawyer, 2022).

When compared to the general population, incarcerated people are in categorically worse physical and mental health. The baseline health disparities are another reason that poor public health decisions are uniquely consequential in carceral settings. A 2021 report by the Bureau of Justice Statistics (BJS), revealed that 13% of state and federal prisoners reported symptoms that constitute serious psychological distress (SPD). An additional 41% reported a history of mental health challenges. Substance dependence, post-traumatic stress disorder, bipolar disorder, anxiety

¹ *The term “harm” in this context encapsulates Covid-19 infection, death, and mental health implications

disorders, and major depressive disorders are all common diagnoses reported by incarcerated populations (Bronson, J., & Berzofsky, 2017).

In terms of physical health, incarcerated populations experience a higher prevalence of chronic disease compared to the general public. Chronic diseases such as hypertension, asthma, arthritis, tuberculosis, HIV, and hepatitis C are significantly more prevalent in prison populations (Binswanger et al., 2009). One California study found that the physical age of incarcerated persons exceeded their chronological age by 10-15 years. The physical age of AIC's experiencing mental illness exceeded their chronological age by 15-20 years (Lundberg, 2012).

The social determinants of health play an inevitable role in the health disparity between incarcerated populations and the general public. New arrests are concentrated in marginalized communities that are disproportionately likely to be impoverished and medically underserved (Dumont et al., 2012). Arrests lead to convictions and the overrepresentation of individuals with physical and mental illness in prisons and jails. Additionally, recent studies suggest that incarceration in and of itself is a social determinant of health, compounding the vulnerability of incarcerated people to Covid-19 and other communicable diseases (U.S. Department of Health and Human Services, n.d). Considering these various vulnerabilities, incarcerated individuals should be recognized as a high-priority population.

An important consideration in the provision of healthcare to incarcerated populations is who foots the bill. In 1976, The Supreme Court decided in *Estelle v. Gamble* that prisoners have a constitutional right to adequate medical care. The vast majority of incarcerated people are uninsured prior to their incarceration, and many states terminate Medicaid coverage when an individual is incarcerated. The costs of prison healthcare are inherited by the state, the burden of

which is shifted onto the taxpayer. Prison healthcare spending varies dramatically between states. In 2015, state corrections departments spent an average of \$5,720 per AIC on healthcare. Four states exceeded an average of \$10,000 in annual healthcare spending per AIC, whereas 5 states spent less than \$3,500 (McKillop, 2017). Additionally, the prison population is aging at unprecedented rates across the nation. This will inevitably translate to greater age-related healthcare needs and similarly inflated costs (Psick et al., 2017). State budgets and taxpayers themselves will ultimately reap the financial benefits of improved carceral healthcare.

Lastly, high infection rates within carceral institutions have public health implications for surrounding areas. A revolving door of corrections employees, lawyers, loved ones, and newly released individuals make it highly likely for communicable disease to escape confinement and infect the public. The Prison Policy Initiative calculated the impact of mass incarceration on statewide Covid-19 case counts during the summer of 2020. In California, mass incarceration contributed to 20% of new cases in the state. On a national scale, their research found that mass incarceration contributed to more than half a million cases total inside and outside of correctional facilities (Sawyer & Hooks, 2020). Additionally, substandard prison screening programs have failed to notify AIC's of their infection, leaving the possibility for a newly released individual to bring disease back into their communities (Restum, 2005). This was the case with a 1978 tuberculosis outbreak caused by an individual newly released from prison without necessary therapy (Stead, 1978).

Scope

Prisons are distinct from jails. Key differences include time served on average, number of admissions on average, and primary funding-source. Jails are reserved for individuals convicted

of minor crimes with sentences of less than one year and pre-trial detainees. Jail populations are constantly changing as a result of frequent admissions, interfering with longitudinal study.

Prisons hold individuals sentenced to a term greater than one year. Jails are typically funded by counties, whereas prisons are generally funded by the state. A minority of AIC's are held in federally-funded prison facilities (Pfaff, 2017). These major distinctions between prisons and jails make their respective approaches to Covid-19 realistically incomparable.

According to John Pfaff, Professor of Law at Fordham University, the private vs. public prison distinction is often overstated, when in reality "mass incarceration is a public affair in the United States" (Pfaff, 2021). For this reason, the focus of this thesis will be limited to state and federal prisons.

Word-Choice

The terminology used to describe people experiencing incarceration is often dehumanizing and/or inaccurate. The use of misnomers contributes to the stigmatization of people experiencing incarceration and should be avoided. Terms such as "prisoner" and "inmate" wrongfully reduce individuals to their confinement and fail to acknowledge personhood. The most progressive option, adult in custody (AIC), is the preferred terminology. Terminology changes over time, and the movement towards person-centered language is relatively new in many fields. Therefore, the research referenced in this paper uses many different terms to discuss AIC's. When discussing prior research, I will use incorrect terminology for consistency's sake. However, the default terminology will be "person experiencing incarceration" or "adult in custody (AIC).

Methods

This thesis will utilize case study methodology to explore three states and the Federal Bureau of Prisons pandemic response in depth. Case studies will take context into consideration to identify and explain causal relationships between interventions and outcomes. This thesis will employ research from a range of sources: government documents, research studies, news articles, and primary source accounts. A theoretical framework is employed to enable research findings to be applied to future pandemics.

Following the case studies, I will outline the relevant information in a set of easy to read data tables. The first table will match corrections systems with the public health interventions that were and were not taken in response to Covid-19. The second table will list the flat infection and mortality rates as well as the disparity ratio of infection and death compared to the general public.

Chapter 1: Oregon Case Study

The state of mass incarceration in Oregon

In 2018, prior to the pandemic, Oregon had a prison population of 14,836 individuals. The prison population has trended slightly upwards, increasing by 2% between 2008-2018 (Vera Institute of Justice, 2019). Currently in 2023, Oregon has 12 state prisons, 1 federal prison, and no privately-operated prisons. In 2017, 74% of the prison population was white, and 9% were black. Black individuals are incarcerated at a rate 3.9x higher than white individuals in Oregon. Most prison admissions originate from the populous Multnomah county. However, rural counties incarcerate at a higher rate than urban counties (Vera Institute of Justice, 2019).

Oregon prisons are structurally diverse, ranging in size, housing type, and security-level. Most Oregon prisons utilize a combination of housing types. For example, Coffee Creek Correctional facility (CCCCF) has both dormitory style housing and double occupancy cells. Columbia River Correctional Institute (CRCI) holds 595 AIC's in dormitory style housing separate from a self-contained group of 50 AIC's enrolled in rehab. Prisons that are built with separate and self-contained housing units, which several Oregon prisons are, have a unique opportunity to mitigate communicable disease by operating as micro-prisons opposed to intermingling units.

Covid-19 in Oregon

Oregon fared relatively well during the Covid-19 pandemic largely due to relatively hard-handed policies combined with a low population. Governor Brown was quick to declare a state of emergency on March 8, 2020 in response to the Covid-19 pandemic. By March 23rd,

Governor Brown had issued a stay-at-home order. Schools closed and masks were mandated. Many Covid-19 restrictions were not lifted until June 25, 2021 by Brown's "Recovery Order". The proactive measures initiated by Oregon's leadership in response to Covid-19 are reflected in the relatively flat infection curve, which peaked in January of 2022.

The Commonwealth Fund traditionally releases annual scorecards for each state, rating different aspects of the state's health system performance. During the Covid-19 pandemic, the Commonwealth Fund added 7 Covid-specific measures to evaluate and rank state level interventions. According to the Commonwealth Fund index, Oregon ranked fifth for their response to Covid-19 (Radley et al., 2022). Oregon's high ranking is reflected by the relatively aggressive public health response in Oregon.

Covid-19 in Oregon Prisons

Although Oregon ranked 5th in the nation for their Covid-19 response, the state level success did not translate to the prison population. The Prison Policy Initiative developed a scoring matrix to assess the effort on behalf of state corrections departments to mitigate Covid-19. Scores were tabulated based on 4 primary measures: 1) the extent to which the prison population was reduced 2) the disparity in the rates of Covid-19 infection and death between the general population and the prison population 3) the degree that incarcerated populations were prioritized in phased vaccine rollout plans as well as the actual number of vaccines administered 4) the state's effort to initiate basic policies in the interest of health and wellbeing, such as providing free telephone minutes to AIC's while visitation is suspended. With that being said, The Prison Policy Initiative assigned most states, including Oregon, a failing grade (Herring & Sharma, 2021).

A primary contributor to Oregon's failing pandemic response grade is the disparity in infection and mortality rates between the prison population and the general public. The mortality rate inside prisons was greater than 5x that of the general public, and infection rates were 6x greater inside prisons (Herring & Sharma, 2021).

In December of 2019, prior to the first confirmed case of Covid-19 in a U.S. prison, Oregon Prisons were operating at 92%-98% capacity depending on the measure (capacity, operational, or design). By July 2020, coronavirus was spreading rapidly, however Oregon prisons maintained between 89%-95% capacity (Widra, 2020). Oregon did reduce its prison population during the Covid-19 pandemic. However, not to the extent necessary to physically distance and mitigate the spread. For example, eliminating dormitory style communal housing would have required a 40% reduction in Oregon's prison population.

The measure involving "basic health policies" includes the provision of free hygiene products, hand sanitizer, face masks, phone/video calls, elimination of medical co-pays and requirements for staff to mask up and test regularly. According to the Prison Policy Initiative, Oregon failed to provide hygiene products, video calling technology, and staff were not required to test for Covid-19. The Oregon Department of Corrections (ODOC) did provide face masks, cost-free phone calls, and required staff to mask up. AIC's self-reported initially receiving two face masks in April of 2020 along with instructions for proper use, however their use was not required (Pyrooz et al., 2020). Oregon did not require medical co-pays from AIC's prior to Covid-19. Ideally, all basic health policies would be initiated by corrections departments.

AIC Perceptions

The voices of individuals experiencing incarceration are often left out of conversations surrounding criminal justice policy. As a result, the current accounts of Covid-19 in prisons are incomplete. One Oregon study by Pyrooz and colleagues focused on the perception of risk and institutional response from a random sample of 31 high-security male AIC's. Researchers conducted In-depth interviews over the phone between April and May of 2020 and then identified patterns. Participating AIC's were housed in either Intensive Management Units (IMU's) or restrictive housing through a "step-up program" (SUP). Participants housed in IMU's are confined to their cell in solitude for 23 hours a day. Participants housed in SUP are confined for 20 hours a day while maintaining some privileges such as extra recreational time (Pyrooz et al., 2020).

The study found that three-quarters of respondents did not express serious concern about a Covid-19 outbreak. Some respondents justified their response by citing their lack of control over the situation and the inevitability of an outbreak, while others were satisfied with the ODOC response. Fewer than one-third of respondents believed they would personally contract Covid-19. Some respondents were certain that corrections staff would bring the virus into the prison, whereas others were confident they could mitigate the spread by continuously cleaning their living spaces (Pyrooz et al., 2020).

