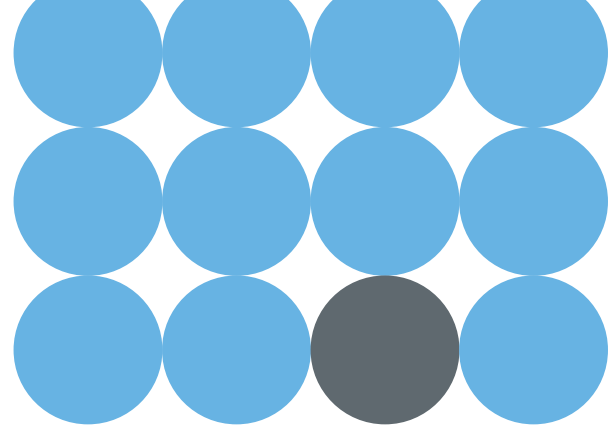


Social Justice Brief

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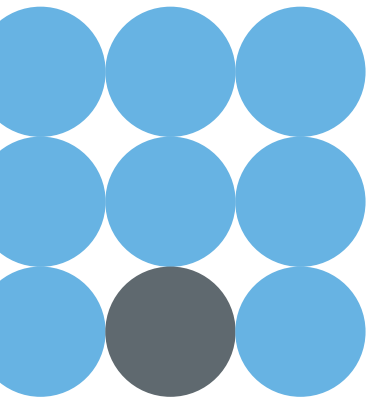


Addressing COVID-19 and Correctional Facilities: A Social Work Imperative



The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty.





Addressing COVID-19 and Correctional Facilities: **A Social Work Imperative**

The COVID-19 pandemic has quickly spread in many of the nation's jails and prisons. Policymakers, correctional staff, and public health service providers can play an important role in responding to the prevention and urgent service needs of people impacted by incarceration who are particularly vulnerable, directly and indirectly, to the effects of the novel coronavirus of 2019 (COVID-19).

The discussion to follow will examine the degree to which COVID-19 has permeated not only adult jails and prisons, but also juvenile detention centers. We will review the existing policies and practices related to communicable disease prevention and treatment in detention facilities. This social justice brief will also identify crucial services required to help incarcerated people receive medical and mental health services, and transition planning to ensure continuity of care as they reenter society.

Background

"Correctional health is public health." We say this often, but what does it mean? The correctional health service delivery system has implications for people incarcerated and staff working in the facilities but also an impact on community health as people come and go between correctional facilities and community settings. The COVID-19 pandemic highlights the critical need for ongoing collaboration among public health professionals, including infectious disease specialists, epidemiologists, social workers, community health workers, and correctional

health experts. The pandemic also draws much needed attention to socioeconomic and minority health disparities, as many communities have disproportionate rates of the underlying health conditions that are risk factors for COVID-19 infection. Certain minority groups are also overrepresented in correctional populations, especially in jails and detention facilities, which can quickly swell to become epicenters of disease.¹

Relatively speaking, the progression of COVID-19 moved quickly through major urban areas from the first confirmed case in the United States on January 23, 2020.² Within that period, which began with very sketchy demographic and epidemiologic data, we now know there are segments of the American population that are at higher risk for contracting the virus, are subject to poor health outcomes, and will ultimately die at a disproportionate rate. Recent and more refined data now show that men and women who are incarcerated (or employed) in the nation's jails and prisons are at high risk for contracting and dying from COVID-19.

COVID-19 Prevalence in Jails and Prisons

The United States has the world's largest total incarcerated population with close to 2.3 million people on average daily,³ with more than half (1.3 million) incarcerated in state prisons. Local jails and federal facilities account for over 85,000. This count does not include 44,000 youths held in juvenile detention⁴ and over 50,000⁵ people held in immigration detention facilities.

As of June 2, 2020, at least 40,656 people in prison had tested positive for COVID-19, and approximately 496 incarcerated individuals have died from the disease.⁶ The average daily population in jails and prisons does not account for the constant movement of staff in and out of correctional facilities on a daily basis. It also does not include the residents of communities where correctional employees live, yet all these are people at higher risk of COVID-19 infection.

Jails and prisons are filled with people who are at higher risk for COVID-19 than the general public. Over the years, the United States has filled correctional facilities to the point of overcrowding, with many of these men and women having high rates of serious health problems.

Vulnerability of Nation's Correctional Institutions in Spreading COVID-19

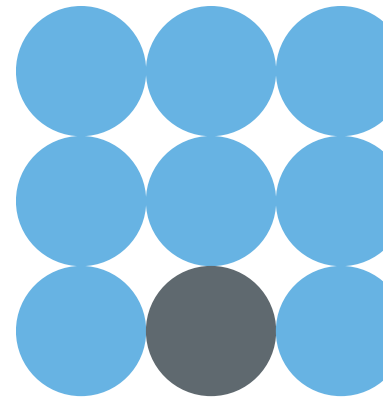
Justice involved populations have an increased prevalence of infectious diseases such as HIV and hepatitis C virus (HCV) infections and tuberculosis – and now coronavirus. Disparities in social determinants of health affecting groups that are disproportionately likely to be incarcerated —

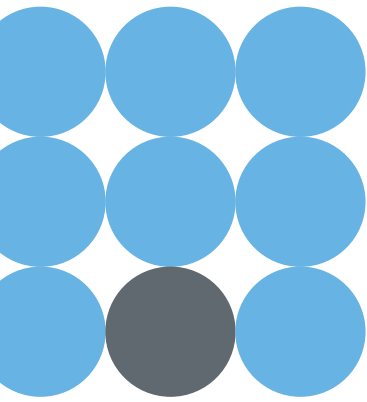
racial minorities, persons who are unstably housed, persons with substance use disorders or mental illness — lead to greater concentrations of these illnesses in incarcerated populations.⁷ However, employing interventions to respond to these conditions is difficult to achieve in correctional settings due to limited resources allocated to this need in correctional budgets.

