

Provision of health care for prisoners during the COVID-19 pandemic: an ethical analysis of challenges and summary of select best practices

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Abstract

Purpose – This paper aims to analyze the COVID-19 pandemic response in prisons, focusing on the USA, which imprisons a higher percentage of its population than any other country in the world.

Design/methodology/approach – This paper evaluates the current pandemic response in prisons based on legal and ethical imperatives for providing health care to prisoners.

Findings – Themes of best practices identified include increasing rapid detection of new cases, reducing transmission and advocating for both short- and long-term ethical health care policies. Halting progress now could risk dire consequences and is unacceptable on legal, ethical and public health grounds.

Research limitations/implications – This paper does not involve primary research with prisoners; rather it focuses on reviewing the pandemic response in prisons. Although it may be possible to translate findings in this study to similar environments (e.g. jails and detention centers), there are unique characteristics pertaining to each that deserve separate, focused analyses.

Originality/value – Outbreaks that occur within prisons are likely to spread to the community and vice versa. Analyses based on ethics, law and public health point to the same conclusion: preventing significant outbreaks within prisons will benefit not only prisoners but also the general public. Furthermore, even though the scientific understanding of the pandemic may change with future research, the ethical and legal principles highlighted in this paper will continue to be foundational when considering just care for prisoners.

Keywords USA, Prisons, COVID-19, Equivalence of care, Confinement, Deliberate indifference

Paper type Research paper

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1. Introduction

There is growing awareness about the potential for structural inequities to impact the distribution of care in the COVID-19 pandemic. This has become particularly evident with the provision of care within prisons, places of confinement for individuals who have been convicted of “serious” crimes and generally given sentences of more than one year. Prisons can have a mix of governmental and private employees subject to different leadership and public health protocols (CDC, 2020a). Prisoners move within the walls of the prison, often in congregate settings as they live, eat and sleep. During their sentence, they have limited movement in the community except for situations such as court hearings, hospitalizations or transfers to other facilities within the prison system. Although it may be possible to translate findings in this article to other types of confinement (e.g. jails or detention centers, which may be locally operated or house individuals awaiting trial), there are unique characteristics pertaining to each of these scenarios that deserve separate, focused analyses. To limit the scope of this article, the following discussion focuses on prisons.

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We also focus most of our attention on the US, which imprisons a higher percentage of its population than any other country in the world (Walmsley, 2018, p. 2). Reports from prisons globally suggest the challenges of pandemic management exist outside the US as well (Burki, 2020; PRI, 2020). As such, we reference peer countries affiliated with the Organization for Economic Co-operation and Development (OECD). We review the legal and ethical imperative for providing health care to prisoners, identify characteristics that make prisoners particularly vulnerable to harm during this pandemic, discuss the current strategies for managing the detection and spread of SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2, which causes the disease COVID-19) within prisons and conclude with a summary of some best practices to help guide ethical provision of care for prisoners moving forward.

We pause here to emphasize the importance of this topic. In addition to the legal and ethical principles that mandate the provision of care to prisoners outside of this pandemic, public health concerns lead us to the same conclusion within the pandemic response. Incarceration facilities are porous. Although barbed wire may separate free and imprisoned persons, there are many people whose daily work requires them to pass between these barriers including physicians, lawyers, correctional officers, housekeeping, repair persons and other prison staff. Outbreaks that occur within these facilities are likely to spread to the community, and outbreaks in communities are likely to spread to prisons. Preventing significant outbreaks within these facilities will, therefore, benefit not only the prisoners who are uniquely situated but also the general public.

2. Providing health care to prisoners

Provision of health care to prisoners is necessitated by ethics and law.

2.1 Ethical obligation

The ethical principle of “equivalence of care” serves as the basis for what the United Nations has outlined as the minimum standard for the provision of health care to prisoners (United Nations, 2015, Rule 24–1, p. 8). This is generally understood to mean the health care provided to prisoners, inclusive of both physical and psychiatric care, is to be equivalent to that which is provided to free persons in the community in that country (United Nations, 2016, p. 9). Often attention on this principle becomes a measure for addressing situations in which the care provided to prisoners is inferior to that in the community (PRI, 2020), a situation more apt to occur when the net resources available to the combined incarcerated and free populations are strained, such as during a pandemic.