Three-quarters of respondents felt that the threat of Covid-19 was being taken seriously by ODOC. Several respondents referenced informational flyers that were in circulation, describing best practices for mitigating the virus. Others felt there was a lack of communication beyond the suggestions of hand washing and masking. Many of the respondents who believed

the pandemic was being taken seriously still lacked confidence in ODOC to contain and/or treat positive cases. Several respondents referenced inadequate medical care they had received on other occasions as evidence of ODOC's inability to treat the virus. Few respondents were optimistic that ODOC could mitigate Covid-19 given the transmissibility of Covid-19 (Pyrooz et al., 2020).

Lastly, three-quarters of respondents felt as though their housing assignment would minimize their risk of infection. Respondents have minimal contact outside of brief interactions with corrections staff as units are self-contained. One respondent housed in IMU noted how "this is the one time in my life I've been grateful to be in isolation". However, respondents were aware they may still transmit the virus through correctional officers or dining services. Respondents also noted disruptions to their usual programming. Dialectical behavioral therapy (DBT), visitation, education and more were halted (Pyrooz et al., 2020).

It is worth noting the sample size of this study is relatively small. Conclusions cannot necessarily be extrapolated to the prison population at large. System-wide data on the perceptions of Covid-19 from AIC's has not been collected, representing a major gap in the literature.

Interventions and Strategy

Within the DOC, the Agency Operations Center (AOC) collaborated with Health Services to develop a tiered prevention plan and protocol for Covid-19. The plan identifies five tiers. Institutions labeled as Tier 1 have no known cases of Covid-19. Tier 5 refers to institutions where Covid-19 is endemic, requiring a multi-institution quarantine. ODOC developed Covid-19 policies in accordance with the tier system, subjecting higher tiered institutions to more stringent

policies. Tier designations are constantly changing as Covid-19 levels fluctuate in a given institution, in turn determining Covid-19 policy (Oregon Department of Corrections, 2020). Policy changes typically require notification and are often followed by an adjustment period with reduced compliance.

Prison Population Reductions

According to the Prison Policy Initiative, Oregon reduced its prison population by 16.3% between March 2020 and July 2021 (Herring & Sharma, 2021). The Oregon Department of Corrections failed to suspend incarceration due to technical violations of probation or parole, develop any accelerated release policies, or release individuals with minor offenses. Technical violations of parole or probation may be as minor as breaking curfew. ODOC did manage to expedite the release of a small number of qualifying individuals through early medical release. 963 individuals had their sentences commuted by Governor Brown. According to a report from Oregon's Criminal Justice Commission (CJC), the decline in the prison population has been driven by declining admissions combined with relatively constant prison releases (See Figure 2). Prison admissions dropped sharply in March 2020 with the onset of the pandemic, but have steadily increased ever since (See Figure 1). The relatively flat trend of prison releases has been largely maintained during the pandemic (Weinerman, 2022).

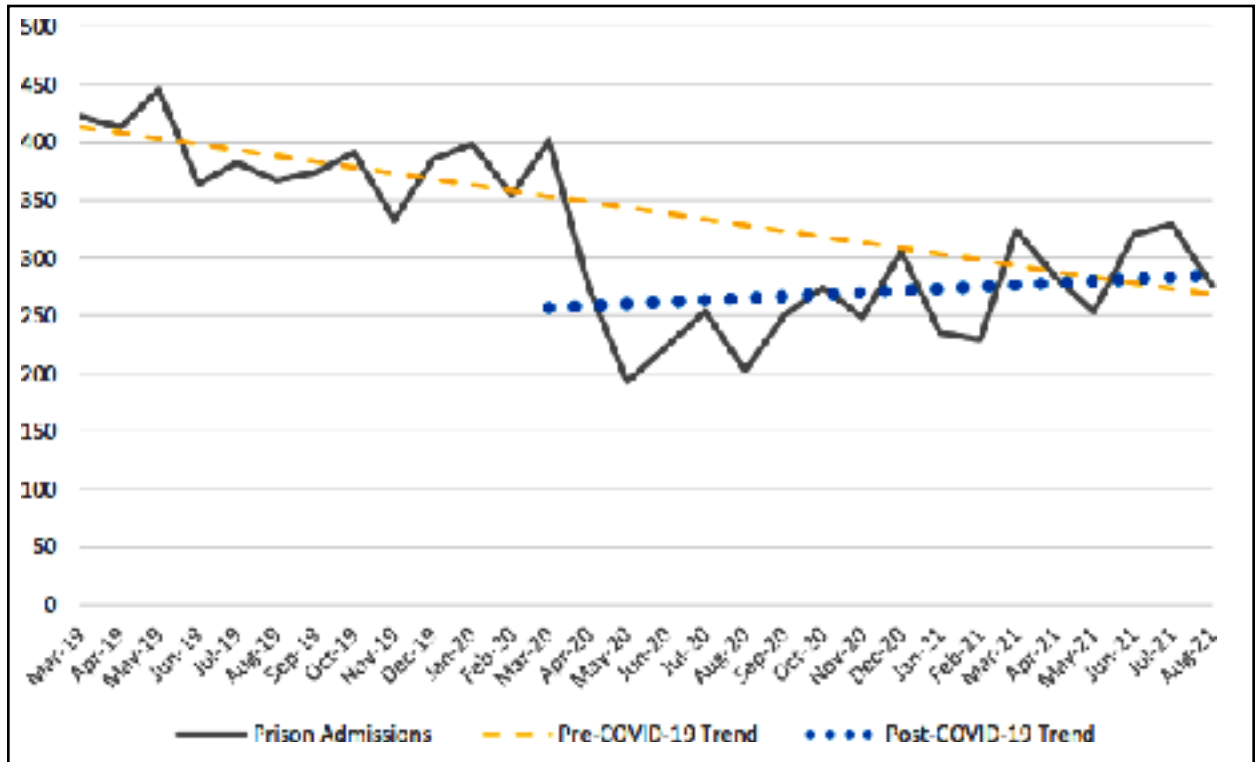


Figure 1: Prison Admissions In Oregon Over Time
 Source: Oregon Criminal Justice Commission (March 2022)

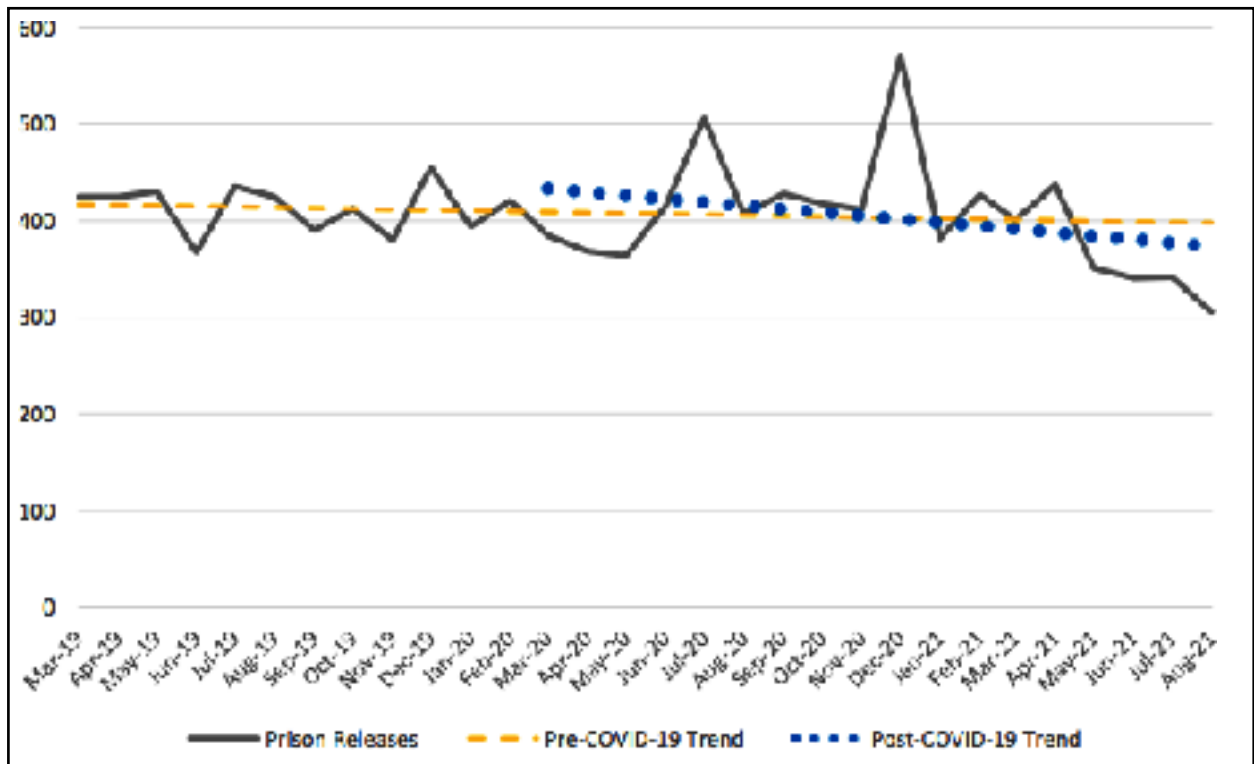


Figure 2: Prison Releases In Oregon Over Time
 Source: Oregon Criminal Justice Commission (March 2022)

Personal Protective Equipment

On March 27th, 2020 ODOC published an initial set of policies regarding personal protective equipment. In this public notice, ODOC reported that face masks were to be worn by AIC's experiencing Covid-19 symptoms as well as confirmed cases. Close contacts of confirmed Covid-19 cases were directed to wear face masks when feasible based on supply. One exception to the face mask policies applied to facilities that quarantined new-intakes upon arrival. ODOC indicated that face masks are not necessary under these circumstances. In terms of staff, the same report indicated that face masks would be worn by staff when providing medical care, conducting temperature checks, and while transporting suspected cases. Face masks were also to be worn by staff in direct contact with asymptomatic AIC's when feasible based on supply. (Oregon Department of Corrections, 2020).

Public records show that on July 13th, 2020, ODOC Deputy Director Heidi Steward pleaded with ODOC staff to wear face masks. The notice began with an acknowledgement that "we each have - and are entitled to - our own thoughts and opinions on face coverings". This sentiment was followed by restating ODOC policy which requires face masks when 6 feet of social distance cannot be maintained, and the admission that "not all of us are following it". The notice attempted to motivate staff into compliance by suggesting that noncompliance will result in legal action and/or a full-time mask mandate. As of July 14th, staff found without face masks when required would be reminded. If staff refused, they may be sent home without pay (Oregon

Department of Corrections, 2020). The language of this notice indicated that resistance from ODOC employees was unfortunately foreseeable.

