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Report to Congressional Requesters

July 2013

BUREAU OF PRISONS

Timelier Reviews, Plan for Evaluations, and Updated Policies Could Improve Inmate Mental Health Services Oversight

GAO-13-1

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GAO Highlights

Highlights of GAO-13-1, a report to congressional requesters

Why GAO Did This Study

BOP is responsible for the care and custody—including mental health care—of more than 219,600 federal inmates. BOP identifies and treats inmates' mental health disorders, and has procedures in place to assess the provision of mental health services in its 119 facilities, and 15 private prisons operating under contract. GAO was requested to provide information on BOP's costs and oversight of inmate mental health services. This report addresses: (1) BOP's costs to provide these services; (2) the extent to which BOP assesses whether its institutions comply with BOP policies for providing services; and (3) the extent to which BOP tracks the costs of providing mental health services to inmates in contract facilities, and assesses compliance with contract requirements.

GAO analyzed obligated funds for fiscal years 2008 through 2012 for the two BOP divisions responsible for mental health services at BOP institutions, examined the most recent review reports for a random sample of 47 BOP institutions and all 15 contract facilities, examined BOP's policies, and interviewed BOP officials.

What GAO Recommends

GAO recommends that BOP (1) take steps to prioritize the completion of postponed program reviews, (2) develop a plan to evaluate treatment programs, and (3) develop and implement updated program statements. BOP concurred with the first and third recommendations and partially concurred with the second. GAO considered additional information provided by BOP about its plan to conduct evaluations and modified this recommendation accordingly.

View GAO-13-1. For more information, contact David C. Maurer at (202) 512-9627 or maurerd@gao.gov, or Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

What GAO Found

During a 5-year period—fiscal years 2008 through 2012—costs for inmate mental health services in institutions run by the Bureau of Prisons (BOP) rose in absolute dollar amount, as well as on an annual per capita basis. Specifically, mental health services costs rose from $123 million in fiscal year 2008 to $146 million in fiscal year 2012, with increases generally due to three factors—inmate population increases, general inflationary increases, and increased participation rates in psychology treatment programs such as drug abuse treatment programs. Additionally, the per capita cost rose from $741 in fiscal year 2008 to $821 in fiscal year 2012. It is projected that these costs will continue to increase with an estimated per capita cost of $876 in fiscal year 2015, due, in part, to increased program funding and inflation.

BOP conducts various internal reviews that assess institutions' compliance with its policies related to mental health services, and it also requires institutions to obtain external accreditations. BOP's internal program reviews are on-site audits of a specific program, including two that are relevant to mental health services—psychology and health services. Most institutions in GAO's sample received good or superior ratings on their psychology and health services program reviews, but these reviews did not always occur within BOP-established time frames, generally due to lack of staff availability. When reviews were postponed, delays could be lengthy, sometimes exceeding a year, even for those institutions with the lowest ratings in previous reviews. Moreover, BOP has not evaluated whether most of its psychology treatment programs are meeting their established goals and has not developed a plan to do so. BOP is developing an approach for reporting on the relative reduction in recidivism associated with major inmate programs, which may include some psychology treatment programs. Using this opportunity to develop a plan for evaluating its psychology treatment programs would help ensure that the necessary evaluation activities, as well as any needed program changes, are completed in a timely manner. Further, BOP's program statements—its formal policies—related to mental health services contain outdated information. Policy changes are instead communicated to staff through memos. By periodically updating its program statements, BOP would be better assured that staff have a consistent understanding of its policies, and that these policies reflect current mental health care practices.

BOP collects information on the daily cost to house the 13 percent of federal inmates in contract facilities, but it does not track the specific contractor costs of providing mental health services. The performance-based, fixed-price contracts that govern the operation of BOP's contract facilities give flexibility to the contractors to decide how to provide mental health services and do not require that they report their costs for doing so to BOP. BOP uses several methods to assess the contractors' compliance with contract requirements and standards of care. BOP conducts on-site reviews to assess the services provided to inmates in contract facilities, including those for mental health. BOP uses results from these reviews, as well as reports from external accrediting organizations, the presence of on-site monitors, and internal reviews conducted by the contract facility, to assess contractor compliance and to ensure that the contractor is consistently assessing the quality of its operations.

Contents

Tables

Figures

Abbreviations

ACA	American Correctional Association
BOP	Bureau of Prisons
BRAVE	Bureau Rehabilitation and Values Enhancement
CFM	Contract Facility Monitoring
DOJ	Department of Justice
DSM-IV-TR	Diagnostic and Statistical Manual, Version IV-TR
FCC	Federal Correctional Complex
FCI	Federal Correctional Institution
FDC	Federal Detention Center
FMC	Federal Medical Center
FPC	Federal Prison Camp
FTC	Federal Transfer Center
MCC	Metropolitan Correctional Center
MCFP	Medical Center for Federal Prisoners
MDC	Metropolitan Detention Center
MH	mental health
MTC	modified therapeutic community
NR DAP	Non-Residential Drug Abuse Treatment Program
ORE	Office of Research and Evaluation
PA	physician's assistant
PDS	Psychology Data System
PRG	Program Review Guidelines
RDAP	Residential Drug Abuse Program
SFF	Secure Female Facility
SHU	special housing unit
SOTP-NR	Non-Residential Sex Offender Treatment Program
SOTP-R	Residential Sex Offender Treatment Program
STAGES	Steps Toward Awareness, Growth and Emotional Strength
USP	U.S. Penitentiary

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July 17, 2013

The Honorable Elijah E. Cummings
Ranking Member
Committee on Oversight and Government Reform
House of Representatives

The Honorable Robert C. Scott
Ranking Member
Subcommittee on Crime, Terrorism, Homeland Security, and Investigations
Committee on the Judiciary
House of Representatives

The Honorable Richard J. Durbin
United States Senate

The mission of the Department of Justice's (DOJ) Federal Bureau of Prisons (BOP) is to protect society by confining offenders in the controlled environments of prisons and community-based facilities that are safe, humane, cost-efficient, and appropriately secure. As part of its duties, BOP is responsible for delivering adequate medical care, including mental health services, in a manner consistent with accepted community standards for a correctional environment.[1] Multiple courts over the years have established the constitutional requirement that prison systems must provide inmates with adequate medical and mental health care, and this

[1]For the purposes of this review, we are defining mental health services as (1) psychiatric and psychological treatments provided to inmates, such as group and individual psychotherapy sessions, crisis intervention and counseling, and clinical case management; (2) psychology treatment programs—typically involving standard protocols that apply to all participants—including residential and nonresidential drug treatment programs, sex offender management programs, and other specialized mental health treatment programs; and (3) psychotropic medication used for the purposes of treating mental illness.

requirement applies to BOP, as well as state and local prisons.[2] To carry out its responsibility for delivering mental health care for inmates, BOP provides mental health services primarily through its Correctional Programs Division's Psychology Services Branch and its Health Services Division.

As of July 4, 2013, BOP was responsible for overseeing more than 219,600 federal inmates—most of whom are housed in BOP's 119 institutions or 15 privately managed facilities with which BOP contracts for confinement.[3] Studies have shown that psychological treatment during incarceration is effective in reducing mental illness symptoms and in reducing recidivism.[4] Moreover, according to an Urban Institute study, public health and correctional stakeholders view prisons as an opportunity to affect factors that contribute to criminal behavior and the cycle of repeated incarceration, such as untreated mental illness.[5] There is no clear consensus on the rate of mental illness among federal prisoners, and estimated rates vary widely. For example, a 2006 Bureau of Justice Statistics report stated that about 45 percent of federal prisoners suffered from a mental health problem, which the report defined as symptoms of a

[2]For example, in May 2011, the United States Supreme Court held in the case of *Brown, Governor of California v. Plata*, 131 S.Ct. 1910, that to remedy the violation of a federal right, specifically the severe and unlawful mistreatment of prisoners through grossly inadequate provision of medical and mental health care, it was necessary to institute a court-mandated prison population limit. The court recognized that for years the medical and mental health care provided by California's prisons had fallen short of minimum constitutional requirements and had failed to meet prisoners' basic health needs. Adequate medical and mental health care must meet minimum constitutional requirements and meet prisoners' basic health needs.

[3]Privately managed contract facilities house low-security, specialized populations such as sentenced criminal aliens. A criminal alien is a noncitizen in the United States, who may be present on a lawful basis or not, who has been convicted of a crime. During the course of our review, BOP had 15 contract facilities, which we included in our study; however, as of May 31, 2013, the contract for 1 facility was terminated and therefore as of this date BOP had 14 contract facilities.

[4]According to BOP guidance, mental illness includes: anxiety disorders (such as post-traumatic stress disorder), mood disorders (such as depression), psychotic disorders (such as schizophrenia), somatization disorders (which are a psychiatric condition in which the sufferer experiences multiple physical symptoms that are not explained by disease), eating disorders, and personality disorders (excluding antisocial personality disorder) that involve a rigid and unhealthy pattern of thinking and behaving.

[5]Urban Institute, *Opportunities for Cost Savings in Corrections Without Sacrificing Service Quality: Inmate Health Care* (Washington, D.C.: February, 2013).

mental health disorder or a mental health problem that was diagnosed or treated within the previous 12 months, as reported by the inmate.[6] Another study of a sampling of inmates newly admitted to BOP custody during fiscal years 2002 and 2003 estimated that 15.2 percent of the inmates were in need of psychological services, which the report defined as having received a current psychiatric diagnosis, having been prescribed antipsychotic or mood-stabilizing medication at any time in the inmate's life, or having had an overnight hospital stay for mental health reasons at any time in the inmate's life.[7] Differences between the two studies' estimates are attributable, in part, to differences in how a mental health problem was defined.

In light of the importance of providing mental health services to BOP inmates, you asked us for information on BOP's costs and procedures associated with providing inmate mental health care services. Specifically, this report addresses the following questions: (1) What have the costs been to provide mental health services in BOP-operated institutions over the past 5 fiscal years, and what are the projected costs? (2) To what extent does BOP assess whether BOP-operated institutions comply with BOP policies and other standards for providing inmate mental health services? (3) To what extent does BOP track the costs of providing mental health services to BOP inmates in contract facilities, and to what extent does BOP assess whether these facilities meet contract requirements and standards of care for inmate mental health services?

To address the first question, we analyzed obligated funds for the past 5 fiscal years—2008 through 2012—for the two BOP divisions that provide

[6]Bureau of Justice Statistics, *Bureau of Justice Statistics Special Report: Mental Health Problems of Prison and Jail Inmates* (September 2006). The Bureau of Justice Statistics is a DOJ agency that collects, analyzes, publishes, and disseminates information on crime, criminal offenders, victims of crimes, and the operation of the justice systems at all levels of government.

[7]Philip R. Magaletta, Pamela M. Diamond, Erik Faust, Dawn M. Daggett, and Scott D. Camp, "Estimating the Mental Illness Component of Service Need in Corrections: Results From the Mental Health Prevalence Project," *Criminal Justice and Behavior*, vol. 36, no. 3 (March 2009), 229-244. The authors of this study excluded from their definition the most severely disturbed inmates who are housed in medical facilities and those who receive psychological services as a result of policy, such as those placed in segregated housing units. Segregated housing units are units within an institution where prisoners are kept apart from the general population in highly restrictive conditions for administrative reasons, such as pending transfer to another prison, or disciplinary reasons, such as violating prison rules.

mental health services—the Health Services Division and the Correctional Programs Division. To project future costs, we discussed BOP's methods for cost projections with budget and program officials and independently examined BOP's population projections and expected staffing positions for fiscal years 2013 through 2015.[8] To assess the reliability of BOP's obligation data, we performed electronic data testing for obvious errors in accuracy and completeness, and interviewed agency officials knowledgeable about BOP's budget to determine the processes in place to ensure the integrity of the data. We determined that the data were sufficiently reliable for the purposes of this report.

To address the second question, we reviewed all relevant BOP program statements, which are BOP's formal policies and procedures, related to mental health services, as well as the accreditation standards of the two organizations that accredit BOP-run institutions—the American Correctional Association (ACA) and The Joint Commission.[9] We analyzed the most recent program review reports, which present results of BOP on-site audits of program areas, for both health services and psychology services for a random sample of 47 of the 94 BOP-run institutions that were operating long enough to undergo a program review as of August 2012.[10] We used the sample to determine the extent to which BOP assesses its institutions in accordance with its own policies. We compared BOP's policies for inmate mental health care and processes for monitoring the provision of inmate mental health care at the institution level with the Standards for Internal Control in the Federal Government

[8]We limited our projections to 3 years as projections that are further into the future are less reliable.

[9]ACA's mission includes the development and promotion of effective standards for the care, custody, training, and treatment of offenders. The Joint Commission accredits and certifies health care organizations and programs in the United States.

[10]In some cases, a number of institutions belong to a Federal Correctional Complex (FCC). At FCCs, institutions with different missions and security levels are located in proximity to one another. For an FCC, BOP performs one program review for the entire complex and not for the individual institutions that make up the complex. For purposes of this report, we use the term institution to refer to either a single institution or a complex of institutions that is considered a single unit for program review purposes. Therefore, BOP conducted 94 program reviews for the 116 institutions that were operating long enough to have a program review as of August 2012. Three additional institutions were not operating long enough to undergo a program review as of August 31, 2012. Program reviews begin at an institution 18 to 24 months after the institution opens.

and risk management principles.[11] In addition, we analyzed the most recent accreditation reports from ACA and The Joint Commission conducted for this same sample of BOP-operated institutions.[12] We interviewed officials from BOP's Office of Research and Evaluation (ORE), which conducts research and evaluation of BOP programs, to determine what evaluations BOP has conducted of its psychology treatment programs in the past and what evaluations are ongoing or planned. We assessed BOP's evaluation planning against standards for project management. We discussed these oversight activities with BOP officials responsible for managing the psychology treatment programs and conducting program reviews. Additionally, to obtain insights into the overall program review process, we observed two psychology services on-site program reviews.[13] Finally, we interviewed officials from the union representing BOP correctional workers who are involved in contract negotiations to gain an understanding of the negotiation process required to institute changes to mental health-related policies.

To address the third question, we reviewed BOP's December 2008 Quality Assurance Plan to identify the policies and procedures related to mental health care that guide the contract facility monitoring process, as well as all contracting documents for information on costs for mental health-related staff and services they provide. We analyzed all of the most recent reports from BOP's 15 contract facilities' monitoring reviews, which BOP designed to determine if the contractors are meeting the performance outcomes specified in the contracts. In addition, for each of these facilities, we analyzed the most recent accreditation reports from the ACA and Joint Commission reviews. We visited two contract

[11]GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999), and Project Management Institute, *A Guide to the Project Management Body of Knowledge (PMBOK® Guide)*, 5th ed. (Newtown Square, PA: 2013). *A Guide to the Project Management Body of Knowledge* provides standards for project managers.

[12]As with program reviews, a single accreditation report may cover either a single institution or a complex with multiple institutions. For the 47 institutions in our sample, we analyzed 37 Joint Commission accreditation reports because not all BOP institutions are required to obtain Joint Commission accreditation.

[13]We chose the two institutions because they provided different levels of care, and their program reviews were being conducted within the timeframe of our study. While the observations from these visits are not generalizable to all BOP institutions or to all program reviews, the visits provided important perspectives about the program review process.

facilities—one to observe its annual Contract Facility Monitoring review, and the other to observe operations. While the selection of these two contract sites does not facilitate generalizations, our observations and conversations with staff provided important context on the operations of a privately operated prison. We interviewed BOP officials responsible for overseeing contracts, contractor operations, and procurement to discuss the extent to which they track costs and the structure of the arrangements with the contracted facilities. Finally, we obtained information on the provision of mental health services from three private firms that operate 14 of the 15 contract facilities, as well as one subcontractor that provides mental health services for one of the primary contractors.[14] Appendix I contains a more detailed discussion of our objectives, scope, and methodology.

We conducted this performance audit from April 2012 to July 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

BOP is responsible for approximately 219,600 inmates in federal custody. About 81 percent, or approximately 176,900 inmates, are housed in 119 of BOP's own federal institutions—operating at different security levels[15]—and about 13 percent, or approximately 29,400 inmates, are housed in privately managed contract facilities—generally housing low-

[14]During the course of our review, the contract for one contract facility was terminated on May 31, 2013; the private firm that managed this facility declined to provide its views.

