The Pandemic Divide

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4. COVID-19, Race, and Mass Incarceration

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In March 2020, the jail in Marion County, Ohio, became one of the first carceral facilities in America to test all its occupants and workers for COVID-19. When the results were returned from the lab, 73 percent of residents tested positive for COVID-19 (Chappell and Pfleger 2020). Soon thereafter Ohio began increasing COVID-19 testing in prisons, and within weeks, 20 percent of the state’s cases were in prisons and jails. Such a finding was no coincidence but rather a harbinger of things to come.

As of June 2021, the United States accounted for 4 percent of the world’s population, 18 percent of worldwide COVID-19 cases, and 21 percent of worldwide prisoners. Outside of college campuses, the largest outbreaks in the United States have occurred in jails or prisons (see New York Times 2020). American correctional facilities are, by design, packed as full as possible, making social distancing nearly impossible (Warmsley 2005). Within prisons, access to medical treatment and personal protective equipment like masks is limited, increasing the likelihood of infection even further. And prisons are indoor facilities, where residents mostly share locales like sleeping quarters, dining halls, and recreation areas. With a powerful, infectious virus, this arrangement is a recipe for disaster.

As of January 2022, reports indicate that 716,546 incarcerated people and carceral staffers had tested positive for the virus (UCLA Law 2021). If the US prison population were its own country, it would rank sixty-third in confirmed cases, above nations like Greece, Egypt, Kenya, and Finland (Worldometer
This disparity is especially problematic given that incarcerated populations have elevated rates of serious health conditions, placing many in the high-risk population for COVID-19 (Maruschak, Berzofsky, and Unangst 2015). Importantly, this crisis of COVID-19 in prisons has contributed to the racial inequality in COVID-19’s impact across America: the racialized carceral state in America has helped amplify the racialized effects of COVID-19 across the country. As described on page 8 of the introduction to this volume, Centers for Disease Control and Prevention (CDC) estimations in late November 2021 suggested Latinos and blacks were, respectively, 90 and 70 percent more likely than non-Hispanic whites to die of COVID-19 (CDC 2021). Given black and Hispanic residents are over three times as likely to be incarcerated as white residents (Gottschalk 2016) the increased likelihood of contracting COVID-19 in prison and America’s racialized punishment regime serve as a critical driver for the racial disparities in COVID-19 contraction.

In this chapter I show how the COVID-19 spread in America is driven in part by our mass incarceration. To do so I collect county-level data on coronavirus spread from the New York Times and data on coronavirus spread among people incarcerated in all state and federal prisons, as well as the staff in those facilities, from the Marshall Project. Using these data I first present rough estimates of how jail and prison populations changed in response to COVID-19. Next, I present rough estimates of the likelihood of infection outside of jail or prison versus the likelihood of infection inside of jail or prison and show that detained residents are far more likely to contract COVID-19. Finally, I explain how America’s racialized carceral state causes racial inequality in COVID-19 impact.

How Incarceration Is Affected by COVID-19

One of the first documented influenza outbreaks occurred in California’s San Quentin prison during the 1918 influenza pandemic. Historical accounts note that nearly half of the nineteen hundred inmates actually contracted the disease during the first wave of the epidemic, but most of the ill were kept in the general prison population because the hospital wards were already overpopulated (Mills, Robins, and Lipsitch 2004). The same pattern emerged when COVID-19 burst on the scene in early 2020. On February 29, 2020, 40 percent of COVID-19 cases reported in Wuhan, China, were from the city’s prison system (Liu and Saltman 2020). But despite the tragedies of 1918, it is not clear that the United States incorporated the lessons learned into its COVID-19 response. Carceral facilities like state prisons and local jails remain hotspots for the virus.
Theoretically, there are strong reasons to believe that COVID-19 is more likely to spread in a detention facility than elsewhere. First, historically, detained and incarcerated populations have been shown to have increased prevalence of infectious diseases like HIV, hepatitis C, and tuberculosis (Akiyama, Spaulding, and Rich 2020). This pattern was, and is, a strong indicator that the conditions of an American detention facility are likely to allow an infection to spread more widely and faster than among the general population. Next, prisons share a number of characteristics with other key “super-spreader” sites such as college dormitories, nursing homes, and meat-packing plants. They are all high-population density areas with shared living quarters, shared sanitation, and limited air circulation. The primary public policy strategies of social distancing and self-isolation are largely unavailable in detention facilities.

