THE CONTRADICTION
OF COLOR-BLIND COVID-19 RELIEF
BLACK AMERICA IN THE AGE OF PANDEMIC

2020

CRIMINAL JUSTICE POLICY PROGRAM
HARVARD LAW SCHOOL

LAW 4 BLACK LIVES DC

THURGOOD MARSHALL
CIVIL RIGHTS CENTER
HOWARD UNIVERSITY SCHOOL OF LAW
ACKNOWLEDGEMENTS

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THE THURGOOD MARSHALL CIVIL RIGHTS CENTER

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CRIMINAL JUSTICE POLICY PROGRAM

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LETTER TO CONGRESS

TO THE MEMBERS OF THE SENATE &
U.S. HOUSE OF REPRESENTATIVES:

We write to you as concerned
advocates for civil rights and racial
justice.

First, we would like to express our
gratitude for the swift and essential
steps Congress has taken to mitigate
the effects of COVID-19 on the
American people, including the CARES
Act and the HEROES Act.

While we acknowledge the potential
positive impact of the recent
legislation, we write to draw your
attention to the disparate impact that
COVID-19 has had on Black Americans.
As you and your colleagues consider
additional legislation and debate the
HEROES Act, we urge you to consider
the impact of COVID-19 on Black
Americans and, as a result, propose
more targeted legislation to address
the racialized disparities in the
following areas:

1. Health
2. Economics
3. Domestic Violence
4. Policing
5. Mass Incarceration

The curve cannot be flattened without
particular attention to how COVID-19 interacts
with already existing inequalities in the Black
community. We encourage your staffers to
reach out to us if you would like any additional
information.

Again, we thank you and your colleagues for
your efforts.

Best wishes,

JUSTIN HANSFORD
Professor of Law, Executive Director,
Thurgood Marshall Civil Rights Center
INTRODUCTION

According to the Joint Center for Political and Economic Studies, the most recent HEROES Act contains provisions that will aid the Black community, including $1.7 billion for Historically Black Colleges and Universities (HBCU) and minority serving institutions, $20 million for Howard University, and provisions that prioritize grants to HBCU medical schools. [1]

To address health disparities, it requests that the Centers for Disease Control establish health inequity field studies, requires the Department of Health and Human Services (DHHS) to propose strategies to reduce infection disparities, and authorizes funds to modernize health inequity data collection methods. [2]

To support Black businesses, it authorizes $2 billion to the Community Development Financial Institution fund, of which $800 million would be set aside for minority-owned lenders to support minority-owned businesses and underserved communities. [3]

To address domestic violence, programs created pursuant to the Violence Against Women Act would receive $100 million dollars. [4]

To prevent police transmission of the virus, Community Oriented Policing Services will receive $300 million, some of which will be used for the purchase of personal protective equipment; and concerning the criminal legal system, the Bureau of Prisons would receive $200 million dollars to prevent, prepare for, and respond to the coronavirus, including funding for medical testing and services, hygiene supplies and services, and sanitation services, $250 million for Second Chance Act grants to facilitate community reentry and prevent recidivism. [5]

We are perhaps most encouraged by the provisions in the “Pandemic Justice Response Act” which would require the release of juveniles and those who have preexisting health conditions that put them particularly at risk. [6]
However noble many of these initiatives are, they have until now failed to consider the disproportionate impact of COVID-19 on the Black community. This disproportionate impact justifies a disproportionate response. If a hurricane primarily lands on the Florida coast and creates a state of emergency there, it is not unfair to Massachusetts or Wyoming to send additional relief funds to Florida and target relief efforts in a way to disproportionately aid the Florida coast. Nor is it noble to pretend that the damage done by this hurricane in Florida and Wyoming is equal when it is not.

Similarly, racially disparate impact is difficult to address if it is not acknowledged; and once acknowledged, it must be acted on. Relief efforts so far have adhered to the notion of colorblindness, described as the notion that “distinctions of race or color play no proper part in the distributions of burdens or benefits in public law or policy.”[7]

This idea was embraced historically to oppose enslavement, segregation, and other uses of racial identity to intentionally and blatantly create the racial hierarchies that still plague us unto today. However, as noted by the noted professor and activist Michelle Alexander in The New Jim Crow: Mass Incarceration in the age of Colorblindness, “Our blindness also prevents us from seeing the racial and structural divisions that persistent in society.”[8]

Even Dr. Martin Luther King, who is so often cited as a prophet of colorblindness for adhering to the desire to be judged by the content of his character and not the color of his skin, would clearly grasp that as a general notion, and in particular during this crisis, it would be a tragedy for million of Black people to be “crucified by conscientious blindness” in this moment that will have long term ramifications for all of us.[6]
A COLOR CONSCIOUS RESPONSE TO COVID-19

HEALTH
- Expand access to testing and emergency care in Black neighborhoods (Brookings Institute)
- Make healthcare access universal to improve access to treatment for Black Americans (Brookings Institute)
- Implement protocols to reduce implicit bias in treatment (Centers for Disease Control)

ECONOMICS
- Create a Minority Business Development Agency (Senator Cory Booker, Senator Ben Cardin)
- Dedicate funds to minority owned businesses (The Center for Responsible Lending)
- Ensure Banks Provide Equal Access to Federal Loans and Free Tax Filing Support (Color of Change)

DOMESTIC VIOLENCE
- Provide support for Black led nonprofit organizations, shelters and advocacy groups (National Network to End Domestic Violence)
- Provide support for digital toolkits and hotlines (National Network to End Domestic Violence)

POLICING
- Divest from Police/Invest in the Black Community (Law for Black Lives, the Center for Popular Democracy)
- Eliminate or Limit Qualified Immunity (Senator Bernie Sanders, Senator Elizabeth Warren)
- Provide Meaningful Local and Federal Oversight that reduces the impact of police brutality, racial profiling, and use of force on Black people (Congresswomen Ayanna Pressley, Ilhan Omar, Karen Bass)
- Eliminate Unfair Police Union Contracts (Campaign Zero)
- Create a fund for victims of police brutality modeled after the 9/11 victims compensation fund, designed for victims and their families to pay for medical treatment, mental health treatment, and legal fees in the aftermath of police violence. (Mike Brown Foundation)

MASS INCARCERATION & CRIMINALIZATION
- Include additional measures guaranteeing appropriate standards of care, including discouraging reliance on solitary confinement (Human Rights Watch)
- Support a vision for safe and healthy communities for impacted Black people in terms of housing, including additional public housing (JustLeadershipUSA)
- Increase Access to SNAP benefits and permit returning citizens to apply for CARES Act funding (Center on Budget and Policy Priorities)
- Urge compassionate release of the incarcerated in high risk cases (Limon Center, Yale)
As of May 29, 2020