[15]There are four security level designations for institutions that house males—minimum, low, medium, and high—and three for institutions that house females—minimum, low, and high. The security level designation of a facility depends on the level of security and staff supervision that the institution is able to provide, such as the presence of security towers, perimeter barriers, the type of inmate housing, and inmate-to-staff ratio. BOP also has administrative facilities that house inmates of all security levels.

security inmates.[16] BOP has eight operational divisions to oversee major BOP program areas, including the Correctional Programs Division and the Health Services Division, that manage the administration of mental health services.[17]

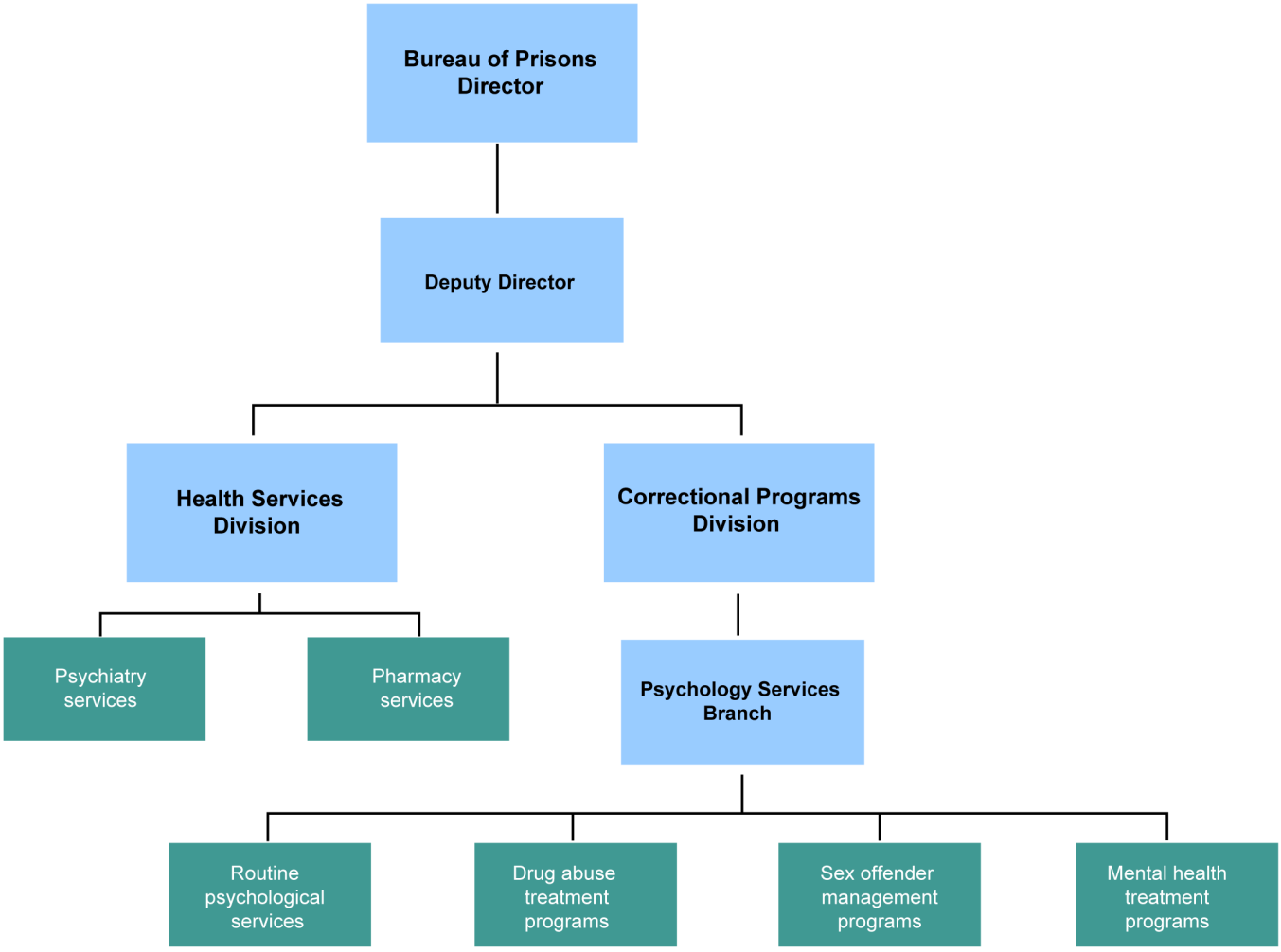
Provision of Mental Health Services in the Federal Prison System

BOP's Psychology Services Branch, which the Correctional Programs Division oversees (see fig. 1), provides most inmate mental health services in BOP-operated institutions, including the provision of individualized psychological care and 11 different treatment programs, which we describe in appendix II. BOP's Health Services Division manages psychiatry and pharmacy services. Most mental health treatment is provided in what BOP calls its mainline, or regular, institutions. Acutely mentally ill inmates in need of psychiatric hospitalization, such as some inmates suffering from schizophrenia or bipolar disorder, may receive these services at one of BOP's five psychiatric referral centers, which provide inpatient psychiatric services as part of their mission. About 71 percent of BOP's psychiatrists work at the psychiatric referral centers with inmates most in need. At other BOP-operated institutions, psychiatrists focus primarily on medication management.

[16]In addition to the federal institutions and contract facilities, BOP also houses about 13,300, or 6 percent, of inmates that fall under community corrections management, which includes 185 residential reentry centers and in-home detention. Residential reentry centers provide a structured, supervised environment and counseling, job placement, and other services to facilitate inmates' reentry to the community after a period of incarceration. We did not review mental health services provided in residential reentry centers because they were outside the scope of our work.

[17]In addition to Correctional Programs and Health Services, the other program divisions are Administration; Human Resource Management; Industries, Education, and Vocational Training; Information, Policy, and Public Affairs; Office of General Counsel; and Program Review.

Figure 1: Bureau of Prisons' (BOP) Organization for Providing Mental Health Services



Source: Source: GAO analysis of information from the Bureau of Prisons.

Note: This figure refers to services provided in BOP-operated institutions.

BOP implemented a mental health care level designation system for both institutions and inmates in 2010.[18] The system identifies the mental health needs of each inmate and matches the inmate to an institution with the

[18]BOP also has a separate medical care level designation system, which it implemented in 2004.

appropriate resources. Institution mental health care levels range from 1 to 4, with 1 being institutions that care for the healthiest inmates and 4 being institutions that care for inmates with the most acute needs. Inmate mental health care levels are also rated in this manner from level 1 to level 4. Table 1 describes each inmate mental health care level and the number of inmates by designation level. For a list of all BOP institutions and their respective mental health care level designations, see appendix III. For more information on the process of assessing inmates' mental health issues and designating care levels, see appendix IV.

Table 1: Number and Percentage of Federal Inmates in Bureau of Prisons (BOP)-Operated Facilities by Designated Inmate Mental Health Care Level, as of May 11, 2013

Inmate mental health (MH) care level	Description	Number	Percentage
MH care 1	Inmates with no identified mental health problem, as well as other inmates with stable mental health conditions requiring individual psychological contacts or clinical intervention no more than once every 3 to 6 months.	155,165	92.46%
MH care 2	Inmates require clinical interventions regularly, usually quarterly to monthly.	5,793	3.45
MH care 3	Inmates require clinical intervention frequently, usually weekly over an extended period of time.	589	0.35
MH care 4	Inmates require psychiatric hospitalization.	857	0.51
MH screen 1[a]		4,038	2.41
MH screen 2		1,093	0.65
MH screen 3		224	0.13
MH screen 4		61	0.04
Total		**167,820**	**100%**

Source: Bureau of Prisons.

[a]According to BOP officials, "MH screen" is the initial mental health designation given to an inmate before the inmate has been assessed at the institution where he or she is assigned. Once an inmate is assigned and evaluated at the institution, the inmate is assigned a "MH care level." The four screening levels match the four care levels in the table.

Among inmates with a level 4 mental health care designation the most common diagnosis among both male and female inmates was schizophrenia or another psychotic disorder,[19] followed by a personality disorder diagnosis.[20] Appendix V contains information on inmate diagnoses by inmate mental health care level designation and gender.

Inmates in contract facilities are predominantly low-security criminal aliens, designated as mental health care level 1 or 2. Inmates who ordinarily would be placed in a contract facility but are designated for a mental health care level higher than 2 are assigned to a BOP-operated facility where BOP can provide the requisite level of care needed to treat the inmate's mental health condition. At some contract facilities, the contractor may subcontract the health care services, including mental health care services.

Internal and External Reviews of BOP-Operated Facilities

BOP reviews prison operations through internal program reviews and external accreditation reviews. BOP established its internal program review process to assess each BOP-operated institution's compliance with applicable regulations and policies, the adequacy of their internal controls, and the effectiveness, efficiency, and quality of their programs and operations. BOP's Program Review Division, one of its eight operating divisions, leads the process. BOP policy states that each program or operation at each BOP institution, such as psychology services and health services—but also, for example, food services and religious services—is to be reviewed on at least a 3-year basis, but potentially more often depending on the institution's prior review results. During each review, a team of reviewers with specialized experience

[19]Psychotic disorders other than schizophrenia include schizoaffective disorder (a mental condition that causes both a loss of contact with reality and mood problems), delusional disorder, and brief psychotic disorder.

[20]A personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, persists over time, and leads to distress or impairment. BOP excludes consideration of antisocial personality disorder in designating an inmate to a mental health care level because, according to BOP officials, such a large proportion of BOP's inmate population could be diagnosed with antisocial personality disorder. Another type of personality disorder is borderline personality disorder. Individuals with borderline personality disorder have long-term patterns of unstable or turbulent emotions that often result in impulsive actions and chaotic relationships with other people.

visits the institution to assess the institution's programs based on a set of Program Review Guidelines (PRG). The PRGs provide a framework for the reviewers to test the institution's compliance with policies and procedures, as articulated through program statements. In particular, program reviews for psychology and health services involve assessments of individual inmate case files, observations of treatment programs, reviews of an institution's policies and procedures, interviews with staff, and interviews with a small number of inmates. Following a visit to an institution, the Program Review Division issues a report noting deficiencies and findings. BOP defines deficiencies to include deviations from policy or regulation, weaknesses in internal controls, or lack of quality controls. Reviewers also assign one of five ratings to the institution.[21] The Program Review Division sends the final report to the institution and to the staff operating the program area that was assessed. Institutions are required to correct any deficiencies identified during the program review.

In addition to program reviews, BOP requires all of its institutions, as well as its contracted facilities, to be accredited by an external organization, ACA. ACA's standards for adult correctional institutions include 63 mandatory standards and 458 nonmandatory standards across five areas of a correctional institution's operations.[22] ACA's standards include 7 specifically related to mental health, 4 of which are mandatory.[23] To be accredited, an institution must meet all mandatory standards and 90

[21]According to BOP, a superior rating indicates the program is performing all vital functions and a history of strong internal controls exists resulting in zero or very minimal deficiencies. A good rating demonstrates the program's vital function areas are sound and internal controls are strong. An acceptable rating is the baseline rating, and each program is assumed to be performing at this level at the beginning of the review. BOP policy states that institutions with an acceptable rating may have deficiencies, but they do not detract from the adequate accomplishment of the vital functions. A deficient rating demonstrates that one or more vital functions of the program are not being performed at an acceptable level and internal controls are weak. An at-risk rating demonstrates that the program is impaired to the point that it is not accomplishing its overall mission and internal controls do not demonstrate substantial continued compliance.

[22]The five areas are administration and management, physical plant, institutional operations, institutional services, and inmate programs.

[23]For example, one standard requires institutions to have a mental health program that includes, among other services, screening for mental health problems on intake, outpatient services, crisis intervention, and stabilization of the mentally ill.

percent of applicable nonmandatory standards.[24] BOP incorporates ACA's standards into the PRGs for its own program reviews. As a result of BOP's inclusion of ACA's standards in its program reviews, ACA relies significantly on findings from BOP's own program review process and its confidence in this review process, when it reaccredits BOP-operated institutions, according to ACA officials.

BOP also requires all of its institutions with a medical care level of 2 or higher to be accredited for ambulatory care by a second external organization, The Joint Commission.[25] The Joint Commission's ambulatory care standards are not specific to mental health services, but apply to any type of medical or mental health service provided by an institution. For example, one standard requires organizations to provide patients with care, treatment, or services according to their individualized care plan. BOP's Joint Commission accreditation covers services provided by the institution's health services unit, including psychiatry and pharmacy services. Certain BOP institutions with specialized medical missions also obtain other Joint Commission accreditations.[26]

Table 2 provides information on the different types of internal and external on-site reviews that BOP institutions undergo, and the specific BOP components providing mental health services that each review covers.

[24]Standards are not applicable if the institution does not serve the specific population covered by the standard or does not have a specific program covered by the standard. For instance, all standards relating specifically to the treatment of female inmates are not applicable to an institution that houses only male inmates.

[25]According to BOP officials, medical care level 1 institutions are not required to be accredited for ambulatory care by The Joint Commission.

[26]Four BOP institutions—Federal Medical Center Rochester, U.S. Medical Center Springfield, Federal Medical Center Devens, and Metropolitan Correctional Center in New York—also have behavioral health accreditations because they have inpatient psychiatric units or a treatment program for individuals addicted to pain-relieving drugs, such as oxycodone or morphine. Two additional institutions—Federal Correctional Complex Butner and Federal Medical Center Carswell—have psychiatric units within inpatient hospital facilities that are also accredited under The Joint Commission's hospital standards.

Table 2: On-site Reviews Related to Mental Health Services at Bureau of Prisons (BOP) Institutions

Review	Internally or externally conducted	Time between on-site reviews	BOP components reviewed
Psychology Services program review	Internally	Up to 3 years, depending on institution's rating[a]	Psychology Services, which include substance abuse programs and other psychology treatment programs
Health Services program review	Internally	Up to 3 years, depending on institution's rating[a]	Psychiatry and pharmacy services
American Correctional Association (ACA) accreditation	Externally[b]	3 years	Psychology, psychiatry, and pharmacy services
The Joint Commission accreditation	Externally	3 years	Psychiatry and pharmacy services

Source: GAO analysis.

[a]BOP policy requires subsequent program reviews be conducted every 3 years for institutions with a good or superior rating, every 2 years for institutions with an acceptable rating, and every 18 months for institutions with a deficient rating. Institutions receiving an at-risk rating are reviewed again when the institution requests closure on the program review.

[b]The ACA relies significantly on BOP's own program review process when it reaccredits BOP-operated institutions. Reviewers from the ACA observe program reviews to determine that the process is sound, but may also cite institutions for any deficiencies the reviewers note during their observation.

Reviews for BOP Contract Facilities

BOP also conducts on-site assessments of its contract facilities, referred to as Contract Facility Monitoring (CFM) reviews. BOP has designed these reviews to assess whether contract facilities are meeting the performance outcomes that the contract specifies. BOP conducts a CFM review at each contract facility at least annually, and more frequently if BOP finds areas of concern in prior reviews, or if a facility recently became operational. In contrast to the internal program reviews for BOP-operated institutions, CFM reviews cover all aspects of the contract facility's operations at once, instead of specifically focusing on a single program area, such as psychology services. Contract facilities are also required to obtain ACA and Joint Commission accreditations to comply with contractual requirements. The contracts indicate that these accreditations must be obtained within 24 months after the facility becomes operational, and the facility must maintain these accreditations through the life of the contract.

Mental Health Services Costs Have Increased in BOP-Operated Institutions since Fiscal Year 2008 and Are Expected to Continue to Increase

During the 5-year period starting in fiscal year 2008 and ending in fiscal year 2012, costs for inmate mental health services in BOP-operated institutions rose in absolute dollar amount, as well as on an annual per capita—or per inmate—basis. BOP projects continued inmate population growth, and as a result, projections for these costs through 2015 are expected to continue to increase.

Mental Health Services Costs Increased from Fiscal Year 2008 through Fiscal Year 2012

BOP's total mental health services costs increased annually from fiscal year 2008 through fiscal year 2012. According to BOP officials, mental health services costs include related expenses from both its Correctional Programs Division and Health Services Division. As shown in table 3, when aggregating these costs, we found that total costs increased annually from $123 million in fiscal year 2008 to nearly $146 million in fiscal year 2012.

Table 3: Actual Costs and Percentage Changes of Inmate Mental Health Services, and Inmate Populations in Bureau of Prisons (BOP)-Operated Institutions

(Cost components and total actual costs are in millions of dollars; inmate population and cost per capita are actual numbers; percentage change is in percent)

		Fiscal year				
		2008	**2009**	**2010**	**2011**	**2012**
Correctional Programs Division	Psychology Services[a]	$42.71	$44.71	$47.26	$49.66	$51.28
	Psychology staff training	0.31	0.80	0.85	0.72	0.64
	Drug abuse treatment programs	57.66	60.62	66.22	68.98	71.33
	Sex Offender Management Programs	4.74	6.94	6.86	6.61	7.19
Health Services Division	Psychotropic medication	11.52	11.58	11.29	9.35	8.49
	Psychiatrist salaries and benefits	6.05	6.83	7.17	7.39	6.75
Total actual costs		**$123.00**	**$131.48**	**$139.64**	**$142.71**	**$145.69**
Inmate population at the end of the fiscal year in BOP-operated institutions		165,964	172,423	173,289	177,934	177,556
Total annual cost per capita		**$741.11**	**$762.56**	**$805.84**	**$802.05**	**$820.52**
Percentage change in per capita cost from prior fiscal year		—	2.89	5.68	-0.47	2.30

Source: GAO analysis of BOP data.

Note: Numbers may not total because of rounding.

[a]According to BOP officials, Psychology Services costs include all expenses related to providing routine psychological treatment to inmates in BOP-operated institutions, salaries and expenses for psychology staff, and some treatment programs. The costs do not include administrative oversight provided by the Central Office, which serves as the headquarters of BOP, or regional offices, which oversee the operations of the institutions within their respective geographic regions. Drug abuse treatment and sex offender management programs are not included in psychology services, but are budgeted separately.