These factors alone suggest that it was always likely COVID-19 would wreak havoc on carceral facilities. However, structural and institutional design features also increased the likelihood of COVID-19’s spread and heightened death tolls. Half of all incarcerated persons have at least one chronic disease, meaning any infections within the prison are more likely to be fatal than infections among the general population (Maruschak, Berzofsky, and Unangst 2015). Next, detention facilities have a high level of population turnover, or churn. Jails or other pretrial detention facilities are designed for short-term, sometimes only nightly, spells of detention and often have hundreds of new residents on a daily basis. Even longer-term facilities like prisons frequently have shuffling in and out on a weekly basis. This high level of turnover means new potential pathogen carriers regularly are entering shared spaces. And American prisons are often overcrowded, so much so that in 2011 the US Supreme Court ruled that overcrowding undermined healthcare in California’s prisons, causing avoidable deaths (Brown v. Plata). That is, in a time without a pandemic, overcrowding can cause death. During a pandemic, it is certain to create mass casualties with an airborne virus.

Experts noted these facts early on. In peer-reviewed journals like the *New England Journal of Medicine* (Akiyama, Spaulding, and Rich 2020) and journalistic outlets like the *Atlantic* (Friedersdorf 2020), epidemiologists, doctors, and virologists argued for reducing the prison population immediately. But to what extent were those calls for change followed by the sheriffs, judges, and district attorneys with authority to make changes to our criminal justice system?

I answer this question by looking at two distinct kinds of facilities where the number of incarcerated individuals can be reduced. The first are jails, which are primarily filled by pretrial detainees. These detainees are legally innocent but usually have bail set at an amount they cannot afford to pay, or have no bail
set because they are deemed to be a safety or flight risk. For that reason jails are shorter-term warehouses with higher levels of churn and turnover. The second are prisons, which are primarily filled by postconviction detainees. These detainees have been found guilty, and usually a sentence has already been issued in their case. As a result, prisons are longer-term residence facilities, with less churn and turnover. I look at how each of these facilities was affected by COVID-19.

How Was Jail Population Affected by COVID-19?
To evaluate whether the number of individuals incarcerated in jails decreased during COVID-19, I use data gathered from the NYU Public Safety Lab Jail Data Initiative (JDI). The JDI scours daily county jail rosters and criminal case records in over eleven hundred counties to provide facility-level data on detainee counts. I use a time series of the JDI data set to show how the total number of detainees changed from February 1, 2020, to March 31, 2021, across 186 county facilities.

Figure 4.1 displays weekly rolling-average jail population counts for 186 counties with jail data throughout the full time series of the sample. Jails in this
sample began decreasing their detained populations soon after COVID-19 outbreaks began spreading across the country. This decrease was relatively monotonic across jails in our sample from the March 1, 2020, peak jail population of 53,986, until it reached its low point of 30,675 detainees on May 25, 2020, a 43 percent decrease in jail population. While we do not have data from these same jails in past years, historically there is an uptick in incarcerated individuals between March and June because of the seasonal trends in crime (McDowall, Loftin, and Pate 2012). Following that low point, we’ve seen a linear increase in jailed populations. As of March 31, 2021, the jailed population among our sample sits at 46,804, or 87 percent of the pre-COVID-19 jailed population.

Importantly, though, this data compilation is only a sampling of all jails in the United States, and it is not a representative or random sampling. Still, it can tell us something about what was happening across jails in the United States at the height of the COVID-19 pandemic. Journalistic accounts using alternate data sources have observed a similar pattern of initial rapid decreases in jail populations followed by a slow and steady increase back toward the pre-COVID-19 jail population (Sharma et al. 2020).

