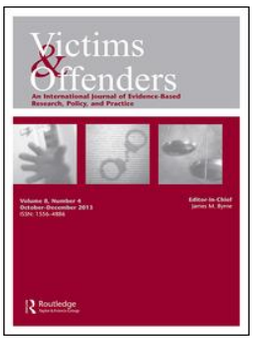

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United States Bureau of Prisons' Response to the COVID-19 Pandemic

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ABSTRACT

As the SARS-CoV-2 (COVID-19) spread across the United States in spring 2020, the Federal Bureau of Prisons (BOP) made the startling announcement that of its 2,700 initial screenings of inmates for the virus, 2,000 had tested positive – an astounding 70% positivity rate. It is obvious to assume that prisons and jails would be locations of outbreaks and rapid community spread given the close quarters, limited access to preventive methods, and movement of both inmates and staff in and out of facilities. Yet, the speed of early transmission through the federal prison system led to questions of whether the BOP was adequately prepared to handle a contagion such as COVID -19, and if the steps that have ultimately been taken (such as moving inmates from prison to community using existing release mechanisms, suspending visitation, and increased screening of both inmates and staff) are sufficient to minimize new infections throughout the system. This article describes and assesses the BOP's COVID-19 mitigation strategies, details treatment programming challenges during the pandemic, and offers suggestions for future infectious disease outbreak response.

KEYWORDS

prisons; prison experience; reintegration; prison resources; Covid-19; Pandemic; Alternatives to incarceration; Early release mechanisms; Prison reform

The incarcerated population is uniquely affected by the dramatic effects SARS-CoV-2 (COVID-19) has had globally. By August 15, 2020, the United States had over 118,742 confirmed cases of COVID-19 in its correctional facilities and 27,153 confirmed staff cases (UCLA Law COVID-19 Behind Bars Data Project, 2020). Early in the pandemic it was assumed that prisons and jails would be locations of outbreaks and rapid community spread given the close quarters, limited access to preventive methods, sanitary issues, and movement of both inmates and staff in and out of facilities that have led to the transmission of other infectious diseases (Ndeffo-Mbah et al., 2018; Niveau, 2006; Saloner et al., 2020). Unlike a number of other diseases that have impacted correctional facilities (e.g., HIV, hepatitis, various sexually transmitted infections, foodborne illnesses), the novel coronavirus has no vaccine, very limited treatment protocols, and is highly contagious via airborne transmission. The close quarters of a prison enhance viral spread. Compounding the issue is that the U.S. inmate population overall has a higher rate of multimorbidity, and an earlier onset of these risk factors, than the general population (Kinner et al., 2020). A byproduct of decades of American mass incarceration is the aging of the correctional population, with the number of inmates over the age of 55 increased by 280% between 1999 and 2016, expanding from 7% of the total inmate population to 10% (Akiyama et al., 2020; McKillop & Boucher, 2018).

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The Bureau of Prisons (BOP) is the largest correctional system in the United States, with over 163,000 inmates in custody (Blakinger & Hamilton, 2020). In April 2020, the BOP instituted its first system-wide lockdown in a quarter-century, in an attempt to arrest the spread of the virus in its facilities[1] (Unlock the Box, 2020). Two months later, the BOP confirmed cases of coronavirus infection at over half of its 122 prisons; however, there are indications that these official figures represent just a fraction of the true number of infections, and that infections are present in the majority of BOP facilities (Blakinger & Hamilton, 2020). The federal government's testing protocol for inmates has been criticized as being too slow to respond to the expanding crisis in the early months of the pandemic, and for not being comprehensive enough to ascertain the true number of infections among inmates and staff. Based on figures from the BOP in early August 2020, 37,625 inmates were tested, with 10,621 positive results, equating to a 28.2% positivity rate (Bureau of Prisons [BOP], 2020). By late July 2020, 100 federal inmates had died of coronavirus contracted while in custody (Hymes, 2020). The August positivity rate was well below the initial rate of nearly 70% (Balsamo, 2020), which was likely inflated due to initial tests being focused on inmates experiencing symptoms of the virus, and those who had come in contact with infected inmates. However, even a positivity rate of almost 30%, if extrapolated to the entire federal correctional population, indicates a rate of infection four to five times higher than the BOP is reporting as of this writing. To give the current positivity rate more perspective, the percentage of positive tests in South Korea in May 2020 was 3%, and the national average in the United States at that time was about 13.2% (Masters, 2020). A spike in the positivity rate in Florida's Miami-Dade county in early July 2020 to 26% was labeled "staggering" (Waldrop, 2020). Initial assessments of death rates show, aggregating state and federal correctional facilities, that prisons had death rates 5.5 times higher than the general population of the U.S. (Saloner et al., 2020).

