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Report to Congressional Requesters

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MENTALLY ILL INMATES

BOP Plans to Improve Screening and Care in Federal Prisons and Jails

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The Honorable Tom Harkin
Chairman, Subcommittee on Disability Policy
Committee on Labor and Human Resources
United States Senate

The Honorable Henry A. Waxman
Chairman, Subcommittee on Health
and the Environment
Committee on Energy and Commerce
House of Representatives

This report addresses the Subcommittees' interest in the identification and treatment of mentally ill inmates in prisons and jails that are operated by the Federal Bureau of Prisons (BOP). It is the second report that you have requested on mentally ill inmates.[1] Specifically, as agreed with your offices, we queried all federal prisons and reviewed samples of inmate records to determine whether mentally ill prisoners were going unidentified or untreated and if so, why. We did not review the quality of care provided or the adequacy of BOP's mental health staff. In addition, our review covered inmates who are housed in BOP-operated prisons and jails but not federal prisoners housed in contract facilities or in Department of Defense facilities.

Background

Few options are available for the noncorrectional placement of mentally ill federal offenders. One option, allowed under the federal statutes dealing with mentally ill offenders (18 U.S.C. Chap. 313), is to have, when possible, persons found to be incompetent or insane and dangerous handled under state civil commitment proceedings. This option is based on Congress' view that the care and custody of the mentally ill has traditionally been a function of the states. (This option is discussed in more detail in app. I.)

Federal offenders who are committed under the authority of the statutes that address mentally ill offenders, or those identified by court or BOP officials as seriously mentally ill, are typically to be sent to one of four BOP psychiatric referral centers. These centers are located in Springfield, Missouri; Butner, North Carolina; Rochester, Minnesota; and

[1]The first report, Mentally Ill Inmates: Better Data Would Help Determine Protection and Advocacy Needs (GAO/GGD-91-35, Apr. 17, 1991), discussed the applicability of the federal protection and advocacy law for mentally ill persons (42 U.S.C. 10801 - 10851) to federal, state, and local prisoners and whether these prisoners were subject to abuse and neglect as defined by that law.

Lexington, Kentucky (females only). Staff at these facilities include psychologists, psychiatrists, psychiatric nurses, and orderlies. All but the Butner facility are also medical referral centers and thus house inmates needing major medical care. The centers also house prisoners who are not mentally or physically ill to help with the facilities' administrative and maintenance needs. The centers also perform court ordered psychiatric evaluations. The Springfield, Butner, and Lexington facilities have been accredited by the Joint Commission on Accreditation of Health Care Organizations; the Rochester center is seeking accreditation.

Other mentally ill offenders are housed in high-, medium-, low-, and minimum-security prisons and in jails. The prisons and jails have on their staffs full-time psychologists and psychiatrists who are hired on a contract basis and used as needed and when budgetary resources permit. The services that are offered on an outpatient basis include the following activities: screening for mental health problems, suicide prevention, crisis intervention, the diagnosis and evaluation of mental disorders, and medication. Depending on the limits set by staff availability and prison overcrowding, the facilities may also have other programs, such as individual counseling or group psychotherapy.

While there is no universally accepted definition of mental illness, many mental health practitioners and organizations, including BOP, use the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) when diagnosing mental disorders. The manual includes two overall categories, referred to as Axis I and Axis II, of mental disorders. Axis I comprises clinical syndromes, such as mood disorders (e.g., major depression), anxiety (e.g., panic attacks), substance use (e.g., cocaine abuse), and schizophrenia. Axis II includes developmental disorders (e.g., mental retardation) and personality disorders (e.g., antisocial disorder). A person could be diagnosed as suffering from one or more disorders in each category.

Results in Brief

According to BOP officials, mentally ill inmates are identified by court officials before they enter the prison system or by prison officials during screening upon the inmates' entry into prison. Mentally ill inmates may also be identified as a result of an observable failure to function in an open prison population. About two-thirds of the 3,131 mentally ill inmates who were identified for us by officials at BOP's 65 facilities were reportedly enrolled in treatment programs run by the facilities' psychology or mental health departments. Some of the others may have been on medication or under treatment by a psychiatrist.

About 650 of the mentally ill offenders, or 21 percent, were located at BOP's 4 psychiatric referral centers.

However, not all mentally ill inmates were being screened, diagnosed, and treated. Officials from 45 of the 65 facilities reported having some inmates who were suspected of being mentally ill but who had not been diagnosed as such, having mentally ill inmates who had been diagnosed but were not enrolled in mental health treatment, and/or having mentally ill inmates who were not receiving needed inpatient psychiatric care. Prison officials gave these major reasons for the untreated inmates: some were successfully coping with prison life and not seeking treatment; some refused treatment and BOP was awaiting or had been denied federal court approval to force treatment; some lacked treatment because there were too few treatment resources; and some had not been identified as mentally ill because of insufficient mental health screening.

