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BY THE COMPTROLLER GENERAL

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# Report To The Congress

OF THE UNITED STATES

## Prison Mental Health Care Can Be Improved By Better Management And More Effective Federal Aid

The mental health care delivery systems of most prisons do not identify all inmates needing help or provide proper care. The systems have been hindered by limited funding and personnel shortages; but managers could begin to improve them by using staff better, maintaining complete, well-organized records, and monitoring and evaluating programs more intensively.

This report contains recommendations on how the Bureau of Prisons could improve its system for providing inmates with mental health care. It also discusses ways in which programs conducted by several Federal agencies could be used to help States improve their prison mental health services.



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COMPTROLLER GENERAL OF THE UNITED STATES  
WASHINGTON, D.C. 20548

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To the President of the Senate and the  
Speaker of the House of Representatives

This report discusses inadequacies in inmate mental health care delivery systems in Federal and State prisons. It makes certain recommendations for improving inmate mental health care in Federal prisons and recommends ways in which Federal programs could be used to improve inmate mental health care in State prisons.

We are sending copies of this report to the Director, Office of Management and Budget; the Attorney General; and the Secretary of Health, Education, and Welfare.

A handwritten signature in black ink, appearing to read "F. A. Staute".

Comptroller General  
of the United States

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COMPTROLLER GENERAL'S  
REPORT TO THE CONGRESS

PRISON MENTAL HEALTH CARE  
CAN BE IMPROVED BY BETTER  
MANAGEMENT AND MORE  
EFFECTIVE FEDERAL AID

D I G E S T

Most prisons do not identify all inmates needing help or provide proper care. Although mental health services have been hindered by limited funding and personnel shortages, managers could begin correcting many inadequacies through improved administration. At the State level, additional improvements could be made if Federal programs operated by the Law Enforcement Assistance Administration, the Department of Health, Education, and Welfare, and other Federal agencies were more extensively used for the mental health care of prison inmates.

This report--the second in GAO's series on health services in correctional institutions--discusses the problems Federal and State prisons are having in providing adequate mental health care to inmates. In it, GAO considers mental health treatment and care to pertain to a broad spectrum of inmate problems. The principal general categories are psychosis, behavioral disorders, mental retardation, and alcohol and drug abuse and addiction.

PRISON MENTAL HEALTH CARE IS  
NOT ADEQUATE

Federal and State prisons generally did not provide adequate mental health care, and mental health services were limited in scope

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and extent. Adequate mental health care involves identifying inmates' individual problems or needs and providing treatment tailored to meet their needs.

Federal and State prisons required that new inmates be screened to determine their needs, but the screening was not always adequate to identify mental health problems. The range of services varied among prisons, and treatment efforts focused on inmates who were violent and dangerous to themselves or others. Inmates who were not an immediate threat were generally ignored unless they requested help or their problems became acute.

The treatment of the mentally ill often fell short of accepted standards. All prison systems had developed a framework of treatment services, consisting of inpatient care at psychiatric hospitals and outpatient services in individual prisons. However, a variety of problems existed in providing adequate and timely care on a daily basis. Due to a shortage of beds and staff, inmates had to wait for admission to psychiatric hospitals, and the hospitals sometimes released inmates before they were ready. Also, psychiatric facilities often did not include adequate provision for inmates in need of long-term care.

GAO also noted that:

--The Bureau of Prisons and three of the five States visited tended to treat behavioral disorders only when inmates requested help or when a crisis arose. Only two States had programs for treating behavioral disorders, and one of those concentrated primarily on sexual offenders.

--The Bureau had made a significant effort to provide treatment programs for drug abusers, but standards had been lacking. Thus, wide variations had existed in their content and staffing. The Bureau had given much less attention to programs for alcohol abusers but had initiated actions to improve efforts in both areas. The States had recognized the need to treat drug and alcohol abusers, but relatively few abusers had been getting help.

#### BETTER MANAGEMENT COULD IMPROVE CARE

Limited funding and shortages of qualified staff will likely continue to affect mental health efforts in both Federal and State prison systems. Through improved administration, however, managers could begin correcting many of the inadequacies in the present level of mental health care. (See ch. 3.)

Effective administration of mental health programs requires information on inmates' needs, adequate records, good use of staff, effective monitoring and evaluation of programs, and independent reviews of activities. To varying degrees, administration in Federal and State prison systems lacked these needed elements:

- Information on the overall extent and type of inmate mental problems was usually not compiled. (See pp. 33 to 35.)
- Records of treatments and needs were often incomplete or disorganized, and pertinent information was not forwarded when inmates were transferred. (See pp. 35 to 46.)
- Staff was not always used effectively. (See pp. 46 to 51.)

--Shortfalls in program monitoring and evaluation were widespread. (See pp. 51 to 55.)

--Independent review of programs was limited. (See pp. 55 to 56.)

Correcting these management shortfalls is essential not only to improve mental health care but also to be sure that managers make the best use of existing resources.

FEDERAL PROGRAMS TO IMPROVE  
MENTAL HEALTH CARE COULD BE USED  
MORE EXTENSIVELY IN PRISONS

The Federal Government conducts a variety of financial and technical assistance programs that could help States improve the availability of treatment services for prison inmates having mental health, alcohol abuse, and drug abuse problems. These programs could assist in bringing about coordinated planning by State criminal justice and health agencies to identify inmates' needs, support development of treatment programs and management, and provide research and training assistance. Agencies that conduct such programs include the Department of Health, Education, and Welfare and the Law Enforcement Assistance Administration. (See ch. 4.)

But the Federal programs have had only limited impact, because the agencies have paid little attention to prison mental health services. To illustrate:

--Guidelines for some of the programs did not specify that participating State agencies consider prison inmates in determining mental health needs and in developing State mental health plans.

--Where guidelines have required such State actions, Federal agencies have not enforced them.



- Federal agencies have not ensured that State criminal justice agencies and health planning agencies effectively coordinate their planning, programing, and funding efforts.

While the Federal Government cannot fully subsidize mental health care in State prisons, it can provide assistance. Federal agencies need to give more recognition to inmates' mental health needs and the importance of the Federal role in meeting these needs.

#### RECOMMENDATIONS

This report contains a number of recommendations for improving mental health care in Federal and State prisons. Among other things, the Bureau of Prisons should:

- Revise screening policy to specify and provide for comprehensive identification of inmates to be referred for treatment.
- Improve the basis for assessing program needs by regularly compiling and summarizing available information on the extent and nature of inmates' mental health problems.
- Require the establishment of a central psychological file for each inmate and reemphasize the need for adequate records of inmate problems and treatment actions.
- Establish greater management control over the quality and performance of substance abuse treatment programs by promulgating standards for their content, staffing, and evaluation.
- Increase management surveillance of the quality of mental health services by expanded use of independent reviews by outside professional organizations.

The Law Enforcement Assistance Administration should:

- Work with State criminal justice agencies to identify the extent of mental health problems in prisons. These results should be used to consider establishing a discretionary grant program for treating mental health problems in prisons. If such a program is established, the Law Enforcement Assistance Administration should require that State criminal justice agencies coordinate their actions with State health agencies receiving assistance under other Federal programs.
- Strengthen procedures for reviewing State criminal justice agencies' comprehensive plans to ensure that the plans adequately address the alcohol and drug treatment needs of prison inmates and provide for effective coordination with State substance abuse agencies to plan and program implementation actions.

The Department of Health, Education, and Welfare should:

- Strengthen National Institute of Mental Health, National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism procedures for reviewing State health and substance abuse agencies' comprehensive plans to ensure that the plans adequately address the mental health, alcohol, and drug treatment needs of prison inmates. It should also ensure effective coordination with State criminal justice agencies to plan and program implementation actions.
- Revise program guidelines for participating State mental health and alcohol abuse agencies to make clear that the agencies should address the needs of prison inmates.

Additional recommendations are on pages 31, 57, 78, and 79.

AGENCY COMMENTS

The Departments of Health, Education, and Welfare and Justice commented on a draft of this report by letters dated August 22, 1979, and August 23, 1979, respectively. (See apps. I and II.) The results of GAO's work were also discussed with each of the States visited.

The Department of Health, Education, and Welfare generally agreed with most of GAO's recommendations.

The Department of Justice generally agreed with the recommendations pertaining to the Bureau of Prisons but believed that some of those applicable to the Law Enforcement Assistance Administration had already been implemented. GAO does not believe the Department's comments support that conclusion.

A detailed analysis of agency comments is included on pages 31-32, 58, and 80-81.



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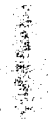
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## ABBREVIATIONS

AA	Alcoholics Anonymous
ACA	American Correctional Association
ADAMHA	Alcohol, Drug Abuse, and Mental Health Administration
AMA	American Medical Association
APHA	American Public Health Association
BOP	Bureau of Prisons
HEW	Department of Health, Education, and Welfare
JCAH	Joint Commission on Accreditation of Hospitals
<u>LEAA</u>	<u>Law Enforcement Assistance Administration</u>
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
NIMH	National Institute of Mental Health



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## CHAPTER 1

### INTRODUCTION

Federal and State governments spend about \$2.1 billion annually to house approximately 280,000 inmates in 500 prisons. One of the most pressing problems in prisons, which normally house inmates with sentences ranging from 1 year to life, is providing adequate health care.

Proper health care for prison inmates has become a major prisoners' rights issue in recent years. Correctional officials, courts, and legislatures have concluded, to varying degrees, that inmates must have access to adequate health care. A definition of adequate health care is evolving through the promulgation of professional standards and Federal court decisions. But many correctional facilities still face the problem of how to make their level of care adequate.

For the purpose of this report, the term "mental health care" covers a broad spectrum of inmate problems. The general categories are psychosis, behavioral disorders, mental retardation, and alcohol abuse and drug addiction 1/.

#### STUDIES HAVE INDICATED THAT PRISON MENTAL HEALTH CARE IS A PROBLEM

The American Medical Association (AMA) and other organizations contend that a significant number of inmates have mental health problems when they enter prison and that many prisons are unable to adequately treat them because prisons are overcrowded, understaffed, and underequipped. As a result, sometimes existing conditions are aggravated or additional mental health problems occur. Available studies and publications seem to support these contentions.

Various studies of Federal and State prison systems show that many of the adult offenders in custody have mental health, alcohol, and drug problems. For example:

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1/This report is our second on health care in correctional institutions. Our first report, "A Federal Strategy Is Needed To Help Improve Medical And Dental Care In Prisons And Jails," (GGD-78-96) was published December 22, 1978.

- Bureau of Prisons (BOP) psychologists have estimated that about 2 percent of BOP's inmates may be psychotic. In studies performed by two of the States visited of 1,084 inmates in one State and 441 inmates in the other, psychotics were estimated to comprise 6.70 and 14.05 percent, respectively, of the total. Psychotic inmates, depending on the seriousness or degree of their problem, require psychiatric care with drug therapy, psychological counseling, supervision, and/or observation, either on an inpatient or outpatient basis.
- BOP has estimated that 50 percent of its inmates may have behavioral disorders. In the studies referred to above, estimates of adult inmates having behavioral disorders were 21 percent in one State and 43 percent in the other. Such inmates include neurotics, kleptomaniacs, sexual deviates, psychological arsonists, and those with phobias and aggressive explosive personalities. They need psychological help through individual and group psychotherapy to help them understand and control their behavior.
- According to a Law Enforcement Assistance Administration (LEAA) document--The Mentally Retarded Offender and Corrections, dated August 1977--9.5 percent of the prison population may consist of retarded persons, that is, those having IQs of 70 or below, combined with deficits in adaptive behavior. Based on a computer analysis of reported IQ scores for fiscal year 1977, about 1 percent of BOP's inmates may be retarded. One State's evaluation of its inmate population between 1974 and 1976 indicated a retarded population of about 2 percent. These inmates require special care: protection from other inmates to guard them from abuse and basic education and occupational training to improve their ability to earn a livelihood after release.

--According to BOP data, its inmate population includes 6 percent who had a history of alcohol abuse 1/ and 35 percent with a history of drug abuse. In one State, a reported 60 percent of the inmate population has had alcohol or drug problems. In another State, almost half of the inmates had been alcohol or drug abusers--including 24 percent who were identified as heroin addicts. These inmates need education on the hazards of these substances, help in understanding the nature of their illness or problems, and psychotherapy to help them overcome their addiction or dependence.

Various court decisions have addressed the right of prison inmates to receive mental health treatment and the adequacy of mental health services provided to them. Courts have ordered some States to take action to correct shortfalls.

THE FEDERAL GOVERNMENT  
IS INVOLVED IN INMATE  
MENTAL HEALTH CARE

The Federal Government provides mental health, alcohol, and drug care to inmates in Federal correctional institutions through BOP. The statute that established BOP makes broad general provision for mental health care and treatment of sentenced offenders. Besides requiring the general care of inmates, the statute provides for (1) classifying and segregating them according to such factors as mental condition and (2) an individualized system of discipline, care, and treatment (18 U.S.C. §§4042, 4081).

Federal statutes more specifically require mental health treatment regarding inmates sentenced under

- the Narcotic Addict Rehabilitation Act of 1966 (Public Law 89-793, 80 Stat. 1438-1448) and
- the Federal Youth Correction Act (18 U.S.C. §§5023-5026).

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1/In commenting on a draft of this report, the Department of Justice informed us that, for a number of reasons, this percentage could be too low. It stated that the number of inmates with alcohol abuse problems could be as high as 42 percent.

The Narcotic Addict Rehabilitation Act of 1966 requires the Attorney General and, by delegation, BOP to provide psychological and other services to eligible narcotic addicts; eligible persons include those not convicted of a crime of violence who are deemed likely to be rehabilitated through treatment. The Federal Youth Correction Act requires BOP to provide guidance and training to correct and prevent the anti-social tendencies of offenders under 22 years of age who the courts believe would benefit from treatment.

In addition, Federal statutes authorize BOP to provide other mental health services, such as performing evaluations and studies to (1) assist the courts in determining a person's competency to stand trial and in making sentencing decisions for convicted offenders and (2) aid the U.S. Parole Commission in determining inmates' suitability for parole. BOP is also authorized to care for persons found incompetent to stand trial.

The Federal Government can also help the States improve mental health care to prison inmates, primarily by providing funds through LEAA or the Department of Health, Education, and Welfare (HEW).

#### HEALTH CARE STANDARDS HAVE NOT YET BEEN NATIONALLY ADOPTED

For many years hospitals and other health care providers have been required to comply with State licensing standards and requirements, but prison hospitals and infirmaries, with few exceptions, have not been subject to these requirements. Until recently, no health care standards were available for correctional institutions. Now AMA, the American Public Health Association (APHA), and the American Correctional Association (ACA) have promulgated health standards for prisons and jails <sup>1</sup>/. Though not adopted as law, these standards provide State and local governments with guidance for making needed improvements to health care in prisons and jails. They are consistent with those expected of other health care providers. The American Association of Correctional Psychologists has recently established a committee to develop psychological standards for prisons.

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<sup>1</sup>/On June 23, 1978, the U.S. Department of Justice released its "Draft Federal Standards for Corrections" for public comment. The standards cover a broad range of correctional issues as well as specific standards for the care of the mentally ill, mentally retarded, and drug and alcohol abusers.

At the time of our review, AMA was working toward approving and publishing its final set of standards. Three sets of distinct standards will be published--Jails, Prisons, Juvenile Facilities--each including standards for medical, dental, psychiatric, and chemical dependency care. The overall theme of the standards will be that adequate health services should be available to all inmates, either within the facility or through the community. The standards will recognize the different characteristics (such as purpose, size, and location) of prisons and jails but will require that, regardless of where or how the services are provided, they should be adequate and include recognition, diagnosis, treatment, and referral services.

The APHA standards for health services in correctional institutions are based on the premise that (1) adequate health care for the incarcerated is a public responsibility to be borne jointly by the criminal justice and health care systems and (2) the level of prison health care services should be similar to that prevailing in the community at large. These standards, published in 1976, cover both prisons and jails. On mental health, the standards address

- mental health screening and evaluation, including personal history elements of mental illness, mental health treatment, education, and drug and alcohol use;
- provisions for hospitalization and treatment of persons who require it because of mental illness;
- staffing; and
- other important issues affecting the overall mental health needs of inmates, such as crisis intervention, and short- and long-term group and individual therapy.

ACA's prison health care standards are part of its overall standards for adult correctional institutions. Published in August 1977, the ACA standards state that there should be

- screening procedures to identify inmates with specific needs, including psychosis, behavior disorders, mental retardation, alcoholism and alcohol abuse, and drug addiction and drug abuse;

--provisions for transferring severely psychotic inmates to facilities that can care for them effectively; and

--sufficient numbers of professional staff available to provide (1) 24-hour care for severely psychotic cases and emergency situations and (2) appropriate treatment programs for less disturbed inmates having special needs.

During our review, we considered all available standards on mental health care; however, we relied primarily on those promulgated by ACA since they were directed specifically toward prisons. Much of our review was conducted on site at 6 Federal prisons and at 8 State institutions in 5 States. The scope of our review is set forth in chapter 5.