The widespread outbreak in BOP facilities is creating a number of unique areas of concern. From a public health standpoint, infections among BOP inmates threaten to overwhelm the system's capacity to handle COVID-19 cases in house, and, including prison employees who contract the virus, health care systems in the rural communities in which many federal facilities are located may be overwhelmed as well (Kinner et al., 2020). Offender supervision is a potential issue as well, given that a primary strategy of the BOP in arresting the spread in coronavirus in facility is to transition many "suitable" inmates to home confinement. U.S. Attorney General William Barr directed the BOP to use the expanded powers granted to it by Congress in the Coronavirus, Aid, Relief and Economic Security (CARES) Act to expedite the release of inmates at elevated risk of contracting the disease and posing low risks to public safety (Cassels, 2020). Presently, over 7,000 inmates have transitioned from in-facility to home confinement. The rapid influx of inmates to non-custodial settings places a strain on U.S. Probation and Pretrial Services, who are tasked with community supervision of federal offenders (Pew Charitable Trusts, 2017). The pandemic has all but eliminated the transitional step of releasing inmates to residential community corrections (RCC) facilities in preparation for release. This crisis presents BOP with a unique opportunity to conduct a natural experiment on the need for RCCs. These roughly 170 private-for-profit and private nonprofit contracted facilities are reimbursed per offender rather than based on performance-based contracts, which many other states now use (e.g., Pennsylvania). One other aspect of current reentry practice that could be tested is the impact of performance contracting.

Measuring the extent of COVID-19 via testing and other measures, or lack of data and testing among staff and inmates

Despite the serious effects a highly contagious virus could have on incarcerated populations, most BOP facilities had few or no preparations in place to address COVID-19 when it began to spread across America in the spring of 2020 (Williams et al. (2020)). Further, correctional administrators feared inmate violence, staffing shortages, and public backlash if the numbers of infected inmates and staff members in their facilities were known (ABC Audio, 2020). Thus, testing protocols differed dramatically from state to state, or within states from facility to facility. Some states (Michigan, Texas, Ohio, and Tennessee) very early on initiated testing of their state prison populations and, as such, had positivity rates far higher than states that did not test (Firth, 2020; The Marshall Project, 2020). Outbreaks were reported in states where the virus spread rapidly during the summer of 2020, such as California and Arkansas (The Marshall Project, 2020). Early testing of correctional populations was hampered for many of the same reasons testing lagged in the general population: a shortage of tests and labs to process them, priority of testing for "frontline" individuals, and a focus on testing only symptomatic individuals. As became evident in short order, asymptomatic spread of COVID-19 was driving the proliferation of the virus, thus testing only those with symptoms missed a large segment of the infectious population (Firth, 2020). In prisons and jails, as were the cases in other settings where people came into close contact with one another (such as nursing homes), this led to the virus circulating for days, or even longer, before the first symptomatic patients presented.

Other than the aforementioned structural impediments to wholesale testing in correctional facilities, inmates could opt out of testing. There is evidence from other pandemics affecting American prisons that even mandatory testing falls short of full coverage of the institutional population. At the height of HIV/AIDs in the United States, the federal prison system and most state prison systems required inmates to be tested for HIV as part of the intake process; however, facilities had a difficult time enforcing this mandate (Andrus et al., 1989). For example, if a non-offender refused to be tested for HIV, they would not, for example, be permitted to donate blood or join the military. But what recourse does a correctional facility have for an inmate that refuses testing? In the case of COVID, if a facility's policy is quarantining COVID-positive inmates until they are no longer contagious, a refusal of testing could mean automatic quarantine. This has ramifications for the health of the inmate, outcomes, and possible liability for the facility if an otherwise healthy inmate is quarantined with known COVID-positive inmates and subsequently becomes ill. Despite these risks, facilities may have no other recourse to prevent the spread of the virus. Unlike other diseases common in correctional settings, there are no specific behaviors from which inmates can refrain (such as sexual activity or intravenous drug use) to prevent infection.

