# Guest editorial

Morag MacDonald and David Kane

Morag MacDonald and David Kane are both based at Birmingham City University, Birmingham, UK.

## Managing Covid-19 and other epidemics in prisons and places of detention

So enthusiastic was the response to this call for papers that we are able to present a double issue: this is a testament to the work done in prisons to respond to the pandemic and the desire shown to introduce measures that mitigate against the potential damage such an epidemic could cause.

It is of little surprise that prisons and places of detention have been affected badly by the pandemic; difficulties stem from known problems, overcrowding in particular and additional factors such as the hesitancy of governments to act decisively, perhaps a result of a desire not to be seen as treating those in detention better than those in the community. As a result, the death rate as a result of coronavirus in prisons is much higher than the rates found in the community (Guardian, 2021). In addition, in the UK, for example, far fewer prisoners have received the vaccine:

> Public health experts from University College London (UCL) found that people in jail had a risk of dying three times higher than people of the same age and sex living in the community. Yet by mid-February only 4 per cent of prisoners in England had received a first dose, compared with 28 per cent of the general public, according to leaked NHS figures obtained by Inside Time (Inside Times, 2021).

It is necessary that there is an element of "joined-up" thinking concerning the most appropriate strategy to vaccinate detainees as prisoners are often an afterthought in debates about such issues. A further complication in this regard is that not all prisoners wish to receive the COVID-19 vaccine due to mistrust of prison health care. It is evident that work needs to be done to challenge false information and rumours that circulate among some imprisoned populations to increase the number who take up offers of vaccination (The Marshall Project, 2021).

COVID-19 has had an impact on the lives of prisoners and prison employees in prison systems worldwide. In March 2021, more than 11 million prisoners worldwide were affected:

> It's estimated there are more than 527,000 prisoners who have become infected with the virus in 122 countries with more than 3,800 fatalities in 47 countries (United Nations, 2021).

It is important to remember that prisons are high-risk environments in which to work, and prison employees are also at risk of infection. In the USA, COVID-19 has been responsible for the death of 2,671 prisoners and 205 prison employees. There are many more prisoners and prison employees in the USA who have contracted the virus with 397,000 prisoners and 11,807 prison employees affected. (The Marshall Project, 2021). Data provided to the Council of Europe from some European prison administrations up to mid-September found at least 3,300 detainees and 5,100 prison staff were infected. In reality, it is likely that figures are far higher (Aebi and Tiago, 2020).

The punishment for prisoners is their lack of freedom, and while detained, according to the principle of equivalence, they should have the same access to health care as those in the

community (WHO, 2007). This concept is often overlooked when the issue of prisoner access to COVID safety measures such as social distancing, provision of PPE and, ultimately, vaccination is debated. It is also important to remember that those in prison come from communities and return to communities on release. As such, there is a risk of transmission into the community, and the effective management of COVID-19 in prisons is necessary to manage the spread of the virus. This means that the process of transition back into the community for released prisoners needs to be carefully managed and collaboration with agencies in the community is necessary to facilitate compliance with any restrictions in force at the time of release. It can be argued that the pandemic is highlighting long-standing deficiencies in the transition process. Ensuring continuity of care upon release and attending to the problematic issue of locating suitable accommodation, for example, have taken on greater importance but are increasingly complex given the restrictions necessary to safeguard public health.

The World Health Organisation (WHO, 2020) developed a checklist to help prison administrations respond to the challenges of the pandemic, detailing the need for wider service planning and delivery. This is a useful tool and covers the following:

- human rights – to ensure good principles and practice in prisoner treatment and prison management;
- risk assessment and management – to prevent COVID-19 from spreading in prisons and to manage the associated risks;
- referral system and clinical management – to enable identified cases to be appropriately managed and receive adequate health care;
- contingency planning – to check that contingency plans are in place and are adequately communicated;
- training – to equip prison staff with skills to deal with COVID-19;
- risk communication – to ensure message coordination and consistency, as well as their accuracy, clarity and relevance in prison settings;
- prevention measures – to assess prevention and control facilities in prison;
- case management – to ensure that cases are appropriately managed; and
- checklist to support prison administrators and policymakers for rapid and effective response to COVID-19. (WHO, 2020).

The extent to which different prison administrations worldwide have implemented the items on the checklist is variable. The findings from the Centre for Crime and Justice Studies survey, regarding prisons in Europe, indicates that:

- Only Austria and Northern Ireland claim to undertake COVID risk assessments for all people (staff and visitors, new prisoners) entering prisons in their country.
- Only Bulgaria, Italy and Spain are reported to ensure that prisoners have a least 1 h per day “exposure to outdoor activities”.
- Only Northern Ireland and Scotland are said to have provided all prison staff with training on basic COVID-19 disease knowledge.
- Austria along with Northern Ireland and Scotland are the three countries where medical masks are available for all prisoners who have or are suspected of having coronavirus.
- England and Wales and Northern Ireland both report that isolated prisoners are medically observed at least twice a day with symptoms and temperature checked (Webster, 2020).

