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COVID-19 in Correctional Settings:
How has the COVID-19 Pandemic Impacted Prison Policies and Conditions?

ABSTRACT. Due to the Coronavirus Disease 2019 (COVID-19), the public has been advised to isolate and quarantine from one another. These social distancing practices have also been applied to institutions such as schools, universities, businesses, and even prisons. Within prisons, officials have been working with the medical community to determine the best course of action to contain the spread of the virus. The current proposed policies for prisons to contain COVID-19 are decarceration or medical isolation. However, in the medical community, there is some concern with implementing medical isolation in prisons. Under supervision of the prison officials, medical isolation could become something similar to solitary confinement. Many researchers have argued against the use of solitary confinement under any circumstances due to the severe damage it can have on an inmate's psychological health. This paper serves to analyze the current policies of decarceration and medical isolation in prisons as well as the effectiveness of those policies in limiting the spread of COVID-19 among inmates. Additionally, this paper serves to compare medical isolation and solitary confinement and how important it is to distinguish between the two for the health and safety of all prisoners. As COVID-19 continues to spread across the country and recommendations to social distance and to isolate are consistently stressed, a proposed policy for effective control of the virus in prisons is offered, keeping both the physical and psychological health of inmates in mind.

INTRODUCTION

Isolation and quarantine; these words have become a staple in society over the past year as Coronavirus Disease 2019 (COVID-19) spread across the globe. People have been forced to quarantine themselves in their homes in order to protect themselves and others from the virus. It has been described as the "new normal" by many public figures. However, this "new normal" is not entirely new for the prison population in the United States. Many individuals within the U.S. prison system are all too familiar with the concept of isolation. While it is challenging to determine an accurate percentage due to lack of reporting and the high number of prisons across the states, it was estimated in 2012 about 20% of the United States prison population had been in

solitary confinement at some point during their incarceration (Beck 2015). Due to the increasing number of COVID-19 cases around the world, prison officials have been seeking guidance from the medical community to determine the best course of action to limit the number of cases in the prison population. Unfortunately, due to the close quarters, limited sanitation practices, and poor medical facilities, prisons have already become super spreader environments, where the virus is easily transmittable between inmates, as well as prison officials. There has been some discussion in the world of corrections to isolate all prisoners from one another, but this possible solution has several drawbacks. In particular, the medical community has expressed concerns for how ethical and effective this solution would truly be. As the COVID-19 pandemic continues to develop around the world, prison officials have been modifying policies and practices in order to contain outbreaks among incarcerated individuals, but their options are limited to decarceration or medical isolation, which many prisoners fear will be too similar to solitary confinement.

COVID-19

Emerging in December 2019 in Wuhan, China, the Coronavirus quickly spread to 187 countries, resulting in six million confirmed cases in the beginning of 2020 (Franco-Paredes et al. 2020). As the number of cases continue to rise around the globe, many in the medical field have been turning their attention towards high-population institutions such as nursing homes, immigration detention centers, and jails and prisons. These institutions have become the epicenter for infectious outbreaks due to the high population numbers, as well as a constant flow of individuals coming and going on a daily basis. For prisons and jails in particular, the potential for an infectious outbreak is substantially higher than most institutions due to “overcrowding, insufficient sanitation, poor ventilation, and inadequate healthcare” (Franco-Paredes et al.

2020:1). As a result, many jails and prisons throughout the world have been working as quickly as possible to determine how to maintain the health of those that are incarcerated, as well as the prison officials who are still required to come into work everyday.

The most effective strategy for reducing the transmission of COVID-19 between individuals is social distancing (Henry 2020). Although, due to prison overcrowding and limited options for social distancing within jails and prisons, this method for containment of the virus is slightly out of reach due to common prison procedures. In prisons, inmates are typically moved in groups out of convenience and some prisons even shackle their inmates together when moving them. If only one inmate is being transported through the prison, guards sometimes are required to physically hold onto the inmate as they move through the prison. Additionally, if guards need to gain control of a situation, they may have to lay hands on the inmates in order to regain the control.