If COVID-19 progresses on a track similar to other diseases common in correctional settings (in addition to HIV/AIDS, viral hepatitis and tuberculosis occur at greater rates among the incarcerated population then the general public), high positivity rates can be assumed (see Tavoschi et al., 2018). However, this does not mean that the rampant spread of any infectious disease is imminent in correctional settings, or that nothing can be done to prevent outbreaks in facilities (Hammett, 2006).

The BOP response – website, media reports, government documents

The BOP communicated its response to the COVID-19 outbreak by establishing a dedicated page on its website. Protocols that are commonplace in society generally are also germane, if not somewhat more difficult to accomplish, in the correctional setting, such as mask wearing, social distancing, and isolation of those confirmed or suspected of being infected. Other strategies are unique to the prison context: suspending visitation, halting transfers between facilities, and remote consultations with legal counsel (Akiyama et al., 2020). Besides testing and home confinement information, the BOP webpage serves as a way to detail its efforts and debunk rumors/myths that have circulated in the media, in government circles, and among prison stakeholders such as staff, attorneys, and relatives of inmates. Examples of these myths include masks not being provided to all staff and inmates, and staff being forced to report for work even when they are exhibiting symptoms or have had close contact with an infected inmate or other person (BOP, 2020). It could be argued that the need to debunk rumors via the agency's webpage is a function of ineffective communication at the onset of the pandemic. Family members of inmates have reported a lack of information being provided about medical conditions of inmates, transfers within the system, and decisions on home confinement. This reluctance or inability to share information, both system-wide and from individual facilities, continued to be an issue into the summer of 2020, when local officials in communities where federal prisons were located reported that their requests for information were being ignored (Cheves & Musgrave, 2020).

Criticism of the Bureau's efforts to mitigate risk has come from a number of constituencies, with the most direct criticism came from inside. The union representing prison workers filed a complaint with the Occupational Safety and Health Administration (OSHA) shortly after the first inmates infected with COVID-19 were confirmed that cited "imminent dangers" within the system due to the lack of preparedness and implementation of mitigation strategies (Buble, 2020). Very early in the pandemic, before the BOP halted all inmate transfers in March 2020 (Segura, 2020), it has been asserted that the BOP moved what were believed to be COVID-19 negative inmates from facilities with outbreaks to facilities thought to not have coronavirus cases. This directive from Washington may have inadvertently spread COVID-19 to facilities – and by extension communities – that had few known or suspected cases (Buble, 2020). If, as mentioned earlier, a small number of "hot spot" facilities were driving overall numbers, then it is logical to infer that as the virus spreads in the community, these hot spot locations will likely change. Without an effective preparedness strategy, the BOP was forced to react to the disease with questionable effectiveness.

Wearing of masks

The BOP (2020) maintains that adequate numbers of masks and other personal protective equipment (PPE) such as gowns, gloves, face shields, and hand sanitizers have been provided to staff and inmates. This was done as soon as the Centers for Disease Control (CDC) guidance called for such measures when social distancing was not possible.[2] This statement, featured on the BOP's coronavirus response webpage, is at odds with reports that masks and other PPE were not available to either inmates or staff,

including as part of the lawsuit brought against the BOP by the union representing employees (Balsamo, 2020; Buble, 2020). The nationwide shortage of PPE, particularly at the onset of the pandemic, meant that prisons and jails at the federal, state, and local levels were behind medical facilities, first responders, schools, and other institutions in priority (Barr, 2020). As a result, there were delays in getting PPE to BOP facilities, and when it did arrive, there were widespread concerns about its quality (Hamilton & Newhauser, 2020).