DEATH TOLL IS HIGHEST AMONG BLACK AMERICANS

COVID-19 infects people indiscriminately, yet Black Americans are more than twice as likely to die from COVID-19 compared to any other group. According to the nonpartisan American Public Media research lab, through May 19, 2020, Black Americans died at a rate of 50.3 per 100,000 people, compared to 20.7 for Whites, 22.9 for Latinos and 22.7 for Asian Americans. [10]

The Centers for Disease Control (CDC) found that Black Americans comprised 33 percent of people hospitalized from COVID-19 despite making up only 13 percent of the U.S. population. [11] By contrast, the CDC found that White Americans made up 45 percent of hospitalizations while accounting for 76 percent of the U.S. population. [12]

In Chicago and Louisiana, Black patients account for 70 percent of coronavirus deaths, even though they make up roughly a third of the population. [13] In Michigan, Black people comprise 40 percent of the deaths despite being only 13 percent of the population. [14]

A recent report compiled by clinicians, epidemiologists, and university professors found that by April 13, there were 283,750 COVID-19 cases and 12,748 deaths in disproportionately Black counties compared with 263,640 coronavirus cases and 8,886 deaths in all other counties. [15]

Legal scholar Khiara Bridges recently remarked that although “the list of structural factors that make people of color sicker than their white counterparts is long . . . If providers’ implicit racial biases contribute to excess morbidity and mortality among people of color, we must recognize that individuals with implicit biases practice medicine within and alongside structures that compromise the health of people of color.” [16]

As many have noted, the high death tolls in Black communities reflect the fact that Black Americans are more likely to have preexisting health conditions that exacerbate COVID-19’s symptoms. These preexisting conditions are the result of inter-
BLACK COMMUNITIES VULNERABLE TO COVID-19

Connected disadvantages rooted in inequitable access to housing, education, employment, healthcare, etc. [17] Black Americans are also more likely to experience “major discriminatory events” such as “being unfairly fired, threatened by police, denied employment, or prevented from moving into a neighborhood” which can cause hypertension and other chronic diseases. [18] Treatment guidelines determining the allocation of life-saving measures like ventilators and access to the ICU depend on such measures as “comorbid conditions, future life expectancy and status as health and public safety workers” also disproportionately impact Black Americans whose “[h]igher disease burdens and shorter life expectancies...reflect social failures, not personal ones.” [19]

Black Americans are also disproportionately likely to be uninsured or underinsured, limiting their options for treatment and leaving them particularly vulnerable should they fall ill. [20] Furthermore, Black neighborhoods are often characterized by a lack of healthy food options, green spaces, recreational facilities, and viable public transit—all conditions that are rooted in the historical legacy of redlining. [21] They are also disproportionately exposed to pollutants which contribute to heart attacks, low birth weights, and high blood pressure as well as asthma prevalence and severity, which is particularly dangerous given that COVID-19 negatively impacts lung function. [22]

Interpersonal bias impacts the treatment of Black Americans with COVID-19. In addition to structural inequities, interpersonal biases undermine the quality of care Black communities receive. [23] Preliminary research from a Boston-based biotech firm suggests that Black people who visited hospitals with COVID-19 symptoms in February and March of 2020 were less likely to get tested or treated than White patients. [24] Stories like those of Rana Zoe Mungin, [25] Gary Fowler, [26] and Deborah Gatewood [27] expose the unfortunate persistence of this reality and its devastating consequences. Delays in treatment have become a central issue in the discourse explaining the disparity in morbidity as a result of the virus. [28]

Recommendations

Color-blind solutions will not go far enough to address Black Americans’ disparate experience of COVID-19, which are exacerbated by deeply entrenched inequities. Experts at the Brookings Institute have also proposed expanding access to testing and emergency care in Black neighborhoods and making healthcare universal to remove barriers to treatment for Black Americans. [29] Advocates at the Poor People’s Campaign have echoed those recommendations and requested rationing of care decisions which “ensure that the poor and people of color are not denied equal access to care and that criteria do not replicate past and ongoing discrimination.” [30] The Centers for Disease Control recommends that system and healthcare providers implement standardized protocols to ensure high quality treatment in facilities catering to marginalized people, work with communities to reduce cultural barriers to care, and address implicit bias which undermines the quality of care marginalized communities receive. [31] Prominent advocates have also called for the creation of state-specific Health Equity Task Forces similar to the task forces that have been created in Ohio and Michigan. [32]
COVID-19 Exposed

DISPARITIES IN BLACK LABOR FORCE

COVID-19 disproportionately burdens the Black labor force. Employment disparities put Black communities at higher risk of contracting COVID-19. Black workers are over-represented in the essential services industry, comprising 37.7 percent of the workforce in these industries. [33] White workers, in contrast, make up 26.9 percent of this workforce. [34] Additionally, Black workers are more likely to work in jobs that require close proximity to others. For instance, Black workers make up a disproportionate share of bus drivers and postal workers—two essential jobs that require close interaction with others. [35]

The risk of employment-related exposure is even higher in the healthcare industry. Black workers are approximately 50 percent more likely to work in the healthcare and social assistance industry and 40 percent more likely to work in hospitals than White workers. [36] Approximately 33 percent of nursing assistants, 39 percent of orderlies, and 39 percent of psychiatric aides are Black, all positions that require close interactions. [37] Black workers are also more likely to be respiratory therapists and personal care aides, both of which increase their risk of exposure to COVID-19. [38] And though the risk of exposure to COVID-19 is more pronounced for healthcare workers, this risk is shared by the broader Black community.

More than 80 percent of Black people have jobs that cannot be done remotely. [39] They are faced with an impossible choice: risk exposure to the virus by going to work or risk financial ruin by staying home. Black workers are under-compensated for their work and, as a result of this pay gap and other structural inequities, most do not have large savings that would permit them to take a voluntary furlough, and so they continue working. [40] Black people are providing essential services to ensure the rest of the country has access to food, healthcare, and transportation and risking their health to do so.
COVID-RELATED UNEMPLOYMENT IN BLACK COMMUNITIES

COVID-related unemployment disproportionately impacts Black Americans.