Even when care is “equal,” some have referenced this principle in calling for reform. For example, recognizing that the needs of an average prisoner may be different from, and often greater than, that of a member of the general public (Maruschak, Berzofsky, and Unangst, 2016), some organizations have advocated for “equity” instead of “equality” of care for prisoners (Royal College of General Practitioners, 2018). Although equal care for prisoners may be sufficient in many case studies, we assert that this expanded standard of equivalence, which focuses on equity is necessary when some characteristics of the prison population diverge substantially from the general population.

In addition to equivalence of care, a review of international and multiple OECD countries' guidelines for provision of health care to prisoners revealed shared emphasis of the ethical principles of justice (narrowly defined by Jotterand and Wangmo (2014) as access to care), respect for autonomy and respect for human dignity (2014). This is not an exhaustive list of ethical principles that apply to this topic and there is notably overlap between these principles, but we use these four shared principles to focus the following discussion.

2.2 Legal mandate

Equivalence of care is the foundation for laws mandating the provision of health care for prisoners in many OECD countries. The development of law with similar intent in the US does not, however, directly mention this principle. Instead, it relies on the principle of respect for human dignity, understood to be the foundation of the Eighth Amendment to the US Constitution, which prohibits cruel and unusual punishment (*Trop v. Dulles*, 1958). Several US Supreme Court cases have helped clarify the expectation of this care for prisoners. In these cases, the court chastised officials for “deliberate indifference,” officially defined in *Farmer v. Brennan* (1994) as behavior that is objectively reckless as operationalized.

Helling v. McKinney (1993), a case, which is more directly translatable to the current pandemic, illustrates this well. In this case, the court ruled prison staff had demonstrated deliberate indifference when subjecting prisoner McKinney unwillingly to secondhand smoke from cellmates because:

1. There was objective data demonstrating these inhaled particles posed risks to his future health.
2. This was not a risk tolerated by the current society.

It is important to note that *tolerated* and *accepted* by today's society are not identical in meaning here. For example, the paucity of comprehensive smoking bans in the US in the early 1990s (Cummins and Proctor, 2014) suggests many found the risk of secondhand smoke *acceptable*. However, guided by the most updated scientific opinion, the court still found that unwilling exposure was *intolerable*. Similarly, in the current pandemic, even if an individual may *accept* the increased risk of exposure to SARS-CoV-2 and development of COVID-19 when voluntarily participating in communal gathering without proper personal protective equipment (PPE), there is objective evidence that suggests these practices pose a risk to the individuals' future health. Thus, we argue unwilling exposure of this type is not a risk *tolerated* by today's society.

3. COVID-19 and related challenges in prisons

There are several ways in which the COVID-19 pandemic has been particularly challenging to manage in prisons. In the following section, we review the basic understanding of SARS-CoV-2 and the associated disease, COVID-19, at the time of this writing. We then discuss the overcrowding of prisons, the susceptibility prisoners have to poor outcomes if they contract SARS-CoV-2, and the anticipated psychological repercussions of infection prevention measures in prisons.

3.1 Current understanding of SARS-CoV-2 and COVID-19

At the time of this writing, it is thought that SARS-CoV-2 is primarily spread through respiratory droplets and close contact (WHO, 2020a). This understanding is the foundation for basic public health measures for decreasing the transmission of SARS-CoV-2 (e.g. washing hands, social distancing, wearing face masks and occupying areas with good ventilation). Decreased transmission of the virus decreases the occurrence of COVID-19. There was originally concern that most people who contracted SARS-CoV-2 would quickly develop acute respiratory manifestations of COVID-19 requiring intensive hospital care. Through increased testing and contact tracing measures, it now appears that most individuals who contract SARS-CoV-2 will be asymptomatic or only develop mild respiratory symptoms (WHO, 2020b). This is part good news: only a small percentage of individuals inoculated with SARS-CoV-2 will acutely require extensive hospital resources. However, COVID-19 now appears to be associated with long-term pulmonary, cardiac and psychiatric sequelae (PAHO/WHO, 2020). Furthermore, asymptomatic persons can still

