Harvard Radcliffe Institute

Event Transcript

Decarceration and Community: COVID 19 and Beyond (Part II)

June 23, 2020
Harvard Radcliffe Institute

Description

The Radcliffe Institute is offering a two-part series of virtual programs to explore the impact of the COVID-19 pandemic on incarcerated people.

Part II of this discussion series considers how public officials responsible for the operation of jails and prisons are responding to the current pandemic. What challenges and opportunities present themselves, given the reality of COVID-19 in carceral spaces? Responding to the issues raised by impacted people during the first session, how do we understand public health in and around carceral spaces, and how do we develop strategies to keep communities safe during the pandemic? Drawing on decades of collective experience running county jails and state prisons along with expertise in addressing health concerns within and outside such settings, the panelists will consider possible solutions, including justice reinvestment, decarceration, and early release.

SPEAKERS

Patricia Caruso, former director, Michigan Department of Corrections

Harold Clarke, director, Virginia Department of Corrections; former director, Massachusetts Department of Correction and Nebraska Department of Correctional Services; former secretary, Washington State Department of Corrections

Homer Venters, president, Community Oriented Correctional Health Services; clinical instructor, NYU Langone Health; former chief medical officer, NYC Health + Hospitals/Correctional Health Services; former director of programs; Physicians for Human Rights

MODERATOR

Mary T. Bassett, director of the François-Xavier Bagnoud Center for Health and Human Rights and FXB Professor of the Practice of Health and Human Rights, Harvard T.H. Chan School of Public Health; former commissioner, New York City Department of Health and Mental Hygiene

Transcript

TOMIKO BROWN-NAGIN:

- Good afternoon, everyone. I'm Tomiko Brown-Nagin, dean of the Radcliffe Institute for Advanced Study at Harvard University. I'm pleased to welcome you to the latest installment in our virtual Radcliffe discussion series exploring health equity in the time of COVID. Today's program is the second of two sessions exploring the pandemic's impact on incarcerated people and their communities.

Before we begin, I want to acknowledge the members of the Radcliffe Institute Leadership Society and all of our annual donors for watching this afternoon. Your generosity keeps Radcliffe's programming free and open to the public, and we thank you.

As I've mentioned at the outset of each of our webinars, this discussion series reflects three critical commitments of the Institute's mission. First, it reflects Radcliffe's commitment to examine and address pressing issues facing our society. Second, it reflects our commitment to cross-disciplinary research and our conviction that insights from across academic disciplines can advance public discourse and reveal innovative solutions to complex problems.

Third, and finally, this series reflects the Institute's commitment to equity and opportunity. We know that COVID-19 is disproportionately affecting vulnerable and marginalized communities. Together, we have a responsibility to examine the deficiencies that this crisis has revealed and exacerbated, and to help chart a more equitable way forward. These discussions are part of that effort.

Today, we continue with part two of our conversation focused on the people and communities affected by incarceration in the United States. American prisons and jails were crowded and susceptible to outbreaks of disease long before COVID-19. Now, despite early warnings and compassionate releases in some states, many prisons have become incubators of the virus. In fact, all of the five largest clusters of coronavirus cases in the United States are in correctional facilities.

I shared before part one of this discussion on June 11th that The New York Times estimated at least 59,000 people had been infected with the virus in American jails and prisons. Today, The Times estimates at least 70,000 have been infected. The number continues to rise. And due to low rates of testing, available figures are almost certainly undercounts.

The virus's spread has profound effects not only for incarcerated people themselves but also for their communities. And these are disproportionately marginalized communities and communities of color, a fact that takes on special salience as our nation continues to reckon with long standing racial injustice.

To continue our exploration of these issues and to help us envision policy solutions, we're joined this afternoon by a panel of distinguished experts. Patricia Caruso is the former director of the Michigan Department of Corrections. Harold Clark is director of the Virginia Department of Corrections, and previously led prison systems in Massachusetts, Nebraska, and Washington state.

And Homer Ventors—Venters, excuse me, who is president of Community Oriented Correctional Health Services and a clinical instructor at NYU Langone Health. He is also former chief medical officer of New York City Health and Hospitals Correctional Health Services, which includes Rikers Island.

We're also pleased to welcome back Mary T Bassett, who will moderate today's discussion. Mary is director of the FXB Center for Health and Human Rights, and the FXB professor of the practice of Health and Human Rights at the Harvard Chan School of Public Health. Before joining Harvard, Mary was Commissioner of the New York City Department of Health and Mental Hygiene.

I'm grateful to each of our speakers for being here this afternoon. Thanks to all of you. And now it's my pleasure to give the virtual floor to Mary Bassett.

MARY T. BASSETT:

- Thank you, Dean Brown-Nagin, for that introduction, and greetings to all of you who've joined us for the part two of this conversation. If you missed part one, the link is in the chat, and I encourage you to copy it and watch it.

You're going to hear from the panelists for about 35 minutes. There's a Q&A tab on which you can type in your questions as we go along. I encourage you to keep the questions brief. We're going to be ending at about 2 o'clock.