Black Americans are more likely to be employed in careers deemed expendable during an economic downturn. A recent McKinsey study found that 39 percent of all jobs held by Black Americans—compared with 34 percent held by White Americans—are now threatened by reductions in hours or pay, temporary furloughs, or permanent layoffs, totaling 7 million jobs. [41]

Research also supports the role of implicit bias in Black workers being selected to be the first fired during economic downturns, and this pattern will likely continue and repeat during the COVID-19 crisis. [42] Already, 21 percent of African Americans have lost their jobs compared to 15 percent of White Americans. [43]

COVID-19 DISPROPORTIONATELY AFFECTS BLACK OWNED BUSINESSES

COVID-19 Disproportionately Affects Black-owned Businesses

A survey conducted for Color of Change and UnidosUs, which included interviews with 500 business owners and 1,200 workers from April 30 to May 11th found that just 12 percent of Black and Latino business owners received the full amount of aid that they had requested from the Small Business Administration, while 26 percent received a fraction of what they requested. [44] This is in contrast to the Census Bureau’s survey, which found that 38 percent of those who asked for a loan had received one. [45] Meanwhile, nearly 400 public traded companies received over a billion in federal forgivable loans meant for small businesses, including large hotel and restaurant chains that obtained loans over the 10 million maximum because they filed more than one application. [46]

There are a number of structural inequities that put Black businesses in peril. For example, because the average Black business has approximately one-third the wealth of the average White business, [47] Black business owners are less likely to have the ability to withstand this economic downturn. [48] Because the median American White family has roughly 10 times more wealth than the median Black family, Black business owners generally have less cushion to absorb economic shocks. [49]
Further, Black business owners often operate their businesses in industries that require a high level of customer interaction and therefore the risk of infection is higher among Black-owned businesses. Approximately 29 percent of all Black-owned businesses that have paid employees are within the healthcare and social assistance fields, which includes independent practices of physicians, as well as continuing care/assisted living and youth services. Additionally, 10 percent of Black-owned businesses provide administrative, support, waste management, and remediation services, which includes recycling and waste management facilities. [50] Also, 8 percent of Black-owned businesses are in retail trade, which includes grocery stores. [51]

These inequities were compounded by the actions of major banks, which gave preferential treatment to wealthier clients and aided their wealthy clients in the application process, while less wealthy, and likely disproportionately Black, businesses couldn’t get their loan requests submitted before the money was used up. [52] The Center for Responsible Lending published an in depth analysis of why the initial relief efforts disproportionately harmed Black businesses. [53] By using the nation’s biggest banks and SBA approved lenders for the relief funding, Black businesses, which less often receive access to credit from financial institutions like JPMorgan Chase, Citibank, and U.S. Bank, and lack pre-existing accounts, and more often lacked the capacity to file the paperwork needed for access to the loan, had less access to support from the banks during the application process. [54]

Undoubtedly, all working-class Americans are suffering from the economic effects of COVID-19. However, the inequities informing the disparate impact of COVID-19 on Black workers require particular attention. Additional proposals must address the unique needs of the Black American working-class.

Recommendations

Following the HEROES Act, Senator Cory Booker (D-NJ) and Senator Ben Cardin (D-MD) proposed additional measures to support minority-owned businesses, including creating a Minority Business Development Agency, expanding access to payroll protection funds for people with felony convictions, and dedicating $10 billion dollars to Community Development Financial Institutions and Minority Depository Institutions. [55] The Center for Responsible Lending strongly recommends relief packages that dedicate more money for minority-owned businesses and provide alternatives to payroll protection loans that can respond to small businesses with no paid employees. Color of Change has also suggested measures that include the provision of Free Tax Filing Support for small and Black owned businesses. [56]
DISPARITIES IN THE BLACK LABOR FORCE

50% MORE BLACK LABOR IN HEALTHCARE & SOCIAL ASSISTANCE

40% MORE LIKELY TO WORK in hospitals than White workers, Black workers comprise the majority of orderlies, respiratory therapists, and personal care aides.

80% BLACK WORKERS CANNOT WORK FROM HOME

MORE BLACK ESSENTIAL WORKERS
Black workers are overrepresented as postal workers and transit operators.
COVID-19 Disproportionately puts members of the Black Community in

ISOLATION & QUARANTINE IN UNSAFE HOMES

In recent weeks, reports of domestic violence have sharply increased, and this increase has dire consequences for Black women. [57] Though statistics show 1 in 4 women experience interpersonal violence, data reflects much higher rates for Black women. [58]

Over 40 percent of Black women have experienced violence at the hands of a partner. [59] These interactions also prove more dangerous for Black women who, despite making up only 8 percent of the U.S. population, account for 22 percent of domestic violence-related homicides. Indeed, domestic violence is one of the leading causes of death for Black women between the ages of 15 and 35. [60]

As alarming as these statistics are, domestic violence is overwhelmingly underreported, and Black women are among the least likely to report it. [61] Though “a strong sense of cultural affinity and loyalty to community and race renders many [Black women] silent,” the criminal legal system also discourages Black women from reporting abuse. [62] Black women are disproportionately likely to experience criminalization following reports of abuse and to experience additional violence at the hands of police, against whom they have limited recourse. [63]
LIMITED ACCESS TO SUPPORT

While Quarantined, Survivors Face Increased Risks and Limited Access to Outside Support

Purveyors of harm are experiencing additional stressors related to the pandemic, putting survivors in particularly precarious positions. [64] In addition to the combined loss of power and control, the rise in housing instability, health-related fears, and financial instability all trigger increased risks of gender-based and family violence. [65] These risks are particularly troubling due to mandatory isolation orders which may force survivors to remain in dangerous settings. Mandatory closures of social settings like schools, churches, businesses, and advocacy organizations also limit survivors’ access to much-needed support. [66]

During the pandemic, several cities have reported spikes in the intensity and frequency of abuse. [67] Domestic violence hotline calls have similarly spiked, but while nonprofit and community-based organizations are usually able to offer survivors housing, financial support and other critical aid, mandatory sheltering and distancing guidelines have limited their capacity to do so. [68] Even so, advocates are attempting to implement safety plans and prepare for worst-case scenarios. [69]

Recommendations
According to the National Network to End Domestic Violence, nonprofit organizations, shelters, and advocacy groups require technical support to ensure the safety of survivors. In addition to the reduction of in-office services, domestic violence hotlines anticipate a reduction in calls and an increase in text messages from survivors unable to speak freely at home. [70] Digital advocacy will enable advocates to offer timely support and monitor survivors’ mental health and well-being. [71] The network also recommends organizations create digital toolkits to aid victims and teach community members how to identify and assist survivors of abuse. [72]
In the wake of COVID-19, Black Americans Remain Disproportionately IMPACTED BY POLICING

Pandemic Policing Disproportionately Impacts Black Americans Structurally

Aggressive policing poses particularly dire risks for those targeted. Initial data suggests the disparities outlined above have not only survived the pandemic, but have been accelerated. In Brooklyn, New York, the district attorney recently announced that 35 out of the 40 people arrested for social distancing violations from March 17th to May 4th were Black. [73] Other data released by the NYPD showed that 81 percent of the 374 summonses issued in regard to social distancing were issued to Black and Latino residents. [74]

Almost as if to address rationalizations of this data that would suggest that perhaps Blacks are more likely to flout social distancing guidelines, during this same period, images circulated of White sunbathers closely packed in a public park without using any facial coverings. Instead of conducting arrests or giving citations, police officers distributed masks. [75]

Ticketing and fees have already been tools used to target Black communities for economic exploitation. [76] In this time of pandemic, as noted by Robyn Maynard and Andrea J. Ritchie, with record unemployment leading to precarity in access to food, housing, and other essentials, aggressive ticketing can inflict even more harm. [77] On the question of use of force, additional contact with law enforcement already resulted in disproportionate use of deadly force against Black communities. [78]

Black people are also more likely to use public transit [79] where police are aggressively enforcing COVID-related mandates. In a Brooklyn subway station, a mother traveling with her child was violently knocked to the ground, handcuffed, and arrested for wearing her mask improperly. [80] In Philadelphia, nine police officers forcibly removed a man from a bus for not wearing a mask. [81] These incidents have been replicated [82] across the nation and offer valuable insights on how efforts to criminalize noncompliance with COVID-related mandates will be disproportionately invoked and enforced in Black communities. [83]
POLICING, CONT’D

Policing in the United States has been designed structurally to racially profile and implement excessive force against Black Americans.