Furthermore, many incarcerated individuals are at a higher risk of contracting the virus due to weakened immune systems, which can occur in response to their environment (Barnert, Ahalt, and Williams 2020). The prison environment is often extremely stressful for inmates due to insufficient mental stimulation, authoritarian guards, and lack of family contact. The additional concern for their health in the age of COVID-19 would only increase their stress levels, weakening their immune system even further. Inmates often have high rates of chronic medical conditions and prisons are argued to be notorious for having little to no medical access for inmates (Wilper, Woolhandler, Boyd, Lasser, McCormick, Bor, and Himmelstein 2009). Researchers have also argued when medical assistance is provided in prisons and jails, the treatment is often ineffective and the quality of care is lacking. According to a 2004 study,

among inmates with chronic medical conditions, “13.9% of federal inmates, 20.1% of state inmates, and 68.4% of local jail inmates had received no medical examination since incarceration” (Wilper et al. 2009:669). If prisons are already lacking in proper medical care, how are they expected to effectively care for their inmates during a global pandemic?

HOW COVID-19 SPREADS

According to the Centers for Disease Control and Prevention (CDC), COVID-19 spreads between people who are in close contact with one another. Close contact is considered to be within six feet (about two meters) of another person. This virus spreads primarily through respiratory droplets or small particles, which is classified as airborne transmission. Airborne transmission occurs when someone sneezes, coughs, or talks. It has also been determined it is possible to contract COVID-19 by touching a surface or object that has the virus on it and then touching one’s own mouth or nose. While individuals were mainly concerned of contracting the virus through touch in the beginning of 2020, scientists have come to the conclusion that contracting the virus through touch is not the main cause of the spread. Lastly, COVID-19 spreads easily and rapidly in high-density populations. As a result, public locations such as movie theaters, restaurants, malls, and theme parks were closed across the world at the beginning of the pandemic.

ADDRESSING COVID-19 IN PRISONS

While many businesses were able to close in an effort to flatten the curve, other institutions such as prisons and jails remained open throughout the pandemic and had to modify their policies in hopes of limiting the number of COVID-19 cases. For prisons in particular, high rates of preexisting health conditions, limited access to quality health care, and an inability to

social distance make it nearly impossible to reduce the impact of COVID-19 among incarcerated individuals (Robinson, Heyman-Kantor, and Angelotta 2020; Franco-Paredes et al. 2020; Henry 2020). As of June 2020, in the United States' correctional population, "over 570 incarcerated people and over 50 correctional staff have died and most of the largest coronavirus outbreaks are in correctional facilities" (Widra and Hayre 2020). These numbers may seem small compared to the prison population but these only account for the number of individuals who died from COVID-19 in correctional settings and does not include those who had the virus and recovered. Additionally, these numbers have most likely risen since June as the number of cases outside of correctional settings has increased substantially as well.

In addition to limited medical care, there has also been concerns raised about personal protective equipment (PPE) and whether or not it has been provided to those who are incarcerated. For most prisons and jails across the country, PPE consists of only non-surgical masks (Widra and Hayre 2020). Several states provided PPE to only some incarcerated individuals and prison officials; for example, inmates who were exposed to someone who tested positive for COVID-19 would receive PPE. Furthermore, as of June 2020, Florida, Rhode Island, and North Dakota did not have any information available to the public regarding the distribution or lack of PPE for their incarcerated populations (Widra and Hayre 2020). Access to PPE is crucial for flattening the curve and maintaining the health of the incarcerated population. Most importantly, providing prisons with PPE must occur in addition to implementing policies that comply with social distancing guidelines as outlined by the CDC.