I do want to point out that this session was conceived at a time when the risk was apparent to COVID-19, as Dean Brown-Nagin has so explained. And then came the murder of George Floyd. And as we begin, I want to acknowledge how these events all shaped the moment that we're in.

All three of our panelists have many years of experience in carceral settings. Each one of them is going to talk about their work to protect these populations for about five minutes. Harold, before I turn it over to you, I want to let the audience know that there's a link to the video that you released after the police killing of George Floyd. It's pasted in the chat box. I encourage the audience to copy it and watch it. Harold Clark, over to you.

HAROLD CLARKE:

- Good afternoon. Thanks, first of all, for inviting me to participate in this conversation on managing COVID-19 in a correctional environment. Correctional agencies must plan for and be prepared to manage large-scale events. These events are sometimes natural disasters, man-made emergencies, and medical events, as well.

In the category of man-made disasters, we have plans for things like hurricanes, and tornadoes, and floods, and they each require different responses. For example, in Virginia, we have several institutions, correctional facilities that are right in the path on the eastern shore of hurricanes. And so annually, we have to track hurricanes and be prepared to implement our hurricane plans. I have been director in Virginia now for almost 10 years. And during my 10 years, we have had to totally relocate over 1,000 individuals from a single institution to get them out of the path of

oncoming hurricanes. We have had to manage things, man-made emergencies such as riots, and disturbances, and insurrections, and we have plans for all of those things.

In the area of medical, every year we have to manage the seasonal flu. We have had to develop plans to manage MRSA, the N1-H1 virus, and other contagious diseases. And these all require some form of isolation and treatment.

COVID-19 is a much bigger challenge than anything else that we have had to manage. It's a new virus with many unknowns, and it seems like every day we are learning something more about it. The experience of having had to manage all of those other types of emergencies gave us a hands-up. It helped us as we prepared to manage the COVID-19.

The governor of Virginia declared a state of emergency on March 12th of 2020. And immediately after the governor declared a state of emergency, I appointed a task force to manage this COVID pandemic consisting of individuals from all disciplines throughout the agency. It was chaired by a medical director and by one of our wardens.

We developed a pandemic plan. And this plan has about 900 pages. It did not start off that big. Initially, it started with about 500 pages, but it's a dynamic plan that we keep on adding to, and we don't take anything out of it for historical purposes or for reference, but we keep on adding to it. And so the plan now has over 900 pages.

In putting our plan together, we sought guidance from the Centers for Disease Control, the Virginia Department of Health, the American Correctional Association, and the Correctional Leaders Association. And pretty much everything that those organizations recommend by way of management are in our plan, and we train our staff on those issues.

For example, some of the contents of our plan include things such as administration and coordination of a pandemic, general prevention measures, communication, employee screening, isolation, and cohort [INAUDIBLE], quarantine, sanitation—which is major in this emergency—managing visitors, volunteers, attorneys, et cetera, intake screening, transportation, care for the sick, and PPE management.

Part of her our requires every institution, every facility of which we have, 46 prisons, and part of our plan requires that each prison have a plan to manage COVID in their facilities. The facilities have what we designate as red zones, yellow zones, and green zones.

And inmates in the red zone, of course, are those individuals who are symptomatic and testing positive. Yellow zones for those who have been exposed. And the green zones for those persons who are recovering. Things that we did immediately includes stopping all movement, internal and external, in the department. For example, even dining for inmates, inmates are now fed in their cells. They recreate in small cohorts, and the same cohorts at all times.

We have suspended intakes from jails. We have suspended intrastate transfers and even movement of offenders within our facilities. We began a very aggressive testing program. Today, we have just over 27,000 inmates, and so far we have tested over 22,000 of the offenders, and we expect to have everyone tested by the end of July.

We are getting some good positive numbers. For example, today, we only have 378 offenders testing positive. At the highest peak of any given point when we had positive tests, that number was right about 590. Staff today, we have 88 staff who are testing positive. And at the peak, staff we're testing at right about 135 positive.

There is just a lot more I can share with you about our plan and what we're doing to include the authority, which was just recently granted to me through legislative action in April, to begin releasing offenders, which is a first time for the director of corrections in Virginia. But I will hold my comments in that area until we have a chance for questions and answering. And now it is my pleasure to pass it over to Homer Venters.

HOMER VENTERS:

- Thank you so much, Harold. It's really a thrill and a privilege to be here with everybody. So I will give very brief comments with a perspective of how the COVID response that's happening behind bars is different from what we hear often and what we think about as an evidence-based or epidemiological sound response.

I actually several months ago left, handed off the leadership of the organization I was running Coaches, a very good policy nonprofit, so that I could do nothing but COVID response in jails, prisons, and ICE detention centers. So I'm involved in the scores of investigations into the adequacy of care and response in all of these places. We have about 7,000 of these places, if you include juvenile detention settings around the country.