By August 12, 2020, all AIC's were required to wear face masks outside of their cell/bunk area when a physical distance of 6 feet could not be maintained. ODOC officials indicated that non-compliance with the mandate may result in disciplinary action. Masks were not required during meal times which take place in a congregate dining hall in cohorts of over 100 AIC's in certain facilities (Oregon Department of Corrections, 2020).

Internal Movement

ODOC stated that non-essential movement was to be minimized in order to mitigate the spread of Covid-19 from one part of a facility to another. However, AIC's largely maintained their work assignments. Oregon Corrections Enterprise (OCE) is a semi-independent agency operating several self-sustaining businesses within Oregon Prisons such as a commercial laundry service. OCE reported that laundry operations were not modified for Covid-19. AIC's with the same OCE work assignment are known to be housed in cohorts so that if a quarantine is initiated, AIC's can continue operating OCE businesses.

Visitation

All in-person visitation was officially suspended on March 13, 2020. The restriction applied to volunteers, contractors, attorneys, probation officers, and other visitors (Oregon Department of Corrections, 2020).

Release Policies

On May 27th, 2020, ODOC released Covid-19 screening, notification, and release policies. The policy brief states that health services will complete a “Community Medical Care Level” form for AIC’s with confirmed or suspected cases of Covid-19 who are within 14 days of their release date as well as notify local Public Health Authorities and the Community Corrections designee.

The policy brief indicates that on the morning of an AIC’s release, health service employees conduct a Covid-19 screening. The screening intends to determine if an AIC is symptomatic or has been in recent contact with a confirmed case of Covid-19. **Determinations were made through verbal questioning as opposed to a testing and/or quarantining approach.** Screening forms are then uploaded to a central database. If an AIC is symptomatic, the brief states the AIC will receive a face mask and both the local Public Health Authority and Community Corrections Designee is notified (Oregon Department of Corrections, 2020).

Testing

As of May 2020, Covid-19 tests administered by ODOC were reserved for symptomatic individuals. ODOC did not pursue mass testing (Oregon Department of Corrections, 2020).

Quarantine

According to ODOC, positive Covid-19 cases were often quarantined in solitary confinement. Solitary confinement in Oregon has several names; Disciplinary Segregation Unit (DSU), Intensive Management Unit (IMU), Behavioral Health Unit (BHU), or Administrative Segregation. Solitary confinement involves up to 24 hours a day of isolation in a six by nine foot

cell. ODOC permits individuals to spend a maximum of 180 days in solitary confinement as punishment. Punishment is often used to justify the inhumane conditions of solitary confinement, despite research confirming the crippling mental and physical implications.

When solitary confinement is utilized for medical quarantine opposed to punishment, adjustments must be made to improve the conditions of confinement. For example, permitting personal items such as tablets, providing access to socially distanced mental healthcare, and increasing phone call minutes to communicate with loved ones. It is unclear to what extent adjustments were made to areas of medical quarantine in Oregon. Without intervention, the conditions of solitary confinement may deter AIC's from reporting symptoms and/or being tested for Covid-19. Anecdotally, the concealment of Covid-19 symptoms was commonplace for AIC's.

Vaccines

In January 2021, all ODOC staff and contractors were offered the first dose of the Covid vaccine. However, ODOC successfully administered the vaccine to a mere 34% of ODOC staff and contractors (Maney v. Brown). It is possible that staff received vaccinations outside of ODOC, however their vaccination status should have been reported to ODOC regardless. The number of staff who received a vaccine elsewhere and did not report their status is unknown. It is worth noting that ODOC approved vaccine exemptions for over 16% of staff (713 individuals), primarily on religious grounds (Wilson, 2021).

As of July 2021, ODOC's public information office reported that over 86% of AIC's had received at least their first dose of the vaccine. Oregon has the third highest vaccination rate

among incarcerated populations of any state. AIC's were offered boosters beginning in December 2022.

An initial cohort of 1,343 AIC's received the first dose of the Covid-19 vaccine in January of 2021. As it turns out, these initial vaccinations were the result of a "miscommunication" and should never have been administered according to ODOC policy. Vaccine administration was halted until February when a federal judge ordered ODOC to offer the vaccine to all AIC's. It wasn't until March that ODOC confirmed the vaccine had been offered to the entire prison population. It is unclear when AIC's would have received the vaccine in the absence of judicial intervention as there was no plan in place to do so.

Relevant Litigation

Once a vaccine for Covid-19 was developed, Governor Brown and the Oregon Health Authority initiated a phased rollout beginning with those living or working in congregate care facilities, as well as individuals working in corrections (including a small number of AIC's with work assignments in healthcare settings). However, Phase 1A excluded those living in correctional facilities (AIC's). The issue before the court was whether or not the exclusion of AIC's in Phase 1A constitutes "deliberate indifference" to the health and safety of individuals in state custody (April 2020). The plaintiffs include 7 AIC's in ODOC custody. The defendants include Governor Brown and other state officials (*Maney v. Brown*).

The plaintiffs filed a third amended complaint in January 2021 seeking provisional class certification for all AIC's in Oregon who had not yet been offered the vaccine. In addition to class certification, the plaintiff sought the provision of vaccines for the remaining class. The court granted class certification as well as injunctive relief.

In this case, the court ordered ODOC to offer the vaccine to any and all AIC's who had not been previously offered (516 F. Supp. 3d 1161 (D. Or. 2021)).

Chapter 2: Texas Case Study

The state of mass incarceration in Texas

Texas has the highest incarceration rate of any democracy in the world at 840 per 100,000 people (including jails). In 2018, Prior to Covid-19, Texas had a prison population of 190,000 individuals. The majority of the prison population, 163,000 individuals, are held in state operated prisons. The Federal Bureau of Prisons (BOP) incarcerates an additional 27,000 adults across 11 prison facilities located in Texas (Prison Policy Initiative, 2023). The Texas Department of Criminal Justice operates an additional 59 adult prisons. An additional 7 prison facilities are privately operated in contract with the TDCJ, holding primarily individuals with minimum custody status (Texas Department of Criminal Justice, 2023). The prison incarceration rate in Texas has been trending downwards since 2003 (See Figure 3).

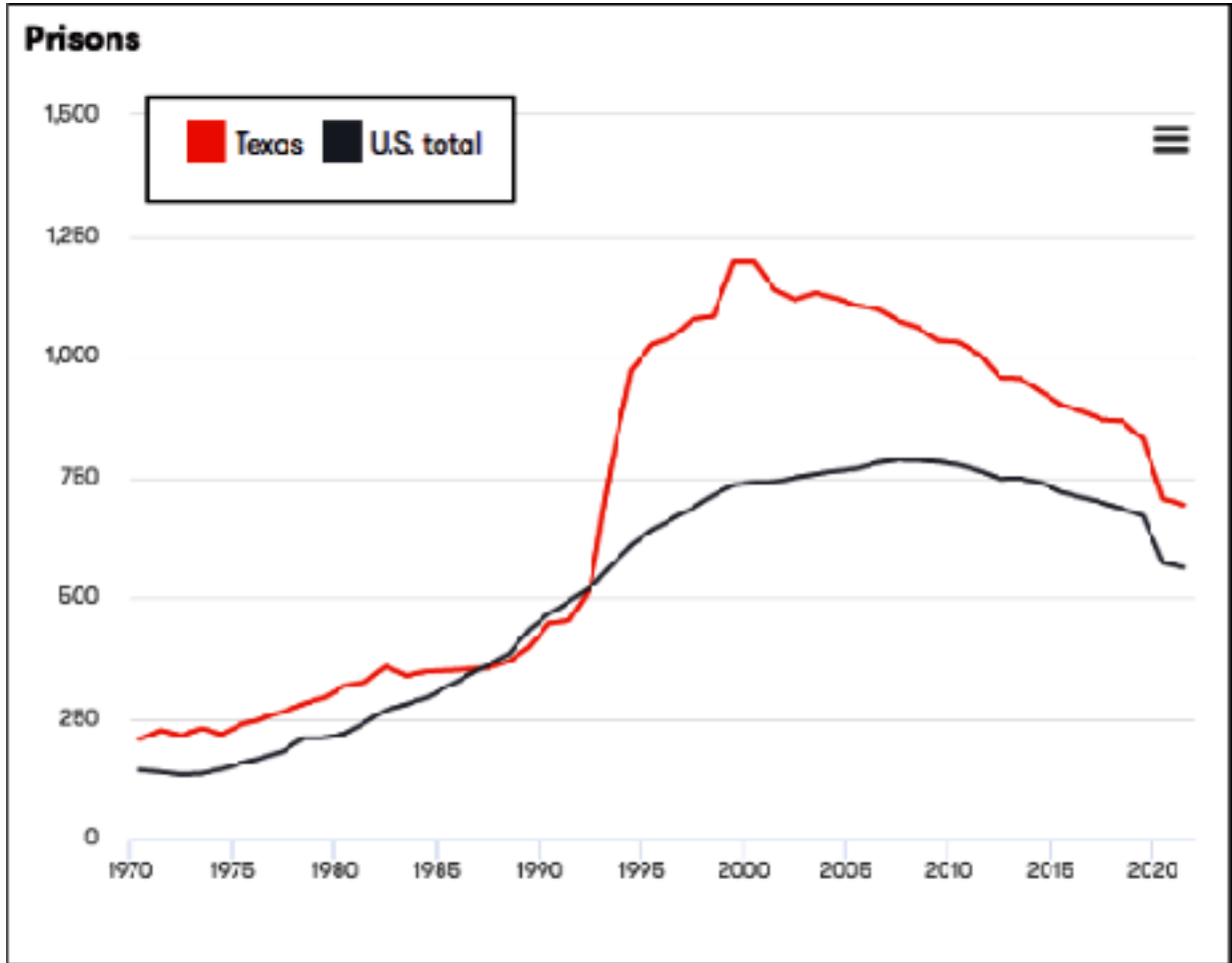


Figure 3: Incarceration Rates Per 100k over time in Texas and the U.S.

Source: Vera Institute of Justice (2023)

In 2017, 33% of the prison population was white, 33% were Black, and 33% were Latinx. Less than 1% of the prison population was Native American or Asian/Pacific Islander. Black Texans were incarcerated at 3.4 times the rate of white Texans. Rural counties have greater conviction rates than urban counties in Texas (Vera Institute of Justice, 2019).

Texas Prison facilities are exceptionally large. The largest facility, Coffield Unit in Anderson County, can hold up to 3,818 AIC’s on the unit, plus an additional 321 AIC’s in an

adjacent work camp. Prison facilities in Texas utilize cell and/or dormitory style housing depending on a facilities custody designation (Texas Department of Criminal Justice, 2023).

Statistical Analysis centers, such as the Criminal Justice Commission (CJC) in Oregon, are tasked with collecting and analyzing data on crime and criminal justice to inform policy and the public. Texas is the only U.S state without this critical resource (Justice Research and Statistics Association, 2023).