One proposed policy to alleviate the spread of the virus in prisons is decarceration. Decarceration "includes reducing the flow of people into prisons and accelerating the flow of

people out of prisons by reducing arrests and increasing early release" (Henry 2020:537). In terms of reducing arrests, anyone in violation of breaking a law would receive a citation or other alternatives to prison to assist with decarceration. This policy also allows inmates to reintegrate into the community and gain access to community resources such as better medical care than what they would have received behind bars. Decarceration has been utilized by several prisons in the U.S. and in most circumstances, those who are released in light of the pandemic are placed in home confinement and are required to stay home. Critics of this policy have proposed one main question since its implementation: who should be released? Regarding who is released, the existing state-by-state policies suggest "releasing people held pretrial on bail, those approved for community supervision, those who are close to their release date, individuals held on minor charges, and those who qualify for medical release" (Henry 2020:538). To further explain, those who are little to no threat to society (at the discretion of prison officials) and those who are high-risk for contracting the virus are the individuals considered for release under decarceration.

The policy of decarceration has been difficult to carry out in prisons though due to a legal barrier referred to as compassionate release. Compassionate release is defined as, "a legal provision that varies by state but typically allows people with terminal illnesses, such as metastatic cancer and end-stage heart failure, to be released before their sentences have been served" (Wang, Western, and Berwick 2020:2257). According to the Bureau of Prisons, where compassionate release was utilized in place of decarceration, only 156 prisoners out of 10,940 who applied were released between March to May 2020 (Wang et al. 2020). At the beginning of the pandemic, many people were unaware of the severity of the virus and prison officials were no exception. Since the symptoms of COVID-19 were initially falsely compared to the flu, prison

officials potentially could have disregarded inmates reporting the symptoms and denied those inmates compassionate release. However, under this provision of compassionate release, decarceration cannot occur effectively because it depends on the state to decide whether or not an individual should be released for medical reasons.

The second proposed policy many prisons have implemented is medical isolation. According to official CDC guidelines, medical isolation is defined as, "the act of separating a sick individual with a contagious disease from healthy individuals without that contagious disease in order to protect the general public from exposure of a contagious disease" ("COVID-19 in Correctional Facilities: Medical Isolation"). However, the implementation of this policy requires prisons and jails to reduce the number of inmates to provide as much physical space as possible. Therefore, decarceration must occur in order for medical isolation to truly be effective. The major concern that has been brought to light regarding medical isolation is without the disease aspect of the definition, could it be comparable to solitary confinement?

SOLITARY CONFINEMENT

Solitary confinement has been defined as "the confinement of a prisoner alone in a cell for all, or nearly all, of the day with minimal environmental stimulation and minimal opportunity for social interaction" (Grassian 2006:327). Solitary confinement also has many names: secure housing unit (SHU), solitary confinement unit (SCU), isolation, super-maximum security confinement (supermax), administrative segregation (AdSeg), but in the eyes of most prisoners, it is just cruel and unusual punishment. In the early 1800s, the Pennsylvania prison system and the New York Auburn prison system emerged in the United States. The introduction of the Pennsylvania system and the Auburn system in Pennsylvania and New York, respectively, served

to establish the concept of solitary confinement within the United States. The Auburn system "was characterized by silent but congregate labor" (Arrigo and Bullock 2008:628). The congregate labor aspect of the Auburn system kept prisoners in solitary confinement overnight, but allowed inmates to work in groups during the day, but there was still a rule of silence enforced at all times. The Pennsylvania system was firmly established in 1829 when Eastern State Penitentiary was opened. Originally developed by the Quakers, this system relied on the idea of isolating prisoners from society as well as each other. The extreme isolation that characterized the Pennsylvania system was based on the idea that keeping prisoners in total isolation would give them time to reflect on the crimes they committed, inspiring them to repent (Arrigo and Bullock 2008). This idea of solitary confinement has long been abandoned and today, solitary confinement serves as a severe form of punishment, despite the controversy surrounding such extreme isolation.