Recognizing that improvements were needed in its identification and delivery of services to mentally ill inmates, in November 1990 BOP established an advisory group to identify and recommend needed improvements. The group concluded that additional resources (e.g., staff), improved staff training, more detailed information on inmate needs, and an overall quality assurance program were needed to cope with the needs of the growing federal prison population. BOP has implemented some of the group's recommendations, and actions on others are just under way or are still being considered. We believe that the objectives of the advisory group's recommendations and BOP's actions to effect the needed changes indicate a willingness to address the resource and screening problems noted in this report and to establish a framework for doing so. Given the challenges of prison overcrowding, budgetary restraints, and difficulties in hiring sufficient staff, it remains to be seen how thorough and effective BOP will be in implementing all its plans.

Scope and Methodology

To determine whether mentally ill prisoners were going unidentified or untreated, we used a three-step approach. First, we mailed a questionnaire to the wardens or directors of the 65 facilities that BOP was operating at the time of our review. This questionnaire was designed to obtain a variety of data, including (1) the extent to which incoming inmates were screened for mental health problems, (2) the existence of inmates who were not receiving needed inpatient mental health care, (3) the number of diagnosed Axis I mentally ill prisoners, (4) the extent to which Axis I mentally ill offenders were participating in treatment, (5) the existence of inmates who were thought to have an Axis I mental

illness but who had not been diagnosed as such, and (6) factors limiting the diagnosis or treatment of prisoners who had an Axis I mental disorder. We excluded those whose sole Axis I disorder involved the use of drugs or alcohol and also those with Axis II disorders, so that we could focus on what would be a smaller and less apparent group of offenders, those with major disorders like depression. BOP has separate programs for both identifying and treating offenders with substance abuse problems, and we have separately reviewed those programs.[2] We excluded Axis II disorders because BOP officials noted that by definition most, if not all, prisoners could be considered as having an Axis II characteristic such as antisocial behavior. These exclusions were agreed to by the congressional requesters.

Before we distributed it to all 65 facilities, we extensively discussed and pretested the questionnaire with various BOP officials. We instructed the mental health staff or other appropriate officials to answer each question on the basis of what their records showed. If the staff could not readily answer the questions by reviewing existing records in the time we allotted for completing the questionnaire, we instructed them to provide their best estimates. All 65 of the questionnaires were completed and returned to us during the period June through August 1990. We then followed up by telephone with 26 facilities whose responses were incomplete or required clarification.

To supplement the information obtained from the questionnaire, we reviewed randomly selected samples of inmate records at the Springfield, Missouri, psychiatric referral center and the medium-security facility in Bastrop, Texas. We selected Springfield because it was the largest psychiatric facility. We also wanted to take a look at a general prison and selected Bastrop because of its convenience to the home area of our staff and its classification as a medium-security facility. At the two facilities, we reviewed the records of inmates who had been admitted to the general prison population of each facility and to the mental health unit at Springfield from July through December 1989. We chose this time period because it was recent enough for BOP policies that were current at the time of our review to have been applicable and to have allowed BOP sufficient time to document the identification and treatment of the mentally ill inmates.

[2]See Drug Treatment: Despite New Strategy, Few Federal Inmates Receive Treatment (GAO/HRD-91-116, Sept. 16, 1991).

We sampled the records of 50 of the 103 inmates who had been admitted to Springfield's general population and 77 of the 219 inmates who had been admitted to Bastrop's general population during the July through December 1989 period. At the time of our review, Springfield had about 350 general population inmates and Bastrop had about 800. For each sampled case, we looked for a documented psychological assessment. We also sampled the records of 32 of the 48 inmates who were admitted to the Springfield mental health unit during the same time period and who were still there during our visit to the facility. For each of these sampled cases, we determined whether the file contained documentation on the inmate's treatment plan and on his or her participation in some kind of treatment. We then discussed each sampled case with BOP officials.

At Springfield, we also reviewed the files from a randomly selected sample of 31 of the 46 prisoners who had been released from both the facility's mental health treatment unit and BOP's custody in 1989. At the time of our review, Springfield had about 280 inmates assigned to its mental health unit. We first determined whether the files contained a prerelease plan and whether postrelease care had been arranged as BOP policy requires. Then, we discussed each case with BOP officials. To obtain a perspective on available aftercare, we also contacted officials, such as federal parole officers and state officials, who had knowledge of the activities of the inmates since their release from custody.

Finally, we interviewed officials, reviewed federal prisoner documentation, and reviewed documentation on mental health policies and programs at BOP's headquarters in Washington, D.C.; at its regional offices in Kansas City, Missouri, and Dallas, Texas; at its psychiatric referral centers in Springfield, Missouri, and Butner, North Carolina; and at its medium-security prisons in Bastrop and Fort Worth, Texas.