## CHAPTER 2

### PRISON MENTAL HEALTH CARE IS INADEQUATE

Adequate mental health care involves identifying inmates' individual problems or needs and providing treatment tailored to meet those needs. Although improvements have been made in recent years, the Federal and State prisons we visited were generally not providing such care.

Our review showed that prisons did not always adequately screen new inmates to identify their problems. Further, although all prisons provided psychiatric care for the severely mentally ill, the treatment provided to them often fell short of accepted standards. Due to a shortage of beds and staff, inmates had to wait for admission to psychiatric hospitals and were sometimes released early.

Inmates were not always getting appropriate care in the hospitals. Some were locked up for long periods, and use of medication did not always seem to conform to accepted standards. We also noted that methods used to transport severely mentally ill patients to and from hospitals were sometimes questionable.

The extent of other mental health treatment services varied among Federal and State prisons, with none providing services for all the general categories of mental health problems. Our review showed that:

- BOP and three States tended to treat behavioral disorders only when inmates requested help or when a crisis arose. Only two States had programs for treating behavioral disorders, and one of those concentrated primarily on sexual offenders.
- BOP and four States placed little emphasis on helping the mentally retarded. Only one State had programs tailored to their specific needs.
- BOP has made a substantial effort to treat drug abusers but only a limited effort to treat alcohol abusers. The States visited recognized the need to treat drug and alcohol abusers, but few were getting help.

We realize that mental health care services have been significantly constrained by limited availability of funds and personnel. Therefore, it is important to point out that in addition to inadequate care, our review showed that treatment systems have not been well managed. Correcting management shortfalls would not only improve mental health care but would also make the best use of existing resources.

The need for improved management becomes even more critical since most correctional systems will likely continue to be underfunded and understaffed. For that reason, a detailed discussion of the management area is found in chapter 3 of this report.

#### PRISONS OFTEN DO NOT ADEQUATELY IDENTIFY INMATES' PROBLEMS

Federal and State prisons often did not adequately screen inmates to identify mental health problems. In BOP and in three of the five States we visited, screening focused on identifying inmates who had obvious and acute problems rather than on comprehensively identifying inmate needs.

According to ACA standards, prisons should have a formal classification system for screening new inmates to identify their needs and for developing program recommendations best suited to fulfill them. The standards specify that screening should, among other things, identify "special needs inmates," including, but not limited to

- inmates who have psychoses or behavioral disorders,
- alcoholics and alcohol abusers, and
- drug addicts and drug abusers.

Screening inmates for special needs is necessary for proper custodial assignment and program placement. After identifying the number, type, and frequency of commitment of inmates with special needs, the institutions can determine the treatment programs needed. Screening includes, as a minimum: reviewing the inmates' personal histories and assessing coping mechanisms, ego strengths, and any desire for help. Several written tests exist that aid in assessing inmates' personality traits.



BOP and the State systems had formal classification procedures that included screening to identify inmates' needs. In Federal prisons, inmates are classified at their assigned prisons. They are screened by various departments--including psychology--whose representatives form a committee to meet with inmates. On the basis of a composite of reports and forms submitted by the departments and a personal interview, the committee is supposed to identify inmate needs and recommend programs to meet them. State systems' classification programs are similar. In the States visited, the principal difference is that all new inmates are supposed to be screened at centralized reception facilities before being assigned to a specific prison.

### Bureau of Prisons

BOP estimates that only 14,000 of the approximately 28,000 inmates in the Federal prison system have received adequate indepth screening to identify any psychosis or behavioral disorder. Not all inmates were screened, and screening was often done only to identify severe problems which might cause a particular inmate to be disruptive. As a consequence, mental health problems are usually not noted unless they are obvious and acute or unless inmates request treatment.

At the five institutions we visited, not all newly arrived inmates received screening. For example at Butner, inmates in one of the three units of the general population were not screened, according to the unit psychologist. He cited lack of time as the reason. At another, Petersburg, our examination of 40 inmate files showed 12 were not screened--3 were new arrivals and 9 were transferred from other prisons where they had not been screened. A Petersburg psychologist said that in June 1978, they began screening transferees, and this should correct much of the problem.

At most of the institutions we visited, screening was focused on identifying inmates who might be disruptive. Thus, screening was adequate to identify the more obvious forms of serious problems, but inadequate to identify other serious, but less overt, ones. To illustrate:

--At Lewisburg, screening was primarily directed at determining the type of housing that would be suitable for the inmate. (Separate units were maintained for three general categories of personalities: "passive-weak," "active aggressive," and "normal.") While the tests indicated

mental problems, the results were reviewed by a psychologist to identify, for treatment purposes, only severe or acute problems. A psychologist did not interview each new inmate, and case managers who interviewed them were not qualified to identify other than obvious problems.

--At Lompoc, screening sought to identify assaultive, escape prone, suicidal, and seriously psychotic inmates. It did not routinely try to identify lesser problems. The Chief Psychologist told us the cited problems were noted primarily for alerting correctional staff to inmate control problems; control is often a greater consideration than the inmates' mental health needs.

--At Petersburg, screening was aimed at identifying inmates having psychiatric problems needing immediate attention and at inmates likely to be a control problem--the actively psychotic, suicidal, psychopathic, or extremely aggressive. Inmates were reevaluated if they, on their own, requested to see a psychologist or were referred to psychology services by other staff.

The general consequence of such narrowly focused screening was that treatment efforts were often deferred until problems became acute--in short, treatment efforts were crisis-oriented. Psychologists at two of the above institutions said that inmates with mental problems could go through the screening process without being identified and not be recognized until either crisis intervention was required or the inmate was referred to psychology services by one of the correctional staff.

Within BOP, the scope of screening has been affected by uncertainty about screening's aim and purposes. BOP has recognized that psychological screening of inmates has been deficient and has initiated actions aimed at improving it. Such actions include the establishment in 1977 of a task force on screening. The task force addressed the need to clarify the purposes of screening, and the group developed a wide-range list of purposes. While these included identifying inmates who might be control problems, they also recognized that screening should be done for inmate treatment. At the time of our review, BOP was drafting a new policy on psychological screening that would, according to the Chief Psychologist, be in accord with the task force's recommendations.

BOP also plans to hire 42 additional psychologists, which should alleviate some of its problems. According to the Psychology Services' 5-year plan for 1979 to 1983, psychological screening of all inmates is a goal to be achieved by October 1980.

#### State prison systems

In two States (California and Michigan), psychological screening was comprehensive, and officials considered it adequate. Screening was aimed at identifying all mental, drug, and alcohol problems for which treatment efforts would be appropriate. However, in the other three States, officials recognized that screening was inadequate. Screening did not comprehensively identify all inmates having mental health problems but, rather, was mainly aimed at identifying those inmates who had obvious and acute problems--that is, inmates who would pose control problems. Moreover, in two of these States, many inmates were not screened or were inadequately screened. In one, 19 percent of new inmates in fiscal 1978 were not screened. In the other, there was no method to administer tests to inmates unable to speak English. Such inmates made up an estimated 20 percent of the State's inmate population.

In the three States visited where officials considered psychological screening to be inadequate, the most commonly cited underlying factors were insufficient staff, limited availability of treatment services, and lack of a specific screening policy.

In two of these States, widespread screening had been established only in recent years, with the substantial assistance of Federal funds. One State, from 1972 to 1976, received \$519,000 from LEAA. The other, from 1976 to 1978, received \$299,000 of Comprehensive Employment and Training Act funds.

While none of the three States had a full range of treatment programs available, one State official did not believe this factor justified limited screening. Instead, he considered expanded screening to be a priority because, without it, the kind of treatment programs needed was unclear.

In two of these three States, there appeared to be a need to clarify policy concerning purposes of psychological screening. Their policies did not specifically provide that screening was to comprehensively identify inmate problems for treatment purposes. In one State, a reception center official

said a more specific State law may be needed to help ensure that inmate needs are identified and treated. The current correction law, as regards classification of inmates, merely requires "consideration" of their mental and emotional needs.

One State had not yet determined what needed to be done to correct the problem. The other two States' corrective efforts largely involved acquiring more personnel:

- One State had requested the State legislature to provide funds for needed additional personnel.
- The other planned to seek Federal funds to provide needed additional personnel. Also, using free consultant services provided under an LEAA project, it was performing a study of its entire classification system.

All States visited screened inmates for drug and alcohol abuse problems. But in one State, officials of a reception center said there was not enough staff to do so effectively. The State obtained LEAA funds to add a psychologist to overcome the deficiency, but the position was not yet filled at the time of our review.

NOT ALL PSYCHOTIC INMATES RECEIVE  
APPROPRIATE CARE AND TREATMENT

BOP and the State prison systems visited have developed a framework to care for psychotics as specified by the ACA standards; however, the efforts have not been fully effective. Psychiatric facilities were sometimes not adequate to provide appropriate full-time care to all inmates needing it and often did not provide services for inmates who needed long-term care. Also, use of medication and methods used to transport the mentally ill were sometimes questionable.

Psychotic inmates--those affected by mental disease or serious mental derangement--probably comprise between 2 and 14 percent of the inmate population nationwide. Their problems vary in severity: some are acute and chronic, others are borderline, and still others are in remission.

Health care standards for adult correctional institutions, published by the ACA in August 1977, require that severely psychotic inmates be transferred to a facility that can treat them effectively and assure public safety. These facilities must be under the supervision of mental health personnel and operated according to the standards and procedures of the psychiatric field. Less disturbed inmates are to be retained in the general inmate population, where possible. They are to be provided with treatment programs that use the least coercion necessary under supervision by competent mental health professionals. The standards also require that a qualified psychiatrist be available 24 hours a day, on either a full-time or a consulting basis, to assist the mental health personnel.

Psychiatric facilities were sometimes not able to provide appropriate full-time care to all inmates needing it

Programs of psychiatric hospitals are not always well staffed or large enough to provide appropriate treatment to all inmates needing inpatient care. Only those inmates whose psychoses were most acute got immediate attention. Others had to wait until space became available and thus were kept in prisons less able to care for them. This situation seemed more pronounced in three of the five States visited than it did in BOP and the other two States, however, we noted that at BOP's main psychiatric hospital, staff was insufficient to provide appropriate supportive services to all patients. Officials at BOP and in one State said they were releasing some psychotics before they were fully recovered or stabilized to make room for more acute cases.

At the time of our visit, one State was housing mentally ill inmates in the main prison's segregation units because the correctional psychiatric hospital was full and so was the prison's psychiatric unit. Since April 1978, the number of psychotics in the segregation units fluctuated from between 40 and 60 inmates. The psychiatrists refused to go to the segregation units to see the psychotics because there were no treatment rooms and they felt that the general environment was not conducive to treatment. As a result:

--The psychotics--occasionally in handcuffs and leg irons--had to be escorted through the yard to the infirmary to have their prescriptions renewed.

--In some cases, the more violent psychotics were gassed with mace and carried to the infirmary on stretchers.

We were told that about five psychotics a week were transferred to the psychiatric hospital as beds became available. At this rate, inpatient care would not be available to the psychotics in the segregation units for several weeks.

Until 3 years ago, treatment in another State was almost nonexistent; the State had no specialized facility for such care. Those who required restraint and/or close monitoring of medication were housed in 20 to 25 cells in one of the cell blocks in its central correctional institution. Also located there were inmates in protective custody and those awaiting the death penalty. Virtually no trained staff was available for around-the-clock observation or supervision or administration of medication.

In January 1976, by using HEW Title XX (Social Security) funds, the Department of Corrections was able to greatly improve care. It obtained 48 cells in its newest medium/maximum security institution, improved staffing, and separated mental patients from other inmate groups. But officials realize that 48 cells were not enough and that, simply in terms of the number of inmates they can serve, gross inadequacies were apparent.

At the Medical Center for Federal Prisoners in Springfield, Missouri, certain inmates were not receiving the appropriate type of care. In our visit to Springfield, we noted that while most of the approximately 280 patients seemed to be getting appropriate care, about 76 inmates in 2 secure cell blocks were not. These inmates included new arrivals awaiting placement in regular blocks, potential suicides, and disciplinary cases.

Inmates in the two secure blocks were locked up from 4:30 p.m. to 6:30 a.m. each weekday and throughout weekends and holidays. The Associate Director of Psychiatry stated that this situation should not exist and would not in a nonprison hospital. He said there should be supportive programs--such as occupational therapy and education classes--for the inmates to participate in during part of this time. However, because of shortages of staff, the Medical Center is unable to staff such programs during those hours. AMA officials said that consistently locking a patient up from 4:30 p.m. to 6:30 a.m. each day would negate any good treatment results realized during the day. In a June 1978 visit,

a BOP regional team had similar observations on the care provided in the two secure units.

Facilities do not include adequate provision for psychotics who need long-term care

Since psychosis varies in severity, psychotic inmates need varying levels of care. Some of them do not need continued hospitalization but cannot sustain themselves in the general prison population, in part because of the stresses involved. BOP and State officials said that prison systems need to establish intermediate care systems--or semi-protective environments--to separate, protect, and care for those psychotics released from psychiatric facilities who are not yet able to cope with normal prison life.

According to the staff psychologist at Petersburg, Butner is successful with, and provides good treatment for, inmates needing short-term care. But inmates needing long-term care are sent back to Petersburg under medication. He said they often became psychotic again and are referred back to Butner, which may or may not take them back a second time. If Butner refuses to take them back, Petersburg then transfers them to Springfield. He said an inmate finds himself on a "treadmill" from Petersburg to Butner, Butner to Petersburg, Petersburg to Springfield, and Springfield back to Petersburg. He said Petersburg is now getting inmates back from Springfield because it no longer has the facilities to treat the inmates. According to him, it makes no sense for Butner and Springfield to send inmates that still need treatment back to Petersburg because if those institutions cannot treat them, Petersburg surely cannot.

The Butner Mental Health Division Chief Psychologist told us that they are not able to provide the long-term care that an estimated 25 to 33 percent of their patients need. He said that because the mental health units are designed to function as crisis care units, long-term care is sacrificed. He also said that many inmates were released to general populations because the facility needed room for more acute cases.

We followed up on 15 of the inmates who were returned from Butner to Petersburg. Petersburg officials said that several inmates did not benefit from Butner. One inmate released from Butner, diagnosed as schizophrenic, was sent to Springfield 2 days after arriving back at Petersburg

because he was still actively psychotic. The Staff Psychologist said some inmates can sustain themselves at Butner but not at Petersburg because Petersburg does not have as extensive a staff or facilities as Butner.

The States visited also recognized the need for semi-protective environments to care for some mentally ill inmates. In a September 1977 presentation to the State Legislature's Committee on Mental Health, the Commissioner of one State prison system summed up the situation this way:

--"In terms of this agency's capacity to treat certain mentally ill inmates in an institutional setting for short periods of time (30-90 days), great improvements have taken place. However, when measured against the number of inmates still in need of such care, our present efforts fall far short. Substantial additional facilities and trained personnel are necessary to bring our psychiatric care up to minimal standards. Simply in terms of the number of inmates we can serve, gross inadequacies are apparent.

--"Essentially, we are doing the same things for inmates, albeit better and for more inmates, as we were doing two years ago. That is, we bring an inmate into the unit, administer treatment, and then release him back into an institutional population. Often, this return to an institutional population results in a recurrence of his symptoms.

--"What we are doing is inadequate, and we see the need for improvement in two major areas. First, we need to augment existing staff so that we can treat more inmates at one time and extend some inmates' treatment programs. Secondly, we must establish an intermediate care system for those who \* \* \* are not yet capable of returning to a regular institution. Our opinion is that we should expand the (45 inmate) psychiatric unit to approximately 60-70 beds and that we should establish an intermediate care unit of approximately 100 beds. The Department of Corrections can, of course, rearrange inmate housing to provide additional space for the above programs. However, our capacity to staff and operate such a program is limited by lack of funds."



Use of medication does not seem to conform to generally accepted medical practices

Medical authorities generally recommend using the lowest effective dosage of psychotropic drugs and, wherever possible, prescribing a single drug. They also recommend the appropriate use of "drug holidays"--the practice of taking patients off drugs for 2 or 3 days a week.

In a previous report 1/ we pointed out the potential dangers associated with polypharmacy--the simultaneous use of more than one psychotherapeutic 2/ drug on the same patient. Numerous research studies, including some by the Veterans Administration, have shown that polypharmacy increases the possibility of adverse reactions. Such research has suggested that it be avoided if possible. At the hospitals visited in our previous review, 2,002 of the 6,171 patients involved, or about 32 percent, were taking more than one psychotherapeutic drug. In that report, we also discussed the inadequate use of drug holidays.

For this report, we reviewed records for 97 inmates in the various institutions we visited and found that 27 (28 percent) of them were or had been treated by multiple drug therapy. Some very high dosages and some extensive use of polypharmacy were noted in two States and at Springfield. Drug holidays apparently were not used. BOP's Chief Psychiatrist told us that BOP had no consistent policies or procedures regarding the use of psychotherapeutic drugs.