As a modern design, solitary confinement is often used to hold prisoners deemed to be most dangerous to themselves, other prisoners, the guards, and society as a whole. Who is considered to be the "most dangerous" is a determination involving the discretion of prison officials. The prisoner in solitary confinement could be an inmate with a mental illness, whose illness could become progressively worse due to solitary confinement; or it could be an inmate who had a physical altercation with a guard and was deemed to be too aggressive. Solitary confinement is used as a form of punishment and is often to be considered to be "cruel and inhumane," regardless of the crimes committed by the person because such isolation denies prisoners of the minimum human necessities (Bennion 2015:742). According to Bennion (2015:774), minimum human necessities include "any condition that imposes unnecessary and

high risk of severe harm." At the very least, inmates should still have these minimum necessities met in prison and solitary confinement fails to reach even these basic needs. Therefore, based on this definition, solitary confinement can destroy the psychological health of prisoners because they are denied access to minimum human necessities, which would otherwise aid in their emotional well-being.

THE EFFECTS OF SOLITARY CONFINEMENT

The main human necessity taken away in solitary confinement is human interaction. Prisoners who have been put in extreme isolation stay in the same six by nine cell for 23 hours a day, and the most human interaction they receive is when their food is delivered through a tiny slot in the door (Haney 2018). Albert Bandura's (1971) social learning theory suggests people's behavior is formed through their relationships with others. Through social interaction, people are able to observe and learn the behaviors of those around them. Bandura (1971) proposes these interactions with others have great influence on the development of one's behavior. In solitary confinement, prisoners are cut off from social interaction with family, friends, and other inmates. Their isolation could eventually result in them withdrawing from all social interaction as a result of having no human interaction while in solitary confinement. Based on social learning theory, this isolation is challenging for prisoners upon release from solitary because they would not be able to interact comfortably with others and may avoid social settings all together, further isolating them from their surroundings both in prison and (eventually) in society at-large. Prisoners in solitary confinement have no behaviors to imitate because they cannot interact with anyone else but themselves. The limited human interaction adds to the mental regression they experience. Solitary confinement is the most extreme form of punishment prisoners often endure

which – more often than not – has severely negative effects on the psychological health of prisoners.

The prison experience is different for everyone and solitary confinement can differentiate the experience even further for prisoners. Solitary confinement can affect an inmate in many different ways but, more often than not, the psychological health of the prisoner is severely damaged in solitary. "The most widely reported effects of solitary confinement are psychological and these effects [vary] depending on the context, length. and conditions of the confinement" (Shalev 2011:156). Solitary confinement should have more regulations regarding the reasons for sending an inmate to solitary and for how long. In regards to the justification of the use of solitary confinement:

> Government entities have long justified the practice of solitary confinement on two general grounds. Prison regulations typically stipulate that "administrative" solitary confinement is warranted for purposes of prison management to ensure the safety and security of the facility—such as when an inmate is awaiting classification, is awaiting transfer to another institution or location, is awaiting a hearing for or under investigation for a violation of a prison regulation, has been classified as presenting a risk to staff or other inmates, is requesting segregation for self-protection, or when the staff has determined that such protection is needed. "Disciplinary" solitary confinement is a punitive status imposed as punishment for the commission of a variety of prohibited conduct, with the goal, in some cases, of restricting or restraining inmates so that their behavior does not escalate. (Birckhead 2015:5)

In some cases, prisoners are placed in solitary confinement to aid in prison management, but in most cases, prisoners are placed in isolation as a means of punishment for misconduct. In most instances, prisoners placed in solitary as punishment are not told why they are being placed there, or for how long they will be there. Some people would argue solitary confinement could be considered a violation of the Eighth Amendment. There are no official standards regarding what could warrant a punishment of such intensity as isolation. Guards can send inmates to solitary confinement with little to no explanation of why they are sending the inmate to solitary.

One of the main matters of contention in terms of solitary confinement is the length of time prisoners are held in solitary. There have been several studies conducted to determine if the length of isolation impacts the psychological health of an inmate (Labrecque 2015; Morris 2015; Zinger 1998). Researchers have also investigated the "disciplinary" justification for solitary confinement because in most cases, solitary is used as a means of punishment to correct an inmate's behavior. Morris (2015) assessed the relationship between short-term solitary confinement and the future violence or misconduct among male inmates. The researcher determined exposure to short-term solitary confinement as punishment for violence had little to no role in increasing or decreasing the probability, timing, or development, of future misconduct among male inmates. This finding could imply the use of solitary confinement as a means of punishment to correct an inmate's behavior is ineffective. If the inmate had any future incidents of misconduct, there would be no indication of when the misconduct would happen or how severe it would be.

