U.S. Department of Justice

Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

October 21, 2010

The Honorable Richard J. Durbin
Chairman
Subcommittee on Human Rights and the Law
Committee on the Judiciary
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Please find enclosed responses to questions arising from the appearance of Bureau of Prisons Director Harley Lappin before the Subcommittee on September 15, 2009, at a hearing entitled "Human Rights at Home: Mental Illness in U.S. Prisons and Jails." We hope that this information is of assistance to the Subcommittee. Please do not hesitate to call upon us if we may be of additional assistance. The Office of Management and Budget has advised us that there is no objection to submission of this letter from the perspective of the Administration's program.

Sincerely,

Ronald Weich
Assistant Attorney General

Enclosure

cc: The Honorable Tom Coburn
Ranking Minority Member

Hearing before the
Subcommittee on Human Rights and the Law
Committee on the Judiciary
United States Senate

Entitled
"Human Rights at Home: Mental Illness in U.S. Prisons and Jails"

September 15, 2009

Questions for the Record
Submitted to
Harley Lappin
Director
Federal Bureau of Prisons
Department of Justice

1. Would you agree that the Federal Bureau of Prisons (BOP) incarcerates fewer offenders overall than state prison systems?

Response: BOP incarcerates more inmates than any individual State, but fewer inmates than the combined populations of all State prisons. According to a Bureau of Justice Statistics report from December 2009, the two States incarcerating the most inmates, California and Texas, had approximately 174,000 and 173,000 inmates respectively as of December 31, 2008. BOP incarcerated almost 202,000 inmates at that time.

2. Does the Federal Bureau of Prisons have authority over or responsibility for state and local prisons and jails?

Response: No.

3. Other than the BOP's medical referral centers where it appears most of your mental health staff is located, how many mental health professionals are on staff at other institutions? How many are permanent staff, and how many are contract staff?

Response: BOP's six medical referral centers have positions for approximately 150 full-time mental health professionals. BOP's other 109 mainline institutions have positions for approximately 330 full-time mental health professionals. The bulk of mental health services are provided by full-time BOP employees, however, BOP does employ contract psychiatrists in a number of its facilities.

a. On average, how many are assigned to each federal prison?

Response: Mental health professional staffing varies considerably based on the mission and size of the individual institution. For example, mental health professional staffing is enhanced at high security and female institutions (*see* response to question 6, infra), and at facilities with specialized treatment programs. At a minimum, the following positions are assigned to each Federal correctional institution or penitentiary: A Chief Psychologist, a Staff Psychologist, a Drug Abuse Program Coordinator (Psychologist), and a Drug Abuse Treatment Specialist. Based on the mission of the institution and size of the inmate population, additional psychologists and treatment specialists may be assigned to the facility.

Psychiatry services are available in all BOP institutions. However, the need for a full-time, BOP psychiatrist does not exist in every institution. In locations with relatively few mentally ill inmates, psychiatry services are more efficiently provided through the use of tele-psychiatry or a contract psychiatrist.

b. What is the typical education and training level of these professionals?

Response: Most BOP mental health providers are doctoral level, licensed or license eligible, clinical or counseling psychologists. Obtaining a doctorate in psychology requires approximately four years of graduate training as well as completion of a one year pre-doctoral psychology internship. In addition to psychologists, BOP employs psychiatrists, social workers, and treatment specialists. Psychiatrists complete both medical school and a three to four year residency in psychiatry. The majority of BOP social workers and treatment specialists have a master's degree in psychology or social work. At a minimum, they have a bachelor's degree in the social sciences field.

c. Other than the BOP's medical referral centers, are most mentally ill inmates concentrated at certain facilities? Is this the reason why there are not psychiatrists at every federal prison?

Response: Several factors are considered when designating a mentally ill inmate to a BOP facility. In addition to medical referral centers, BOP also preferentially designates mentally ill inmates to intensively staffed facilities based on their mental health needs. Facilities with specialized mental health programs and/or large Psychology Services departments house proportionally more mentally ill inmates.