Inmate transfers

Movement of inmates throughout the system – for example, transferring inmates nearing their release dates to less secure facilities in preparation for release to residential community corrections or home confinement – ground to a halt early in the pandemic, sometimes so quickly that inmates in transit were caught in limbo between facilities in temporary housing (Segura, 2020). Keeping more of the inmate population in place during the initial rapid spread of the virus in spring 2020 was sound logic from a public health standpoint (Akiyama et al., 2020). If it were assumed that inmates were highly likely to have come in close contact with someone infected with COVID-19, then quarantining within facilities represents the best course of action in the short term.

Of course, not all movement of inmates (or staff, visitation, and others entering facilities) could be suspended throughout the system (e.g., Hawks et al., 2020). Though the BOP asserts that transfers were reduced by 95% between the outbreak of the pandemic and late April 2020, in May 2020, the Bureau transferred nearly 7,000 inmates within and into the system for a variety of reasons including for forensic studies, medical or mental health treatment, residential reentry, intake of federal offenders being housed in local jails, and inmates who had detainers by other jurisdictions (Balsamo & Sisak, 2020).

The BOP has established protocols and screening tools for specific constituent groupings that enter facilities, and a set of guidelines and contingencies for those individuals who may pose a risk of bringing infection into a facility (BOP, 2020). Even with these measures in place, BOP has met resistance from local elected officials and legal action to stop the transfer of inmates to facilities in communities with lower infection counts (Plum, 2020). In May 2020, the U.S. District Court for the Northern District of Ohio ordered the BOP, in detail, to "determine the appropriate means of transferring" elderly and medically vulnerable inmates out prisons with high numbers of coronavirus infections to other facilities within the system (Howe, 2020). A month later, the court was not satisfied with the BOP's response and instructed the agency to explain, within 7 days, why ineligible inmates could not be moved to another prison "where social distancing is possible (Howe, 2020)." In response, the BOP released a statement that emphasized the numbers of inmates who had recovered from COVID-19 and indicated how facilities were managing outbreaks through testing, use of "field-ready" tents to maximize social distancing, and providing protective gear where resources permit (Satija, 2020). Directives such as these from the courts are indicative of a system-wide inmate transfer plan that was inconsistent with safe and secure facility management and placed inmates and staff at risk.

Policies for staff who are ill

Protocols for staff to self-isolate and not report for work if they have come into contact with an infected inmate, family member, or other person, have been established within the BOP. But, there have been claims[3] that staff have felt compelled to come to work even if they have been exposed to a COVID-19 positive individual or were even exhibiting symptoms themselves (Buble, 2020). More problematic to prison workers has been the BOP's policy of outsourcing coronavirus testing to local institutions and community partnerships (Bur, 2020). There has been criticism of testing protocols generally in the United States since the pandemic began, beginning with faulty tests, insufficient numbers of testing kits, and an inability of many to access testing. Even as of this writing, in August 2020, delays in obtaining results of administered tests in many communities continue to be a vexing problem for communities trying to limit the spread of the virus in their jurisdictions. A prison employee, therefore, who is tested, is asymptomatic, and returns to work, but has to wait for a week or more for the results of their test could potentially contract and/or pass the virus to many others in a correctional setting, rendering the initial test useless, or worse yet, erroneous.

Being cautious with staff who have come in contact with an infected inmate, have COVID-19-like symptoms, or are at higher risk themselves of medical complications if they were to become infected, and not having them report to work, is fully in line with CDC guidelines. These employees are not part of the total institution, and leave facilities after each shift, potentially bringing with them into their households and communities coronavirus infection. Over 1400 BOP employees had been infected as of late August 2020, demonstrating the symbiotic relationship between prisons and the communities in which they are situated, and the difficulties inherent in preventing the spread of the disease during the course of the employee's everyday work (Bellware, 2020).