Transportation methods used by BOP were sometimes questionable

Most of Springfield's psychiatric patients were referred by other BOP institutions. In getting to and from Springfield, many inmates had to take long bus rides of a week or more--one patient took 2 months. At each stop enroute, inmates were locked up solitarily. Springfield officials agreed that such a situation could worsen a patient's mental

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1/ "Controls On Use Of Psychotherapeutic Drugs And Improved Psychiatrist Staffing Are Needed In Veterans Administration Hospitals," Apr. 18, 1975 (MWD-75-47).

2/ Both terms--psychotherapeutic and psychotropic--refer to drugs used to ameliorate the principal symptoms occurring in mentally disturbed persons.

health condition. They and our psychologist said it was counterproductive to treatment to send patients by bus, and lock them up at night for periods of a week or longer, while awaiting the next bus to take them toward their final destination. Center officials added that the problem could be more profound if an inmate were on medication and ran out or did not receive any enroute. To complicate matters, buses generally arrived at Springfield on a Friday afternoon; thus incoming inmates would be locked in the secure unit throughout the weekend.

In March 1979, after we completed our fieldwork, BOP initiated an air transportation system for transferring inmates, including those who were mentally ill. BOP uses an airplane and pilots supplied by the Department of the Interior's Bureau of Land Management through an interagency agreement. The plane follows a set route every other week, picking up and discharging inmates at airports close to major BOP installations. A BOP official informed us that the system has significantly reduced the time required to transfer inmates, and it has already been used to transfer mentally ill inmates to Springfield without incident.

Each flight is accompanied by a physician's assistant who makes sure that proper medication is available for mentally ill inmates. This type of transfer system may be a solution to the problems of busing, but delays continue. The route is covered only every other week, and the schedule is disrupted if the aircraft is diverted to other uses by the Bureau of Land Management. BOP is actively looking at alternative means for establishing a more timely air transfer system.

In discussing the subject with AMA officials, they said there is no standard on the issue of transportation; in fact, they said they never considered the area as a possible problem area. Officials said the problem could very well be detrimental to patients' welfare, and they now intend to have the AMA Standards Committee include a standard on transportation practices in its final standards.

TREATMENT OF BEHAVIORAL  
DISORDERS IS LIMITED AND NOT  
TAILORED TO SPECIFIC NEEDS

The extent and formality of effort directed toward treating behavioral disorders varied widely among the prison systems visited. All systems had psychiatrists and psychologists to help inmates with specific problems, but only two

States were making an extensive effort to identify and treat inmates with behavioral disorders. Even these States could not treat all inmates with therapy tailored to their individual needs.

Briefly put, methods used to treat behavioral disorders are aimed at behavior modification--that is, helping patients understand why they act as they do and convince them to act otherwise. The methods commonly used are individual and group psychological counseling sessions. Aversive behavior modification techniques--such as electroshock therapy--were tried over the years but are not used in prisons today.

While we found no hard statistics on the matter, available information indicates that thousands of inmates are affected by behavioral disorders. Estimates provided by BOP's psychologists indicate that 50 percent of Bureau inmates are affected by behavioral disorders. According to estimates provided by the seven major institutions in BOP's North Central Region as of June 20, 1978, as many as 5,203--77 percent--of their 6,726 inmates had behavioral disorders. Further estimates indicated that many would benefit from treatment and that some would be motivated to accept help if it were offered.

#### State efforts

One State--Michigan--aimed its effort at types of inmates that have an unusually high potential for violence while on parole. To reduce this risk, it requires sex offenders and other inmates convicted of violent crimes to have group psychotherapy as a condition for parole. Written policy specifies that such inmates are to be identified during initial screening, on the basis of their crime and past history, and referred for group psychotherapy in the following order of priority:

- (1) Sexual maladjustment group--Individuals who have been convicted of or have committed offenses of a sexual nature where there are indications of emotional disturbance.
- (2) Impulse control group--Individuals who have difficulty controlling their impulses and, as a result, commit violent crimes.
- (3) General control group--Individuals who need psychotherapy but do not fall into the above categories.

- (4) Institutional supportive services--Individuals who have a history of severe emotional disorders and who are presently in a state of remission.

Due to staffing shortages, treatment efforts were being directed entirely to inmates in the three highest priority groups. However, many of these inmates were on waiting lists. As of July 1978, 412 inmates were receiving treatment but 2,246 were awaiting it. These included 1,300 in high risk categories. Some sex offenders were not getting psychotherapy before their first possible parole date and, as a result, had been denied parole.

In a second State--California--efforts to identify and treat inmates having behavioral disorders were similarly aimed at helping resolve emotional conflicts or personality problems. The goal of treatment was having inmates released from confinement with a greater likelihood of successful community living. Treatment is provided to inmates who, in the judgment of psychiatrists or other professional staff, are amenable to and could benefit from psychotherapy. Those selected possess a wide range of personality disorders.

Treatment involves group psychotherapy for approximately 18 months, depending on a therapist's evaluation of the inmate's progress. The correctional system's full-time mental health care institution allocated about 500 beds for those inmates involved. In December 1977, 504 inmates with personality disorders and 23 psychotics in remission were eligible for the group therapy sessions, and 402 were actually participating. The group therapy program is conducted in two separate 250-bed housing units, each supervised by a program administrator. Staff consists of one full-time psychiatrist, two psychologists, two correctional counselors, a program lieutenant, who assists in case management duties and acts as liaison between treatment, and custodial staff.

Each therapy group consists of about 8 to 12 inmates whose participation is voluntary. Inmate treatment plans are formulated when necessary. Groups meet either once or twice a week for 2-1/2 or 1-1/4 hours, respectively. A moderator encourages the inmates to discuss their problems before the group, as a means of helping them discover their motives for committing a crime. Therapists prepare biannual progress reports on each inmate. Supplementing these, the

housing unit's Psychiatric Council assesses the patient's overall status through discussing and reviewing reports from custody, work, vocational, educational, and recreational programs.

The Chief Psychiatrist said individual--rather than group--therapy sessions could better assist certain participants, such as sex offenders like child molesters who may be reluctant to discuss their problems before a group; sex offenders comprise 20 percent of the total. However, he estimates that providing these inmates with minimum individual sessions of 1 hour a week would require adding four full-time psychiatrists and/or psychologists.

None of the remaining three States had programs to treat behavioral disorders, primarily due to lack of staff or because officials did not believe these disorders could be effectively treated in a prison.

#### BOP efforts

BOP's policy is to treat inmates requesting help or having problems dangerous to them or others. It has not established an order of treatment priorities regarding behavioral disorders or prescribed specific types of programs institutions should conduct to treat such problems.

In our visits to BOP institutions, we found the extent of individual and group psychotherapy varied among prisons and units in the same prison. For example:

--At one prison, psychotics in remission and inmates with personality disorders were treated through group psychotherapy.

--The chief psychologist at another prison estimated that 39 to 58 inmates needed psychotherapy to prevent their return to criminal behavior on the outside and would accept help if it were offered. He said, however, that only about 19 of them (about 5 percent) were getting any counseling. Psychotherapy was generally given to inmates only when they were in a crisis situation or when they demanded it. He said a shortage of psychologists, coupled with other duties and priorities established by prison officials, precluded psychologists from devoting ample time to those services.

--A prison having three general population units conducted a psychological counseling and group psychotherapy program for inmates in two of the units. In the third unit, however, the staff psychologist did not routinely conduct any counseling or therapy sessions for inmates. He said he lacked the time due to other duties.

PRISONS GENERALLY DO NOT COMPLY WITH  
STANDARDS REGARDING THE MENTALLY RETARDED

According to a 1977 LEAA study <sup>1/</sup>, retarded inmates have a greater capability to become responsible and independent than is generally realized. ACA standards call for prisons to identify and, when warranted, establish programs for them. However, in general, prisons have done little to meet their special needs.

According to the American Association on Mental Deficiency, retardation exists when an individual has significantly subaverage intellectual functioning--represented on most standardized tests by an IQ of 70 or below--combined with deficits in adaptive behavior; such behavior is defined as the degree to which he meets the standards of personal independence and social responsibility expected of his or her age and cultural group. Its degree varies from mild and moderate to severe and profound. The 1977 LEAA study stated that the severely retarded would be easily identified at the time of arrest and would be directed to State residential facilities for the retarded rather than to prison.

Mentally retarded inmates require special care, such as protection from other inmates to guard them from abuse and basic education and occupational training to improve their ability to earn a livelihood after release. In the prison systems visited, special programs were provided for retarded inmates in only one State--South Carolina.

According to the professional literature, there is little emphasis on helping mentally retarded inmates in most of the Nation's prisons. Often they are not identified. If they are, some prisons do not recognize the need to protect them and others, due to overcrowding, protect some but not all. Additionally, retarded inmates often do not receive appropriate education and training.

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<sup>1/</sup>"The Mentally Retarded Offender and Corrections,"  
August 1977.

BOP had no specific policies or standard procedures for treatment and care of the retarded. BOP officials at all but one of the locations we visited did not believe the numbers of mentally retarded inmates was large enough to justify programs to help them.

At Petersburg, officials estimated that 34 to 47 inmates (5 to 7 percent of the institution's population) were retarded, but the Assistant Education Supervisor told us there is nothing that Petersburg can do for such inmates. The other Federal institutions we visited had no estimates on the number of retarded inmates in their population.

EFFORTS TO HELP DRUG AND ALCOHOL  
ABUSERS ARE TOO LIMITED AND DO  
NOT MEET STANDARDS

Appropriate programs to treat drug and alcohol abusers are not being provided for many Federal and State inmates. BOP has made a significant effort to provide treatment programs for drug abusers but has recognized that these efforts could be improved. It has given much less attention to programs for alcohol abusers but has initiated action to improve their content and coverage. In contrast, State systems reviewed generally had very limited treatment programs for either drug or alcohol abusers; for inmates in many institutions there were no programs at all.

Programs to treat inmates affected by drug addiction and alcoholism are an important element of mental health care in prisons. In BOP's institutions, for example, about 35 percent of the inmates had a history of drug abuse and up to 42 percent had a history of alcohol abuse.

ACA's standards for adult correctional institutions require that drug and alcohol abusers be directed to substance abuse programs. These programs should include, at a minimum:

- staff trained in drug and alcohol treatment to design and supervise the program,
- former addicts and recovered alcoholics to serve as employees or volunteers in these programs,
- coordination with community programs,
- efforts to motivate addicts to seek help, and

--realistic goals for rehabilitating inmates  
with drug or alcohol abuse problems.

### BOP efforts

BOP has concentrated treatment on drug rather than alcohol abusers. Large number of drug abusers and legislative and funding factors have encouraged its emphasis. BOP initiated drug programs primarily because of the Narcotic Addict Rehabilitation Act of 1966, which required treating drug offenders sentenced under the act. Since these were relatively few, BOP in 1971 expanded treatment units to assist the much larger number of drug abusers not covered by the act. Further, BOP headquarters budgets funds for treating drug abusers. In contrast, BOP has no specific legislative mandate to treat alcohol abusers, and budgeting of funds for treatment activities is left to the discretion of the individual institutions.

To enhance the benefit of treatment, its policy is to concentrate treatment of drug abusers on offenders who are within a year or two of their release date. Its approach to drug and alcohol treatment has centered on the unit management concept. Under this concept a group of inmates having a common problem, such as drug or alcohol abuse, are housed together as a unit and work closely with a specially assigned treatment team. They are not separated from other inmates in other respects, such as work assignments and vocational education. Units may have about 100 inmates, and typical staff includes a psychologist, a case worker, and correctional counselors. However, not all inmates are treated under the unit approach--not all institutions have drug and alcohol units. As of March 1978, BOP in its 38 institutions had:

- 26 drug abuse units in 21 institutions,
- 5 alcohol abuse units in 5 institutions, and
- 2 chemical (combined drug and alcohol abuse) units in 2 institutions.

Inmates not assigned to such units received help through what an official termed "less intensive" activities, such as, for alcoholism, Alcoholics Anonymous (AA) chapters.

Concerned about the future direction of these units in BOP, the Director formed a task force in January 1978 to review and evaluate the drug and alcohol units and to make recommendations regarding the present and future direction



of programs. According to its March 1978 final report, the task force found that units needed to be improved in a number of basic aspects. Among its principal findings were that standards were lacking, and wide variations existed, as to (1) staffing patterns and training and utilization of staff, (2) program content, and (3) what constituted successful completion of treatment. It also found that units need to continuously evaluate both program and inmates' performance. The task force recommended, among other things, that

--all institutions establish a drug and, if appropriate, an alcohol unit, and

--standards be established for (1) staffing, including training, (2) program content, (3) inmate completion of treatment, and (4) evaluating program and inmate performance.

As a follow-on to the task force study, BOP had begun surveying institutions to determine what further resources they would need to meet the task force's standards. Further BOP action was being deferred pending completion of the survey. According to its authorization request for fiscal 1979, however, BOP, in the short term, intended to:

--Increase the number of inmates involved in drug programs from 3,200 in fiscal year 1977 to 4,000 by fiscal year 1979 through implementing the unit management concept.

--Institute drug units at existing and new institutions.

--Increase the number of group counseling opportunities offered in drug programs.

In the long term, BOP intended to provide drug abuse treatment programs for all inmates with identified needs through specialized units.

The recommended expansion of treatment units would, however, not provide unit-based treatment for all alcohol abusers. A BOP official told us the number of such abusers at some institutions may not be large enough to warrant establishing alcohol units.

BOP did not have a written policy or guidelines for institutions to follow in treating alcohol abusers. At most institutions visited, programing was limited to AA meetings. While such meetings offer some help, institution officials believed they were inadequate because professional counseling was greatly needed to reinforce AA teachings.

According to BOP officials, the major obstacle in establishing appropriate treatment for all alcoholics appeared to be lack of funds rather than lack of interest by prison officials. Although promising treatment methods have emerged in recent years, they have not yet been greatly used in prisons.

In 1978, BOP performed a general survey of alcohol programs. A report sent to the Director recommended a variety of steps to improve nonunit based alcohol abuse treatment efforts. It urged implementing programs that would, in part:

- Encompass full-scope coverage for the inmate, from presentencing through time spent in an institution to reintegration with his or her family and community.
- Use a multidisciplined approach that realistically recognizes AA as only one of several therapeutic techniques. The approach envisions a combination of services, including psychiatric, psychological, and group therapy.
- Train facility staff in alcoholism matters.
- Establish halfway houses in the community for inmates close to the end of their sentences.

As a result of the survey, the Director authorized development of a design for a comprehensive pilot program for alcohol treatment.

#### State efforts

The State prison systems reviewed generally lacked statistics on the number of alcohol and drug abusers in their inmate populations. However, the indication was that their number was substantial.

--In one State, a reported 60 percent (about 4,500) of the inmate population had alcohol or drug problems.

--In another State, almost half the inmates had been drug or alcohol abusers--including 24 percent who were identified as heroin addicts.

Despite the need for alcohol and drug treatment programs, many State institutions had no programs. When institutions did have programs, they were basically experimental and too small to enable prompt placement. Correctional personnel in each State visited said drug and alcohol abuse programs were not adequate to meet the inmate needs. The treatment provided was usually an occasional psychotherapy session for drug addicts and an AA meeting for alcoholics.

In one State--which had about 4,500 substance abusers--treatment was available to inmates through a therapeutic community program at one institution or a comprehensive drug and alcohol program. The therapeutic program provided intensive care for about 80 inmates in a unit setting. The comprehensive program included a complete evaluation and referral, individual counseling, and group socializing activities. This program is voluntary and limited to inmates with a history of chemical abuse. During fiscal year 1977, this program delivered counseling services to 1,376 inmates.

Another State provided drug and alcohol programs for inmates in some sections of the State. In one area, services were contracted through community organizations. In another area, a pilot program, financed with about \$265,000 of LEAA funds, was available for about 1,000 alcohol and drug abusers at several camps. In this program, the inmates learned about the effects of drugs on the human body and discussed their attitudes, beliefs, and literature on alcohol and drugs. Drug and alcohol programs, however, were not available to inmates at all institutions in the State.

One State had not established separate drug and alcohol programs. Instead, inmates with drug and alcohol problems were referred to the program for treatment of behavioral disorders.

In another State, responsibility for providing alcohol and drug treatment for inmates was transferred in 1977 from the Department of Corrections to the State substance abuse

agency. However, the agency had done little to provide treatment because it was devoting its resources to community programs for the general public. The Department had no idea what programs individual institutions were providing. However, the State Director of Guidance and Counseling sent a questionnaire to the 27 largest general confinement facilities to determine the extent and nature of the various drug and alcohol abuse treatment groups. Our summary of the responses from the 19 responding institutions showed that there were:

- 28 drug-related groups in 15 facilities, averaging about 17 participants in each group. Most of the groups meet weekly for about 2 hours each.
- 226 inmates on a waiting list at one correctional facility to get into the two drug groups that only have enrollments of 12 inmates each. Three other facilities indicated there were waiting lists, and two other facilities reported waiting lists totaling 37 inmates.
- 21 alcohol-related groups in 15 facilities, averaging approximately 30 inmates in each. Most of the groups met for 2 hours weekly, and only two facilities reported waiting lists.
- 16 polydrug groups (15 at one institution), averaging about 28 inmates in each meeting biweekly for 2 hours each. The institution having 15 groups reported a total waiting list of only 18 inmates.
- 51 other mental-health-related groups at seven correctional facilities, varying in size from 9 to 61 inmates per group. Almost all the groups meet weekly for about 2 hours each. One institution reported a total waiting list of 31 inmates. Another reported a waiting list of 35, and a third said only that there was a waiting list.