We also found that in general, despite some annual variations, costs for most components of mental health services rose from the start to the end of the 5-year period. These increases were due in part to a concurrent population increase of more than 11,000 inmates during the period. To adjust for this, we estimated the annual per capita, or per inmate, costs by dividing the total costs for mental health services by the number of inmates—and this figure also increased over time, from about $741 in fiscal year 2008 to about $821 in fiscal year 2012. BOP officials told us that per capita increases are generally due to inflation.

With respect to overall cost increases for some programs, including the drug abuse treatment programs and the Sex Offender Management Programs, BOP attributed this growth to an increase in available slots, which has increased inmate participation in these programs. For example, according to BOP data, during the 5-year time period, participation in the Non-Residential Drug Abuse Program (NR DAP) increased by about 51 percent, from 13,361 participants in 2008 to 20,141 in 2012, and participation in the Sex Offender Treatment Program saw an overall increase of about 98 percent, from 373 participants in 2008 to 740 in 2012. Additionally, while the participation rate for the Residential Drug Abuse Program (RDAP) remained relatively constant, BOP reduced the number of inmates on the waiting list by about 31 percent (see app. II).[27]

With respect to costs for psychotropic medication, this was the one line item whose related costs showed a downward trend.[28] According to BOP

[27]Pursuant to 18 U.S.C. § 3621(e), BOP is required to make available appropriate substance abuse treatment for each prisoner the BOP determines has a treatable condition of substance addiction or abuse, including the provision of residential substance abuse treatment for all eligible prisoners (and make arrangements for appropriate aftercare), subject to the availability of appropriations.

[28]The cost data for psychotropic medications may not be exact because some psychotropic medications can be used to treat certain non-mental health conditions and some non-psychotropic medications can be used to treat certain mental health conditions. For example, antihistamines used to treat allergies are considered psychotropic medications.

officials, the decline in psychotropic medication costs is likely a result of a number of these medications becoming available in a generic version, which often means lower costs.

Mental Health Services Costs Are Projected to Grow through Fiscal Year 2015

Including all the same elements in table 3, we projected costs through fiscal year 2015, and expect that mental health services costs will continue to increase (see table 4). In estimating annual future costs, we used fiscal year 2012 as a baseline and discussed with BOP officials their projections for underlying factors that would affect future changes in costs. Specifically, we used their data for anticipated inmate population growth and expected budgetary increases. For example, in its fiscal year 2014 budget, BOP requested an additional $15 million to expand the RDAP, which, according to BOP officials, should enable BOP to reduce the wait list for this program. We also applied national inflation factors for the health care industry to account for inflationary increases.

Table 4: Projected Costs and Percentage Changes of Inmate Mental Health Services, and Projected Inmate Populations in Bureau of Prisons (BOP)-Operated Institutions

(Total projected costs are in millions; inmate population and cost per capita are actual numbers; percentage change is in percent)

	Fiscal year		
	2013	**2014**	**2015**
Total projected costs	**$149.82**	**$155.86**	**$161.22**
Projected inmate population in BOP-operated institutions	179,178	182,124	184,092
Total projected annual cost per capita	**$836.15**	**$855.81**	**$875.75**
Percentage change in projected annual per capita cost from prior fiscal year	1.90	2.35	2.33

Source: GAO analysis of BOP data.

BOP Assesses Compliance with Its Policies for Inmate Mental Health Services, but Reviews Are Not Always Timely; BOP Has Not Evaluated the Effectiveness of Most Treatment Programs or Updated Most Policies

BOP conducts various internal reviews to assess BOP-operated institutions' compliance with its policies related to mental health services, and BOP policy also requires institutions to obtain external accreditations. While most BOP-operated institutions received good or superior ratings in their psychology and health services program reviews, the majority of reviews we examined did not occur within the BOP-specified time frames. Additionally, BOP has not evaluated the effectiveness of most of its treatment programs and has not developed a plan to do so. Finally, BOP's program statements related to mental health services, which formally document BOP's policies and procedures, contain outdated information.

BOP Conducts Internal Reviews That Assess Compliance with Policies for Mental Health Services, but Most Reviews Do Not Occur on Time

BOP's psychology and health services program reviews identify the extent to which institutions are complying with BOP policies. While most institutions received good or superior ratings on these program reviews, we found that the reviews are not always conducted within the time frames BOP's policies specify. The Psychology Services Branch also conducts other types of reviews to ensure compliance with mental health policies.

Psychology Services and Health Services Program Reviews

Program Reviews: The Bureau of Prisons' Program Review Division conducts separate program reviews of each program area at an institution. Reviewers assess an institution's performance based on Program Review Guidelines and earn one of five ratings—superior, good, acceptable, deficient, and at risk.

Source: GAO analysis of BOP information.

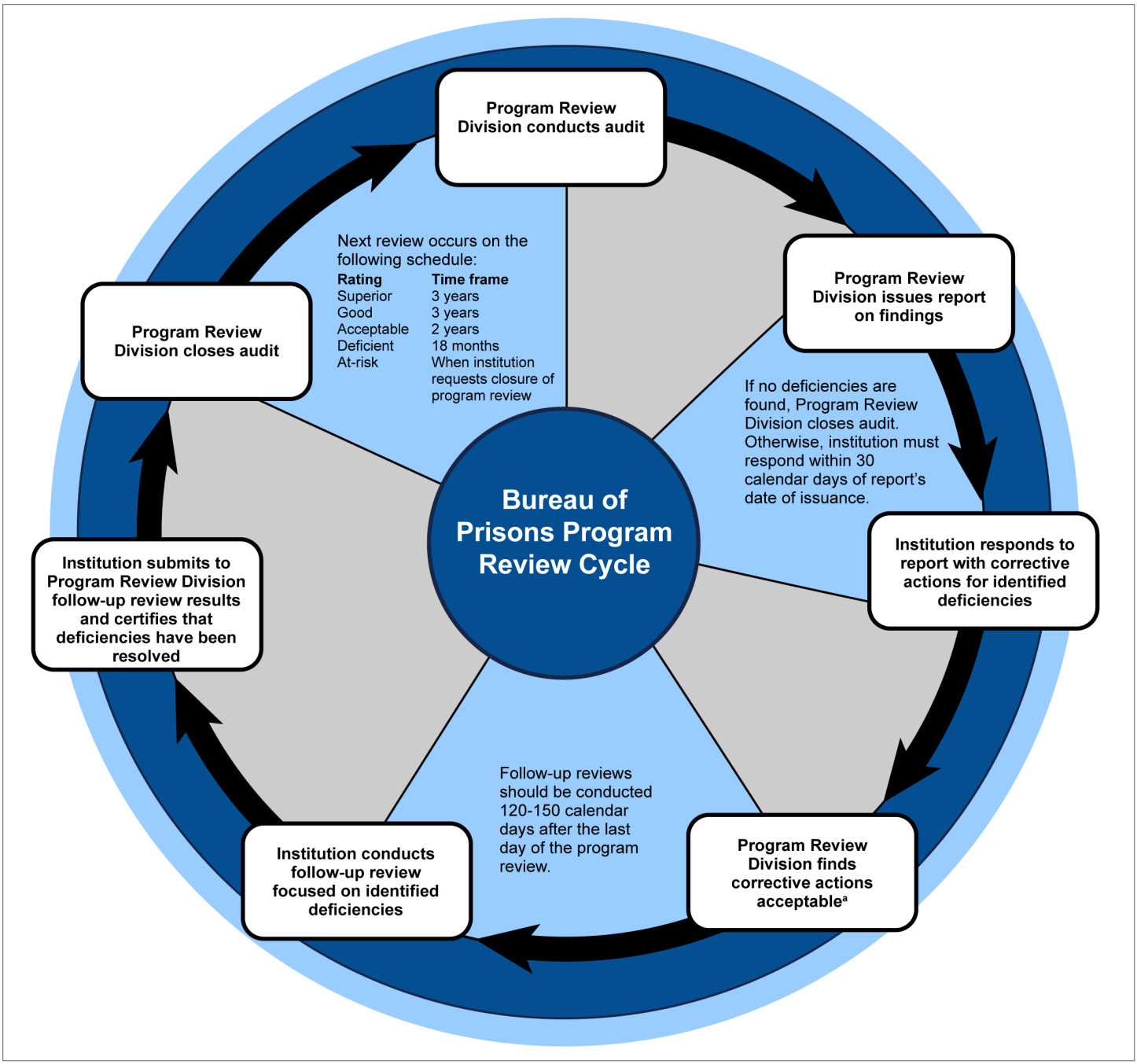
BOP's program review process includes elements that allow the agency to identify whether its institutions are complying with BOP's mental health services policies, and to be assured that institutions have corrected any problems that the review identified. (See fig. 2.) BOP's PRGs related to mental health services are developed jointly by either its Psychology Services Branch or its Health Services Division, as appropriate, and its Program Review Division. All of the steps in the PRGs link to specific BOP policies. For example, a psychology services PRG step that requires reviewers to look at a sample of intake screening interviews is based on the agency's policy that new inmates must receive an intake screening interview within 14 days of arrival, and that inmates' identified treatment

needs receive appropriate follow-up. The psychology services PRGs also contain steps to review any psychology treatment program, such as RDAP,[29] that an institution offers.[30] While not generalizable to all program reviews, the review teams conducting the two psychology services program reviews that we observed followed the applicable PRGs.

[29]RDAP targets inmates who volunteer for drug abuse treatment and have a verifiable and diagnosable substance abuse disorder.

[30]The psychology services PRGs do not contain program review steps related to sexual offender treatment programs because BOP issued the related program statement in February 2013, and had not yet developed PRG steps related to these programs. According to BOP officials, they anticipate that a meeting to develop PRGs related to these programs will occur in May 2013.

Figure 2: The Bureau of Prisons' Program Review Process



Source: GAO analysis of information from the Bureau of Prisons.

If a program review identifies a deficiency, BOP has a process in place to ensure that the institution takes action to correct the deficiency. Specifically, an institution must submit to the Program Review Division a corrective action plan or a certification by the warden that staff have resolved the deficiencies. Further, when an institution requests that a program review be closed, it must submit findings from a follow-up review that institution staff have conducted to demonstrate that their corrective actions have resolved the deficiency. Our review of the sample of 47 program review files found that institutions were generally following this process.

We found that most institutions in our sample received a good or superior rating in the psychology and health services program review reports we examined. Among those reviews we examined, about 89 percent and 77 percent of institutions, respectively, received a good or superior rating. The lowest rating among the psychology services program reviews was acceptable, while one institution received a deficient rating for its health services program review. The most common deficiencies cited in the psychology services program review reports related to the care provided in residential treatment programs,[31] and a variety of issues related to suicide risk assessments, suicide watch logs, and follow-up care after a suicide watch.[32] Examples of the deficiencies BOP reviewers found in psychology services and health services program reviews, as well as examples of corrective action steps to address them, are included in appendix VI.

We found BOP was not always in compliance with the time frames stated in its policies for when program reviews should occur. About 65 percent of the psychology services program reviews that we examined were not conducted within the time frame stated in BOP policy,[33] including about

[31]An example of a deficiency related to care provided in a residential treatment unit was that not all inmates who completed RDAP were enrolled in follow-up services in a timely manner. Inmates who complete the residential portion of RDAP are to receive follow-up services in their institution or in the community at a residential reentry center.

[32]A suicide risk assessment is a psychologist's assessment of an inmate's potential for suicide. Suicide watch logs are documentation of observations of an inmate's behavior while the inmate is on suicide watch. After each suicide watch, a psychologist completes a report that documents the guidelines for the inmate's follow-up care.

[33]The estimate is 66.0 percent. The differences in the reported estimates are due to rounding error. The associated 95 percent confidence interval is (54.3, 76.6).

23 percent that were more than 6 months late, based on the institution's prior ratings.[34] (See table 5.) For example, one institution that had received an acceptable rating—and therefore should have been reviewed 24 months later—did not get reviewed again for more than 38 months. Among the 47 health services program review reports that we examined, about 70 percent did not occur within BOP's established time frames, including 6 percent that occurred more than 6 months late.[35] According to BOP officials, institutions that do not receive timely program reviews are required to use their staff to conduct an internal operational review using the relevant PRGs,[36] which provides assurance to BOP that the institution is compliant with the agency's policies. However, these operational reviews do not provide the same level of independence provided through BOP's program review process.

Table 5: Timeliness of Bureau of Prisons (BOP) Psychology and Health Services Program Reviews

Percent				
	Review conducted on time (confidence interval)	**Less than 3 months late (confidence interval)**	**3 to 6 months late (confidence interval)**	**More than 6 months late (confidence interval)**
Psychology Services	34% (23.4-45.7%)	23% (14.9-34.0%)	19% (10.6-29.8%)	23% (14.9-34.0%)
Health Services	30 (20.2-41.5)	51 (41.5-64.9)	13 (5.3-20.2)	6 (3.2-14.9)

Source: GAO analysis of Bureau of Prisons' psychology and health services program review reports.

Notes: Numbers may not add to 100 percent because of rounding. We reviewed the most recent health and psychology services program review reports for 47 institutions and calculated the time

[34]The estimate is 23.4 percent. The associated 95 percent confidence interval is (14.9, 34.0).

[35]For the estimate of 70 percent, the confidence interval is 54.3 to 76.6 percent; and for the estimate of 6 percent , the confidence interval is 3.2 to 14.9 percent.

[36]BOP requires all institutions to conduct their own internal audits in each program area. These reviews, called operational reviews, use the same PRGs that are used by Program Review staff during their reviews. Operational reviews are expected to be conducted 10 to 14 months from the week of the previous program review. For those institutions with a good or superior rating, an additional operational program review should be conducted 22 to 26 months from the week of the previous program review. In addition, according to BOP officials, if a program review is delayed, the institution is still required to conduct an annual operational review.

elapsed between that review and the previous review. The 95 percent confidence intervals for the estimates are shown in parentheses.

According to BOP policy, institutions that previously received a superior or good rating are to be reviewed within 36 months. Institutions that received an acceptable rating are to be reviewed within 24 months, and institutions with a deficient rating are to be reviewed within 18 months.

Program Review officials told us that the tardiness of the program reviews was often due to staffing issues at the institution or within the Program Review Division. For example, one program review for an institution that had received an acceptable rating was delayed by 16 months, in part because one reviewer did not complete the required training in time to conduct the program review. Program Review officials told us that institutions can also request to postpone a review when, for example, a key staff position is vacant, such as the clinical director of the institution's health services unit. According to Program Review officials, when an institution requests a program review postponement, the Program Review Division considers the results of the institution's annual operational reviews to help determine whether it would be prudent to adjust the institution's review schedule.[37] Additionally, the Assistant Director for the Program Review Division approves any deviation in schedule.[38]

Although it is important that BOP officials review and approve postponements of program reviews, when reviews are postponed the delays can be lengthy, even for institutions with the lowest ratings. For example, BOP officials told us that to reduce travel costs, they delayed the review of an institution rated acceptable by 14 months to combine its review with that of another nearby institution's review. Of the 11

[37]BOP requires institutions to conduct their own internal audits in each program area. These reviews, called operational reviews, use the same PRGs that are used by Program Review staff during program reviews. Operational reviews should be conducted 10 to 14 months from the week of the previous program review. For those institutions with a good or superior rating, an additional operational program review should be conducted 22 to 26 months from the week of the previous program review. In addition, according to BOP officials, if a program review is delayed, the institution is required to conduct an internal operational review annually.

[38]We found that institutions were generally following the time frames specified in BOP policy with regard to the submission of corrective action plans. Among the 35 institutions that were required to submit corrective action plans in response to a psychology services program review, 33 submitted the plans within BOP's established time frame of 30 days. The remaining 2 submitted their corrective action plans within 10 additional days.

institutions in our sample with an acceptable rating in their prior psychology services program review, 4 received their next review more than 6 months late and 3 of those were more than a year late. In contrast, among the 36 institutions with a prior rating of good or superior, 7 had their next review more than 6 months late, including 2 more than a year late. Because institutions with an acceptable rating are to be reviewed within 24 months—compared to 36 months for facilities with higher ratings—a 1-year delay is potentially more problematic . According to *A Guide to the Project Management Body of Knowledge*, which provides standards for project managers, agencies should place the highest priority on oversight of facilities, programs, or operations that are most at risk of not meeting key performance objectives; in BOP's case this would be institutions with the lowest ratings.[39] Therefore, when scheduling postponed reviews, proper risk management would call for BOP to give highest priority to those institutions with the lowest ratings. Because delays in program reviews may hamper BOP's ability to adequately monitor inmate care, it is important for BOP to minimize delays, especially for the lowest-rated institutions. Furthermore, with BOP's inmate population expected to increase through 2020,[40] it will be even more important for BOP to ensure that it conducts timely program reviews to identify potential problems with access to care or compliance with its treatment policies that growing institutional crowding might exacerbate.