Every year there are 600,000 admissions to prisons and 10.5 million admissions to jails.⁸ Most people admitted to jails, unlike prisons, have not been convicted and may pay bail soon after admission, although those too poor to pay bail will be detained in between court appearances. The minority are people sentenced to short stays, generally one year or less. At least 25% of people admitted to jail will be reincarcerated within the same year—generally for issues related to poverty, substance use (20%) and, untreated mental health conditions⁹, which worsen as a consequence of incarceration. In addition to returning to the community, people detained in local jails may be transferred to local hospitals, other jurisdictions, or other correctional facilities.¹⁰

As would be expected in congregate living environments, prisons and jails are virtual petri dishes for the COVID-19 virus¹¹, with close quarters and significant challenges to maintaining basic sanitary conditions. A clearer picture of major COVID-19 infection rates in larger states and those with large prison populations has emerged.¹²

- » Cook County jail was dubbed the “largest-known source” of coronavirus cases in the U.S.¹³ Nearly one in six COVID-19 cases in Chicago and Illinois





can be traced to people moving through the Cook County jail. In early April 2020, at least 238 incarcerated people and 115 staff tested COVID-19 positive.¹⁴ Significantly, the majority of the jail system's approximately 4,500 incarcerated population had not undergone testing. Another study found cycling through Cook County jail was associated with 15.7% of all documented cases of the virus in Illinois and 15.9% in Chicago through mid-April.¹⁵

- » In Arkansas prisons, it was recently reported that 690 incarcerated and 30 staff were infected with COVID-19.
- » In the California Department of Corrections prison facilities,¹⁶ 149 incarcerated and at least 105 staff tested COVID-19 positive in just a single week.
- » At Marion Correctional Institution in Ohio, it was reported¹⁷ that 73% of the incarcerated tested COVID-19 positive.
- » In the New York City jail system (including Rikers Island), there were 370 confirmed incarcerated patients with COVID-19 on May 8, 2020, down from a peak of 381 on April 27, 2020. As of May 8, 2020, a cumulative total of 1,420 staff tested positive for COVID-19 with over 87% correction staff and the remainder correctional health staff. Three patients died in correction's custody at the public hospital;¹⁸ and at least seven correction staff deaths are attributed to COVID-19 from March 15 to April 22, 2020.¹⁹

Jail and Prison Staff at Risk

More than 8,400 prison staff members have tested positive. However, only 34 deaths have been publicly reported.²⁰ This clear under-reporting demonstrates how problematic

it is that there is no mandatory national reporting on COVID-19 prevalence by all congregate living facilities. That said, a primary concern for community exposure to COVID-19 is the daily movement of staff in and out of correctional facilities, generally across three shifts over a course of 24 hours a day. This flow creates exponential risk for the spread of COVID-19 not only to the staff, but also to the communities in which they live.

Because of the risk for COVID-19 infection that this continuous movement presents, it is important that corrections' administrators implement protocols²¹ that are formulated specifically for infectious disease prevention. The protocols would follow public health protocols similar to skilled nursing facilities such as daily COVID-19 testing of staff and reporting to public health agencies for contact tracing, isolation and quarantine to reduce the risks of ongoing transmission.

Jail and Prison Operational Standards in the Era of COVID-19

The COVID-19 crisis may have inadvertently triggered a necessary change in how prisons and detention centers protect detained individuals and staff against infectious diseases—a recognition that it is imperative that congregate living facilities must operate under uniform national standards.²² As discussed, COVID-19 is not the first infectious disease crisis to pervade jails and prisons. We need only to reflect on the public health concerns about the transmission of HIV/AIDS among incarcerated individuals. As with the current COVID-19 crisis, it has been well documented that there are high prevalence rates of HIV infection among the incarcerated making prisons high-risk environments for the spread of HIV.²³

Just as public health researchers and professionals advocated for HIV education, voluntary HIV testing and counselling, and provision of antiretroviral treatment for incarcerated HIV-positive patients, there is an emerging call for similar national standards for COVID-19. The following are examples of proposed and existing uniform standards for responding to COVID-19 in jails, prisons, and other centers for detention:

- » California Department of Corrections and Rehabilitation: [COVID-19 Preparedness](#)²⁴
- » Centers for Disease Control and Prevention (CDC): [Interim Guidance on Management of Coronavirus Disease 2019 \(COVID-19\) in Correctional and Detention Facilities](#)²⁵
- » National Commission of Correctional Health Care: [COVID-19 Coronavirus: What You Need to Know in Corrections](#)²⁶
- » National Sheriffs Association: [Information for Handling COVID-19 in the Jails Setting](#)²⁷
- » Vera Institute of Justice: [Guidance for Preventive and Responsive Measures to Coronavirus for Jails, Prisons, Immigration Detention and Youth Facilities](#)²⁸
- » World Health Organization: [UNODC, WHO, UNAIDS and OHCHR Joint Statement on COVID-19 in Prisons and Other Closed Settings](#)²⁹