Covid-19 in Texas

The state of Texas was ravaged by Covid-19 infection, hospitalization, and death as the state government played a light-handed role in terms of preventative measures. Governor Abbott declared a state of emergency on March 13, 2020. Despite the majority of states temporarily closing schools, Governor Abbott announced that cities, counties, and school districts would have discretion over their Covid-19 response. On March 19th, Governor Abbot issued an executive order temporarily limiting gatherings and closing schools. Bars, gyms, and other businesses were reopened by May.

The Commonwealth Fund ranked the state of Texas 44th for its Covid-19 response. The index docked Texas for having a high rate of uninsured adults, as well as an overstressed healthcare system. ICU's in Texas operated at high capacity for over 566 days of the Covid-19 pandemic (Radley et al., 2022).

Covid-19 in Texas Prisons

The prison population in Texas fared even worse during the pandemic than the rest of the state. The Prison Policy Initiative scoring matrix assigned the Texas Department of Criminal

Justice (TDCJ) an “F” grade for their Covid-19 response. Texas performed equally poorly on all measures; population reductions, disparate infection/mortality rates, vaccine rollout, and basic health policies (Herring & Sharma, 2021). The lowest scoring category was vaccine rollout, as the state of Texas did not include incarcerated persons in the vaccine distribution plans at all.

In December of 2019, prior to the arrival of Covid-19 to U.S. prisons, Texas state prisons were operating between 86%-89% capacity. Several months into the pandemic, the state prison population was increasing. According to public records, by May 2020, Texas prisons were operating between 97%-101% capacity (Widra, 2020). The Texas Department of Criminal Justice ignored recommendations from public health officials to reduce the prison population at the expense of their health and well-being.

According to the UCLA “Covid Behind Bars Project”, the Covid-19 infection rate in Texas prisons was 29.5%. This translates to 34,738 individuals, nearly 3 times the infection rate of the general population in Texas (Herring & Sharma, 2021). The facilities with the highest rate of Covid-19 infection were all TDCJ operated: Sayle Unit, “Substance abuse felony punishment Facility” for Men in Breckenridge, Duncan Unit, a low-security geriatric facility for Men in Diboll, and Halbert Unit, “substance abuse felony punishment facility” for Women in Burnet (Texas Department of Criminal Justice, 2023).

As of July 2021, 260 AIC’s had died of Covid-19 in TDCJ custody (Herring & Sharma, 2021). Covid-19 deaths varied by facility. Black and Hispanic AIC’s died at disproportionate rates according to a study from the UCLA “Covid Behind Bars Project” (2021).

Nearly 6% of geriatric men incarcerated in Duncan Unit had died from Covid-19 by September of 2020 (Deitch, et al., 2020). The TDCJ considers AIC’s 55 years of age or older to

be geriatric (Texas Department of Criminal Justice, 2018). The U.S. Sentencing Commission found that AIC's over the age of 60 have the lowest likelihood of being rearrested, reconvicted and reincarcerated of any age group (Steven-Hunt & Easley, 2017). Texas could have released geriatric AIC's in large numbers with minimal threat to public safety. For this reason, the deaths of low-level geriatric men at Duncan Unit should be considered excessive and avoidable.

The TDCJ failed to implement the most basic prevention measures such as providing free hygiene products such as soap to the incarcerated population. Hand sanitizer was not widely available in TDCJ facilities. Even when visitation was suspended, the TDCJ continued to charge AIC's for phone calls by the minute. Additionally, the TDCJ continued charging AIC's for medical co-pays throughout the pandemic (Herring & Sharma, 2021). Medical care in corrections is often unaffordable considering the exceptionally low wages afforded to AIC's.

Interventions and Strategy

AIC's in Texas are assigned a custody designation according to the length of the sentence, criminal history etc. Custody designations typically determine an AIC's housing, work opportunity, and supervision level. The TDCJ has six levels of custody designation: General population level 1 (G1) through General population level 5 (G5), and administrative segregation. Special status designations exist for individuals sentenced to death, individuals with physical disabilities, individuals in need of "safekeeping" etc. (Texas Department of Criminal Justice, 2005).

The TDCJ released a detailed Covid-19 policy manual on July 13 2022 despite the TDCJ's claim that the manual was formulated promptly in March of 2020. A former version of the manual published in January 2022 has been made unavailable by the TDCJ. The policy

interventions described in the July 2022 manual have come long after Covid-19 had spread throughout TDCJ facilities. Additionally, the manual proscribes everyday strategies as well as enhanced strategies for facilities with greater risk/infection rates. Facilities are expected to self-assess their risk level (low, medium, or high) and implement prevention strategies accordingly. However, the manual acknowledges that facilities with medium or high-risk levels may not always be capable of implementing the enhanced strategies. It is worth noting that the use of face masks while indoors is not an everyday prevention strategy, but rather an enhanced prevention strategy recommended for facilities with greater risk (Texas Department of Criminal Justice, 2022).

Population Reductions

According to the Prison Policy Initiative, Texas reduced its prison population by 15.9% between March 2020 and July 2021. The TDCJ did not suspend incarceration for technical violations of probation or parole, implement accelerated release policies, compassionate medical release policies, or any release policies for minor offenses (Herring & Sharma, 2021). State prison admissions declined by 37.4% from year end 2019 to year end 2020, largely as a result of reduced admissions (Carson, 2021). However, admissions quickly began to recover, increasing 19.4% from year end 2020 to year end 2021 (Carson, 2022).

Governor Abbott, who is responsible for oversight of the parole board, stated in March 2020 that “releasing dangerous criminals makes the state even less safe” (McCullough, 2021). Within this statement is a false presumption that individuals eligible for release are or have ever been “dangerous” and that their release implies a reduction in public safety. These are the kinds of empirical claims that could be investigated by a Statistical Analysis Center, which Texas does

not possess. Regardless, national level criminological data suggests the opposite; Covid-era prison depopulation would not have harmed public safety (Franco-Paredes et al., 2021).

Personal Protective Equipment

According to the TDCJ “Covid-19 FAQ” page which is regularly updated, all staff and AIC’s are issued face masks and encouraged to wear face masks when social distancing is not possible. The TDCJ reports no shortage of PPE, having manufactured 1.5 million cloth face masks within adapted prison factories (Texas Department of Criminal Justice, 2023).

However, the 2022 TDCJ “Infection Control” manual classifies the most basic Covid-19 prevention measures such as physical distancing and the use of face masks as “enhanced” strategies, reserved for facilities with medium to high risk levels. The manual suggests that higher risk TDCJ facilities should “consider setting up a separate waiting area for inmates with suspected or confirmed COVID-19. At a minimum, ensure that inmates wear cloth face coverings... while waiting to be seen by healthcare staff” (Texas Department of Criminal Justice, 2022). By 2022, there was a general consensus among public health experts and the CDC about how to effectively mitigate Covid-19 (social distancing, hand-washing, avoiding groups, and face masks), which one might have expected to be reiterated in the TDCJ manual.

Visitation

Non-essential visitation was suspended in TDCJ facilities on March 13 2020 with governor Abbott’s emergency declaration. Visitation did not resume until March 15 2021 (Texas Department of Criminal Justice, 2023).

Internal Movement

According to the 2022 TDCJ “Infection Control” manual, minimizing AIC movement/contact between housing units is an “enhanced” prevention strategy recommended for facilities at medium to high risk designation. The manual additionally advises TDCJ prisons to “consider limiting transfers to other facilities unless necessary”. When necessary, transferring AIC’s should be screened for Covid-19 symptoms (Texas Department of Criminal Justice, 2022). Symptom-checks are not sufficient for preventing the transfer of positive Covid-19 cases as individuals are regularly asymptomatic.

The manual states that “inmates may go to the dining hall, work, commissary, recreation etc., if they do not mingle with inmates from other housing areas during the process” (The Texas Department of Criminal Justice, 2022). Considering what we know about Covid-19 as a communicable disease, ensuring that housing units did not physically overlap would have been a stronger preventative measure.

Another concerning policy in the 2022 TDCJ manual related to internal movement states that “Inmates should not be allowed to use dayrooms in housing areas unless all inmates using the day room are suspected or confirmed Covid-19 cases” (The Texas Department of Criminal Justice, 2022). A suspected case refers to an individual with Covid-19 symptoms that has not tested positive. Grouping individuals that have not tested positive with individuals that have tested positive appears to be a gaping oversight in the protection of AIC’s.

Release Policies

According to a report from the Prison and Jail Innovation Lab at the University of Texas at Austin, thousands of parole-approved individuals remained incarcerated in Texas throughout

the pandemic, costing some their lives (McCullough, 2021). The Texas Board of Pardons and Parole (BPP) has the option to grant parole upon completion of a re-entry related program. Many of these programs were suspended during the pandemic, however completion requirements for parole approved AIC's were not. Prior to Covid-19, parole approved AIC's spend an additional 3-4 months incarcerated on average before being released. During Covid-19, this wait increased to 5-11 months (Deitch et al., 2021).

From TDCJ's initial lockdown in March 2020 through March 2021, 42 parole-approved individuals died while awaiting release, 18 of which can be attributed to Covid-19. In order to be approved for parole, the BPP must determine that the release of an individual will not harm public safety (Deitch et al., 2021). According to the BPP's own determinations, the TDCJ could have safely initiated the immediate release of parole-approved individuals.

The 2022 TDCJ "Infection Control" manual describes AIC release procedures for higher risk facilities using "enhanced" prevention strategies. The manual states that "when possible" AIC's will undergo an observation period of 7 days, and then be tested for Covid-19 prior to their release date. AIC's will also be screened for Covid-19, which involves a symptom and temperature check. AIC's who do not pass the screen are placed in medical isolation to be evaluated by healthcare staff before being released. The Texas Department of State Health Services is notified and AIC's are released with a face mask (Texas Department of Criminal Justice, 2022).

Staffing Shortages

The TDCJ experienced significant understaffing prior to and during the Covid-19 pandemic. As of November 2021, Texas prisons were short 7,000 correctional officers. This translates to a vacancy rate of 29% among correctional officers (Jones et al., 2022).

The TDCJ “Infection Control” Manual requires TDCJ staff to be screened for Covid-19 before entering a prison facility when “enhanced prevention” strategies are underway. Staff that do not pass the screen are sent home. However, when staffing shortages interfere with safe operations, “staff with confirmed Covid-19 cases will be permitted to return to work if they are well enough and willing” (Texas Department of Criminal Justice, 2022).

If the TDCJ does not have enough staff to operate the largest prison system in the country without knowingly exposing the incarcerated population to Covid-19, decarceration is paramount.

Testing

The testing of symptomatic individuals is considered an “everyday prevention” Strategy in the TDCJ “infection Control” manual. Diagnostic testing, even for staff, is reserved for symptomatic individuals and close-contacts (ex. cellmate) of a suspected or confirmed case (Texas Department of Criminal Justice, 2022).