Impact of COVID-19 on implementation of the First Step Act

Before the global coronavirus pandemic began, almost exactly 1 year earlier, President Donald J. Trump signed the First Step Act into law in 2019. Lauded by some as the most significant federal criminal justice reform bill in years, the components of the First Step Act collectively sought to reduce the size of the federal prison population while maintaining public safety (Cohen, 2019; James, 2019). The act reauthorized the Second Chance Act of 2007 (James, 2019) and mandated that the Fair Sentencing Act of 2010 be applied retroactively to some federal offenses, resulting in lesser sentences for many criminal offenders (Ferrill, 2020). Lastly, the First Step Act promoted correctional reform via the establishment of a risk/needs assessment within BOP facilities (James, 2019). Specifically, the last component of the First Step Act:

> . . .requires the Department of Justice (USDOJ) to develop a risk and needs assessment system to be used by BOP to assess the recidivism risk of all federal prisoners and to place prisoners in programs and productive activities to reduce this risk. Prisoners who successfully complete recidivism reduction programming and productive activities can earn additional time credits (i.e., "earned time credits") that will allow them to be placed in prerelease custody (i.e., home confinement or a Residential Reentry Center) earlier than they were previously allowed. The act prohibits prisoners convicted of any one of dozens of offenses identified in the chart above from earning additional time credits,though these prisoners can earn other benefits, such as additional visitation time, for successfully completing recidivism reduction programming." Defender Services Office Training Division, 2020)

By January of 2020, the USDOJ should have posted a full list of approved programs on www.bop.gov, and the BOP should have completed initial risk and needs assessments for each prisoner and begin to assign programming (James, 2019). What constitutes "effective programming and productive activity" was not at first delineated, though a subsequent report produced on behalf of the First Step Act Independent Review Committee provided an assessment of which programs demonstrated positive results after empirical testing, as well as programs that were deemed promising but for which not enough evidence had been accumulated to deem a particular strategy a "success" (Byrne, 2019).

Ostensibly, the complete formula for how program participation and completion would translate to earned time credits would be provided as well. While some elements of the First Step Act were implemented immediately after the bill was signed by President Trump, such as sentence reductions for newly sanctioned offenders and for certain offenders sanctioned under prior, disproportionate sentencing guidelines (e.g., powder vs. crack cocaine) (Grawert, 2020), the risk and needs assessment has proven to be more of a challenge – a challenge complicated by a global pandemic that struck just as the key January deadlines occurred. The USDOJ produced a detailed report in July 2019 that outlined the development of a risk and needs assessment system, as well as recommended steps for the implementation of such a system across BOP facilities (United States Department of Justice [USDOJ], 2019). Byrne's (2019) report on behalf of the First Step Act Independent Review Committee concludes that the programming the BOP has implemented in its facilities and labeled as "approved Evidence-based Recidivism Reduction (EBRR) Strategies and Productive Activities (PAs) [as] required by law" (USDOJ, 2020a, 2020b) has not been evaluated sufficiently to determine if they are effective. Specifically, the First Step Act Independent Review Committee Report states:

> Serious, formal evaluations of current BOP programming are too scarce to tell us much about the effectiveness of that programming. The Bureau's Directory of National Programs appears to suggest that only 3 of the 18 "national program models" have ever been directly evaluated, and only one of them during the past two decades. Based on the research evidence currently available, no reliable judgment can be made about the recidivism reduction effects of particular BOP programs now in operation. [T]he effects of current BOP programs are most accurately described as "unknown. (Byrne, 2019, p. 16)

It seems somewhat counterintuitive to be constructing a recidivism risk mitigation strategy with untested behavioral programming, yet the BOP is left few options given the wording of the First Step Act, and the roster of programs available that can be feasibly implemented in a majority of BOP facilities. USDOJ recommended programs that have become EBRR strategies and PAs were derived mostly from already implemented programs at the federal, state, and local correctional levels. There is also the question of whether inmates are appropriately matched with programming best suited to facilitate their desistence from crime upon release from supervision. As part of First Step Act implementation, the BOP has a comprehensive needs assessment system that is used to assign appropriate EBRR and PAs based on an inmate's criminogenic needs and other needs that are associated with an increased risk of recidivism, such as anger & hostility, dyslexia, and financial literacy (USDOJ, 2020b).