Program Review Division officials take steps to share information learned from program reviews with other relevant BOP officials. For example, officials from the Program Review Division and the chiefs of every division that they review, including the Psychology Services Branch and the Health Services Division, meet quarterly and discuss deficiencies identified during the previous quarter. Program Review officials also send wardens a summary that lists the most common deficiencies identified during the previous quarter's reviews to alert the wardens to focus attention on certain program areas. For example, a November 2012 quarterly report stated that the most frequent psychology services

[39]Project Management Institute, *A Guide to the Project Management Body of Knowledge (PMBOK® Guide), Fifth Edition.* We have used *A Guide to the Project Management Body of Knowledge* as criteria in previous reports, including *Nonproliferation and Disarmament Fund: State Should Better Assure the Effective Use of Program Authorities*, GAO-13-83.

[40]GAO, *Bureau of Prisons: Growing Inmate Crowding Negatively Affects Inmates, Staff, and Infrastructure*, GAO-12-743 (Washington, D.C.: Sept. 12, 2012).

deficiency cited was that not all mental health care level 3 inmates had a treatment plan or were being seen on a monthly basis.[41]

Additional Psychology Services Branch Reviews

Certification of Use of Modified Therapeutic Community Model: The Psychology Services Branch certifies new RDAPs and Challenge programs within 6 months of the treatment program becoming operational to ensure that the institution is adhering to the modified therapeutic community model of treatment. This model stresses values and behaviors that are needed in the outside community, such as responsibility to self and others, and thinking and acting in accordance with the norms of the community.

Source: GAO analysis of BOP information.

Remote Reviews: The Psychology Services Branch considers remote reviews to be a mechanism for the central office to provide ongoing technical assistance to institutions. Headquarters staff conduct the reviews and send the results to the institution.

Source: BOP Psychology Services.

An additional review activity that BOP's Psychology Services Branch conducts is certification reviews of 2 of the 10 current residential and nonresidential psychology treatment programs—RDAP and the Challenge Program.[42] The branch conducts the certification reviews to ensure that the program adheres to the 10 elements of a modified therapeutic community (MTC), the treatment model BOP uses for residential psychology treatment programs. (See app. VII for additional information on the elements of a MTC.) Psychology Services officials told us they would like to expand the certification process to all eight residential treatment programs, but expansion was contingent on securing additional funds for travel because the certification reviews are done at the program location.

The Psychology Services Branch is planning to implement remote reviews of treatment programs and has begun to implement remote reviews of clinical services. In March 2013, officials from Psychology Services told us they plan to implement procedures in 2013 for annual remote reviews for 9 of BOP's 10 residential and nonresidential treatment programs.[43] Staff plan to conduct these reviews from BOP's headquarters using electronic medical records; the reviews are expected to focus on areas such as staff utilization, treatment planning and services, and documentation quality. The Psychology Services Branch has also started to conduct remote reviews of selected clinical services provided. In early 2013, the Psychology Services Branch conducted a remote review of the mental health classification at each institution for inmates whose mental health care level did not appear to align with the level of care the inmate

[41]According to BOP guidance, a psychologist or psychiatrist should meet with all inmates classified as mental health care level 3 more frequently than monthly.

[42]The Challenge Program is a residential program designed to facilitate favorable institutional adjustment and successful reintegration into the community through the elimination of drug abuse or the management of mental illness. The Challenge Program targets high-security inmates with a history of drug abuse or a major mental illness. During the course of most of our review, BOP had 11 psychology treatment programs. At the end of fiscal year 2012, BOP discontinued one of its programs, the Habilitation Program.

[43]There are no remote review procedures for the Commitment and Treatment Program—a civil commitment treatment program for persons certified as sexually dangerous—because BOP has not yet issued a relevant program statement.

was receiving.[44] Psychology Services officials also plan to conduct remote reviews of suicide risk assessments to evaluate whether the assessments are well reasoned and, for at-risk inmates, treatment began when the inmate was on suicide watch.

External Accreditation Reviews Assess Whether BOP Is Meeting Established Standards of Care

In addition to requiring program reviews, BOP policy also requires institutions to obtain external accreditations to assess whether they are meeting external standards of care. ACA assesses all facets of correctional institutions, including mental health services, while The Joint Commission focuses on the services provided by the institution's Health Services Unit.

In both accreditation reviews, mental health care represents a small component of the review's overall focus. ACA identifies seven standards specific to mental health care, four of which are mandatory. For example, one standard specifies what should be covered during an inmate's mental health screening.[45] All of The Joint Commission's standards are mandatory. If, during the on-site review, examiners find insufficient compliance with a standard, the institution must submit documentation to The Joint Commission that it has resolved the issue prior to being granted full accreditation.

We reviewed the most recent ACA and ambulatory care Joint Commission accreditation reports for our sample of 47 institutions.[46] We

[44]For each institution, headquarters staff did a reclassification of one or two of the inmates who were receiving a level of care higher than their mental health care level designation indicated. Headquarters staff then sent these one or two examples of reclassification, along with a list of all inmates who may require reclassification at the institution, to the institution for further review.

[45]The other three mandatory standards relate to the required elements of an institution's mental health program, mental health screenings for inmates transferred from another institution within the same system, and suicide prevention plans. The three non-mandatory mental health standards relate to providers' credentials, the timeliness of certain mental health evaluations, and the placement of inmates with severe mental illness or developmental disorders.

[46]For the 47 institutions in our sample, we reviewed 37 Joint Commission accreditation reports. Nine of the 47 institutions were medical care level 1 institutions and therefore not required to be accredited by The Joint Commission. An additional institution changed from a Level 1 to a Level 2 institution and had not gone through accreditation. Level 1 institutions serve the healthiest inmates.

found limited findings related to mental health care in both the ACA and Joint Commission accreditation reports, meaning that the institutions generally were complying with applicable standards. Findings from our analysis are detailed in appendix VI.

We also reviewed the accreditation reports of the four BOP-operated institutions that have Joint Commission accreditations for behavioral health care. All four institutions received full accreditation. One of the institutions had no findings, and for two institutions, The Joint Commission examiners found that the suicide risk screenings did not specify the inmate's protective factors, which are factors that decrease an inmate's risk of suicide.

BOP Has Not Evaluated Most of Its Psychology Treatment Programs and Has Not Yet Developed a Plan To Do So

Evaluations: An evaluation determines whether a program is meeting its intended outcomes. Intended outcomes of psychology treatment programs could include lower recidivism rates, lower rates of misconduct, or better management of mental illness symptoms.

Source: GAO analysis of BOP information.

BOP's ORE has not evaluated and has not yet developed a plan to evaluate 7 of BOP's 10 treatment programs to assess whether they are meeting their established goals; of the 3 others, ORE completed two reviews over 11 years ago and has one under way. Evaluation can play a key role in program management, providing feedback on both program design and execution, and providing agencies with important information to improve performance.[47] ORE completed its review of RDAP in 2000 and the Bureau Rehabilitation and Values Enhancement (BRAVE) Program in 2001 and found positive results.[48] For example, inmates who participated in RDAP had less recidivism after 3 years of release than inmates who did not go through the program.[49] BOP used the results from ORE's RDAP and BRAVE evaluations in its budget justifications to support continued funding in these areas. In addition, ORE is currently

[47]GAO, Designing Evaluations, 2012 Revision, GAO-12-208G (Washington, D.C.: Jan. 2012).

[48]The BRAVE program, which addresses institutional adjustment, antisocial attitudes and behaviors, and motivation to change, is for inmates 32 years old and younger serving sentences of at least 60 months.

[49]Specifically, 44.3 percent of male inmates who completed RDAP were likely to be rearrested or have their supervision revoked because of a violation of their conditions of supervision within 3 years after release to supervision in the community. In comparison, 52.5 percent of inmates who did not receive treatment were rearrested or had their supervision revoked within 3 years. For women, 24.5 percent of those who completed RDAP were likely to be rearrested or have their supervision revoked within 3 years after release, compared with 29.7 percent of the untreated women. Among female inmates, the effect of treatment was not statistically significant. See Federal Bureau of Prisons, Office of Research and Evaluation, *TRIAD Drug Treatment Evaluation Project Final Report of Three-Year Outcomes: Part 1* (Washington, D.C.: 2000).

working on an evaluation of the Sex Offender Treatment Program.[50] ORE officials said this study will likely take a number of years because they are examining the program's effect on recidivism rates, which requires waiting until after the inmates have been released for some period of time.

BOP has not yet developed a plan for evaluating any additional psychology treatment programs. As part a statutory requirement, BOP is to provide an annual report containing statistics demonstrating the relative reductions in recidivism associated with major inmate programs (including residential drug treatment, vocational training, and prison industries programs).[51] After we provided a draft of this report to DOJ for comment, BOP officials told us they have begun to develop an approach to complete the first report, which they plan to submit to Congress in 2016. BOP officials said that as of June 2013, they were in the process of determining which psychology treatment programs to include in the 2016 report and could not provide us with documentation as to what programs they were considering or the criteria they would use to determine which programs would be included. Furthermore, BOP was unable to provide documentation as to whether the first report would focus solely on recidivism or whether the report would also include additional outcomes that these programs are intended to affect, such as inmate disciplinary actions or self-management of a mental illness.

Given the annual reporting requirement and the lack of clarity regarding how BOP intends to meet this reporting requirement, it is important that BOP develop a plan, within its available resources, for evaluating its psychology treatment programs. The plan would indicate whether the evaluations would focus solely on recidivism, or also include additional

[50]The Sex Offender Treatment Program is a high-intensity 12- to 18-month program designed for high-risk sexual offenders.

[51]Second Chance Act of 2007, Pub. L. No. 110-199, § 231, 122 Stat. 657, 683-86 (2008) (codified at 42 U.S.C. § 17541). By statute, the Director of BOP is to submit a report containing statistics demonstrating the relative reduction in recidivism for inmates released by the BOP within that fiscal year and the 2 prior fiscal years, comparing inmates who participated in major inmate programs (including residential drug treatment, vocational training, and prison industries) with inmates who did not participate in such programs. The Director of BOP is to select a measure for recidivism (such as rearrest, reincarceration, or any other valid, evidence-based measure) that the Director considers appropriate and that is consistent with the research undertaken by the Bureau of Justice Statistics under statute. Further, the report is not required to include statistics for a fiscal year that begins before April 9, 2008. According to BOP, subsequent to the Second Chance Act of 2007, BOP was appropriated $2.6 million to conduct the activities related to the report.

outcomes. Standard practices for project management call for agencies to define specific goals in a plan, as well as to describe how the goals and objectives are to be achieved; including identifying the needed resources and target time frames for achieving desired results.[52] With a plan, BOP could have greater assurance that the activities necessary to conduct the evaluations of the psychology treatment programs, as well as any needed program changes that may be identified during those evaluations, would be completed in a timely manner.

BOP Program Statements Related to Mental Health Services Contain Outdated Information

More than half of the BOP program statements—which outline BOP's formal policies and procedures—related to mental health services are out of date, despite BOP's acknowledgment that policies need to be current. Five of the eight program statements we identified as related to inmate mental health services have not been updated within the past 5 years, including two that have not been updated in 18 years (see app. VIII).[53] For example, although BOP's psychology services program statement states that it "is periodically updated to reflect the rapidly changing nature of professional psychology within a correctional setting," BOP has not updated the statement since 1995.

Psychology Services officials told us that they want to update the program statements for psychology services and institution management of mentally ill inmates, both of which were last updated in 1995. BOP needs to negotiate with its union on all changes to existing program statements that affect the conditions of employment of members of the collective bargaining unit, if the unit chooses to negotiate. Until recently, BOP, in conjunction with the union, has placed a higher priority on negotiating other program statements. In May 2013, the union and BOP came to an agreement to restart the negotiation process and BOP's Psychology Services Branch was drafting changes to the two program statements.

[52]Project Management Institute, *A Guide to the Project Management Body of Knowledge (PMBOK® Guide), Fifth Edition.*

[53]The two program statements that have not been updated since 1995 are the program statement that serves as the Psychology Services Manual, which establishes policies, procedures, and guidelines for the provision of psychology services throughout BOP, and the program statement on institution management of mentally ill inmates, which establishes policies, procedures, and guidelines for the management of mentally ill inmates at regular (i.e., nonmedical) correctional institutions.

However, until program statements are updated, they will continue to contain information that does not reflect current practices or relates to systems or processes that are no longer in use. For example, in the 18 years since the program statements for psychology services and institution management of mentally ill inmates were last updated, BOP's total inmate population increased significantly; BOP revamped its system for assessing and classifying mental illness in the inmate population; and several new medications, programs, and treatment models have been established. The outdated program statements, which officially articulate BOP policy, also do not reflect important developments in the provision of mental health services, such as the increased emphasis on evidence-based treatments.

According to the BOP program statement on management directives, program statements serve as the formal policies guiding agency operations, thereby setting the expectations for how BOP-operated institutions should operate. BOP states that less formal documents, such as memos, should generally not be used to communicate requirements or instructions because these documents are not authenticated, numbered, annually reviewed, or historically traced. We found, however, that in the absence of officially updated policy in key areas related to mental health services, the Psychology Services Branch is relying on internal memos to implement some changes. For example, in 2009, BOP's assistant directors for the Correctional Programs Division and the Health Services Division issued a memo to all wardens to implement the newly established mental health care level designations for inmates. The memo contains the necessary details about how inmates should be designated to the four different mental health care levels, making obsolete the elements of the program statement that describe an older inmate classification system. Formally documented policies and procedures provide guidance to staff in the performance of their duties and help to ensure activities are performed consistently across an agency, according to the standards for internal controls in the federal government.[54] Standards for internal controls also require that agencies regularly review their policies and procedures and update as necessary.

BOP officials said they plan to update the agency's outdated program statements and implement the revised program statements, but have not

[54]GAO/AIMD-00-21.3.1.

said when this process will begin or when it will be completed. Taking action to update and implement its program statements regarding inmate mental health care would help BOP better position itself to ensure consistent adherence to policies and reduce any confusion that may alter the provision or quality of inmate mental health care. By updating the program statements, BOP reduces the risk of, among other things, having psychology staff not understanding their required duties and inconsistently implementing treatment program activities, which may lead to unintended variation in services and outcomes for inmates across BOP-operated institutions.

BOP Does Not Track Contractors' Costs of Providing Inmate Mental Health Services but Does Assess Compliance with Requirements and Standards of Care

BOP does not track its contractors' costs of providing mental health services to the 13 percent of BOP inmates housed in privately managed facilities. The performance-based,[55] fixed-price contracts that govern the operation of BOP's privately managed facilities give flexibility to the contractors to decide how to provide mental health services. Nevertheless, BOP assesses the contractors' compliance with contract requirements and accreditation standards related to mental health through Contract Facility Monitoring (CFM) reviews, external accreditation reviews, and other reviews.

BOP Does Not Track Contractors' Cost of Providing Inmate Mental Health Services in Contract Facilities

BOP tracks the overall daily cost for housing the 13 percent of federal inmates—who are generally designated as mental health care level 1—in its 15 contract facilities, but BOP does not track the specific costs of providing mental health services to these inmates. This is because the BOP contracts that govern the operation of these privately managed facilities are performance-based, fixed-price contracts that only require the contractors to provide BOP with their costs on a per inmate per day basis.[56] According to officials from BOP's Administration Division, which

[55]According to BOP, performance-based contracts generally establish the performance standards for the contractor, including those related to mental health services, and it is up to the individual contractors to determine how they will meet those standards. BOP's fixed-priced contracts only require the contractors to provide BOP with their costs on a per inmate per day basis.

[56]This daily rate covers all the costs the facility incurs to house the inmate, including for mental health services. BOP inmates housed in contract facilities are designated as a low security level, and most have a mental health care level designation of 1 or 2.

oversees contracting for BOP, the structure of the fixed-price contract model prohibits BOP from asking contractors to provide more specific cost information. While other contract models exist, guidance from the Office of Federal Procurement Policy within the Office of Management and Budget encourages agencies to issue fixed-price contracts, when appropriate, because they provide greater incentive for the contractor to control costs and perform efficiently.

BOP officials told us that because the contracts are performance-based, when contractors do not meet the terms of work in the fixed-price contract, BOP reduces the contract price to reflect the value of the services actually performed.[57] BOP officials told us they have done this for deficiencies related to mental health. For example, BOP officials stated that from 2008 to present, they imposed deductions ranging from over $75,000 to $1,000,000 on contractors for 91 deficiencies, including 6 for mental health, found during the CFM reviews. The mental health deficiencies that make up some of these deductions were mostly related to mental health screenings not being completed in a timely manner or in accordance with standards.

Two of the three BOP contractors we spoke with—which are the primary contractors responsible for operations at 11 of the 15 private facilities[58]—said that they track mental health services costs internally and take them into account when calculating the per diem inmate cost they use when bidding for BOP contracts.[59] Additionally, two of the primary contractors told us that they subcontract for health services, including mental health services, and do not know the subcontractors' specific cost for providing mental health services. We spoke with one subcontractor that told us it tracks these costs internally. We requested this cost information from that subcontractor and two of the three primary contractors we spoke with, but

[57]Pursuant to the contract and the Federal Acquisition Regulation, 48 C.F. R. § 52.246-4, if any of the services do not conform with contract requirements and the defects in services cannot be corrected by performance, the government may reduce the contract price to reflect the reduced value of the services performed.