These issues came to a head in a rash of racial policing incidents during the pandemic, including the killings of Breonna Taylor in her home by police who raided the wrong address in Louisville, Kentucky, [84] and the killing of George Floyd who died after a police officer put his knee to Floyd’s neck while pinning him to the ground in Minneapolis, Minnesota. [85] In both circumstances, the situations became inflamed as police responses to protests against these killings were significantly more harsh and violent than the heavily armed protests against the closing of American businesses conducted by predominantly White conservative protesters. [86]

Following the killing of Michael Brown in Ferguson and the rise of the Black Lives Matter movement, the Department of Justice launched investigations into the Ferguson Police Department as well as police departments in Baltimore, Chicago, Cleveland, and other major cities across the nation. [87]

These investigations revealed high incidences of racial profiling and the disproportionate use of ticketing, fees, and deadly force by police in Black communities, conclusions that reinforced the claims of activist organizations like Campaign Zero. [88] For example, research has concluded that Black men are more than 2.5 times more likely to be killed by police than White men. [89] This data has inspired debates over whether such drastic disparities are unintentional or, as Georgetown law professor Paul Butler concluded, the byproduct of a system working exactly as it was intended. [90]

SURVEILLANCE

Surveillance and Perceptions of Criminality

Perhaps one of the most pernicious policing phenomena in relation to the pandemic has been the creation of a “false dichotomy” between privacy and public health. [91] Around the world, millions of people have agreed to allow more intrusive surveillance tools to track them than they perhaps would have otherwise, including at least 27 countries that are using data from cellphone companies to track people through their smartphones. [92] Over 30 governments around the world are seeking to identify people who are infected in order to maintain quarantines. [93] There have also been proposals to use artificial intelligence to track pedestrians and monitor when they are maintaining social distancing guidelines. [94] Smartphone data [95] has also been used to track the location of citizens, including protesters. [96] The concern is that increased levels of surveillance allowed during this period of pandemic on the grounds of public health are unlikely to be undone after the period of pandemic ends.

The risks are especially dire for Black communities, as racialized perceptions of what it means to look “suspicious” become entrenched. [97] In an environment where traditionally the use of face coverings were a grounds for suspicion, Blacks are put in the position of anxiety where failure to use face coverings will disproportionately expose them to violent policing, and using face coverings is also potentially seen as grounds for suspicion. [98] The emergence of digital tools that amplify the capacity for law enforcement officers to act on their suspicions only heightens the likelihood of abuse. This has been demonstrated by the use of artificial intelligence tools in predictive policing, which has been shown to harbor the same biases [99] as the humans who provide input for the programs, based on historical data.
In the context of targeted enforcement against Black communities, it is not difficult to imagine how this enhanced technology could be weaponized against Black communities to increase criminalization. This is also likely to amplify the disproportionate effect of COVID-19, as Public Health Scholar Denise Herd has recently noted in her work describing the emerging prevalence of pre-existing health conditions like high blood pressure and obesity in communities where the residents are more likely to be questioned by the police and experience stress of police harassment. [100]

Recommendations - Policing

Because of the legal doctrine of qualified immunity, over 99 percent of the dollars that plaintiffs recover in lawsuits alleging civil rights violations by law enforcement are paid government budgetary allocations and are not paid personally by police officers themselves. [101] This court created immunity has been criticized by analysts from both the conservative [102] and liberal [103] political orientations, including the Cato Institute, which has launched a litigation campaign seeking to overturn the doctrine, [104] and both Elizabeth Warren and Bernie Sanders, who have each recommended that, in order to provide a financial disincentive for police brutality, the legal doctrine of qualified immunity be revisited. [105]

Robyn Maynard and Andrea Richie suggest that instead of investing in more policing, ticketing, and arrests, they would recommend funding Black community-based organizations to reach out and support their members in following public health guidance. [106] This is in line with the invest/divest model advocated by Law for Black Lives and the Center for Popular Democracy and Black Youth Project 100, [107] and a more general call to increase police oversight led by Congresswoman Ayanna Pressley and Ilhan Omar, in partnership with Congresswoman Karen Bass, Chair of the Congressional Black Caucus, and Barbara Lee. [108] The Michael O.D. Brown We Love Our Sons and Daughters Foundation has also recommended the creation of the Mike Brown Fund, modeled after the 9/11 victims compensation fund. The fund exists to compensate victims and their families for their injuries, to provide support with mental health treatment and expenses in the aftermath of a traumatic police violence related incident, and to assist with the payment of legal fees and other costs associated with plaintiffs who seek to bring suit for police misconduct. [109]

Because of the high contact nature of policing and the risk of viral transmission, Georgetown Law’s Innovative Policing Program and Harvard’s Safra Center for Ethics recommend the cessation of measures that require physical contact between law enforcement personnel and members of the public, unless there is a threat of imminent danger. This is in line with the recommendation issued by the American Public Health Association. At the local level, Communities United for Police Reform and more than 50 other advocacy organizations have called on the Mayor of New York to suspend broken windows policing and reduce enforcement actions. The Center for Constitutional Rights released a similar letter urging policymakers to implement a zero tolerance policy for abusive policing, an immediate moratorium on all unnecessary summons and arrests, and transparent emergency-planning that prioritizes safeguarding human and civil rights. They also recommend ending the criminalization of entire communities, namely Black, Brown and poor communities, and the reinvestment of funds dedicated to the expansion of the NYPD in vulnerable communities. [110]

These recommendations are in harmony with those of Campaign Zero, which specifically note the need to eliminate unfair police union contracts that make true accountability unlikely. [111] The Leadership Conference on Civil and Human Rights also released a statement endorsed by over 100 civil rights organizations and law enforcement groups. The statement outlines the need for clear limitations, robust audit mechanisms, transparency, and community engagement which will be essential to the adoption of any new surveillance measures. The statement also champions a public health response to this public health crisis in lieu of a law enforcement response. [112]
87.5% of arrests in Brooklyn for social distancing were Black.

35 out of the 40 arrests for social distancing violations from March 17 - May 4, 2020 were Black.

81% of NYPD’s social distancing summonses were issued to Blacks & Latinos.

Aggressive policing heightened.

