The Covid-19 pandemic and the future of the prison

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Title: The Covid-19 Pandemic and the Future of the Prison

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Abstract

Since the discovery of the "jail disease," probably typhus, in the 18th Century, health experts have recognized that the prison is a near perfect incubator of contagious disease. Early in the Covid-19 pandemic, therefore, public health authorities and human rights groups advocated immediate and sustained decarceration of overcrowded prisons to save lives and stop the spread of the virus. Yet, decarceration efforts globally were uneven and largely failed to live up to expectations. Instead, prison systems typically sought to control the spread of Covid-19 by imposing strict "lockdowns" on prisoner movement that bordered on long-term solitary confinement in many jurisdictions. The consequences of these severe conditions on prisoners' mental and physical health are only just emerging. The ramifications for future prison reform efforts may be more profound. If a deadly pandemic is not enough to instigate a reimagining of the role of prison in society, it is unclear what could.

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> *Disease has played a central role in shaping episodes of public controversy about the humanity of punishment. Disease has a distinctive power to strip away the general invisibility of life that takes place behind the walls of prison, and narrow the gulf that normally separates the fate of prisoners from the imagination of the free. These moments have been particularly consequential because of their potential to motivate legal elites ... to "see" the existing penal regime anew and actively to reimagine the American prison. (Simon 2013, p. 223)*

In his sweeping history of the "medical model" in prison, Jonathan Simon argues that disease has been the primary catalyst of change in prison policy and practice since the origins of the institution. Beginning with what the English reformer John Howard described as the "jail disease" (presumably typhus) that spread through prisons in the late 1700s, Simon argues that the correctional enterprise has been "repeatedly reshaped by moments of heightened concern about disease, prisons, and the general health of the public" (p. 218). New diseases and new discoveries in medicine and public health, he argues, led to "periodic transformations [in] … correctional philosophy and ultimately constitutional understandings of the prison" (p. 218).

Labelled the worst public health crisis for a generation (Maycock and Dickson 2021; Maycock 2022), the Covid-19 pandemic appears to be a perfect example of history repeating itself. From its onset, the pandemic has highlighted the extreme vulnerability of incarcerated populations. By February 29, 2020, half of reported Wuhan Covid-19 cases were within the city's penal institutions, and an outbreak at a prison 450 miles away was traced to Wuhan

officials who had visited and possibly infected seven prison guards and 200 prisoners (Barnert, Ahalt, and Williams 2020). The first Covid-19 diagnosis in a US prison was announced in March 2020 (Pitts and Inkpen 2020) and the first death was only weeks later, on March 26, 2020. Within eight months, the number of prisoner deaths from Covid-related illnesses exceeded the number of prisoners executed in the United States during the preceding 30 years, creating a "new death penalty" (Mortaji et al. 2021, p. 801).

In 2021, the UN Office on Drugs and Crime estimated that approximately 550,000 prisoners around the world had at that point had contracted the virus, resulting in an estimated 4,000 fatalities (UNODC 2021). By July 15, 2022, the US prison death toll alone reached nearly 2,900 with over 600,000 reported cases tracked according to the Covid Prison Project (2022). Covid-related mortality rates have been estimated to be at least 2.5 times higher in prison than in the general population in different jurisdictions (Braithwaite et al. 2021; Toblin and Hagan 2021) and infection rates are estimated to be up to 5.5 times higher (Edge et al. 2021; Marquez et al. 2021; Byrne et al. 2022). These figures are almost certainly underestimates, as many prison systems are suspected of not disclosing complete or accurate information (Lemasters et al. 2020; Natolli et al. 2020). Human Rights Watch (2022, para. 1) observes: "Many countries around the world are not monitoring and reporting on Covid-19 infection, death, and mitigation efforts in detention settings." Furthermore, these figures do not include deaths of infected prisoners after release; nor do they include populations in jails where controlling Covid can have dramatic impact (Byrne et al. 2022). For instance, at the end of 2021, Rikers Island in New York City reported that over 17 percent of its jail population tested positive (CNN 2021). Similar patterns can be found in penal institutions around the world (Franco-Paredes et al. 2020; Dunkel, Harrendorf, and van Zyl Smit 2022).

As Simon suggests, this pandemic will almost certainly re-shape how prisons are understood, and incarceration is practiced. What that impact will look like, however, is not obvious. At the outset of the pandemic, penal systems internationally had to choose between at least two potential responses if they were to save lives and prevent the spread of the disease inside and outside the justice system. The most obvious option – advocated by the United Nations and numerous human rights organizations – was large-scale decarceration, defined by the National Academies of Science, Engineering, and Medicine (2020, p. 15) as "the process of reducing the number of people in correctional facilities by releasing those currently incarcerated and by diverting those who might otherwise be incarcerated."

The pandemic led to the previously unthinkable shutting of schools, universities, workplaces, funeral homes, sporting events, and nearly every other aspect of social life in order to save lives and stop the spread of disease. Penal institutions are almost unparalleled in their ability to spread Covid-19 internally and to the wider community (Presidential Health COVID-19 Equity Task Force 2021). Overcrowded prison systems and jails could have enacted decarceration and excarceration measures (defined by Drucker 2018 respectively as getting people out of prison and stopping putting more people in) to prevent deaths and protect the public. Of course, this is exactly what several countries around the globe did (HRW 2020).

By far the more common response, however, was to enact penal "lockdowns" involving heightened levels of isolation and containment (Dunkel, Harrendorf, and van Zyl Smit 2022). Rather than decarceration, prison systems around the world implemented an experiment in solitary confinement at a massive scale. In other words, in order to save lives, prison systems did more of what prisons do best: isolating residents from human contact.

This stark choice between decarceration and heightened lockdown could shape the future of the prison for decades (Simon 2013). In the following sections, we examine both options in depth. In Section I, we begin with an analysis of the spread of disease both within penal institutions and from prisons to the wider public. Prison populations are uniquely vulnerable to viruses like Covid-19, both because of the backgrounds of people in prison and because of the nature of penal institutions. We begin Section II by reviewing the case for substantial decarceration in light of these vulnerabilities. The reality of decarceration fell badly short of the ambitions of reformers who called for swift action to reduce overcrowding and save lives. In this section we review both the successes and the multiple failings of decarceration in practice and address the question of "what went wrong" with prison releases worldwide.

In Section III, we review what happened to the people who remained inside prison during the pandemic. Instead of or in addition to decarcerating, most prison systems engaged in forms of "lockdown" resembling widespread solitary confinement. We assess emerging research regarding the effects of this vast lockdown on prisoners' mental health and well-being. In doing so, we draw upon an array of global examples; however, most of our focus is on the United States, which has the world's highest incarceration rate (Fair and Walmsley 2021). In Section IV, however, we also draw upon original data collected as part of our own 18-month study, co-produced with the User Voice organization, involving 10 prisons in England and Wales. British prisons experienced a dramatic, system-wide lockdown that has had a measurable impact on the mental health and well-being of the incarcerated.

Finally, Section V concludes that, with some notable exceptions, state responses to the pandemic in prisons around the globe have been an immense failure, on almost every level, but most especially a failure of imagination or what Davis (2003, p. 103) calls the "stultifying idea that nothing lies beyond the prison." Decarceration responses were far too cautious, in most jurisdictions releasing only small numbers of prisoners at the lowest risk levels. Yet, the pandemic exposed the prison's enormous vulnerabilities for public health. As almost perfect incubators for spread of infectious diseases such as Covid, prisons presented serious health risks to both those living and working inside them, and to the wider communities outside. In short, prisons put communities at heightened risk. Stripped of any pretense toward rehabilitation or any countervailing policy justification, the prison's survival is deeply puzzling, especially when so many other institutions (from schools to offices to places of worship) were closed and reinvented through use of technology in order to prevent the spread of disease.