In another State there had not been any systematic approach to treating alcohol and drug abusers before September 1977. Various facilities had established different types of treatment or education programs; there was no consistent or

uniform statewide delivery of services. In September 1977, the Department of Corrections received a \$150,000 grant from the State Office of Substance Abuse Services to develop a working relationship with the State Department of Public Health. The grant gives the Corrections Department, for the first time, the potential to establish a viable statewide program in interface with various community agencies.

Under the grant, the Corrections Department joined forces with the State office to develop an intensive and comprehensive treatment program beginning during incarceration and extending into the community upon release from prison. The ultimate objective was to reduce the incidence of drug abuse and dependence and eliminate the high prison recidivism rate among substance abusers, particularly heroin addicts.

The pilot program is now underway. Its purpose is to identify the "target" population needing treatment for drug or alcohol abuse and to test various treatment methods. As of June 1978, the staff was testing, screening, and interviewing inmates for the program at selected institutions. Also, individual and group therapy sessions had been started. The program consists of four phases:

- (1) "Drug Education," which is concerned with teaching inmates about the medical and biological effects of a variety of drugs and narcotics on the human body.
- (2) "Peer Awareness," which gives inmates an opportunity to gain insight into their behavior and how they interact with others.
- (3) Another phase, group psychotherapy, which consists of an indepth inspection of an inmate's personality, attitudes, ideas, and motives for getting involved with drugs.
- (4) The last phase involves community programs and permits some inmates to be placed in therapeutic communities having intense treatment programs.

By systematically monitoring and later measuring the results of this pilot program, State officials anticipate the program may someday be expanded from its limited scope at selected institutions to full services at all major institutions.

Until then, inmates not participating in the pilot program only have access to limited treatment--individual and group psychotherapy or AA chapters.

The State institutions visited generally lacked funds for both alcohol and drug programs. In a few instances some States were able to obtain Federal grants or to allocate a small amount of State funds to begin or expand drug programs. Few funds, however, were available for alcohol programs. Most AA chapters were funded by contributions from community services.

### CONCLUSIONS

Although improvements have been made in recent years, the treatment and care of inmates affected by mental disorders, mental retardation, and alcohol and drug abuse is inadequate in most Federal and State prisons. They generally do not meet minimal standards for identifying inmates' needs and providing a range and level of treatment appropriate for addressing these needs. We believe the Federal Government can and should take action to improve this situation.

BOP should upgrade the level of care available to its prison inmates. Among other things, BOP should make sure all of its inmates receive proper screening. BOP should also review the use of psychotropic drugs and issue a policy on the matter, to make sure that administering drugs conforms with generally accepted medical practices.

At the State level, the States are responsible for initiating actions to improve mental health care. But the Federal Government can help by improving the assistance available to the States through programs administered by various Federal agencies. As discussed in Chapter 4, these programs have not been extensively used in prisons.

### RECOMMENDATIONS

To upgrade the level of mental health care in Federal institutions, we recommend that the Attorney General require the Director, BOP to:

- Revise screening policy to specify and provide for comprehensive identification of inmates to be referred for treatment.

- Consider providing semiprotected environments for psychotic inmates needing less than hospital-level care by establishing facilities in several existing institutions to accommodate such inmates on a regional basis.
- Review psychotropic drug use to confirm that their administration conforms with generally accepted medical practices, and issue a policy on the matter.
- Consider establishing a program for the care of mentally retarded inmates at one or several institutions to accommodate such inmates on a centralized or regional basis, since their numbers may not warrant special programs at all institutions.
- Give added impetus to alcohol abuse treatment efforts conducted in other than formal substance abuse units by budgeting funds for such efforts at the headquarters level.

Recommendations to various Federal agencies for improving the effectiveness of Federal assistance to State prison mental health systems are included in chapter 4.

#### AGENCY COMMENTS

In a letter dated August 23, 1979, the Department of Justice stated that the draft report provided a fairly thorough and constructive analysis of mental health care delivery systems for inmates. It generally agreed with our recommendations but included a number of comments designed to clarify and otherwise strengthen the draft report. The comments that pertain to this chapter are discussed below.

The Department expressed concern with the "diagnostic" terms used in our report and stated that they were not consistent with those used by the American Psychiatric Association. In our report, the use of refined "diagnostic" terms was not essential because we did not deal with diagnosis. Rather, we discussed what was being done to treat inmates having problems which fell within certain general categories--psychotic and nonpsychotic mental problems, mental retardation, and alcohol and drug abuse problems. Determining the

specific types of problems that inmates had within those general categories was not within the scope of our review.

The Department expressed concern that we were advocating coerced treatment and stated that the "medical model" was considered to be outmoded. We recognize the rights of inmates to refuse treatment; however, we believe that inmates having problems should be identified and offered help. We sanction encouragement but not coercion.

The Department also cited an apparent contradiction in our estimates of mental retardation, but the estimates were not contradictory. In one instance, we were referring to a bureauwide estimate; in the other, we were referring to the information obtained at individual institutions.

According to the Department, only five inmates in its population were retarded, but our review indicated there could be more. As pointed out in our report, officials at Petersburg estimated that 34 to 47 inmates were retarded, and the other institutions we visited had no estimates.

Finally, the Department concurs with our recommendation on psychotropic medication but said that it could not comment on individual cases unless it knew which ones we examined. In our opinion, the overriding problem is the need for a written policy statement on the prescription of drugs. Doing this, and making sure that the policy is implemented, should resolve the matter.



### CHAPTER 3

#### MENTAL HEALTH CARE COULD BE

#### IMPROVED THROUGH BETTER MANAGEMENT

In addition to problems in identifying and treating inmates who need psychiatric care or other services, we found that prison mental health care delivery systems have not been well managed. Management shortfalls need to be corrected not only to improve mental health care but also to be sure that managers make the best use of existing resources. We believe that fully using resources is especially important since most correctional systems will probably continue to be underfunded and understaffed.

Among the elements of effective administration are extensive information on inmates' needs, adequate records, good utilization of staff, effective monitoring and evaluation of programs, and independent reviews of activities. To varying degrees, Federal and State prison systems lacked these needed elements. More specifically:

- Information on the overall extent and type of mental problems in inmate populations usually was not being compiled.
- Records of treatment actions and needs were often incomplete or disorganized, and pertinent information was not forwarded when inmates were transferred.
- Staff was not always well utilized.
- Shortfalls in program monitoring and evaluation were widespread.
- Independent review of programs was limited.

#### MANAGERS LACK INFORMATION ON THE EXTENT OF INMATE PROBLEMS

Prison mental health managers need reasonably accurate information on the number of inmates having mental health problems and the general types of problems. This information is fundamental for adequate planning, because it provides a basis for gaging the extent and types of treatment and care services that should be established. Further, it can assist managers in determining, and supporting requests for, additional resources necessary to provide them.

However, the Federal and State systems, as well as the individual prisons reviewed, generally lacked this basic information. BOP headquarters and prisons had statistics on the overall number of inmates identified as drug and alcohol abusers. But they did not have statistics showing how many were affected by psychosis, behavioral disorders, or mental retardation. Most State systems and individual prisons had incomplete data on the number of inmates having mental health problems.

The situation existed in part because the screening of inmates was often inadequate to comprehensively identify their problems. Additionally, the results of the screening that was done were generally not compiled and summarized.

BOP has a computerized information system that collects and summarizes available information, overall and by prison, but it has only partially used it for this purpose. Based on input reports from the prisons, the system produces a wide variety of summary data on inmates, such as their overall number by State of residence and by type of offense.

One of the input reports the prisons are to prepare for each new inmate provides for reporting diagnosed medical, dental, psychiatric, psychological, drug, and alcohol problems. From these forms, the system produces reports that summarize the number of inmates having alcohol and drug abuse problems. However, it does not produce similar reports regarding inmates that prisons identified as having psychiatric and psychological problems. Also, the system produces a report summarizing inmates' IQ scores but only down to "80 and below;" it does not breakout scores of 70 or below, which are indicators of inmates affected by mental retardation.

Evidently, the information system was not well used for data on the extent of inmates' problems because officials did not fully recognize a need for the data. According to a system official, no one had asked for reports on inmates' psychiatric problems. The Bureau's Chief Psychologist told us that prisons are not required to include psychological diagnoses in their input reports to the system because, in part, BOP wants to avoid "labeling" individual inmates. However, he told us he had begun to believe the information would be desirable for management purposes.

Headquarters officials advised us that the present information systems furnished only "bits and pieces" of data useful to management--for example, data as to the number of inmates referred to drug programs, the number and percent who had terminated these programs, and the number in psychotherapy programs. BOP is planning to implement a more comprehensive automated information system in the near future; however, one BOP official told us that because of other information priorities, it may take several years for that system to benefit mental health, drug, and alcohol program managers in the central office.

In most of the States visited, no attempt had been made to regularly collect and summarize data on the extent of identified mental health problems among inmates. Some State officials were reluctant to document specific mental problems. While raw data on some mental health problems existed in individual inmate files, it had not been combined to form an overall data base.

Only one State (North Carolina) was in the process of designing and implementing an information system that would include this information. The system, which will be computerized, is a comprehensive one. As well as providing data for resource management, it will allow tracking of each offender. The State had an initial LEAA grant of \$143,000 to assist it in the project.

ACCURATE AND COMPLETE  
RECORDKEEPING IS  
NECESSARY--BUT LACKING

Adequate records of inmate treatment are essential for facilitating efficient continuity of care--that is, providing appropriate services with a minimum of duplication or wasted effort. Records are needed because treatment circumstances often change, due to such factors as turnovers in mental health staff and transfer of inmates. Good recordkeeping includes documenting all important aspects of treatment efforts. While the records' confidentiality should be safeguarded, they should be readily accessible to appropriate mental health staff. And, if the inmate is transferred, his or her records should also be transferred to enable the receiving mental health staff to quickly determine the problem, treatment provided to date, and the further treatment needed.

Mental health recordkeeping at the Federal and State institutions we visited should be improved. Various deficiencies existed, which are summarized below.

- Treatment actions were often not adequately documented.
- Psychological records were frequently not readily accessible to mental health staff, and their confidentiality was not well protected.
- Pertinent information was not always transferred along with inmates.

Details on these deficiencies follow.

Treatment efforts  
should be documented

Some of the facilities had documented certain aspects of treatment efforts, but none of them had fully documented all important aspects.

Standards of the American Psychiatric and American Psychological Associations call for accurate and current documentation of all significant information on the mental health treatment of an individual. The information to be recorded includes the diagnosis of the problem, treatment planned to address it, treatment given, and its results.

To assess prisons' actions in the matter, we reviewed records of 97 inmates who had been treated in the mental health programs of five of the six Federal institutions and two of the State prison systems visited. Our review of records in the State systems was limited because most of them did not allow us access to inmates' records due to their confidentiality.

To varying degrees, there was a lack of background summaries, treatment plans, progress summaries, and details of what treatment had been provided. In many institutions, it was hard to know whether and what treatment had been provided and whether progress had been achieved or assessed. No records were made on inmates involved in crisis interventions or what their problems were--except for a number count. BOP estimated that 30,000 crisis interventions would occur in fiscal year 1979.

The most widespread deficiency among the facilities involved written treatment plans--a key element of documentation. Properly prepared, these summarize the diagnosis of the inmate's problem, specific treatment to be applied, and treatment results. They provide a basis

for reviewing and assessing the services provided and, if appropriate, for changing or modifying them. Without such plans, continuing care for a highly mobile inmate population is more difficult.

Joint Commission on Accreditation of Hospitals (JCAH) standards for accrediting psychiatric facilities require treatment plans, and BOP uses JCAH standards as a guide; however, neither of BOP's full-time psychiatric facilities--Butner and Springfield--were preparing them. Officials at these psychiatric facilities, though, planned to begin using treatment plans. Their use at Springfield had been recommended in a recent JCAH survey, and the facility's Associate Director of Psychiatric Services was writing procedures and developing a form for this purpose.

None of the five States visited required treatment plans for mental health services. However, two prisons visited were preparing some form of a treatment plan. More specifically:

--At a treatment clinic at one State prison, psychiatrists and psychologists used an admissions form to record prior history data, current physical status, a general summary with symptoms and syndrome descriptions, and immediate treatment needed. The treatment approach, frequency of treatment, responsible staff, and status of the inmate's problem were recorded on another form.

--At a prison in another State, officials told us plans were prepared for inmates needing care but only after they were sent to the State's prison psychiatric hospital. They were not prepared for inmates treated outside that facility. The plans included an evaluation of the inmate's needs and treatment to be provided. Progress reports contained specific treatment goals and additional time needed to reach them.

Due to the plans' confidentiality, we were unable to assess the adequacy of these records.

Prison officials generally agreed that mental health actions regarding inmates should be documented. They attributed inadequacies in part to shortages of staff, particularly clerical staff. However, some psychologists told us they

did not document certain actions because they wanted to avoid stigmatizing inmates by saying they had mental problems. Another told us they could not agree on what should be documented or how it should be done. Further, some psychologists were reluctant to document actions because they feared the confidentiality of such information would not be safeguarded-- a point explained in more detail in the paragraphs below.

Accessibility and confidentiality  
of records could be improved

The usefulness of psychological records was impaired at most Federal and State institutions visited because the records were not readily accessible to staff psychologists. Instead of being centrally maintained, records were scattered among several files kept at different locations within the institutions. Additionally, the confidentiality of psychological records was often not adequately protected.

A centralized psychological file on each inmate would help facilitate and expedite treatment. The file would be maintained by the psychology staff and would contain all psychological reports and related data on the inmate. By enabling psychologists to go to one location for psychology records, such files permit quick assessment of the health status of inmates, treatment plans, and treatment provided.

Separate psychological files were not maintained at four of the six BOP facilities visited, and most States were not maintaining separate files either. While two prisons had separate files, they were incomplete; they contained only test scores and handwritten notes useful solely to the writer.

When it existed, psychology data on inmates, such as test scores and psychology evaluations, were usually scattered throughout two general types of files--institution files, which also contained security, classification, and administrative data, and medical files, which also contained medical and dental data.

Both types of files were often quite voluminous--sometimes consisting of several volumes for a single inmate. Psychology data was usually commingled with other documents which sometimes were not in chronological order. From these files, it would be extremely difficult, and sometimes impossible for psychologists to quickly and accurately assess an inmate's condition and treatment needed. For example, in a review of the institution and medical files for four inmates

at one BOP institution, we found that one institution file was missing. In two instances it was not possible to judge what treatment had been undertaken. In one file, the data was inadequate to evaluate the diagnosis, and in three others, the diagnosis needed clarification.

Moreover, institution and medical files were not conveniently located for psychologists' use. Whereas most psychologists' offices were located in prison cell blocks to permit ready access to inmates, institution files were maintained in the prison's administrative offices and medical files were in the hospital or infirmary. Thus, when psychologists wanted to consult the files, they had to go through a security check and a series of gates to and from their offices.

In short, there was no one source of data which psychologists could consult to assess an inmate's mental condition. As a consequence, psychologists usually treated inmates only for the immediate or obvious mental problems; they did not search the institution or medical files for a history or status of the inmates' mental condition or treatment.

American Psychological Association standards for psychologists and BOP policy call for maintaining the confidentiality of psychology records. Placing the records in psychology files would aid confidentiality. Because such files were not maintained, many Federal and State prisons were not adequately protecting such data. Existing psychology information--for example, test scores and psychology evaluations--were usually kept in the institution and medical files. Prison personnel other than psychologists frequently used these files in connection with security, classification, parole, medical, dental, and routine administrative matters.

The lack of separate psychology files in State prisons was attributable in part to lack of specific requirements for them; most of the State systems visited did not have clearly written policies concerning psychology records. BOP policy, in contrast, specifically called for psychology staff to maintain such files, but the policy was not being implemented at all BOP institutions. For example, one prison prohibited mental health staff from keeping mental health files on inmates--it required them to place all mental health information in the institution files. The Associate Warden for Programs told us separate files were not allowed because prison officials considered them superfluous and inefficient.

In our view, action to provide centralized psychological files would not only facilitate psychologists' use of needed records but would help bring about better documentation of treatment information. As explained on page 38, psychologists were reluctant to document efforts concerning inmates because, in part, they feared the confidentiality of the records would not be properly safeguarded.

Pertinent information should be forwarded when inmates are transferred

When inmates are transferred or released early, their health records should accompany them. We found that this information is not always shared or provided in a timely fashion.

During their incarceration, inmates receiving mental health treatment are often transferred between institutions in a correctional system to receive specialized care. In these instances, APHA and AMA draft standards require that health files accompany, or track, inmates. This permits health staff at the receiving institutions to know: (1) what the inmates' needs are, (2) what treatment has been provided, and (3) what further treatment is needed. By transferring health files with the inmates, health staffs are better able to communicate with each other about a particular inmate. Moreover, the transfer of records facilitates continuity of care for inmates and avoids unnecessary duplication of tests and evaluations.