Keeping these issues in mind, the COVID-19 pandemic has had profound impacts on the implementation, and therefore inmate participation in, EBRR and PAs. From its own internal memo in August 2020, the BOP appears to indicate that some First Step Act programming

was altered or suspended in the wake of COVID-19, impacting facilities (USDOJ, 2020a). The memo directs facilities to "resume programs" in both residential and nonresidential contexts, without restrictions based on group size (e.g., groups with more than ten participants) (USDOJ, 2020a). Facilities are encouraged to maintain social distance for program participants – for example, by offering meetings in outdoor or "unused" spaces – however, the caveat remains in place to make exceptions to any of the programming directives if the safety of staff and inmates cannot be assured (USDOJ, 2020a). Ambiguities, therefore, remain in determining the extent to which programming is even being offered at various BOP facilities, much less how inmate participation is being translated into hours awarded for completion of programs and, ultimately, the amount of time reduced from an inmate's sanction per the provisions of the First Step Act. It is unclear is whether the pandemic prevented the implementation of First Step Act components and the training of BOP employees on system procedures and protocols. The implementation timeline by the USDOJ is somewhat nebulous, though provisions in the act assert that BOP was to have completed initial assessments of *all* inmates (James, 2019). At this same point, staff training was to be completed, as was the establishment of EBRR and PAs at BOP facilities such that an annual audit by the USDOJ could be performed to monitor and ascertain how the components of the act had been operationalized throughout the BOP (USDOJ, 2020a).

It is unclear how the pandemic has affected the flow of funds for the implementation of First Step Act programming. It has yet to be determined how the COVID-19 pandemic has impacted specific parts of the federal budget. With trillions of dollars going toward sustaining small businesses and stimulus payments to citizens, it seems inevitable that monies earmarked for EBRR and PAs have/will be impacted. Finally, the status of those tens of thousands of inmates who had commenced programming, such as drug treatment and vocational training, prior to the COVID-19 outbreak remains unclear. While the BOP has established guidance for continuing programming while attempting to mitigate infections, the key question becomes whether sufficient resources will be available to sustain First Step Act implementation or if the Department of Justice will need to work with Congress to identify an alternate funding stream. Most importantly, the global pandemic hit 3 months *after* the FSA's risk reduction focused system was required to start. It may certainly be argued that the BOP missed an opportunity to have a defensible population reduction strategy in place *prior* to the start of the pandemic. This opportunity was not realized due to a lack of implementation of both the Prisoner Assessment Tool Targeting Estimated Risk and Need ("PATTERN") risk instrument, and the programming that is at the core of the BOP's risk-driven early release strategy (USDOJ, 2020d). Since these changes were mandated externally by the United States Congress, and not the result of an internal policy/practice/strategic initiative, it is certainly possible that resistance to organizational change was at least partially responsible for the delay. Even more likely, BOP line and mid-level managers were working in a turbulent environment, due to no less than three leadership changes between August 2019 and February 2020 (Phillips, 2020).

Recommendations

As the coronavirus pandemic continued through the summer of 2020 and hit hard the correctional populations of some U.S. states that had widespread COVID-19 infection in the overall population (such as California), the BOP continued to take measures to reduce

the spread of the virus in its facilities. Because the trajectory of the pandemic nationally is yet to be determined, any strategies or recommendations are predicated on changing rates of infection, potential breakthroughs in treatment regimens, and, ultimately, whether a vaccine is developed relatively quickly, ending the pandemic. Until such a time comes about, all of the society will need to rely on social distancing, wearing of masks, self-isolation when ill, contact tracing of those infected or who were in contact with a known infected person, and other preventative measures. Prisons are not optimal settings for these practices to take place, but steps can be put into place to limit the spread of this highly contagious coronavirus, and help ensure the safety of those living and working in BOP facilities.