Prisons have not survived the pandemic unchanged, however. They were radically transformed. Yet, in many jurisdictions, this took the form of a regression to their most basic state of pure punishment and social isolation. Emerging research suggests that this massive social experiment in prolonged solitary confinement -- explicitly proscribed by United Nations revised Standard Minimum Rules for the Treatment of Incarcerated People, known as the "Mandela Rules" -- may be having enormous adverse effects on the mental health and well-being of those confined in these extraordinary conditions. The long-term effects will be shouldered by communities over the next decade.

The implications for the future of the prison are particularly bleak, suggesting the near impenetrability of carceral logic in many countries with the largest prison systems. That is, if states cannot decarcerate during a pandemic, it is difficult to imagine a context in which substantial decarceration could be contemplated. At the same time, the efforts of a minority of prison systems globally give hope that the structural mechanisms exist for rapid decarceration if states have the political will to make it happen. The experiences of the

pandemic in prisons over the last three years have raised awareness within the medical community of the considerable public health threats posed by mass incarceration. This may ultimately expand the base of support for decarceration and penal abolition.

I. Confinement and Contagion

Since their origins, prisons have been places of illness and disease (Braun et al. 1989; Valway et al. 1994; Young et al. 2005; Franco-Paredes et al. 2020). For instance, well before the 2020 Covid outbreak, San Quentin Prison in California was the site of two previous influenza epidemics (Chaddock 2018) and an eruption of swine flu in 2009 (Reutter 2010). The first influenza outbreak was documented by Dr. Leo Stanley; between 500 and 1000 of San Quentin's 1900 prisoners contracted the "Spanish Flu" in 1918 (Arnold 2018; Hawks et al. 2020). Stanley (1919), who had worked in the prison since 1913, traced the first wave to one prisoner who was transferred from Los Angeles County Jail on April 13, 1918. By May 26 of that year, Stanley reported 101 admissions to the prison hospital, seven cases of bronchial pneumonia, and three deaths. Since then, there have been multiple waves of influenza outbreaks among prison populations internationally, especially in 1957-58 and 2003 (Franco-Paredes et al. 2020).

In a systematic review of existing studies, Baussano and colleagues (2010) found that the rate of tuberculosis (TB) in prisons was as much as 23 times higher than in the general population and that the rate of latent TB infections was as much as 26.4 times higher. Hepatitis rates are 9 times higher among prison populations than in the general population (Gough et al. 2010; Dolan et al. 2016; Getaz 2019; Kinner et al. 2020; Wegel, Wardak, and Meyer 2022) with around 15 percent of prisoners internationally testing positive for Hepatitis C (Harm Reduction International [HRI] 2020). Finally, approximately 3.8 percent of prisoners globally are thought to be living with HIV. Research suggests that these individuals can face fear, hostility, prejudice, and indifference from prison staff (Belenko et al. 2016).

Prisons are vulnerable to outbreaks of infection and disease for many reasons. They include pre-existing health conditions of the incarcerated population, widespread overcrowding, high mobility of staff and short-term inmates, poor living conditions, and limited access to healthcare (Maruschak, Berzofsky, and Unangst 2015; Novisky 2018; Akiyama, Spaulding, and Rich 2020).

Prison populations may be disproportionately ill-equipped to fight (and survive) infectious diseases because of pre-existing health vulnerabilities. First, the prison population now contains a far greater number of medically vulnerable, elderly prisoners as a result of the extraordinary lengthening of US prison sentences over the past four decades (Tonry 2016) – including a quadrupling of the number of people serving life sentences between 1984 and 2017 (The Sentencing Project 2017). Indeed, between 1993 and 2018, US prisons experienced a 400 percent increase in the number of adult inmates aged 55 or older (Carson and Sabol 2016; Bronson and Carson 2019). Second, prison populations have disproportionately high rates of chronic medical conditions such as obesity, diabetes, cardiovascular disease, and hypertension (Williams et al. 2012). Of course, incarcerated people are also far more likely to suffer from mental health problems, especially addiction and substance abuse disorders (Haugebrook et al. 2010). These issues are compounded by health inequities relating to socioeconomic status, race, and incarceration (Link and Phelan 1995; Phelan and Link 2015; Franco-Paredes et al. 2020; Lemasters et al. 2020). All these factors make the prison

population much more vulnerable to hospitalization or death as a result of contracting the coronavirus (see esp. Prost et al. 2021).

The experience of imprisonment is in itself a serious risk factor for numerous diseases. Drawing on Link and Phelan (1995)'s "social cause" framework, Novisky and colleagues (2021, p. 1630) argue that "incarceration is a potent structural driver of health inequalities that must be considered as a fundamental social cause of disease." This framework explains correlations between socioeconomic status and health "across time and place," indicating that social factors are integral to understanding health inequity due to unequal access to resources that create health protection in some groups and increase risk for others. Novisky and colleagues extend this conception by proposing that incarceration is a fundamental cause of health disparity, due to its relation to the four fundamental social cause criteria: multiple disease outcomes; multiple risk factors for disease and death; access to resources; and the reproduction of this association between prison and health across time and place. These risks are compounded by "intramural factors," policies within facilities that increase vulnerability to viruses, and "extramural factors" including the levels of prison staff rotating in and out of facilities daily, population "churn," and the absence of mass testing of residents and staff (Novisky 2021, pp. 1637-38).

Overcrowding, chief among these intramural factors, has been the subject of the most research on the public health risks of incarceration. Research on the differential manifestation of Covid-19 in prison suggests that every 10 percent increase in prison population results in a 14 percent risk increase in Covid-19. Prisons running at 70-100 percent capacity increase their risk three-fold, and those at 100 percent capacity increase risk five-fold (Leibowitz et al. 2021). With prisons in at least 125 countries chronically overcrowded (HRW 2020), this is a considerable issue. Research further suggests that contagion risk is heightened by poor ventilation, lack of sanitation and hygiene, poor nutrition, lack of autonomy regarding preventative measures, and inequitable medical care -- all of which are endemic in penal environments globally (Lemasters et al. 2020; Altibi et al. 2021; Chin et al. 2021; Toblin and Hagan 2021; Kim et al. 2022; Klein et al. 2022).

Movement of incarcerated people from one facility to another for administrative reasons also increases risks of contamination (Parsons and Worden 2021). Using analyses of time-series data from one mid-size prison in the US, Brinkley-Rubenstein and colleagues (2021) found significant associations between the rate of weekly transfers and positive Covid-19 cases. For example, in May 2020, 122 men were transferred from California Institute for Men to San Quentin, and within days, almost a third of the San Quentin population tested positive for Covid-19, with 28 individuals dying.

Those in prison are also more likely to suffer serious health consequences after contracting Covid-19. Altibi et al. (2021) found that of all patients hospitalized in two settings in Michigan, incarcerated people during a two-month period were more likely to present with fever, tachypnea, hypoxemia, and markedly elevated inflammatory markers than were their community-based counterparts. Furthermore, the study found that people in prison were more commonly admitted to intensive care and had higher rates of mortality within 30 days of admission (Altibi et al. 2021). Brelje and Pinals (2021, p. 197) observe: "Impaired provision of health care is particularly problematic because, at baseline, the imprisoned population has an increased rate of chronic medical conditions compared to the general population (Maruschak et al. 2016). These chronic conditions increase prisoners' risk of morbidity and mortality if infected by SARS-CoV-2."

The ramifications of these intramural and extramural factors, moreover, follow prisoners after release, creating "significant implications" for "spread of and susceptibility to Covid-19" (Novisky et al. 2021, p. 1638). These factors include insecure housing, barriers to health care access, and return to neighborhoods with disproportionate levels of Covid-19 due to "structural marginalization" regarding health care access, unemployment, housing density and stability, and structural discrimination.

This is just one way in which the pandemic risks of penal institutions extend into the communities in which they are sited (Drucker ; et al. 2015). For instance, failure to contain the spread of Covid in custodial settings carried severe potential consequences for diverse communities outside the prison gates, from "the homeless encampments in Los Angeles, California, to the rural households surrounding Maine State Prison" (Barnert, Ahalt, and Williams 2020, p. 966): "Outbreaks that occur within these facilities are likely to spread to the community, and outbreaks in communities are likely to spread to prisons. Preventing significant outbreaks within these facilities will, therefore, benefit not only the prisoners who are uniquely situated but also the general public (Brelje and Pinals 2020, p. 195)."

