

March 31, 2020

Hon. Charlie Baker

Governor of Massachusetts

Massachusetts State House

Boston, Massachusetts

Dear Governor Baker:

We are writing as faculty members of the Harvard Chan School of Public Health and Harvard Medical School to express our urgent concern about the spread of COVID-19 in Massachusetts prisons, jails, and juvenile detention centers. We are grateful for the robust stance you have taken to stem the spread of COVID-19, which is a highly contagious global threat. However, these steps will not suffice to protect those who are incarcerated, those who work in these settings, or the communities connected to them. Only reducing the size of the incarcerated population will achieve this. Now is the time to act.

Although the Massachusetts Department of Correction has taken some measures to reduce transmission of COVID-19 in the incarcerated population, such as increased access to hand sanitizer and soap for hand washing, the most important strategy of physical distancing simply is not possible in prisons, jails, and detention centers. These congregate living facilities have long been associated with high transmission probabilities for infectious diseases, with documented outbreaks of tuberculosis, multi-drug resistant tuberculosis, influenza, MRSA (methicillin resistant staph aureus), and viral hepatitis. More recently, U.S. immigration detention facilities have reported several deaths associated with ARDS (acute respiratory distress syndrome) following influenza A, including a 16-year-old immigrant child who died of untreated ARDS in custody in May 2019. ARDS is the life-threatening complication of COVID-19 disease and has a 30% mortality rate, even with ideal care.

Incarcerated or detained people often have risk factors that make exposure to COVID-19 more dangerous, including above average rates of chronic disease, compromised immune systems, substance use disorders, and mental health issues. Following a COVID-19 infection, aging prison populations (in Massachusetts, more than 10% are 60 years of age or over) may be vulnerable to more severe illnesses and death. Further, studies show that conditions in jails, prisons, and detention centers create unique stressors that accelerate biological aging processes, such that incarcerated people who are age 50 or older may be at increased risk. In Massachusetts, the incarceration rate is eight times higher for African Americans than whites, and six times higher among Latinos. These groups will be placed disproportionately at risk.

Furthermore, for incarcerated individuals who are infected or very sick, the ability to treat themselves properly is very limited. Testing kits are in short supply, as is personal protective equipment, including masks and gloves. Some facilities have limited options for proper respiratory isolation. Finally, prisons and jails are not closed systems. The high rate of turnover and population mixing of staff and detainees also increase the likelihood of exposure. This has led to prison outbreaks of COVID-19 in multiple detention facilities in China, associated with introduction into facilities by staff. At Rikers Island Jail in New York City, the prevalence of COVID-19 is 14 per 1,000, a figure seven times more than the 2 per 1,000 in the general NYC population (data as of March 25, 2020). The first case was diagnosed in a Massachusetts prison on March 20; one week later, that prison had 14 cases among incarcerated people, correctional staff, and medical staff.

Prison, jail, and detention center staff may bring the virus into the facility and are also at risk of acquisition from infected incarcerated individuals. Once infected, staff may also transmit the virus back into communities and to their families. These staff should be seen as the frontline responders they are - people in need of education, protection and support. As jail, prison, and detention center health care staff themselves get sick with COVID-19, workforce shortages will make it even more difficult to adequately address all the health care needs in facilities. Demands for care of the sick will be placed on already overburdened community hospitals.

Every effort should be made to reduce exposure in jails and other detention facilities, and we appreciate the efforts thus far of administrators toward this goal. It is critical to ensure that there are no impediments for people who are incarcerated to come forward when sick and to be fully assessed with transfers to other care settings as needed. Lockdowns and solitary confinement may introduce barriers to accessing care. Moreover, lockdowns and solitary confinement should not be used as public health measures, both because they have limited effectiveness and because

these actions would violate the rights of incarcerated people and have damaging health effects. But escalating numbers of COVID-19 infected people who either work or are incarcerated in the Commonwealth's jails and prisons underscores the reality that control of transmission is extremely difficult in these congregate settings, given the design features of the facilities. It is therefore an urgent priority in this time of national public health emergency to reduce the number of persons in detention as quickly as possible.