[58]One of the contractor companies operates several private facilities, but for two of those facilities it acts as a subcontractor to operate the facility. Throughout this report we will refer to this company as a primary contractor.

[59]We did not speak to one primary contractor that manages 1 of BOP's 15 contract facilities: the contractor declined to participate in interviews because the contract was terminated as of May 31, 2013.

were unable to obtain this information because the contractors consider it proprietary and confidential.[60]

BOP Assesses Compliance with Mental Health Requirements and Standards in Several Ways

BOP uses a number of approaches to assess each contractor's compliance with its mental health requirements and standards. These include CFM reviews; reports from external reviews that accrediting bodies perform; reports from internal reviews that the contractors conduct; and the monthly, less formal inspections and continuous monitoring activities performed by the two to four BOP staff stationed on-site at each privately managed facility—one of whom is a contracting officer. BOP officials stated that the combination of these various accountability mechanisms gives them assurance that the contract facilities are providing the appropriate mental health services to federal inmates.

BOP's Contract Facility Monitoring Reviews

BOP conducts annual on-site CFM reviews at each contract facility, the objective of which is to assess whether the contract facilities are meeting performance outcomes outlined in the contract. Following a CFM review, BOP issues a report to the facility noting deficiencies and findings from the review.

With respect to mental health, each contract requires that "all inmates are [to be] screened for mental health, substance abuse, and other behavioral problems and receive appropriate intervention, treatment, and programs to promote a healthy, safe, and secure environment." According to BOP, this language is more generic than prescriptive because of the contracts' performance-based nature. The contract also specifies that private facilities must obtain and maintain ACA and Joint Commission accreditation. BOP officials told us that while BOP gives contractors discretion in deciding how to deliver mental health services—and does not dictate adherence to BOP's mental health policies—they believe that requiring contractors to achieve and sustain the same accreditations as BOP institutions helps ensure a high level of service.

BOP developed a Quality Assurance Plan that sets out the areas that BOP is to assess during the CFM reviews. The plan includes auditing

[60]We did not request cost information from one contractor because a subcontractor provides mental health services in its BOP contract facilities; this subcontractor is not the same subcontractor we interviewed.

check lists that cover the spectrum of services that BOP requires its contractors to provide, and includes six specific steps for assessing contractors' provision of mental health services. BOP staff with expertise in medical and mental health issues are part of the review team conducting the reviews, and the six steps include components such as checking that all inmates are screened for mental health, substance abuse, and other behavioral problems and receive appropriate intervention, treatment, and programs.

BOP's CFM process is designed to determine overall contractor performance. Our review of the recent CFM reports for all 15 private facilities, related discussions with three primary contractors that manage 14 of BOP's 15 contract facilities and one subcontractor, and our direct observation of a CFM review at 1 contract facility found that the process generally was implemented in accordance with policy. In addition, our review of the CFM review time frames for the 15 contract facilities from 2008 through 2012 found that the reviews are generally taking place on time, with each facility being reviewed at least once annually.

According to BOP officials, they track and characterize the deficiencies from the CFM reports at a high level, such as whether they are related to health services, but they do not specifically track whether those deficiencies are related to mental health. Across the CFM review reports we assessed, we found four policy areas where deficiencies that could be related to mental health services were cited at more than 1 facility—Inmate Classification and Program Review, Health Information Management, Patient Care, and Medical Designation and Referral Services for federal Inmates.[61] In particular, the deficiencies in these policy areas involve the identification and documentation of inmate program needs; inmate health records having missing, incomplete, or inaccurate information; and health documents not being written so that correctional staff can understand the inmate's health needs. Inmate program needs, inmate health records, and other health documents may include mental health information. For more information on the deficiencies BOP identified in the CFM reports, see appendix VI.

[61]In conducting our analysis, we determined that a deficiency was related to mental health if it involved psychology, psychiatry, or pharmacy care, as these areas have relevance to the provision of mental health services.

On completion of the CFM, BOP reviewers provide the contract facility with their report. BOP requires the contract facility to prepare a corrective action plan within 30 days and submit it to the on-site monitors and BOP Privatization Management Branch. BOP's on-site staff review the corrective action plan, and if they accept the plan, they oversee its implementation to ensure that the facility is taking action and that the actions appropriately address the deficiency. Our conversations with the on-site monitors indicated that this oversight is taking place at the locations we visited. Our analysis found that of the 100 CFM reviews conducted from 2008 through 2012 that required a contract facility to submit a corrective action plan, 16 were not submitted within the 30 days. However, those that missed the deadline were all submitted no later than 2 months after the specified deadline. If the on-site staff reject the plan, they can discuss issues with the contract facility staff and supervisors within BOP's Privatization Management Branch—which oversees contractor compliance—to provide feedback so the contractor can make needed changes and resubmit the plan for approval. If BOP continues to have concerns about the corrective action plan, it can file a "notice of concern." However, BOP officials told us this is a rare occurrence that has not happened recently because most contractors have been working with BOP for some time and are familiar with the contract requirements. BOP officials also told us that all the staff involved with overseeing contractor compliance meet regularly to discuss any common findings and observations from the CFM reviews and the corresponding corrective action plans. They said the objective of their discussions is to ensure that staff are aware of the findings and to facilitate any future changes to the structure of the contracts that the Privatization Management Branch staff may need to undertake to address some of these issues.

External Accreditation Reviews by ACA and Joint Commission

Like BOP-operated facilities, contract facilities are also required to obtain ACA and Joint Commission accreditations and are assessed under the same standards, and contract facilities must be accredited no later than 24 months after becoming operational. According to BOP officials, establishing a 24-month window for contract facilities to receive accreditation is appropriate because this is consistent with the requirements for BOP facilities. Once a contract facility is accredited, both ACA and The Joint Commission evaluate it once every 3 years to substantiate continued accreditation. As of April 2013, 13 of the 15 BOP contract facilities have received ACA and Joint Commission accreditations. The 2 contract facilities that have not received ACA and Joint Commission accreditations became operational in 2011 and therefore must undergo their reviews in 2013 to meet the contract's requirements.

Once ACA and The Joint Commission complete their respective reviews, they provide BOP with copies of their reports to verify that the contract facility is in compliance with the accreditation standards. If the facility is not compliant with any of the standards, BOP requires the contract facility to develop and submit to both BOP's on-site staff and the Privatization Management Branch a corrective action plan that outlines the changes the facility is making to comply with the accreditation standards. The on-site staff review the plan and verify that the corrective actions have been implemented. ACA and The Joint Commission also require the contractors to provide them with copies of the respective corrective action plans, and each accrediting body conducts its own follow-up to confirm that actions have been taken before finalizing an accreditation decision.

Our analysis of the most recent ACA accreditation reports for the 13 contract facilities that were reviewed found that all but one of the facilities were compliant with all ACA standards related to mental health services, including pharmacy care, psychology, and psychiatry services. The facility that was found not compliant with all of ACA's mental health-related standards was as a result of the facility's failure to develop and utilize a health care staffing plan and the reviewers' related concerns about the mental health staffing levels at the facility.[62] Our review of the most recent Joint Commission accreditation reports found that 6 of the 13 contract facilities were fully in compliance with the ambulatory care standards we determined were related to mental health services—a small subset of the 192 standards by which they are assessed. The Joint Commission found the remaining 7 facilities to be either partially or insufficiently compliant with these standards.[63] The areas related to mental health in ambulatory care accreditation standards that were most frequently cited include medication management, such as medication labeling and storage issues, and the lack of documentation of the competency of medical staff, including mental health staff. In addition to the ambulatory care accreditation that contract facilities are required to obtain, 1 of the 7 facilities specifically chose to also be accredited on behavioral health

[62]This contract facility had since submitted its corrective action plan to ACA and was granted reaccreditation.

[63]According to The Joint Commission, a facility is found to be partially compliant if it has two occurrences of noncompliance with the standard's area during the review. A facility is found to be insufficiently compliant with the standards if it has three or more occurrences of noncompliance in the standard's area during the review. As a part of the scoring, The Joint Commission considers the potential risk to patient care or safety for noncompliance.

standards, and that facility was found to be insufficiently compliant with 3 of those standards.[64] These compliance issues related to: inmate assessments not including information on addictions other than alcohol or drugs; inmate treatment plans not including goals and metrics to measure an inmate's progress; and the lack of documentation of an assessment of clinical competence for staff being hired.[65] For more information on the specific ambulatory care and behavioral health standards for which the contract facilities were not in compliance, see appendix VI.

Contractor Internal Assessments and Quality Control Plans

In addition to accreditation and its own reviews, BOP conducts oversight of contract facilities by requiring them to conduct routine internal assessments of their operations. BOP requires contractors to develop a Quality Control Plan, which serves as the basis for these internal reviews, and to share the results of their reviews with the BOP on-site monitors, who verify in their monthly reviews that the internal reviews have occurred. According to officials from the contractors that manage 14 of BOP's 15 contract facilities, when they develop their Quality Control Plans, they generally use BOP policies and accreditation standards as a resource to ensure that the company's policies either meet or exceed BOP's own standards. For example, one contractor noted that it requires inmates who have just completed suicide watches to be seen by a mental health provider daily for the first 5 days, weekly for the next 2 months, and then monthly thereafter. This requirement is more specific than BOP's own policies, which leave discretion to the chief psychologist to determine how frequently an inmate needs to be seen by mental health staff.[66]

According to BOP officials, the contractors' Quality Control Plans are much more detailed than BOP's Quality Assurance Plan because the contractors are monitoring many more areas than BOP does in order to

[64]The ambulatory care accreditation covers the broad categories of surgical, medical/dental, and diagnostic/therapeutic services, and represents a variety of settings, including outpatient hospitals and prisons. The behavioral health accreditation focuses on organizations that provide services to persons with intellectual and developmental disabilities, as well as mental health and chemical dependency services.

[65]As of April 2013, all 7 of the facilities that had been found to be either partially or insufficiently compliant with Joint Commission standards have since submitted their corrective action plans to The Joint Commission and were granted reaccreditation.

[66]According to the contractor, it wanted to have more specific time frames because it relies more on master's-level clinicians than on the doctoral-level clinicians more prevalent at BOP institutions.

ensure they are properly prepared for BOP's review. Our review of the Quality Control Plans that we received from two of the three primary contractors and the subcontractor we spoke with found that all of their Quality Control Plans had mental health-related elements that were aligned with those in BOP's Quality Assurance Plan, and two of the three plans assessed additional areas beyond those established in BOP's plan. For example, each of the Quality Control Plans contained steps to review psychological assessments of inmates in the special housing units, which are also included in BOP's plan. An example of a plan going beyond BOP's plan is that one contractor has reviewers evaluate inmate medical records to determine whether the psychiatrist documented that less restrictive treatment options have been exercised without success.

Conclusions

Providing mental health services to the federal inmate population is an important part of BOP's broader mission to safely, humanely, and securely confine offenders in prisons and community-based facilities. As BOP's inmate population has grown, so have its costs for mental health services. Likewise, as the inmate population is projected to continue to increase and BOP plans to continue maximizing inmate participation in its treatment programs, it is expected that future costs for mental health services will also rise. Given the fiscal pressures facing BOP—as with the rest of the government—it is critical that the agency focus its efforts on ensuring the prudent use of resources.

At the same time, it is important for BOP to provide mental health services that comply with its internal policies and external accreditation requirements. Program reviews provide important insight into whether these requirements are being met and inmates are being provided the appropriate services. We found that BOP was frequently unable to complete required monitoring within its own established time frames. To its credit, BOP schedules program reviews with the intention that those institutions with the lowest ratings are reviewed more frequently, and any delays in reviews require approval by BOP officials. However, when reviews are postponed, the delays can be lengthy—sometimes over a year—even for those institutions with the lowest ratings. Because delays in program reviews hamper BOP's ability to adequately monitor inmate care, when scheduling postponed reviews BOP should take action to minimize delays and give highest priority to those institutions with the lowest ratings.

BOP would have greater assurance that it is effectively using its resources if it had better information on whether the programs were

meeting their intended objectives and if any program changes were needed. While BOP has evaluated a few, but not all, of its psychology treatment programs and is in the process of determining what information to include in its statutorily required report related to recidivism, it would be beneficial for BOP to develop a plan that identifies the resources necessary and target time frames to carry out future evaluations specifically related to psychology treatment programs, consistent with standards for project management. With such a plan, BOP would have greater assurance that the activities necessary to conduct the evaluations of the psychology treatment programs, and any needed changes identified through the evaluations, would be completed in a timely manner.

Finally, BOP has many outdated program statements related to mental health services, including two which are more than 15 years old. According to BOP, program statements serve as the formal policies guiding agency operations across the entire federal prison system, setting the foundation for how all institutions should operate. BOP policy states that less formal documents, such as memos, should generally not be used to communicate requirements or instructions, yet BOP is relying on internal memos to implement some key policy changes. By updating and implementing mental health care-related program statements, BOP would better ensure that its policies reflect currently accepted treatment practices and standards. This would also ensure that all BOP staff have a common set of guidelines to direct their activities, which would also better ensure appropriate services and outcomes for inmates across BOP-operated institutions.

Recommendations for Executive Action

To improve BOP's ability to oversee BOP-operated institutions' compliance with inmate mental health policies and monitor the effectiveness of treatment programs for mentally ill inmates, we recommend that the Director of BOP take the following two actions:

- when program reviews are delayed, ensure institutions with the lowest ratings receive the highest priority for the completion of reviews; and
- develop a plan to carry out future evaluations of BOP's psychology treatment programs, within available resources; the plan should include the identification of necessary resources and target time frames.

To ensure policies related to inmate mental health care accurately reflect current practices, we recommend that the Director of BOP take the following action:

- develop and implement updated program statements to ensure that these statements reflect currently accepted treatment practices and standards.

Agency Comments and Our Evaluation

We provided a draft of this report to DOJ for review and comment. DOJ did not provide official written comments to include in this report. However, in an e-mail received on June 27, 2013, a BOP audit liaison official stated that BOP concurred with the first and third recommendations and partially concurred with the second recommendation, which called for the Director of BOP to assess which psychology treatment programs could be evaluated within the agency's existing resources and develop a plan to conduct future evaluations. After we provided the draft to DOJ for comment, BOP provided additional information about its program evaluation plans, which we reviewed and incorporated in this report as appropriate.

Specifically, as part of the additional information, BOP officials stated that the agency is in the process of developing an approach to assess which additional programs to evaluate. According to the BOP officials, as of June 2013, they are making plans to complete the first report required under the Second Chance Act of 2007 and are in the process of determining which psychology treatment programs to include in the report. However, BOP officials could not provide any documentation as to the criteria to be used in selecting which programs would be included in the report or whether the report would include information on outcomes, in addition to the required outcome on recidivism. After evaluating the additional information BOP provided, we modified the second recommendation to reflect the assessments and planning discussions that BOP has under way and to highlight the importance of developing a plan, including elements such as time frames, for such evaluations.

BOP also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the Director of BOP, selected congressional committees, and other interested parties. In addition, this

report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any further questions about this report, please contact Dave Maurer at (202) 512-9627 or MaurerD@gao.gov, or Debra A. Draper at (202) 512-7114 or DraperD@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Key contributors to this report are listed in appendix IX.

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Appendix I: Objectives, Scope, and Methodology

Our objectives for this report were to address the following questions:

1. What have the costs been to provide mental health services in Bureau of Prisons (BOP)-operated institutions over the past 5 fiscal years, and what are the projected costs?
2. To what extent does BOP assess whether BOP-operated institutions comply with BOP policies for providing inmate mental health services?
3. To what extent does BOP track the costs of providing mental health services to BOP inmates in contract facilities, and to what extent does BOP assess whether these facilities meet contract requirements, including standards of care for inmate mental health services?

To address the question on the BOP's costs over the past 5 fiscal years and projected costs to provide inmate mental health services in BOP-operated institutions, we interviewed officials from BOP's Administrative Division, Psychology Services Branch, and Health Services Division to understand what constitutes mental health services, what costs are relevant to providing these services, what factors drive changes in cost, and BOP's current practices for developing budgets and expenditure plans in these areas. Because BOP does not report a comprehensive mental health services cost, as costs are included in two BOP divisions (the Health Services Division and the Correctional Programs Division), we analyzed obligated funds for fiscal years 2008 through 2012 for these two divisions. Specifically, within Health Services, we examined obligations for psychiatry staff and for pharmaceuticals, including psychotropic medication. Within Correctional Programs, we looked at the obligated funds for Psychology Services, psychology staff training, drug abuse treatment programs, and Sex Offender Management Programs. To determine the per capita costs for the same time period, we divided the total cost by the inmate population at the end of the fiscal year in all BOP-operated institutions. In addition, to project future costs, we discussed with these same officials their methods for cost projections and independently examined BOP's population projection and expected staffing positions for fiscal years 2013 through 2015. We limited our projections to 3 years, since the further into the future an estimate is, the less reliable it becomes. Additionally, there could be future changes in law or agency initiatives that may significantly impact the integrity of longer-term projections. To determine projected costs, we used the total cost of inmate mental health services for fiscal year 2012 as the baseline, and

adjusted this by BOP's projected population and the IHS Global Insight Outlook inflation factor.[1] For the projected per capita costs, we divided the projected cost by the projected population. To assess the reliability of BOP's obligation data, we (1) performed electronic data testing and looked for obvious errors in accuracy and completeness, and (2) interviewed agency officials knowledgeable about BOP's budget to determine the processes in place to ensure the integrity of the data. We determined that the data were sufficiently reliable for the purposes of this report.