We did our work between October 1989 and June 1991 and in accordance with generally accepted government auditing standards.

Most Inmates With an Identified Major Mental Disorder Were Being Treated

Both our survey of prison officials and our review of selected records of inmates who were being treated at the Springfield psychiatric referral center indicated that most of the identified mentally ill inmates were participating in one or more treatment programs. Of the 65 facilities we surveyed, 56 estimated having 3,131 inmates who had been diagnosed as suffering from an Axis I type mental disorder other than one involving drugs, and 9 reported having no such inmates. These inmates who had been diagnosed accounted for about 5.5 percent of the total

reported prison population of about 56,900. Of these 3,131, about 650 (21 percent) were located in BOP's 4 psychiatric referral centers. The 56 facilities reported that about two-thirds of the 3,131 inmates were involved in programs or activities run by the facilities' psychology services or mental health departments. The others may have been under treatment by a psychiatrist or on medication. (Officials from 24 facilities reported that at least "some" of the Axis I inmates were under the care of a psychiatrist and not a psychologist).

From our review of the records for 32 of the 48 inmates who were admitted to Springfield for inpatient mental health care, we found that treatment was being provided to 29 inmates.[3] The other three inmates refused treatment; BOP was awaiting federal court approval for two of the inmates and military authorization for the third to provide involuntary treatment.

Of the 29 who were being treated, 26 had documented treatment plans in their medical files. Two did not have the required documented treatment plans, and one inmate's records were unavailable, which precluded us from determining whether the treatment provided was in accordance with a documented treatment plan. (This inmate was temporarily assigned to another facility pending an appearance at a federal court hearing.) The two inmates receiving treatment without a treatment plan were Cubans.[4] Our review of the Cubans' files and our subsequent discussions with prison officials revealed that the 20 Cubans housed at Springfield were not receiving the same level of care that was available to other inmates. In addition to lacking a treatment plan, the Cuban inmates had not had their needs assessed before they were admitted as inpatients. Springfield officials told us that since the Cubans were unsentenced detainees, they were not entitled to the same services that were available for sentenced inmates. We brought this unequal treatment to the attention of the BOP Director in November 1990. He subsequently told us that the policy had been changed since our visit to Springfield and that essentially all of the offenders would be treated equally.

[3]At the 95-percent confidence level, we estimated that between 3 and 9 of the 48 inmates were not being treated.

[4]The Cubans were aliens detained under Immigration and Naturalization Service authority. They were part of the 125,000 individuals who left Cuba in 1980 through the port city of Mariel. Springfield is the only BOP psychiatric center that provides inpatient care for Cubans with mental problems.

While at Springfield, we also sampled inmate records to test whether Springfield had complied with the policy for arranging the needed mental health aftercare for released offenders. BOP's policies on mental health treatment include planning for an offender's care upon release from prison. Our review of 31 of the 46 released inmates' records revealed that aftercare treatment was recommended for 29 inmates, including 2 offenders who were released to the custody of the Immigration and Naturalization Service.[5] Officials considered treatment unnecessary for the two offenders who were not recommended for aftercare. The types of aftercare recommended by BOP included medication and counseling in both inpatient and outpatient settings. In June 1990, we followed up with federal immigration and parole officials as well as state and local officials, who told us that 25 of the 29 released inmates had available to them or had participated in aftercare treatment.[6] Information on the other four was not available. (Of the 31 offenders in our sample, 5 had been returned, as of June 1990, to BOP's custody because they committed new crimes and/or violated their parole.)

BOP officials maintained that mentally ill inmates are identified by court officials before they enter the prison system, during the prison screening, or when they are unable to function in the prison environment. These officials believed that seriously mentally ill inmates are sooner or later treated in BOP's psychiatric referral centers. They also believed that inmates who are not seriously mentally ill or inmates who are undergoing a temporary emotional crisis generally have access to programs in BOP's regular prisons and jails.

Some Mentally Ill Inmates Were Not Treated

While most mentally ill offenders were reported to be receiving treatment, some were not. Of the 65 BOP facilities that we surveyed, officials from

- 35 facilities estimated that they had at least "some" Axis I mentally ill inmates who had not been diagnosed;
- 21 facilities said that they had mentally ill inmates who needed inpatient care but were not receiving it; and

[5]At the 95-percent confidence level, we estimated that between 39 and 44 of the 46 released inmates were recommended for aftercare.

[6]At the 95-percent confidence level, we estimated that between 33 and 40 of the 46 released offenders had available or participated in aftercare.