In addition, many inmates are released from prison early, on parole or for good behavior, and are transferred to the custody of parole or probation officers. These officials likewise should have adequate records of the inmates' mental health status to help expeditiously arrange needed aftercare.

Information is not always shared or timely provided when inmates are transferred within the prison system

Some inmates transferred from institutions at which they had been receiving treatment for mental problems are in need of follow-on (continued) treatment by prison mental health staff. They include inmates returning from prison systems' central psychiatric facilities and inmates transferred from other prisons. In the Federal system and most



State systems visited, policies and procedures were not adequate to assure that mental health staff at an inmate's new facility received appropriate records of his or her status and needs in a timely manner.

Since its inception in 1976 through May 8, 1978, BOP's psychiatric facility at Butner had returned 146 inmates to other prisons or moved them to Butner's general population units. And, in fiscal year 1977, its Springfield psychiatric facility returned 814 patients to their regular institutions--of whom 268 needed follow-on care.

Upon returning an inmate, the facilities prepare a "discharge summary" describing the treatment given the inmate and containing recommendations for follow-on treatment, if any. The facility includes the summary in the inmate records forwarded to the prison. Additionally, the BOP's Psychology Services Handbook states that psychology staff should expect inmates to be returned from other institutions when they had been transferred for emergency care and should require the establishment of appropriate plans for followup treatment. However, these policies have not been fully effective in assuring timely receipt of needed information by the new prison's staff.

As explained earlier, institutions did not always adequately document their actions. We followed up on 11 inmates returned to Petersburg from the facility at Butner. Our review showed that files for only 2 of the 11 contained Butner discharge summaries.

Also, the records involved did not always arrive at the new institution when the inmate did; they sometimes arrived later. According to a January 1978 BOP audit report, inmates transferred from Butner's psychiatric facility to a general population unit at the same institution arrived before the discharge summary. The report stated in part that there was a need to ensure that the summary arrives "either ahead of or at least with the inmate."

In addition, the prisons that sent inmates to the psychiatric facilities did not always establish plans for follow-on treatment. For example, the psychologist in one of Butner's general population units told us he may be informed in advance of inmates to be transferred in from the Butner psychiatric units but there was no formal process for informing him. Similarly, the Chief Psychologist at another prison told us the prison had no procedure for ensuring inmates returning from central psychiatric facilities are identified. He said they often are "lost" in the

general population and go without needed follow-on care until they have another "behavior episode."

Deficiencies also existed in transmitting information on inmates who received mental health treatment at prisons and were transferred to other prisons. BOP requires that the inmates' medical records, which must include psychiatric records, be transferred to the new prison. But it does not require that psychological records be transferred. The Bureau's Chief Psychologist told us it had been assumed they would be transferred, but our review showed they sometimes were not. For example, according to a psychologist at one prison:

The prison forwarded psychological information when an inmate was transferred to BOP's central psychiatric facilities. However, until recently it did not forward information when the inmate was transferred to another prison--except for one with which the psychology staff had good working relations. The prison began sending the psychological records with all inmates transferring to other Federal prisons in July 1978, after we had inquired into the matter. The psychologist further told us the psychology staff did not know in advance when inmates with mental health problems were being transferred to the prison. Inmate psychological records were not transferred with them.

BOP's Chief Psychologist advised us that the psychological policy would be revised to require that psychology records accompany an inmate transferring to a new institution. While this should assist in improving the transmittal of mental health data, we think further action in the matter is needed. We noted that neither BOP policy nor policies of the psychiatric facilities visited required mental health personnel to directly notify their counterparts at other prisons when they transferred inmates needing follow-on care. We believe the transmittal and receipt of needed records would be better assured if the BOP required that mental health staff of the transferring institution

- send direct and advance notice of such transfers to mental health staff of the receiving institution,
- ensure records are forwarded in time to arrive before or at the same time the inmate arrives, and
- provide for the receiving staff to acknowledge receipt of the records.

Of the five States visited, only one had established procedures for assuring that prisons identified inmates returning from central mental health facilities who need continued, follow-on care or treatment. Another State was developing a written policy on this point.

The first State until recently had no uniform procedure for alerting institutions' mental health staff to psychotics transferred from the prison system's psychiatric hospital who were in need of follow-on treatment at the institutions. As a consequence, needed treatment was not always provided. To illustrate:

An inmate that a prison psychiatric unit had sent to the psychiatric hospital was, while at the hospital, involved in several altercations with staff members and an attack on his mother during a visit. After being stabilized on medication, he was returned to the prison--but its psychiatric unit was not notified. He continued his violent behavior and was eventually returned to the psychiatric unit for further evaluation.

To correct the matter, the psychiatric hospital in August 1978 implemented a referral system. Under this system it sends the psychiatric unit at the prison an advance written notice of pending transfer and reconfirms by phone on the day of actual transfer. The medical file is transferred with the returning inmate.

Another State required transfer of data, but it was not always done on a timely basis. The State required that treatment summaries and continued treatment needs be recorded in a psychiatric file to be forwarded to a transferred inmate's new prison. It also provided that medical staff at the receiving prison review the file to identify inmates needing

continued treatment. However, the Chief Psychiatrist at one prison told us the files forwarded by the central psychiatric facility were usually not received until several days after the inmate arrived.

In some cases, this delayed providing needed treatment. The Chief Psychiatrist cited a recent case in which a transferred inmate considered cured of a severe psychiatric problem did not receive medication or close supervision because the prison was not aware of his possible needs, due to late receipt of his records. As he described it:

The psychiatric facility transferred to the prison an inmate who had attempted suicide and who had been placed on antidepressant medication. The prison's psychiatric staff, however, was not aware of these facts because the inmate's records did not arrive until 6 days after the inmate arrived; they therefore did not continue the medication. In the interim, 2 days after his arrival and 4 days before his records arrived, the inmate hanged himself.

BOP prisons should better communicate information on aftercare needs of inmates released early

Many inmates of BOP prisons are released before their sentences expire. In the year ended June 30, 1977, BOP released about 7,700 inmates early--5,222 through parole and 2,521 due to good behavior. A significant percentage of such inmates have mental health problems that call for aftercare. For example, about 6 percent of BOP inmates have alcohol abuse and 35 percent have drug abuse problems; according to mental health professionals, both types of problems normally necessitate continued care. The U.S. Parole Commission is authorized to stipulate participation in mental health and alcohol and drug aftercare as a special condition of release. Officers of the Federal Probation System, acting as agents of the Commission, are responsible for ensuring the releasee obtains the services. But the evidence shows that prisons are not adequately communicating information needed to facilitate continuity of care for inmates released early.

To assist parole and probation officials in determining the appropriate kind of aftercare, BOP policy specifies that, when an inmate is initially considered for release, the prison involved is to furnish the Parole Commission with a file containing a wide variety of information about the inmate. Such information includes his or her mental health and alcohol and

drug abuse problems. Also, the prison is to furnish copies of the documents to the appropriate U.S. Probation Office when the inmate is released. The key information regarding after-care is to be included in a progress report--namely, information on the extent of the inmate's problem, efforts made to correct it, how the problem affects release readiness, and postcommitment treatment needs.

However, we conducted a review of progress reports furnished to the Parole Commission and probation officers by three prisons on 12 releasees we had identified as having mental health or alcohol and drug abuse problems. Our review disclosed that the reports were incomplete in all 12 cases. More specifically:

- Only one contained information on the extent of the inmate's problem.
- None contained information on what efforts were made by the prisons to correct the problem except to say what programs the inmates participated in.
- None showed whether the problem affected release readiness.
- None contained a statement regarding postrelease treatment needs.

A Parole Commission official informed us that the Commission is not guided solely by prison reports in arriving at aftercare decisions. It also considers information from other sources, including presentence investigation reports prepared by probation officers and interviews of inmates.

When the Commission stipulates that an inmate needs aftercare, probation officers should have good information on problems and treatment provided while the inmate was in prison and its effectiveness, to arrange appropriate care. The Commission's stipulation describes only the general type of care needed, such as mental health or drug treatment. But probation office and BOP community treatment center staffs we interviewed told us they place little emphasis on prisons' reports because they are usually general and vague.

A combination of factors account for the situation. In summary:

- Prisons often do not prepare adequate records of inmates' problems or the treatment that was provided.

--BOP guidelines do not clearly specify the nature of information needed for assuring continuity of treatment after the inmate's release.

--BOP guidelines do not adequately specify the responsibilities of prison mental health personnel as regards aftercare information.

As explained on pages 36 through 38, there are widespread deficiencies in prison documentation of inmate problems and prison treatment of the problems. These deficiencies in themselves make it difficult for prisons to properly identify and communicate information on inmates' postrelease treatment needs.

Additionally, BOP guidelines do not specify the kind of information prisons should include in the progress reports to the Parole Commission and probation officers. The guidelines require that reports contain information on the extent of the problem and efforts made to correct it. However, they do not explain what specifically should be included under such terms as "effort made to correct" or how the matters should be described in specific mental health, alcohol, or drug treatment terms. In short, the guidelines do not clearly state what are pertinent aspects of the inmates' history and treatment.

Further, BOP guidelines do not say who is responsible for determining and reporting the extent of the problem and efforts made to correct it or for identifying problems which affect release readiness. At one prison we visited, the psychiatrist and psychologists told us they did not determine if prospective releasees had any postcommitment needs. The psychiatrist only became involved when requested by either the parole board or the case manager. He said this happened infrequently, and even then, he only prepared reports of his observations. He said he did not make recommendations for aftercare and did not know what uses were made of his observational reports.

AVAILABLE STAFF COULD  
BE BETTER UTILIZED

The prison systems visited were affected by funding limitations and professional staff shortages. But better use of available staff could help offset effects of these constraints. Management could

--reduce professional staffs' involvement in nonprofessional tasks through expanding the use of paraprofessional personnel, and providing adequate clerical support and

--ensure that available professional and paraprofessional personnel are appropriately trained.

ACA standards require that sufficient numbers of professional staff be available to provide (1) 24-hour care for severely psychotic cases and emergency situations and (2) appropriate treatment programs for less disturbed inmates having special needs. The standards also require that competent mental health professionals supervise the programs.

However, every prison system reviewed--Federal and State--was, to varying degrees, inadequately staffed to meet inmates' mental health needs. BOP had 20 full-time psychiatrists and about 100 full-time psychologists for about 28,000 prisoners. One institution visited had no psychiatrist at all, even on a part-time basis. BOP needed more full-time and part-time consulting psychiatrists and 42 more full-time psychologists to meet its goal of having psychologists available to all prison units under its unit management concept.

Most States were even more understaffed. For example, one State prison system having about 15,000 inmates had one full-time psychiatrist and 27 psychologists. At another State having 20,387 inmates at July 12, 1978, the Department of Corrections Chief Medical Officer told us the Department had proposed funding 236 new medical care positions, including 39 positions for psychiatric care activities. However, only 33 of the 236 positions were funded--none of them in the psychiatric field.

In most Federal and State prison systems, contract psychiatrists were also used to supervise most of the care to mentally ill inmates maintained in prisons. The part-time psychiatrists were available only for short-time periods--generally for 4 hours a week.

The number of psychiatrists, psychologists, nurses, and others has been inadequate due to funding shortages and the difficulty prisons have hiring professionals, even when funds

are available. The probability that these constraints will continue to exist underscores the need for greater efforts to effectively use present personnel.

Paraprofessional personnel should be better used, and adequate clerical support should be furnished

As one way of better using staff, prison managers should seek to reduce professional staff members' involvement in nonprofessional activities through increased use of paraprofessional and clerical personnel.

Professional staff in the BOP and State systems have various important duties along with providing direct treatment services. For example, BOP psychologists are expected to be also involved in improving the overall prison environment by training line staff and by participating in unit team meetings. The overall extent of their activities is shown by the following summary of their anticipated actions in fiscal year 1979:

<u>Direct services</u>	<u>Number</u>
Individual therapy sessions	15,000
Group therapy sessions	8,500
Inmates in group therapy	14,000
Crisis intervention sessions	30,000
<u>Additional duties</u>	
Court evaluations	2,000
Routine evaluations	18,000
Staff training sessions	2,500
Unit team meetings	7,000

Further, BOP professional staff had significant administrative responsibilities. Chief psychologists for BOP regions were assigned to, and worked out of, correctional institutions and played dual roles as chief psychologists for those institutions. Sometimes they were also assigned to units.

The Bureau Chief Psychiatrist was expected to evaluate the psychiatric care at institutions and assist staff in improving care. But he was assigned to, and worked out of, the Medical Center for Federal Prisoners in Springfield, Missouri, where he also functioned as the Center's Chief Psychiatrist



and its Unit Manager of Forensic Service for Unsentenced Prisoners. Over 50 percent of his time was used for administrative tasks and attending court hearings.

Prison managers should seek to identify ways in which paraprofessional personnel could appropriately be used to perform certain tasks now performed by professional personnel. Professionals would then have more time for duties in which their involvement is essential. For example, BOP's Psychology Services Handbook points out that psychological tests do not have to be administered by professional psychologists--they can be administered by adequately trained and supervised paraprofessional personnel. However, in 1978 a BOP task force that reviewed screening activities reported that only 15 percent of the personnel administering tests were paraprofessionals; the remainder were staff psychologists or contract personnel. According to the task force's report, such limited use of paraprofessional personnel diverts psychologists from performing more interpretative and therapeutic professional duties and, in addition, increases the cost of testing.

Prison managers should also recognize the importance of providing adequate clerical support to mental health professionals. Without this support, professional staff must perform routine clerical tasks related to their work or the tasks are not fully carried out and incomplete records and poorly maintained files result.

BOP's Psychology Services Handbook provides that wherever possible, an institution's psychology services should have a full-time secretary or clerk to be responsible for record maintenance, typing, and similar duties. It further provides that, if none is available, specific written agreements should allow unit secretaries or other secretaries in the institution to absorb these duties.

However, individual prisons are evidently giving little priority to mental health staffs' clerical needs. A need for better clerical support was mentioned at most Federal institutions visited. Comments of a Chief Psychologist at one prison were typical. He told us that, due to other priorities, the Psychology Services secretarial position was eliminated in May 1978. The result: the staff has had to spend up to 120 hours a month in clerical duties. The Warden told us that because of other priorities, he did not plan to replace the secretary, and that the psychology staff would have to rely on unit secretaries. However, the Chief Psychologist

told us that Psychology Services' work was second to other unit work and, as a consequence, much of its clerical work was not being done.

Appropriate training  
should be provided

Staff utilization could be improved in some cases by increased training of available professional and paraprofessional personnel. Attention should also be given to the qualifications and training of paraprofessionals, where they are used by BOP and State prisons to lead group counseling sessions.

BOP officials are aware of a need for better training of personnel involved in alcohol and drug abuse treatment programs. On July 25, 1978, before the House Select Committee on Narcotics Abuse and Control, the Director stated that, in general, there was no formal training given to such personnel. The task force BOP appointed in 1978 to evaluate the programs recommended that:

- Unit Managers develop a training plan reflecting the specific types of training needed.
- A minimum standard of one specialized training program be provided for each staff member.
- All staff complete a course in drug education.

At one BOP prison, we were told that drug unit counselors were selected from among the best qualified correctional staff with the most promise for being successful counselors. However, according to officials, counselor backgrounds in general were inadequate and counselors lacked sufficient psychological perspective to successfully lead group sessions.

While there were no criteria to evaluate the quality and adequacy of their training and backgrounds, it appeared that some paraprofessionals had reasonably good backgrounds while others did not. The educational backgrounds of counselors and case managers in the prison's two substance abuse units ranged from no college to a master's degree in counseling psychology. Officials told us there were no formal training requirements for them other than BOP's basic counselor course. Additional training consisted of on-the-job training through attending group sessions to learn how they

were conducted and by occasional 2 to 3 day visits to community drug treatment centers. Of the eight personnel involved:

--All but two had 80 to 120 hours of the BOP's "Interpersonal Relations Training," the basic counselor course. One had no training because she was new; the one with an M.A. in Counseling Psychology had 480 hours as an intern in an alcohol and drug community treatment center. Four had 40 to 160 hours of on-the-job training classes given by a psychological consultant to teach them to lead group counseling sessions, and two had little or no other counseling training. Three of the eight had no formal training or prior experience in drug or alcohol abuse.

MENTAL HEALTH PROGRAMS SHOULD  
BE BETTER MONITORED AND EVALUATED

BOP and State correctional agencies could better monitor and evaluate their health care systems. Effective periodic analyses of programs are an important management tool. Besides disclosing specific shortfalls within programs, they can, as noted in ACA standards, identify the productive and nonproductive programs and indicate the need for reordering priorities or restructuring programs. Further, by providing information on the quality and effectiveness of programs, they can give prison managers an improved basis for obtaining funds.

While certain actions can be taken to improve the monitoring of program quality, research is needed to identify the best methods for treating certain mental disorders and the techniques for evaluating success or failure.