Identifying Those at High Risk for COVID-19 in Jails and Prisons

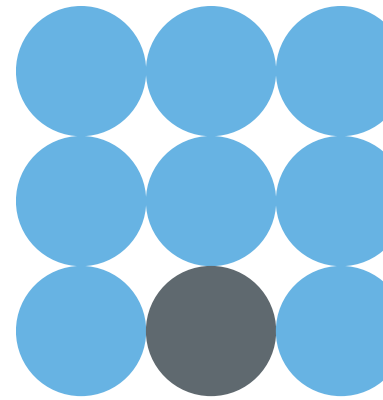
Without a doubt, the most vulnerable people incarcerated in jails and prisons are those over 55 years of age. It is widely accepted that the incarcerated aged 55 and older often physically and cognitively present similarly to someone 10 or more years older from the general population. For that reason,

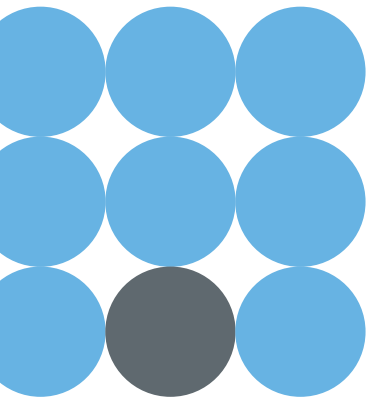
correctional medical and mental health providers classify the incarcerated 55 and older as being elderly, for treatment purposes.³⁰ It is hypothesized that the incarcerated often have histories of poor health and limited access to health care prior to incarceration. After incarceration, people, especially those confined for decades, often age prematurely and develop chronic health conditions, such as diabetes, cancer, high blood pressure, and heart disease, at an earlier age than their counterparts in the general population. These pre-existing health conditions put older people confined in prisons at a higher risk of complications following COVID-19 infection.³¹

Based on currently available information and clinical expertise, treatment plans should identify incarcerated people age 55 and older, particularly those with pre-existing health conditions,³² as presenting with high risk and adopt protocols consistent with the higher level of care needs associated with older adults.³³

Mental Health

There is a high rate of serious mental illness in the country's jails; half of all those incarcerated in state and federal prisons have either a chronic medical or a mental health condition.³⁴ Therefore, presenting mental and cognitive disorders should also be considered when people are required to adhere to COVID-19 social distancing and related protocols during incarceration. Such underlying conditions are of concern due to the potential for extreme anxiety or emotional trauma associated with incarceration as well as COVID-19 safety requirements such as social distancing. Similarly, those with communication and physical mobility disorders





may face challenges with social distancing and have additional barriers to access medical care due to physical limitations.

Need for a Coordinated National Plan for COVID-19 Testing and Contact Tracing

As of this writing, there is no national COVID-19 oversight body that would coordinate prevention, testing, and treatment across correctional facilities. A national coordinating entity could be effective in working with correction administrators and correctional health leadership to develop best practices and establish protocols for COVID-19 testing and contact tracing³⁵ consistent with and informed by a standardized national testing and contract tracing plan.³⁶

The testing rates, prevention and treatment protocols, and best practices for addressing COVID-19 are inconsistent throughout the nation's correctional departments. A more uniform approach would facilitate getting a handle on states whose jails and prisons are being more severely impacted by the virus. A national COVID-19 testing and contact tracing plan would also go a long way toward addressing undercounts of infection rates, as well as helping to formulate allocation of medical and prevention resources based on rates of infection.

Epidemiologic Data Surveillance Tracking/Racial Disparities

However, planning best practices for handling COVID-19 and other infectious diseases in correctional and detention centers is hampered by the relatively limited availability of reliable national prevalence and disease transmission data. More

important, there is a paucity of disaggregated COVID-19 prevalence data that capture race, ethnicity, and age.

Disaggregated COVID-19 prevalence tracking in the United States is very inconsistent. For instance, in at least three states, officials confusingly comingled probable with confirmed COVID-19 death counts, which creates ambiguous cause-of-death data at best. Compounding this confusion, most do not specify how they are counting deaths.³⁷ Louisiana, Nebraska, Nevada, and New York do not report the racial or ethnic breakdown of COVID-19 cases; other states do not provide a racial analysis of COVID-19 deaths.³⁸ If we depend on state-reported data, it continues to be unclear exactly many Black people have died of COVID-19—the paradox is that these data have been reliably tracked using nongovernmental resources.³⁹ The existing disparities are concentrated and compounded by the U.S. system of mass incarceration.⁴⁰

Reducing Prison and Jail Populations (Decarceration)

Because jails are veritable incubators for viruses and COVID-19 prevention methods such as social distancing are impractical,⁴¹ other means of impeding its spread have to be explored. One idea that has increasingly gained currency among criminal justice reform advocates and public health professionals is to reduce the jail and prison populations to greatly mitigate overcrowding.⁴² Decarceration to reduce COVID-19 risk has been adopted at the federal,⁴³ state, and local jurisdictions across the U.S.