- 28 of the 56 facilities that reported having inmates with Axis I disorders provided data that showed that at least 609 of these Axis I inmates (about 20 percent) were not receiving treatment by the facilities' psychology services or mental health departments and were not receiving psychotherapy or counseling under the care of a psychiatrist.

A total of 45 facilities reported having Axis I inmates who had not been diagnosed, having diagnosed Axis I inmates who were not enrolled in treatment, and/or having inmates who were not receiving needed inpatient psychiatric care.

In our survey, we asked prison officials for their opinion on why some mentally ill inmates were undiagnosed, why some inmates needing inpatient mental health care were not receiving it, and why some diagnosed mentally ill inmates were not participating in treatment. The officials identified four major reasons that inmates were not receiving care: (1) they successfully coped with general prison life, (2) they refused treatment, (3) they did not have access to resources, and (4) they received incomplete screening.

Inmate Ability to Cope With Prison Life

Of the 35 facilities that reported nondiagnosed inmates, 34 cited inmate ability to successfully function in the general prison population as a major reason for the inmates not being diagnosed. This reason was also cited by 25 of the 28 facilities that reported housing diagnosed Axis I mentally ill inmates who were not participating in treatment.

BOP officials believed that it was not their primary mission to seek out and treat all inmate problems. They said that inmates who were known or suspected by prison officials to be mentally ill but who were coping with general prison life and who were not seeking treatment should not be forced into treatment. BOP's chief of psychology services noted a couple of exceptions to this rule. He noted that BOP does seek to have pedophiles,[7] as well as Axis I inmates who also have a substance abuse problem,[8] participate in treatment.

[7]These are persons affected with a sexual perversion in which children are the preferred sexual objects.

[8]Our report entitled Drug Treatment: Despite New Strategy, Few Federal Inmates Receive Treatment (GAO/HRD-91-116, Sept. 16, 1991) addresses BOP's efforts to identify and treat inmates with substance abuse problems.

In discussing the results of our work, BOP officials told us that they believed that the ability to cope with general prison life is the predominant reason, of the four that we identified, why suspected or identified mentally ill offenders may not be participating in treatment.

Inmate Refusal of Needed Treatment

Of the 28 facilities that reported having Axis I inmates who either were not participating in psychology treatment programs or were not under the care of a psychiatrist, 23 identified inmate refusal as a primary reason for the nonparticipation. Inmate refusal was also identified as a primary reason by 13 of the 21 facilities that reported having inmates who were not receiving needed inpatient psychiatric care.

BOP officials told us that under the law they generally cannot force psychiatric treatment without specific approval by a federal court. They noted that although participation is encouraged, BOP policy is not to seek authority to compel psychiatric treatment unless inmates become a threat to themselves, to others, or to the operations of the institution.

BOP officials told us that they often experience long delays while awaiting court decisions on compelled psychiatric treatment. This delay results in some inmates not receiving needed treatment for extended periods of time. The officials also said that delays in treatment often cause the inmate's condition to worsen, which further reduces the chances for successful treatment. With regard to psychiatric medications, BOP policy provides for forced treatment, over an inmate's objection, on an emergency basis for not longer than 72 hours. The inmate may also be secluded and, for example, placed under a suicide watch. If improvement occurs, the inmate can be returned to the general population. If improvement does not occur, the inmate may remain secluded. According to BOP officials, a cycle of emergency medication, inmate improvement, inmate return to the general population, and inmate deterioration can occur repeatedly for an indefinite period of time while the court decides for or against treatment. BOP officials told us that they have been working with the federal courts to devise ways of reducing the amount of time courts need to make these decisions.

The Prisons Have Too Few Mental Health Resources

Over half of the facilities that we reviewed reported insufficient resources (staff, programs, or facilities) as a reason for some mentally ill inmates going untreated. At the time of our survey, for example, BOP had 116 psychologists in its general prisons and jails. The number is 56

fewer psychologists than the 172 that BOP's own guidelines suggest[9] and 17 fewer than had been authorized. Fifty-four of the 56 vacancies or nonestablished psychologist positions were at the general facilities that reported a shortage of staff as a major reason for the nondiagnosis or nontreatment of mentally ill prisoners. BOP officials said that noncompetitive salaries and the prison environment make recruiting enough psychologists difficult. They also said that personnel ceilings and budgetary limitations are the major reasons that the number of authorized psychologist positions is significantly lower than the number computed by their staffing criteria.

The shortage of staff is also a problem at BOP's psychiatric referral centers. At the time of our survey, the 4 psychiatric facilities had 1 of 26 authorized psychologist positions vacant and 8 of 26 authorized psychiatrist positions vacant. These facilities did not have overall staffing guidelines with which the authorized positions could be compared. The Springfield, Butner, and Rochester facilities were only taking new admissions on a bed available or emergency basis. Because of these staff shortages, Springfield was unable to perform all of its planned quality assurance reviews during both 1989 and 1990. Such reviews are required by BOP policy and by the Joint Commission on the Accreditation of Health Care Organizations to help ensure that the care provided meets with quality standards.