Why Did the Jail Population Fall?
What caused the decrease in jail population for these few months? There are three key policy changes that drove these decreases. First, magistrates, judges, prosecutors, and sheriffs began changing their pretrial detention practices to reduce the number of new detainees entering facilities. For example, on April 6, 2020, California set a statewide emergency bail schedule that reduced bail to $0 for most misdemeanor and some low-level felony offenses; and survey data from the National Association of Pretrial Services Agency (NAPSA) conducted in June 2020 showed that in nonviolent cases surveyed agencies reported a 65.17 percent increase in cite and release and a 67.98 percent increase in release on personal recognizance, two policies that don’t involve pretrial detention unless there is a failure to pay or appear in court (Smith 2020; NAPSA 2020).

Next, some jurisdictions began releasing previously detained individuals who were awaiting trial. The same NAPSA survey had responding jurisdictions also reporting an 81.46 percent increase in releases from jail for persons awaiting trial (NAPSA 2020). Many major cities like Philadelphia and St. Louis convened special court hearings to handle petitions for release upon recognizance petitions among those already detained (Vargas 2020; Cardinale 2020). Other states like Kentucky and Kansas enacted legislative or judicial orders issuing emergency
administrative release schedules that expanded the use of release on recogni-

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However, as cities and states opened up, these policies halted. Police re-

How Was the Prison Population Affected by COVID-19?

To evaluate whether the number of individuals incarcerated in prisons de-

Figure 4.2 shows that the prison population monotonically decreased from

000 prisoners or 16.6 percent of the total prison population. To put this amount in context, between 2018 and 2019, the
Figure 4.2. Monthly counts of total prison population (March 31, 2020–January 31, 2021). Data courtesy of the Marshall Project Prison Population database. Data for May 2020 were not collected and thus that month does not appear on the graph. Each state population was sampled between the 27th and 31st of the month.
United States prison population dropped by about 33,000 prisoners. The decline during the COVID-19 pandemic is about seven times the size of that earlier drop.

**Why Did the Prison Population Fall?**

Prison populations fell during COVID-19 in large part because of two types of policy changes. First, a number of states released prisoners early or commuted ongoing sentences. There are two types of prisons in America: state and federal. The vast majority of prisoners are in these state facilities, giving governors the authority to change the composition of the state facilities. Many governors used this authority to either commute sentences or sign executive orders to release prisoners. In New Jersey, Governor Phil Murphy passed an executive order allowing the temporary release of more than seven hundred individuals convicted of nonviolent offenses, and he most recently passed a bill that will allow early releases to continue for nonviolent offenders (O’Dea 2020). Similar orders were passed in Michigan, California, and New York, among others (van Wagtendonk 2020; California Department of Corrections and Rehabilitation 2021; Taddeo 2020). Importantly though, these orders were not all meant to create permanent changes to the prison populations. For example, similar orders in Pennsylvania and New Jersey temporarily suspended the sentences of incarceration for qualifying inmates (Prison Policy Institute 2021). Other states commuted sentences entirely, like Kentucky, where Governor Andy Beshear commuted more than one thousand sentences for medically vulnerable prisoners who were often imprisoned on technical parole violations (Ragusa 2020). Governors in many states issued executive orders that blocked new transfers into state prisons, and many states began holding mass hearings among their parole boards (Crime and Justice Institute 2021). Versions of these approaches have been adopted relatively uniformly across the country and are the primary reason that prison populations began to fall soon after COVID-19 began spreading.

Next, prison populations remained lower because of changes in the functioning of courts and prosecutors, akin to the changes that occurred in jail populations discussed above. Most states implemented a moratorium on statewide jury trials during the COVID-19 pandemic, and many more implemented citations in lieu of arrest policing, each of which reduces the inflow of potential new prisoners through the criminal justice system (Prison Policy Institute 2021). Some locales went even further, with governors in sixteen states, including Colorado and Florida, issuing executive orders halting new prison admissions for at least some period of time (Crime and Justice Institute 2021). Coupled with statewide lockdown orders that left individuals inside more often and
closed businesses, criminal activity is likely to have fallen, though it is difficult to render any conclusions about crime rates given changes in the policing style during the COVID-19 pandemic.