Members of the medical community are proponents of “Decarceration” as a

COVID-19 prevention tool, prioritizing both individuals who present low-risk to community safety or the older and seriously ill.⁴⁴

Recommendations for those who remain incarcerated includes:

- 1) Isolate people infected with COVID-19, providing access to healthcare and services and do not house in solitary confinement;
- 2) Quarantine people exposed to COVID-19, with limited movement, and separate from the general population;
- 3) Hospitalize the seriously ill; and
- 4) Identify staff (correctional and health care providers) infected with COVID-19 early who have recovered⁴⁵ for potential assignment to units with people in isolation or quarantine.

Alternatives to Incarceration and Early Release

There is no dispute that people entering and exiting correctional facilities—including staff—deserve priority attention from government and public health officials due to greater risk of COVID-19 infection than the general population. In adhering to best practice guidelines for COVID-19 prevention, courts, district attorneys, and local and state elected officials must take steps to reduce the incarcerated population.

As a result, integrating alternatives to incarceration into the adjudication process becomes a priority form of court-sanctioned sentence, as opposed to serving time in jail. Choosing alternatives to incarceration offers public health benefits for those who remain incarcerated, the staff and the community at large by decreasing opportunities for COVID-19 exposure.

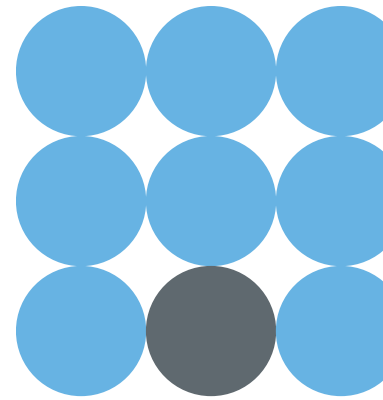
Reducing Arrests and Bookings for Minor Nonviolent Crimes

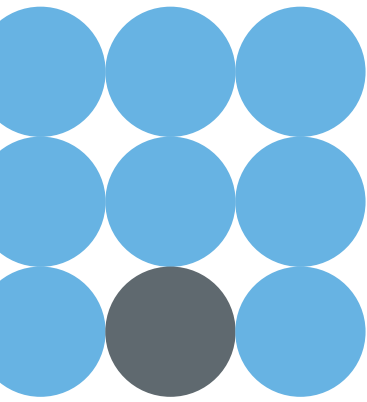
The COVID-19 outbreak has affected the

criminal justice process in a number of arenas, including law enforcement decision making for minor violations. There is consensus that reducing jail populations also reduces transmission of COVID-19 and policies that facilitate alternatives to incarceration are one viable and proven approach. For example, COVID-19 shelter-in-place orders are usually enforceable by law. For most jurisdictions, violations of social distancing orders are misdemeanors. However, police officers are instructed to adopt an educational approach, explaining the public health order and issuing a warning.⁴⁶ This community education approach serves to avoid exacerbating existing jail overcrowding by locking up shelter-in-place violators. Similar law enforcement tactics can be applied to many other nonviolent minor misdemeanors.

Alternate sentencing options include placement in mental health and substance use treatment facilities, and nursing home and hospice care placements through use of existing compassionate release policies. Although the federal Bureau of Prison's COVID-19 policies on compassionate release proved to be less than stellar,⁴⁷ such community alternatives, coupled with community supervision and court collaborations, led to safer single person housing, access to therapeutic treatment and reduced length of incarceration.

Recently, the American Civil Liberties Union (ACLU) partnered with epidemiologists,⁴⁸ mathematicians, and statisticians to create an epidemiological model that shows that if we ignore incarcerated people in the country's response to COVID-19, as many as 200,000 people in the general population could die from the virus. Given such dire predictions,





the ACLU and others have proposed that law enforcement agencies switch from arrests to summons or tickets to reduce the consequences of arrests on minor charges that are not public safety threats. The ACLU also supports early release⁴⁹ from jails, prisons, and immigrant and juvenile detention facilities. By adjusting policing and sentencing policies, we can prevent as many as 23,000 COVID-19 infections among people incarcerated and 76,000 in surrounding communities outside correctional facilities.⁵⁰

Pretrial Confinement as a Factor in Early Release

Prior to the COVID-19 pandemic, an individual arrested in the United States who was either denied bail or unable to post bail was likely to be detained in jail for between five and 200 days awaiting trial.⁵¹ The average time detained in a U.S. jail pretrial is about 35 days. Social distancing policies that shut down business activities also significantly curtailed activities in the nation's criminal legal system. More important, many criminal trials have been postponed, which means that pretrial detention will be lengthier. These delays in court hearing, coupled with already overcrowded state prisons and jails, lead to very dense populations at high risk for COVID-19 infections. Recently, prison systems in Florida and California discontinued new admission intakes as a precaution in fighting COVID-19 infections.

In response, some police departments have begun to use "cite and release"⁵² policies for low-level offenses. The concern for spread of COVID-19 in jails has become so immediate that many states and counties have been decarcerating people charged with less serious, non-violent crimes. In addition, bail is being

vacated for some and others are placed on home detention. For example, a Maryland Court of Appeals chief judge issued instructive orders⁵³ for state district and circuit court judges recommending that they consider outright dismissals and alternatives to incarceration for pretrial detainees during the pandemic.