At Springfield, we found that of the 12 reviews planned for 1989 and 1990, 5 were not done. For example, a planned review to determine whether consent forms existed for medication was not done. A review in this area was last performed in August 1986 and found that the forms were often missing. Springfield officials agreed that improvements were needed in their quality assurance program, but they did not expect any improvement in this situation in the near future. In discussing this report, BOP officials did say, however, that Springfield had hired additional staff, which should lead to more quality assurance reviews being done. Officials at the other three psychiatric centers told us that all of their planned quality assurance reviews for 1989 and 1990 had been done.

[9]The guidelines call for 3 full-time psychologists for the first 500 inmates and 1 for every additional increment of 500 or fewer inmates, except for low- and minimum-security facilities. For low-security facilities, the guidelines are 2 psychologists for the first 500 inmates and 1 for each additional 500 or fewer inmates. For the minimum-security facilities, the guidelines simply call for 1 psychologist per each facility housing more than 300 inmates.

BOP's chief of psychology services told us that staff shortages coupled with prison overcrowding were significant factors in limiting the inmates' access to mental health care. He noted that in addition to the problems of nondiagnosis and nonparticipation in treatment, staff shortages also resulted in the available staff handling exceptionally high caseloads, which increased the risk of providing substandard patient care.

All Newly Admitted Inmates Are Not Fully Screened

BOP's policy requires that each new or transferring inmate should undergo screening by a physician assistant within 24 hours of arriving at a facility to identify obvious mental or medical problems that may require immediate attention. Within 30 days of arrival, institution psychologists are required to prepare a psychological assessment based in part on a questionnaire that each inmate is to have completed on his or her mental history and in part on an interview the inmate is to have had with the psychologist. Psychological assessments for pretrial detainees at BOP's jails are to be done only when the persons are referred to a psychologist because of suspected problems. These assessments are a key part of the information used by the prison staff to determine the inmates' treatment programs as well as their housing and work assignments.

BOP's headquarters and regional officials have noted in their reviews of facility operations that not all of the required screening was done. In our survey, officials from 17 of the 65 facilities reported inadequate screening procedures as a reason some mentally ill inmates were not diagnosed. Officials from 31 of the facilities reported an inability on the part of nonmental health staff to identify mental illness as a reason that some mentally ill inmates were not diagnosed.

In our survey, we also asked the extent to which all inmates who had been admitted during the 30 days preceding our survey had been screened. The 65 facilities reported admitting 13,448[10] new or transferring inmates during the 30 days preceding our survey. Almost all (97 percent) of these inmates were reported to have been screened. Of those screened, 82 percent were said to have been screened by physician assistants or case managers within 24 hours of the inmates' arrival at the facilities. These screenings resulted in 387 inmates being referred to a prison psychologist.

[10]This number excludes inmates who were received at the psychiatric referral centers for known or suspected mental health or medical problems.

Officials from 26 of the facilities reported that they had not prepared all of the required psychological assessments. About 68 percent of the inmates who had completed questionnaires at these 26 facilities had not had psychological assessments prepared when prison officials completed our questionnaire. Some of these assessments could have gone undone because some of the inmates were pretrial detainees or had not been there long enough to have been assessed. Other inmates, according to prison officials, had not been assessed because of such factors as staff shortages and delays in cases in which an inmate was undergoing psychological testing.

We noted similar findings during our file reviews at the Springfield and Bastrop facilities. At Springfield, we noted that 6 (12 percent) of our sample of 50 of the 103 inmates[11] who had been admitted to the facility's general prison population during the period from July through December 1989 did not have documented psychological assessments as of our review in June 1990. The psychologist in charge told us that the assessments had probably been done but either they had not been documented or the documentation had been misplaced. At Bastrop, we noted that 52 (68 percent) of our sample of 77 of the 219[12] general population inmates who had been admitted during the July through December 1989 period did not have documented psychological assessments as of our review in May 1990. Bastrop's chief psychologist confirmed our finding, which he attributed to a lack of staff. At that time, one of the four psychologist positions at Bastrop was vacant. The chief psychologist said that prison officials would take corrective action (hire additional staff) to ensure that future admissions received all required psychological assessments. Bastrop's response to our questionnaire indicated that corrective action had been taken.