spread the virus and may do so with fewer cues to curb outbreaks in their earliest stages; symptom screening alone is insufficient to identify and slow new paths of transmissions in settings prone to rapid spread because of high rates of silent spreading from pre-symptomatic persons (Kimball *et al.*, 2020). In addition, the impacts on those vulnerable to more significant symptoms are of serious concern in complex settings where spread may be less controlled. Herd immunity has not yet been achieved and vaccine development is ongoing.

3.2 Overcrowding

The ability of SARS-CoV-2 to be rapidly transmitted can quickly result in the acute health care needs of a population exceeding its finite resources. Prisons are particularly opportune locations for rapid spread because of the close living quarters, a risk factor already observed on cruise ships, in nursing homes, in meat packing factories and on college campuses. This situation is exacerbated when prisons are filled beyond capacity, an unfortunate common global reality (PRI/TIJ, 2020, p. 21). Even outside of pandemics, overcrowding violates the human dignity of prisoners [1] (PRI/TIJ, 2020, p. 10) and can directly harm the mental health of prisoners (United Nations, 2013). It also impairs the provision of physical and psychiatric health care (*Brown v. Plata*, 2011).

3.3 Susceptibility to poor outcomes

Impaired provision of health care is particularly problematic because, at baseline, the imprisoned population has an increased rate of chronic medical conditions compared to the general population (Maruschak *et al.*, 2016). These chronic conditions increase prisoners' risk of morbidity and mortality if infected by SARS-CoV-2 (CDC, 2020b). Furthermore, social determinants of incarceration and poor chronic health are also risk factors for poor COVID-19-related outcomes outside prison. For example, poor black communities in the US have had disproportionately high rates of death from COVID-19 (Yancy, 2020).

3.4 Psychological implications of infection control

A third important challenge for consideration is the psychological implications of infection control, especially through social distancing. Using the resources available to attempt social distancing, the Federal Bureau of Prisons (BOP) reduced interfacility transfers and suspended in-person visitation in early March (BOP, 2020a). Then, on March 31, 2020 plans were announced for "inmates in every institution [to] be secured in their assigned cells/quarters" (BOP, 2020b). Originally planned for two weeks, this has since been extended to seven weeks at the time of this writing (BOP, 2020b, 2020c). This is consistent with the timeline of many stay-at-home orders for free persons across the US, based on information supplied by the Centers for Disease Control and Prevention (CDC), a health authority [2] in the US that has developed recommendations for the general public, as well as specific groups of vulnerable populations including prisoners and prison staff (CDC, 2020a). However, this functional confinement can equate to "restrictive housing." Additionally, despite the reassurance from BOP that this plan is "based on health concerns, not disruptive inmate behavior" (BOP, 2020b) it still has strong punitive connotations. Health care providers are placed in a situation of dual loyalty to the patient and the prison system; their evaluation of the patient is used to help determine who the system will place in functional confinement. Although the balance with protection from viral spread is real, restricting movement even in this context has been argued by some to constitute cruel and unusual punishment; (*Torres v. Milusnic*, 2020) especially if housing is restricted in the absence of programming access.

Recognizing the unintended psychological consequences of these measures, BOP increased access to phone and video visitation in line with the direction provided in the [Coronavirus Aid, Relief, and Economic Security \(CARES\) Act of 2020](#) (§ 12003.c1). BOP also proffered that “to the extent practicable, inmates should still have access to programs and services that are offered under normal operating procedures, such as mental health treatment” ([BOP, 2020d](#)). Despite this goal, it is possible that access to psychiatric services in prison, which was already the subject of scrutiny before the pandemic outbreak, may be further limited as resources are directed toward COVID-19 specific physical concerns. This is particularly concerning when there is a growing consensus about the psychiatric ramifications of the pandemic in the community ([Fiorillo and Gorwood, 2020](#); [Galea et al., 2020](#)), a population, which has fewer risk factors and greater access to resources than the imprisoned population.