Public Health, Reentry Transition Planning, and Continuity of Care

Since the beginning of the COVID-19 crisis, criminal justice and public health advocates have been seeking to reduce the incarcerated population to stem the spread of the virus. However, the rapid return to the community may not have left time for structured transition planning, leaving concerns about limited access and availability of health care, housing, transportation, food, and other essential services for the returnees.⁵⁴

The terms *reentry or transition planning*⁵⁵ generally describe a set of practices or activities that support the goal of successful linkage to and continuity of care after incarceration. The concept of transition planning has been a standard for the social work profession for many years. The practice was initially used in hospital settings, and has been adapted for those returning to the community after a period of incarceration. The process is fairly straightforward.

Effective transfer protocols and discharge planning strategies can facilitate safer reentry by including public health considerations. Transitional planning and linkages to care interventions need to adapt to current physical distancing requirements. While traditional handoffs from one provider to another through interactions with jail-based

social workers and community health workers are significantly limited during this period of social distancing, adaptive strategies and approaches are being used to facilitate a successful transition despite physical distancing.

Reentry planning is usually somewhat of a nerve-racking and strained experience for the client and the case manager staff assigned to assist with the process. After incarceration, people returning to their communities often lack the social supports needed to navigate through rules and regulations to obtain needed essential services.

Perhaps the most important reentry need in the era of COVID-19 is transitional linkages to community-based health care, mental health care, and substance use treatment. Many of these services are deficient behind bars, particularly at local and county jails. Reentry planning at a time of extreme physical and mental health risk⁵⁶ is of critical import.

Reentry Needs Assessment and Planning Process during the COVID-19 Crisis

Reentry planning activities usually include, at a minimum, an individualized assessment and a written discharge plan. Terminology can vary but, in general, case managers administer a needs assessment designed to identify what people will need on return to the community after incarceration.⁵⁷

For prisons, reentry transition planning begins in earnest within six months of planned community return. For jails, such planning begins on the first day of incarceration. Basic transitional plans include:

- » Housing
- » Continuity of care for medical, mental health, and substance use treatment

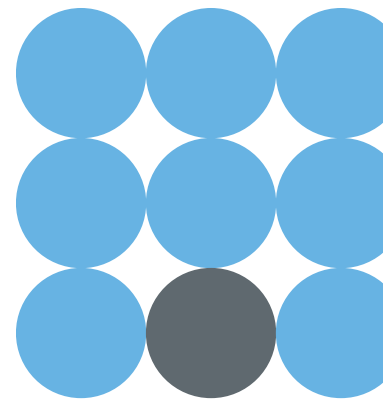
(including making appointments)

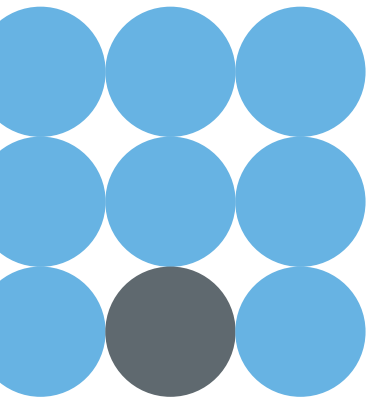
- » Health insurance
- » Employment
- » Benefits (information about obtaining supplemental nutrition, Social Security and Disability, veteran services)
- » Probation and parole coordination
- » Victim and public safety notifications
- » Obtaining identity documents
- » Linkages to community resources

It should be noted that of the needs listed above, safe and affordable housing is perhaps the most important and the least available. Therefore, reentry planning during the COVID-19 crisis must recognize that linking people to permanent community-based housing after incarceration presents additional challenges.⁵⁸

In any case, COVID-19 has altered the transition planning process. The Council of State Governments' (CSG) Justice Center suggests that during the COVID-19 crisis, reentry transition planners, policymakers, and corrections administrators ask seven key questions:⁵⁹

- 1) Are there procedures in place in advance of community return to ensure that the person is free of COVID-19, and are they implemented in a timely manner to avoid unnecessary delays?
- 2) Does the person have the basic supplies they need—food, hand sanitizer, and so on—to ensure they remain healthy once they are home?
- 3) Does the person have a safe home to return to that is also virus-free? If not, what alternative community-based housing options may be utilized?
- 4) What medical or behavioral health medications and services does the person





require immediately and potentially during a two-week quarantine? Do arrangements need to be made for them to access some of those services virtually?

- 5) Have we prepared the person with the technological literacy and equipment to receive and benefit from virtual, rather than in-person, supports?
- 6) If the person is being released or restored to the custody of parole or other community supervision, how are we asking them to interact with their parole officer in a time of social distancing?
- 7) If the local economy has collapsed, are we providing the person with access to public benefits to support themselves and their loved ones?

CSG emphasizes the importance of reexamining reentry planning, underscoring the need for a collaborative effort to address these seven questions. They see it as an interdisciplinary coalition of corrections administrators; housing providers; health care professionals; and local, state, and federal policymakers. It should be added that the interdisciplinary collaboration must include behavioral health practitioners and transition planning professionals. However, the social work profession agrees that “it’s imperative that we embrace this crisis as an opportunity to ensure better outcomes at release by planning ahead and cooperating across systems.”⁶⁰

There are several federal and local demonstration projects that have been implemented and sustained that offer approaches to transition planning and continuity of care and treatment for people impacted by mass incarceration. Not surprisingly, these efforts have been led and

developed by social workers. During the COVID-19 crisis, it is important to adapt evidence-informed interventions as we cannot wait to evaluate demonstration projects in the midst of this crisis. For example:

- » **Support services available at hotels and other alternatives to congregate housing:** Station case managers and social service staff in safe spaces at hotels or supportive housing residences tailored to vulnerable populations—the elderly; people living with HIV, mental illness, or substance use disorder; and others who are unstably housed. Staff must be appropriately trained and follow public health guidelines for physical distancing and personal protective equipment.
- » **Home delivery:** Food, documentation, medication, and supplies can be delivered and coordinated to maintain essential needs following public health guidelines for drop-off and pickup.
- » **Information technology solutions:** Telehealth or video conferencing and Web-based applications can be adapted for screening, prevalence mapping, case management support, and more. Community corrections, including parole and probation, is moving to telephone appointments to facilitate supervision and supports, such as locating support groups and assisting with online applications for unemployment benefits.