Shortfalls in monitoring and  
evaluation are widespread

BOP mental health programs have not been fully monitored or evaluated by regional staff or staff at institutions visited. Psychiatric services were subjected to very little review. BOP's Medical Director is ultimately responsible for monitoring and evaluating the services. His Regional Administrators for Medical Services audit the various health facilities in their respective regions. The administrators conduct formal audits at least annually at each prison, using audit guidelines that cover many aspects of health

services, such as medical records, personnel and space utilization, training, and budgets. However, their audits of psychiatric services are done as part of audits of medical services and do not involve an indepth review.

BOP's Chief Psychiatrist, located at Springfield Medical Center, is responsible for reviewing psychiatric programs bureauwide, but he has little time for monitoring the programs. Due to his institutional duties at Springfield, he spends over half his time on administrative matters and court evaluations. Additionally, he has not submitted formal reports on monitoring visits he has made.

To correct the situation, we think the BOP should take action to allow the Chief Psychiatrist to have adequate time for reviewing services or, if appropriate, designate other personnel to assist him in his review function.

Shortfalls also existed in the review of psychology services. BOP policy provides that psychology services in BOP facilities be visited and reviewed at least once a year by Regional Administrators for Psychology Services, based on guidelines covering numerous areas (such as, physical plant, staff location and facilities, and training). However, the guidelines do not require a review of psychological records, and we found that records were not reviewed. For example, eight reports we examined on BOP facilities in the Northeast Region contained no indication of an evaluation of any psychology files maintained by mental health personnel.

BOP should require that records be reviewed because it is a basic element of the monitoring process. The point is underscored in that most institutions, contrary to BOP policy provisions, were not maintaining inmate psychology files.

Additionally, according to BOP's Chief Psychologist, efforts to evaluate the effectiveness of psychology services have, at best, been sporadic and not uniform among institutions. Psychologists at institutions we visited were not fully evaluating their own programs, even though BOP's Psychology Services Handbook requires that they do so. For example:

At one institution, the staff psychologist said Psychology Services had not formally evaluated .

its program to determine whether it was effective. At another, staff said they had made no attempt to periodically review program effectiveness for each inmate, whether in group or individual therapy. The staff said they provided services only as needed and desired by inmates and when they had the time, and would assess program effectiveness only when it seemed appropriate to them.

BOP has not effectively monitored programs to treat drug abusers. As explained on page 25, the special task force BOP appointed in 1978 to evaluate the programs found a lack of standards necessary for assessing program quality and performance--such as standards for content, staffing, and evaluation. BOP anticipated that most of the task force recommendations for establishing these standards would be implemented by October 1979. The need for program monitoring was highlighted in our visit to the drug abuse unit at the Petersburg facility:

--Each resident of the unit initially enters an orientation period, usually lasting 60 days, to decide whether he wishes to participate in the program. Of the 19 inmates in the orientation period at June 1978, 3 had been there 7, 8, and 9 months.

--If the inmate decides to participate, he is expected to move through three program stages, conforming to certain behavioral expectations, before proceeding to subsequent stages. Stage I is supposed to last a minimum of 3 months. Of the 65 residents in Stage I at June 1978, 32 (49 percent) had been there for 7 months or more--13 (20 percent) for a year or more. If such lengthy stays are reasonable, perhaps the criteria should be revised.

Prison staff likewise did not fully evaluate programs to treat drug and/or alcohol abusers, as evidenced by actions at the two institutions visited that had such programs. At one of them--which had two substance abuse units--the units' managers and psychologists told us they had made no attempt to evaluate program effectiveness.

The other institution, which had one drug unit, had attempted to evaluate its program. In August 1977, it conducted a mail questionnaire survey of parole officers regarding the parole status of all inmates released from the unit.

Of 197 questionnaires mailed, 81 (41 percent) were returned with complete or partial information. The unit manager said the preliminary results indicated they were having some success in keeping people from returning to prison. Of the 81 former inmates, 19 (23 percent) had violated parole, 50 (62 percent) had not violated parole, and 12 (15 percent) had completed parole.

However, the significance of the data is questionable in that, according to various mental health officials, effectiveness cannot be measured solely on the basis of recidivism rates. Additionally, the unit and case managers disagreed as to the adequacy of the questionnaire response rate.

The unit hired a psychologist in August 1978, and one of his projects was to develop an ongoing research model with a built-in measuring mode to monitor the drug program. The project was in the planning stage at the time of our visit.

Like BOP, States' programs have not always been fully evaluated. At the time of our review, none of the States were evaluating the effectiveness of programs for drug and alcohol abusers.

#### Research is needed

While officials recognized the need to help inmates having mental health problems, some were uncertain about the best way to help some inmates, at least in a prison setting, and others were uncertain about the best way to measure success or failure. Both matters need to be researched.

Virtually no research has been done on treatment programs for violent inmates needing help, and institutions visited varied in their ability to work with them. Also, officials of prison systems we reviewed doubted, in some cases, that all behavioral disorders could be effectively treated. Officials of one State system were not certain sex offenders could be effectively treated, and another State system had no programs to treat inmates having behavioral disorders generally because officials believed the prison system was not equipped to handle them. They told us such inmates have to be completely resocialized. They said this takes a long time and a controlled environment, and cannot be done in a prison.

BOP's Chief Psychologist told us that a number of professionals believe effective methods exist for treating behavioral disorders. But he said there is a great need for research and pioneering efforts to find out what treatment of behavioral disorders "works" and, specifically, to devise some sound methods for determining effectiveness. Similarly, the Chief Psychologist of a State facility that was treating sex offenders said research should be done to determine whether such offenders need therapy and how effective the therapy is. While some relatively recent studies have highlighted the need to help specific categories of inmates--the mentally retarded, drug abusers, and sex offenders--most point out the need for the additional research into treatment approach and effectiveness. For example, a January 1978 publication on treatment programs for sex offenders 1/ stated that many questions remain unanswered--that it is a field for pioneering and a time for research. The publication described a large variety of relatively new treatment programs for sex offenders. But it pointed out that the innovations can now be evaluated only by intuition--no one can precisely and conclusively demonstrate that new programs are more effective in reducing sex crimes than traditional prisons or mental hospitals.

Research and evaluation efforts have been limited due to shortages in prison mental health staff, combined with the press of their other duties. For example, the Chief Psychologist told us BOP psychologists have not had time to develop an evaluation system. He also said that specialists are needed for evaluation techniques.

INDEPENDENT REVIEWS OF  
MENTAL HEALTH PROGRAMS  
COULD ASSIST PRISON MANAGERS

Independent reviews of prison mental health programs by outside groups could help managers identify program weaknesses that may be overlooked by internal staff. Some independent reviews have been made, and been beneficial, but in general these important management aids have not been widely employed.

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1/"Prescriptive Package, Treatment Programs for Sex Offenders," January 1978. The project was supported by a grant awarded to ACA by the National Institute of Law Enforcement and Criminal Justice, LEAA.

BOP uses JCAH accreditation reviews of psychiatric services. However, according to the Deputy Medical Director, only two BOP psychiatric facilities--Springfield and Butner--are large enough to warrant an effort to obtain JCAH accreditation. The BOP relies on its own staff to review remaining psychiatric facilities. JCAH also performs accreditation reviews of programs for the mentally retarded and for alcohol abusers, but the BOP likewise relies on its own staff for reviewing such services.

The JCAH reviews of BOP psychiatric facilities have been helpful in identifying areas needing improvement. For example, JCAH in 1978 inspected Springfield and awarded a 1-year accreditation. Its survey team made recommendations alerting the facility to areas where performance did not substantially comply with JCAH standards. These areas included policies, procedures, medical and nursing services, and safety and sanitation. JCAH specified that these deficiencies should be corrected before its next survey.

Only two State correctional institutions visited had had independent reviews, and they were similarly beneficial. Licensing and accreditation studies performed at one California prison by JCAH and the State Department of Health identified many operational problems, including instances where written procedures and practices were lacking, house-keeping procedures were lax, patient personal comfort items were not being provided, and good recordkeeping procedures were not being followed. California now has a long-range goal to promulgate modern correctional standards and identify those actions necessary to meet ACA standards statewide. Also, North Carolina had its Central Prison mental health facility inspected in April 1977 by the State department responsible for licensing private mental health facilities. The inspection was performed as a prelude to seeking JCAH accreditation. Deficiencies noted centered around staffing and workload requirements.

Independent reviews of State facilities are hindered in part by limitations in State licensing inspections of prison mental health units. Most States exempt such units from State inspections. In others, there are conflicting opinions as to whether current statutes require inspecting correctional health facilities.

#### CONCLUSIONS

Services have been significantly constrained by limited availability of funds and personnel shortages, but treatment systems have also not been well managed. Improvements needed



include better information on the overall extent and nature of mental problems in inmate populations, preparation of adequate records, more efficient use of personnel, better monitoring and evaluation of services, and more extensive independent reviews of programs. Correcting these management shortfalls is essential not only to improve mental health care but also to be sure that managers make the best use of existing resources. We believe the latter point is especially important since most correctional systems will likely continue to be underfunded and understaffed.

We believe the Federal Government should improve mental health care for prison inmates by correcting management shortfalls in program administration. BOP should correct deficiencies in its correctional institutions. As will be discussed in chapter 4, the Federal Government can help States by improving the assistance available to them through programs administered by various Federal agencies.

#### RECOMMENDATIONS

To improve mental health care system management in Federal institutions, we recommend that the Attorney General require the Director, BOP, to:

- Provide an improved basis for assessing program needs by regularly compiling and summarizing available information on the extent and nature of mental health problems in the inmate population.
- Require the establishment of a central psychological file for each inmate and reemphasize the need for adequate records of inmate problems and treatment actions and the importance of protecting their confidentiality.
- Assure proper continuity of treatment or care by requiring the transfer of psychological records when inmates are transferred among institutions and by requiring mental health staff of transferring institutions to (1) provide advance notice of transfers directly to counterpart staff of the receiving institutions and (2) ensure that records are forwarded timely.
- Improve the effectiveness of the BOP's role in assuring appropriate aftercare for inmates released early by revising guidelines to more specifically describe the nature of inmate mental health information to be furnished to the Parole Commission and

probation officers, and by requiring mental health personnel to be responsible for preparing the information.

- Increase the time available to professional personnel for professional duties by making greater use of paraprofessional personnel and by giving greater priority to providing clerical support staff.
- Use staff more effectively by ensuring that qualification criteria is established and appropriate training provided for all personnel engaged in mental health and substance abuse treatment activities.
- Improve the internal review of psychiatric services by allowing BOP's Chief Psychiatrist to have adequate time for reviewing the services or by designating personnel to assist him in his review function.
- Monitor psychology services more effectively by requiring that psychological records be reviewed as part of the monitoring process.
- Establish greater management control over the quality and performance of substance abuse treatment programs by promulgating standards for their content, staffing, and evaluation.
- In collaboration with LEAA, the National Institute of Mental Health, and State prison systems, expand research to identify best methods of diagnosing and treating prison inmates affected by behavioral disorders and develop criteria for evaluating the effectiveness of treatment programs.
- Increase management surveillance of the quality of mental health services by expanded use of independent reviews by outside professional organizations.

#### AGENCY COMMENTS

The Department of Justice generally agreed with our recommendations; but it stated that our draft report implied that managers can overcome limited funding and staff shortages through effective administration. We realize that better management will not completely solve all of the problems discussed in this report. But we believe that effective administration would enable managers to begin to make improvements. Better management is not a panacea, but it would certainly be a step in the right direction.

## CHAPTER 4

### FEDERAL PROGRAMS COULD BE USED

#### MORE EXTENSIVELY TO IMPROVE

#### MENTAL HEALTH CARE

The Federal Government conducts a variety of financial and technical assistance programs that could help States improve the availability of treatment services for prison inmates having mental health, alcohol abuse, and drug abuse problems. They include programs conducted by LEAA, which offer a wide range of aid to correctional systems, and programs administered by HEW's Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). These agencies could help bring about coordinated planning by State criminal justice and health agencies to identify inmates' needs, support development of treatment programs and management mechanisms, and provide research and training assistance.

But Federal programs have had only limited impact, primarily because Federal agencies have given only minor attention to prison mental health services. To illustrate:

- Guidelines for some of the programs did not specify that participant State agencies were to consider prison inmates in determining mental health needs and in developing State mental health plans.
- Where guidelines have required such State actions, Federal agencies have not enforced them.
- Federal agencies have not ensured that State criminal justice agencies and health planning agencies effectively coordinated their efforts in planning, programing, and funding.

While the Federal Government cannot fully subsidize mental health care in State prisons, it can provide more effective assistance. Federal agencies need to give more recognition to inmates' mental health needs and the agencies' role in meeting them.

## LIMITED USE OF LEAA ASSISTANCE

LEAA was established under the Omnibus Crime Control and Safe Streets Act of 1968 to assist States and localities in improving their law enforcement and criminal justice systems. Under this mandate, LEAA provides financial grants that States can use for improving their correctional systems. Part of this aid is even specifically earmarked for correctional systems; Part E of the act encourages States to develop and implement programs and projects for improving correctional programs and practices. In addition to Part E programs, other parts of its legislation authorize LEAA to sponsor additional grant programs for correctional practices and training programs for correctional personnel.

### LEAA assistance for mental health has been limited

LEAA has not made any substantial efforts to assist or encourage States to improve inmate mental health care through its financial and technical aid programs.

Because of its broad legislative mandate, LEAA could assist in improving prison mental health care systems. LEAA could do so through both of its general categories of grants-- block grants, which LEAA awards to States so they may carry out their annual criminal justice plans, and discretionary grants, the uses of which LEAA can prescribe.

LEAA, however, has taken little action in the matter. It has not (1) directed that State criminal justice planning agencies specifically address prison inmates' mental health needs in their planning efforts, (2) encouraged States to use block grant funds for inmate mental health, or (3) established a program for applying discretionary grant funds to prison mental health care.

Only one of the five States we visited used LEAA assistance to improve the mental health care of prison inmates. South Carolina used about \$47,000 for a 1977 to 1978 project to provide testing and referral services for about 3,000 inmates. In 1978, it also used free consultant services provided under an LEAA technical assistance project to assess its correctional systems' classification process.

Some other States not included in our review have also used LEAA funding for inmate mental health programs. For example:

- The New Hampshire Department of Mental Health used LEAA grant funds to provide mental health services to inmates in State correctional institutions.
- Ohio used LEAA grant funds to provide mental health care at several State correctional institutions.
- Missouri used LEAA grant funds to expand psychiatric and psychological services for inmates in Missouri prisons.

However, on a national basis, inmate mental health care has not been an area of primary effort for LEAA.

An LEAA official told us that LEAA has put little emphasis on inmate mental health care because the matter has not been shown to be a national problem. He explained that LEAA earmarks discretionary grant funds for specific criminal justice problem areas only if there is evidence they are significant. The official advised us that, if studies should indicate prison mental health care is such a problem, it possibly could become a priority.

AMA contends that a significant number of inmates have mental health problems when they enter prisons and additional problems may result from imprisonment. This contention seems to be supported by available literature. Also, in 1978, the President's Commission on Mental Health recognized that a high percentage of prison inmates are mentally disturbed. The Task Panel on Legal and Ethical Issues of the President's Commission concluded that each State should conduct a mental health survey among inmates to determine incidence/prevalence rates and need for services.

LEAA assistance could help States in taking these actions. States could use block grants to fund surveys to ascertain prison mental health needs and to fund actions for unmet needs. The National Institute of Law Enforcement and Criminal Justice and LEAA's National Criminal Justice Statistics Service 1/ could provide technical and/or research

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1/The National Institute of Law Enforcement and Criminal Justice is LEAA's research arm. The National Criminal Justice Statistics Service is responsible for nationwide criminal justice data gathering and interpretation.

assistance to States conducting an inmate mental health care needs survey or could take an active role in a national survey. If perceptions of the significance of the problem are confirmed, the LEAA discretionary grant mechanism could be used to address the problems of inmate mental health care as a national priority program.

LEAA needs to work with ADAMHA's National Institute of Mental Health (NIMH) to coordinate efforts. NIMH has a legislative mandate to assist States and localities in improving mental health services in general, but its programs have provided only limited help to services for inmates. Since LEAA's mission pertains specifically to law enforcement and criminal justice, we believe it is essential that LEAA do what it can to assure that NIMH adequately considers inmates' mental health needs. Additionally, if LEAA becomes more involved in the area, coordination is essential if the resources of each agency are to be used most productively.

LEAA assistance for drug  
and alcohol treatment could  
provide more help to inmates

LEAA has not effectively implemented legislative requirements designed to improve treatment for inmates of State correctional systems who are alcohol or drug abusers or addicts. It recently initiated pilot programs in the area, but generally LEAA has had little impact on promoting the proper planning and development of alcoholism and drug treatment programs in prisons.

Part E of LEAA's legislation requires it to ensure that States, in their criminal justice plans, provide for the development and operation of narcotic and alcoholism treatment programs for all inmates in correctional institutions and facilities who are drug addicts, drug abusers, alcoholics, or alcohol abusers. States may use LEAA funds for these programs or may fund them from other sources.