Quarantine

The TDCJ “Infection Control” manual states that individuals with suspected or confirmed cases of Covid-19 who are considered infectious may be isolated. The manual advises that medical isolation take place in single-occupancy cells. However, lower security Texas prisons

often have a limited number of single occupancy cells as they rely on cubicle or dormitory-style housing. When necessary, individuals may be isolated in cohorts with other confirmed cases. When possible, suspected cases are isolated from confirmed cases (Texas Department of Criminal Justice, 2022).

Vaccines

Despite high levels of Covid-19 infection in Texas prisons, incarcerated populations were not explicitly mentioned in state level vaccine rollout plans at all (Herring & Sharma, 2021). An initial allotment of 2,000 vaccines were administered in March 2021, the same week that all adults in Texas became eligible (Bohra, 2021). Vaccines were first made available to staff, before being offered to AIC's (McCullough, 2021).

However, as of July 2021, the TDCJ had administered 60,034 doses of the Covid-19 vaccine, covering 50.9% of the incarcerated population (Herring & Sharma, 2021). The TDCJ is either no longer counting the number of doses administered, or has chosen not to make this data publicly available. Additionally, the TDCJ is not reporting the vaccination rate among staff.

According to a report from the Prison and Jail Innovation Lab at the University of Texas-Austin, the vaccination rate among TDCJ staff is far below both national and state level averages (64% and 62%, respectively). As of September 2021, 47% of TDCJ employees had received the first dose of the Covid-19 vaccine (Jones et al., 2022). Data related to booster shots has been made unavailable by the TDCJ. Despite low vaccination rates, the TDCJ reports that vaccines have been made available to all "staff and inmates" (Texas Department of Criminal Justice, 2023).

Relevant Litigation

Laddy Curtis Valentine and Richard Elvin King, two AIC's located in "Pack Unit" for geriatric men, brought a class action lawsuit against the TDCJ and its executive director Bryan Collier, alleging a failure to protect themselves and similarly situated AIC's from Covid-19. Their case reached the Supreme Court. The questions before the court were 1) did the TDCJ violate the eighth amendment by acting with "deliberate indifference" to the health and safety of AIC's during Covid-19, and 2) did the TDCJ violate the Americans with Disabilities Act (ADA) by refusing to make necessary accommodations. The plaintiffs sought injunctive relief, requiring basic public health protocol to be followed in the "Pack" unit.

The fifth circuit court eventually reversed a lower court's decision, vacating a judgment in favor of Valentine, King, and other AIC's in the "Pack" unit. The previous judgment ordered the TDCJ to implement basic preventive measures such as providing unrestricted access to soap, cleaning supplies, and PPE, as well as hand sanitizer for mobility-impaired AIC's. The fifth circuit court held that the TDCJ did not demonstrate "deliberate indifference" because some interventions were taken. The decision states that a lack of written policy does not mean that adequate precaution wasn't taken. Furthermore, the policies that have been documented were deemed sufficient (*Valentine v. Collier*, 956 F.3d 797 (5th Cir. 2020)).

Chapter 3: New Jersey Case Study

The state of mass incarceration in New Jersey

In 2018, New Jersey had a prison population of 19,041 individuals (Vera Institute of Justice, 2019). The prison population has been trending downwards, decreasing by 25% between 2008-2018. In 2017, 21% of the prison population was white, and 16% were Latinx. Black individuals were significantly overrepresented in the prison population, comprising 14% of the state population but 61% of the prison population. Black individuals are incarcerated at a striking 11.4x the rate of white individuals in New Jersey (Vera Institute of Justice, 2019). The largest number of prison admissions originate from Camden and Essex Counties.

The New Jersey Department of Corrections currently operates 8 adult prisons. New Jersey prisons vary in size with capacities between 647 and over 3,400 at South Woods State Prison. The New Jersey Department of Correction (NJDOC), assigns AIC's to one of six custody statuses (close custody through community custody), which determine housing and work assignments (New Jersey Department of Corrections, 2023).

Covid-19 in New Jersey

The populous and urban state of New Jersey did not fare well during the Covid-19 pandemic despite considerable executive action. Governor Murphy declared a public health emergency on March 9th, 2020 in response to Covid-19. Stay-at-home orders took effect on March 21st. Schools closed and masks were mandated. The public emergency wasn't lifted by Governor Murphy until March of 2022.

Covid-19 infections peaked in January of 2022, with a daily average of more than 31,000 positive cases. According to The Commonwealth Fund index, New Jersey ranked 17th in the nation for their response to Covid-19 (Radley et al., 2022).

Covid-19 in New Jersey Prisons

According to the Prison Policy Initiative, New Jersey was rated higher than all other state prison systems for their Covid-19 response, earning a “C” letter grade. This relatively high grade can be attributed to New Jersey’s effort to reduce the prison population as well as vaccinating AIC’s. Despite these successes, the Prison Policy Initiative is clear in its assessment that New Jersey “did not do enough to mitigate Covid-19” (Herring & Sharma, 2021). The largest deductions are attributed to the disparity in infection and mortality rates between the general population and the prison population. The prison population was infected with Covid-19 at a rate 3.8 times the general public, and faced nearly twice the mortality rate (Herring & Sharma, 2021).

In December of 2019, prior to the first confirmed case of Covid-19 in a U.S. prison, New Jersey prisons were operating at 100% rated capacity. Rated capacity refers to the number of beds available to AIC’s within a prison system. The prison population in New Jersey went up before it went down. By May of 2020, the prison population increased by more than 1,500 individuals, with New Jersey prisons operating at 110% rated capacity (Widra, 2020).

According to the Prison Policy Initiative, the NJDOC provided face masks, hygiene products, phone call minutes, and postage to AIC’s at no cost (Herring & Sharma, 2021). Medical copays were suspended on March 26th of 2020, and remain suspended in 2023 (Herring, 2022). As of July 2021, NJDOC policy required staff to wear face masks (Herring & Sharma, 2021).

Executive Action

In the interest of protecting medically vulnerable AIC's from Covid-19 as well as enabling social distancing in NJDOC facilities, Governor Murphy signed Executive order No. 124 promptly in April of 2020. The executive order established an Emergency Medical Review Committee tasked with recommending eligible AIC's for temporary home confinement. According to the NJDOC, more than 1,200 individuals were released through this mechanism by October of 2020 (Office of the Governor, 2020).

On October 19th of 2020, Governor Murphy signed Senate Bill 2519 to further reduce the prison population in an unprecedented manner. Senate Bill 2519 enables corrections commissioners to award "public health emergency credits" to AIC's who were incarcerated during the pandemic. The Act applies to individuals who are scheduled for release within the following year, translating to early release. Each month an eligible AIC is incarcerated will be supplemented by 3 months of additional "time served" credit. This means that one month of real time can accrue 4 months of credit. Credits can reduce a sentence by up to 8 months, and do not apply to certain crimes (Office of the Governor, 2020). Senate Bill 2519 took effect on November 4th, initiating the release of 2,258 individuals in the largest single-day reduction of any state prison population (Brennan Center for Justice, 2022).

The Re-entry Experience of Individuals Released Through SB2519

Researchers from Rutgers University conducted a study involving in-depth interviews with formerly incarcerated individuals who reported pre-existing substance use disorders and were released via SB 2519. Interviews sought to investigate the successes and challenges related to re-entry following a large-scale release. Participants included 21 individuals with past or

present substance use disorders. Fourteen respondents reported having an opioid use disorder. Eleven respondents were released November 4, 2020, during the large-scale release event (Treitler et al., 2021).

Expedited release can interfere with the process of planning for re-entry, and large-scale releases have the potential to overburden re-entry services. For these reasons, most of the participants did not have a government-issued ID at the time of their release. Some individuals who applied for benefits while incarcerated were not yet enrolled by the time of release. A number of respondents faced housing insecurity while a few individuals were released to houselessness. Participants varied in their perceptions of their own preparedness for release (Treitler et al., 2021).

All participants applied for Medicaid before released as encouraged. However, not all of them were able to enroll by the time of release, causing a gap in coverage. The continuity of medical care is critical for individuals with substance use disorders as there is a heightened risk of overdose following release. Some respondents felt they had been released with too little medication to last until an appointment could be scheduled in the community (Treitler et al., 2021).

Respondents also noted the difficulty of being released into the Covid-19 reality. One interviewee described their difficulty finding employment as businesses struggled to survive. Another interviewee described their difficulty adapting to virtual substance abuse recovery meetings (Treitler et al., 2021).

In conclusion, the study found that most respondents depended heavily on their social networks during their release and transition. Respondents identified a greater need for future

employment, transportation, and housing assistance during re-entry. Interviewees also expressed a critical need for a smart-phone, and smart-phone literacy, in order to connect with services in the era of Covid-19 (Treitler et al., 2021).

Interventions and Strategy

NJDOC policies to mitigate Covid-19 were generally universal. It does not appear that other factors beyond community transmission were considered in determining facility level risk with the exception of vaccination status. As of 2023, risk is assessed strictly to inform visitation procedures, which was initially suspended on March 10, 2020 and reinstated on May 1, 2021 (The Marshall Project, 2021). The factors currently assessed are community transmission levels (low, medium, or high), and individual vaccination status (See Figure 4).

VISITATION

The color-coded system remains in place with the following noted:

ORANGE (HIGH RISK):

- **Not Up to Date Incarcerated Person:** No in-person visitation.
- **Up to Date Incarcerated Person:** Socially distanced **outdoor, non-contact visitation.**
- **Visiting Party also Up to Date:** Indoor socially distanced, **non-contact visitation.**

YELLOW (MEDIUM RISK):

- **Not Up to Date Incarcerated Person:** Socially distanced **outdoor, non-contact visitation.**
- **Up to Date Incarcerated Person:** Socially distanced **outdoor, contact visitation.**
- **Visiting Party also Up to Date:** **Socially distanced, indoor, contact visitation.**

GREEN (LOW RISK):

- **Not Up to Date Incarcerated Person:** Socially distanced **indoor, non-contact visitation.**
- **Up to Date Incarcerated Person:** **Socially distanced indoor, contact visitation.**
- **Visiting Party also Up to Date:** **No additional enhancement.**

Figure 4: New Jersey Department of Corrections Visitation Policy

Source: New Jersey Department of Corrections (2023)

Prison Population Reductions

From the onset of the pandemic until July 2021, the NJDOC had reduced the prison population by 41.9% or 7,717 individuals (Herring & Sharma, 2021). This constitutes the greatest reduction to the prison population of any state in response to Covid-19. The prison population reduction was the result of both expedited releases and reduced admissions (Carson et al., 2022). However, incarceration was not suspended for technical violations of probation or parole (Herring & Sharma, 2021).