BOP Is Taking Steps to Improve the Delivery of Mental Health Care

Anticipating further growth in the inmate population and recognizing that its mental health care delivery could be improved, BOP established an advisory group in November 1990 to identify mental health issues and recommend corrective actions. Other advisory bodies have existed since 1986 that have dealt with various issues within the medical and psychiatric areas of BOP's mental health activities. The new group had a broader focus (mental health), encompassing BOP's psychology services

[11] At the 95-percent confidence level, we estimated that between 6 and 20 of the 103 inmates did not have a documented psychological assessment.

[12] At the 95-percent confidence level, we estimated that between 128 and 168 of the 219 inmates did not have a documented psychological assessment.

program area as well as medical and psychiatric services. Group members included headquarters officials having overall responsibility for inmate correctional programs, psychology services, psychiatric services, and medical services; a member of BOP's legal staff; and officials representing BOP's psychiatric centers and regular prisons.

As a result of this group's recommendations, some actions have been taken, and others are just getting under way or are still being considered, according to BOP officials. A mental health organizational unit has been established within BOP's headquarters to ensure a continuing focus on the area. As of June 1991, BOP reported having 162 authorized psychologist positions at its facilities, 3 more than it had at the time of our survey. Another 37 psychologist positions have been authorized, and BOP expects to fill most of those positions by the fall of 1991. Plans call for hiring additional psychologists over the next few years. The goal is to have enough psychologists to meet 90 percent of the staffing level required under BOP's guidelines. According to BOP's chief of psychology services, the 90-percent goal represents a major effort to recruit additional psychologists, but BOP also recognizes that, because of recruiting difficulties, it will not get all that it needs.

Other actions that are either under way or being considered for implementation over the next couple of years include

- providing training to improve the ability of mental health staff and others (e.g., correctional officers) to identify and manage mentally ill inmates;
- developing an intermediate type of care unit at certain general prisons to serve those inmates who need a level of care somewhere between that offered by the psychiatric referral centers and by the general prisons and jails; and
- implementing a standard classification system and a standard for data collection on mentally ill inmates.

Longer term actions, which may take up to 5 years to complete, include the construction or acquisition of additional medical and psychiatric centers as well as the development of an overall quality assurance effort for monitoring the care provided by the psychiatric centers and intermediate care facilities.

Implementation of these actions should address the resource and screening problems noted in this report. For example, hiring needed

staff and implementing an intermediate form of care at selected facilities should reduce the likelihood of inmates not getting the care needed because of insufficient staff or facilities. Having more trained staff who are able to interact with the inmates may also lead some inmates who have refused or avoided treatment in the past to seek needed help. Furthermore, the establishment of a headquarters mental health organizational unit and the development of standardized data on mentally ill inmates should provide more of a focus on the area of mental health and should enhance BOP's overall capacity to determine mental health program needs and monitor how well those needs are being met.

We did not evaluate BOP's plans or its time frame for accomplishing these changes. Some of the advisory group's recommendations are still being considered and others (e.g., standardizing the data collection and classification on mentally ill inmates), while under way, are still in the early stages of development and have yet to be fully defined.

Conclusions

BOP has a substantial number of mentally ill inmates, and not all have been diagnosed or treated—some because they have coped successfully with general prison life and others because they have refused treatment, have been incompletely screened, or have lacked access to treatment resources. BOP officials, however, maintain that inmates with serious mental disorders do become known and do receive some type of treatment before being released.

Nevertheless, a 1990 advisory group put together to identify mental health care issues and needed actions has proposed extensive recommendations to improve BOP's identification, management, and delivery of such care. We believe that the group's recommendations and BOP's actions to effect these improvements to date signal a willingness to address the resource and screening problems noted in this report and to establish a framework for this undertaking. Given the challenges BOP faces, it remains to be seen how thorough and effective BOP will be in implementing all of its plans. Consequently, we are not making any recommendations.

Agency Comments and Our Evaluation

We provided a draft of this report to the Department of Justice for comment. Justice said the report was generally well balanced in its treatment of the issues but raised three matters for further discussion.

First, Justice believes that our report significantly understates the percentage of mentally ill inmates in treatment. Justice's belief is based on our finding that about two-thirds of the 3,131 Axis I inmates were participating in programs operated by the prisons' psychology or mental health departments and that some of the remaining inmates (1,074) may have been on medication or under a psychiatrist's care (emphasis added) (see p. 2). We believe the report clearly reflects the data provided by BOP headquarters and the 65 facilities we surveyed. BOP headquarters had no empirical data on the extent that the 1,074 Axis I inmates were under medication or participating in psychiatric care programs. The data the federal prisons provided us indicated that at least 609 of the 1,074 Axis I inmates were not under the care of a psychiatrist and were not participating in psychology or mental health department programs. The data do not allow us to determine whether the remaining 465 Axis I inmates were under psychiatric care or the extent that the 1,074 inmates were on medication.