And what I have seen as I have reviewed and gone into these places is a real disconnect between what we know to be evidence-based practice and what people who are incarcerated are experiencing. And this is not a surprise to anyone, because we have built a system that has kept the health and welfare of people who are incarcerated separate and apart from the evidence-based structures that we rely on in the community.

Most of the organizations we hear about the, CDC, our state and local departments of health, have been AWOL from caring about the health or health access of people who are incarcerated for decades. So right now we have all focused on COVID, and it is a terrifying scenario for people who are detained and for staff.

Every time I go to a facility, it's obvious that many people have been infected who were never tested. Some facilities are calling them recovered, are treating them as a presumptively recovered group. But while they were clearly in the throes of COVID infection, they often received little to no care. There certainly is not documentation of what happened to them.

And many of the people I speak with who are in recovery from COVID have new symptoms that are not going away. This is something that we don't talk about much, but it is really critical that places, as they expand testing, as they do a better job of screening for and looking for COVID, they also acknowledge that when people come out the other side, and you may know this, many of you from people colleagues, friends, family members who have had COVID, that people may have shortness of breath or chest pain. They may have headaches. They may have ringing in the ears. They may have symptoms that persist.

And the way that we have built our health systems behind bars, to keep them walled off and separate from evidence-based practices, means that there is a constant effort to minimize and avoid dedication of resources, keep people away from either having their problems detected or giving them adequate care.

And so this is not new, but COVID is, now for a brief MOMENT bringing some of the local, state, and national evidence-based health structures into these places, and forums like this are really critical. And so one of my core concerns is that this fleeting interest of the CDC, of your State Department of Health, of your local public health organizations, in the plight of people behind bars, because it's tethered, obviously like it always is, to everybody's health, we have to leverage this, so that when this interest subsides, all these organizations don't go running for the doors, which is their natural tendency.

It is a shame that the CDC spends millions of dollars every year, for instance, to find and prevent traumatic brain injury in youth sports, but they don't spend a single dollar on the same problem behind bars, even though it's very common behind bars. Any disease you pick, any health problem you pick, you can see that the public health evidence-based systems we have for those of us in the community that aren't incarcerated that go to a hospital or clinic, that most of those structures and practices and transparency is absent in these places.

And so one of my driving concerns and interests right now is to leverage the response to this pandemic to build connections. Because that's also the way that we're going to help keep people out is, if we shine the light of what really happens behind bars.

I'll just end with, I've seen many places that have done a fair job at release, at decreasing the numbers inside their jails, and prisons, and ICE detention centers. That's important for managing the outbreak. But in those same places, many of them, it's impressive to me that still there's no, really, effort to social distance. There's no real effort at basic infection control.

So that while it's true that reducing the numbers is important, it's not enough. And I think that release is our first and primary objective. So thank you, and I'll hand it off to Pat.

PATRICIA CARUSO:

- Thank you, Homer. And thank you to Radcliffe and my colleagues for inviting me to join you. It's a critical and important subject for us to be discussing. In preparing for this, I realized that this past January was 32 years that I have been working in corrections. And I have found that it's been my calling. It's something in my Heart it wasn't a career I sought OUT but it turns out it's what I was meant to do.

More than half of those 32 years I spent time my time as both a warden and the director of the Michigan Department of Corrections. For more than nine years, I was the warden of a male prison with 2,300 men and five levels of security in the upper peninsula Michigan, which is where I live.

And for almost eight years, I was the director of our department, a member of the cabinet of governor Jennifer Granholm. When I became the director, we were the fifth largest prison system, state prison system in the United States. And we had 50,000 prisoners incarcerated, and went up from there.

I am not, unlike my friend and colleague Harold Clark, am not currently running a prison or prison system, and my remarks should be made in that context. I do, however, have a lot of contact with corrections around the country, and certainly still within Michigan with the leadership, and even with the line staff here. and speak in that context.

But also in terms of some parallels of things I dealt with during my time there, one of the things Harold said and I wrote down was that all of the different crises we've dealt with, nothing was like this. And I agree with that. I dealt with some very, very difficult situations. I would not say any of them were of this magnitude and the length of time and everything that's gone with it, the life and death circumstances inside and outside prison and the community.

And so I have tremendous respect for the people in this business of ours, who continue to be there every single day and do what they need to do. And I always thank them, and intentionally, because they really are unsung in this situation. One of the things that I did deal with, and it really became a focus of my time as the director in Michigan was, I call it the opportunity that grew from crisis.

But after September 11th and huge recession countrywide, Michigan was at the front end of that. Because we had always been a wealthy state, and the auto industries floundered, and we found ourselves for the first time not having the money to support this huge system we had, and we made a very conscious decision to first stabilize and then appropriately reduce the incarcerated population in Michigan.

And we did it publicly. We talked about what we were doing. And I can recall the thought process of mine. I remembered as a warden, I used to say, my priority is, "keep a lid on the joint. Everyone goes home safely every day."

