MANAGEMENT OF THE SARS-Cov-2 PANDEMIC IN CORRECTIONAL SETTINGS

THE CHALLENGES

The recent coronavirus pandemic has brought to light the unexpected dangers existing in nature that can have an extraordinary impact on our lives. Whereas, this has changed all our lives and raised safety concerns, nowhere has the impact been greater than in nursing homes, the elderly with comorbidities, health care workers, 1st responders, and, correctional facilities[1]. Inmates are highly vulnerable because of the economic, medical, social & living conditions prior to and after being incarcerated. The recommended precautions of masks, social distancing, sanitizing, avoiding crowds & going outdoors are challenging, if not impossible in correctional facilities.

The SARS-CoV-2 pandemic has highlighted how disruptive hidden natural dangers can be. Although most of the morbidity and mortality has occurred in the elderly and those with comorbid conditions, others living in congregate settings and those working with them are also at high risk. Although universal implementation of mitigation measures—masking, social distancing, and use of viricidal sanitation—can reduce related harms, these measures, politically controversial and difficult to implement in the outside community, present challenges to the point of impossibility in correctional settings.

CARE & MANAGEMENT

Penal institutions vary greatly. The duration of detention can range from hours or days, to months, and on to years. Some house thousands while others are limited to below twenty-five. Some have essentially no on-site health services while others may have licensed hospitals. Policies and procedures may describe goals, but implementation must vary. One size will not fit all. The hallmarks of a successful program in managing these are communication, collaboration & education. This must occur among custody, justice, medical & public health in conjunction with federal, state and county agencies. Communication between custody, medical, inmates and ancillary services is a cornerstone in controlling disease spread. Penal institutions vary tremendously in their medical capabilities to manage ill persons. Some have a hospital, others an infirmary of varying sizes, and many with nowhere to place a sick patient. It is difficult to create a policy or position statement to fit all.

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[1] COVID-19 Cases and Deaths in Federal and State Prisons by: Brendan Saloner, PhD; Kalind Parish, MA; Julie A. Ward, MN, RN; et al *JAMA.* 2020;324(6):602-603. doi:10.1001/jama.2020.12528

It seems obvious that population reduction will ease the stresses of managing SARS-CoV-2 in correctional agencies. Again, there is no single approach that can accomplish this. Changes have been attempted at all points in the confinement process. These include (this is not an exhaustive list):

- Decreasing arrests for minor offenses
- Decreasing barriers to release, such as release on recognizance or on lower bond
- Decreasing barriers to placement on parole or probation
- Increasing release to home confinement
- Increasing attempted use of compassionate release

Some of these measures, while effective, require cooperation with agencies outside of the direct control of the correctional settings, not limited to police agencies, judges etc. Informed cooperation is a keystone of all programs which can decrease the SARS-CoV-2 load in correctional settings.

Some judicial agencies have instituted measures such as allowing more persons to be released on their own recognizance and making fewer arrests. Institutions have transferred inmates with the hope of concentrating those infected and separating them from others. Decarceration may be done by increasing compassionate releases, releasing those nearing their release date and releasing those with low level offenses to home monitoring. These measures can only be done after communicating with the correctional and justice officials and community social services. The National Academies of Science, Engineering & Medicine has developed a scheme to make decarceration practical[2]. Supply chains must be well established and maintained, so that needed urgent supplies can readily be obtained. A list of personnel health care staffing agencies, for provider, nursing and ancillary medical staff must be maintained and good working relationships established.

Management of SARS-CoV-2 in short- and long-stay detention facilities has many similarities to that in the surrounding community. Clinical personnel must be available to identify patients at high risk, to provide education and testing to them, and to treat them when required. Access to test kits must be easy, more so because of the risk for transmission within congregate settings. Properly equipped treatment settings, including safe outpatient areas and various levels of residential/inpatient care need to be identified, both on and off site. Hospitalization in particular must be utilized when necessary. Personal protective equipment should be available and used as appropriate (again, this is not an exhaustive list:

[2] National Academies of Sciences, Engineering, and Medicine. 2020. *Decarcerating Correctional Facilities during COVID-19: Advancing Health, Equity, and Safety.* Washington, DC: The National Academies Press. doi: https://doi.org/10.17226/25945.

- N95 or equivalent masks, disposable gloves, appropriate impervious gowns, and eye protection (goggles or shields) for all facility personnel having contact with infected patients, whether symptomatic or not
- Simple masks (cloth or surgical) for all facility personnel not having contact with infected patients (this is not likely to be a large group)
- Simple masks (cloth or surgical) for all inmates, known to be infected or not
- Widely available handwashing sinks and/or hand sanitizer

Cohorting is an intervention available in some correctional settings. This intervention can create separate living areas, feeding times, recreational opportunities, and so on, for detainees depending upon when they arrived to the facility, their risk level should they become infected, their willingness and ability to use proper PPE, and so on. Cohorting may be especially useful after intake; universal testing may be helpful in identifying patients, but even this intervention does not provide instantaneous information. Reduction in interfacility and in intrafacility transfers can also provide a type of cohorting.

Social distancing is nearly impossible to implement in a correctional setting, but facilities should consider moving to video conferencing for visitation, court appearances, and other actions which might otherwise require transport. Telehealth has become more widely available and can be utilized with an increasing number of specialists.