Prisoners are suffering from the pandemic in the majority of countries on all continents including prison administrations that are relatively better resourced. Dealing with the pandemic is hindered in prison systems where there is a lack of staffing, poor health-care provision, overcrowding, poor sanitation and hygiene. All these factors make it difficult to introduce infection prevention and control mechanisms that are demanded to control COVID-19.

In the UK, a settings-based approach was suggested to vaccinate all prisoners and prison staff rather than adhering to the age approach adopted in the community (SAGE EMG Transmission Group, 2021). This was rejected for this current pandemic but should be considered as the response to future pandemics. A settings approach enables a:

> [. . .] strong and tailored surveillance and public health response to infectious diseases to limit spread and reduce the impact among prisoners and staff. Prisons are an intricate environment where public health and prison authorities and other stakeholders interact, and have a dynamic population and staff with significant daily turnover. Whilst prisons are by definition closed environments, the connections with the local community mean that progress in addressing infectious diseases in the community will be hampered if prisons are not addressed (Sage EMG Transmission Group, 2021, p. 1).

Submissions to this special issue largely address reaction to the pandemic by prison administrations in Australia, Europe and the USA. It should be noted, however, that the pandemic has also caused disruption in other places of detention (Soussy *et al.*, 2021 in this issue) It is evident that prison administrations in these continents responded to the World Health Organisation's published interim guidance. As previously noted, implementing an effective response to outbreaks that develop within the prison setting is problematic, given that the primary objective of correctional facilities is security and the construction of prisons is not conducive with the principles of infection control. In addition, although the prison population can be categorised as highly vulnerable, there are inherent difficulties in implementing effective treatment of infectious diseases: maintaining social distancing and reducing mobility, for example, is challenging in view of the large amount of time spent in cells and the issue of crowding in communal areas.

Early in the pandemic, many prisons introduced a number of measures designed to minimise the risk of infection to both prisoners and correctional staff. These included, for example, suspending prisoner visitation, a measure aimed at reducing the flow of individuals entering and leaving the institution, together with restricted movement of detainees between facilities. Decarceration was a further measure aimed at reducing the number of people in prison: it is, however, unclear how successful this strategy was given that release was only considered for those close to the end of their sentence and/or on medical or compassionate grounds. Other measures included the screening of both detainees and health workers to identify asymptomatic patients, followed by isolation of positive cases within dedicated sections within the prison. Other jurisdictions introduced a policy of isolation for 14 days for all those entering the prison to minimise the risk of transmission into the population.

The introduction of such measures are necessary to combat risk of transmission with the estate. These can, however, pose risks of a different nature. Isolation, for example, has the potential to result in psychological distress and lead to long-term trauma or self-harm. It is also possible that at a time when prison resources are directed toward COVID-19 concerns, access to psychiatric and other health services in prison could well be limited. This is a concern when it is recognised that, as a result of the pandemic, those in the community, with greater access to resources than detainees, are suffering with mental health issues. As Hwang *et al.* note in this issue:

> Overall, the potential challenges to routine, policies and infrastructure that prisons need to consider to properly deal with COVID-19 tend to blur and tread a line between "security", the more traditional purpose of prisons and "care". Care may mean granting incarcerated people access to physical and social comforts and resources that have previously been considered inappropriate, particularly if being kept isolated within cells for long periods of time. While many may find this contentious, there are human rights arguments and public health benefits in

> treating incarcerated persons. . .first and foremost as citizens eligible for care. (Hwang *et al.*, 2021)

Many of our contributors have emphasised the importance of a collaborative approach in tackling the pandemic since its onset and that such collaborations need to be maintained in the longer term. The involvement of public health departments, in particular, was recognised as valuable, and this should be supplemented by input from other experts including epidemiologists, for example. In addition, the importance of sharing experiences to enable the formulation of strategies to respond rapidly in the event of a future epidemic has been noted. As Brelje *et al.* observe in their contribution to this issue:

> The global impact of COVID-19 presents a unique opportunity for prison and health care reform that extends beyond borders. . .. 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 (Brelje and Pinals, 2021).

It is also evident that examples of good practice have emerged resulting from the response to the pandemic in prisons. Examples that could be adapted to the prison context as we move beyond the pandemic include telemedicine and other services that use communication technologies. The use of virtual visitation with family members is another innovation that could be implemented on an ongoing basis. It should be noted, however, that while the benefits of this were apparent during a period when physical visits were curtailed, switching to a technical solution does present its own difficulties, including access to the required technology and issues of security.

It is clear that the response to the pandemic in prisons has proven challenging but has resulted in collaboration and innovative practice that should form the basis of a robust strategy to combat any future epidemics of this nature. The papers submitted to this special edition demonstrate that prisons can react quickly and implement new procedures that helped to protect the health of prisoners during the COVID-19 pandemic. It is hoped that the political will, innovative practice and collaboration demonstrated during this time continue and begin to address other long-standing prison issues such as overcrowding and diversion from custody.

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## Further reading

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