**But Was This Enough?**

In many respects these changes to the incarcerated and detained population in America are remarkable. These decreases are substantively and historically significant, and they appear to be the largest decrease in prison and jail populations across a single year in the past fifty years. But that does not mean they are sufficient to handle the public-health crisis that COVID-19 poses. In response to COVID-19, schools closed to reduce face-to-face contact, businesses were temporarily shut down, and shelter-in-place orders were issued across the country. These are actions that dramatically altered the way of living for most of the population, but government officials viewed them as necessary steps to mitigate the spread of the virus and to limit fatalities. While the operation of jails and prisons in our criminal justice system certainly changed, a 16 percent reduction in prison populations and a temporary decrease in our jail population (that was quickly met with an increase close to normal levels) was not sufficient in scope to effectively mitigate the spread of COVID-19 both within prisons and jails and in our communities.

Importantly, even when states did reduce their prison populations, they often did little to ensure that released or deferred individuals were economically and medically secured. COVID-19 saw an economic downturn and high levels of contraction among employers, placing formerly incarcerated individuals—already at a disadvantage in the job market—in the position of choosing between economic precarity or taking up employment at frontline positions that carried a higher risk of COVID-19 contraction. Additionally, released or deferred individuals were likely to be placed directly into crowded family living arrangements that increased their likelihood of contracting disease, a cycle that appeared to contribute to COVID-19’s community spread (Reinhart and Chen 2020).

In April 2020, the American Civil Liberties Union (ACLU) wrote that COVID-19 epidemiological models were underestimating the potential death count in America because our mass incarceration was likely to accelerate the virus. Because many of these models were trained on data from countries that do not have jail and prison populations anywhere near the United States’, like South Korea and Italy, the ACLU analysts argued that these estimates were greatly underestimating the potential spread of COVID-19. With the privilege of hindsight, it is clear that those analysts were right, as the COVID-19 death
count in America is far above what initial projections estimated. Epidemiological models suggested that a 90 percent decrease in all incarcerations and discontinuing incarceration for low-level offenses would result in a 60 percent decrease in COVID-19 deaths within the jails (Lofgren et al. 2020). Polling suggested that these mitigation strategies had broad support. A Data for Progress survey showed that in order to dramatically reduce jail and prison populations to slow the spread of COVID-19, a majority of likely voters supported releasing people who were within six months of completing their sentence (Ganz 2021). The decision to only marginally reduce prison and jail populations was a choice made by political operatives and criminal justice officials, and this choice cost lives.

How COVID-19 Is Affected by Mass Incarceration

Certainly, the American government and criminal justice officials could have done more to prevent COVID-19. But given that they did not, what were the consequences? Put another way, how much more likely were incarcerated individuals to contract COVID-19 than nonincarcerated individuals? In this section I estimate the differences in the likelihood of contracting COVID-19 in prison or jail versus in the general community.

To provide evidence on this claim, I rely on publicly available data sets. However, these numbers are not official or verified by any governmental authority, because currently no central government reporting and collection agency, such as the Centers for Disease Control and Prevention (CDC) or the Bureau of Justice Statistics, tracks data on COVID-19 in correctional facilities. Nonprofits and universities have taken it upon themselves to provide some form of data to the public, although these data are not necessarily accurate or comprehensive. This deficiency has been a substantial limitation on the ability of scholars to conduct research on incarceration, detention, and COVID-19 spread. In fact, one of the major nonprofits that has gathered data on COVID-19 in prisons is the Marshall Project. The Marshall Project requests these data every week from state departments of corrections and the federal Bureau of Prisons; however, not all departments provide data for the date requested, leading to occasionally missing and incomplete data.

To overcome these weaknesses, I built a data set of state-by-state and county-by-county COVID-19 infections by merging two publicly available sources of data: the Marshall Project’s efforts and the UCLA Prison Law and Policy Program’s COVID-19 Behind Bars Data Project. I then merged these data sets with the New York Times county-by-county and state-by-state COVID-19 infection
Finally, I folded in Marshall Project state-by-state and county-by-county monthly prison population counts.