I came to realize over a period of time that we were part of a continuum of public safety. 95% percent of the people in our facilities are going home, and they're coming home to our communities. And if we aren't running our facilities in a way that encourages that safely and appropriately, then we're not doing our jobs. And I've said many times, the goal "get out and stay out", easy to get out, frankly, but not easy to stay out. And there's a systemic problem oftentimes that makes that true.

And so this was something we worked hard at attacking in Michigan and looking at the drivers. And our population drivers, huge length of stay was a big issue. High percentage of our prisoners, substance abuse problems, mental health problems.

And so when you're working with people to get them out safely and stay out successfully, you have to address all those issues. We had people in both of those areas who were getting treatment in prison, who maybe didn't have access to that when they got out.

A very specific case I still remember of a gentleman who got a medical parole, very ill, was no threat. I mean, based on the illness, we couldn't let him out because he had nowhere to go. He had no family who would take him. Nursing homes would not take him because of his crime. We literally had no choice but to—I mean, our choice would have been to leave him on a corner. That's immoral to do that, because he was being cared for in a prison hospital.

And so there are a lot of factors that go into this, and I get that it gets difficult on all sides of it. And that's why this is such a vibrant, important discussion for us to have. And I am happy to be part of that. And I'm going to stop on this, because we're going to cover a lot of these things as we get into our individual questions.

And at this time, I'm going to turn the floor back to Mary, so she can begin our discussion. Thank you.

MARY T. BASSETT:

- Thanks very much, Pat, and thanks to all three of our panelists for pretty much keeping to time. And I know that that's not easy. You have many, many years of experience to reflect upon. So for the next 15 minutes, I'm going to have a conversation with you.

I thought I would start out by asking you about something that all of you alluded to in your remarks about the idea that one of the key ways to protect the incarcerated population is to reduce its size and get as many people out as possible, given the risk to public safety, so that anybody who's not a risk to public safety should not be incarcerated at the time of COVID.

That's been a call. I'd like this—and this is a question for each of you. I'd like you to reflect on the real world implementation of this strategy. Harold, you mentioned that you, for the first time, have been given authority to make these decisions. Could you just comment on how that authority came to you, and how it's going? Are you able to release people?

So first you, Harold, then I'd like to ask Homer and then Pat, who'll get to wrap up again.

HAROLD CLARKE:

- So thank you. As I mentioned, the governor made an amendment to the budget this past April, giving the directive corrections authority for the first time in Virginia, to my knowledge, to release offenders, but only during the pendency of the emergency.

So when the emergency he declared in March is over, then that authority goes away. The emergency has been extended, and it's now indefinite. So we're continuing to review cases and to release offenders. Now, there are some parameters established for me to abide by.

First of all, I cannot release anyone that has more than one year to serve. And that's a rolling date throughout the emergency. Secondly, I cannot release anyone that's serving a class one felony. And also I cannot release anyone that's a violent sex offender.

So I'm able to release or to consider anyone to release between that. And I don't really have to release anyone. The legislation is permissive. I may release. I don't have to release anyone. So I set a team together. We developed guidelines, and I established two teams that will review these cases that fit the guidelines.

And so we have been doing that steadily from that point on. So far we have reviewed right about 729 cases, and of those 729 as of today, 586 were approved to be released. And that process is going to continue until the emergency is declared over or is ended by the governor.

I must tell you that we are encountering a lot of challenges in this process from both sides of the spectrum. We have those who are saying that we are doing a good job managing the pandemic within our department, so therefore why are we releasing anyone? And then on the other end, some folks are saying, why not release everyone that fits the criteria, regardless of crime, criminal history, or anything else?

Why establish criteria, and why not just release everyone that has less than one year serve that is not a violent sex offender or someone incarcerated for a class one felony? So therein lies the challenge.

MARY T. BASSETT:

- Before I go to Homer, I'm going to use my prerogative as a moderator. Can you just give us an idea of what the universe is of people whom you have the option of releasing? Meaning that, they have a year or less to serve, and they haven't been convicted of something that would make them ineligible? You said 586 have been released. How many—

HAROLD CLARKE:

- 500 have been approved to be released.

MARY T. BASSETT:

- Say again?

HAROLD CLARKE:

- We have reviewed 729 so far.

MARY T. BASSETT:
- Uh-huh.

HAROLD CLARKE:

- And as of today, 526 of those have been approved to be released. And so you're asking about—

MARY T. BASSETT:

- What's the universe?

HAROLD CLARKE:

- Well, for example, we have—no one in Virginia really is serving time for a first sentence of their first crime unless it's a very serious crime. And so you earn your way into the system. In Virginia, we went away from the paroling system, so we now have truth in sentencing.
So every offender is serving about—they serve minimally 85 percent of their sentences, and then they're released. The people that we are looking AT mostly everyone has a lengthy history of crimes, or they've committed a very dangerous or heinous crime that got them incarcerated, a very serious crime.

And so for example, well, I may look at a case and this person who fits the criteria may have five previous incarcerations or five previous charges for assaulting family members, but their home plan is for them to go back home to that family. So is that something that you should do?