During the pandemic, aggressive policing poses particularly dire risks.
COVID-19 Disproportionately Affects Black People Impacted by MASS INCARCERATION & CORONAVIRUS

According to the Marshall Project, there are over 25,239 cases and 373 deaths reported by prisoners, and over 6,779 cases and 28 deaths reported by staff in US prisons. [113] People directly impacted by incarceration, comprising both currently imprisoned and returning community members, are overwhelmingly Black, [114] Brown [115] and poor [116]. Black people represent approximately 40 percent of the incarcerated population [117] and experience significant and debilitating disparities related to health and healthcare provisions, housing, and financial stability.

People in Jails and Prisons are More Vulnerable to Infection and Resulting Complications from COVID-19

Compared to the general population, directly impacted people are more likely to be in poor health. [118] Approximately 40 percent of incarcerated people are reported to have at least one chronic health condition. [119] This is largely a function of arrest policies targeting Black and Brown people from under-resourced communities where access to both healthcare and the socioeconomic resources supporting health is limited. [120]

The lack of prior preventive care may increase the risk of health complications for imprisoned people. [121] Prison conditions also exacerbate the experience of chronic illness due to the brutal conditions of confinement. [122] These conditions include "overcrowding, violence, sexual victimization, use of solitary confinement, and lower standards of medical care [which] are harmful to the physical and mental health of incarcerated individuals." [123]

Despite prisoners' constitutional right to healthcare, [124] correctional facilities too often serve as ill-equipped treatment providers of last resort for medically underserved, marginalized people." [125]
Treating is inconsistently administered, [126] and “the standard of care lags far behind community health standards.” [127] The constitutional standard does not require “good, or even non-negligent care,” but “forbids only care so deficient as to constitute ‘deliberate indifference’ to the health of those incarcerated in jails and prisons.” [128]

Deliberate indifference is an incredibly exacting standard and limits opportunities for relief for imprisoned people who must establish prison officials’ knowledge about the severity of their medical conditions and intent behind the deprivation of care. [129] Imprisoned people hoping to prove deficiencies in care are also precluded from making their case in federal court unless they have first exhausted every available administrative remedy “by pursuing to completion whichever grievance or appeal procedures the prison administration provides.” [130]

Imprisoned people with serious and timely concerns must then file grievances and appeals and wait for each to be denied in turn before finally becoming eligible to make a legal claim contesting their care. [131] And often, they are filing these administrative complaints with the very staff members denying them care, an unduly dangerous exercise that often prompts punishments such as being placed in solitary confinement or transferred to another prison. [132] For those who eventually file a case in federal court, success rates remain low. [133]
MASS INCARCERATION CONT’D

Organizations like the National Commission on Correctional Health Care have established guiding principles and accreditation criteria for adequate care, but accreditation proceedings are voluntary and provide no incentive for compliance. As a result, though mandated compliance with standardized protocols governing the care of imprisoned people would do much to ease the burden on medically vulnerable prisoners and establish appropriate standards of care, only 17 percent of correctional facilities have received some sort of health-related accreditation, and inadequate correctional care persists. [134]

Imprisoned people depend on their correctional institutions for care, and the health of the general public depends on the health of those in prisons and jails. In the midst of this pandemic, experts have warned that “[f]ailure to mount an adequate response to potential COVID-19 outbreaks throughout the nation’s jails and prisons has the potential to devastate the health and well-being of incarcerated Americans, the nation’s correctional work-force, and people living in the thousands of communities in which our jails and prisons are located.” [135]

As has been noted, jails experience frequent population shifts that make them “vectors of infection” for those already in jail, new admissions, and correctional officials. [136] Jails admit approximately 10.7 million people annually, and there are approximately 737,900 new admissions each day. [137] Though some jurisdictions have made significant strides to reduce jail populations and limit new admissions, [138] many more have failed to implement such measures. [139] The American Civil Liberties Union and affiliate researchers have determined jurisdictions who persist in their inaction will contribute as many as 188,000 jail deaths to the overall COVID-19 death count. [140]

The language in the HEROES Act recognizes this risk and supports the release of low-risk individuals and people awaiting trial from jails, but jurisdictions are undermining this intention. Jurisdictions are prioritizing release on electronic monitoring, and some are limiting release in accordance with the number of electronic monitoring devices readily available. [141] Others are limiting release by releasing only those able to pay monitoring costs. [142] This limitation prolongs the unnecessary confinement of imprisoned people otherwise eligible for release in high-risk facilities and will disproportionately impact Black, Brown and poor community members who represent a majority of jail populations.

Prisons, like jails, are capable of spreading COVID-19 as a result of poor ventilation, overcrowding, limited access to hygienic products, and limited opportunities for adequate care. Though some prisons have taken steps to implement quarantine protocols meant to keep people safe, these measures have effectively resulted in widespread and longstanding isolation orders. Today, approximately 300,000 people in prison are being held in some form of prolonged isolation. [143] Some prisons use solitary units, confining one person alone in a cell for 23 hours a day. Some isolate people in larger cells holding 2 to 4 people or in open dormitories holding many more. The recent HEROES Act acknowledges the dangers of punitive confinement, but the danger is not in the intention rather in prolonged confinement for any reason, including as a medical intervention.
MASS INCARCERATION CONT’D

Experts have warned against the reliance on prolonged solitary confinement, which has been “overwhelmingly shown... to cause severe psychological distress in [imprisoned people] including, but not limited to, extreme anxiety, hallucinations, violent fantasies, hypersensitivity to external stimuli, and an increased tendency to inflict self-harm.” [144] These effects caused Nils Melzer, the United Nations Special Rapporteur on torture, to classify prolonged solitary confinement as psychological torture. [145] For imprisoned people already disproportionately impacted by mental illness, [146] prolonged solitary confinement will only exacerbate serious underlying issues and generate new health crises. The threat of solitary confinement will also discourage unwell people from seeking medical care or taking appropriate precautions and may accelerate the spread of the virus. [147]

Though individual isolation is dangerous, isolating people in groups also threatens the health of imprisoned people. Few prisons are testing people that are not visibly sick despite the virus’ capacity for transmission via asymptomatic carriers. [148] Poorly ventilated rooms packed with healthy and unhealthy people will hasten the speed of transmission in many prisons. In the California Institution for Men, a man died from COVID-19 after being quarantined in a dorm where 64 others later also tested positive for COVID-19. [149]

It is also important to note prisons remain packed due to jurisdictions’ reluctance to release people imprisoned for violent offenses. Though policymakers and advocates have encouraged jails to maximize release and prioritize the vulnerable, “[e]fforts to move people out of prisons and jails have mainly focused on the lowest-hanging fruit: those detained for inability to pay bail, technical parole violations, minor misdemeanors, and the like.” [150] These efforts exclude nearly 1 million people imprisoned for violent offenses who are also vulnerable to COVID-19. [151]