To address the question on the extent to which BOP assesses whether BOP-operated institutions comply with BOP policies for providing inmate mental health services, we reviewed all relevant policies and program statements related to mental health services provided to inmates. Program statements outline BOP's formal policies and procedures. We also met with BOP officials responsible for oversight in the Psychology Services Branch, Health Services Division, and Program Review Division to understand each unit's oversight activities and how the units communicate with each other and with institution staff. We compared BOP's policies for inmate mental health care and processes for monitoring the provision of inmate mental health care at the institution level with the Standards for Internal Control in the Federal Government and risk management principles.[2] We conducted site visits to two institutions because they serve inmate populations with significant mental health care needs—one institution with several psychology treatment programs and another with a level 4 mental health care designation.[3] During each of these site visits, we discussed with institution staff the programming provided to inmates with mental health conditions and the institution's experience with BOP oversight activities. Although not generalizable, the visits provided important insights into the services

[1]IHS Global Insight is a firm that provides comprehensive economic and financial information on countries, regions, and industries.

[2]GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999), and Project Management Institute, *A Guide to the Project Management Body of Knowledge, Fifth Edition* © (Newtown Square, Pennsylvania: 2013). *A Guide to the Project Management Body of Knowledge* provides standards for project managers.

[3]Institution mental health care levels range from 1 to 4, with 1 being institutions that care for the healthiest inmates and 4 being institutions that care for inmates with the most acute needs.

provided to inmates and oversight of staff working at the institutional level. We also interviewed officials from BOP's Office of Research and Evaluation (ORE) to determine what evaluations ORE has conducted of psychology treatment programs in the past and what evaluations are ongoing or planned for the future. We assessed BOP's evaluation planning against project management standards.

To understand BOP's program review process, and the psychology and health services findings from recent program reviews, we conducted additional site visits to two institutions for the purpose of shadowing program review staff as they performed a psychology services program review. We chose the two institutions because they provided different levels of care—one institution was a mental health care level 4 and another was a mental health care level 1—and because the program reviews were being conducted within the time frame of our study. While the observations from these visits are not generalizable to all BOP institutions or to all program reviews, the visits provided important insights into the program review process.

In addition, we conducted a content analysis of recent psychology and health services program review reports. To conduct the content analyses, we selected a simple random sample of 47 BOP institutions from the study population of 94 BOP institutions that had been operating long enough to undergo a program review as of August 31, 2012.[4] Because we followed a probability procedure based on random selections, our sample is only one of a large number of samples that we might have drawn. Since each sample could have provided different estimates, we express our confidence in the precision of our particular sample's results as a 95 percent confidence interval (e.g., plus or minus 7 percentage points). This is the interval that would contain the actual population value for 95 percent of the samples we could have drawn. Due to the small size

[4]In some cases, a number of institutions belong to a Federal Correctional Complex (FCC). At FCCs, multiple institutions with different missions and security levels are located in proximity to one another. For an FCC, BOP performs one program review for the entire complex, and not for the individual institutions that make up the complex. For purposes of this report, we use the term *institution* to refer to either a single institution or a complex of institutions that is considered a single unit for program review purposes. Therefore, BOP conducted 94 program reviews for the 116 institutions that had been operating long enough to undergo a program review as of August 31, 2012. Three additional institutions were not operating long enough to undergo a program review as of August 31, 2012. Program reviews begin at an institution 18 to 24 months after the institution opens.

of the population, we used a hypergeometric distribution to estimate the 95 percent confidence intervals for our sample estimates.[5]

For each of the 47 institutions included in our sample, we received from BOP the most recent psychology and health services program review reports. In order to minimize the chance of nonsampling errors occurring in our file review, we took the following steps. A GAO analyst first reviewed each psychology and health services program review report to capture the dates of each review to determine the timeliness of the review in relation to the previous review, and the deficiencies identified in the final program review report. BOP defines deficiencies as deviations from policy or regulation, weaknesses in internal controls, or lack of quality controls. A separate GAO analyst verified each of the data elements collected. Our content analysis captured all deficiencies cited in psychology services reviews and deficiencies related to pharmacy and psychiatry in health services reviews. A GAO analyst independently created categories for the psychology and health services deficiencies and then sorted the deficiencies into the applicable categories. A separate GAO analyst verified the categorization of the psychology and health services deficiencies. For psychology services program review reports, we also received and reviewed additional documentation from BOP including (1) institutional responses to the program review's findings (which include a corrective action plan to address any identified deficiencies), (2) the Program Review Division's acceptance of the institution's submitted corrective actions, (3) the institution's submission of results from a follow-up audit conducted by institution staff to ensure that deficiencies were resolved, and (4) the Program Review Division's closure of the program review. According to this additional documentation, we determined whether institutions were submitting their corrective action plans and follow-up audit results in accordance with BOP policy. We also reported illustrative examples of deficiencies and the corrective action plans that institutions developed to address deficiencies. We did not review this additional documentation from the health services program review reports because most of the deficiencies cited in the reports were unrelated to inmate mental health care.

[5]The hypergeometric distribution is used when sampling without replacement from a small population whose elements can be classified into two mutually exclusive categories (i.e., Yes/No).

To understand the accreditation process for BOP institutions, we interviewed officials and reviewed standards from the American Correctional Association (ACA) and The Joint Commission, the two accrediting organizations for BOP institutions.[6] We also interviewed an official from the National Commission on Correctional Health Care, another organization that accredits correctional health care programs, to understand differences in standards among the three accrediting organizations. We conducted a content analysis of the most recent ambulatory care accreditation reports from ACA and The Joint Commission for the same random sample of institutions that we used for the analysis of program reviews. We reviewed 37 Joint Commission ambulatory care accreditation reports.[7] For our review of the ambulatory care accreditation reports, we focused on findings related to psychiatry and pharmacy care, as these were the areas covered by the review most applicable to inmate mental health care. The Joint Commission's accreditation is for those services provided by the institution's health services unit and does not include psychology services. Because of the level of detail presented in the reports, findings related to pharmacy care are not specific to the administration of psychotropic drugs. We also reviewed the findings from The Joint Commission's behavioral health accreditation reports for the four BOP institutions with behavioral health accreditations.

We interviewed officials from the union representing BOP correctional workers who are involved in contract negotiations to gain an understanding of the negotiation process required to institute changes to mental health-related policies. Finally, to obtain context about correctional mental health programs, we interviewed correctional mental health experts, including representatives from the American Psychological Association, academics, and practitioners who have worked in the correctional setting. While the views of these experts are not

[6]ACA's mission includes the development and promotion of effective standards for the care, custody, training, and treatment of offenders. The Joint Commission accredits and certifies health care organizations and programs in the United States.

[7]As with program reviews, a single accreditation report may cover either a single institution or a complex with multiple institutions. For the 47 institutions in our sample, we analyzed 37 Joint Commission accreditation reports. Nine of the 47 institutions were medical care level 1 institutions and therefore are not required to be accredited by The Joint Commission. An additional institution changed from a level 1 to a level 2 institution and had not gone through accreditation. Level 1 institutions serve the healthiest inmates.

representative of all correctional mental health experts, they provided us with perspectives on BOP's inmate mental health care system.

To address the question about the extent to which BOP tracks the costs of providing mental health services to BOP inmates in contract facilities, and the extent to which BOP assesses whether these facilities meet contract requirements and established accreditation standards for inmate mental health services, we reviewed the contracts for all of the 15 contract facilities that housed BOP inmates during the course of our review to see what cost information they included. We also reviewed federal guidance from the Office of Management and Budget on recommended contracting mechanisms for federal agencies.[8] We spoke with BOP officials responsible for procurement and the contracting process as well as each of the three primary contractors that operate 14 of BOP's 15 contract facilities,[9] and one of the subcontractors that provides mental health services for one of the primary contractors to discuss the extent to which they track the costs of providing mental health services to inmates in contract facilities. One primary contractor that managed 1 of BOP's 15 contract facilities declined to participate in interviews because the contract was terminated as of May 31, 2013.

To understand BOP's requirements for the provision of mental health services and oversight activities for the contract facilities, we reviewed each contract for the 15 contract facilities. We also reviewed BOP's Quality Assurance Plan, the contractors' Quality Control Plans, and the ACA and Joint Commission accreditation standards to identify the policies and procedures related to mental health that guide the various reviews of contract facility operations. We also reviewed the most recent contract facility monitoring reports, and ACA and Joint Commission accreditation review reports to determine the deficiencies identified that may be related to mental health. We also met with officials from BOP's Administration Division, Privatization Management Branch, and Program Review Division who are responsible for overseeing contracts to understand each

[8]Executive Office of the President, Office of Management and Budget, Office of Federal Procurement Policy, *Memorandum for Chief Acquisition Officers and Senior Procurement Executives: Increasing Competition and Structuring Contracts for the Best Results* (Washington, D.C.: Oct. 27, 2009).

[9]One of the contractor companies operates several private facilities, and for one of those facilities it has a subcontract from the primary contractor to operate the facility. Throughout this report we refer to this company as a primary contractor.

unit's oversight activities, how the units communicate with each other and with contract facility staff, and how BOP contracts are structured. In addition, we spoke with officials from ACA and The Joint Commission to understand their accreditation standards and oversight activities. We also interviewed officials from each of the three primary contractors that operate 14 of BOP's 15 contract facilities as discussed above, as well as one subcontractor that provides mental health services for one of the primary contractors, to discuss the types of mental health services provided and internal and external oversight mechanisms for contract facility operations. In addition, we conducted site visits to two contract facility, one to observe the Contract Facility Monitoring (CFM) review process, and another to observe operations. We chose the first facility because the review was being conducted at the facility during the time frame of our study. We chose the second because it was a fairly new contract, which would provide a comparison to the first facility with a more established contract. While the selection of these two contract facilities does not facilitate generalizations, our observations and conversations with staff provided important context on the operations of privately operated prisons.

To understand the deficiencies BOP identified in its contract facility monitoring reports that may be related to mental health, we performed a content analysis of all of the most recent reports from BOP's 15 contract facilities' monitoring reviews to determine the most frequent findings related to mental health. For our analysis, we determined that a deficiency may be related to mental health if it is related to pharmacy, psychiatry, or psychology services within the contract facility. We also reported illustrative examples of deficiencies. Similarly, for each of the 15 contract facilities, we analyzed the most recent accreditation reports from the ACA and Joint Commission reviews to determine the most prevalent findings related to mental health services.

To understand the types of mental health services that are being assessed and the extent to which BOP's review differs from the contract facility's internal reviews, we obtained the Quality Control Plan from the subcontractor and two of the primary contractors and compared these plans with BOP's Quality Assurance Plan, which is used to guide the contract facility monitoring process. One contractor was not willing to provide its plan because it considers the information to be proprietary and confidential.

We conducted this performance audit from April 2012 to July 2013 in accordance with generally accepted government auditing standards.

Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix II: Bureau of Prisons' Psychology Treatment Programs' Descriptions and Numbers of Participants for FY 2008 and 2012

Program name	Program description	Fiscal year	Number of inmate participants	Number of inmates on waiting list at the end of the fiscal year
Non-Residential Drug Abuse Treatment Program (NR DAP)	NR DAP is available to inmates at every institution. The purpose of the NR DAP program is to afford all inmates with a drug problem the opportunity to receive drug treatment. NR DAPs are conducted for 90-120 minutes per week for 12 to 24 weeks.	2008	13,361	2,392
		2012	20,141	9,825
Residential Drug Abuse Treatment Program (RDAP)	RDAP targets inmates who volunteer for drug abuse treatment and have a verifiable and diagnosable substance use disorder. Inmates in RDAP complete a minimum of 500 hours of programming in 9 to 12 months. BOP also offers RDAPs for inmates with co-occurring substance use disorders and serious mental health disorders. BOP may reduce, by up to 1 year, the sentence of an inmate convicted of a nonviolent offense who successfully completes RDAP.	2008	14,721	6,980
		2012	14,482	4,807
Challenge Program	The Challenge Program is a residential program designed to facilitate favorable institutional adjustment and successful reintegration into the community through the elimination of drug abuse or the management of mental illnesses. The Challenge Program targets high-security inmates with a history of drug abuse or a major mental illness.	2008	1,613	284
		2012	2,139	482
Bureau Rehabilitation and Values Enhancement (BRAVE) Program	The BRAVE program is a residential program intended to facilitate favorable institutional adjustment and reduce instances of misconduct. The program encourages inmates to interact in a positive manner with staff members and take advantage of opportunities to engage in self-improvement during their incarceration. BRAVE targets inmates who are 32 years old or younger, with a sentence of at least 60 months, and who are serving a sentence with BOP for the first time. BRAVE includes 350 hours of programming over 6 months.	2008	255	38
		2012	199	24
Habilitation Program	The Habilitation Program was a residential program that targeted high-security, low-functioning inmates who could not successfully adapt to a penitentiary environment, but who may have the ability to function well at medium-security level institutions. The Habilitation Program was discontinued in fiscal year 2012.	2008	29	4
		2012	19	1
Skills Program	The Skills Program is a residential program designed for inmates with significant cognitive limitations and psychological difficulties that create adaptive problems in prison and in the community. Inmates participating in the program must have a serious mental illness or behavioral disorder and a need for intensive treatment services.	2008	72	2
		2012	40	9
Steps Toward Awareness, Growth and Emotional Strength (STAGES) Program[a]	STAGES is a residential program that provides treatment to male mental health care level 3 inmates with a primary diagnosis of borderline personality disorder. Individuals with borderline personality disorder have long-term patterns of unstable or turbulent emotions that often result in impulsive actions and chaotic relationships with other people. The program is designed to increase the time between the inmate's disruptive behaviors and foster living in the general population or a community setting. The program includes 12 to 24 months of residential treatment.	2008	—	—
		2012	17	2

Program name	Program description	Fiscal year	Number of inmate participants	Number of inmates on waiting list at the end of the fiscal year
Step-Down Unit Programs	Step-Down Units provide an intermediate level of mental health care for seriously mentally ill inmates. These residential units provide intensive treatment for inmates released from psychiatric hospitalization or may function as Step-Up Units to intervene and house inmates before they require hospitalization.	2008	NA	NA
		2012	90	9
Resolve Program	The Resolve Program is a trauma treatment program for female inmates. The Resolve Program consists of two components: a psycho-educational workshop and a nonresidential program for inmates with trauma-related disorders.	2008	208	589
		2012	2,358	1,636
Sex Offender Management Programs[b]		2008	373	381
		2012	740	1,776
• Non-Residential Sex Offender Treatment Program (SOTP-NR)	SOTP-NR is a voluntary, moderate-intensity program designed for low- to moderate-risk sexual offenders. Inmates in SOTP-NR must complete no less than 144 hours of programming over the course of 9 to 12 months.			
• Residential Sex Offender Treatment Program (SOTP-R)	SOTP-R is a voluntary, high-intensity program designed for high-risk sexual offenders. Inmates in SOTP-R must complete no less than 400 hours of programming over the course of 12 to 18 months.			
Commitment and Treatment Program[c]	The Commitment and Treatment Program is a civil commitment program for persons certified as sexually dangerous persons. It is a civil commitment program for the confinement and treatment of persons deemed sexually dangerous by the court. The program was established in response to requirements from the Adam Walsh Child Protection and Safety Act of 2006.[d]	2008	—	—
		2012	23	No waiting list

Source: GAO analysis of Bureau of Prisons information.

Notes: Participation is defined as the number of unique inmates who participated in the program at any time during the fiscal year.

— = Program was not operating.

NA= Not available

[a]The STAGES Program was activated in fiscal year 2012.

[b]The number of inmates participating in the Sex Offender Management Programs includes those inmates participating in both SOTP-NR and SOTP-R.

[c]Participation in the Commitment and Treatment Program is defined as the number of new participants each year. Therefore, the numbers represent the number of new inmates admitted each year and do not reflect the total number of inmates in the program for each fiscal year.

[d]Pub. L. No. 109-248, 120 Stat. 587 (2006).