Testing

The NJDOC collaborated with the Correctional Healthcare and Accurate Diagnostics Lab at Rutgers University to provide on-site Covid-19 testing to both staff and AIC's. This partnership utilized the FDA-approved Rutgers saliva test, which involves spitting in a vial that

is sent to a lab for testing. Test results are available within 48-72 hours (New Jersey Department of Corrections, 2020).

Phase 1 of Universal Covid-19 testing in NJDOC facilities began in April 2020 and entailed an initial round of testing which uncovered more than 2,700 positive cases among the incarcerated population (New Jersey Department of Corrections, 2021). Phase 2 of Universal Covid-19 testing was initiated in July 2020 and included individuals who had previously tested negative. Phase 2 involved weekly testing of NJDOC staff, and monthly testing of AIC's. The second round of testing uncovered more than 100 positive cases (New Jersey Department of Corrections, 2021). Phase 3 of the Universal Covid-19 testing initiative began in August 2020. Phase 3 uncovered 1,668 positive cases among AIC's (New Jersey Department of Corrections, 2021).

By February 28 2021, more than 252,000 Covid-19 tests had been administered to the prison population in New Jersey, 4,300 of which were positive, for a test positivity rate of 1.7% (Carson et al., 2022).

Personal Protective Equipment

Face masks were distributed to NJDOC staff on March 25 2020, and to the incarcerated population on April 16 (Widra & Herring, 2020). Anyone entering NJDOC facilities was required to wear a department-issued mask (New Jersey Department of Corrections, 2020). However, AIC's were permitted to not wear face masks in their bunk area even in dormitory settings where social distancing is not feasible. AIC's were provided unlimited access to soap and other cleaning supplies. However, NJDOC policy does not mention the provision of

additional PPE such as surgical gloves, gowns, or goggles for staff or AIC's (New Jersey Department of Corrections, 2020).

Internal Movement

As of October 2020, individuals newly admitted to NJDOC facilities were held at intake for 15 days while being monitored for Covid-19. Activities that typically require AIC's to gather such as recreation or dining were modified, however the NJDOC does not specify how (New Jersey Department of Corrections, 2020). Substance abuse treatment, educational programming, and religious gatherings were suspended in order to limit foot traffic and permit social distancing. However, some AIC's continued reporting to their work assignments throughout the pandemic (New Jersey Department of Corrections, 2020).

Visitation

According to an NJDOC Newsletter, visitation was suspended in March of 2020 (Velez, 2020). In-person visitations resumed with precautions on October 9 2020 (New Jersey Department of Corrections, 2020). However, visitation was suspended for a second time just two weeks later on October 20th, according to the NJDOC (New Jersey Department of Corrections, 2020). A 2021 press release states that visitation was resumed for a second time in May 2021 (New Jersey Department of Corrections, 2021).

Release Policies

An AIC nearing release from an NJDOC facility completes a medical assessment including guidance on protecting oneself from Covid-19 and getting connected with social services (New Jersey Department of Corrections, 2020). The NJDOC does not clarify the content

of the guidance that was provided pertaining to Covid-19 nor do they provide any other information on release procedures during Covid-19.

Quarantine

In October of 2020, NJDOC policy stated that anyone in contact with a confirmed Covid-19 case for more than 15 minutes at a distance less than 6 feet will be quarantined for 14 days (New Jersey Department of Corrections, 2020). According to the NJDOC, quarantine units were prepared for asymptomatic individuals, and medical isolation units were prepared to accommodate symptomatic individuals (New Jersey Department of Corrections, 2020).

When NJDOC staff are required to quarantine, they are afforded the option to do so at home or in non-congregate housing provided by the NJDOC. The alternative housing provided by the NJDOC allows staff to avoid infecting loved ones with Covid-19 that has been contracted in the workplace. Staff members are directed not to report to work if they are sick (New Jersey Department of Corrections, 2020).

Vaccines

Incarcerated populations were prioritized for Covid-19 vaccine distribution in New Jersey. AIC's were scheduled to receive the vaccine in Phase 1b, whereas correctional staff were included in Phase 1a (Covid Prison Project, 2021). Members of Phase 1b received the vaccine throughout the month of March 2021 (New Jersey Department of Health, 2021). By July 2021, more than 9,000 incarcerated individuals had received an initial dose of the Covid-19 vaccine, translating to 88.8% of the prison population (Herring & Sharma, 2021).

Currently, as of 2023, 72.5% of NJDOC staff have received an initial Covid-19 vaccine (New Jersey Department of Corrections, 2023).

Chapter 4: Federal Bureau of Prisons Case Study

The state of mass incarceration in the U.S.

In 2019, prior to the pandemic, the Federal Bureau of Prisons (BOP) incarcerated 177,214 individuals across 122 prisons (Federal Bureau of Prisons, 2023). The Federal prison population has been trending slightly downwards since 2014, returning to an upward trend after 2020 (See Figure 5).

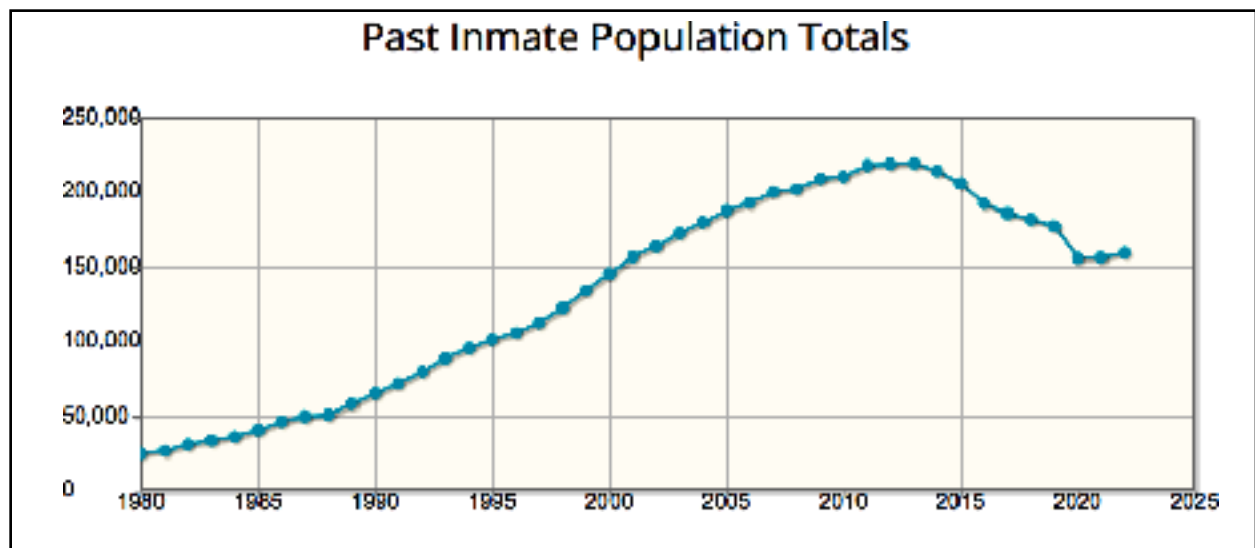


Figure 5: Federal Bureau of Prisons Population Totals Over Time

Source: Federal Bureau of Prisons (2023)

The 122 federally operated prisons are located throughout the country, with multiple facilities in the majority of states. In 2023, 38.5% of the federal prison population is Black, and 57.5% is white. 18% of federal AIC's are not U.S. citizens (Bureau of Prisons, 2023). The federal prison population is composed of individuals convicted of federal crimes and individuals convicted of crimes on federal property or in the District of Columbia.

Federal prisons are categorized by security level: minimum, low, medium, high, complex, or administrative. The largest category of facilities are medium security. Minimum security facilities, also known as “Federal Prison Camps” hold as few as 27 individuals at FCI McDowell in West Virginia, and as many as 17,740 individuals confined at low security FCI Seagoville in Texas (Federal Bureau of Prisons, 2023). Housing types vary by security level, with primarily dormitory style housing in minimum security facilities. Low security facilities utilize a mix of dormitory and cubicle style housing. Medium and high security facilities generally rely on single and double occupancy cell-type housing. Federal complexes involve a conglomeration of security levels between facilities on a single campus. Lastly, administrative security facilities hold a variety of security levels for special purposes such as providing care to extremely medically vulnerable or escape-prone individuals (Federal Bureau of Prisons, 2023).

Covid-19 in Federal Prisons

The Covid-19 infection rate in federal prisons was three times that of national infection rates (Herring & Sharma, 2021). According to the BOP website, 128,655 Covid-19 tests have been administered, 55,303 of which have been positive for an infection rate of 43%. The number of cases reported is guaranteed to be an undercount of the true incidence of Covid-19 for several reasons. For one, tests are imperfect and false negatives occur. AIC’s were never tested as a population sample, which would better represent the true incidence. Lastly, symptomatic testing schemes neglect asymptomatic cases and individuals who do not verbalize their symptoms for a number of reasons.

The Prison Policy Initiative assigned the federal BOP’s Covid-19 response a failing grade according to their scoring matrix. The failing grade indicates a poor response to all index

measures: population reduction, disparity of infection/mortality rates, vaccine rollout and basic health policies. The largest point reduction was in the vaccine rollout category, highlighting the federal government's failure to prioritize incarcerated populations for the vaccine and to actually vaccinate the prison population. The BOP lost the fewest points on the population reduction category according to the Prison Policy Initiative's scoring matrix (Herring & Sharma, 2021).

Prior to the Covid-19 pandemic, the federal BOP was operating above 100% capacity. It is worth noting that solitary confinement beds are included in measures of rated capacity, meaning that solitary confinement was also at full capacity prior to Covid-19. As of December 31st 2019, the BOP was operating at 110% rated capacity. By December of 2020, a full year into the pandemic, the BOP was still operating at 103% rated capacity (Widra, 2020). The BOP managed to reduce its prison population, but still operated above capacity during the pandemic, and continued to do so. Anecdotally, prisons are known to reconfigure communal spaces into dormitories when capacity is reached. For example, filling a former gymnasium or day room with rows of bunk beds.

Another consequence of operating a prison above-capacity during a public health crisis is the shortage of healthcare materials and providers. The BOP ensures that all facilities have a healthcare professional on-site. However, one healthcare professional can only serve so many patients. According to data from the Bureau of Justice Statistics, the average vacancy rate for medical and healthcare positions in BOP facilities in 2019 was 16%. Some additional medical/healthcare positions were filled in 2020, with the average vacancy rate reduced to 9% in 2020. Medical vacancy rates rose back up to pre-pandemic levels in 2021 (Bureau of Justice Statistics, 2022).