Social Work Model for Correctional Transition Planning

Transition planning for those returning to the community after incarceration and detention is often overlooked as a necessary component to decarceration to reduce COVID-19 risks. Transition planning during

incarceration is key to facilitate a warm transition including access to essential social services, health care, mental health and substance use treatment on return to the community. Evidence-informed interventions are needed to implement reentry planning and continuity of care and services including:

Transitional Care Coordination

Transitional Care Coordination (TCC),⁶¹ is an evidence-based intervention based on social work principles using a public health approach (see Figure 1). Supported, recognized, replicated, and distributed by the Health Resources and Services Administration, the TCC intervention has demonstrated significant health and social determinant outcomes six months after incarceration, including (1) improved clinical indicators and increased rate of viral load suppression; (2) fewer visits to the emergency department, from an average of 0.60 per

person in the six months prior to baseline to .20 visits at follow-up; (3) reduced housing instability and food insecurity from over 20% at baseline to less than 5% at follow-up; and (4) individuals self-reported feeling in better general health.⁶²

Medicaid as an Essential Program for Transitioning Individuals during the COVID-19 Crisis

While *Estelle v. Gamble* made the incarcerated population the sole group with a constitutional right to universal health care, under Social Security law known as the “Medicaid Inmate Exclusion Policy”, public health insurance is prohibited for people during incarceration.⁶³ Thus, there are no required regulations of health services provided in correctional facilities. Although the National Commission on Correctional Health Care offers standards, there are no regulatory requirements.

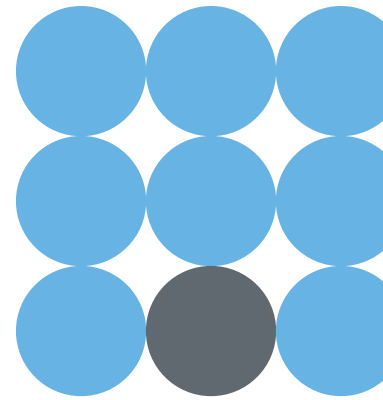
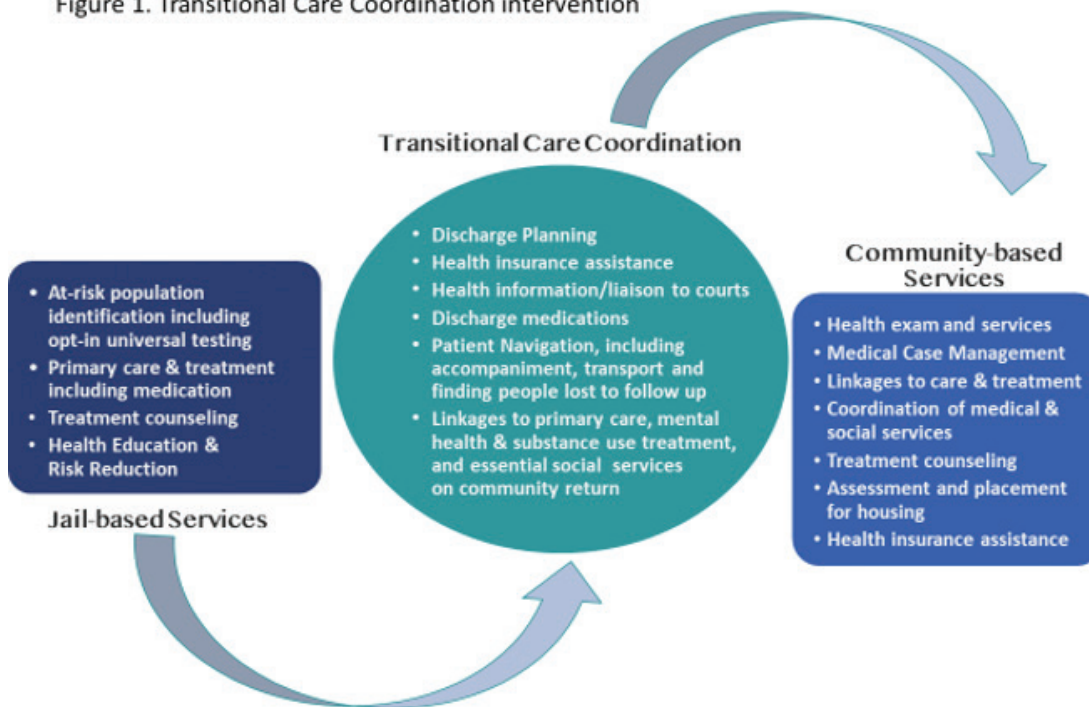
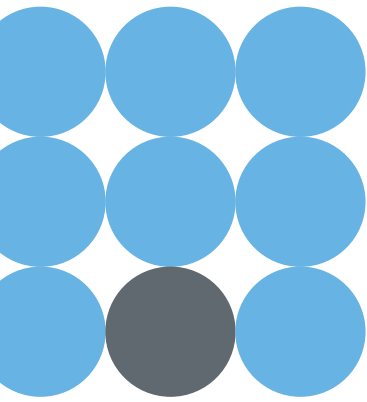


Figure 1. Transitional Care Coordination intervention





This is important, especially for jails, because health care expenses are the responsibility of local government with a wide range in the quality of services provided based on local policies and economics, with some jurisdictions charging people for health care services during incarceration and others providing health care comparable to the community standard of care.