Depending upon the illness burden and the physical plant layout, additional and/or temporary clinical personnel may be required. Facilities should plan in advance for this need, working with temporary staffing agencies so that they can "staff up" when necessary.

As part of the intake process, all must be tested upon arrival, and consider isolating them for 10-14 days. Separating those who are asymptomatic with a positive test from other inmates is mandatory.

Facility testing is important. This requires frequent testing of as many inmates and staff as is reasonable, especially in jails. If positive, custodial staff must not be allowed in the facility. Once an inmate is symptomatic, depending on the magnitude of the symptoms and the capabilities of the facility, a determination to hospitalize, or place in the infirmary must be made. Communicating and working with custody and the referring community hospitals is mandatory. Although difficult, access for routine health care and management, and chronic care, should continue. Emergencies must be handled. Innovative measures may have to be developed; i.e. more cell side visits, seeing patients of one pod, dormitory or housing unit at a time. This may require extended "sick-call" hours. This will impact staffing time and is

where contract staffing agencies will be of value. Correctional facility health care workers must be provided with appropriate personal protective equipment (PPE). Out of necessity, there is constant movement throughout correctional facilities. Offenders go to court hearings, are transferred from cell to cell or dormitory to dormitory, have to keep medical & legal appointments, etc. During a pandemic, movement such as those should be kept at a minimum, with only "necessary" changes made. It is imperative that medical & custody work together. Dormitory living is particularity hazardous, but necessary in many facilities innovative precautions, such as sleeping head-to-toe, instead of head-to-head, can be implemented. If positive inmates are found in a dorm, they should be immediately transferred and testing of all residents of that dorm done immediately and isolation of those positive. If in a cell, the cell mate(s) need to be tested and isolated for 14 days. This will require cell feeding.

VACCINES AND EPIDEMIOLOGICAL CONSIDERATIONS

Health services personnel and those living in residential health care settings will be the first to receive the newly available vaccinations. It remains unclear when persons living or working in congregate settings including correctional facilities will be offered them, or even what mechanisms will be utilized. Until vaccination provides herd immunity, it is crucial that mitigation measures be encouraged and, where possible, mandated.

Proper management of infectious diseases in correctional settings has always benefitted from close cooperation between services inside and outside of the walls. Not only is it important to assure that released SARS-CoV-2 patients be passed smoothly from inside healthcare providers to those outside the walls, but proper management of vaccination will similarly require information transfer and proper patient management.

Early recognition is of paramount importance. Basic infection control measures must be strictly adhered to. Quarantine, treatment, and vaccination are necessary to prevent spread. There may be a delay in vaccination for a variety of reasons. When available, existing recommended vaccinations must be offered to prevent a compound effect of concomitant diseases. Intense planning and education of patients are mandatory to facilitate acceptance. Facilities should communicate with their pharmaceutical supplier to have vaccines delivered and in the correct amounts and at the correct time. During the development of a vaccine, a careful well thought out decision may be made whether inmate patients may participate in trials. If so, participation must be in accordance with standard protocols overseen by an institutional review board with the necessary patient education and consents, and no promises of

sentence reduction. Unless behind glass, in-person visitation should be suspended. Innovative visitation such as Zoom, tablets and other remote forms should be instituted, as feasible. Telephones must be sanitized after each use. Here too, education of the inmates and availability of protective items is imperative. Unfortunately, it may be necessary to limit inmate workers. If not possible, they must be afforded protective gear and instructed in practicing infectious safety precautions.

In light of the challenges and susceptibilities of persons in a correctional facility setting, if and when vaccines are available, correctional workers and inmates must be considered as high risk and vaccine be offered early, along with other high risks groups. Coordination with local public health and governmental agencies is a must. Correctional workers, especially those in close and frequent contact with inmates must be afforded the same high-risk provisions. They return to their homes and lives and must practice appropriate safety precautions to include frequent testing. Contact tracing is imperative with close communication and cooperation with custody and public health agency. If testing of contacts isn't feasible, those contacts should be isolated, to the extent possible, provided with masks and educated as to safety measures to the extent recommended by CDC. From a public health perspective and to better plan, accurate reporting of infectivity data is imperative. Because of the circumstances, mental health concerns may increase amongst the inmates. The mental health team must be extremely involved in the management of pandemics. The possibility of recurrent disease must be considered. To facilitate inmate compliance, all co-pays and clinic visit charges must be waived. Ventilation management is another challenge. These viruses are airborne. There may be an antiquated and/or poorly functioning ventilation system. Medical must work closely with the facilities maintenance department to ensure proper working ventilation system with adequate filters of the correctional facility.

FINAL COMMENTS

Correctional healthcare workers function in a challenging setting, with difficult and often transient patients often coming from an environment where healthcare is an afterthought, and with too few resources. Successfully navigating the continuing pandemic requires collaboration and communication among all stakeholders, education of stakeholders and patients, and cooperation among all. Public health agencies, local, state, and national, play a large role in guiding us.

We must move past the politicization of SARS-CoV-2; it is a real and dangerous virus and mitigation measures work. Now that vaccine-mediated herd immunity is on the horizon, we must redouble our efforts to minimize the harm brought by the virus to our patients and our communities.

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