We therefore urge you to take the following steps:

1. Require correctional facility administrators to make their plans for prevention and management of COVID-19 in their institutions publicly available, as the San Francisco Sheriff's Department has done, and available to incarcerated people in their custody. Protocols should be in line with national CDC guidance. Frequently updated recommendations and model protocols are available from the [National Commission on Correctional Health Care](#);
2. Ensure that intake screening protocols are updated to include COVID-specific questions;
3. Monitor and ensure the availability of sufficient soap and hand sanitizer for all staff and incarcerated individuals, without charge;
4. Implement other precautions to limit transmission within prisons and jails without relying on widespread use of lockdowns and solitary confinement. Provide [additional precautions](#) jointly issued by the Vera Institute of Justice and Community Oriented Correctional Health Services;
5. Substantially curtail pre-trial detention, reserving it only for genuine cases of proven security concerns. Persons held for non-payment of fees and fines, insufficient funds to pay bail, and parole or probation violations should be prioritized for release. No one in these categories should be sent to jail;
6. Expedite consideration of all incarcerated individuals age 50 and over and those with chronic conditions predisposing to severe COVID-19 disease (heart disease, lung disease, diabetes, immune-compromise) for parole or other form of release from prison, with alternative forms of supervision and supports in the community once released. Consider release for anyone with such vulnerability due to age or predisposition for severe COVID-19, regardless of crime of conviction.
7. Instruct the Department of Correction to issue new medical parole guidelines that recognize the combination of a condition predisposing to a severe case of COVID-19 (heart disease, lung disease, diabetes, immune-compromise) coupled with the high likelihood of rapid spread should COVID-19 enter a correctional setting

as sufficient eligibility for a condition qualifying for compassionate release under the medical parole statute;

8. Require the Department of Correction, during the pendency of the COVID-19 pandemic emergency, to develop medical parole release plans within 7 days of receiving a petitioner's submission;
9. Grant executive clemency, beginning with those who have at any time received a favorable recommendation from the Parole Board acting as the Advisory Board of Pardons within the last 15 years, and expand authority in Massachusetts law for administrative parole. Remove restrictions in the clemency guidelines that foreclose clemency for individuals pursuing claims of actual innocence;
10. Invest increased resources in community-based organizations and service providers for discharge planning and re-entry transitions to facilitate release of people under these revised policies. Shift resources from correctional budgets to effectuate transitions to the community;
11. Ease or eliminate public housing restrictions that prevent people with records of arrest or conviction from living with loved ones who receive housing assistance, to ensure that people released from incarceration have homes to return to where they can safely practice social distancing;
12. Invest resources in both housing and substance use treatment that accommodate the public health need for social distancing, including through take-home dosing consistent with [SAMHSA Federal Guidelines for Opioid Treatment Programs](#) and renting vacant hotels and college dormitories for people released from incarceration who would otherwise turn to congregate shelter;
13. Arrange for COVID-19 testing of incarcerated individuals and corrections staff who become ill;
14. Review how restrictions aimed to reduce contraband may hinder delivery of supplies urgently needed for protection against COVID-19, such as masks, gloves, and hand sanitizer.
15. Seek a [Medicaid 1135 waiver](#) (to enable hospitals to provide an appropriate level of care to incarcerated individuals who are sick).

This pandemic is shedding a bright light on the interconnection of all members of society. Jails, prisons, and other detention facilities are not separate; they are a part of our community. As experts in public health and medicine, we believe these steps are essential to support the health of incarcerated individuals, who are some of the most vulnerable people in our society; the vital personnel who work in prisons and jail; and all people in the state of Massachusetts.

Our compassion for and treatment of these populations helps us all.

Thank you very much.

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