I think if we send someone back into that environment, we will be criticized if that person goes back into the environment with that history and assaults a family member once more. And we see a lot of those. We have—it just runs the gamut.

We have to take a look at criminal history and make a decision as to whether or not the person, even though they fit that criteria, is one that's suitable to be released.

HOMER VENTERS:

- Thanks. And Dr. Venters, Homer, do you want to comment on what you've been able to see about the use of decarceration as a strategy for reducing the risk of COVID-19?

- Yes, thank you. It's, I think, the primary—this is the primary approach, the one we need to start with. This does several things, promoting release. The first is that it helps protect the lives of people who are at high risk.

So we know that a fair number of people who are incarcerated, maybe half, have risk factors that put them at higher risk for serious illness or death should they contract COVID. And so saving the lives of those people is one benefit of promoting release.

There's a second benefit, which is managing an outbreak behind bars, and having done this quite a bit in the New York City jails, managing an outbreak is next to impossible when the facilities are full. It's very difficult when they're not full, but for places that are at 75 or 100% of their capacity, it is almost impossible to do some of the basic management operations, like establishing quarantines or keeping newly admitted people separate from everybody else for 14 days. And so there's an operational benefit to it.

The third benefit is that it really can help save the local hospital system. When coronavirus gets behind bars, it spreads like wildfire. And we have lots of facilities that haven't had it yet that may well have it, but when it gets into a place, we've seen it in multiple towns where a local hospital and especially in rural areas can get completely overwhelmed in just a few days as COVID-19 runs through the detention center, whether it's ICE, or jail, or prison. And then those sick patients have to go to the hospital, and completely overwhelm the logistics, and the resources, and the bed space of the hospital.

So those are all three attributes of this approach. I've seen some county jails do a fairly good job of it around the country. Most prisons have not done much at all. And there are political reasons for that as we just heard. ICE detention has not moved aggressively. I'm part of a large class action suit to compel that, to focus on high risk people. So it's been moderate in terms of implementation, but it's critical to do much more of.

MARY T. BASSETT:

- And Pat, last word to you.

PATRICIA CARUSO:

- Thank you.

MARY T. BASSETT:

- If you can make it brief. I'm sorry I shouldn't have asked Harold that follow-up question. I'm hoping we'll have time for one more question.

PATRICIA CARUSO:

- No problem. I will say something, I should note, and I'm very proud of the leadership shown in Michigan, Michigan, to my knowledge, is still the only State Department of Corrections who has tested 100% of those incarcerated, the men and women incarcerated in Michigan. 100% have been tested, and they did that in conjunction with the National Guard.

So it was taken very seriously. Michigan is a state, not like Harold where he's being given the authority to release people, we are an indeterminate sentencing state parole board. The parole board literally is focusing seven days a week. I know I was reading just last week that they've their highest release rates right now.

Michigan is down to about 36,000 people incarcerated. We were at 44,000 when I left, after a high of 51. And so that is a system taking this seriously. And there are a lot of pieces that go into this. And I made the comment earlier about, it's not just getting out. I mean, it's easy to say to somebody "get out." We want these people to be successful. We want them to be cared for. If someone has no access to medical care, that's not appropriate.

So we need to look at all of the factors. You can open the door and push people out. That's not a humane thing to do. The humane thing to do is look at the whole piece of it and work through that. I am someone, and a lot of my colleagues who believe that we do. I mean, we have the highest incarceration rate in the world in this country. And that's not appropriate. And we need to find and attack that in a way that's sustainable.

MARY T. BASSETT:

- Thanks. And—oh, all right, Harold.

HAROLD CLARKE:

- Just a quick comment. I just want to say that in addition to Michigan testing all of their offenders, Tennessee and Arkansas have also tested 100% of their offenders. And I know states like Colorado and several others have made a commitment to do just that.

MARY T. BASSETT:

- OK, the last question that I'm going to ask as moderator is one that I hope is challenging to all four of us. In the first conversation, someone, one of the panelists, remarked that however well-meaning people are who work in criminal justice institutions, we need to acknowledge that we

are part of a racist system. That is something that I'm sure you've reflected. Pat has just made a comment referencing it.

I think that the audience would like to hear from you on how you feel about the observation that our criminal justice system is systemically racist. Pat, this time you can start off.

PATRICIA CARUSO:

- No one wants to believe something like that. And I will tell you, as a warden, I had 700 employees, as the director of our department, at one time 18,000. And across the board, good people. I mean, but there are issues there.

And I remember as a warden at one point looking at some research on this, and one of the things I read was that 65% of initial arrests are white Men and I looked at those incarcerated in our system, and realized how it was the criminal justice system from an initial arrest to incarceration that changes that.

And that was a really light bulb moment for me. And I will tell you another thing as a warden. And in the upper peninsula of Michigan, I mean, it's not the most diverse place you're going to find, even though we have a lot of prisons up here, but one of the things that became very apparent to me was the people I needed to worry about the most in my prison, the incarcerated people I needed to be most aware of, were the white supremacists, who were the most dangerous people.