Psychiatry services are available in all BOP institutions. However, the need for a full-time, BOP psychiatrist does not exist in every institution. In locations with relatively few mentally ill inmates, psychiatry services are more efficiently provided through the use of tele-psychiatry or a contract psychiatrist. BOP's approach to psychiatry services meets or exceeds community standards of care.

d. If the BOP does not have mental health professionals at every institution, how do you know the needs of the mentally ill population in all federal prisons are being met?

Response: BOP has mental health professionals at every institution. If a mental health professional determines that the inmate's mental health needs exceed the institution's capacity to meet those needs, the inmate is transferred to a more appropriate facility.

4. You state in your testimony that those facilities without a full-time psychiatrist either receive services via contractual psychiatrist or via "tele-psychiatry." How effective is "tele-psychiatry?" Is it not difficult to treat and make diagnoses via a teleconference?

Response: Telemedicine, including telepsychiatry, is very effective and is increasingly utilized in a number of different fields, including dermatology, radiology, and psychiatry. Telemedicine facilitates the delivery of specialized medical assessment and treatment services in rural areas. It is often difficult to recruit specialized health care professionals to live and work in these rural locations. Telemedicine addresses this issue and ensures specialized services are available in all locations. In addition, effective tele-medicine relies on a close consultative relationship between the specialized professional and the on-site provider. With respect to telepsychiatry, an on-site physician and psychologist collaborate with the tele-psychiatrist to ensure accurate diagnosis and appropriate treatment.

a. If a facility does not have a psychiatrist on staff and tele-psychiatry is used, who administers the treatment to an inmate if it is needed?

Response: Telepsychiatry orders are issued by the telepsychiatrist in BOP's Electronic Medical Record (BEMR) where they are accessible to all Health Services staff at the institution. The orders are then administered by the medical staff at the institution – depending on the nature of the order, the staff administering the order may be nurses, physicians, psychologists, social workers, laboratory technicians, or mid-level practitioners. When mental health follow-up care is required at the institution, the bulk of this care can be provided by on-site psychologists with as needed consultation with the telepsychiatrist.

5. You state in your testimony that screening and assessment for mental illness are conducted "at initial intake, during reviews of inmates in special housing units, and as part of ongoing evaluations of mentally ill inmates."

a. How are "ongoing evaluations" conducted? Is it via rounds by mental health staff, or is it voluntary reporting by the patient or his/her cellmate?

Response: Ongoing mental health evaluations of inmates are triggered by a number of factors. Inmates classified as seriously mentally ill receive regular contacts with

psychologists, regardless of whether they volunteer for treatment services. These clinical contacts occur at least monthly and more frequently if clinically necessary. Inmates with a history of suicidal ideation, suicide attempts, and/or the need for crisis intervention services are seen for appropriate follow up evaluation, regardless of whether they voluntarily seek treatment.

Inmates also have the opportunity to voluntarily seek mental health services through a variety of mechanisms. Psychologists are a visible presence in the institution - in the cafeteria, on the compound, and in the housing units. Admission and orientation and intake procedures ensure inmates are familiar with psychology staff upon their arrival to the institution. An inmate may speak with a psychologist during the department's weekly "open house" hours or during a psychologist's routine visits to the inmate's housing unit or the institution's cafeteria. The inmate may submit a written request for an appointment or may ask *any* staff member to contact Psychology Services to arrange an appointment. Psychology Services also receives referrals from staff members, all of whom are trained to identify potential mental health concerns. Inmates also contact Psychology Services regarding mental health concerns of their fellow inmates (e.g., cellmates or coworkers).

BOP psychologist is on-call 24 hours a day, 7 days a week, at all institutions, with a prompt response to the facility in the event of a mental health crisis.

b. How often do these "ongoing evaluations" occur?

Response: The frequency of these ongoing evaluations depends upon the individual inmate's treatment needs and general level of mental health functioning. Contacts range from daily to quarterly.

6. Some on our witness panel today have testified to the greater prevalence of mental illness in female offenders in state systems. Do you find this to be true in the federal system?