In a similar study, Zinger (1998) aimed to determine how offenders in segregation and those in the general population think and feel about many different areas of their lives. For the study, the participants placed in segregation voluntarily agreed to be segregated for the study's fixed period of 60 days. The researcher found that there was no significant evidence that over the 60 day period that the mental and psychological health of the segregated inmates had been severely negatively affected. Based on the findings of these two studies, it is evident short-term solitary confinement has little impact on inmates. There are no severe negative mental effects of short periods of isolation; however, but in terms of correcting an inmate's behavior, solitary confinement also has little to no impact in preventing future incidents of misconduct. To further

corroborate these findings, Labrecque (2015) explored the lack of literature regarding the effect solitary confinement has on inmate adjustment to prison. By the end of the study, it was determined there was a severe lack of evidence of any effect of solitary confinement on subsequent inmate misconduct. The findings of the study also suggested solitary confinement had no significant effect on criminal behavior. The misconduct of a prisoner often leads to the placement in solitary confinement, but the research suggests any length of isolation has no bearings on an inmate's history of misconduct or future occurrences (Labrecque 2015). Guards continue to send prisoners to solitary confinement in hopes of correcting their behavior, but in the end, the guards are doing more harm than good. While short-term solitary confinement has very little effect on an inmate, longer periods of isolation can have severe negative impacts on the psychological health of the prisoner.

MEDICAL ISOLATION VERSUS SOLITARY CONFINEMENT

The major argument against medical isolation in prisons is the potential that it could look too similar to solitary confinement. It is important to note that medical isolation is supervised by medical staff as opposed to prison officials because it is assumed carrying out this policy will be more humane and ethical under the medical supervision (Cloud, Ahalt, Augustine, Sears, and Williams 2020). Solitary is mainly used as a form of punishment and medical isolation should bear no resemblance to this practice because medical isolation is intended to help inmates, not harm them. Additionally, medical isolation has a definitive end while solitary confinement does not. Inmates who are medically isolated are removed from the isolation as soon as they have been cleared by medical staff. In solitary confinement, inmates are held for an indefinite length of time and prison officials are those responsible for determining how long the confinement will

last. Prison officials also have the power to add additional time to an inmate's period of solitary confinement. Currently, the use of medical isolation and length of time prisoners will be isolated to one another is determined by the pandemic and the guidance of the medical community. If prison officials do not seek out assistance from medical professionals to assist in isolating prisoners during this time, it is possible they could damage the psychological health of the inmates. In any prisons with limited medical staff, medical isolation could morph into something more comparable to solitary confinement. It is impossible to predict when exactly the pandemic will end and when social distancing will no longer be necessary so if prisoners are kept in isolation by prison officials until then, their psychological health could suffer greatly.

Additionally, the use of punitive isolation (as opposed to medical isolation) during COVID-19 could deter people from reporting any symptoms, in turn threatening the health of all those who work in jails and prisons as well as those who are incarcerated (Cloud et al. 2020). When comparing these two practices, the only similarity medical isolation and solitary confinement should have to one another is a physical separation from other people.

PROPOSED POLICY

In order to effectively reduce the spread of COVID-19 among incarcerated populations, medical isolation and decarceration should be used concurrently. This method has been utilized in some states but should be implemented across the country in all prisons and jails. Medical isolation can be effective to a certain extent, but decarceration needs to happen as well. Due to the limited physical space in prisons, it is challenging to social distance properly and this has led to prisons becoming epicenters for the virus. There also needs to be a stark contrast between medical isolation and solitary confinement. Prison management and medical personnel need to

work together to ensure those placed in medical isolation are treated humanely and not at risk for any damage to their psychological health.