This combined data set allowed me to measure the likelihood of contracting COVID-19 outside of prison (general population) and the likelihood of contracting COVID-19 within state or federal prisons (among prisoners). Specifically, I calculated three measures. The first measure is the likelihood of contracting COVID-19 in prison. This metric is calculated by looking at the number of COVID-19 cases in each jail or prison and looking at the total population in the jail or prison. I calculated the ratio of positive tests to total number of incarcerated individuals using only snapshots of jail and prison populations. This approach meant that I had total incarcerated individuals at a moment in time, but I did not have the daily individual-level counts that would have allowed me to measure the daily churn in and out of jails and prisons.

Instead I was left with an approximate ratio of positive tests to approximate population. Next, I calculated the ratio of the positive tests among nonincarcerated individuals to the total nonincarcerated population in a given county or state. Finally, I calculated a third metric, the difference in likelihood of a positive COVID-19 test among incarcerated individuals in a state or county relative to the likelihood of a positive COVID-19 test among nonincarcerated individuals.

Maps 4.1 and 4.2 display the number of COVID-19 cases in US prisons (excluding jails) and the number of COVID-19 cases in American counties, respectively.
as of October 20, 2020. While many counties have jails, there are only about eighteen hundred state and federal correctional facilities across the country—meaning most counties do not have any state or federal prisons (Stephan 2008). Relatedly, many individual facilities were not reporting COVID-19 data in states like Delaware, Idaho, and Rhode Island. Still, the counties with the five highest counts of COVID-19 positive tests are Los Angeles County, California; Miami Dade County, Florida; Cook County, Illinois; Harris County, Texas; and Maricopa County, Arizona. Each of these five counties rank among the one hundred counties with the highest number of COVID-19 cases in state or federal prisons.

Finally, Map 4.3 presents differences in the likelihood of contracting COVID-19 inside a state or federal prison facility versus the likelihood of contracting COVID-19 outside of a state or federal prison facility. These numbers can be interpreted as odds ratios, or increased odds of contracting COVID-19 in a state or federal prison facility versus outside the prison facility. I use the state as the unit of analysis here because the data set is more complete than at the county level.

Forty-seven out of fifty states had a higher likelihood of contracting COVID-19 in a state or federal prison than outside a state or federal prison. As of June 2021, the crude estimated rate of contracting COVID-19 inside state or federal prisons appears to be around 33.4 percent, while the crude estimated rate outside of state or federal prisons appears to be 9.1 percent. Put substantively, these estimations suggest that the likelihood of contracting COVID-19 inside of prison are about 3.67 times higher than the likelihood of contracting COVID-19 outside of prison. This finding fits with existing research, conducted
in June of 2020, that estimated that the COVID-19 case rate for prisoners was 5.5 times higher than among the US population at large (Saloner et al. 2020). The median state in my data set had a ratio of 4.18, meaning federal and state prisoners were 4.18 times more likely to contract COVID-19 than the general population.

Differences in death rates are less pronounced. The likelihood of a prisoner dying from COVID-19 is about 213 per 100,000, and the COVID-19 death rate for a nonincarcerated individual is 183 per 100,000. This comparison means that prisoners are actually 1.16 times more likely to die from COVID-19 than nonincarcerated individuals, a substantially lower ratio than the 3.67 times higher case rate for incarcerated individuals than for nonincarcerated individuals. This lower death ratio is likely driven by differences in the composition of the general population and the incarcerated population. Specifically, the incarcerated population is more male and younger than the nonincarcerated population. Analysis in the Journal of the American Medical Association (JAMA) that estimates demographic adjusted mortality rates found that the adjusted death rate in the prison population was 3.0 times higher than would be expected if the age and sex distributions of the US and prison populations were equal (Saloner et al. 2020).

These increased death rates (3.0 times, when demographic adjusted) and increased contraction rates (4.23 times) do not merely affect those within prison. They also are likely to affect those outside of prison. According to the Marshall Project’s estimates, 28,721 prison staffers have contracted COVID-19.
These staffers live among the community, risking spread to their families and friends. Research in the *Health Affairs* journal analyzed data from the Cook County Jail, showing that jail-to-community cycling was a significant predictor of cases at the zip-code level, and it even seems likely to have accounted for about 16 percent of all cases in the state of Illinois (Reinhart and Chen 2020). Additional work focused on Milwaukee, Wisconsin, came to similar conclusions (Escobar and Taheri 2020). Even well-intentioned policies aiming to reduce the size of prison and jail populations may increase risk. Unless facilities are mass testing their incarcerated population, many virus-carrying residents may return to their communities. Reflecting these concerns, an analysis from the ACLU in August 2020 estimated that the American mass imprisonment could increase the number of COVID-19 deaths in the United States by 99,000 to 190,000 people.