Better and ongoing testing of inmates and staff to prevent spread within the system and in communities where facilities are located

Widespread testing has been consistently shown, globally, to be a key first step in arresting the spread of COVID-19. Although the scope, institution, and effectiveness of testing have become politicized in the United States, what is clear is that without an accurate accounting of the extent of infection in a given setting, there is no way to effectively devise a strategy to isolate those infected and contain the spread. An ineffective testing strategy will either overinflate the extent of infections or underreport the true number of infections within a facility. For example, by testing those individuals who are already symptomatic and were exposed to the virus, testing is simply confirming an assumed outcome. This example was seen in some BOP facilities early in the pandemic when outbreaks were first reported in specific facilities, and then testing implemented afterward. The second likely outcome is the result of a lack of testing, which misses asymptomatic or pre-symptomatic carriers of the virus who go on to infect others, in an exponential fashion, when proper social distancing does not occur.

The screening tools for inmates, staff, and visitors/volunteers/contractors presently in use by the BOP (BOP, 2020) are helpful to a limited extent; however, to mitigate COVID-19 spread in closed institutions, a continual testing regimen would need to be in a place that tested a majority of those already in or entering facilities. Further, these tests would preferably be "rapid result" tests or at the very least allow for results to be returned in 2 days or less. Without widespread testing, and with people flowing into and out of facilities, it is impossible to obtain accurate reflections of the number of infections and how fast the virus is spreading throughout facilities in the BOP system.

Limiting/halting inmate transfers

The BOP maintains that it has limited inmate movement within the system as much as possible and that transfers between March 13, 2020, and April 23, 2020, were down 95% compared to the same time period in 2019 (BOP, 2020). While this was certainly the correct action to take, it is problematic that, during February and early March of 2020, internal BOP records showed that inmate transfers proceeded normally until the middle of March, in all likelihood spreading the virus through the BOP system (Blakinger & Hamilton, 2020). Movement within the system should only be occurring when absolutely necessary, and when it cannot be avoided, protocols must be in place to protect the safety of the transferring inmate and the inmate population of the facility into which that inmate is

entering. These protocols include screening inmates prior to transfer, use of PPE by both inmates and correction staff transporting the inmate, screening at intake into the new facility, and a 14-day quarantine to ensure the inmate is asymptomatic before being placed into the general population (BOP, 2020). These measures must be employed for every necessary inmate transfer, and BOP must coordinate with non-USDOJ entities so they are made aware of the BOP's requirements for accepting inmates into federal facilities.

Alternatives to incarceration/detention to prevent infections

Correctional facilities were not designed for social distancing. Space is always at a premium in any jail or prison; thus, the easiest way to maintain social distance is for there to be fewer inmates in facilities. The USDOJ and BOP maintain that there was an "immediate" response at the beginning of the pandemic to review all inmates in the federal prison system for COVID-19 risk factors and to move suitable inmates to home confinement (BOP, 2020). Despite this action item being prominently featured on the BOP's coronavirus response webpage, data from the Marshall Project and the Associated Press indicate that by June 2020, the BOP's total inmate population had only been reduced by roughly 10%; roughly the same proportion as the states of Nevada, Mississippi, Utah, and Iowa (Sharma et al., 2020). The first months of the pandemic have shown the coronavirus spreads easily and rapidly in closed environments (indoors) where people are not socially distanced. Even using PPE, the risk of infection in a correctional facility is greater than elsewhere in society. One initial assessment determined the coronavirus infection rate to be three times higher in prisons than in the population at large (Unlock the Box, 2020).

It is clear that one tool for preventing COVID-19 infections in BOP facilities is to reduce the overall populations within them. The assessments that USDOJ called for early in the pandemic should be altered slightly, and determinations perhaps not made based on which inmates *could* be released, but rather on inmates that *should not*, thus hastening the rate at which BOP inmates are moved to home confinement. There will, of course, always be a subjective element to such assessments; however, if the key criteria become release from incarceration if an inmate is not deemed a significant risk to public safety, the process may lead to a faster reduction of total inmate populations.[4] There are reports that Prisoner Assessment Tool Targeting Estimated Risk and Need ("PATTERN") scores, the tool designed by BOP to measure recidivism risk of inmates, have been quietly revised by the USDOJ to make minimum scores required to qualify for home confinement more difficult to attain (Grawert, 2020). The implications of this unilateral modification are potentially grievous in the midst of a deadly pandemic.[5]