Second, Justice said that BOP has an extensive system of mental health treatment. According to Justice, inmate records are carefully screened to ensure that appropriate care and treatment are provided. Also, Justice said that if the mental health condition of an inmate progresses beyond the capability of the general prisons and jails, the inmates are transferred to a psychiatric referral center. Justice's comments are generally consistent with the BOP policy noted in this report. However, the information provided by the prison officials we surveyed and the improvements proposed by BOP's mental health advisory group suggest that the BOP policy is not always followed.

The third matter is related to the second and involves the identification of mentally ill inmates by their inability to function in the general population. Justice was concerned that our report could give the impression that BOP merely "warehouses" mentally ill inmates who can cope in the general prison population, and Justice noted that such inmates do receive mental health treatment if they require it. We did not say that BOP warehouses mentally ill inmates. BOP officials told us that the ability to cope with general prison life is the predominant reason (of the four major reasons prison officials identified) why suspected or identified mentally ill inmates may not be participating in treatment. They said that mentally ill inmates who are coping with general prison life and not seeking treatment are not forced into treatment, with the exception of pedophiles and substance abusers. Justice's comment implies that in addition to pedophiles and substance abusers, others who are coping with prison life may require treatment and if so, receive it. However, as

noted above, our survey and BOP's planned improvements suggest that not all needed treatment is being provided. The complete text of Justice's comments is included as appendix II.

As arranged with the Subcommittees, we plan no further distribution of this report until 30 days after its date unless you publicly release its contents earlier. At that time, we will send copies to the Attorney General, BOP, and other interested parties. Copies will also be made available to others on request.

Major contributors to this report are listed in appendix III. Should you need additional information on the contents of this report, please call me on (202) 566-0026.

Harold A. Valentine
Associate Director
Administration of Justice Issues

Efforts to Place Mentally Ill Offenders Through State Civil Commitments

In certain circumstances, federal law provides that offenders who are found to have a mental disease or defect and are also found too dangerous to release be handled under state civil commitment proceedings. However, according to BOP officials, this is often not done either because suitable facilities are too costly or because the states are unwilling to assume the burden and cost of caring for those persons.

This issue involves offenders who have been placed in the custody of the Attorney General (in actuality, placed in BOP's custody)[1] under one of the provisions addressing the mentally ill contained in chapter 313 of title 18 of the United States Code. These offenders have been confined under the statutes that relate to determinations on, among other things, mental competency to stand trial, insanity at the time of offense or shortly after the conviction (within 10 days), and the placement of an insane offender scheduled for release.

For the purposes of a hearing to determine an offender's mental competency, the provisions addressing mentally ill offenders provide that a court may temporarily commit an offender to the custody of the Attorney General for examination in a suitable facility. If after the hearing the court finds an offender to have a mental disease or defect and is too dangerous to be released, the court remands the offender to the Attorney General, who is directed to make all reasonable efforts to cause the state in which the person was domiciled or was tried to assume responsibility for the person's custody and care (18 U.S.C. 4243 and 4246).

Essentially, the Attorney General is seeking to have the states commit these persons under civil commitment proceedings. This action is based on the view that the care of incompetent or insane persons has traditionally been a function of the states. These offenders, however, retain what BOP officials call a "compelling federal interest" in view of the seriousness of the original charges. The states must advise the committing federal court of any determination that such persons' release would no longer create a substantial risk of bodily injury to another or of serious damage to the property of another. The court will then decide either to order discharge or to hold a hearing to determine whether such persons should be released.

[1]The Attorney General has delegated authority in this area to BOP pursuant to 28 C.F.R. 0.96, which states in pertinent part: "The Director of the Bureau of Prisons is authorized to exercise or perform any of the authority, functions, or duties conferred or imposed upon the Attorney General by any law relating to the commitment, control, or treatment of persons (including insane prisoners and juvenile delinquents) charged with or convicted of offenses against the United States."

If unsuccessful in having the states take responsibility for these persons, the Attorney General must confine the persons in suitable treatment facilities until either the state agrees to take the persons or the court finds that the persons' conditions are such that their release would not cause risks to others and to property. The term "suitable facilities" is meant to include the psychiatric section of a prison. Thus, BOP's psychiatric facilities would be considered suitable. The statutes also require that periodic efforts be made by the Attorney General to cause a state to assume responsibility for these mentally ill persons.

As of August 1990, BOP had 243 offenders incarcerated at its psychiatric facilities under statutes addressing the mentally ill. Of the 243, 76 were persons who met the criteria for civil commitments in the states. Of the others, 145 were undergoing examination for competency or sanity.[2] On the basis of prior experiences, BOP officials estimated that from 10 to 20 percent of them would likely be found to be suffering from a mental disease or defect and to be considered too dangerous for release, thus becoming eligible for transfer to the states.