Health screenings should also be available for all inmates. They are a vulnerable population and their health is often poor because of their environment making them more susceptible to diseases and viruses. In addition to limiting the spread among inmates, the guards also have to be taken into account. Screenings for COVID-19 should be mandatory for all guards. They come and go from these institutions on a daily basis, making it possible for them to bring the virus into the prison or even introduce it to the public if someone on the inside has already been exposed.

The importance of personal protective equipment (PPE) and availability of COVID-19 for incarcerated individuals must also be taken into consideration. There is limited information concerning the provision of PPE among jails and prisons which could imply it has not been consistently provided in correctional settings across the nation. The CDC has provided extensive guidelines and recommendations for the implementation of social distancing within prisons and jails but they also stress the importance of supplying inmates and prison officials with PPE. It is unclear whether or not state governments have acted on these recommendations because the data from correctional settings is limited and much of it is often unavailable to the public.

Concerning the provision of PPE and COVID-19 tests, in this proposed policy, there should be a push for national government funding. Cases of COVID-19 have been handled on a state-by-state basis but based on the current status of COVID-19 in the United States, it should be given more attention at the national level. The same reality holds true for correctional settings; state governments have been handling their COVID-19 cases individually and this includes

funding for PPE and COVID-19 tests. Receiving funds from the national government would be challenging, but if decarceration had already been implemented, the prison population would decrease substantially. With fewer people incarcerated, any funds that would have gone towards providing additional services for the inmates could be allocated towards medical care, including PPE and COVID-19 tests. The importance of national government funding for adequate medical care in correctional settings would also provide the public with the sense that the health of everyone in America is being tended to, rather than just select groups of people.

CONCLUSION

When the Coronavirus pandemic was first confirmed in the United States, the medical community under the guidance of the CDC began to issue social distancing guidelines and proper methods of isolation to the public. While there was great concern for the health of those in the general population, many high-population institutions, such as prisons, were top priority for the medical community. These institutions, and prisons in particular, had the potential to become epicenters for COVID-19 outbreaks. Due to lack of physical space, mass incarceration, and little to no medical care, prisons quickly held the title for "largest coronavirus outbreaks" in the nation. The possibility of social distancing is arguably impossible in correctional settings so this realization forced prison officials to seek out assistance from the medical community to address these concerns. In an effort to flatten the curve, prison officials had two options: decarceration and medical isolation. The implementation of both policies proved to be more challenging in states than many people would anticipate though. In attempts to decarcerate prisons, the provision of compassionate release presented an obstacle in reducing the prison population to manageable numbers for social distancing. There have also been concerns among the medical

community about the use of medical isolation within prisons and jails. Specifically, if prison officials were to supervise medical isolation, the medical community and inmates feared it would be comparable to solitary confinement.

In order to address the rising concerns regarding COVID-19 in correctional settings, prisons and jails should adopt a two-fold policy including both decarceration and medical isolation. Social distancing has proven to be the most effective method in reducing COVID-19 cases and in order to replicate social distancing requirements in prisons, enough inmates need to be released in order to medically isolate those left inside behind bars. Additionally, medical officials should be supervising any isolation that occurs in response to the pandemic to ensure there will be no risk of psychological damage for the inmates. Finally, PPE, COVID-19 tests, and health screenings should be provided for all inmates and prison officials. Prison officials are at risk of bringing the virus into the prison so it is crucial to screen them for any signs of the virus each time they enter and leave the prison. All inmates should be provided with PPE as well because even if medical isolation is possible, they are still in close contact with one another and therefore, at risk of contracting the virus from a fellow inmate or prison staff member. The pandemic has presented society with many new challenges. However, the presence of the virus in correctional settings has created a ticking time bomb, counting down to the next massive outbreak of cases if prison officials do not take action to fully address stopping the spread of the virus on the inside.

References

Arrigo, Bruce A. and Jennifer Leslie Bullock. 2008. "The Psychological Effects of Solitary Confinement on Prisoners in Supermax Units." *International Journal of Offender Therapy & Comparative Criminology* 52(6):622–40.

Bandura, Albert. 1971. "Social Learning Theory." New York: General Learning Press.

