RECOMMENDATIONS FOR A METROPOLITAN COVID-19 RESPONSE
SPECIAL EMPHASIS SERIES

Guidance on Protecting Incarcerated Individuals

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This document reflects recommendations for the response to the COVID-19 pandemic for anyone held in custody at a state prison, county or city jail, or juvenile detention center in the US as of April 30, 2020, focused on Maryland. We recommend:

1. Increase transparency of COVID-19 response plans and of the number of infections occurring at facilities.

2. Reduce density of incarcerated people through emergency release and diversion measures, adjust release procedures to ensure safe re-integration, and adjust parole supervision procedures to account for increased caseload.

3. Implement measures to reduce the risk of transmission and to ensure the continued physical health of currently incarcerated individuals.

4. Protect the mental health of incarcerated individuals by maintaining communication channels and providing substitutes for cancelled congregate activities.
INTRODUCTION

Currently, there are approximately 2.3 million people detained behind bars in the U.S., including 21,142 people in Maryland state prisons and Baltimore city jails (1,2). As evidenced by a surge of cases in jails and prisons across the country (for instance, Rikers Island Jail in NYC, Cook County Jail in Chicago, a federal prison in Louisiana, and others) and by prior infectious epidemics spreading in prisons and jails, institutions of incarceration are environments where COVID-19 is likely spread rapidly; furthermore, many incarcerated individuals have chronic health conditions and other risk factors that put them at risk for more severe disease. As of April 9, 57 COVID-19 cases have been reported by the Maryland Department of Public Safety and Correctional Services, a more than threefold increase in 5 days (3). These numbers—which only reflect those in DPSCS custody (state prisoners and people in the Baltimore City jail system) but not local jails—can be expected to increase as they have in other jurisdictions.
Ensuring the safety of incarcerated persons and the other individuals who interact with them in these settings is critical to preventing transmission of COVID-19 not only inside the facilities, but also in the wider state community. To ensure their safety, measures need to be taken urgently to identify potentially infected individuals, to reduce the possibilities for transmission in institutions of incarceration, to ensure that infected incarcerated individuals get appropriate treatment, and to facilitate the safe reintegration of individuals from these settings back into the community (4).

The recommendations below call for a concerted, state and local government-supervised strategy across facilities in which incarcerated persons are held across the state of Maryland. This is especially important to have meaningful, centralized oversight with enforcement mechanisms since many institutions contract out their health care to private entities.

This document applies to anyone held in custody at a state prison, county or city jail, or juvenile detention center.
**RECOMMENDATION 1**

**INCREASE TRANSPARENCY OF COVID-19 RESPONSE PLANS AND OF THE NUMBER OF INFECTIONS OCCURRING AT FACILITIES**

Prisons, jails, and detention centers across the state have likely implemented COVID-19 response plans. However, without knowing the content of these plans or circumstances unfolding in these settings, it is difficult to discern risk for transmission or for public health officials to provide guidance on measures that need to be taken to ensure safety. Tracking infection numbers can help identify facilities experiencing surges that need additional intervention. For these reasons, other jurisdictions across the country have released their plans.

Correctional institutions, private correctional health contractors, and state correctional agencies should make the following information publicly available by posting to the facility's or agency's website and reporting to the state Department of Health:

A. Their facility's COVID-19 custody, health care, and other response plans, including but not limited to protocols pertaining to:

   a. Screening for newly admitted individuals, those already in custody, and staff and all other persons entering the facility, including the process for testing symptomatic and exposed individuals

   b. Isolation and quarantine of infected individuals or persons under investigation in accordance with the Centers for Disease Control and Prevention's Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities.

   c. Education of staff and incarcerated people about prevention measures
d. Social distancing measures undertaken in the facility

e. Disinfection and cleaning procedures, accessibility of cleaning supplies, and incarcerated individuals’ access to hand hygiene

f. Use of PPE for staff, incarcerated individuals, and others entering the facility

g. Arrangements for hospital transfer when indicated.

B. Number of new COVID positive individuals and COVID-related deaths in their systems, tests ordered, and, if a death, whether it occurred on-site or at an outside health care facility. Data should be grouped by correctional and health care staff, contractors, probation and parole employees, and incarcerated individuals. These numbers should be reported within 24 hours to a statewide registry established specifically for tracking infections in the state’s correctional facilities. The registry should also collect basic demographic data on age, race and ethnicity, relevant medical comorbidity, and, when applicable, pregnancy.

