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What the coronavirus crisis reveals about vulnerable populations behind bars and on the streets

May 14 2020, by Stephanie Hartwell, Ijeoma Nnodim-Opara and Sheryl Kubiak

The notion that COVID-19 is an equal opportunity killer has crumbled. The health and economic fallout from the crisis has disproportionately hit lower-income areas and communities of color. Nowhere is this discrepancy more evident than in prisons, jails and homeless shelters—made up disproportionately of poorer, black and Latino men and women.

Here, COVID-19 cases have mushroomed due to dormitory-style living conditions and the inability of people, often with underlying health issues, to practice social distancing. As the virus rages on, comprehensive COVID-19 testing for these populations remains elusive.

As experts on jails, health disparities and how to help former prisoners reintegrate into society, we believe that missteps in how we transition incarcerated individuals back to the community would only put this vulnerable populace at greater risk of getting and transmitting COVID-19.

Health officials agree that incarcerated individuals and correctional staff are at high risk of contagion due to crowded settings. But while both prisons and jails have curtailed visitations, they have fared differently amid the pandemic.

In prisons, where diversion and early release are often elusive, inmates with COVID-19 are quarantined in solitary confinement. However, this measure, more commonly used as punishment, may spur individuals with symptoms to skirt testing and avoid these conditions.

Though prisons have also become hot spots for COVID-19, they should be better placed than jails to limit exposure to outside diseases. That's because they are efficient at confining their populace, and the flow of individuals in and out of prisons is tightly monitored. Prisons have larger medical units, more comprehensive assessment and release planning protocols including parole supports for individuals returning to their communities.

Jails are not designed for long-term stays. And they have flexibility with releasing individuals due to special circumstances like overcrowding. Thus, they have been a focus of calls for decreased admissions and the release of nonviolent inmates to keep incarcerated numbers low amid COVID-19.

Michigan's 81 jails, for example, with 20,000 beds, have decreased incarceration levels by more than half due to reductions in bookings, posting of bonds and limiting bookings to violent offenders. Other measures such as eliminating bench warrant arrests—typically issued when an individual fails to make a fine payment or appear in court—and the early release of individuals at risk of COVID-19 have also helped bring down the populace.

Still, it's important to recall that individuals who are jailed differ from those in state prisons in that they are often coming straight from the street. Many are experiencing financial, health and behavioral health issues. Others may be navigating substance misuse issues like withdrawal symptoms and intoxication. Scores suffer from psychosis or depression.

Jail diversion and public health

This poses a problem for states: Where will individuals with these behavioral health needs, with few financial and social resources, and possibly COVID-19, go?

In Michigan, inmates are being released with a signed, written promise to not engage in illegal activities and to appear in court when mandated. But these promises are hard to keep when you are struggling with addiction or mental health problems.

It is dangerous to release people into the community without first testing them for COVID-19 and providing them with access to public health and treatment services. Our research, informed by the Gains Center, which expands access to services for those with mental health and substance abuse disorders, shows that extensive transition planning, led by multidisciplinary teams, results in better outcomes for those reentering society. That includes giving them access to detox beds, housing and connections to day treatment.

The pandemic, however, has upended all norms. It has resulted in skeleton social service crews, restricted access to medical facilities and remote care requiring access to technology that homeless and recently incarcerated people often lack. People in jails have limited access to mental health services. This might make it harder for inmates to continue receiving the same medications when they leave jail, especially when it comes to treating psychiatric and opioid use disorders.

In worst-case scenarios, individuals attempting to stave off withdrawal may obtain drugs without maintaining social distancing. We have anecdotal evidence of suicide rates increasing among opiate addicts awaiting treatment. Other substance abusers are refusing treatment all together.

Similarly, individuals with mental health disorders who need medications and housing need to be connected with providers who can assist them. But COVID-19 has disrupted many of these services. The result is often homelessness.

Homelessness in the age of COVID-19

To beat COVID-19, we believe it is essential to secure housing for the homeless. "Staying at home," for instance, is impossible when you don't have one. And how do you social distance when you live in a shelter with no access to private quarters?

Cities like San Francisco and New York are attempting to reduce the homeless population by using hotel rooms. Other communities are erecting tent cities or getting people into permanent housing.

Despite these efforts, individuals in unstable housing are vulnerable to the coronavirus as well as food insecurity, violence and victimization. Some homeless people visit emergency rooms for health care and social needs—warmth, food, shelter and human touch. This renders them susceptible to contracting COVID-19 in the ER if they are negative or transmitting it if they are positive.

A coordinated national strategy

A coordinated and structured strategy, through a health equity approach, would likely interrupt the significant impact on marginalized communities.

For instance, while telehealth holds promise, it's not ideal for people without access to technology. And social service providers do not have adequate staff, technology or finances. Consequently, they lack the

capacity to plan for care during this unprecedented crises—because they are always operating in crisis mode.

The inability to plan, coupled with disinvestment in a robust public health and social safety net infrastructure, magnify health disparities. These shortfalls remind us that the structural and social health determinants for vulnerable populations need to be addressed. To not do so suggests that the value of life is not equally distributed.

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