Big city jails in particular, with their daily influx of detainees, often briefly released for court and health appointments, become hotspots of contamination, both inside institutions and in their wider communities (Barnert, Ahalt, and Williams 2020, p. 964; see also Collica-Cox and Molina 2020). With their transient, short-term populations rotating in and out, porous city jails, especially, can act as vectors for infection to the communities around them. Reinhart (2021, section 2, para. 2) notes: "Neglect of the welfare of incarcerated populations boomerangs back upon the rest of the United States, multiplying harm in many forms: biological, psychiatric, economic, and social. Even just short pre-trial detention in a jail followed by acquittal inflicts long-term disadvantages on individuals and their communities."

In addition to the churn of entering and exiting prisoners, the long list of commuters into and out of penal facilities includes prison staff, medical staff, legal professionals, maintenance workers), outside rehabilitation and education providers, and, in normal times, visitors, inspectors, and researchers.

Although proving a causal link between these institutions and community outbreaks is difficult (Murphy 2021), several studies have highlighted broad public health implications, including increased Covid-19 infection rates in areas surrounding jails and prisons (Hooks and Sawyer 2020; Lofgren et al. 2020; Sims, Foltz, and Skidmore 2021). Reinhart and Chen (2020) explored this at Cook County Jail in Chicago, which reported in January 2022 that over 450 staff members and over 430 detainees had tested positive. They found that jail–community cycling accounted for 55 percent of case rate variance across Chicago ZIP codes and 37 percent of variance across Illinois. By April 19, 2020, jail-community cycling through Cook County was associated with 15.7 percent of documented Illinois cases. In the authors' view, current arrest and jailing practices "in highly policed neighborhoods" were turning arrested people into "potential disease vectors" in their communities. They argue (Reinhart and Chen 2020, p. 1417) that this may "bear partial responsibility" for the "striking racial disparities" of Covid-19 with the African American population.

II. The Covid Decarceration: What Went Wrong?

From the beginning of the pandemic, the potentially catastrophic effects of Covid-19 on people living in or near penal institutions were widely recognized by experts in fields ranging from epidemiology to criminology to medicine and law (Jiménez et al. 2020; Hwang, Kim, and Havins 2021; Leibowitz et al. 2021; Murphy 2021). Early modeling in these fields suggested that decreasing overcrowding through prison depopulation should be a central strategy in saving lives and reducing Covid-19 transmissions (Academies of Science 2020; Malloy et al. 2021). As a result, almost immediately, numerous calls for large-scale decarceration measures emerged (Strassle and Berkman 2020). The primary justifications can be broken down into cases based on:

- human rights (Commissioner for Human Rights 2020; Inter-American Commission on Human Rights 2020; Bagaric, Isham, and Svilar 2021)
- public health and epidemiology (Barnert, Ahalt and Williams 2020; Sivashanker et al. 2020; Murphy 2021), and
- ethics and social justice (Reinhart and Chen 2020; Denney and Valdez 2021).

Despite these overlapping arguments, the numbers released during the first two years of the pandemic fell far short of expectations (Clear 2020; Lockwood 2021), begging the question of what went wrong.

A. The Case for Decarceration

When cases began spreading in prisons and jails in early 2020, the United Nations High Commissioner for Human Rights, Michelle Bachelet, highlighted the urgent need for governments to take action to protect incarcerated people, including pressing states to reduce prisoner numbers (OHCHR 2020*a*). In particular, she highlighted the need to release "those particularly vulnerable to Covid-19… older detainees and those who are sick, as well as low-risk offenders," while providing for "the specific health-care requirements of women prisoners, including those who are pregnant, as well as those of inmates with disabilities and of juvenile detainees" (OHCHR 2020*a*, para. 7). This was reinforced by the United Nation Inter-Agency Standing Committee (IASC) which called for prioritizing the release of "children, persons with underlying health conditions, persons with low risk profiles and who have committed minor and petty offenses, persons with imminent release dates and those detained for offenses not recognized under international law" (IASC 2020, p. 3).

Releasing incarcerated people during a contagion crisis was framed as an issue of international human rights law, with the UN Standard Minimum Rules for the Treatment of Prisoners (2015) setting out the obligation of states to safeguard the mental health and well-being of prisoners (OHCHR 2020*a*). The Council of Europe Commissioner for Human Rights (2020) reminded member states that efforts should be made to find alternatives to the deprivation of liberty in order to safeguard human rights standards, as outlined by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) in its COVID-19 Statement of Principles (CPT 2020). This aim was reiterated by the Inter-American Commission on Human Rights (IACHR 2020*a*) in Resolution 01/20, "Pandemic and Human Rights in the Americas," calling for identification of those whose status could be converted to an alternative to imprisonment (IACHR 2020*b*). In addition, the IASC stressed that the pandemic provided "an opening for engagement with police…[and other] law

enforcement institutions as well as the judiciary about risks and opportunities related to pre-trial detention" (IASC 2020, p. 3).

Medical experts focused on the public health threat posed by imprisonment. In an editorial, the *American Journal of Public Health* emphasized that the most urgent front-line strategy for correctional facilities must be population reduction "to limit spread and improve containment" (Barnert, Ahalt, and Williams 2020, p. 964). Likewise, the *British Medical Journal* urged that "healthcare needs to lead the charge ... (and) urgently organize to advocate for safe decarceration." The pandemic was seen to highlight "the deep interconnections between public health and social justice," further widening inequalities in communities at the intersection of race and disability who disproportionately bore "the human and economic cost" of incarceration (Sivashanker et al. 2020, p. 1). States were urged to develop comprehensive plans to address custodial setting risk, in an effort to prevent incarceration enacting "cruel and unusual punishment" (Barnert, Ahalt, and Williams 2020, p. 965). Early in the pandemic, with support from Arnold Ventures and the Robert Wood Johnson Foundation, the National Academies of Sciences, Engineering, and Medicine (2020) formed an ad hoc committee with expertise in law, medicine, public health, and social sciences to provide a blueprint for decarceration during the Covid pandemic. Their report recommended that large-scale release and decarceration efforts were "an appropriate and necessary mitigation strategy" for containing Covid-19 (p. 88).

From a social justice perspective, the emerging picture of prison and jail contagion risk levels led to grassroots mobilization, with activists inside and outside prisons rallying around decarceration demands. A significant element of this mobilization in the US focused on the effects of Covid-19 on specific racial and ethnic groups in and out of prison (Apm Research Lab 2020; Reinhart and Chen 2020; Farr 2021; Novisky et al. 2021). The Color of Coronavirus Project reports that the national Covid-19 mortality rate for Pacific Islander, Latino, Indigenous, and Black Americans between March 2020 and February 2021 was twice that of the White and Asian population, a difference which triples when adjusted for age (Apm Research Lab 2020). Farr (2021, P. 14) observes, "Neither public health nor political strategies for COVID-19 prevention and containment have provided Black, Latinx, and Indigenous people the necessary means to protect themselves," with mass incarceration and the "deeper history of racialized custody" key factors these communities face. Denney and Valdez argue that pre-existing "racial vulnerability" fed into the spread of Covid-19 in prison, "mainly among race-class subjugated (RCS) communities" (2021, p. 863).

The impact of the pandemic on these groups was heightened by three enmeshed factors which "compound[ed] racial vulnerability": health care inequity on the basis of class and race; "external shocks" disproportionately affecting RCS communities; and government responses that entrenched the inequitable effects (Denney and Valdez 2021, p. 863). Predictors of higher community Covid-19 rates including mean household size, proportion of food service workers, number of foreign-born noncitizens, and pre-existing health issues are all prevalent features of RCS populations. These factors were compounded by government responses that "disregarded or harmed RCS communities," including rushed reopening of the economy and slackening of public health measures, despite rising death rates within these communities (Denney and Valdez 2021, p. 865).