Indeed, people imprisoned for violent acts are amongst the most vulnerable to COVID-19. Many of these people are over the age of 55, serving sentences for offenses committed in their teens, twenties, and thirties. [152] The threat COVID-19 poses to older people is compounded by the comparatively poor health of older people in correctional settings and the poor conditions of confinement. [153] People in prison for violent acts are not only among the most vulnerable to COVID-19, but they also pose a low risk to public safety. The concern underlying releasing people imprisoned for violent acts is the fear that those people will commit additional violent acts, but the evidence overwhelmingly refutes this. Contrary to popular characterizations, people released following imprisonment for violent offenses actually report the lowest levels of recidivism of any group. They have the lowest rate of return for both technical violations and new offenses. [154] The risk of recidivating for people who have committed serious felonies is particularly low—approximately 1.3 percent. [155]

Furthermore, “most violent crime is far more mundane than most imagine—fights, drunken assaults of friends and acquaintances, hurting a loved one.” [156] Though these offenses are serious, they are not capital offenses, and “[n]o one [has been] sentenced to die in a pandemic, even if their crime and conviction is a serious one.” [157]
Recently Released People Struggle to Access Healthcare Coverage

Release from correctional settings comes with its own health-related challenges. Because many impacted people are uninsured or underinsured prior to their incarceration and are ineligible for Medicaid coverage while incarcerated, most people leaving jails and prisons are leaving uninsured. [158] This gap in insurance is dangerous and may prove life-threatening to returning citizens given most people coming home from prison “have at least one chronic problem with physical health, mental health, or substance use.” [159] Indeed, people returning from prison are “12 times more likely than the general public to die of any cause in the 2 weeks following release and 129 times more likely to die of a drug overdose.” [160]

Lack of stable housing makes it difficult for returning citizens to practice social distancing guidelines.

Directly impacted people also experience challenges related to housing insecurity [161] and homelessness that leave them particularly vulnerable. Many were homeless prior to their incarceration, and many experience homelessness following their incarceration. [162] For imprisoned people at risk of contracting COVID-19, this presents additional challenges, as jurisdictions have been limiting release to those who can guarantee access to stable housing. [163] Directly impacted people are nearly 10 times more likely to be homeless than those with no history of incarceration. [164] There are approximately 552,830 people experiencing homelessness in the United States, [165] and “[a]n estimated 25 to 50 percent of people experiencing homelessness also have a history of incarceration.” Approximately 50,000 are released from correctional settings into shelters each year. [167]
MASS INCARCERATION CONT’D

Though stable housing is critical to the reintegration of returning community members, inadequate resources, the lack of affordable housing, status-based discrimination, and the “use of credit checks, exorbitant security deposits, and other housing application requirements—such as professional references—can also act as systemic barriers for people who have spent extended periods away from the community and out of the labor market.” Additional barriers include the exclusion of people with felony convictions from living in public housing or even with family members already residing in low-income housing. These burdens are disproportionately borne by Black people: following incarceration, Black men are much more likely to be “unsheltered homeless” than White or Hispanic men, and Black women experience “the highest rate of sheltered homelessness—nearly four times the rate of White men, and twice as high as the rate of Black men.”

The lack of stable housing makes compliance with communal guidelines like sheltering in place and social distancing nearly impossible. Recently released people required to self-isolate for the recommended two-week period may not have a place where they can safely remain for 14 days. And shelters may be reluctant to house recently released people who they fear may have the virus. Furthermore, the criminal consequences of homelessness, triggered by the commission of survival offenses or the inability to comply with mandatory COVID-related measures like wearing a mask or staying home, may mean a return to jail or prison where there’s a high risk of exposure to everyone involved.
MASS INCARCERATION CONT’D

Though some jurisdictions have been organizing hotel rooms for unhoused people, only a fraction of these rooms are reserved for recently released people. [175] The recently passed CARES Act included more than $12 billion in aid for HUD programs, but it is unclear whether funding has been allocated to directly address the plight of impacted people experiencing housing insecurity and homelessness compounded by the structural barriers mentioned above. [176] The HEROES Act reserves funding for community re-entry advocates doing the essential work of supporting returning community members. Those advocates understand safe release means supported release. Many are formerly incarcerated leaders who possess the requisite expertise concerning urgently needed policy interventions to ease the transition from correctional to community settings.

Formerly incarcerated people face additional challenges related to financial stability.

Before the pandemic, 27 percent of formerly incarcerated people were unemployed, “nearly 5 times higher than the unemployment rate for the general United States population, and substantially higher than even the worst years of the Great Depression.” [177] These percentages are much higher for formerly incarcerated Black women and men whose respective rates of unemployment are 43.6 percent and 35.2 percent.” [178]

COVID-related unemployment will affect impacted people more acutely than the general population. In the preceding weeks, unemployment has risen sharply, with more than 33.3 million people—approximately 20 percent of the United States workforce—filing for unemployment since mid-March. [179] Those numbers are increasing, and impacted people whose jobs are “often the most insecure and lowest-paying positions,” are particularly vulnerable. [180] Impacted business owners are also at risk. Many turned to entrepreneurship when they could not find a job, and in the preceding weeks, small business owners have faced “unprecedented economic disruption.” This disruption prompted the passage of the CARES Act, which provided $376 billion in loans and debt relief for struggling workers and businesses. Though the bill did not originally exclude formerly incarcerated people, the Small Business Administration later adopted a rule to prevent people convicted of a felony within the last five years, currently incarcerated, under criminal indictment, enrolled in community supervision, or whose case concluded without a conviction from receiving a forgivable loan. [182] The HEROES Act limits this exclusion to impacted people with felony convictions for financial fraud or deception within the last 5 years, but the exclusion is a blow considering “[s]mall business loans can be lifelines for formerly incarcerated people. [183]

Formerly incarcerated people also remain excluded from other kinds of relief. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 prohibits people with felony drug convictions from receiving food stamps and cash assistance through SNAP and TANF. [184] States can modify or lift this prohibition, but Mississippi, South Carolina, West Virginia and Guam have maintained the ban on SNAP assistance. [185] This exclusion is particularly problematic given 91 percent of recently released people experience food insecurity. [186] Arizona, Georgia, Mississippi, Missouri, Nebraska, South Carolina, South Dakota, Texas, Virginia, and West Virginia have retained the full ban on TANF assistance. [187] Over 20 states modified the prohibition. [188]
MASS INCARCERATION CONT'D

Some have done this by "limiting the classes of drug felonies subject to the restriction, implementing temporary bans, and requiring enrollment and participation in a drug education or treatment program." Others have incorporated additional barriers to assistance like mandatory drug testing. [189]