The act further provides that State planning agencies--those responsible for administering LEAA block grants and other Federal and State criminal justice funds at the local level--establish in their plans procedures for coordinating efforts with the single State agencies responsible for substance abuse treatment planning. Coordination with single State agencies is important in that these agencies plan and implement treatment programs for substance abusers in general, using Federal assistance provided by ADAMHA's National Institute on Alcohol Abuse and Alcoholism (NIAAA) and National Institute on Drug Abuse (NIDA).

LEAA's implementing guidelines specify that State planning agencies should make concerted efforts to provide treatment programs for substance abusers within correctional system, and they emphasize the need for coordination with State alcohol and drug abuse agencies. Yet LEAA has not ensured that these actions have been carried out. A recent LEAA internal audit <sup>1/</sup> assessed the implementation of Part E legislative requirements based on a review of six selected States (all different from the five States covered in our review). The report concluded that:

"\* \* \* neither LEAA or the SPAs [State planning agencies] effectively exerted their roles as change agents to actively produce the impact on the correctional system envisioned by Congress. While we found that individual program goals were addressed, there did not exist a systematic strategy for improving the correctional system. Further, we found no organized method for determining which Part E requirements might positively influence the efficiency and effectiveness of the correctional system."

Among other things, the report discussed the need for additional coordination to address drug/alcohol programming of correctional systems and the need for additional narcotic and alcohol treatment programs for inmates. The report recommended that the Office of Criminal Justice Programs strengthen its procedures for review of State planning agencies' comprehensive plans to ensure that the States are adequately addressing Part E requirements.

#### Need for improved coordination

LEAA's internal auditors found that the State planning agencies had not fully coordinated with State agencies responsible for drug and alcohol abuse treatment planning. According to their report, these agencies in four of the six States reviewed had entered into agreements with the agency

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<sup>1/</sup> "An Assessment of Selected Correctional Requirements Contained in Part E of the Omnibus Crime Control and Safe Streets Act of 1968, as Amended," report number GR-NA-78-02, LEAA - Office of Audit and Investigation, Sept. 22, 1978.

responsible for statewide drug and alcohol programing. But, while the agreements provided for coordinating services regarding the criminal justice system, very little discernible coordination had taken place with correctional institutions.

For instance, no information--such as the number of inmates having drug problems--was being gathered to assist the State criminal justice planning agencies in devising programs to meet the needs of all persons with substance problems within correctional institutions. Additionally, the review showed that comprehensive plans included information on available resources for providing treatment services within the community but did not include data on the magnitude of the problem specifically within the correctional system. Such information would be of value to the State planning agency in developing programs to ensure that all inmates with drug and alcohol abuse problems are provided treatment.

Four of the five State planning agencies we reviewed had executed an agreement to coordinate efforts. Only two of the State agencies coordinated for both drug and alcohol programing; the remaining two coordinated for drug programing only. Further, while four State agencies had coordination agreements, their State plans lacked certain basic information:

- Two of the plans contained no information on the number of inmates having alcohol and drug problems.
- Three of the plans included no information on the number of inmates receiving alcohol and drug treatment.
- One plan contained no information on the type of drug and alcohol services presently available in institutions.
- None of the plans had information on the additional services needed.

Narcotic and alcoholism  
programs within institutions  
given little emphasis

The LEAA audit showed that the States reviewed had placed limited emphasis on developing and operating narcotic and alcohol treatment programs within correctional



institutions. Only \$2.6 million, or 5 percent of the total Part E funds for corrections, was awarded for drug and alcohol treatment services, and most of that amount was awarded to community-based programs. The audit also disclosed that State plans did not show the number of drug abusers in institutions. According to the audit report, in three of the States reviewed, there were significantly more inmates with drug abuse problems within corrections institutions than were receiving treatment services. Only one of the five States (North Carolina) we visited used LEAA funds for operating a narcotic and alcohol treatment program within a prison for adult inmates.

LEAA's major offender drug abuse efforts have been concentrated on a program to provide community treatment of drug abusing offenders instead of incarceration--the "Treatment Alternative to Street Crime Program." This program identifies drug abusing offenders who can, through suspended sentences, probation, or other means, such as bail release, be referred to community-treatment programs. At the time of our review, there were programs in 52 locations, and plans had been made to fund additional statewide programs. The program is not designed to provide drug treatment inside correctional institutions, although two programs have, or are considering, expanding to include treatment for incarcerated offenders.

LEAA has recognized the need to improve drug and alcohol treatment programs within institutions and has developed two pilot programs--the "Treatment and Rehabilitation for Addicted Prisoners Program" and the "Corrections Program Standards Implementation Program." Although the requirements to upgrade program and practices of institutions and facilities were added to Part E in the 1973 amendments, these programs represent the first concerted efforts by LEAA to help State prison systems.

The Treatment and Rehabilitation for Addicted Prisoners Program will provide grants for comprehensively treating and rehabilitating offenders with a history of serious drug abuse while they are incarcerated in State correctional institutions and while on subsequent parole status. More specifically, it includes both a 6- to 9-month treatment phase inside the institutions and a 6- to 9-month parole phase for the voluntary offender participants. Grantees must comply with detailed program requirements including: (1) procedures to screen and identify inmates with a history of drug abuse, (2) provisions

for group and individual counseling, (3) processes for providing treatment after release, while on parole, and (4) provisions for testing for drug use while on parole. No more than four grants of up to \$330,000 each were to be awarded in fiscal year 1979. The grantee must furnish a 20-percent match in the first year and a 30-percent match in the second. LEAA is planning an independent national evaluation of the program. Should it prove to be effective, it would serve as a model program for other correctional agencies with a need for drug treatment programs.

The objective of the Corrections Program Standards Implementation Program is to support the adoption and implementation of advanced practices for health care and alcohol and drug treatment programs in prisons and jails. Under the program separate grants will be given for medical health care and for drug and alcohol treatment. The program envisioned for grantees of the drug and alcohol grants are not as comprehensive as those required by the Treatment and Rehabilitation for Addicted Prisoners program, but are expected to assist grantees in implementing minimum standards for drug and alcohol programs. Up to five grants, not to exceed \$200,000, were to be awarded to long-term correctional institutions, and up to 15 grants, not to exceed \$100,000, were to be awarded to local jails during fiscal year 1979. A 20 percent match of State funds was required.

These programs should help the recipient States increase compliance with Part E requirements for drug and alcohol treatment programs for inmates. However, they will directly benefit only 24 correctional institutions at most (9 prisons and 15 jails).

#### ADAMHA PROGRAMS COULD HELP IMPROVE INMATE TREATMENT

ADAMHA, under HEW, is the lead agency for carrying out Federal efforts to reduce the incidence of and improve the treatment for mental health problems, drug abuse, and alcohol abuse. These responsibilities are centered in three national institutes: NIMH, NIDA, and NIAAA. These three institutes are responsible for Federal efforts to reduce and eliminate, where possible, health problems caused by the abuse of alcohol and drugs and to improve the mental health in the United States. Generally, however, they have not actively focused on prison inmates.

NIMH assistance programs have  
been of little benefit to  
prison inmates

NIMH was established to provide a focus for Federal efforts to improve the treatment and rehabilitation of all persons with mental health problems; but few of these efforts have reached prison inmates. NIMH encourages States to assess their needs for mental health services and develop comprehensive plans to meet those needs, primarily through establishing community mental health centers. However, NIMH has not taken action to ensure States consider prison mental health needs in their planning efforts, and centers have provided only limited services to prison inmates. Additionally, NIMH's research efforts have not addressed mental health care of inmates.

Prison inmates should be  
better serviced by community  
mental health centers

The Community Mental Health Centers Act (Public Law 88-164, 77 Stat. 290) requires that a State agency in each State be designated responsible for a State plan for providing comprehensive mental health services through the centers. The act requires that centers provide a variety of such services to the geographic area they serve, including

- inpatient and outpatient services;
- consultation and education services, including those for the courts, State and local law enforcement, and correctional agencies;
- assistance to courts and other public agencies in screening residents being considered for inpatient treatment at a State mental health facility; and
- followup care for residents of its geographic area who have been discharged from a mental health facility.

The State agency is required to set forth a program for centers based on a statewide inventory of existing facilities and a survey of need for the services they offer. The plan is also required to provide for adequate centers to furnish services for persons unable to pay.

The mental health needs of prison inmates should be considered by States in developing their plans. The act requires that a center, within the limits of its capacity, provide comprehensive mental health services "to any individual residing or employed in [its geographic] area regardless of his ability to pay for such services, his current or past health condition, or any other factor \* \* \*." (Underscoring added), 42 U.S.C. § 2689.

However, only one of the five States we visited included inmates in their comprehensive mental health survey of needs. None made provisions for them in their plans for center services and centers have provided only limited services to prison inmates. Instances in which centers have provided services to them included:

- A center in Massachusetts provided education and group discussion for inmates in a State prison.
- One in Colorado provided consultation and services to a State prison.
- One in Utah worked in the area of prerelease programs for women in a State prison.

Inmate needs were not adequately addressed primarily because NIMH regulations and guidelines have never been finalized and drafts of those documents do not specify that States are to consider inmates. This lack of guidelines was the main reason State officials generally gave us for not including inmates. Further, an HEW regional office responsible for reviewing State plans did not, as part of its review process, verify that the plans addressed inmate needs and, thus, did not question the absence of provisions concerning them. In explanation, regional officials told us review guidelines issued by NIMH headquarters did not direct that the plans be reviewed for adequacy as regards prison inmates.

While he agreed that centers should address inmate needs, an NIMH official told us financing services would pose a problem. Under the act, NIMH provides funding support for centers only during their first 8 years of operation. The Congress intended that they become self-sustaining after that initial period by charging for services provided or by seeking third-party reimbursement from private health insurers or

Medicaid or Medicare. However, inmates (1) are ineligible for medical assistance under Medicaid, (2) are generally unable to pay for services they receive, and (3) generally do not carry health insurance. If centers were required to provide extensive services to inmates without reimbursement, they would be faced with funding problems. The NIMH official stated that becoming self-sustaining is one of the basic problems facing many centers. To require them to offer additional free services to State prison inmates could aggravate the problem.

We believe one solution might be for State correctional systems to sign contracts with centers located close to prisons, whereby the center could provide mental health services to inmates where the prisons are unable to provide them in a cost-effective manner. The correctional system could pay centers on a fee per service basis or on a retainer basis. The results could be mutually beneficial--prisons would be able to assure proper inmate mental health care and centers would have an assured market.

LEAA and NIMH research  
has not addressed  
inmate mental health care

NIMH's Center for Studies of Crime and Delinquency is responsible for conducting research in the areas of crime and delinquency. It has sponsored a broad range of research projects involving criminal justice systems--but none have specifically addressed mental health care of inmates in correctional institutions. Center officials stated that they felt that LEAA has the mandate to sponsor research in this area.

LEAA's National Institute of Law Enforcement and Criminal Justice has a broad mandate to conduct research and evaluation of ways to improve law enforcement and criminal justice. However, the Institute is not specifically mandated to research inmate mental health issues, and LEAA officials stated that it has not sponsored any research in the area.

The lack of research by the two agencies regarding the mental health care of prison inmates is significant. As explained on pages 54 to 55, officials of both Federal and State prison systems and various recent studies have cited the need for more research. Officials were uncertain as to the best way to treat certain categories of inmate mental health problems and about the ways to measure treatment effectiveness.

NIDA assistance for prison drug  
treatment programs  
can be improved

NIDA, established in 1973 under the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255, 86 Stat. 65), is responsible for focusing the comprehensive resources of the Federal Government on drug abuse, with the immediate objective of significantly reducing the incidence of drug abuse in the United States. To achieve this end, NIDA, among other things, provides grants to State drug abuse agencies to assist them in planning needed drug treatment activities and in establishing and conducting treatment programs. NIDA guidelines make provisions for State agencies to include the needs of criminal justice systems in these program planning and development efforts.

However, such NIDA assistance has had limited impact on improving drug abuse treatment services for prison inmates.

--States have not adequately addressed inmate needs in their planning process.

--NIDA has restricted the use of its funds for establishing drug treatment programs in prisons.

NIDA's efforts to improve services for inmates have been limited because it has relied largely on LEAA to take necessary actions and by a lack of adequate NIDA-LEAA coordination.

NIDA needs to better assure  
State drug agencies consider  
inmates in planning treatment  
activities

NIDA's legislation calls for designating a State agency to survey the State's needs for drug abuse programs and to develop a State plan to meet those needs. Section 409 of the act authorizes NIDA to make grants to the States primarily to assist them in these planning efforts. Although the act is silent on the matter, NIDA program guidelines provide that the planning should, among other things, address the needs of the criminal justice system, which include the needs of prison inmates. They further provide that the State agencies execute coordination agreements with the State criminal justice planning agencies that receive LEAA funds. Together they should plan and develop a coordinated program to service delivery to drug abusers in the criminal justice system.

Despite the provisions of NIDA guidelines, only one of the five States we reviewed had adequately addressed prison inmates' needs in its drug program planning. Drug abuse agencies in three of the four remaining States had executed coordination agreements with the State criminal justice agencies, but the coordination was incomplete regarding prison systems. The drug agencies' plans we reviewed sometimes contained partial data, such as the number of inmates who were drug abusers. Yet, only one of the three showed the drug treatment services presently available and the additional services that would jointly be required to meet inmates' needs.

According to a NIDA official, NIDA personnel, in reviewing State plans, check to see whether the plans provide for joint efforts to meet inmates' needs--but they take no action to correct the plans if they find them deficient. The official told us NIDA sends the State a critique of the plan, which points out any shortfalls regarding efforts for inmates, but does not disapprove the plan due to the shortfalls.

The official explained that NIDA did not expect State drug agencies to themselves gather planning data regarding prison inmates' needs--it only expected them to see whether the data was available. His rationale on the point was that the LEAA-assisted criminal justice agencies had primary responsibility for addressing the drug treatment needs of inmates. However, as was explained on page 63, LEAA-assisted agencies, in their State plans, did not adequately address the needs of prison inmates.

#### NIDA funding policy impairs expansion of treatment programs for inmates

Section 410 of NIDA's legislation provides funds to States and localities to, among other things, support about 95,000 "treatment slots." (The term "treatment slot" refers to the ability to treat one person for 1 year.) The legislation includes specific provision for NIDA grants to establish, conduct, and evaluate drug abuse treatment programs within State and local criminal justice systems.

While Section 410 grants offer an important potential means of improving the drug abuse treatment of prison inmates, NIDA policy significantly restricts their use and impact in the matter. In a February 1977 letter, NIDA informed State program directors that Section 410 funds may not be used to fund treatment for persons in correctional institutions, with the exception of the first 30 days--for inmates who were in a treatment program when arrested--and the last 60 days of incarceration. A NIDA official advised

us the letter was issued to clarify its policy because it had found that States had been applying such funds to prisons, contrary to earlier established policy.

In explaining the action, an official told us it had never been NIDA's mandate or intent to address prison inmates--that their needs were an LEAA responsibility at the Federal level. He said that NIDA's policy was adopted based on a policy of the Special Action Office for Drug Abuse Prevention, relating to the LEAA-initiated Treatment Alternative to Street Crime Program. (See p. 65.) More specifically, he stated that the Special Action Office for Drug Abuse Prevention had directed that, under the program, LEAA would fund screening and referral of offenders for treatment, whereas NIDA-assisted community programs could be used to provide treatment for these offenders. NIDA interpreted the directive as meaning that NIDA, as a general policy, should restrict its assistance for offenders to community treatment and that LEAA was responsible for assistance for programs within prisons.

In our opinion, NIDA's restriction of Section 410 funds for programs in prisons is not well founded. We believe the policy that influenced its adoption did not provide a basis for NIDA's belief that LEAA was primarily responsible for funding drug treatment in prisons. The Treatment Alternative to Street Crime Program, to which the policy pertained, was intended to provide for community treatment, and thus the policy statement concerning LEAA-NIDA funding responsibilities apparently did not apply to funding programs within prisons. By interpreting that policy to have such applicability, NIDA in effect created a gap in the provision of Federal assistance for drug abusing offenders. NIDA assistance is available for community treatment of offenders who are not incarcerated--a proper and needed form of assistance--but it is limited for offenders incarcerated in prisons.

Moreover, according to an LEAA official, NIDA's decision to restrict use of the funds for prison inmates was a unilateral decision by NIDA--NIDA did not coordinate or consult with LEAA in the decision. Since NIDA's action served to place the burden of assisting prison inmates largely on LEAA, we think NIDA should have coordinated with LEAA.

An LEAA official informed us that because of NIDA's restriction on funds, many prison inmates are not receiving drug treatment who could otherwise benefit from NIDA treatment programs. He pointed out that, while LEAA has a legislative mandate to assist such programs, LEAA's ability to



do so is constrained because its overall funds are limited and must be used to assist an entire spectrum of law enforcement and criminal justice activities.

After pointing out that only a small percentage of the 63 percent of drug abusers in the State's prisons were receiving drug treatment services, one 1978 State drug program plan we reviewed added that:

"In view of the need for drug abuse services in the correctional system, it is hoped that NIDA will reconsider its policy limiting provision of services in correctional facilities and its allocation of funds for this purpose."