Finally, an additional element of the grassroots mobilization was the "ableist" implications of Covid-19 responses. The American Civil Liberties Union and disability rights groups campaigned for release of disabled persons imprisoned for non-violent offenses. As Schotland (2021, para. 1) observed, disabled prisoners face "multiple and overlapping injustices and

oppressions" including "race and ethnic discrimination, poverty, trauma, multiple physical impairments, mental illness, and/or cognitive limitations." In the US prison system, disability levels are three times higher than in the general population, and in US jails, four times higher (Schotland 2021). Disability added an intersecting and additional risk to justifications for court sentences when "conditions of confinement are so dangerous they violate human rights" (Schotland 2021, para. 3).

In short, the public health risks of Covid-19 intersected with human rights and ethical concerns creating a broad coalition of support for decarceration. Beyond the risk of prisons acting as an amplifying contagion vortex during the pandemic, the risks inside were seen potentially to breach both the 8th Amendment of the US Constitution's prohibition of "cruel and unusual punishment" and, more broadly, obligations of governments set out in the European Convention on Human Rights (1950) and the UN's Mandela Rules (United Nations 2015). For legal observers, the elevated "risk" of incarceration caused by the pandemic raised additional issues regarding the legal principle of "proportionality" that requires that severity of punishments be proportionate to the seriousness of breaches of law for which they are imposed. With imprisonment during the pandemic "more burdensome than was previously understood," decarceration was a policy more "consistent with the proportionality principle" (Bagaric, Isham, and Svilar 2021, p. 127).

B. Decarceration in Practice

Despite these arguments from disparate quarters, the numbers of released prisoners in the first two years of the pandemic were far lower than anticipated in most countries (Lockwood 2021). Across the globe, reviews by Harm Reduction International (HRI) and Human Rights Watch (HRW) suggested that at least 109 countries enacted decarceration measures between March-June 2020 with the potential to release around 5 to 6 percent of the 11 million people in prison worldwide (HRI 2020; HRW 2020*a*). However, not all announced release schemes were actually implemented (Grierson 2020*c*; HRW 2020*a*, 2020*b*), and many of those that were fell "significantly short of expectations and the significant political commitments made in the name of public health" (HRI 2020, para. 6). Moreover, many releases were temporary, with released prisoners reimprisoned at later stages of the pandemic. By the end of 2021, the global prison population was estimated to be 10,771,204, a rate of 140 per 100,000. This represented an *increase* from 10,743,619 prisoners in 2018, but a decrease in real terms from 45 per 100,000, with all continents but the Americas experiencing population drops (Fair and Walmsley 2021). Penal Reform International's *Global Prison Trends 2022* describes current prison expansion globally to be "at an all-time high" with a population around 11.5 million.

Some countries did, however, achieve more substantial and sustained decarceration. This was especially the case in countries with long-standing issues with prison overcrowding. Before the pandemic, the Philippines had one of the world's most overcrowded prison systems, operating at 537 percent of capacity in its 400 prisons and jails (Arambulo et al. 2021). By October 2020, nearly 82,000 prisoners and detainees were released in one of the largest such initiatives globally (Arambulo et al. 2021). In Kenya, reduction initiatives included scaling down services and activities in the justice system for 30 days; a directive to dispense with police bonds for low-level offenses; and suspension of new admissions to custodial institutions. Additionally, after reviewing 19,000 case files, the High Court in Kenya decided that 15,379 prisoners should be released, have their sentences reduced, or be placed on a community service order (Deche and Bosire 2020). Other decarceration efforts highlighted by the Harm Reduction International analysis in 2020 include India releasing over 66,000 people (14 percent of the population); Iran issuing 10,000 pardons and releasing 75,000 of its 240,000

prisoners (over 30 percent); Iraq reducing its 45,000 population by just under 40 percent; and Myanmar pardoning 27 percent of its 92,000 prisoners (HRI 2020).

The Council of Europe (2022) reports that the Covid-19 pandemic resulted in prison population reductions in 49 prison administrations of 52 member states, due largely to reduced crime rates and court backlogs in conjunction with various release schemes. The Portuguese government in 2020 planned to release around 10 percent of the prison population, approximately 2000 prisoners, including those serving sentences under two years and those nearing the end of a sentence for non-violent crimes, corruption, drug trafficking, or state actors. Portugal also enacted an "exceptional presidential pardon" for the release of many individuals over the age of 65 with pre-existing health issues (Frois 2020, p. 25). Likewise, France decreased its prison population by an estimated 20 percent in the pandemic's first year (HRI 2020).

These were exceptions to the general rule, however. Decarceration was far less successful in most countries. Zeveliva and Munof (2020) found that only 16 of 47 jurisdictions in the Council of Europe effectively implemented decarceration measures in the first year of the pandemic. Overall, imprisonment rates decreased by only around 2.3 percent across the continent primarily due to decreases in crime and backlogs in the courts (Council of Europe 2022). The Prison Service of England and Wales had a particularly troubled experience. In April 2020, the Ministry of Justice announced that it would release up to 4,000 prisoners, about 5 percent of the population (Grierson 2020*a*). Over 2,000 electronic monitoring tags were purchased to facilitate the releases. The chair of the Independent Advisory Panel on Deaths in Custody (IAPDC) warned that the scheme was "hard to understand, difficult to explain and close to impossible to deliver" with processes and eligibility criteria "mired in complexity and risk aversion" (Grierson 2020*b,* paras. 2-6). By the end of June 2020, only 57 individuals had been released, six mistakenly. The Conservative Government lost its political nerve. By October 2020, the scheme was "closed." In total, 275 individuals were released, a fraction of one percent of the overall prison population (Grierson 2020*c*).

Of course, the success of decarceration around the world largely depended on the United States, which holds a quarter of the world's prisoners (Fair and Walmsley 2021). The scale and complexity of criminal justice systems in the US means that a wide variety of disparate strategies were required rather than the centralized, top-down approach taken in smaller countries with a single prison system. For example, California expanded use of "good time'' credits to promote prisoner release while also establishing a statewide emergency bail schedule to reduce use of cash bail and lower jail populations (Prison Policy Initiative 2021). Inevitably, these multiple, overlapping, and enmeshed local, state, and national initiatives were neither universally nor consistently implemented resulting in wide variation across states and localities (Council on Criminal Justice 2020, p. 5).

The Bureau of Justice Statistics reported a 15 percent drop in state prisoners by the end of 2020 (Carson 2021). Three states were able to decrease their overall prison populations by over a quarter in this first year of the pandemic: West Virginia (33 percent), New Jersey (31 percent), and Connecticut (26 percent) (Byrne et al. 2022). However, most of these drops are not the result of prisoner release strategies, but rather can be explained by the dramatic 40% drop in prison admissions in the first year of the pandemic – a result of crime declines, court delays, and temporary suspension of transfers from local jails (Sawyer and Wagner 2022). Prisoner numbers started to increase again in 19 states between January 2021 and January 2022 (Vera Institute of Justice 2022). The Prison Policy Initiative (2021, p. 1) concluded that

US lawmakers have "failed to reduce prison and jail populations enough to slow the spread of Coronavirus" (see also Lemasters et al. 2020; Lockwood 2021).

At the federal level, more systematic attempts were made to decarcerate with mixed success. In March 2020, Attorney General William Barr asked the Bureau of Prisons (BOP) to transfer older and medically vulnerable prisoners to home confinement if they were low-risk and convicted of non-violent crimes (Office of the Attorney General [OAG] 2020*a*; Bagaric, Isham, and Svilar 2021). By April 3, 2020, only 552 prisoners had been released (Prescott, Pyle, and Starr 2020). The CARES Act (2020) authorized federal prisons to release elderly prisoners and those convicted of non-violent crimes to home confinement (Office of the Attorney General [OAG] 2020*b*; Prison Policy Initiative 2021). Recognizing the limited facilities of the federal probation system, Barr also authorized BOP to release prisoners to home confinement even if electronic monitoring was unavailable (OAG 2020*b*). However, his memo, warned against "too liberal releases" and urged continued incarceration of the vast majority of prisoners sentenced for violent offenses (Prescott, Pyle, and Starr 2020*a*, para. 17). Finally, the Trump Department of Justice announced that released individuals whose terms extended beyond the pandemic must be returned to prison (Bagaric, Isham, and Svilar 2021). The Biden administration rescinded that policy, giving discretion for sentences to be finished at home (Prison Policy Initiative 2022).