Appendix III: Bureau of Prisons (BOP)-Operated Institutions by Mental Health Care Levels as of February 2013

Mental health (MH) care level	Institution name	Institution location
MH care 1[a]	Atwater USP	Atwater, CA
	Bennettsville FCI	Bennettsville, SC
	Berlin FCI	Berlin, NH
	Big Sandy USP	Inez, KY
	Herlong FCI	Herlong, CA
	Lee USP	Pennington Gap, VA
	Manchester FCI	Manchester, KY
	McDowell FCI	Welch, WV
	McKean FCI	Lewis Run, PA
	Oxford FCI	Oxford, WI
	Pollock FCC	Pollock, LA
	Ray Brook FCI	Ray Brook, NY
	Safford FCI	Safford, AZ
	Sandstone FCI	Sandstone, MN
	Three Rivers FCI	Three Rivers, TX
	Yankton FPC	Yankton, SD
	Yazoo City FCC	Yazoo City, MS
MH care 2[b]	Aliceville FCI	Aliceville, AL
	Ashland FCI	Ashland, KY
	Bastrop FCI	Bastrop, TX
	Beaumont FCC	Beaumont, TX
	Beckley FCI	Beaver, WV
	Big Spring FCI	Big Spring, TX
	Brooklyn MDC	Brooklyn, NY
	Bryan FPC	Bryan, TX
	Butner Low FCI	Butner, NC
	Butner Medium II FCI	Butner, NC
	Canaan USP	Waymart, PA
	Chicago MCC	Chicago, IL
	Cumberland FCI	Cumberland, MD
	Duluth FPC	Duluth, MN
	Edgefield FCI	Edgefield, SC
	El Reno FCI	El Reno, OK
	Elkton FCI	Lisbon, OH
	Englewood FCI	Littleton, CO

Mental health (MH) care level	Institution name	Institution location
	Estill FCI	Estill, SC
	Florence FCC	Florence, CO
	Forrest City FCC	Forrest City, AR
	Fort Dix FCI	Fort Dix, NJ
	Gilmer FCI	Glenville, WV
	Guaynabo MDC	Guaynabo, PR
	Honolulu FDC	Honolulu, HI
	Houston FDC	Houston, TX
	Jesup FCI	Jesup, GA
	La Tuna FCI	Anthony, TX
	Leavenworth USP	Leavenworth, KS
	Lewisburg USP	Lewisburg, PA
	Lompoc FCC	Lompoc, CA
	Loretto FCI	Loretto, PA
	Los Angeles MDC	Los Angeles, CA
	Marion USP	Marion, IL
	McCreary USP	Pine Knot, KY
	Memphis FCI	Memphis, TN
	Mendota FCI	Mendota, CA
	Miami FCI	Miami, FL
	Miami FDC	Miami, FL
	Milan FCI	Milan, MI
	Montgomery FPC	Montgomery, AL
	Morgantown FCI	Morgantown, WV
	New York MCC	New York, NY
	Oakdale FCC	Oakdale, LA
	Oklahoma City FTC	Oklahoma City, OK
	Otisville FCI	Otisville, NY
	Pekin FCI	Pekin, IL
	Pensacola FPC	Pensacola, FL
	Petersburg FCC	Hopewell, VA
	Philadelphia FDC	Philadelphia, PA
	Phoenix FCI	Phoenix, AZ
	San Diego MCC	San Diego, CA
	Schuylkill FCI	Minersville, PA
	Seagoville FCI	Seagoville, TX
	SeaTac FDC	Seattle, WA

Mental health (MH) care level	Institution name	Institution location
	Sheridan FCI	Sheridan, OR
	Talladega FCI	Talladega, AL
	Tallahassee FCI	Tallahassee, FL
	Texarkana FCI	Texarkana, TX
	Victorville FCC	Victorville, CA
	Williamsburg FCI	Salters, SC
MH care 3[c]	Alderson FPC	Alderson, WV
	Allenwood FCC	White Deer, PA
	Atlanta USP	Atlanta, GA
	Butner Medium I FCI	Butner, NC
	Carswell FMC	Fort Worth, TX
	Coleman FCC	Sumterville, FL
	Danbury FCI	Danbury, CT
	Devens FMC	Ayer, MA
	Dublin FCI	Dublin, CA
	Fairton FCI	Fairton, NJ
	Fort Worth FCI	Fort Worth, TX
	Greenville FCI	Greenville, IL
	Hazelton USP/SFF	Bruceton Mills, WV
	Lexington FMC	Lexington, KY
	Marianna FCI	Marianna, FL
	Terminal Island FCI	San Pedro, CA
	Terre Haute FCC	Terre Haute, IN
	Tucson FCC	Tucson, AZ
	Waseca FCI	Waseca, MN
MH care 4[d]	Butner FMC	Butner, NC
	Carswell FMC	Fort Worth, TX
	Devens FMC	Ayer, MA
	Rochester FMC	Rochester, MN
	Springfield MCFP	Springfield, MO

Legend:

FCC refers to Federal Correctional Complex

FCI refers to Federal Correctional Institution

FDC refers to Federal Detention Center

FMC refers to Federal Medical Center

FPC refers to Federal Prison Camp

FTC refers to Federal Transfer Center

MCC refers to Metropolitan Correctional Center

MCFP refers to Medical Center for Federal Prisoners

MDC refers to Metropolitan Detention Center

SFF refers to Secure Female Facility

USP refers to U.S. Penitentiary

Source: Bureau of Prisons.

Notes: Butner is an FCC consisting of four facilities with different MH care levels—two that are MH care level 2, one that is MH care level 3, and one that is MH care level 4—therefore in this table Butner is listed four times. Carswell and Devens are each a single institution but are rated as both MH care levels 3 and 4, and are therefore each listed twice in this table. There are 14 FCCs—Allenwood, Beaumont, Butner, Coleman, Florence, Forrest City, Lompoc, Oakdale, Petersburg, Pollock, Terre Haute, Tucson, Victorville, and Yazoo City. Each FCC represents more than one institution.

[a]All MH care level 1 institutions are classified as care level 1 for both medical and mental health needs. Inmates in these facilities tend to have minimal treatment needs.

[b]MH care level 2 institutions have Psychology Services staffing that serves inmates classified as care level 2 who require a moderate level of intervention.

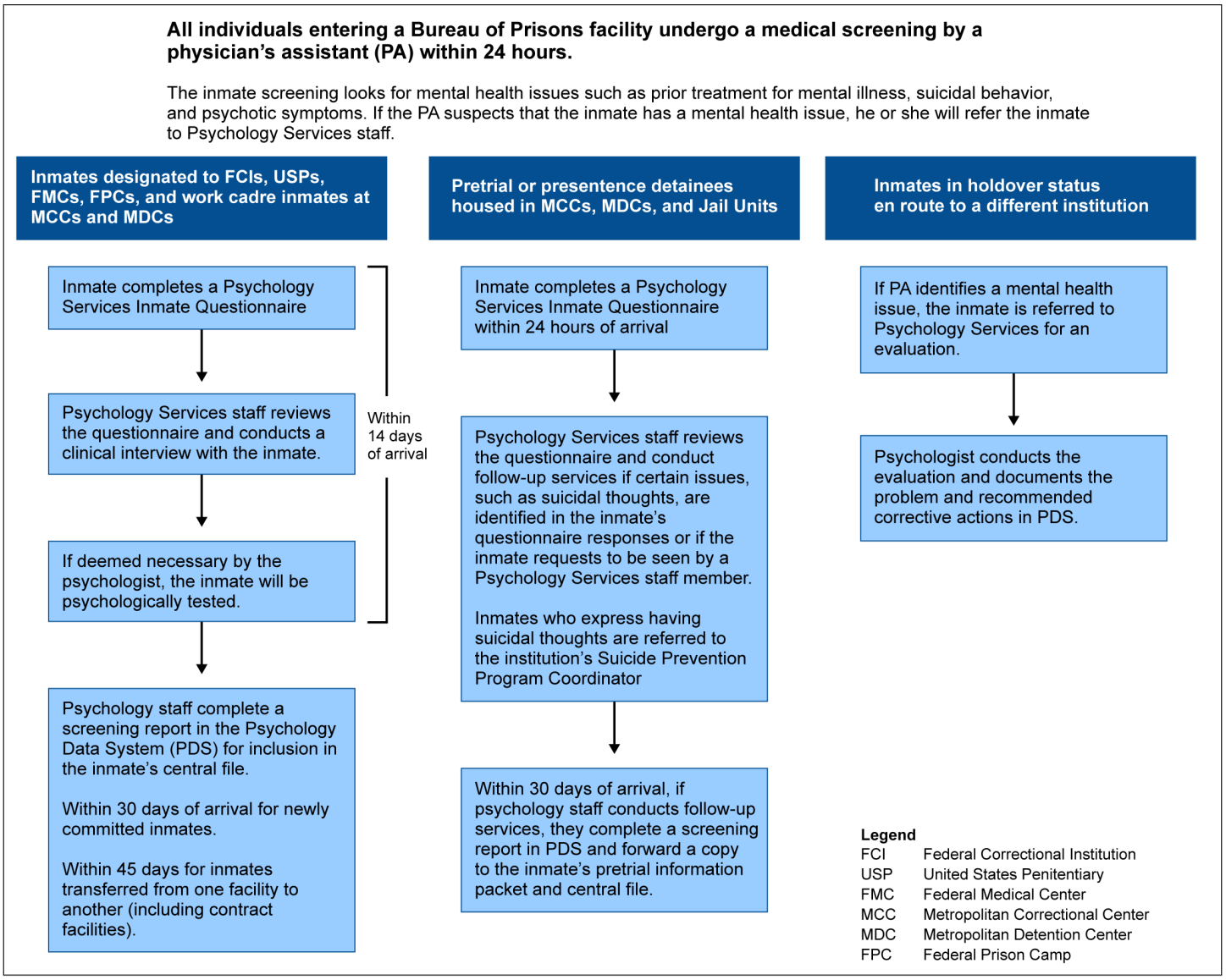
[c]MH care level 3 inmates—who require significant mental health interventions but not inpatient treatment—are served by institutions with enhanced staff specifically designated to address these needs. This enhanced staffing may involve a fully staffed residential treatment program, such as the STAGES Program, or a care level 3 psychologist with an outpatient caseload of care level 3 mental health cases. Therefore, entire institutions are not designated as care level 3 for mental health; rather, specific programs/psychologists are designated to provide services for care level 3 mental health cases. (STAGES is a residential program that provides treatment to male mental health care level 3 inmates with a primary diagnosis of borderline personality disorder. Individuals with borderline personality disorder have long-term patterns of unstable or turbulent emotions that often result in impulsive actions and chaotic relationships with other people.)

[d]MH care level 4 institutions are classified as care level 4 for both medical and mental health needs. Inmates in these facilities have acute needs that require inpatient treatment.

Appendix IV: Inmate Intake and Mental Health Assessment Process

All individuals entering a Bureau of Prisons facility undergo a medical screening by a physician's assistant (PA) within 24 hours.

The inmate screening looks for mental health issues such as prior treatment for mental illness, suicidal behavior, and psychotic symptoms. If the PA suspects that the inmate has a mental health issue, he or she will refer the inmate to Psychology Services staff.



Source: GAO analysis of information from the Bureau of Prisons.

Appendix V: Inmate Diagnoses by Inmate Mental Health Care Level and Gender, as of February 9, 2013

Class of mental disorder	Inmate mental health care level 1[a]	Inmate mental health care level 2	Inmate mental health care level 3	Inmate mental health care level 4[b]
Male inmates				
Total number of male inmates	**144,700**	**4,541**	**432**	**809**
Anxiety disorders[c]	1,128	538	54	17
Mood disorders[d]	2,801	2,001	162	62
Personality disorders[e]	2,360	1,055	232	168
Schizophrenia and other psychotic disorders[f]	251	1,115	244	402
Somatoform disorders[g]	3	1	1	2
Other disorders not used in mental health care level designations[h]	34,538	2,180	284	282
Female inmates				
Total number of female inmates	**10,449**	**991**	**124**	**46**
Anxiety disorders[c]	573	320	36	4
Mood disorders[d]	671	540	77	9
Personality disorders[e]	260	240	84	9
Schizophrenia and other psychotic disorders[f]	11	70	45	25
Somatoform disorders[g]	0	1	0	0
Other disorders not used in mental health care level designations[h]	3,820	583	82	22

Source: GAO analysis of data from the Bureau of Prisons (BOP).

Notes: Inmates with multiple diagnoses are included under all applicable classes of disorders. Therefore, the numbers of inmates in the classes cannot be totaled. Classes of mental disorders are from the Diagnostic and Statistical Manual, Version IV-TR (DSM-IV-TR), which is the standard classification system of mental disorders used by mental health practitioners in the United States. The specified classes of mental disorders are those that BOP uses to determine an inmate's mental health care level assignment. Diagnosis information was drawn from records that explain an inmate's mental health care level or from open treatment plans.

[a]Mental health care level 1 includes inmates without mental health problems and inmates with diagnosed mental health conditions who do not need to be seen more than once every 3 months. According to BOP, 120,023 male inmates and 7,144 female inmates at mental health care level 1 did not have a diagnosed mental health disorder as of February 2013.

[b]According to BOP, a precise number of diagnoses at mental health care level 4 is not available because those inmates directly designated to medical referral centers may not have diagnostic information in the Psychology Data System, BOP's electronic medical record system for psychological services, because paper charts are still in use at these facilities. Additionally, diagnoses may be pending if inmates are undergoing forensic evaluations, which are evaluations for a court.

[c]Anxiety disorders include generalized anxiety disorder, panic disorder, post-traumatic stress disorder, obsessive compulsive disorder, and specific phobias.

[d]Mood disorders include major depressive disorder, dysthmia (chronic low-level depression), and bipolar disorders.

[e]BOP excludes consideration of antisocial personality disorder in designating an inmate to a mental health care level. A personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment. Borderline personality disorder is a personality disorder in which individuals have long-term patterns of unstable or turbulent emotions that often result in impulsive actions and chaotic relationships with other people.

[f]Other psychotic disorders include schizoaffective disorder (a mental condition that causes both a loss of contact with reality and mood problems), delusional disorder, and brief psychotic disorder.

[g]The common feature of the somatoform disorders is the presence of physical symptoms that suggest a general medical condition but are not fully explained by a general medical condition, by the direct effects of a substance, or by another mental disorder (e.g., panic disorder).

[h]This category represents diagnoses for all mental health disorders that are not used to designate an inmate to a mental health care level. The largest category is for substance abuse disorders.

Appendix VI: Findings from Program Review Reports, Accreditation Reports, and Contract Facility Monitoring Review Reports

Results from Analysis of Psychology Services and Health Services Program Review Reports

The Bureau of Prisons (BOP) conducts program reviews of each program area at all of the agency's institutions. According to the results of the program review, institutions receive one of five ratings: superior, good, acceptable, deficient, and at risk. The scores indicate the institution's level of compliance with BOP's policies and strength of internal controls. We reviewed the most recent psychology services and health services internal program review reports for the 47 BOP institutions in our sample. We found that 89.4 percent of the institutions were rated as good or superior in the psychology services program reviews, compared with 76.6 percent rated as good or superior in the health services program reviews.[1] Table 7 provides information on the rating levels garnered by the institutions.

Table 6: Institutional Ratings in Psychology Services and Health Services Program Review Reports for BOP-Operated Institutions

Rating	Percentage (number of institutions)	Confidence interval
Psychology Services program reviews		
Superior	44.7% (21)	34.0-56.4%
Good	44.7 (21)	34.0-56.4
Acceptable	10.6 (5)	5.3-20.2
Deficient	0 (0)	0-5.3
At risk	0 (0)	0-5.3
Health Services program reviews		
Superior	23.4 (11)	14.9-34.0
Good	53.2 (25)	41.5-64.9
Acceptable	21.3 (10)	12.8-31.9
Deficient	2.13(1)	1.1-8.5
At risk	0 (0)	0-5.3

Source: GAO analysis of BOP data.

Note: We reviewed the most recent report for a random sample of 47 of the 94 institutions that had been operating long enough to receive a program review. For purposes of this report, we use the term institutions to refer to both single institutions and a complex of two or more institutions that are reviewed as a single unit for purposes of program reviews. The estimates shown in this table are generalizable to the population. The confidence intervals shown in the table were calculated at the 95 percent level of confidence. According to BOP, a superior rating indicates the program is performing

[1]The associated 95 percent confidence interval for 89.4 percent is (79.8, 94.7), and for 76.6 percent is (66.0, 85.1).

all vital functions and a history of strong internal controls exists, resulting in zero or very minimal deficiencies. A good rating demonstrates the program's vital function areas are sound and internal controls are strong. Institutions with an acceptable rating may have deficiencies, but they do not detract from the adequate accomplishment of the vital functions. A deficient rating demonstrates that one or more vital functions of the program are not being performed at an acceptable level and internal controls are weak. An at-risk rating demonstrates that the program is impaired to the point that it is not accomplishing its overall mission and internal controls do not demonstrate substantial continued compliance.

We also analyzed the most frequently cited deficiencies identified in the psychology services and health services reports that we reviewed. Among the findings from the psychology services program review reports, 10 institutions had a deficiency related to care provided to inmates in a residential treatment program. Table 8 shows the most frequently cited deficiencies in the psychology services and health services program review reports that we reviewed. The table also includes examples of deficiencies in each category.