**RECOMMENDATION 2**

**REDUCE DENSITY OF INCARCERATED PEOPLE THROUGH EMERGENCY RELEASE AND DIVERSION MEASURES, ADJUST RELEASE PROCEDURES TO ENSURE SAFE RE-INTEGRATION, AND ADJUST PAROLE SUPERVISION PROCEDURES TO ACCOUNT FOR INCREASED CASELOAD**

Reducing the density of incarcerated people is essential to reduce transmission of the virus. It makes it more feasible to implement social distancing practices in housing assignments, at mealtimes, and
in daily use of space. At current population levels, social distancing is nearly impossible. Further, as the correctional health care staff workforce and custody staff become ill, their ability to provide coverage and support for the health care of incarcerated people onsite will be more constrained.

Thus, as an infection prevention measure, when possible, emergency release should occur, especially of certain groups who are at high risk of severe morbidity and mortality if they acquire COVID-19 and those whose sentences allow early parole or release. In addition, when possible, pre-trial detention and arrests for low-level charges should be avoided, in favor of community diversion and alternatives to incarceration. Several counties, states, and the U.S. Department of Justice have enacted such measures (5). Maryland’s Attorney General Brian Frosh has also called for release of incarcerated people to avoid a catastrophic outbreak in Maryland’s prisons and jails (6).

Populations to be prioritized for release and diversion should include, but are not limited to:

A. People over the age of 55

B. People with chronic medical conditions requiring care (such as, but not limited to, those with asthma, cancer, heart disease, kidney disease, underlying lung disease, and diabetes) and people who are otherwise medically fragile

C. Individuals who are pregnant

Furthermore, the Governor should use his commutation authority to release from prison people whose release has already been approved by the parole board, regardless of whether that person falls into a high-risk medical category.

Key considerations related to release should include:

A. Provide accommodations/transitional housing and arrangements for food security and other basic
needs for individuals released into the community to facilitate safe re-entry in a manner that does not burden or create risk for existing social services.

B. Provide people upon release with infection control instructions and packs containing hygiene supplies such as hand sanitizer, wipes, a mask, and gloves to enable them to protect themselves and others as they re-enter the general population.

C. Reduce contact between parole and probation officers through use of video appointments and similar technology.

D. Screen persons being released for temperature and symptoms and follow the relevant section in the CDC’s Interim Guidance for those not cleared.

As the aforementioned early releases will lead to more people under parole supervision, the following efforts can help ensure that the parole system can adequately supervise this influx of caseloads and existing people, and to avoid unnecessary incarcerations:

A. Remove individuals from parole who have had no criminal behavior in the past 12 months and have passed their discharge date.

B. Prevent detention of individuals and suspend parole revocations for people who commit technical violations of their parole.

C. Suspend unnecessary in-person parole check-in's, as a social distancing measure, using methods set.

D. Terminate supervision of people who have been on parole for two or more years.
Incarcerated persons do not have the freedom to practice mitigation measures such as social distancing and may not have access to frequent hand washing and are therefore reliant on the correctional facility to ensure safety and prevent transmission. Measures must be taken to reduce contact in facilities and enable physical distancing of individuals, as well as to enable and educate incarcerated individuals on proper hand hygiene.

To ensure the continued physical health of currently incarcerated individuals, correctional facilities should implement the CDC’s Interim Guidance. In conjunction with and in addition to these guidelines, facilities should take measures to directly reduce the risk of transmission:

A. Enable hand washing at frequent and unrestricted intervals and increase frequency of cleaning and disinfection of common areas.

B. Provide access to supplies such as soap and cleaning supplies without charge and lift any restrictions on hand sanitizer and make available to incarcerated individuals and staff.