In all, between March 2020 and August 2022, over 46,000 federal prisoners were placed on home confinement for part of their sentence as a result of these initiatives (US Bureau of Prisons 2022*a*). The federal prison population dropped from 177,214 to 155,562 between the end of 2019 and the end of 2020, but had risen again to 158,162 as of August 2022 (US Bureau of Prisons 2022*b*). As Clear (2021, p. 1419) writes: "These numbers may seem large. They are not. … If the aim is to target people in prison who are elderly, infirm, or doing time for less serious crimes, there is plenty of room to release more people from confinement."

C. Impediments to Successful Decarceration

Reflecting back on the first two years of the pandemic, the question becomes "what happened to decarceration?" Given the perceived risk of Covid-19 to the public and the extreme protective measures taken in nearly every other sector in society, the lack of substantial decarceration of prisons raises considerable questions.

Stringent eligibility requirements for release initiatives were one major obstacle. Release schemes largely followed IASC (2020) recommendations concerning release of medically vulnerable and elderly prisoners and those nearing the ends of their sentences. However, as Prescott and colleagues (2020*a*, 2020*b*) point out, two-thirds of people in prison over age 55 in the United States are serving long sentences for offenses considered to be "violent crimes." As such, the majority of older, at-risk prisoners were precluded from Covid-responsive release measures.

Another impediment concerns drug users. The UN Human Rights Office of the High Commissioner highlighted distinct risks faced by drug users because of chronic health problems and socioeconomic marginality and urged consideration of early release for people convicted of non-violent drug offenses (OHCHR 2020b). Nonetheless, by June 2020, 25 percent of countries undertaking decarceration initatives "explicitly excluded people incarcerated for drug offences" (HRI 2020, para. 5).

In addition to impeding decarceration efforts, this decision created racial disparities by deeming drug offenders to be riskier than white-collar offenders. In one analysis, Hager (2020) found that only seven percent of African American prisoners were considered sufficiently low risk for release compared with 30 percent of whites (non-US citizens with immigration-related offenses were ineligible). Likewise, the Council on Criminal Justice (2020, p. 3) observed that pandemic decarceration efforts in the US "may have exacerbated some racial and ethnic disparities." As jail populations began to decrease in the early months of the pandemic, the disproportionate confinement of minorities increased (Council on Criminal Justice 2020, p. 3). Such biases were not limited to the United States. Miranda and colleagues (2021) found in Portugal that public opinion about decarceration was more favorable to early release of White than of Black prisoners. They conclude that documented racial disparities in policing and sentencing may also be "present in the early-release decisions, even when it represents an important measure to address the Covid-19 pandemic" (Miranda et al. 2021, p. 10).

US policies governing compassionate release of disabled prisoners were also said to be "too narrowly drawn," and were administered "too stringently by the wardens, prosecutors, and judges" (Schotland 2020, section 1). Implementation of compassionate release required "ad hoc litigation" and depended too much on criteria for release applied to individuals. Compassionate release applicants usually had no right to counsel; outcomes too often depended on individual prisoners' resources. Nearly 98 percent of release applications by federal prisoners were denied; only 156 were approved (Neff and Blakinger 2020). Similar failings occurred in many countries. The São Paulo Court of Justice in Brazil, often called "the epicenter" of the pandemic in the Global South, for example, also ruled against the vast majority of compassionate release petitioners (Pires de Vasconcelos, Machado, and Wang 2020, p. 1473).

Issues also emerged concerning support and services for safe and secure reintegration of released prisoners. Portuguese reports highlighted that "dozens of inmates were simply given one day's notice and left at the prison gate, with their possessions in a handbag or a bin bag" with no means of transport and restricted public transport (Fois 2020, p. 26). Fois asks whether the deficiencies in implementation of release policies heightened Covid-19 risks for those released, "in effect abandoning rather than liberating them – in a global pandemic emergency" (Fois 2020, p. 26). Lockdown measures outside of prisons created a "compromised community environment" for released prisoners including diminished reintegration services, lessened socioeconomic activity, and overwhelmed mental health and social security services (Shepherd and Spivak 2020, p. 59). These problems disproportionately affected particular groups, including homeless people and members of indigenous groups (Ricciardelli et al. 2021; Schneider 2021). UN recommendations urged that those released from prison during the pandemic should be provided support with housing and health care (IASC 2020, p. 4; OHCHR 2020, para. 9). Releasing prisoners without addressing structural inequalities and service deficits can impede reintegration efforts (National Academies of Science, Engineering, and Medicine 2020).

Overall, implementation of decarceration was neither as widespread nor as efficient as it should have been. Globally, most states failed not only to prevent Covid-19 spread within prison systems, but "also did little to prevent the transmission of the virus from prison and jail hotspots to nearby surrounding communities... ignoring, downplaying, and distorting this systematic failure left communities exposed" (Hooks and Sawyer 2020, para. 3). In the context of a global environment of unprecedented policy initiatives to reduce the spread of Covid, the failings of decarceration became all the more stark. Schotland (2021, section 8) concludes that

"the neglect of prisoners during the pandemic reflects a combination of racism, classism, disablism and stigma" and that there was "no countervailing public policy justification" for incarceration in such dangerous conditions.

III. The Covid Lockdown

With only a small fraction of incarcerated populations released, prison administrations everywhere were faced with the challenge of containing a highly contagious and deadly disease under near impossible conditions (Pont et al. 2021; Dunkel, Harrendorf, and van Zyl Smit 2022). As in other workplace or residential environmente, penal institutions introduced standard mitigation practices, including the use of lateral flow and PCR testing, enhanced sanitization, personal protective equipment, and, beginning in 2021, vaccination (Cloud et al. 2020; Mortaji et al. 2021). Prisons around the world sought to become "Covid responsive" in much the same way as previously they sought to achieve "gender responsivity" or "trauma responsivity" (Bloom, Owen, and Covington 2003; Durr 2020).

The delivery of these measures differed in quality and speed across jurisdictions and between individual prisons. For instance, in July 2021, the World Health Organization reported that more than 84 percent of Spanish prisoners had been fully vaccinated against Covid-19, but only 34.4 percent in Finland (WHO 2021). A number of studies suggest vaccine hesitancy played a role in low rates of uptake, particularly in some US states (but not in California; see Kwan et al. 2022). Prison populations are often over-represented in clinical trials (Lieu et al. 2022) and, perhaps unsurprisingly, have been found to have high levels of medical mistrust (Chin et al. 2021; Stern at al. 2021).

The most controversial community mitigation measure in most contexts was the introduction of strict policies prohibiting social congregation. Public spaces from nightclubs to children's play parks were closed, and members of the public were urged (sometimes required) to stay in their homes. In what became known as the Covid-19 "lockdown," residents of most countries found their ability to socialize with others outside their household legally curtailed, with nearly unprecedented restrictions imposed on all aspects of social life, including congregating with outsiders inside one's own home. "Lockdowns," in the form of restrictions on out-of-cell time, swiftly became the heart of Covid-responsivity practices in prisons everywhere (Brandon and Dingwall 2022; Dunkel, Harrendorf, and van Zyl Smit 2022). In their comparative survey, Zeveliva and Nazif-Munof (2020) found that all Council of Europe member states, as well as Belarus and Kazakhstan, implemented "lockdowns" of various severity in the first year of the pandemic. Essentially, prisons did what prisons do best: lock residents away from human contact. In thus section, we explore the "intended and unintended consequences" of these "strict medico-carceral measures" (Durnescu and Morar 2020, pp. 1144-45). We draw in particular on a recently completed case study of the effects of the Covid-19 lockdown in prisons in England and Wales (User Voice/QUB 2022).