According to the BOP, federal AIC’s were provided daily face masks and hygiene products free of charge during the pandemic (Bureau of Prisons, 2020). The Prison Policy Initiative also indicated that AIC’s had access to free phone/video calling. Additionally, staff were encouraged but not required to wear face masks on BOP compounds, and were not required to test for Covid-19. However, the BOP continued to charge AIC’s for medical co-pays during the pandemic (Herring & Sharma, 2021)

Interventions and Strategy

The BOP developed a risk-based index and directed facilities to self-assess their risk level based on the rate of AIC’s in quarantine as well as the rate of infection in the local community (See figure 6).

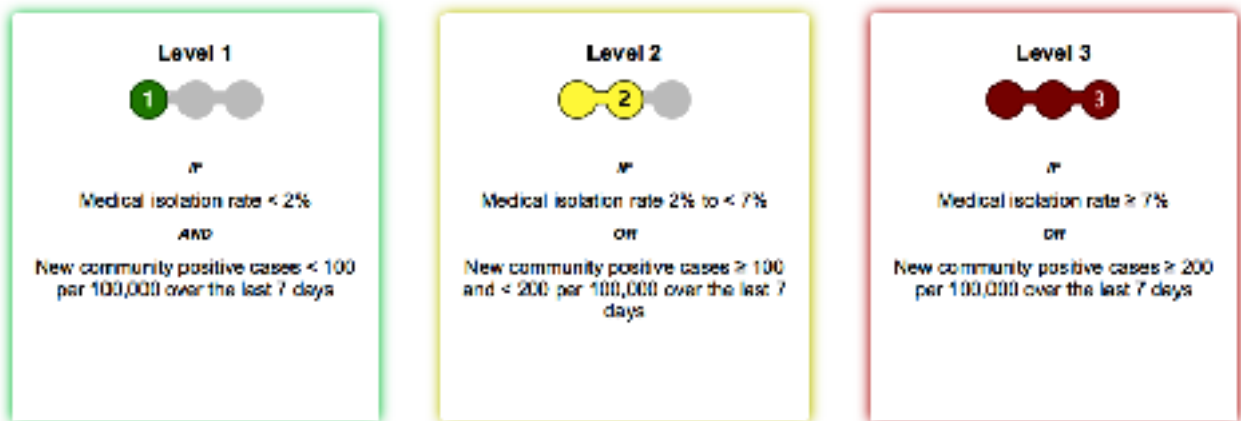


Figure 6: Federal Bureau of Prisons Covid-19 Operational Risk Levels

Source: Federal Bureau of Prisons (2023)

The operational risk level at a given facility determines the Covid-19 prevention strategy. The prevention strategies provide guidelines for PPE, social distancing, AIC programming etc. Operational levels at BOP facilities are constantly changing as Covid-19 cases rise and fall. Therefore, the prevention strategies at a given facility were equally impermanent. It is logical for

compliance to be reduced when the rules are ever changing. The BOP consulted with the CDC, who approved the Covid-19 strategy. However, the CDC signed off on a policy on paper and not the reality of correctional operations.

Prison Population Reduction

The Federal BOP experienced a 15.8% population reduction from March 2020 to June of 2021. The majority of the population reduction is the result of reduced admissions opposed to expedited releases. Methods for reducing prison admissions include limiting arrestable offenses, suspending incarceration for technical violations of probation or parole, substituting a sentence of incarceration with home confinement or civil penalties, increasing reliance on diversion courts etc. Methods of expediting prison release include shortening existing sentences when possible, releasing medically vulnerable or otherwise eligible individuals, and increasing executive commutations or pardons.

The BOP responded fairly quickly to calls from public health officials to reduce the prison population, decreasing admissions by over 90% in the first months of the pandemic (January-April 2020) (Widra, 2022). However, BOP admissions quickly returned to normal. For example, more individuals were admitted to BOP facilities in February of 2021, following the deadliest month of the pandemic, than in January of 2020 prior to the pandemic (Widra, 2022).

The federal BOP failed to implement any expedited release policies or suspend incarceration for technical violations. One tool the BOP possessed for expediting releases were pre-existing compassionate medical release processes. In response to Covid-19, more applications for compassionate medical release were filed and granted than ever before. In 2020, 25.7% of applications were granted, translating to 1,805 individuals. The courts cited many

reasons for granting relief. However, 71.5% of applications granted cited Covid-19 as a factor. The most common outcome of granted applications were release with supervision or home detention (Breyer, 2022). AIC's assigned home detention are still considered incarcerated in BOP data, however they have different and reduced vulnerabilities to Covid-19.

Personal Protective Equipment

On April 14th of 2020, the Office of the Deputy Attorney General in The Department of Justice issued a memo instructing DOJ employees and contractors to “wear cloth face masks or coverings to the extent practicable within common area”. The BOP reports issuing face masks to all staff and AIC's (U.S. Department of Justice, 2020).

Internal Movement

According to the BOP, internal movement, or movement of AIC's between facilities, was drastically reduced beginning on March 13, 2020. In an FAQ sheet posted for the public, the BOP states that “movement nationwide is down 95% when comparing March 13, 2020 - April 23, 2020 to the same time frame last year” (Federal Bureau of Prisons, 2020). Any AIC's that were transferred during this time reportedly wore cloth face masks. News sources such as AP News and the Marshall Project have been skeptical of this statement. Regardless, transfers were resumed shortly thereafter in May 2020 (Federal Bureau of Prisons, 2020).

Visitation

In-person visitation was temporarily suspended for all BOP facilities on March 13, 2020. No-contact visitation resumed on October 3rd. Legal visitations were approved on a case by case basis, with the majority taking place over the phone (Federal Bureau of Prisons, 2020).

Staff Screening

Covid-19 screening for staff and other essential service providers was initiated in certain facilities on March 13, 2020. Covid-19 screening was limited to facilities with “sustained community transmission” as defined by the CDC in increments of 30 days. In applicable facilities, screening involves the **self-reporting** of Covid-19 symptoms as well as temperature checks. Staff screening did not involve testing for Covid-19 (Federal Bureau of Prisons, 2020).

Release Policies

The BOP release protocol is based on an AIC’s history of Covid-19. AIC’s nearing release who have never tested positive for Covid-19 are tested again and if negative they are placed in a 14-day group quarantine with other releasing AIC’s. AIC’s are then required to test out of quarantine before being released (Federal Bureau of Prisons, 2020).

AIC’s who have experienced Covid-19 symptoms or have tested positive in the 90 days prior to release are exempt from being quarantined prior to release. In cases that require the immediate release of an AIC, a Covid-19 screening and rapid test are provided on the day of release. Local health authorities are notified of any positive cases. Released individuals are “required” to wear face masks when departing BOP facilities (Federal Bureau of Prisons, 2020).

Testing

According to BOP data, accessed in 2023 but regularly updated, 128,645 Covid-19 tests have been administered, 55,293 of which were positive. Individual facilities have administered anywhere from 69 Covid-19 tests to 3291 tests (Federal Bureau of Prisons, 2023). Covid-19

testing is typically reserved for symptomatic AIC's. Asymptomatic AIC's who have been exposed to a positive case were tested inconsistently (Federal Bureau of Prisons, 2020).

Quarantine

On April 1st, 2020, the BOP implemented a system-wide quarantine (Federal Bureau of Prisons, 2020). Quarantine in this context involved the confinement of AIC's to their living quarters for 14 days. However, the same memo announcing the quarantine ensures that programming will continue and that gathering will be permitted to the extent possible for purposes of laundry, showers, phone calling and more. No directions were provided for conducting a quarantine in dormitory-style communal housing (Federal Bureau of Prisons, 2020).

The May 2020 FAQ sheet published by the BOP stated that new intakes are quarantined for 14-days before being introduced to the general population. By November of 2020, the BOP stated that any intakes are screened and PCR tested for Covid-19. Symptomatic/positive AIC's are put in medical isolation. Asymptomatic/negative AIC's complete a 14-day group quarantine and are re-tested before joining the general population.

Vaccines

In December 2020, the BOP secured enough vaccines to vaccinate the entire staff and AIC population from the federal government through "Operation Warp Speed". However, initial allotments were "reserved for staff" according to internal documents (Balsamo & Sisak, 2020). By April 2021, all BOP staff members had been offered the vaccine, yet only 48% had accepted the first dose (Bertram & Sawyer, 2021). Just 69.8% of AIC's had been offered their first dose by

the same time in April, 64.2% of which accepted. Of the 2,514 AIC's who initially declined the vaccine, 56.3% accepted the vaccine when offered a second time (Hagan et al., 2021). By 2022, AIC vaccination rates far exceeded staff vaccination rates.

Relevant Litigation

The Cares Act, which passed in March 2020, authorized the director of the BOP to transfer AIC's to home confinement for extended periods of time, potentially indefinitely. The Cares Act will remain in effect for the length of the Covid-19 emergency. Determinations under the Cares Act were made on an individual basis according to an AIC's health, behavior, security level, and risk scores. Risk scores controversially attempt to assess an individual's likelihood of recidivating. The Cares Act excluded certain AIC's from consideration.

The BOP successfully transferred 4,902 AIC's, or 2.2% of the federal prison population to home confinement pursuant to the Cares Act as of January 2022. Research has found that the Cares Act did not threaten public safety, proving the viability of home-confinement alternatives to incarceration (Federal Register, 2022). However, the BOP did not take the opportunity to transfer thousands of additional eligible AIC's to home confinement through the mechanism of the Cares Act.

Chapter 5: Case Study Analysis

Variation in Approach

	Universal Testing	Capacity during 2020	% Population Reduction	Date of Visitation Suspension	AIC Vaccination Rate as of 7/21
New Jersey	Yes	110%	41.9%	3/10	88.8%
Oregon	No	89%+	16.3%	3/13	86%+
Texas	No	97%+	15.9%	3/13	50.9%
Federal	No	103%	15.8%	3/13	56.6%

Table 1: Key Prevention Measures by Case Study

As seen in Table 1, certain measures were taken by all corrections departments in this study to mitigate Covid-19. All corrections departments suspended visitation at similar times and reported providing face masks to AIC’s and staff. Other measures were less universal. For example, New Jersey was the only state to initiate mass testing. States varied significantly in terms of decarceration. However, all systems operated above 85% capacity in the height of the pandemic.

There were a range of attitudes towards Covid-19 by the corrections departments in this study. In New Jersey for example, leadership was proactive and spoke publicly and frequently about their intention to prevent the spread of Covid-19 in the prisons. Statements were followed up with action, such as the large-scale releases initiated by Executive Order No.124. This is not

to suggest the interventions taken in New Jersey were sufficient for preventing widespread infection, but to provide juxtaposition to those in Texas. Texas leadership fixated on public safety to justify continuously high prison populations despite staffing shortages, overcrowding, and the highest number Covid-19 deaths in the country.

Not only was there significant variation in the approach taken by corrections departments to mitigate Covid-19, there were varying degrees of policy actions available to analyze. In Oregon, the department of corrections website maintains a media library of all communications pertaining to Covid-19. The material ranges from media releases to the health information provided to AIC's. Texas and New Jersey were far less forthcoming with the documents that would be relevant to my research. Previous versions of policies and procedures were not made available, unlike in Oregon where a virtual record is stored.