Table 7: Most Common Deficiencies in Psychology Services and Health Services Program Reviews Related to Mental Health Services for BOP-Operated Institutions

	Number of institutions with deficiency	Examples of deficiencies cited at BOP institutions
Psychology services program review deficiencies		
Issues related to care provided to inmates in residential treatment programs	10	• Inmates who completed the Residential Drug Abuse Treatment Program (RDAP) were not always enrolled in follow-up services in a timely manner. • Not all of the inmates in the Challenge Program had treatment plans that were individualized and had goals commensurate with the inmate's treatment needs. • Treatment plans for RDAP inmates are not completed in a timely fashion.
Issues related to suicide risk assessments, suicide watch, or post suicide watch care	10	• Not all inmates removed from suicide watch received follow-up consistent with the clinician's plan. • Not all inmates placed on suicide watch have documentation of a daily visit by a psychologist in the suicide watch logs or the Psychology Data System (PDS). • Not all suicide risk assessments were entered into PDS within 24 hours of the referral.
Issues related to the care provided to inmates in nonresidential treatment programs	9	• Not all inmates who have successfully completed nonresidential treatment have received a program completion award. • Not all treatment plans for inmates participating in nonresidential drug treatment are completed in a timely fashion. • The identification, referral, and interview process, which informs the chief psychologist of female inmates recommended for trauma education, is inadequate.

	Number of institutions with deficiency	Examples of deficiencies cited at BOP institutions
Health services program review deficiencies		
Issues related to documentation of diagnosis information	12	• Inmates in mental health chronic care clinics do not always have Diagnostic and Statistical Manual of Mental Disorders, Version-Fourth Edition (DSM-IV) axis codes documented on the problem list and follow-up chronic care clinic visits, as necessary.[a] • Initial psychiatric visits did not always have all DSM-IV axes documented and addressed appropriately.[b]
Issues with the management and administration of medication	6	• Management and administration of pharmaceuticals (medications) were not always in accordance with policy. • Providers with prescribing authority do not reevaluate a prescription prior to its renewal, and a medication was prescribed without proper diagnosis. • Medications were prescribed when not clinically indicated. Also, a prescription was renewed without reevaluation.
Issues related to the administration and storage of controlled substances	6	• Medication Administration Records are not always completed for inmates on controlled substances. • Medication orders for controlled substances were reordered without the proper ongoing documentation. • Not all orders for controlled substances were cosigned by a physician on his/her next work day.
Issues related to the safe storage of needles and syringes	5	• Not all needles and syringes in the main stock were inventoried and stored correctly. • Not all syringes, including prefilled needles and syringes, were inventoried and stored correctly.

Source: GAO analysis of BOP data.

Notes: We reviewed the most recent Health Services and Psychology Services program review reports for a random sample of 47 of the 94 institutions that had been operating long enough to receive a program review. For purposes of this report, we use the term institution to refer to both single institutions and a complex of two or more institutions that are reviewed as a single unit for purposes of program reviews. These results are not generalizable to the population of BOP institutions.

[a]The Diagnostic and Statistical Manual of Mental Disorders, Version IV, is the standard classification system for mental disorders used by mental health practitioners.

[b]The DSM-IV is organized into a five-part axis system, with each axis representing a part of a patient's overall assessment.

Following a program review, BOP institutions are required to submit a corrective action plan to the Program Review Division addressing all reported deficiencies. Institutions must submit these plans within 30 days of when the program review report is issued. Table 9 provides examples of corrective actions submitted by BOP institutions in response to deficiencies identified in psychology services program review reports.

Table 8: Examples of Deficiencies and Institutional Corrective Actions from Psychology Services Program Review Reports for BOP-Operated Institutions

Deficiency	Example of an institution's corrective action plan
Not all 60-day progress reviews for inmates participating in RDAP are completed in a timely manner.	The institution responded that it developed and implemented a timetable for conducting 60-day reviews.
A review of 10 treatment plans revealed the following: (1) Three were missing signatures. (2) Four inmates did not receive treatment in accordance with the treatment plan. Goals for treatment were not always referenced in the notes. (3) Four were not updated as needed. (4) Two were not closed out at the completion of treatment.	The institution responded that all signed treatment plans will be scanned into the Psychology Data System (PDS) for easy review and access. When entering PDS notes on inmates with treatment plans, the notes will be directly related to the inmate's treatment plan goals. All treatment plans will be reviewed and updated at least annually. PDS rosters will be run on a monthly basis to guarantee that all treatment plans of departed inmates have been closed.
Not all inmates received appropriate follow-up after crisis intervention.	The institution responded that the chief psychologist now requires immediate notification of any instance of crisis intervention to ensure documentation is appropriate. In addition, a PDS roster of crisis intervention contacts is run at least monthly to ensure follow-up, if warranted, has been conducted as stipulated.
Inmates with PSY ALERT codes are not being cleared for release to the general population.[a]	The institution responded that a new tracking mechanism has been developed and is currently being utilized to identify all inmates who arrive with a PSY ALERT code. This tracking mechanism incorporates a roster that will be run on a daily basis to identify inmates in the pipeline who are PSY ALERT. All inmates with this code will be screened by a psychologist prior to their release to the general population. This screening will be reported in PDS under the heading "Psychology Alert screening."
Not all inmates housed in special housing units (SHU) for 30 days or more received a timely 30-day SHU review by a psychologist.	The Institution responded that the system of control previously utilized was abandoned and a new system established. Currently, inmates housed in SHUs are being tracked on a 28-day rotation with all inmates receiving a SHU review contact on the first day of the week in which their review is due.

Source: GAO analysis of BOP data.

Notes: We did not analyze corrective action plans associated with deficiencies identified in health services program review reports because most of those deficiencies were not related to mental health care.

[a]Inmates with a PSY ALERT code are not to be released into the general population until they have been assessed by a psychologist.

Results from Analysis of ACA and Joint Commission Accreditation Reports for BOP-Operated Institutions

BOP requires that all of its institutions obtain accreditation from the American Correctional Association (ACA) and that all institutions with a medical care level of 2 or higher obtain accreditation for ambulatory care from The Joint Commission.[2] We reviewed the most recent accreditation reports from ACA and The Joint Commission for our sample of 47 BOP institutions. Only 37 of the BOP institutions had Joint Commission accreditation reports because nine are medical care level 1 facilities and are not required to obtain Joint Commission accreditation and the final institution recently changed to a medical care level 2 institution but had not yet received its Joint Commission accreditation.

In our review of the most recent ACA accreditation reports, we found one deficiency that although not directly related to a mental health standard, had a connection with mental health services. ACA reported that correctional officers in the special housing unit were not conducting required 30-minute checks of inmates that help ensure that inmates are not attempting suicide or harming themselves or others. The institution responded that it would reemphasize the importance of the checks and that lieutenants, who are generally responsible for the day-to-day staffing of correctional services, would check the logs on every shift to ensure the checks were taking place.

The Joint Commission's ambulatory care standards relate to all aspects of an institution's health services. The Joint Commission accredits only those services at BOP institutions that are provided by the institution's health services unit. Table 10 provides information on The Joint Commission findings at BOP institutions related to psychiatric care and pharmacy care.

[2]Four BOP institutions—Federal Medical Center Rochester, U.S. Medical Center Springfield, Federal Medical Center Devens, and Metropolitan Correctional Center in New York—also have behavioral health accreditations because they have inpatient psychiatric units or a treatment program for individuals addicted to pain relieving drugs, such as oxycodone or morphine. Two additional institutions—Federal Correctional Complex Butner and Federal Medical Center Carswell—have psychiatric units within inpatient hospital facilities that are also accredited under The Joint Commission's hospital standards.

Table 9: Most Common Deficiencies Cited in Joint Commission Ambulatory Care Accreditation Reports for BOP-Operated Institutions

	Number of BOP institutions with partial or insufficient compliance with standard[a]	Examples of observations at BOP institutions resulting in findings of partial or insufficient compliance
Psychiatry		
Provider certification	1	• A psychiatrist's board certification had expired and the institution had not verified that the psychiatrist had a current certification.[b]
Pharmacy		•
Safe management of high-alert and hazardous medications[c]	5	• The institution did not have an institution-specific list of high-alert and hazardous medications. • Two high-concentration medications were not included on the institution's list of high-alert medications.
Use of look-alike/sound-alike medications[d]	5	• Not all look-alike/sound-alike medications had a high-alert label. • While the institution had developed a list of sound-alike medications and implemented a process for risk reduction for those medications, the institution had not implemented a list or process for reducing the possibility of look-alike errors for injectable medications.
Safe storage of medication	5	• The temperature ranges for a medication refrigerator were found to be out of range, and the institution did not take action to change the refrigerator's temperature or move the medications stored in the refrigerator. • Medications that had expired were still available for use.

Source: GAO analysis of Joint Commission data.

[a]If an institution is found to be in partial or insufficient compliance with any Joint Commission standard, the institution must submit evidence of compliance with the standard before an accreditation decision is made.

[b]According to an official from BOP's Office of Quality Management, BOP policy does not require psychiatrists to be board certified.

[c]High-alert medications are those medications involved in a high percentage of errors or unexpected occurrences involving death or serious injury, as well as medications that carry an increased risk for abuse or other adverse outcomes.

[d]Look-alike drugs are two drugs in which the names of the drugs can be confused with each other and result in medication errors. Sound-alike drugs are two drugs that, when their names are spoken, can be confused with each other and result in medication errors.

Findings from the BOP and Accreditation Review Reports for Contract Facilities

In our review of each of the recent Contract Facility Monitoring (CFM) reports for the 15 private facilities, we found four main policy areas where deficiencies that could be related to mental health care were cited at more than 1 facility—Inmate Classification and Program Review, Health Information Management, Patient Care, and Medical Designation and Referral Services for Federal Inmates (see table 11). We determined that these deficiencies may be related to mental health because they can involve mental health professionals, such as psychiatrists, psychologists or licensed professional counselors; pharmacy care, which can include psychotropic medications; or health information that may include information on mental health.

Table 10: Most Common Deficiencies in Contract Facility Monitoring Reviews That May Be Related to Mental Health Services in Contract Facilities

	Number of institutions with deficiency	Examples of deficiencies cited in each category
Contract facility monitoring review policy area		
Inmate classification and program review	7	• Program needs of the inmates need to be identified in program review reports, measured in terms to demonstrate an inmate's progress through treatment, and reviewed at the treatment team meetings. Inmate program needs could include mental health treatment programs that would be discussed with mental health staff at treatment team meetings.
Health information management	5	• Information that may include mental health information is missing from inmate health records. • Errors in inmate health records, which may include mental health information, were inadequately corrected.
Patient care	3	• Patient care records for inmates seeking mental health clinic evaluations were incomplete.
Medical designation and referral services for federal inmates	2	• Forms containing important medical information, which may include mental health information, for inmates in transit from one institution to another were not always written in lay terms for correctional staff to understand.

Source: GAO analysis of BOP data.

Our analysis of the most recent ACA accreditation reports for the 13 contract facilities that have been reviewed found that all but one of the facilities were compliant with all ACA standards related to mental health services involving pharmacy care, and psychology and psychiatry services. The facility that was found not compliant with all of ACA's mental health-related standards was as a result of the facility's failure to develop and utilize a health care staffing plan and the reviewers' related concerns about the mental health staffing levels at the facility.

Our review of the most recent Joint Commission accreditation reports for each of the 13 contract facilities The Joint Commission reviewed found that 6 of the 13 were fully in compliance with the ambulatory care standards related to mental health services. The Joint Commission found the remaining 7 facilities to be either partially or insufficiently compliant with the ambulatory care accreditation standards related to mental health services (see table 12). In addition to the ambulatory care accreditation that contract facilities are required to obtain, 1 of the 7 facilities specifically chose to also be accredited on behavioral health standards, and that facility was found to be insufficiently compliant with three of those standards.[3]

Table 11: Most Common Deficiencies in Joint Commission Accreditation Reports Related to Mental Health Services in Contract Facilities

The Joint Commission deficiency category	Type of accreditation	Examples of deficiencies cited in each category
1. Medication management	Ambulatory care	• Medications were mislabeled or stored improperly. • A list of look-alike/sound-alike medications was not developed.
2. Documentation of the competency of medical and behavioral health staff	Ambulatory care/ behavioral health care	• The initial assessment of staff clinical competence was not documented. • An assessment of clinical competency was not documented for staff during performance reviews. • No primary source verification of the education of the clinical psychologist.
3. Inmate assessments	Behavioral health care	• Inmate assessments did not include information on addictions other than alcohol or drugs.
4. Inmate treatment plans	Behavioral health care	• Inmate treatment plans did not include goals and metrics to measure an inmate's progress.

Source: GAO analysis of Joint Commission Accreditation reports.

[3]The ambulatory care accreditation covers the broad categories of surgical, medical/dental, and diagnostic/therapeutic services, and represents a variety of settings, including outpatient hospitals and prisons. The behavioral health accreditation focuses on organizations that provide services to persons with intellectual and developmental disabilities, as well as mental health and chemical dependency services.

Appendix VII: Bureau of Prisons' Elements of Modified Therapeutic Communities

Element of a modified therapeutic community	Examples of standards contained in each element
Community as method	• Inmates can verbalize the program philosophy. • Feedback from the group is a routine intervention. • Treatment plans and interventions are directly tied to the inmate and his or her peers. • Group sessions are dominated by peer interactions.
Unit appearance	• The unit is separate from the general population. • The community philosophy is posted. • Group rooms and unit are decorated with treatment themes. • All participants are involved in sanitation.
Rules and norms	• Participants are engaging in positive behaviors. • A team approach to treatment is used. • Inmates can verbalize the rules and norms of the modified therapeutic community. • Problem behaviors are dealt with as a treatment team and by the group. • Incentives are based on achievement of personal growth.
Staff roles	• Staff and inmates display mutual respect in their interactions. • Staff model appropriate communications and behavior. • Staff meet weekly for scheduled time as a treatment team. • Record keeping should provide a story about the inmate with obvious individuality. • Staff conduct daily rounds in the community.
Supervision and training	• Staff function as a team. • Supervision is skill focused and conducted through regular, direct observation. • Supervisors provide training and conduct semi-annual needs assessments of each staff member.
Transition	• Staff have determined expectations for participants for each treatment phase. • Participants can describe the behaviors expected of them as well as prohibited behaviors. • Participants can describe their treatment goals and treatment plan. • Inmates and staff provide an orientation to new inmates to the unit.

Element of a modified therapeutic community	Examples of standards contained in each element
Community activities	• A programming schedule is posted. • Senior participants role model and actively seek to help junior participants. • Community meetings are held daily, and all staff are present whenever possible. • Homework and group projects are interactive in nature and require all to participate.
Treatment phase through journals	• Inmates receive journals and use them sequentially. • Inmates complete journals during nongroup time and have them reviewed in group. • Journal concepts are evident in all aspects of the program. • Staff test inmate behavior, not just knowledge.
Small therapy groups	• Small therapy groups include participants from every phase. • Participants remain in the same process group with the same facilitator throughout treatment. • Farewell and welcome rituals are utilized for incoming and departing group members. • Group sessions include discussions and expressions of painful emotions in a prosocial manner. • Sessions are dominated by peer interactions.
Community jobs	• Community jobs are described, posted, and selected based on therapeutic need. • Participants are able to describe their jobs and how they relate to the modified therapeutic community and recovery. • Staff monitor job assignments and work groups in the community and use incentives and sanctions to promote positive behavior and reduce negative behavior.

Source: GAO analysis of Bureau of Prisons information.

Notes: The Residential Drug Abuse Treatment Program targets inmates at the end of their sentence who volunteer for drug abuse treatment and have a verifiable and diagnosable substance abuse condition. The Challenge Program is a residential program designed to facilitate favorable institutional adjustment and successful reintegration into the community for high-security inmates with a history of substance abuse or a major mental illness.

Appendix VIII: Bureau of Prisons (BOP) Program Statements Related to Mental Health Services for Inmates

BOP program statement	Description	Date program statement was last updated
Psychology Services Manual	Establishes operational policy, procedures, and guidelines for the delivery of psychological services within BOP	March 7, 1995
Institution Management of Mentally Ill Inmates	Establishes policy, procedures, standards, and guidelines for managing mentally ill inmates in all regular (i.e., nonmedical) correctional institutions	March 31, 1995
Psychiatric Services	Establishes policy, procedures, and guidelines related to the identification of inmates in need of psychiatric services, psychiatric diagnostic and treatment services, and continuity of psychiatric care	January 15, 2005
Suicide Prevention Program	Establishes the components of a suicide prevention program that should be in place at each institution	April 5, 2007
Forensic and Other Mental Health Evaluations	Describes the procedures BOP shall follow to prepare a psychological or psychiatric evaluation on an inmate committed to its custody	April 16, 2008
Psychology Treatment Programs	Establishes policy, procedures, and guidelines for the delivery of psychology treatment programs	March 16, 2009
Psychiatric Evaluation and Treatment	Describes procedures for voluntary and involuntary psychiatric evaluation, hospitalization, care, and treatment, in a suitable facility, for persons in BOP custody	July 13, 2011
Sex Offender Programs	Establishes procedures and guidelines for Sex Offender Treatment and Management Services in BOP	February 15, 2013

Source: GAO analysis of BOP program statements.

Appendix IX: GAO Contacts and Staff Acknowledgments

GAO Contacts

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