4. Current strategies

Current strategies for managing the COVID-19 pandemic are based on increasing detection and decreasing transmission, discussed below. Appropriate management of COVID-19 once detected among prisoners is another important component of the strategy but is not discussed due to the limited scope of this article.

4.1 Increase detection

There are two main categories of tests being used in this pandemic, namely, viral tests and antibody tests. Viral tests identify whether a person is *currently* infected with the SARS-CoV-2 virus by analyzing specimens commonly gathered by nasopharyngeal swab or saliva. Antibody tests involve the analysis of blood samples to identify whether a person currently has SARS-CoV-2 antibodies, which indicates inoculation at least two weeks prior to specimen sampling ([CDC, 2020c](#)). Antibodies confer protection against future attacks by the same virus, however, it is not certain at the time of this writing that the SARS-CoV-2 antibodies will confer transient or lifelong immunity. Case reports have indicated that at least a few people have been inoculated with SARS-CoV-2 twice ([Kupferschmidt, 2020](#)), so at the time of this writing, the CDC recommends against antibody tests being used to determine immunity from future inoculation with SARS-CoV-2 ([CDC, 2020d](#)). New means of test sampling continue to develop with increasingly less intrusive options. Additional details that pertain to maximizing the positive predictive value of testing strategies are important but outside the scope of this paper; they may in the future shed light on further improving safe health practices in prison.

Relatively early in the first peak of COVID-19 cases in the US, the positive viral test rate reported among US prisoners was higher than that reported in the community ([Gurman, 2020](#)). Recognizing that the growing percentage of positive viral tests in prisons may be an artifact of limited testing, some states later began administering viral tests to all state prisoners whether or not they endorsed symptoms ([So et al., 2020](#)). At some locations, people who had a positive viral test were given repeat viral tests during their isolation until they had two consecutive negative tests ([Cameron et al., 2020](#), p. 27). This strategy enabled facilities to adhere to strict isolation guidelines for the least amount of time that was necessary, a strategy that prudently managed limited isolation resources and reduced the amount of time that prisoners were subject to functional confinement.

Another strategy to increase prompt detection of new cases focuses on maximizing access to health care within prisons. In the US, one way this can be done is to eliminate medical co-pays for prisoners. These have been promoted within the US as a method to reduce unnecessary medical visits, thereby reducing costs and maximizing resources to where they are needed. Medical co-pays by prisoners, however, have also created barriers to appropriate requests for care. To increase the rate at which prisoners self-report symptoms and expeditiously initiate medical isolation if SARS-CoV-2 positive, many US states have

followed the CDC recommendation (2020a) and reduced or entirely suspended medical co-pays during the pandemic ([Prison Policy Initiative, 2020](#)). These measures are supported by the ethical principle of justice (access to care) and are consistent with the long-term reformation position advocated by the [National Commission on Correctional Health Care \(2017\)](#). The CDC has also recommended making medical isolation operationally distinct from restrictive housing, a recommendation that has been more strongly emphasized by prison reform advocacy groups such as Amend at the University of California San Francisco ([Cloud et al., 2020](#)). For example, in addition to having increased regular evaluation from medical health professionals, it has been advocated that prisoners in medical isolation receive dramatically increased privileges from standard prison life such as increased free access to educational programs, as well as entertainment via television, music and reading material ([Cloud et al., 2020](#)). This helps reduce the punitive association with restrictive housing and buffers medical personnel from the reality of dual loyalty, a challenge that exists when health care providers have the responsibility to consider not only an individual prisoner's health but also public health across the institution for other prisoners and staff.

4.2 Decrease transmission

The CDC has outlined strategies to slow COVID-19 transmission in the community and specialized environments such as correctional facilities ([CDC, 2020a](#)). As the understanding of the epidemiology of this disease has changed and resources for responding to it have become less scarce, so too, have the recommendations by the CDC. For example, the widespread use of masks as a form of PPE was not initially recommended. Reports from US federal prisons suggest compliance with the updated PPE recommendations ([BOP, 2020d](#)), which we will assume have merit to focus the scope of this paper.