Recommendations

Health and Healthcare Recommendations for those Impacted by Mass Incarceration: The HEROES Act provides funding for testing, equipment, supplies, and services, but experts recommend additional measures guaranteeing appropriate standards of care, patient-centered treatment protocols, and adequate numbers of qualified staff. [190] Experts also recommend (1) national healthcare organizations develop a national forum for sharing correctional pandemic protocols; (2) state and local public health systems "deploy an infectious disease and/or public health professional to each correctional facility;" (3) state actors facilitate continuous care between correctional settings and local hospitals and include these facilities in their pandemic protocols; (4) emergency credentialing of hospital workers authorizing their treatment of people in correctional settings when correctional healthcare staff fall ill and; (5) emergency medical training for correctional staff. [191]

Advocacy groups like the Human Rights Watch have also discouraged reliance on solitary confinement as an inherently punitive practice. [192] In Cook County, Illinois, advocacy groups like the Chicago Community Bond Fund and the Challenging E-Carceration Campaign demand "judges...stop arbitrarily placing people on electronic monitoring, which needlessly places lives at risk as they wait in the jail for a monitor to become available." [193] They also demand the judiciary "receive guidance designed to limit the use of EM at this time and prioritize pretrial liberty." [194]

To address the disruption of care between correctional and community settings, some jurisdictions have implemented assistive enrollment programs in criminal legal settings to help impacted people secure health insurance following their incarceration. [195] Jurisdictions like Michigan, Florida, and Washington with enrollment assistance programs have observed corresponding reductions in recidivism. [196] Experts also recommend care coordination, case management, and sufficient discharge planning to ensure the successful transition of imprisoned people from correctional to community settings. [197] In Ohio, the Ohio Department of Rehabilitation and Correction works closely with the Department of Medicaid to create managed care plans 90 to 100 days before release, and, following release, provide recently released people with "a care coordinator to help them find a primary care doctor, make and confirm appointments, and learn about urgent care, healthcare specialists and transportation benefits." [198] In the preceding weeks, jurisdictions have observed recently released people testing positive for COVID-19. [199] Well-coordinated care will be critical for the health outcomes of impacted people.

Additionally, racial bias alone impacts the quality of care Black people receive. Combined with the stigma of incarceration, which one study found more than 40 percent of formerly incarcerated people experience in healthcare settings, Black people returning from correctional settings will be particularly vulnerable without guidelines ensuring they receive high-quality care. [200]
Recommendations, cont’d

As a result, the Centers for Disease Control guidelines prohibiting stigmatizing and discriminating against it in the provision of treatment should be understood to include stigma against returning citizens as well. [201]

Housing Recommendations

In New York, JustLeadershipUSA released policy proposals related to the provision of safe and affordable housing. These proposals support a vision for safe and healthy communities for impacted people and include: (1) doubling the availability of permanent affordable housing units reserved for homeless New Yorkers; (2) constructing additional public housing units accessible to people with prior convictions; (3) restoring vacant properties “to active uses that contribute to the supply of affordable housing for low-income New Yorkers;” (4) reserving a portion of low-income housing in every development and establishing prices reflecting the median income of that development’s residential neighborhood; (5) eliminating barriers to housing for people with records using legislation similar to Seattle’s Fair Chance Housing Act; [202] and (6) establishing long-term supportive housing for people “with mental and behavioral needs, substance dependencies, personality disorders, cognitive and developmental disabilities, and history of severe trauma.” [203] Though specific to New York, those proposals are adaptable and replicable across jurisdictions.

The National Law Center on Homelessness and Poverty has also identified “best practices” for homeless and housing insecure people further destabilized by COVID-19, [204] while the Centers for Disease Control has issued interim guidance for homeless service providers and people experiencing unsheltered homelessness in the midst of this pandemic. [205]

Financial Stability Recommendations

Expanding access to government assistance will provide critical support for impacted communities ravaged by unemployment, resource scarcity, and financial insecurity in the wake of COVID-19. Experts from the Center on Budget and Policy Priorities recommend SNAP agencies” (1) promote streamlined, timely access to benefits for individuals who are leaving incarceration and particularly vulnerable; (2) enable these individuals to participate in E&T activities that build employable skills, mitigate impediments to work, and take into account the consequences of incarceration and conditions of parole; and (3) remove eligibility limitations for the formerly incarcerated.” [206] Advocates have also advised federal policymakers to permit returning citizens to apply for CARES Act funding. [207]
Endnotes


2 Id.

3 Id.

4 Id.


6 Todd Ruger, House pitches justice system changes in new COVID-19 relief bill, ” (May 12, 2020) available at: https://www.roll-call.com/2020/05/12/house-pitches-justice-system-changes-in-new-covid-19-relief-bill/ (In a 44-page report called the “Pandemic Justice Response Act,” the bill would require the release of prisoners and those in the custody of U.S. Marshals Service who are within a year of being released, or those who are juveniles, over 50 years old or have a health condition such as diabetes, heart disease, HIV, cancer or are pregnant.)


9 Martin Luther King Jr., Strong to Love 45-48 (1963).


12 Id.


33 Margo Schlanger, The Political Economy of Prison and Jail Litigation, PRISON LEGAL NEWS, (June 15, 2007), https://www.prisonlegalnews.org/news/2007/jun/15/the-political-economy-of-prison-and-jail-litigation/ ("...the vast majority of these lawsuits fail, and even those that do succeed tend to have very low damages. To use one year's outcomes as an example, in 1995, over 80% of prisoners' civil cases in federal district court were dismissed rather than settled or tried...").


36 Hawkins, supra, note 33.


43 Id.


47 Supra, note 44.


49 Id.


58 Supra, note 49


69 Id.


71 Id.

72 Supra, note 61

73 Id.

74 Supra, note 63


76 Id.

77 Id.
78 Adrian Carraquillo, 81 Percent of NYPDs Social Distancing Summons Were Issued to Blacks and Latinos: ‘It's the New Stop and Frisk’, Newsweek (May 8, 2020, 5:02 PM), https://www.newsweek.com/81-percent-nypd-social-distancing-summons-are-now-issued-blacks-latinos-its-stop-frisk-1502841?bclid=1wA2jusz68GjXPlxv6O&djlomapH6kETDkXAg=indVYXNt3bX7z-FF
92 Investigation of the Ferguson Police Department, United States Department of Justice Civil Rights Division (March 4, 2015), available at: https://www.justice.gov/sites/default/files/crt/press-releases/attachments/2015/03/04/ferguson_police_department_t_report.pdf
113 Campaign Zero: Fair Police Contracts, available at: https://www.joincampaignzero.org/contracts

114 These recommendations and others have been most directly articulated by the Community Resource Hub for Safety, & Ace. naumbility, in its COVID19 & Policing Toolkit.


116 Id.

117 Criminal Justice Facts, Sentencing Project, https://www.sentencingproject.org/criminal-justice-facts/ (reporting that “Black men are six times as likely to be incarcerated as [White] men”); (reporting that “Hispanic men are more than twice as likely to be incarcerated as non-Hispanic [White] men”) (last visited Apr. 27, 2020).