A. Locking Down the Locked Up

Prior to the pandemic, 50,000 to 80,000 prisoners in the US were held in solitary on a given day. During the pandemic, this increased by 500 percent to 300,000 (Cipriano 2021). Yet, even ordinary incarceration in the early months of the pandemic could be considered a form of solitary confinement. According to Rule 44 of the United Nations revised Standard Minimum Rules for the Treatment of Incarcerated People, known as the "Mandela Rules,"

solitary confinement is defined as confinement for at least 22 hours a day, without meaningful contact. The Mandela Rules proscribe the use of such confinement for more than 15 days at a time. Yet, initial research suggests that prisoners in much of the world were confined to their cells for 23 hours each day for months at a time at the beginning of the pandemic (Zeveliva and Nazif-Munof 2020; Prisoners Education Trust 2021; Dunkel, Harrendorf, and van Zyl Smit 2022; Heard and Padfield 2022). Informal association time between prisoners, group counseling, workshops and classrooms, gym activity, religious services, family visits, and more were discontinued, and prisons were reduced to something akin to their nineteenth century origins as places of isolation and solitude. Although this enforced social distancing almost certainly mitigated the spread of the Covid-19, saving lives, it is also unquestionable that "indefinite or prolonged solitary confinement is an inhumane or degrading form of treatment and, in its more extreme manifestations, a form of torture" (Mulgrew and van Zyl Smit 2022, p. 596).

Heard's (2020, 2022) comparative analysis of prison regimes, before and after the onset of the pandemic, provides a rare glimpse into what this change looked like in ten countries (Australia, Brazil, England and Wales, Hungary, India, Kenya, the Netherlands, South Africa, Thailand, and the United States). Almost all suspended prison visitation for family and friends beginning in March 2020 (Anthony et al. 2022). Prior to the pandemic, prisoners in South Africa averaged around 5 visits per month. Those in the Netherlands and Australia averaged one per week, and those in Thailand reported meeting with visitors through an outdoor partition several times each week. For the first months of the pandemic, all visits essentially ended across the surveyed countries except in Thailand, where the time families were allowed was reduced from 20 to 10 minutes (Heard and Padfield 2022). Some jurisdictions sought to compensate for this dramatic shutting down of contact with the outside world. In the United States, the federal Bureau of Prisons (BOP) facilitated 500 minutes of free calls each month for each prisoner (US BOP 2020). In the United Kingdom, in-cell telephones were installed in half of prisons (Heard 2020; Brandon and Dingwall 2022). This acknowledged the inherent difficulties in expecting dozens of prisoners safely to share a single payphone, especially when each prisoner was allowed out of cell only for an hour (User Voice 2021). In addition, new technology which facilitated online family visits (known as "purple visits") were introduced in many facilities (House of Commons 2020).

Restrictions on visitation were not confined to family, but also encompassed legal representatives. Prison-based research essentially came to a halt; thus the voices of those in prison were largely absent from public debates (Pyrooz et al. 2020; Maycock and Dickson 2021). Of course, some studies captured the views of those who had loved ones in prison (Lockwood et al. 2021; Minson 2021; McDonald et al. 2022), and others drew on data derived from letters and blogs written by prisoners (Armstrong, Davis, and Pickering 2020; McDonald et al. 2020; Prison Reform Trust 2020*a*; Fair Trials 2021; Sorge et al. 2021; Maycock 2022). Prison inspections were also suspended in many jurisdictions (Dunkel et al. 2022), although in England and Wales the inspectorate carried out interviews with women, men, and children in 6 prisons between September 30 and November 5, 2020 (HMCIP 2021). In 2020, the World Health Organization stated that the pandemic should not be used to prevent external inspection bodies and human rights agencies from obtaining access to prisons, yet research indicates that this recommendation was seldom followed. Charities, human rights agencies, and independent monitoring bodies were denied access in numerous jurisdictions (Heard 2021; Mulgrew and van Zyl Smit 2022).

Although prisoners have a right to the same medical care as those on the outside, this access was sharply curtailed in many jurisdictions during the first years of the Covid pandemic (Pont et al. 2021). Hutchings and Davies (2021) found that prisoners during the pandemic sometimes waited 14 weeks for a doctor's appointment, extending already long waiting times. In many jurisdictions, the suspension of group-based rehabilitation activities had implications for both mental health and progress toward parole release. Heard (2022, p. 627) argues that ending group therapeutic activities denied those in prison "the opportunity to demonstrate good behavior or rehabilitation and made it harder to prepare for release…because there would be nothing to inform the relevant risk assessments or recommendations."

Finally, the lockdown conditions were often elongated as a result of pandemic-related staffing shortages (Akiyama, Spaulding, and Rich 2020; Wang et al. 2020; Nowotny, Kapriske, and Brinkley-Rubenstein 2021; Pont et al. 2021; Vest 2021). In some countries, understaffing and lack of experienced staff worsened conditions experienced by prisoners and resulted in violence, protests, hunger strikes, and riots (Heard and Padfield 2022). Riots were reported to have broken out in more than 22 prisons in Italy over a two-day period in March 2020 (Sorge et al. 2021). In England, the pandemic caused massive turnover in prison staff with more leaving than could be hired, including the most experienced senior staff. Currently, around a third of officers have been in post for less than three years, compared to one in eight in 2010 (Cooney 2021). Staffing issues have also contributed to deteriorating healthcare with unavailability of prison escorts leading to missed appointments. Like the prisoners they work with, prison staff faced considerable health risks, including mental health risks; absentee levels in prison systems have been extremely high throughout the pandemic (Kathari et al. 2021).

B. Effects of the Lockdown

It is too early to assess the long-term consequences of the pandemic lockdown on the lives of those in prison. Emerging evidence suggests that the extreme isolation, cessation of visits, lack of meaningful activity, and deteriorating relationships with prison staff may be taking an immense toll on the mental health of prisoners (Johnson et al. 2021; Brandon and Dingwall 2022; Kim et al. 2022). Casey and colleagues (2021, p. 481) found:

The experience of lockdown was both traumatising and punitive for people who were already marginalised and subject to criminal justice control...In effect, the severity of sentences for people completing custodial sentences and community sentences increased. Crucially, both people in prison and people under supervision suffered extension to and exacerbation of the ways in which punishment suspends and disrupts their lives; their efforts to progress towards a life beyond punishment were often frustrated and stalled.

Pre-pandemic research suggests that incarceration itself is associated with a 45 percent increase in the odds of suffering major depression (Kessler, Berglund et al. 2005; Schnittker, Massoglia, and Uggen 2012). These effects are magnified by the experience of long-term solitary confinement, which has been found to have "often devastating psychological consequences" (Wildeman and Anderson 2020, p. 107; see also Smith 2006; Shalev 2011; Haney 2018). Incarcerated people who experience solitary confinement have higher rates of Post Traumatic Stress Disorder (PTSD), self-harm, and suicide (Kaba et al. 2014), and experience long-lasting physical, neurological, and physical health problems (Smith 2006; Haney 2018; Luigi et al. 2020; Jahn et al. 2022). Wildeman and Anderson (2020) found that, compared with the general population, people subjected to solitary confinement in Norway were almost ten times more likely to die within five years of release. Cloud and colleagues

(2020, p. 2738) observe: “The hallmarks of solitary confinement — social isolation, physical idleness, and sensory deprivation — lead to immense psychological suffering and lasting trauma, and too often resultin self-harm, violence, and suicide, even after only relatively short periods of time.”