And I remember saying, I said it publicly at the time, one white supremacist could turn over a whole housing unit. The most hateful mail I got as a warden was from these guys, because they were so hate-filled. And it got me thinking about issues of race and racism very differently than I had previously.

And to look at all of this differently and to accept the fact that there are some things, some of it is societally, some of it systemically, and if we don't say it, if we pretend it's not there, we're not helping. We need to acknowledge it, even though most people are not buying into that, or may not behaving inappropriately, we're still in a system where some of those things are just accepted.

And I remember early on as a warden, I was at a program, and we were talking about something, and someone said if you're not a white man, you carry the banner for your race and gender. And we were all like, what does that mean?

And they said, well, if John Jones white man gets a promotion, and he's a big mess, someone's gonna say, "I told you John Jones couldn't do that job." But if John Jones is a black man, or Joan Jones is a woman or a woman of color, someone's gonna say, "I told you a fill in the blank couldn't do that job."

And I repeated that in many groups over the years, and every time I do, someone says, "I never thought of it that way. You're right." It is part of what we deal with, sadly.

MARY T. BASSETT:

- Thanks, Pat. And, Homer, would you like to comment on the—

HOMER VENTERS:

- Yeah,. Thank you. And this is something where I was blessed to have Dr. Bassett as a mentor and boss at a time, a very difficult time in the New York City jails. These are places that exacerbate racial disparities, and they are built on racist foundations. There is no doubt.

And what is unfortunate is, because we have built such a lack of transparency into these places, there's just a florid, florid exposure to overt racism and structural racism for people who are incarcerated and for staff in these settings that is not seen, although it's widely felt.

Every health system that I know of in the community for decades has measured racial disparities. And the Institute of Medicine, I think two decades ago, said we need to look at this. We need to think about racial disparities.

When I go to jails and prisons all over the country and ask, how do you measure disparities in access care, in delivery of care in health outcomes, it's crickets. I have not yet found, except for when I was at Rikers under the expert tutelage of Dr. Bassett, a system that would look at itself, at its own health system, and say, how are we messing up?

And the lack of connection to the evidence-based structures that the rest of us rely on when we go to the hospital, when we go to our doctor, when we get dialysis in the community, the lack of that kind of evidence and quality, approach to quality and transparency about what happens, that's a big part of the structural racism inherent in these places, that we've allowed them to—every place in the country pretty much, the person who controls the health service is the commissioner of correction or the local sheriff. That's part of the structural racism that we're talking about.

MARY T. BASSETT:

- Right, Harold, I am going to apologize to you and remind the audience that there's a link to a wonderful video that you made in response to the police killing of George Floyd. And we have a lot of questions coming in from the audience, and I want to be sure to be able to ask them those. So please weave your comments into—there's a lot of these questions.

HAROLD CLARKE:

- May I just one—

MARY T. BASSETT:

- Yes, go ahead.

HAROLD CLARKE:

- Can I make just one quick comment?

MARY T. BASSETT:

- Sure.

HAROLD CLARKE:

- I just want to say quickly, racism permeates our country. And it's not specific to prisons. It's across our country. And as a black man, I have seen it in various different environments in my communities in four states that I've lived in. So yes, it exists in prisons as well, but it's not specific to prisons.

MARY T. BASSETT:

- So I have a lot of—thanks. And I think that's something that we, in this time, we all need to attest to. And we're having, I hope, as a nation and as a world, a more serious conversation about racism than I've seen in decades.

Let me just turn to some of the audience questions. There are a number of questions coming through about transparency of information. For example, if somebody wanted to know how many people were eligible for COVID-related related release, how many people were assessed to be able to be released, and how many actually were released? Are those data available? And more generally, are there data available on the health needs and health services that are provided to the incarcerated population?

I think this is probably a question for all three of you. One of the routes to accountability is data. And do you want to talk about how available those data are for the incarcerated population? Including in the time of COVID. How do people find out about it? Let's see, I have to pick who'll go first? Harold, why don't you go first?

HAROLD CLARKE:

- OK. Well, I will say to you that, first of all, who is eligible for release, the criteria is published. It's out there. We have a plan that's on our website. Also, the legislation is out there for all to see as to who is eligible. In terms of who we review and who actually gets out, that information is updated at 5:00 PM every day on the department's website. So anyone can go to that website and see that information.

Also we are posting the cases that are positive and the cases that are not recovered, but just basically positive cases, I'm sorry, of people, of staff and offenders.

MARY T. BASSETT:

- Thanks. Anybody else want to come in on data transparency? Homer, was that you? I'm muting.

HOMER VENTERS:

- Thank you. Yes, I think that one of the things, if you're a public health professional or epidemiologist or anybody in the community, you come to expect that you'll be given a

numerator and a denominator when you look at data. That is to say, how many people got what we're talking about, and how many people needed it?