A final concern of not reducing inmate populations significantly enough during the pandemic is that facilities will fall back on the use of solitary confinement to either isolate COVID-positive inmates or protect non-infected inmates from potentially contracting the virus. There is evidence to suggest this practice had been occurring in BOP facilities – in early June of 2020, the BOP acknowledged that it had instituted a "total lockdown" in response to growing numbers of inmates contracting coronavirus, which in many cases includes cutting off telephone communications and video visits (Unlock the Box, 2020). These are measures typically instituted when there is violence, unrest, and/or contraband found in a facility. The deleterious effects of solitary confinement while incarcerated are well-documented (e.g., Haney, 2018; Smith, 2006; Wildeman & Andersen, 2020) – home

confinement serves as a better alternative for the overall well-being of the inmate during the course of the pandemic, likely with minimal risks to public safety.[6] The process by which compassionate release occurs in the federal system under the First Step Act is rather convoluted, with the BOP acting as an intermediary between the inmate and the courts (who make a final determination on release). Whether an inmate's case proceeds, and the BOP requests it from the court, or rejects the petition, potentially initiating an appeals process, it is too much of a bureaucratic slog during a pandemic (Merkl, 2020). Inmate welfare would be better served if the USDOJ and BOP could work with the courts to streamline the process.

Conclusions

There are questions about how the Department of Justice (USDOJ) and the BOP managed their coronavirus response plan, and it is likely will be even more questions in the future. Some reports labeled the response as slow to be initiated, and, once up and running, was not flexible enough to respond to a dynamic viral outbreak in specific BOP facilities (Pavlo, 2020). Further, given the data collected thus far during the pandemic from correctional facilities nationwide, the strategies in place to mitigate spread are insufficient to control the spread, and more effective infection control is needed (Saloner et al., 2020).

For those inmates who do not win compassionate release under the provisions of the First Step Act, it is imperative that the reforms incorporated in the First Step Act be maintained so that inmates can continue working toward the reduction of their sentences through participation in EBRR and PAs, despite the challenges posed to federal prisons by the COVID-19 pandemic. The latest report (June 2020) released by the USDOJ on First Step Act implementation represents initiatives in place primarily during the calendar year 2019 (USDOJ, 2020c). It is almost certain there was interruption to programming – the USDOJ's (2020a) internal memorandum indicates as much when it indicates that programs are to "immediately resume" – as priority was placed on short-term assessments and PATTERN scores, while longer ranging goals of the First Step Act were understandably placed on the back burner. However, once the majority of inmates are assessed, attention should turn back to those components of the First Step Act that were established to make sentences fairer.

Notes

1. It has been reported that a small number (under 10) of the more than 120 federal prisons accounted for over 70% of all reported cases, but this information cannot be confirmed. There is no mention of "hot spot" federal prisons on the BOP website. Coronavirus cases spread across the country over summer 2020 from the east and west coasts, likely changing hot spot locations.
2. It is near impossible, of course, to follow the CDC mandate on social distancing in any correctional facility in the United States.
3. It must be emphasized that these are unsubstantiated, anecdotal perceptions of individual employees.
4. Conversely, it would be erroneous to say there is no public safety risk in compassionate release. There is both the public safety component and potential political fallout of releasing, as an example, a low-risk offender who commits another crime. It is not so much the probability as it

is the possibility in these cases, and who takes the blame if such an incident were to occur (see Byrne, 2019).

5. It must be noted that Grawert (2020) is basing his views on the assumption that the revised PATTERN was being used during this time period. If indeed it is being used to reduce inmate scores, this would require both program completion AND reassessment and rescoring of the risk instrument for FSA-eligible inmates. Because of staffing shortages due to COVID illnesses in facilities, assessment staff have been temporarily reassigned to correctional officer duties. Therefore, it is doubtful that there are personnel – and a system – available to even assess and reduce scores.
6. As the pandemic and its impacts continue, it is necessary to examine suicide rates and changes/deterioration in mental health associated with in-prison mitigation strategies.

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