C. Launder clothing and other items more frequently in accordance with recommended precautions.

D. Encourage universal face mask use among incarcerated individuals and correctional and health care staff, as feasible based on local supply.
E. Implement policies to facilitate access to testing for individuals who are incarcerated and those who work in the facility. This is crucial to enable safe isolation of certain individuals and potential quarantine of their contacts to prevent spread within and beyond correctional facilities. Testing with on-site collection of samples should be conducted in the following circumstances:

a. On all incarcerated people and facility staff or contractors who have symptoms of COVID-19 or who have been in contact with someone who has tested positive.

b. On all persons entering custody of a correctional facility, regardless of symptoms.

c. Rapid and broad testing of those in custody in the facility in response to a case of COVID-19 in the facility.

d. Retesting when individuals (staff or incarcerated persons) who previously tested negative subsequently develop symptoms or are identified as a contact of someone who tested positive.

F. Provide education to incarcerated individuals and staff on proper hand washing, social distancing, and other COVID-19 prevention strategies. Ensure incarcerated persons have access to important health information and transparently communicate protocols for how confirmed or suspected infections will be handled.

In addition, correctional facilities should implement operational practices designed to facilitate care for all incarcerated persons and ensure sound clinical practice through the following:

A. Eliminate health care co-pays so that people are not deterred from seeking health care.

B. Assure seamless communication and collaboration with local hospitals, making sure that a clear understanding of the division of labor for care for exposures and infections is in place.
C. Ensure that incarcerated individuals continue to have access to routine and urgent, non-COVID related health care, especially for chronic medical conditions and pregnancy that require regular visits.

D. Develop a dedicated mechanism to assure that measures contained herein and measures contained in response plans are effectively implemented and access to necessary health care provided at facilities whether by state-employed health care staff or private health care contractors.

E. Assure that health care and custody staff at correctional facilities have access to resources for obtaining technical assistance.

F. Plan for and implement proactive health care and monitoring of particularly vulnerable sub-populations, including those with serious mental illness, who may be unable to report symptoms or possible exposure. Persons needing assistance with activities of daily living and those held in secure housing should be ensured unfettered access to health care.

G. Reassign correctional staff who themselves have high risk medical conditions to roles which minimize the likelihood of transmission.

**RECOMMENDATION 4**

**PROTECT THE MENTAL HEALTH OF INCARCERATED INDIVIDUALS BY MAINTAINING COMMUNICATION CHANNELS AND PROVIDING SUBSTITUTES FOR CANCELLED CONGREGATE ACTIVITIES**

Having contact with family and friends in the community is an essential coping and mental health strategy for incarcerated individuals. While visitation has been suspended there are ways to
facilitate communication between family and loved ones through the distribution of cells with preset telephone numbers to allow for safe and regular communication.

Correctional facilities should:

A. Enable video visitations by friends and family without travel to the facility.

B. Provide access to stimulation through disinfected materials such as books, televisions, personal electronic devices, music, journals, puzzles, handicrafts, and similar substitutes for cancelled congregate activities.

C. Enable video religious activities for those religions where such activities are acceptable.

D. Ensure uninterrupted written correspondence and consider expanded telephone access using disinfected devices.

E. Guarantee that incarcerated persons have timely and sufficient communication with attorneys and their staff. Coordinate with local, state, and federal courts for video and telephone hearings and appearances.

F. Use of conditions that resemble solitary confinement or lockdown for medical/public health purposes (e.g., isolation and quarantine) should not be punitive or disciplinary in nature and should be employed for limited periods of time consistent with the medical/public health purpose (7).

G. Provide actionable and practical guidance for how individuals can reduce their individual risk of infection, which can help to reduce anxiety and ensure a sense of agency during the crisis.

• Community Oriented Correctional Health Services and Vera Institute Policy Briefs for Government Agencies to keep justice-involved people and workers safe during COVID-19 • https://cochs.org/COVID-19/
• Centers for Disease Control and Prevention, Interim Guidance on Management of COVID-19

- Amend, University of California San Francisco, [https://amend.us/covid/](https://amend.us/covid/)

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This is a special area of emphasis emerging from Recommendations for a Metropolitan COVID-19 Response developed by Melissa A. Marx, Emily Gurley, Jennifer Nuzzo, Lauren Sauer, Rupali J. Limaye, William Moss, Justin Lessler, and Joshua Sharfstein.

For more COVID-19 insights and expertise from the Johns Hopkins Bloomberg School of Public Health, please visit: https://www.jhsph.edu/covid-19/