The cessation of visits from outside is also likely to undermine the precarious mental health of imprisoned people (Sorge et al. 2021). Research since the early 1990s suggests positive effects of family visits on a variety of outcomes for prisoners (Hairston 1988; La Vigne et al. 2005; May, Sharma, and Stewart 2008; De Claire and Dixon 2015; Woo et al. 2016; Turanovic and Tasca 2019). Research findings consistently show positive effects of visits on reduced symptoms of depression in female and adolescent prisoners and positive associations between visits and reduced rule breaking behavior, reduced recidivism, and improved chances for survival in the community after release (La Vigne et al. 2005; De Claire and Dixon 2015). Hewson (2020, p. 569) argues that the systematic elimination of visits “could lessen the use of social support for mitigating against and coping with mental distress, and the risk of suicide and self-harm. This scarcity of social support might make adjustment to prison more difficult, risking the use of maladaptive coping strategies.” Furthermore, suspension of visits in many countries led to dramatic loss of access to essential items often brought in by family, such as medicine, ood supplies, clothing, and sanitary products (Heard 2021; Bucerius and Sandberg 2022).

Ironically, the lockdown may have even exacerbated susceptibility to Covid-19. Novisky and colleagues (2021) argue that highly restrictive Covid-responsivity measures can increase vulnerability because of increased cortisol levels resulting from elevated levels of stress associated with isolation. In short, Covid-responsivity as practiced in many parts of the world was achieved at considerable cost to the physical and mental health of prisoners. As Lachsz and Hurley (2021, p. 55) conclude: “In light of the well-documented harm that solitary confinement can cause, it is a practice that should be prohibited by law and must not form part of the response to Covid-19. Safer alternatives exist, like reducing the number of people detained in prisons.”

IV. A Case Study of the Pandemic Lockdown in England and Wales

Prior to the onset of the pandemic, HM Prison Service of England and Wales was widely viewed to be in a state of crisis (Brennan 2020; Corker 2020). For a decade, prisons had faced dramatic budget cuts, staff shortages, poor infrastructure, and an overcrowded system that had nearly doubled in size from a population of 44,246 in 1993 (Ministry of Justice 2013) to 83,023 at the end of 2019 (HMPPS 2019). Levels of violence, suicide, and self-harm were at or near record levels in the years leading up to the pandemic (HMPPS 2022*a*). The former Conservative Party Minister for Prisons Rory Stewart compared the prisons he visited (unfavorably) to war zones he had worked in during his military experience: “Violence had tripled to 30,000 assaults a year, every institution was overcrowded, filthy and rat- and drug-infested” (Cohen 2022, para.11).

The first Covid-19 infection was reported in HMP Manchester in March 2020. Within two months, 21 prisoners and 7 prison staff died at the high security facility (Heard 2022; Heard and Padfield 2022). Overall, just over 200 people in prisons in England and Wales died having

tested positive for Covid-19 between the onset of the pandemic and July 31, 2022 (Ministry of Justice 2022). It could have been much worse. In April 2020, modeling conducted by HM Prison and Probation Service (HMPPS) and Public Health England suggested that 800 to 2,000 more prisoners might die as a result of the pandemic if no action was taken to reduce contact in prisons (Townsend et al. 2020; HMIP 2021).

As terrifying as that possibility was, it also represented an opportunity to make dramatic changes to a prison system that was already in a desperate state. As the Chair of the Prison Officers Association for England and Wales stated in August of 2020, "Returning to chaos is not an option" (Fairhurst 2020, section 2). In other words, British prisons could have followed the lead of other European countries, such as France, Switzerland, and Portugal, and initiated swift decarceration, even seeking to return numbers to 1990s levels in order to close dysfunctional and unsanitary Victorian era prisons.

Decarceration efforts in England and Wales were, however, shambolic. Only a fraction of one percent of prisoners were released (Grierson 2020*c*). Scotland and Northern Ireland, which have separate and independent prison systems, fared considerably better (Morrison and Graham 2022; O'Connell et al. 2022). In England and Wales, the prison population did drop from 83,023 at the end of 2019 to 79,092 by the end of 2021 (HMPPS 2020; HMPPS 2022*a*). For the most part, this resulted from falling crime rates during the Covid period and from courts running at lower capacity rather than from explicit efforts at decarceration. Indeed, the prison population is now rising again with 81,274 prisoners in the last week of August 2022 (HMPPS 2022*b*). Moreover, these same court backlogs led to delays in processing cases of remanded defendants, resulting in periods of incarceration longer than the normal "custody time limit" of six months, leaving remand imprisonment rates at the highest level since 2010 (Dimsdale and Saunders 2022*a*).

Instead of decarceration, the prison system's primary strategy for mitigating the spread of the virus was a drastic 23-hour lockdown, involving a suspension of visits and almost all out-of-cell activities including workshops, group therapy, and education (House of Commons' Justice Committee 2020, July 27). These severe conditions were mitigated in some but not all facilities by the introduction of in-cell telephones and technology allowing for online "purple visits" with family members (House of Commons 2020; Brandon and Dingwall 2022; Heard and Padfield 2022).

Although criticized by prison reform groups (e.g., Prison Reform Trust 2020*b*; User Voice 2021), the lockdown was described as a "blessing in disguise" by the head of the Prison Officer Association and some politicians (UK Justice Committee 2020, June 23). Proponents touted, in particular, huge drops in levels of violence among prisoners and against prison staff (BBC 2020, Oct 8). These drops from historic highs in 2019 were, however, both predictable and meaningless given that prisoners were allowed out of their cells for only one hour per day. More surprisingly, the initial statistics collected by prisons indicated no immediate increase in officially recorded self-harming behaviors in men's prisons in 2020 as might have been expected. (Notably, women's prisons experienced a significant increase in both 2020 and 2021; HMPPS 2022). The Prison Officers Association chief observed that "The government should listen to the experts in prisons – the staff – who say the situation is now safer and more stable" as a result of the draconian lockdown (BBC 2020, Oct. 8).

In those early days of the pandemic, the government had little choice about whom to listen to, as no external observers were allowed inside the prisons except eventually HM Inspectorate of Prison. As a result, for the first several months of the pandemic, prisoners' voices were

seldom heard in the media or elsewhere (Prison Reform Trust 2020*a*; User Voice 2021). On September 18, 2020, *The Guardian* newspaper invited submissions: "Tell us: What are pandemic conditions like in UK prisons?" A website where responders could upload their stories was provided, although almost no one in British prisons had access to the internet to respond.

In this context, the authors and our partner organization User Voice succeeded with a funding application to the UK's Economic and Social Research Council to develop a participatory action research project in ten prisons (Fine and Torre 2006). Participatory research methods, in which "research participants are regarded as potential collaborators in the co-production of knowledge and become co-researchers" seek to "fundamentally change the dynamic of research" (Schubotz 2019, p. 3). One of our initial premises was more pragmatic: if outside researchers could not get into prisons, then perhaps people in prison could be trained to conduct their own study of prison conditions. This is what we did. During summer 2021, we delivered an accredited 2-day "peer research methods" course to 99 prison residents from 10 facilities, outlining the basics of participant observation, interviewing, and peer surveying. These peer researchers became the "eyes and ears" of the prison, writing field notes, doing one-on-one interviews, and collecting over 1400 completed surveys from fellow prisoners. We returned to three of the prisons to analyze the anonymized results in collaboration with the peer research volunteers.

The findings painted a striking portrait of the pandemic lockdown from the perspective of the imprisoned. At the time interviews were conducted (summer 2021), nearly 60 percent of survey respondents said they had not had a single in-person visit since the pandemic began. Eighty-five percent said they were out of their cells for an hour or less per day during the first six months of the pandemic. Over 80 percent said they were still out of their cells for less than two hours per day at the time of the interviews in 2021. Moreover, few agreed with the Prison Officers Association assessment that the lockdown was a "blessing in disguise." Only 1 in 5 agreed that the lockdown reduced violence and bullying. Just 8 percent agreed that "This prison is listening to the concerns of residents." Most importantly, over two-thirds agreed that "mental health has never been worse in this prison."

To confirm these assessments, we included two validated mental health measures in the peer survey: the Patient Health Questionnaire-9 (PHQ-9) measure of depression and the Generalised Anxiety Disorder-7 (GAD-7) used to screen for post-traumatic stress and related conditions. These two scales are widely used as screening tools in care settings and in epidemiological surveys. They have been used extensively in studies both of the general public during the pandemic and in prison settings prior to the pandemic, thus allowing for multiple comparisons. A PHQ_9 score between 5–9 points indicates "mild depression," 10–14 points indicates "moderate depression," 15–19 points indicates "moderately severe depression," and 20 or more points indicates "severe depression."