**Limits to This Analysis**

There are important limits to this analysis. First, these are crude estimates of COVID-19 case rates and fatality rates in prisons. Because no publicly available data sets of individual-level inflow and outflow through jails and prisons exist, there is no way to measure jail and prison churn. This churn means that I do not know the “true” number of prisoners but rather only the counts at a moment in time. Relatedly, I have no ability to identify individuals who contracted the virus while incarcerated but who only tested positive after they left the prison or jail. Finally, these estimates are limited by the availability of testing in prison facilities. Because many facilities do not engage in surveillance or mass-population testing, they severely underestimate the number of positive cases present in their locations. For example, a report published in the *Morbidity and Mortality Weekly Report* analyzed data from sixteen prisons and jails in six jurisdictions that engaged in mass testing (testing all inmates). These scholars found a median 12.1-fold increase in the number of cases that had been identified by earlier symptom-based testing alone (Hagan et al. 2020). As of July 2020, researchers at the COVID Prison project estimate that only around 40 percent of incarcerated individuals in prisons received a COVID-19 test (Macmadu et al. 2020; Lemasters et al. 2020). This shortcoming indicates that the number of positive tests may reflect testing capacity across facilities within a state.

Alabama, Georgia, and Mississippi each stand out for being the only states with substantial prison populations that maintained a lower likelihood of contraction of COVID-19 while incarcerated. However, these lower relative rates may have been driven by high likelihood (generally) of contraction within the
state. Alabama, Georgia, and Mississippi were three of the twelve states with the highest rates of contraction outside of a state or federal prison. Still, many other states used similar measures but were not as effectively able to combat the virus among their general populations. Future work should seek to explain variation in COVID-19 spread across jurisdictions based on prison and jail policies in response to the virus.

Incarceration Contributes to Racial Disparities in COVID-19

One striking feature of COVID-19 has been its racially disparate impact across rates of infection, hospitalization, and death. Some have attributed these disparities to simply the product of economic inequality that is correlated with race. But in line with Whitney Laster Pirtle (2020), I argue that racism and capitalism together are the fundamental causes (Link and Phelan 1995) of racial and socioeconomic inequality in COVID-19. Specifically, these disparities are the product of deep structural racial inequality in the United States. Racial inequality in access to healthcare (Williams and Sternthal 2010), employment in essential jobs (McClure et al. 2020), and economic resources (Darity and Myers Jr. 1998; Oliver and Shapiro 2006) leaves racial and ethnic minorities more at risk of contracting COVID-19. Residential segregation (Massey and Denton 1993; Williams and Collins 2016), lower water quality (Jones and Rainey 2006), limited access to healthy food (Odoms-Young, Zenk, and Mason 2009), increased exposure to police violence (Ang 2021; Legewie and Fagan 2019) and to environmental pollutants (Mikati et al. 2018), and day-to-day discrimination (Geronimus et al. 2006) leave racial and ethnic minorities more likely to have comorbidities that increase the fatality rate of COVID-19 (Gravlee 2020).

Racism within the medical field means that, often, even if patients do access and receive medical treatment, patients of color have their symptoms, claims, and self-reports dismissed or minimized by medical personnel (Porter 1993). These layers of inequality in access, resources, and treatment come together to produce stark racial inequality in COVID-19 contraction and fatality rates, despite survey data suggesting white residents are less likely than racial and ethnic minorities to follow key COVID-19 transmission protocols like mask wearing (Igielnik 2020).

