How To Do Time: Part 4

By **Alan Ellis and J. Michael Henderson** (July 19, 2018)

Alan Ellis

Most lawyers are understandably unable to advise a first-time federal inmate as to what it will be like in prison. Rarely do they ever get beyond an attorney visiting room. In this four-part series of articles, we, the co-authors of "Federal Prison Guidebook," with the help of Philip S. Wise, retired Bureau of Prisons assistant director of heath services, offer answers to many questions attorneys, their clients, and their clients' family and friends may have. (Read the first part here, the second part here and the third part here.)

This final installment covers mental health care and substance abuse treatment in the Bureau of Prisons.

J. Michael Henderson

Alan Ellis: Can and will an inmate receive mental health care and substance abuse treatment in the Bureau of Prisons?

J. Michael Henderson: The Bureau of Prisons has, as with medical care, adopted mental health classifications. In addition to receiving a classification for security and health care, BOP inmates are now classified based on mental health care need. Similar to the four medical care levels, all inmates are assigned to one of four mental health levels.

1. CARE1-MH: No Significant Mental Health Care

Those who show no significant level of functional impairment associated with mental illness and demonstrate no need for regular mental health interventions, and either has no history of serious functional impairment due to mental illness or, if a history of mental illness is present, have consistently demonstrated appropriate help-seeking behavior in response to any reemergence of symptoms.

2. CARE2-MH: Routine Outpatient Mental Health Care or Crisis-Oriented Mental Health Care

Those requiring routine outpatient mental health care on an ongoing basis, and/or brief, crisis-oriented mental health care of significant intensity, e.g., placement on suicide watch or behavioral observation status.

3. CARE3-MH: Enhanced Outpatient Mental Health Care or Residential Mental Health Care

Those requiring enhanced outpatient mental health care, such as weekly mental health interventions or residential mental health care, such as placement in a residential Psychology Treatment Program.

4. CARE4-MH: Inpatient Psychiatric Care

Those who are gravely disabled and cannot function in general population in a CARE3-MH environment.

In determining an appropriate mental health care level assignment, an individual’s current, recent and historical need for services is considered, along with any type of psychotropic

medication required.

The BOP offers a number of formal, organized psychology treatment programs with specific target populations, admission criteria and treatment modalities. Many of these are residential programs offered only at select facilities. General psychological services and mental health crisis intervention are available throughout the BOP. Psychiatric services, including psychotropic medication, are generally coordinated through health services in conjunction with psychology services staff. Psychiatry services may be available either through contracts with a community psychiatrist, or increasingly, through telepsychiatry with a BOP psychiatrist at another location.

While it may vary from institution to institution and from mental health professional to mental health professional, generally speaking, mental health treatment in the BOP is designed to enable the inmate to function within the prison system, meaning they are not a danger to themselves, staff or other inmates.

Outside of the formal programs mentioned above, rarely will an inmate receive any meaningful treatment for underlying disorders such as post-traumatic stress disorder, major depressive disorder, bipolar disorder, and the like, because not all treatment modalities are offered. For example, eye movement desensitization and reprocessing for treatment of PTSD is not available outside of the programs.

This is regrettable. The U.S. Department of Justice estimates are that one in four inmates in this country suffers from a diagnosable mental health disorder. With the BOP's emphasis on reducing recidivism, more attention given to the mentally ill would go a long way toward achieving this result.

The medical staffing also can vary from one federal prison to another, and offenders whose needs cannot be managed at one might be placed in another, which may mean a move further from their families. Families should be as supportive as possible under such circumstances, understanding that the health of their loved one should supersede proximity to the family. Also, the family should know that many prison facilities augment their medical care with doctors from the community, usually specialists, on a contract basis. These consulting specialists are available if BOP staff determine that a specialty consultation is required, and any recommendations made by a consulting specialist will be evaluated by a BOP physician for compliance with the agency's scope of service.

Mental health care, or lack thereof, in the BOP is exacerbated by the fact the bureau has had a difficult time recruiting competent mental health professionals. The same holds true for medical care.

One of the hardest parts for the family, I believe, is not having a choice in the health care of their loved one during confinement. But focusing on the positives of the BOP's system can help, even if that system is more impersonal to the inmate than private medical practice.

Finally, the family can be assured that each BOP region has a regional health services administrator who is usually open to knowing about serious and significant health care concerns, should an inmate believe medical needs are not being adequately addressed.

Q: Does the bureau have any drug and/or alcohol substance abuse treatment programs?

A: Yes, the bureau has a 500-hour, nine-month-long comprehensive Residential Drug and

Alcohol Treatment Program. RDAP is a highly successful program with a greater lack of relapse and recidivism rates than many other such programs. It ensures that an inmate will serve four to six months at the end of his sentence in a halfway house for the out-patient component of RDAP. Obviously, it is one thing to be able to abstain from drugs or alcohol while in prison, but it is harder once back in the community. This transitional care, outpatient component is a required follow-up to the 500-hour in-prison program. It has the added advantage of enabling inmates who successfully complete the program to earn one year off the amount of time they have to serve. Needless to say, it is very popular.

Q: Can anyone qualify for the program?

A: The presentence report must document that defendant had a substance abuse problem within one year prior to his or her arrest. Generally, this self-reporting by the defendant is sufficient. Unfortunately, many defendants not wanting to "blacken their character" any more than it has been, will downplay their drug and alcohol problems when being interviewed by the U.S. probation officer. If the presentence report does not document substance abuse within one year prior to the individual's arrest, the only other way to get into the RDAP program is if the defendant sought treatment from a physician, mental health professional or drug and alcohol counselor and that person is able to document the treatment. This may suffice to get the inmate into the program.

Q: Do you have any final words of advice?

A: Let me offer the three most important pieces of advice that I can to the offender who will be going to a federal prison facility for the first time.

First, the federal court proceedings and, ultimately, sentencing to prisons has likely taken a very serious toll on the offender and their family — psychologically, emotionally and often financially. When the time for confinement finally arrives, which suspends the individual's freedom and separates him or her from family, it sometimes happens that the offender and/or family will vent frustrations on or toward the BOP. It is important to keep the perspective, however, that the BOP is not responsible for the current circumstances. Ultimately, it will not be the BOP's responsibility to rebuild lives or relationships. Straight thinking in this regard can empower the offender and family to help them avoid the nonproductive trap of feeling as though they are victims.

Second, the offender would be well-advised to keep important personal information about themselves and their families confidential, period! This does not mean being so secretive as to arouse the suspicions of other inmates, but it should be obvious that there are predatory criminals in federal prisons and becoming vulnerable to such individuals will only complicate the lives of the well-meaning inmates who truly wish to serve their sentences with as little hassle as possible. Well-meaning inmates can be conned, their family's privacy and well-being compromised, and lives seriously disrupted if they are too friendly with the wrong inmates.

Last but not least, humility, clear conduct and an understanding that federal prison, while offering a variety of programs and activities, may be an experience of some drudgery can and should help maintain a positive mindset. There are no "entitlements," which should help the offender appreciate freedom and family even more. With self-reliance and keeping the "big picture" in mind, the offender can focus on the confinement term and returning home and staying out of prison. There is no sounder advice than this.

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