BOP officials told us that during 1989 and 1990, after expending varying amounts of time and effort, they were successful in placing with the states 63 prisoners who were classified as having a mental disease or defect and as being dangerous: 25 were classified under 18 U.S.C. 4243 and 38 were classified under 18 U.S.C. 4246. These included 23 of the 76 persons who were eligible for transfer to the states in August 1990. However, BOP was unsuccessful in placing another eight offenders who ended up being released during these 2 years because they were no longer considered to have a mental disease or defect and to be dangerous. According to BOP officials, the transferred and released prisoners spent from several months to up to 5 years incarcerated in federal prisons under the provisions of 18 U.S.C. 4243 and 4246.

BOP officials noted that the statutes contain no provision that assists BOP in getting these offenders placed with the states. They said that placement depends essentially upon the"salesmanship" of the referring BOP facility. The law does allow the Attorney General to contract with states, among others, for the care of these offenders, but BOP officials noted that space, when available, is quite costly. They also noted that

[2]The remaining 22 inmates were incarcerated under 18 U.S.C. 4244 and 4245, which deal with the involuntary hospitalization and treatment of offenders found, subsequent to conviction, to be mentally ill and needing treatment.

some states have difficulty with the "compelling federal interest" requirement, thus lessening their interest in accepting the offenders.

Comments From the U.S. Department of Justice

U.S. Department of Justice

Washington, D.C. 20530

OCT -4 1991

Richard L. Fogel
Assistant Comptroller General
General Government Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

The following information is being provided in response to your request to the Attorney General, dated August 30, 1991, for comments on the General Accounting Office (GAO) draft report entitled, "MENTALLY ILL INMATES: BOP Plans to Improve Screening and Care in Federal Prisons and Jails." We have reviewed the draft report and believe it is generally well balanced in its treatment of the issues. We note that GAO identifies the procedures and activities that BOP is initiating to ensure that all inmates needing mental health care have access to adequate treatment. We further note that GAO acknowledges the numerous challenges the Prison System faces in trying to implement its program. We appreciate GAO's recognition of the difficulties that BOP faces in its implementation of the program. However, we would like to raise a few points which we believe require further discussion.

GAO indicates that two-thirds of the inmates diagnosed as having an Axis I mental disorder (clinical syndromes, such as disorders involving mood and schizophrenia) are in treatment programs. It then notes that other prisoners may be on medication or under treatment by a psychiatrist. We are concerned that readers may not recognize the impact of this latter statement and will assume that one-third are not receiving any treatment. We consider those prisoners who are on medication prescribed by a psychiatrist or who are otherwise under treatment by a psychiatrist or psychologist to be in treatment. We believe, therefore, that GAO significantly understates the percentage of prisoners in treatment. We recommend that GAO correct this misunderstanding.

BOP has an extensive system of mental health treatment ranging from individual and group counseling by staff psychologists at all facilities to acute mental health patient treatment at its psychiatric referral centers. Records of inmates are carefully screened prior to their designation to any facility to ensure

that they are provided appropriate care and treatment. If the mental health condition of an inmate ever progresses to a point beyond the treatment capabilities of the in-house personnel and community consultant resources, BOP transfers the inmate to a psychiatric referral center.

BOP will soon augment its existing mental health care delivery system for sentenced inmates with a transitional care unit. This unit will provide a step-down unit alternative for those patients moving from acute treatment back into the general population. The unit will also be used for patients who are unable to function in a regular institution environment, but do not require the special resources of a psychiatric referral center. Offenders who require evaluation and treatment are being placed in one of BOP's psychiatric referral centers or in one of seven forensic study sites. The forensic study sites have the additional resource to accomplish the court evaluations and provide special treatment as stipulated by the court.

Finally, we note that, in discussing the identification of inmates requiring treatment, GAO indicates that one method of identifying such inmates is their inability to function in the general population. To some this may suggest that BOP merely warehouses inmates who can function in the general population. This is not accurate. We think it may be useful for GAO to add language to explain that even inmates who can function in the general population receive mental health treatment if they require such treatment. BOP makes every effort to meet inmates mental health treatment needs.

We appreciate the opportunity to review and comment on the draft report. We hope you will find our comments beneficial.

Sincerely,

Harry H. Flickinger
Assistant Attorney General
for Administration

Major Contributors to This Report

General Government Division, Washington, D.C.	Richard M. Stana, Assistant Director, Administration of Justice Issues Carl Trisler, Assignment Manager Thomas H. Givens III, Social Science Analyst
Office of the General Counsel	Geoffrey R. Hamilton, Attorney-Advisor
Dallas Regional Office	Vernon Tehas, Regional Management Representative Raimondo Occhipinti, Evaluator-in-Charge Ruth Kasten, Staff Evaluator Gerald Hoppmann, Staff Evaluator

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