In this chapter I put forward one more key structural determinant of racial inequality in COVID-19 impact: the racialized American carceral state (Alexander 2020; Gilmore 2007; Gottschalk 2016). As outlined above, COVID-19 is more likely to be spread within prisons and jails. But American carceral facilities are sites of deep racial inequality because of the same racial capitalism.
(Robinson 2000) that defines the racial inequality in COVID-19. The carceral state is used to reduce the political power of minority groups (Eubank and Fresh 2022); to raise funds for fiscally distressed municipalities (Goldstein, Sances, and You 2020); and to warehouse individuals for whom the state fails to secure necessary financial, medical, and housing security (Subramanian et al. 2015). This political project leaves blacks, Native Americans, and Latinos dramatically overrepresented, with incarceration rates over 2.5 times higher than that for whites in the United States (Gottschalk 2016).

This overrepresentation in a high-risk location means these groups are far more likely to contract COVID-19 simply because of their being more likely to reside in a facility like a jail or prison. But in fact, many people of color who were not incarcerated at all during the COVID-19 pandemic also faced increased risks of contraction due to the racialized carceral state, because of the deep residential racial segregation in America (Massey and Denton 1993). When residents leave carceral facilities and return to their communities, they usually return to communities and neighborhoods that consist of members of their own racial group. And because these carceral facilities seldom provide adequate personal protective equipment (PPE) or testing to their residents, oftentimes these individuals return to their neighborhoods as active carriers or spreaders of the virus without knowing it. In Chicago, for example, black residents represent only 30 percent of the population but make up about 75 percent of detainees at the Cook County Jail. Analysts found that 60 percent of COVID-19 cases associated with cycling through Cook County Jail were in majority-black zip codes (Reinhart and Chen 2020).

In fact, there are real incentives for political officials and criminal justice operatives to leave prisons and jails full. Roughly half of the 1.4 million people incarcerated in state and federal prisons work behind bars, and throughout COVID-19 they served in essential roles for the state at pay rates unavailable outside of a carceral facility. For example, in California, during the rampant forest fires in fall 2020, prisoners served as firefighters at wages of $1 per hour, saving the state tens of millions of dollars. The nonprofit advocacy organization Worth Rises has found that more than forty states have used prisoners to make hand sanitizer and protective equipment despite often not having access to the same PPE and hand sanitizer themselves (Kamisher 2020). This reliance on prison labor may explain why levels of arrests remained high throughout COVID-19 and why carceral facilities did not engage in mass decarceration across the country despite evidence that high levels of arrests and mass incarceration negated the positive benefits of social distancing and stay-at-home orders (Reinhart and Chen 2020).
Conclusion

This chapter provided a brief overview of the relationship between COVID-19 and mass incarceration in three parts. First, I explained how COVID-19 affected pretrial detention policies and prison release policies across the United States. Using data from the NYU Public Safety Lab Jail Data Initiative and the Marshall Project’s COVID in Prisons data sets, I showed how pretrial detention (jail) populations and state prison populations changed during COVID-19. These data show that while there were meaningful decreases in the prison and jail population, these decreases were generally small in magnitude. Next, I showed how mass incarceration affected COVID-19 spread in the United States. I estimate the differences in likelihood of contracting COVID-19 in state or federal prisons as compared to the likelihood of contracting COVID-19 outside of prison, demonstrating that inmates were far more likely to contract COVID-19. Finally, I explained how America’s racialized mass incarceration contributes to the racial inequality in the effects of COVID-19.

The choices made by America’s political officials and criminal justice operatives have consequences. The choice of mass incarceration for nonwhite people in America has consequences. And as COVID-19 arrived in the United States, the choice to not decarcerate en masse also had consequences: tens of thousands of lost American lives. As researchers begin to reckon with the inadequate American institutional response to the coronavirus pandemic, mass incarceration should not be overlooked. Future research should continue to study the public-health consequences of the political project of mass incarceration in America.

NOTES


2. Baltimore, Maryland, State’s Attorney Marilyn Mosby dismissed pending criminal charges against anyone arrested for drug offenses, trespassing, and minor traffic offenses, among other nonviolent offenses; see Prudente and Jackson 2020.

3. The UCLA COVID-19 behind Bars data can be found at https://uclacovidbehindbars.org/.

REFERENCES


Geronimus, Arline T., Margaret Hicken, Danya Keene, and John Bound. 2006. “‘Weathering’ and Age Patterns of Allostatic Load Scores among Blacks and Whites in the United States.” *American Journal of Public Health* 96, no. 5 (May): 826–33.