Suspending transfers within correctional facilities and in-person visitation, as discussed in Section 3.4, has also been attempted to decrease transmission. Increasing access to telecommunication is a promising start, but the technology imperfections that disrupt these communication platforms in the community are also present, and anecdotally worse, with the "equivalent" platforms inside prisons ([Paul, 2020](#); [Toohey, 2020](#)).

In addition to providing directives for granting free access to video and phone visits during the pandemic (§ 12003.c1), the CARES Act has also granted authority to the BOP to increase access to home confinement where appropriate (§ 12003.b2), in lieu of holding federal prisoners in a carceral setting. Depopulation strategies, especially in settings that are operating with prison populations above capacity, are a critical component to preventing widespread transmission and psychological ramifications of lengthy lockdowns. BOP operationalized their new authority from the CARES Act by outlining criteria for release including relative medical risk if the prisoner were to contract COVID-19, relative reduction in risk if they were to have home confinement, the threat posed to the public by their release, and the likelihood of recidivism ([Barr, 2020](#)). "Compassionate release," which can be invoked in "particularly extraordinary or compelling circumstances that could not reasonably have been foreseen by the court at the time of sentencing" ([BOP, 2013](#)) serves as precedent. Additional power to grant clemency predates the pandemic. For example, most Governors have documented legal power to grant clemency to state prisoners ([Restoration of Rights Project, 2020](#)). Despite this legal authority supporting action, and the evidence suggesting diminishing returns of long-term sentences for most prisoners ([Mauer, 2018](#)), decarceration has been limited. Some have argued that this slow progress in moving prisoners toward release from facilities is evidence of the BOP demonstrating deliberate indifference ([Torres v Milusnic, 2020](#)).

Other measures suggested in the setting of the pandemic to decrease prison population have included using alternatives to imprisonment, such as issuing citations instead of arrests for “low offenses” (Brennan Center for Justice, 2020); this could also theoretically apply to persons on parole from prison at risk of return on technical or minor non-technical violations. Although somewhat novel within the context of a pandemic, these suggestions have previously been the subject of advocacy from prison reform experts (United Nations, 2011) and the Fair Sentencing Act of 2010 provides precedent for reducing punishment for crimes previously considered “serious” enough for prison sentences but later deemed out of proportion to the severity of the crime. There are, however, inherent challenges to these strategies when law enforcement has also been tasked with enforcing executive orders to maintain stay in place orders among the population of free persons. A robust discussion of these challenges is beyond the scope of this paper but is an important topic for future research.

5. Summary of select best practices

As outlined above, strides have been made in providing care for prisoners during this pandemic, but we argue that stopping now could result in dire consequences and neglect this marginalized population, which is both illegal and ethically impermissible. The following summary of select best practices, compiled from our review of the rapidly developing body of literature available at the time of this writing, affirms the ethically good progress that prison leadership has made in the face of challenges presented by COVID-19 and advocates for further refinement and evolving practices comporting with available knowledge and guidelines. Although the details of these best practices may change as scientific understanding develops, the ethical principles of equivalence of care, justice, autonomy and human dignity will continue to be foundational when considering just care for prisoners. These recommendations were developed after a focused analysis of the pandemic response within prisons in the US, but our goal is to contribute to and learn from a global conversation on best practices. The global impact of COVID-19 presents a unique opportunity for prison and health care reform that extends beyond borders (PRI/TIJ, 2020). Transparency in collecting data and reporting progress toward achieving these recommendations are necessary components of developing evidence-based solutions during the pandemic and, afterward, long-term reform:

1. Encourage measures to increase the rapid detection of new cases:
 - *Adopt widespread viral testing strategies in all prisons.* Symptom screening alone, which may be sufficient in some low-risk subpopulation of the general public, is associated with increased risk for rapid, silent transmission among pre-symptomatic persons with communal living spaces. For prisoners who acquire SARS-CoV-2, repeating the viral test until it is negative twice, as described by Cameron, Duarte and McCoy can help maximize infection control with limited resources for isolation (2020, p. 27).
 - *Limit medical co-pays during the pandemic in all prisons.* Demonstrate respect for prisoners’ limited autonomy. Empower them to present for medical evaluation early in the course of disease to help decrease transmission.
2. Support ethical measures to reduce transmission:
 - *Promote equitable access to PPE for both prison staff and prisoners.* Follow guidelines pertaining to PPE and actively develop the supply chain and distribution strategies to ensure the sustainability of allocation schema.
 - *Temper the burden of cell confinement for public health measures.* Increase access to video visits with friends and family. Provide mental health resources and programs, as needed, in modified formats to prevent viral spread.

Engage prisoners in solution-driven protocols that respect their human dignity and limited autonomy, such as encouraging voluntary self-quarantine consistent with people in the community. Recognizing the complex risks within the prison facilities, establish protocols that balance of the psychological consequences of mandated cell confinement, the need for mental health services and the public health benefits of social distancing. Minimize confinement using opportunities for innovative programming and scheduling.

- *Continue “compassionate release” of prisoners to reduce inhumane overcrowding.* Engage with the full range of population reduction tools including decriminalizing “low offenses” and acting on criteria outlined by BOP (Barr, 2020). Gather further input from prison reform experts (United Nations, 2013) so the transmission-reducing potential of this action afforded under the CARES Act (§ 12003.b2), and the legal power for granting clemency outside the pandemic, is materialized.
 - *Reduce barriers to a safe disposition “home.”* Systematically assist former prisoners in establishing safe plans for confinement outside the prison and reduce barriers to release by following a public health informed checklist such as that developed by the Justice Center and National Sheriffs’ Association (2020) and reentry guidelines developed by Substance Abuse and Mental Health Services Administration (2017) using the Assess, Plan, Identify, and Coordinate (APIC) model (Osher et al., 2002). Support continuity of health care (Pinals, 2019, p. 16) for services such as addiction recovery programs (if applicable) to help prevent recidivism, relapse and mortality, especially in the first two weeks after release (Binswanger et al., 2007; Ranapurwala et al., 2018).
3. Advocate for both short- and long-term ethical health care policies:
- *Include vulnerable populations in prioritization scheme for scarce allocation of resources.* Challenge standards based on instrumental social value – such as prioritizing health care workers for receiving intensive care during a pandemic – as standards such as these increase the risk of discriminating against people based on incarceration status (McGuire et al., 2020).
 - *Partner with global experts in health care and the criminal-legal system* to inform discussions on health care and prison reform, which should be based on understanding the overlap between social determinants of poor health and incarceration. Use prison health surveillance practices such as those established by the Five Nations Health and Justice Collaboration (Perrett et al., 2019).
 - *Stay current.* COVID-19 details continue to develop requiring continual reflection and appropriate revision of recommendations to ensure ethical standards continue to be upheld.

6. Conclusion

Globally, there are strong ethical and legal foundations for providing basic health care to prisoners. The COVID-19 pandemic has presented challenges in providing this basic health care. Creative strategies to overcome these challenges have started to emerge in the US prison system, and we argue that slowing down the pace of refining these strategies would risk dire negative consequences. As information about COVID-19 becomes available, adjusting approaches in light of science and medical information will help defuse assertions of deliberate indifference. We encourage global leaders to continue to share best practices so those involved in prison health care can continue to optimize the ethical, evidence-based provision of health care to prisoners even after this pandemic ends.

Notes

1. Violation of human dignity was the ethical foundation that supported the January 2020 ruling by the European Court of Human Rights against conditions in French prisons resulting in over €500,000 in damages (PRI / TIJ, 2020, p. 10).
2. Apparent inconsistencies in messaging from the CDC during this pandemic (Bailey, 2020; Sun, Janes and Olorunnipa, 2020) have jeopardized its recognition as an independent, authoritative expert, but a thorough discussion on the implications of this is beyond the scope of this paper. For the sake of argument, we will be recognizing the CDC as the strongest independent health authority in the US issuing guidance on the pandemic.

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