122 Dumont et al., supra note 25 (reporting that “arrests are concentrated in low-income, predominantly nonwhite communities where people are more likely to be medically underserved”).


124 Id. (“Incarceration itself also has dramatic effects on psychological and physical health, subjecting people to higher rates of infectious disease and medical neglect; exacerbating or instilling mental health conditions; and hastening death.”); see also Dumont et al., supra note 25, https://www.annualreviews.org/doi/pdf/10.1146/annurev-publichealth-031811-124614 (“...there is a suggestion that chronic conditions tend to be at a more advanced stage among the incarcerated, compared with the age adjusted general public...”).

125 Cloud, supra note 21

126 See Estelle v. Gamble, 429 U.S. 97, 103 (1976) (establishing “the government's obligation to provide medical care for those whom it is punishing by incarceration”).

127 Cloud, supra note 21; In addition to the approximately 40 percent of imprisoned people managing a chronic illness, approximately 50 percent of state prisoners and 68 percent of people in jail have diagnosable substance use disorders. Fewer than 15 percent receive appropriate treatment; Id. at ?.

128 Dumont et al., supra note 25 (noting “that despite many improvements since Estelle v. Gamble, the actual delivery of health care remains as uneven as screening. Treatment is consistently provided for only a fraction of those needing it”).


129 See Farmer v. Brennan, 511 U.S. 825, 837 (1994) (holding that an inhumane treatment claim under the 8th Amendment requires that a prison official "knows of and disregards an excessive risk to inmate health or safety"); see also Estelle v. Gamble, 429 U.S. 97, 104 (1976).


131 Id. note 112; see also Ian Head, Another Clinton-Era Law That Needs to Be Repealed, New Republic (Apr. 18, 2016), https://newrepublic.com/article/132678/another-clinton-era-law-needs-repealed ("Imagine a prisoner who is in pain and in need of medical treatment, but ignored by prison staff. She must not only file her complaint with the same staff that is denying her treatment, but wait for a referral, appeal that decision, and only after a judgment on that appeal can she then file a legal case beyond prison walls.").

Drapkin, supra note 112

132 Margo Schlanger, The Political Economy of Prison and Jail Litigation, Prison Legal News (June 15, 2007), https://www.prisonlegalnews.org/news/2007/jun/15/the-political-economy-of-prison-and-jail-litigation/ ("...the vast majority of these lawsuits fail, and even those that do succeed tend to have very low damages. To use one year’s outcomes as an example, in 1995, over 80% of prisoners’ civil cases in federal district court were dismissed rather than settled or tried...").

133 Cloud, supra note 21


136 ACLU et al., supra note 21

137 Id. at 3 (noting that “most states have failed to take any steps to stem the impact of the COVID-19 pandemic in jails and the broader community”).

138 Cary Aspinwall & Joseph Neff, These Prisons Are Doing Mass Testing for COVID-19—and Finding Mass Infections, Marshall Project (Apr. 24, 2020), https://www.themarshallproject.org/2020/04/24/these-prisons-are-doing-mass-testing-for-covid-19-and-finding-mass-infections (noting “many prisons across the nation are only testing people who are evidently sick, not reporting any testing results for guards and other staff, or not testing at all”).


141 Jessica Schultzberg, Candidates For Home Confinement Have a Problem: Many Can’t Afford It, Huffington Post (last updated May 6, 2020), https://www.huffpost.com/entry/prisoners-approved-home-confinement-coronavirus_n_5e-b1bc3e9cb62b50d9557a8


Doris James & Lauren E. Glaze, Mental Health Problems of Prison and Jail Inmates. Bureau of Justice Statistics 1 (revised Dec. 14, 2016), https://www.bjs.gov/content/pubs/pdf/mhlpip.pdf (“At midyear 2005 more than half of all prison and jail inmates had a mental health problem, including 705,600 inmates in State prisons, 78,800 in Federal prisons, and 479,900 in local jails. These estimates represented 56% of State prisoners, 45% of Federal prisoners, and 64% of jail inmates.”).

Cloud et al., supra note 117.


Kathy Boudin, Come Close In: Voices of Survivors of Mass Incarceration 272 in DECARcERATING AMERICA: FROM MAss PuNISHMENT TO PuBLIC HEALTH (Drukker, ed. 2018).

Farid & Whitehorn, supra note 134; see also Yang Hui Kim, 2010 Inmate Releases: Three Year Post-Release Follow-up, New York Department of Community Corrections (June 2014), https://bloximages.chicago2.vip.townnews.com/nupubpub.com/content/tncms/assets/v3/editorial/a3/3d/38d04d4275-59ed-3e21-c3b89e1508a3487671b4846c.pdf.


Dumont et al., supra note 25 (reporting “90% of people released from jail lack coverage and thus access to most health services”); see also Alexandra Gates, et al., Health Coverage and Care for the Adults Criminal Justice-Involved Population, Kaiser Family Foundation (Sep. 5, 2014), https://www.kff.org/issue-brief/health-coverage-and-care-for-the-adult-criminal-justice-involved-population (“Federal Medicaid law prohibits the payment of federal Medicaid matching funds for the cost of any services provided to an ‘inmate of a public institution,’ except when the individual is a ‘patient in a medical institution.’”).


Dumont et al, supra note 25.

Caire W. Herbert, et al., Homelessness and Housing Insecurity Among Former Prisoners, 1 RSF J. of Soc. Science 44, 47 (Nov. 2015), https://www.rsfj.org/issue/pdf/10_7758/rsf.2015.1.2.04.pdf?reffield=execute%3A66cf790322b61a1f80a31585f27b611 (defining housing insecurity as “a broad spectrum of precarious housing situations…”).

Dumont et al., supra note 142 (“Because homelessness and incarceration share similar risk factors, many of the incarcerated were homeless before entering the criminal justice system. Mentally ill inmates were particularly likely to be homeless before their arrest. Incarceration in turn increases the odds of being homeless or marginally housed.”).


188 Christine Karamagi et al., Repairing the Road to Redemption in California, Californians for Safety and Justice II (May 2018) ("Stable housing, like employment, is strongly correlated with reduced recidivism and increased capacity for people with convictions to become contributing members of society.")

189 Lucas Couloute, supra, note 146

190 See 14-15


192 Lucas Couloute, supra, note 146


199 Id.


201 Lucas Couloute & Daniel Kopf, supra note 159


153 Id.


156 Thompson, supra note 166

157 Id. at 7.

158 Id.

159 Wolkomir, supra note 167

160 David Cloud et al., supra note 117

161 Id.


164 Id.


166 Kavita Patel et al., Integrating Correctional and Community Health Care For Formerly Incarcerated People Who Are Eligible for Medicaid, 33 HEALTH AFFAIRS 468, 471 (Mar. 2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4028693/.


171 Id.


204 Wolkomir, supra note 167

205 Ray, et al, supra note 29