An updated policy brief⁶⁴ makes it clear that Ryan White HIV/AIDS program funding may be used to provide medical, mental health, and discharge planning services for people living with HIV/AIDS (PLWH) during incarceration—from intake to 90 days after incarceration from jails and as part of reentry planning in prisons. Continuity of Medicaid is needed for all.

Similarly, in response to the COVID-19 public health emergency, the Centers for Medicare & Medicaid Services developed a new Medicaid Section 1115 demonstration opportunity and application template.⁶⁵ These demonstration projects are intended to help states provide medical services to safeguard the health, improve safety, and promote the welfare of individuals (and providers) affected by COVID-19. As of May 2020, as many as 15 states have submitted Section 1115 COVID-19 emergency waivers. The hope is that states will use the 1115 waivers for COVID-19-affected people in jails and prisons.

NASW is a co-leader of a criminal justice behavioral health work group along with National Alliance on Mental Illness and the American Psychiatric Association that has taken a public position on the issue of Medicaid access. The work group's position

is that jails and prisons serve as the default providers of mental health care for the nearly 2 million people with mental illness who are incarcerated every year. Federal law prohibits Medicaid from financing the care of anyone committed to a jail, prison, detention center, or other correctional facility. This policy has resulted in states terminating or suspending Medicaid benefits for people who are incarcerated. Once incarcerated, the individual's health care becomes the responsibility of the state and local governments that run over 1,700 state prisons and 3,000 local jails nationwide. Because of the high coronavirus risks, the workgroup made the argument that extending Medicaid to incarcerated individuals reentering the community is fiscally sound and reasonable and makes good sense for public health.

Such a Medicaid policy also makes sense because shifting between two systems of health care causes many people to become disconnected from treatment, negatively affecting their overall health. The COVID-19 pandemic adds urgency to increase access and continuity of care for people who are leaving criminal justice settings. Many states and local jurisdictions are implementing large-scale depopulation as a way to control the spread of the virus inside jails and prisons. The aforementioned challenges already require stress management, and a public health epidemic such as COVID-19 is likely to exacerbate their mental health needs, the need for Medication Assisted Treatment, other drug treatment services, and harm-reduction services to help prevent drug overdose after incarceration.

Related Federal Legislation

It is important that people entering and exiting correctional facilities as determined by the courts have access to and continuity of health care, consistent with the community standard of care, especially during this pandemic. The bipartisan Medicaid Reentry Act⁶⁶ would allow Medicaid to pay for care for the incarcerated during the 30-day period prior to projected community return. Enacting this bill as part of the next phase of COVID-19-related legislative package would ensure health care coverage after incarceration and facilitate immediate coverage of community health care, protecting local resources already strained by the pandemic.

This legislation would also support the mental health needs of people after incarceration and curb risks of overdose, suicide, or reincarceration. These supports are critical when considering the myriad challenges people face after incarceration including finding employment; dealing with housing instability and food insecurity; and processing the emotional impact of experiences faced before, during, and after incarceration.

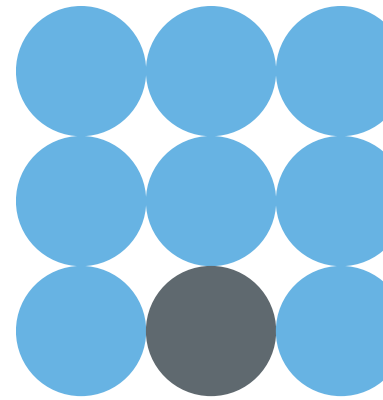
Resources

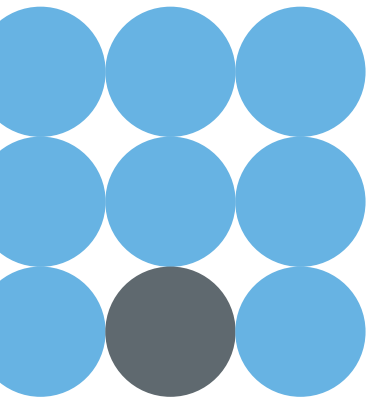
There are many organizations that have weighed-in on how to best anticipate, plan for, and respond to infectious disease outbreaks in congregate living environments such as correctional and detention facilities. This, of course, is not new. In previous years when HIV/AIDS was reaching epidemic proportions in jails and prisons, there were similar efforts to develop evidence-based best practices for treating PLWH and establishing best practices for continuity of care after incarceration. For example, the Transitional Care-Coordination (TCC) intervention⁶⁷ was

implemented for HIV populations in New York City jails, including Rikers Island. The TCC Tools & Tips Handbook⁶⁸ developed for direct service staff has relevance for adapting best practices during the current COVID pandemic.