The mean PHQ-9 score for our sample of prisoners during the pandemic was 13.9 -- at the high end of "moderate depression" and more than 4 times higher than the general population norm of 2.91 (Kocalevent et al. 2013). For context, it is useful to compare this score to research findings during the pandemic when mental health suffered throughout most sectors of society. In two studies of the general public in Britain during the pandemic, Shevlin and colleagues (2022) found mean a PH-Q scores of 5.37, whereas Jia and colleagues (2020) found PHQ-9 scores averaging 7.69. It is also useful to compare our findings to research in prisons prior to the pandemic. In a large-scale prevalence study of 1,205 male prisoners in England and Wales conducted in 2019, Butcher and colleagues (2021) found that around 20.7 percent scored over

15 on the PH-Q (i.e. in the "severe" depression categories). Nearly half (49 percent) of our sample scored over 15.

The statistics on the measurement of anxiety disorder (GAD-7) are equally stark. Like the PHQ-9, the GAD-7 is calculated by aggregating scores on self-reported measures of symptoms such as inability to sleep and inability to control one's worries. The measure is also used for screening three other common anxiety disorders — panic disorder, social anxiety disorder, and post-traumatic stress disorder (or PTSD). A score of 10 or more represents the generally accepted cut-off point for identifying potential cases of anxiety disorder, with a score of 15 and above suggesting severe anxiety. The mean GAD-7 score for our sample was 10.67 compared to the population norm of 2.95. In studies of the wider British population, Shevlin and colleagues (2022) found mean GAD-7 scores of 5.15, and Jia and colleagues (2020) found GAD-7 scores of 7.69. The median score for our prison sample was 11, indicating that just over half were reporting symptoms consistent with PTSD and over one-third (34.9 percent) were in the "severe anxiety" category of 15 and up. In a prison survey conducted in 2019, Butcher et al. (2021) found that only around a third of British prisoners (31.4 percent) scored above 10 and only 18 percent above 15. In our research during the lockdown, 52.5 percent scored above 10 and 34.4 percent scored over 15. These comparisons suggest a considerable deterioration in prisoners' mental health over the lockdown period with measures of severe anxiety nearly doubling.

Although adverse mental health effects of solitary confinement are well established (Shalev 2011; Haney 2018), seeing statistics like these for a sample of over 1400 ordinary prisoners across 10 British prisons is truly striking. The consequences of this mental health crisis may only be beginning to be understood. In 2021, British prisons saw a record 371 deaths in prison, of which 86 were self-inflicted, representing a 28 percent increase from the previous year (HMPPS 2022). Remand prisoners accounted for 40 percent of self-inflicted deaths (Dimsdale and Saunders 2022*b*) despite being only 16 percent of prisoners.

V. Prisons after the Pandemic

The Covid-19 pandemic has exposed the gaps, deficits, and inadequacies of carceral institutions globally in failing to respond adequately to a major public health risk. Despite previous outbreaks ranging from typhus to SARS, few prison systems could be said to have been "sufficiently prepared for a large-scale public health crisis" in 2020 (Council on Criminal Justice 2020, p. 5). At the same time, the prioritization of in-prison mitigation over decarceration strategies demonstrated the robustness and near impenetrability of carceral logic internationally.

In 2020-21, the unthinkable became reality across the world. Whole cities and town centers essentially closed. Schools and workplaces shut their doors; weddings, funerals, sporting events, and other gatherings were cancelled or held without spectators; regulations prohibited socializing in groups and controlledg nearly every aspect of social life. In this remarkable and unprecedented context, the prison regime not only remained firm, but became more extreme in its punitive form.

This is particularly remarkable considering the historic lack of evidence that prisons actually reduce recidivism. Petrich and colleagues' (2022) meta-analysis of 116 existing studies of the effects of custodial sanctions found no evidence that incarceration reduced recidivism above

and beyond community penalties. The authors conclude that "Incarceration cannot be justified on the grounds it affords public safety by decreasing recidivism" (p. 353). As such, available evidence suggests that decarceration efforts could be expanded "with no increased threat to public safety" (Byrne et al. 2022, p. 18). For instance, recidivism data for the 7,251 US federal prisoners released under the First Steps Act (2018) through September 2020, suggests a reoffending rate of only 11.3 percent (OAG 2020; see also Harvey, Taylor and Wang 2020; Wegel, Wardak, and Meyer 2022). In August 2022, the US Bureau of Prisons reported that of the 11,000 people released early from Federal Prisons as party of the CARE Act, only 442 had been returned to prison and only 17 of those were returned for committing new crimes (most of which were drug-related) (Johnson 2022). As Clear (2021, p. 1423) writes, fears of a "crime wave" emerging from early release programs appear extremely exaggerated on the basis of existing evidence: "It should be plain that the effects of a handful of moderately earlier releases on public safety are bound to be negligible."

In short, the Covid-19 pandemic proved that mass decarceration and excarceration is feasible, even on a global scale. Even if that process failed to reach its full potential, even reducing prison populations by 5 percent worldwide can be seen as something of a success. At the very least, proactive efforts in a minority of prison systems demonstrate that mechanisms are available to address overcrowding and implement decarceration, illuminating pathways for real change (Wegel et al. 2022). For example, after struggling for decades to reduce overcrowding in its prison system, Kenya used the impetus provided by Covid to implement rapid decarceration in 2020 – described as a "silver lining in the Covid-19 cloud" (Deche and Bosire 2020, p. 921).

However, that these mechanisms exist and many countries nonetheless struggled to decarcerate even chronically overcrowded prison systems represents a warning sign for those hoping the pandemic would be "the catalyst" for mass decarceration (Bagaric et al 2021, p. 124). The turn toward a heightened form of solitary confinement occurred notwithstanding the well-documented health risks associated with this kind of forced isolation (Cloud et al. 2015) . Even successful decarceration efforts may prove temporary, with reincarceration emerging in numerous countries (HRW 2020*b*). In India, by December 2020, an estimated 90 percent of those released during Covid had been returned to prison (Dhanuka 2022). Following release of around 35,000 prisoners, Brazilian prisons experienced a 19 percent increase in its prison population by July 2020 (Rodriguez and Khouri 2022). More recent increases can also be seen in Portugal (Rodrigues and Pinto 2022) and France (Herzog-Evans 2022). These returns to the status quo cast real doubt on any expectation that the pandemic will foster "sustained structural changes vital for future pandemic preparedness and public health" (Reinhart and Chen 2020, p.1412). Herzog-Evans (2022, p. 220) writes: "It has quickly become clear that there will be no Utopian 'day after.' Indeed, no reform is currently being planned to try and draw upon the potentially positive dimensions of the crisis or to learn from the mistakes which have been made." Considering that the contagion risks exposed in the past two years are not unique to Covid-19, but have been "reproduced across time and space," (Novisky et al. 2021, p. 1638), this suggests a troubling trend for future outbreaks.

Still, the lessons learned from the Covid pandemic can help inform future decarceration efforts. Amy Fettig (2022, p. 419) of The Sentencing Project, for instance, argues that United States' efforts were "largely incompetent, inhumane and contrary to public health policy," but nonetheless provide "a roadmap for policy priorities and legal reform in our ongoing need to decarcerate."

Finally, if there is a silver lining, globally, it is that the pandemic may have alerted the wider public health and medical communities to the risks penal institutions pose to public safety. Sivashanker and colleagues (2020, pp. 1-2), in the *British Medical Journal*, observe: "Despite the clear health risks, healthcare organisation have not broadly organised to advance decarceration as a public safety measure. … Covid-19 is a call to healthcare workers and organizations to help tackle the deeper sociopolitical root causes of disease, and to intervene before the harm is done. That call is nowhere clearer than in our broken criminal justice system. It's time to pick up our loudspeakers and insist on caring for all." History suggests that such voices can be crucial in shaping penal futures (Simon 2013).

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