It is worth noting that the experience of an AIC in Texas residing in a work-camp is drastically different from an AIC in Texas who spent the majority of the pandemic in solitary confinement. The range of experiences is endless and under-documented. There is no single "Texas" experience of Covid-19 in prisons, nor is there a coherent "Oregon" experience.

Variation in Outcomes

	Cumulative cases per 10k (through 1/18/2022)	Cumulative deaths per 10k (through 1/18/2022)	Infection Ratio Compared to Public	Mortality Ratio Compared to Public
New Jersey	7,859	33	3.8	2
Oregon	4,441	41	6	5
Texas	3,843	38	3	1.1
Federal	3,732	22	3	1

Table 2: Covid-19 Outcomes by System as a Flat Rate and Ratio

Sources: UCLA “Covid Behind Bars” Data Project (2022), Prison Policy Initiative (2021)

The first two columns in Table 2 indicate the cumulative number of positive Covid-19 cases and deaths per 10 thousand adults in custody, with data from the UCLA “Covid Behind Bars” Data Project. The last two columns state the ratio of infection and death in the prison population as compared to the rates in the general population. While there are a range of outcomes, the data is limited in several ways.

Firstly, the number of Covid-19 infections and deaths reported by corrections departments are most certainly an undercount (Franco-Paredes et al., 2020). Particularly in the beginning of the pandemic, PCR tests were a limited resource. AIC’s were not tested universally nor consistently, guaranteeing that numerous positive cases went uncounted, similarly to the general public. Additionally, PCR testing is imperfect and may incur a false-negative result, leading an infected individual to believe they are not infected and continue to interact with others. Beyond under-testing, departments of corrections have been known to underreport

infection and death even prior to Covid-19. This history of undercounting is what incited the numerous external tracking projects of Covid-19 in U.S. Prisons.

Secondly, the lack of standardized data reporting has led the numerous tracking projects to return different cumulative counts of Covid-19 infection and mortality. Methods of data collections varied by corrections departments as well as between external Covid tracking projects. Some corrections departments tracked active cases, while others monitored infections over time. Some tracking projects rely on data that is reported directly by corrections whereas others utilize news reports and other media.

Lastly, the final columns of Table 2 represent the ratio of infection and mortality within prison systems as compared to the rates in the general public of a given state; the numerator being the infection and mortality rates within a given prison system and the denominator being the infection and mortality rate in the general public. The denominators in this ratio are inconsistent, complicating the ease of comparison. For example, the denominator in the populous New Jersey ratio far exceeds that of Oregon. The effect of which may be an overstatement of the disparity in systems with smaller denominators and the understatement of the disparity in systems with larger denominators. The flat rates listed in the first two columns are included to contextualize these disparity ratios.

Correlation Between Approach and Outcomes

Table 1 suggests that New Jersey took the strongest measures to mitigate the spread of Covid-19. New Jersey saw the greatest reduction to the prison population, successfully vaccinated the majority of AIC's, was the first to suspend visitation, and was the only state to implement a universal testing scheme. However, New Jersey prisons continued to operate well

above capacity during the pandemic. If the approach were correlated with Covid-19 outcomes, I would expect to see comparatively favorable Covid-19 outcomes in Table 2. In reality, New Jersey prisons experienced the highest infection rates. Mortality rates however are comparable to the other case study states.

As seen in Table 2, the most favorable Covid-19 outcomes come from the Federal Bureau of Prisons. This relative success was not foreshadowed by their approach to Covid-19. As seen in Table 1, the BOP saw a comparatively small reduction to the prison population, operated above capacity during 2020, and successfully vaccinated just over half of AIC's. Visitation was suspended on the same date as Texas and Oregon.

As demonstrated by Tables 1 and 2, the implementation of preventative measures within corrections are not directly correlated with Covid-19 outcomes. There are several reasons this may be the case. Firstly, policy may not reflect everyday operations. For example, just because official policy states that all incarcerated people will be provided with face masks does not guarantee that every AIC did in fact receive a face mask. Additionally, face masks disintegrate with use, offering little protection from Covid-19 after multiple days of wear. If face masks were not regularly replaced, enforcement of face mask policies only goes so far.

Secondly, the Covid-19 pandemic is highly politicized. Anecdotally, the enforcement of official policy was largely at the discretion of individual correctional employees who are susceptible to political influence, contributing to the variation within facilities. For example, if the politics of individual correctional officers on duty within a specific housing unit do not align with official face mask policy, AIC's may be discouraged or even prohibited from wearing a face mask.

Lastly, adults in custody are a socially stigmatized population. The public is rarely privy to the reality and experience of incarcerated peoples. Negative experiences such as the previous example often go unreported due to fear of retaliation.

CDC Guidelines

Throughout my research, one of the most common statements I encountered was that “policy is in accordance with CDC guidelines”, even when it was not. It appeared that when in doubt about a specific policy or policy area, corrections departments filled in the gaps by re-stating that policy is in accordance with the CDC Guidelines. My research has found this not to be true. Examples of violations of the CDC guidelines include but are not limited to those listed below.

- CDC Guidelines direct corrections to test staff and AIC’s who are exposed to Covid-19, even without symptoms. This guidance was not followed uniformly in Oregon, Texas, or at the federal level.
- CDC guidelines direct corrections departments to prioritize AIC’s and corrections employees for the Covid-19 vaccination as it became available. AIC’s were generally not prioritized nor incentivized to receive the vaccine.
- CDC Guidelines state that individuals with confirmed and suspected cases of Covid-19 should not be housed together. TDCJ policy directly contradicts this guidance.
- CDC Guidelines task corrections departments with ensuring the continuation of support services in isolation. The availability of services was not measured, however it was certainly insufficient in all corrections departments.

The lack of adherence to the CDC guidelines are reflected in the extraordinary rates of Covid-19 and infection and death in U.S. prisons as compared to the general public.

Mental Health

I began my research with the oversimplified assumption that it would be in the best interest of incarcerated people for corrections to take the strongest action possible to prevent the spread of Covid-19. In reality, Covid-19 interventions such as isolating positive cases in solitary units otherwise used for punishment, are double-edged swords. While isolation mitigates the spread of Covid-19, it has been shown to diminish mental health. Each and every policy decision made by state governments and departments of corrections during Covid-19 have both advantages and drawbacks for the health and wellbeing of AIC's.

The isolation of AIC's has been linked to insomnia, anxiety, withdrawal, hallucinations, paranoia, depression, self-mutilation, and suicidal ideation (Mitchell et al., 2022). Individuals who have previously attempted suicide are at heightened risk and should only be isolated when absolutely necessary, in which case they should be monitored closely and provided access to treatment.

One aspect of mental health that was seldom discussed in my research is the experience of loss and grief for those incarcerated during Covid-19. Due to the sheer number of Covid-19 deaths among the prison population, AIC's are likely to have witnessed the death of a cellmate, a loved one, or a peer. None of the corrections departments in this study address grief or the provision of grief counseling specifically to AIC's.

Policy Recommendations

Mandate Standardized Data Reporting from Corrections

Data is arguably the most valuable tool available to policy makers for addressing public health emergencies in real time. The lack of standardized data reporting actively prevents policy makers from understanding the scope of a problem and making informed policy decisions.

In January of 2021, Senator Elizabeth Warren collaborated with Dr. Brinkley-Rubinstein and Dr. Nowotny, founders of the Covid Prison Project, to co-author an op-ed entitled, “End the silence about what Covid-19 is doing to America’s Prisons”. The authors introduce a potential solution to the “alarming shortage of comprehensive data” on Covid-19 from corrections, in the form of legislation. *The Covid-19 in Corrections Data Transparency Act* mandates the collection and public reporting of Covid-19 data measures including the number of staff and incarcerated persons who are tested for Covid-19 as well as the type of test, the results of any tests including the average time that results are returned, the movement of any positive cases including hospitalizations, deaths, isolations, and recoveries. Lastly, corrections would be mandated to report on the term of imprisonment and time served of individuals infected with Covid-19. Additionally, all data is required to be disaggregated across demographics. Failure to report will result in the penalty of a 10% reduction in future funding by the Justice Assistance Grant (JAG), the primary federal criminal justice fund (Warren, 2020). My research has led me to endorse *The Covid-19 in Corrections Data Transparency Act* and its mission.

Recognize Prisons as High-Risk Settings in Public Policy

In the face of the pandemic, certain settings and communities were recognized as being high-risk, and were therefore prioritized in terms of resource allocation. Examples include healthcare settings, retirement homes, and schools. The incarcerated population is a socially stigmatized group. For this reason, correctional institutions were not equally prioritized despite being notably high-risk. Correctional staff were routinely prioritized ahead of incarcerated persons in terms of vaccine eligibility (Strodel et al., 2021). Underlying this marginalization is the false belief that individuals who violate the law, volunteer their rights. In reality, incarcerated persons are constitutionally entitled to adequate healthcare. Once an individual commits a crime, they are deemed unworthy of any form of social investment. This is a violent rhetoric which fails to recognize the humanity of all people, nor the interactions of race and class in criminal justice. Correctional facilities must be recognized as the high-risk settings they are in the provision of resources during future public health emergencies.

Impose Universal Minimum Standards (with acknowledgement that one size does not fit all)

A lack of universal standards within corrections during public health emergencies contributed to the wide range of protocols between institutions and states. The most basic, evidence-based strategies were not uniformly imposed in correctional settings. This is a glaring oversight. Universal minimum standards would ensure the health and wellbeing of incarcerated populations are not entirely neglected. Evidence-based minimum standards worthy of consideration include an increased reliance on alternatives to incarceration such as probation, parole, and home-confinement, minimizing inter-facility transfers, reducing prison capacity, and incentivizing vaccination for both AIC's and staff. If necessary, universal minimum standards

should be quantifiable. For example, mandating that correctional facilities not exceed 90-95% rated capacity during a public health emergency.

Bolster Systems of Accountability

Throughout my research I have observed a major lack of accountability for low-performing departments with exceptionally high Covid-19 infections and deaths. In order for any minimum standards to be effective, there must be mechanisms of enforcement. Considering how federal funding is already used to influence criminal justice policy at the state and local level, the Federal government has an opportunity to remedy this lack of accountability through the withholding of federal funding through grants such as the Justice Assistance Grant.

For example, state corrections departments may be penalized for violations of minimum health and safety standards during future public health emergencies. Penalties may resemble that of the *The Covid-19 in Corrections Data Transparency Act*, which entails a 10% reduction in future funding from the JAG. In contrast, the Federal government may also offer economic incentives for achieving specific and measurable outcomes during a public health emergency. For example, corrections departments could be rewarded for each additional 5% reduction in their prison population beyond the maximum capacity standard during a public health emergency.

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