Most correctional health systems do not provide denominators. That is to say, when I go into a jail or a prison, which I've done, looked at probably 30 or 40 COVID responses, everybody can tell me a long list of things they did, but they almost never can tell me how many people needed those things.

So for instance, sick call, the way that people get health care, most of the time or much of the time is they say, "I have a problem. I need to be seen." They write it down on a piece of paper. What I have found is, when I go into a place to look at how many of those sick call requests included a COVID symptom on it? They write down something like that. "I have shortness of breath, chest pain, fever." Many facilities destroy those sick call requests. Many of those places, many places do nothing with those sick call requests.

And what they will provide me with or anybody with is a list of all the people they saw. But invariably, they almost never can say how many people needed to be seen, how many people expressed something that should have led to them being seen. And that is a core weakness that is emblematic of the systemic problems that I find throughout correctional health settings.

MARY T. BASSETT:

- Thanks. And, Pat, do you want to make a comment, or should I go into another question?

PATRICIA CARUSO:

- Well, I would just say without belaboring it, the situation in Michigan, very similar to what Harold described in terms of transparency. Just in preparation for this, I went to the website. I just went to what anyone could look at. I didn't use any of my special internal things. And as Harold said, that information is posted, and that they are available by facility.

My experience, with all due respect, is somewhat different than Homer's in terms of writing. But we have a lot of people incarcerated in a lot of systems and a lot of prisons. So we are going to have different experience. And I mean, that's part of why we're discussing this. It's not the same everywhere.

MARY T. BASSETT:

- A couple of questions have referred to the jail setting as opposed to prisons. In jails, of course, the majority of people are pre-trial, meaning that they have not been convicted, although they may have a criminal record of prior convictions. Is there any sense that people who are pre-trial should have a quicker way out of detention?

I know that Homer has worked in jails, and both Pat and Harold work in prison systems, but if you have any knowledge of whether a different lens is being applied to the jails than to prisons, that would be helpful. Several people have asked about it.

HOMER VENTERS:

- Sure. One of the things I've seen in jail settings that I've examined is that increasingly as we have access to testing for everybody, that people are tested right when they come in, because the CDC has advised us that newly admitted people should be in a new admission housing area that's quarantined away from everybody else for 14 days. But one of the ways to obviate that or potentially speed up that process, because people should not be incarcerated just because there's a COVID concern. That's a red herring. It's a violation of their rights.

But one way to ease the path to the community for people coming into a county jail is to front load the testing, so that on day two or three or four, we have results, and we know what kind of plan of care we're setting up for them as they leave.

MARY T. BASSETT:

- A couple of other things. There are a couple questions also about elder people who are serving sentences in prisons. These are a group of people who have especially high COVID-19 risk, and arguably are, because of their age, unlikely to pose a risk that they may have posed years before. And to their questions about, I know you didn't make these criteria, Harold, and I don't know what the criteria are in Michigan, but what do you think of the idea, one, of simply as a rule, letting elders, who are more likely to die of COVID if they get it, helping them to release?

And additionally, if you could also reflect on whether you think this might be an exercise that shows that decarceration in a more general way might be possible? If you are able to get follow up data on people who've been released, and show that the protection of public safety has been upheld? So that's a two part question, I think mainly for Pat and Harold. Pat, do you want to go first?

PATRICIA CARUSO:

- Certainly.

MARY T. BASSETT:

- Why not just let the old people out?

PATRICIA CARUSO:

- I mentioned anecdotally an experience I had with—and it was an older person who had been granted a medical parole, and the difficulties we had in dealing with that. And it's a good example of how tough this is. There's a lot of emotion built into this. There's a lot of things that are counterintuitive in terms of corrections.

And it's easy to say people shouldn't be in prison. People shouldn't be in jails. But when you're responsible for that, and we're not in corrections responsible for who's there. We don't put them there. We don't sentence them. We deal with what's there, and the rules are different in every state of how you can get people out.

But we've looked very carefully at this. And a lot of people, I mean obviously I gave some numbers, and we significantly reduced, one of the leading states in terms of reducing the incarceration numbers in the state. But those are still very legitimate issues.

And you have to balance all of that. And one of the things that is always there is that when something bad happens, frankly, and that probably doesn't apply, in fact, in my experience doesn't apply to many of those elderly people regardless of what crime they committed. But you still have a systemic issue with it.

And it's why we would argue that part of what we need to look at is the entire system of who we incarcerate. And for how long we incarcerate. Do we incarcerate people because they're dangerous? Do we incarcerate them because we're mad at them? Were they dangerous, but we're still mad at them? Or are they not?

It's all of those things. And the virus has brought this to the forefront, but it's something people like Harold and I have been dealing with for many years. And I mean, this is not a new subject to us, other than that it has this piece attached to it. But if there's something good that's come from this, it's that it is highlighting something that we and our colleagues have been working at for years, which is to make the argument that we need to look at who should be incarcerated in this country.