Response: Yes. We estimate that among newly committed female offenders, the overall rate of mental illness is higher than that of male offenders. For example, among newly committed female offenders who had a diagnosis of a serious mental illness, or a history of either inpatient mental health hospitalization or psychotropic medication the mental health prevalence is 26.3%. Our estimate for males is 14.4%.

a. Are programs offered to women, such as The Resolve Program and the Step-Down Program, structured differently than those offered to men? Why or why not?

Response: The structure of the programs is similar, in that services are delivered as either outpatient or residential treatment in an individual and/or group setting by psychologists, psychiatrists, and social workers. However, the content of the programs is

gender specific. As these programs were initially developed and as they have evolved over time, the professional literature on female offenders and female offender subject matter experts were consulted extensively to ensure the programs addressed the needs of female offenders. Specifically, these programs attend to such topics as traumatic stress, resilience, assertiveness, interpersonal relationships, and co-occurring mental illness and substance use disorders.

7. You also mention several programs available to mentally ill inmates in specific federal institutions; however, only the Challenge Program is available in all penitentiaries. Are there any plans to expand other programs into additional institutions?

Response: The BOP is determining the feasibility of expanding the Step-Down and Resolve Programs to serve a larger subsection of mentally ill offenders.

a. Other than the Federal Medical Centers, how does the BOP determine when/if a federal institution should establish one of these mental health programs?

Response: Central Office and Regional Office Administrators regularly consult with the field and review mental health records to identify the mental health needs of the inmate population. In addition, large scale research projects conducted internally, as well as reviews of the professional literature, inform our decisions about program development and activation. When a need for a particular program is identified and resources are available to activate the program, the BOP's Assistant Directors and Regional Directors collaborate to identify an appropriate location for the program. At the institution level, each Chief Psychologist conducts an annual assessment of their inmate population's mental health and substance abuse treatment needs. Based on this assessment, the Chief Psychologist will implement local programming efforts, such as specialized psychotherapy groups.

b. How many of these programs are purely voluntary on the part of the inmate? Is this more effective than making some programs mandatory if the inmate is diagnosed with a mental illness?

Response: The BOP's mental health treatment programs are voluntary. The Bureau's emphasis on voluntary participation in mental health treatment is consistent with the standard of care in the community. Bureau psychologists make a concerted effort to engage inmates in treatment through the use of motivational interviewing techniques and incentives for program participation.

i. Are any programs mandatory?

Response: While mental health treatment services are voluntary, some mental health related services are mandatory. Psychologists and psychiatrists deliver clinical interventions to effectively manage mentally ill inmates in the prison setting. For

example, these interventions may include monthly monitoring appointments or placement in a specialized housing unit or work assignment.

During a mental health emergency, psychiatric medications may be administered without first obtaining the inmate's informed consent. In non-emergency situations, informed consent is obtained and documented prior to administering medication for psychiatric symptoms or conditions. Psychiatric medication may be administered in a mental health emergency only by order of a physician, and if the inmate is at immediate risk of: bodily harm toward self or others; serious destruction of property that would immediately endanger self or others; serious disruption of the therapeutic milieu that places the inmate at risk of harm from others; or extreme deterioration of functioning secondary to a psychiatric illness.

8. How many federal inmates would you estimate have been diagnosed mentally ill?

Response: The Bureau estimates that 15.2% of newly committed Federal inmates would be diagnosed mentally ill. Diagnoses included in this estimate are limited to Schizophrenia, Schizo-affective Disorder, Bipolar Disorder and Major Depressive Disorder.

a. What definition of "mentally ill" does the BOP use in its evaluations?

Response: If evaluations refer to forensic examinations performed by Bureau psychologists for the courts, then "mentally ill" can best be thought of as a Mental Disease or Defect, as that term has been defined in statute and case law. However, in practical terms, mental health professionals (psychologists and psychiatrists) who complete evaluations, use diagnostic terms found in the DSM-IV-TR to describe mental illness.

b. Are all diagnosed inmates monitored by a mental health professional in some capacity? How often?

Response: No, inmates who are functioning reasonably well and who have no active interest in treatment may not be directly monitored by a mental health professional. This practice is consistent with the community standard, in that individuals with mild to moderate mental health symptoms are not routinely monitored or mandated to receive mental health services.