Barnert, Elizabeth, Cyrus Ahalt, and Brie Williams. 2020. "Prisons: Amplifiers of the COVID-19 Pandemic Hiding in Plain Sight." *American Journal of Public Health* 110(7):964–66.

Beck, Allen J. 2015. "Use Of Restrictive Housing In U.S. Prisons And Jails, 2011-12." *Bureau of Justice Statistics (BJS)*. Retrieved December 6, 2020 (https://www.bjs.gov/index.cfm?iid=5433).

Bennion, Elizabeth. 2015. "Banning the Bing: Why Extreme Solitary Confinement Is Cruel and Far Too Usual Punishment." *Indiana Law Journal* 90(2):741–86.

Birckhead, Tamar R. 2015. "Children in Isolation: The Solitary Confinement of Youth." *Wake Forest Law Review* 50(1):1–80.

Cloud, David H., Cyrus Ahalt, Dallas Augustine, David Sears, and Brie Williams. 2020. "Medical Isolation and Solitary Confinement: Balancing Health and Humanity in US Jails and Prisons During COVID-19." *Journal of General Internal Medicine* 35(9):2738–42.

"Coronavirus Disease 2019 (COVID-19)." *Centers for Disease Control and Prevention.* Retrieved December 6, 2020 (https://www.cdc.gov/coronavirus/2019-ncov/index.html).

"COVID-19 in Correctional Facilities: Medical Isolation." *Amend*. Retrieved December 6, 2020 (https://amend.us/covid-19-in-correctional-facilities-medical-isolation/).

Franco-Paredes, Carlos et al. 2020. "COVID-19 in Jails and Prisons: A Neglected Infection in a Marginalized Population." *PLOS Neglected Tropical Diseases* 14(6).

Grassian, Stuart. 2006. "Psychiatric Effects of Solitary Confinement." *Washington University Journal of Law & Policy* 22:325–83.

Haney, Craig. 2018. "The Psychological Effects of Solitary Confinement: A Systematic Critique." Crime & Justice 47(1):365–416.

Henry, Brandy F. 2020. "Social Distancing and Incarceration: Policy and Management Strategies to Reduce COVID-19 Transmission and Promote Health Equity Through Decarceration." *Health Education & Behavior* 47(4):536–39.

Labrecque, Ryan M. 2015. "The effect of solitary confinement on institutional misconduct: A longitudinal evaluation." (Doctoral dissertation, University of Cincinnati).

Morris, Robert G. 2015. “Exploring the Effect of Exposure to Short-Term Solitary Confinement Among Violent Prison Inmates.” *Journal of Quantitative Criminology* 32(1):1–22.

Robinson, Lauren K., Reuben Heyman-Kantor, and Cara Angelotta. 2020. “Strategies Mitigating the Impact of the COVID-19 Pandemic on Incarcerated Populations.” *American Journal of Public Health* 110(8):1135–36.

Shalev, Sharon. 2011. “Solitary Confinement and Supermax Prisons: A Human Rights and Ethical Analysis.” *Journal of Forensic Psychology Practice* 11(2/3):151–83.

Wang, Emily A., Bruce Western, and Donald M. Berwick. 2020. “COVID-19, Decarceration, and the Role of Clinicians, Health Systems, and Payers.” *Jama* 324(22):2257-58.

Widra, Emily and Dylan Hayre. 2020. *“Failing Grades: States' Responses to COVID-19 in Jails and Prisons.” Failing Grades: States' Responses to COVID-19 in Jails and Prisons | Prison Policy Initiative*. Retrieved December 6, 2020 (https://www.prisonpolicy.org/reports/failing_grades.html).

Wilper, Andrew P., Steffie Woolhandler, J. Wesley Boyd, Karen E. Lasser, Danny McCormick, David H. Bor, and David U. Himmelstein. 2009. “The Health and Health Care of US Prisoners: Results of a Nationwide Survey.” *American Journal of Public Health* 99(4):666–72.

Zinger, Ivan. 1998. “The Psychological Effects of 60 days in Administrative Segregation.” (Doctoral dissertation, Carleton University, Department of Psychology).