And we do incarcerate a lot of people who we have some other options that we could be looking at. Absolutely.

MARY T. BASSETT:

- Harold. Thank you, Pat.

HAROLD CLARKE:

- As I indicated earlier, the legislation was provided and given give it to us to implement. So we didn't have any chance to determine what was going to be in the legislation. And so we implement that legislation, and we release those who fit the criteria that we are convinced will go out and not commit further crimes. At least, we think they're a good risk.

Now, I believe that there are a lot of individuals locked up, older individuals locked up, that if they were to be released, who would not go out there and commit a crime. But there are a couple of problems.

One, they don't meet the criteria, first of all for release. And secondly, a lot of those individuals really have no place to go. They have no place to go. They don't have valid home plans. And I know that there are many individuals and organizations out there that say that, oh, they'll find places for these folks. They can put these folks up. But that's not what we see on the ground. What we run into is that we have tried to get these individuals out in the past. And we have no place to send them. I have visible images in my head about one case in particular, an individual who was laying in bed in a fetal position. We could get no one to take Him we ended up having to keep him, because no one accepted him, even nursing homes, and he had the resources to pay for the nursing home.

So it's a challenge that we have been dealt, and we are having to manage it the best possible way that we can.

MARY T. BASSETT:

- Homer, did you want to comment on this one, the idea that—and maybe you've just seen this because you've visited so many different facilities. Do you think that the COVID pandemic may represent a sort of feasibility study for the release of people that could be applied even when the pandemic ends? Right now the idea is all predicated on COVID-19.

HOMER VENTERS:

- Yeah, I think that since I'm not a criminal justice expert, I'll focus on the part that I see and understand best, which is, people who are high risk, who tend to be the people who are older, who have chronic health problems, they are receiving completely inadequate care in almost every place I look.

People may get their temperature checked, but they don't get asked about the symptoms they have. They have a hard time getting their medicines before there's a pandemic. Once a pandemic starts, it's less likely that their care for their diabetes, or their hypertension, or their kidney problems, or mental health problems is going to be—even as inadequate as it was before, it will be harmed even more.

So what this has helped me understand in much more granular detail is that the health systems in most correctional settings are inadequate. They are not linked to transparency or quality in a way that we would expect for ourselves when we're out in the community, and that the disparate impact on these people who are ill, but primarily people of color and people who are poor, should push us to rethink all levels of incarceration. Because it's just, we're not able to provide the services and health care that we say we do in most of these places.

MARY T. BASSETT:

- I'm afraid we're up to the last question, please. So I'm going to ask it, and thank the audience for asking many more questions than the panel was able to address. Both Harold and Pat have talked about the high proportion of people who've been tested, but the question is, have they been tested once? Is there any plan to retest people?

Obviously, the test today tells you what your test is today. It may not say anything about what your test will be in the future. Quickly, please.

HAROLD CLARKE:

- No, you're correct. We do what we call as well point prevalence testing. And so that means that we may have to go back and test somebody again, who have once been tested before, if there is some reason to believe that that individual has been exposed to the virus.
So you may test someone more than once.

MARY T. BASSETT:

- All right. And the data on all this is being made available. Same in Michigan, Pat?

PATRICIA CARUSO:

- To my knowledge. I'm not saying 100% are going to be tested again, but based on whatever is happening and evidence and circumstances, that is certainly happening, yes. it is.

MARY T. BASSETT:

- Very good. And, Homer, if I could just ask you, and this should be very quick, are any of the regulatory authorities that oversee hospital care, for example, also have oversight over systems in corrections?

HOMER VENTERS

- In very few instances. The joint commission does accredit a few hospitals, pseudo-hospitals in some prison systems, but most of the folks, most of the rigorous accreditation that happens in hospitals and community health settings is absent. And so we have left these places to monitor themselves. And surprise, surprise, they generally think they're doing a good job, but we wouldn't accept that for our community hospitals.

MARY T. BASSETT:

- Well, I'm really sorry, Pat, Harold, I expect you'd want to challenge some of that, but it's left to me to thank Harold, Homer, and Pat for participating in the program today, and for your thoughtful remarks, and frank conversation. This is an awkward medium, but I think we managed to have a conversation, and I want to thank you for the work that you each do every day and the audience for the very many questions.

I now want to tell you about some of the upcoming programs, and I hope you'll take the time to join. The audience should be aware that this, the first one coming up is on June 20th, Friday, June 26th, rather. It's at 12:00 noon, and it's titled Amplifying Community Voices, LGBTQ, Health and Well-being during COVID-19.

And then on Monday, June 29th at 1:00 PM, there will be a virtual program titled American Policing and Protest, Abolition and Ethics from Slavery to Current Times.

And there's going to be more information about this and other programming available at the Radcliffe website. It's radcliffe.harvard.edu. And I hope we'll see all of you then. Let me thank our panelists one more time. Thank you.

[APPLAUSE]

HAROLD CLARKE:

- Thank you.

HOMER VENTERS:

- Thank you.