9. Is BOP aware of the innovative ideas that many states have utilized to treat this inmate population? How often does the BOP add to or update its mental health services?

Response: BOP has Regional and Central Office mental health professionals dedicated to identifying and developing evidence based treatment programs. The staff reviews the professional literature, visits programs in the community and/or State prisons, and collaborates with subject matter experts to develop more effective mental health services for BOP. BOP adds

or updates mental health services as the needs dictate and resources permit. In Fiscal Year 2009, BOP continued to expand the Challenge Program at penitentiaries and increased the number of Resolve Programs in female institutions.

10. What type of training does correctional staff receive to enable them to recognize and appropriately react to inmates with mental illness? How often does staff receive such training?

Response: All new staff, including correctional officers, participate in a 200-hour course of training within the first year of employment. This training is offered at the local institution and at the Federal Law Enforcement Training Center in Glynco, GA. The curriculum includes specific training in managing mentally ill offenders. This subject is also addressed regularly with all staff during annual training. This component of annual training is facilitated by a doctoral level psychologist. In addition, specialized training in suicide prevention is offered semi-annually to key staff in the institution, to include health care workers, supervisory correctional officers, and unit management staff.

Due to this staff training, it would be very unusual for an inmate's mental illness to go undetected by correctional staff. Early warning signs of a mental illness are easily observed by staff working in close proximity to inmates. Psychologists regularly communicate with unit management staff, unit officers, teachers, chaplains, health care workers, recreation staff, and supervisors of inmate workers to effectively manage the care of mentally ill inmates. Staff is provided with the necessary information to assist in the monitoring of mentally ill inmates and they routinely share information and concerns with psychologists.

11. How do your correctional staff and mental health staff work together?

Response: Among the many benefits of BOP's "correctional worker first" philosophy is the strong sense of camaraderie that develops between all staff. Mental health professionals in BOP are well respected by other staff and are readily consulted regarding the management and treatment of mentally ill inmates. Correctional officers and unit management staff who work closely with inmates frequently interact with psychologists, making referrals on an almost daily basis.

a. **Would you agree that, based on their daily interaction with inmates, that the correctional staff plays a key role in monitoring inmates' mental health?**

   Response: Yes.

b. **I realize that the roles of mental health and correctional staff are very different within the prison system. Does this make it difficult to coordinate sharing of information and cooperation between these two staff groups when treating mentally ill inmates?**

Response: As noted above, BOP's "correctional worker first" philosophy yields a collaborative, cooperative relationship across departments. In addition, a number of mechanisms are in place to enhance and encourage staff communication. Staff members communicate by e-mail, by telephone, and through in-person meetings. Psychologists identify mentally ill inmates in the population and ensure staff is aware of the special needs of these inmates. Procedures are in place to ensure that a psychologist is notified if a mentally ill inmate encounters difficulties. For example, if a mentally ill inmate engages in disruptive behavior and is placed in segregation, Psychology Services is immediately notified and the inmate is assessed.

12. Do you specifically request appropriations for mental health services for inmates? Why or why not?

Response: Funding for mental health services is included in the BOP budget request. The BOP budget structure is comprised of four decision units: Inmate Care & Programs; Institution Security & Administration; Management & Administration; and Contract Confinement. Funding for inmate mental health services is incorporated under the Inmate Care & Programs decision unit.

In FY 2011, the BOP requested $2,382,820,000 to fund all programs under the Inmate Care and Programs decision unit that includes Inmate Mental Health Treatment (Psychology, Drug Treatment, and Psychiatry). Also addressed in the decision unit are other programs (Food, Medical, Clothing, Religious Services, Recreation, Unit Management, and Receiving & Discharge). The Inmate Care & Programs Decision Unit Funding Request amount for Fiscal Year 2011 was 37% of the BOP Total FY 2011 Funding Request for the Salaries & Expenses Appropriation.

a. If not, how much is generally allocated to such services from the overall appropriations BOP receives?

Response: *See* above response.