COVID-19-specific resources for correctional health providers addressing testing, medical treatment, infectious disease prevention and transitional planning include:

- » Amend, Inc., University of California at San Francisco: *Guidance on COVID-19 to Correctional Facilities*;
- » American Bar Association: *Reentry Planning for COVID-19 Releases*;
- » Brennan Center for Justice: *Police Responses to COVID-19*;
- » Community Oriented Correctional Health Services: *Policy Guidance to build connectivity between jails and community health care providers*;
- » Hampden County Sheriff Department: *A Public Health Model for Correctional Health*;
- » National Association of Social Workers (NASW), Social Justice Brief: *COVID-19's impact on a range of vulnerable populations*;
- » Project START: *A CDC linkage and risk reduction evidence-based intervention for people living with HIV returning to the community after incarceration using a health education/risk reduction approach to behavior change*;
- » The Sentencing Project: *Protect Incarcerated People from COVID-19*;
- » Urban Institute: *Release Planning for Successful Reentry*; and
- » Vera Institute of Justice: *Coronavirus Guidance for the Criminal and Immigration Legal Systems*.





Conclusion

The current COVID-19 pandemic is not the first infectious disease crisis to strike correctional facilities.⁶⁹ Thus, one might expect that the nation would have had policies and best practices in place to uniformly respond to the COVID-19 outbreak. Instead, the lack of universal health policies, regulations, and practices to address correctional public health has been brought to the forefront with dire consequences. As the nation's correctional systems and public health professionals have had to scramble to cobble together COVID-19 standards, facility operational protocols, and comprehensive medical and psychosocial best practices to address this impact of this pandemic, it is time to reflect and prepare before the next crisis.

What has become clear is that there is a need for the following:

- » Health care access and removal of the “Medicaid Inmate Exception” policy⁷⁰
- » A national correctional infectious disease coordinating body with state and local liaisons to facilitate operations using a public health approach⁷¹
- » National standards for transitional care planning and coordination for people living with chronic and communicable health conditions, substance use disorders, and mental illness; this model should incorporate the factors of social determinants of health priorities in linking people to community services after incarceration
- » National policies that reflect a concerted effort to eliminate racial disparities in access to health care, social services, and related services, with consideration of the additional challenges during and after incarceration

- » Best practices for responding to epidemic-level infectious disease outbreaks including requirements that all jurisdictions collect and maintain disaggregated data by race and ethnicity using public health epidemiologic standards.

It is important that in the face of national emergencies such as the COVID-19 pandemic, the nation's correctional, health and public health systems build, train, and sustain a comprehensive workforce that is readily prepared to mobilize on short notice. Health and social service professionals, including social workers, medical providers, mental health clinicians, substance use and harm reduction specialists, and community health workers, can impact the health and wellness of communities through public health interventions and approaches during this time of crisis. Collectively, these multi-disciplinary professionals have the training, tools, and resources to collaborate across disciplines and address the issues faced by our nation's most vulnerable populations, primarily Black and ethnic minorities. Social workers must collaborate across helping professions and leverage our collective expertise as an essential resource to fight the COVID-19 pandemic and to be better prepared to address future public health crises.

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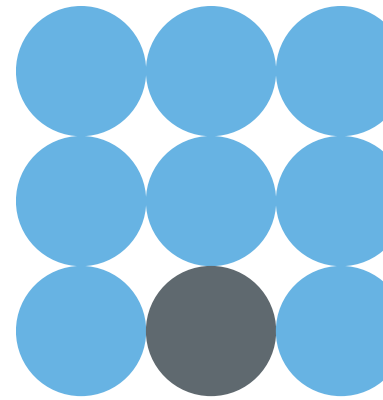
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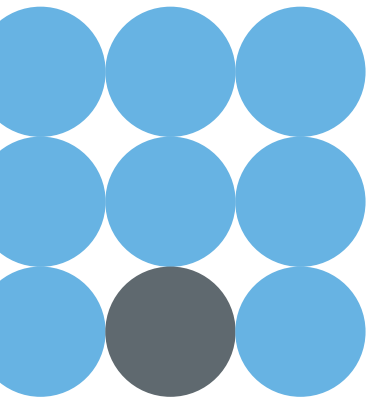
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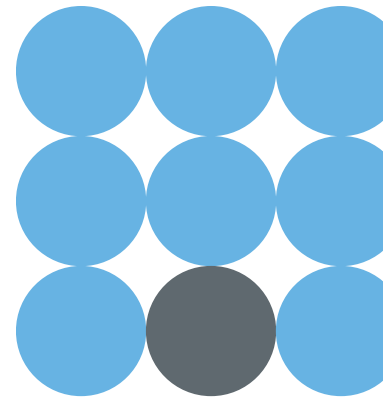
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NASW Resources

NASW » [SocialWorkers.org](https://www.socialworkers.org)

NASW Foundation » [NASWFoundation.org](https://www.naswfoundation.org)

NASW Press » [NASWPress.org](https://www.naswpress.org)

NASW Assurance Services, Inc. » [NASWAssurance.org](https://www.naswassurance.org)

Find A Social Worker » [HelpStartsHere.org](https://www.helpstartsHere.org)

Social Work Blog » [SocialWorkBlog.org](https://www.socialworkblog.org)

NASW Research and Data » [SocialWorkers.org/News](https://www.socialworkers.org/news)

Social Work Advocacy » [SocialWorkers.org/Advocacy](https://www.socialworkers.org/advocacy)



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