A NIDA official told us that, if it were required to drop the restriction, NIDA might have to double its budget to meet prisons' needs. However, the amount of additional funds that might be needed is uncertain, since prisons' needs have not been adequately determined. Further, in a March 1979 statement to a Senate subcommittee on NIDA drug abuse treatment efforts, an official of our office reported that NIDA programs could serve more drug abusers without any significant increase in costs because its treatment capacity is underutilized. For example, if its 1978 national average utilization rate of 89 percent was increased to its 1975 rate of 95 percent, about 12,000 more drug abusers would be treated annually. And our statement brought out that reported utilization rates are inflated--indicating there is even more potential for treating additional drug abusers. It appears that expanded NIDA assistance for prison inmates could be achieved, at least in part, if NIDA used funds now being applied to underutilized, nonprison programs.

NIAAA assistance for alcohol treatment services should be targeted to include prisons' needs

NIAAA, established under the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (Public Law 91-616, 84 Stat. 1848), is responsible for developing and conducting comprehensive health, education, training, research, and planning programs for the prevention and treatment of alcohol abuse. As one means of achieving these ends, NIAAA provides grants to State alcohol abuse agencies to assist them in planning, establishing, and conducting needed treatment programs.

NIAAA's assistance effort, however, has hardly been applied to improving alcohol abuse treatment services for prison inmates. This situation exists because NIAAA gives

very low priority to needs of the criminal justice system in general. In addition, there has been little coordination between NIAAA-assisted State alcohol abuse and LEAA-assisted criminal justice agencies. NIAAA has not required coordination, and LEAA, as explained earlier, has not adequately implemented LEAA requirements concerning coordination.

NIAAA does not require State alcohol abuse agencies to consider inmate needs in planning treatment services

NIAAA's legislation provides that a State agency is to be designated to survey the State's needs for alcohol abuse treatment programs and to develop a State plan for meeting the needs. It further provides that the State agency coordinate its planning with local alcoholism and alcohol abuse planning agencies and with other State and local health planning agencies. The act authorizes NIAAA grants to assist the States in determining needs and developing their program plans.

The act calls for NIAAA to develop "comprehensive" planning and other programs. However, neither the act nor NIAAA implementing guidelines specify that the State agencies, as part of their planning efforts, are to address the alcohol program needs of criminal justice, including correctional, systems or coordinate with State criminal justice agencies.

Only two of the five State alcohol abuse agencies we visited addressed prison inmates' needs in their State plans--and one of these did not address them adequately. More specifically:

--One of the State plans (1) cited recent statistics on the number of inmates who were alcohol abusers, (2) identified the number being assisted in present treatment programs, and (3) cited a plan for providing programs to inmates not presently being assisted.

--The other State plan cited current treatment programs for inmates. But it only contained nonrecent data on the number of inmate drug abusers and did not show the extent to which additional programs were needed.

Both agencies had coordinated their planning efforts with the State criminal justice planning agencies. Since NIAAA did not require them to address inmates' needs in their planning, the two agencies had done so essentially on their own.

In explaining why their State plans did not address inmate needs, officials of alcohol abuse agencies in the remaining three States pointed out that the plans were not required to address these needs. One agency--a combined drug-alcohol abuse agency--had executed with the State criminal justice agency a coordination agreement that covered both areas. But little coordination had taken place regarding alcohol program planning for inmates. An official told us the Department of Corrections had not provided enough data to enable an accurate assessment of inmate needs. Some officials also cited as a factor a lack of sufficient funds for assisting treatment programs in prisons.

An NIAAA official advised us that a State can, if it wishes, address inmate needs in its alcohol abuse planning, but NIAAA does not require it to do so. He said that NIAAA gives greater priority to the needs of other segments of the population. For example, NIAAA guidelines require that State plans address needs of such other segments as women and youth.

The LEAA-assisted State criminal justice agencies play--or should play--an important role in the matter. But as explained on page 63, LEAA has not effectively implemented legislative requirements for coordinated criminal justice and alcohol abuse agency action in planning and developing alcohol abuse treatment services for inmates.

Little NIAAA assistance has  
been applied to improving  
treatment services for inmates

NIAAA's legislation authorizes grants to assist in establishing, maintaining, and evaluating projects for developing more effective alcohol abuse treatment programs and for related research, training, education, and counseling. NIAAA makes such grants available in two principal forms:

- Block grants, which can be applied to specific alcoholism activities at the recipient's discretion.
- Discretionary grants, the uses of which NIAAA can prescribe.

The grants could be applied to improving alcohol abuse treatment of prison inmates; however, their use for this purpose has been limited.

In fiscal year 1977, NIAAA awarded to the States \$56.8 million of block grants. A NIAAA official informed us the agency did not know how much of this amount was applied to services for inmates. However, it was evidently limited. As explained above, NIAAA does not require States to address inmates in their State alcoholism plans, and most of the States we visited did not.

In the area of discretionary grants, NIAAA had established a Criminal Justice Alcoholism Program--1 of 11 programs established for specific areas of effort--but it had the lowest funding of any of the programs.

Programs having the main funding priority pertained to services for women and youths. Few projects in other areas were being funded. Since fiscal year 1976, NIAAA's capacity for funding new applications under these programs had diminished--budgetary allocations had barely met continuing obligations and new applications continued to flow in from the field. A backlog of "approved but unfunded" projects, amounting to over \$30 million had developed.

In fiscal year 1977, NIAAA assisted 11 projects under the criminal justice program in the amount of about \$1.7 million. In fiscal year 1978, it funded only seven in six States, in the amount of about \$660,000. It disapproved several other projects, so as to apply the funds involved to other program categories. Moreover, the criminal justice program concerned the entire range of persons within the criminal justice system who are charged with or convicted of crimes--pretrial releasees, probationers, and parolees, as well as inmates. Program information obtained from NIAAA did not show which, if any, of the projects pertained to prison inmates.

Additionally, according to NIAAA personnel, projects under the other programs could include services for prison inmates. For example, 18 projects amounting to about \$1.2 million that were primarily targeted at a specific group, such as American Indians, Spanish Americans, and the poor, could include prison inmates within the groups. However, NIAAA data did not show whether inmates were actually included.

As is the case with NIMH-assisted community mental health centers, NIAAA-funded projects are expected to obtain financial support from other sources and become self-sustaining. These other sources of support include,

but are not limited to, client fees and third-party payments (insurance, Medicare, Medicaid, local welfare contributions, and contributions from private corporations). However, as stated earlier, inmates are ineligible for Medicaid assistance, generally are unable to pay for services they receive, and generally do not carry health insurance.

We think the solution to the problem is the same as the one we described concerning community mental health centers (see p. 69). The State could reimburse projects on a fee per service basis or on a retainer basis. A NIAAA official stated that services could be provided to prison inmates if some form of reimbursement existed.

ASSISTANCE IS AVAILABLE  
FROM OTHER FEDERAL PROGRAMS

We did not examine in detail all Federal programs which could possibly provide assistance. For example, in the States visited, there is evidence that assistance was also obtained from the following Federal sources:

- HEW (Council on Development Disabilities) funded mental retardation and other specialized programs.
- The Department of Commerce (Economic Development Administration) funded the construction of a mental health facility.
- HEW (under Title XX of the Social Security Act) funded social service programs for a residential mental health unit, a mental retardation unit, and group counseling services.
- The Department of Justice (National Institute of Corrections) funded consultant services.
- The Department of Labor (under the Comprehensive Employment and Training Act) funded the continuation and expansion of testing and evaluation services.

The National Institute of Corrections has recognized the need for a publication that would identify all the Federal programs which can potentially provide assistance to State

and local correctional facilities. It is planning to sponsor a project in fiscal year 1980 to develop such a document. An Institute official told us that the project, still in the early planning stage, will likely include programs which could assist in improving inmate mental health care, drug treatment, and alcohol treatment. Such a document would be a valuable resource for State and local correctional officials seeking Federal aid and assistance for improving such care and treatment in their facilities.

### CONCLUSIONS

The Federal Government has programs that can be used to improve mental health care, but they have not been extensively used for prisons. Federal agencies have not taken appropriate action to bring about effective, well planned use of resources for improving prisons' mental health care delivery systems. Federal agencies need to more adequately communicate and enforce assistance program requirements as they pertain to mental health care of prison inmates. Such action would help ensure the development of clear plans for improving inmate care, based on a coordinated effort by State criminal justice and health agencies, to identify inmates' needs, services presently available, and additional services needed. The plans, in turn, would provide a sound basis for determining the appropriate State actions and the extent and nature of Federal assistance to alleviate shortfalls.

LEAA can also play a more expanded role in identifying the extent of the mental health problem in prisons. LEAA efforts to identify the number of mentally disturbed and mentally retarded inmates would be a first step in improving the effectiveness of programs for them.

### RECOMMENDATIONS

To help States improve mental health in prisons, we recommend that the Attorney General require the Administrator, LEAA, to:

- Work with State criminal justice agencies to identify the extent of mental health problems in prisons. These results should be used to consider establishing a discretionary grant program for treating mental health problems in prisons. If such a program is established, LEAA should require that State criminal justice agencies coordinate their actions with State health agencies receiving assistance under other Federal programs.

- Strengthen procedures for reviewing State criminal justice agencies' comprehensive plans to ensure that the plans adequately address the alcohol and drug treatment needs of prison inmates and provide for effective coordination with State substance abuse agencies in planning and program implementation actions.
- Disseminate the results of the planned evaluation of the recently initiated Treatment and Rehabilitation for Addicted Prisoners Program to prison system officials nationwide and to NIDA.
- Consider funding a project for developing standards addressing the diagnosis and treatment of prison inmates affected by behavioral disorders.

To help prison systems identify sources of assistance, the National Institute of Corrections should include in its planned directory of Federal programs identification of programs that could assist prison services for inmates having mental and substance abuse problems.

We also recommend that the Secretary, HEW, require the Administrator, ADAMHA, to:

- Revise NIMH and NIAAA program guidelines for participating State mental health and alcohol abuse agencies to make clear that the agencies should address the needs of prison inmates.
- Strengthen the procedures of its three institutes--NIMH, NIDA, and NIAAA--for reviewing State health and substance abuse agencies' comprehensive plans to ensure that the plans adequately address the mental health, alcohol, and drug treatment needs of prison inmates and provide for effective coordination with State criminal justice agencies in planning and programming implementation actions.
- Direct NIDA to remove its present restriction on using Drug Abuse Office and Treatment Act funds for treating inmates in correctional institutions.

--Direct NIMH and NIAAA to help State and local agencies identify or develop means by which community mental health centers and alcoholism projects could be reimbursed for services provided to prison inmates.

#### AGENCY COMMENTS

In an August 22, 1979, letter, HEW generally agreed with all but one of our recommendations. It also included a number of general comments which are shown in appendix II.

The Department only partially concurred with several of our recommendations, primarily because it did not believe it had the authority to compel a State to consider the needs of prisoners in its planning or to earmark funds specifically for treating inmate populations. Instead, it said it would encourage State involvement in this area.

If encouragement works, there should be no problem with the Department's approach, but we continue to believe that the Department has the authority to require the States to consider the needs of inmates in the plan development process. We agree with the Department's general conclusion that present law does not require State plans to earmark or obligate funds specifically for inmates. But that conclusion is distinguishable from ensuring that the States consider the needs of the population to be served.

The Department did not concur with our recommendation that NIDA remove its present restriction on the use of Drug Abuse Office and Treatment Act funds for treatment of inmates in correctional institutions. The Department believed that removing the restriction would seriously threaten the provision of services to individuals whose needs are currently being met. It also stated that its policy was consistent with overall Federal policy in this area.

During our review, and again after receiving HEW's comments, we reviewed the documents containing the Federal strategy for treating and preventing drug abuse. We found nothing in the strategy that stated which agencies should fund drug treatment in State prisons. If such a Federal policy does in fact exist, we believe it should be changed.

The problem with the restriction is that the States are prevented from using NIDA funds for prison inmates regardless of how high a priority they feel inmates should be given.



We recognized in making our recommendation that the funds available were not sufficient to treat everyone. But States should be allowed to direct their NIDA resources to prisons, if they believe that prisons have the greatest need.

HEW also offered a technical comment aimed at modifying one of our recommendations to the Attorney General. Basically, it involved BOP initiating contact with local community-based mental health service providers in order that they might provide services on a reimbursable basis to BOP inmates. Although we did not cover this during our review, the suggestion appears to have merit. We believe the Department of Justice should consider it when implementing the report's recommendations.

The Department of Justice commented on only two of the recommendations contained in this chapter and stated that it believed that both had been implemented. The Department also stated that we did little to display the positive accomplishments of LEAA and other Federal agencies. We have several problems with the Department's comments as they relate to LEAA.

Many of LEAA's stated accomplishments pertain to mental health services in local jails. Jails were not included in this review because we are looking at them separately. Accomplishments relating to prisons were noted in the report.

The comments also identified problems and sensitive issues in providing mental health services in correctional institutions. We recognize that problems exist and included comments on those which we considered to be the most significant. We did not believe it was necessary to include a discussion of each and every one. Our basic message is that problems exist, that they will probably continue to exist, and that management needs to work within them if they expect to achieve improvements.

The Department's comments on two of our recommendations already being implemented were supported by providing us with funding information. These expenditures pertain to both jails and prisons, but more importantly, the amount of funds spent was not the issue involved. We recommended that LEAA work with State criminal justice agencies to identify the extent of mental health problems in prisons. There was no information in the comments to show that this was done. Also, no information showed what had been done on our recommendation to strengthen procedures for reviewing State comprehensive plans.

## CHAPTER 5

### SCOPE OF REVIEW

To determine the adequacy of correctional health care nationally, we made literature searches, examined court decisions, and reviewed reports and studies published by professional groups such as ACA and AMA. We also interviewed representatives of ACA, AMA, the American Psychological Association, and the American Psychiatric Association. Our work was done primarily between May 1978 and January 1979.

We interviewed officials and reviewed policies and procedures for providing mental health services to determine the adequacy of health care in Federal institutions and in five States. (See app. III.) To observe the actual delivery of health care, we visited prisons where we (1) interviewed administrators and psychiatric/psychological staffs, (2) observed activities, (3) reviewed records, and (4) inspected facilities and equipment. In addition, a GAO-clinical psychologist accompanied the audit team on visits to prisons to inspect the psychiatric/psychological facilities, determine the adequacy of the related staffs, and determine the quality of care provided. In some States, we examined inmate records, but in others we were denied access because the States believed the information was privileged.

We did limited work on aftercare. To assess whether BOP prisons were providing appropriate information on aftercare needs of parolees and mandatory releases, work was done at the U.S. Penitentiary, Lewisburg, Pennsylvania; the U.S. Probation Office for the Southern District of New York; and the BOP's Community Treatment Center in New York City. We held discussions with appropriate officials and reviewed pertinent records at these locations regarding mental health, drug and alcohol aftercare. We also interviewed officials of the U.S. Parole Commission and the Division of Probation, Administrative Office of the U.S. Courts, in Washington, D.C.

We interviewed HEW and Department of Justice officials to (1) assess their role in helping States provide mental health care in correctional institutions, (2) determine what Federal programs are available and being used by the States, and (3) determine what the Federal role should be in assisting the States to meet inmate health care needs.

The primary reason for our visits to California, Michigan, New York, North Carolina, and South Carolina was to identify ways in which the Federal Government could improve its health care assistance. The States in our review were selected on the basis of their geographic location and were not considered by us to be better or worse than those we did not visit. Because the focus of this report is not on evaluating the specific health care problems of individual States, they generally have not been identified unless they seemed to be making headway in solving certain problems. They were only identified so that other States might be able to contact them to obtain additional information.



## UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C. 20530

Address Reply to the  
Division Indicated  
and Refer to Initials and Number

AUG 23 1979

Mr. Allen R. Voss  
Director  
General Accounting Division  
United States General Accounting Office  
Washington, D.C. 20548

Dear Mr. Voss

This is in response to your request to the Attorney General for the comments of the Department of Justice (DOJ) on your draft report entitled "Prisons Are Not Providing Adequate Mental Health Care: Better Management And More Effective Federal Involvement Are Needed."

The report provides a fairly thorough and constructive analysis of mental health care delivery systems of inmates. In our opinion, the General Accounting Office (GAO) staff conducting the audit took a very professional, positive approach in dealing with some very complex issues.

Nevertheless, the present version of the report raises a number of issues and concerns. Our comments relating to the Bureau of Prisons (BOP) and the Law Enforcement Assistance Administration (LEAA) are set forth individually below.

Bureau of Prisons

BOP is in general agreement with the recommendations of the report. However, one of the concerns as the report appropriately points out on page iii is that mental health efforts in both Federal and State prison systems are affected by limited funding and shortages of qualified personnel and that such constraining factors are likely to continue. The report implies that managers can overcome limited funding and staff shortages through effective administration. Effective administration in terms of BOP is identified by



GAO as including "sound information on inmates' needs, adequate records, good utilization of staff, effective monitoring and evaluation of programs, and independent review of activities." Implementation of some of the above elements of effective administration would, in turn, require more funding and staff. We agree that more can be done with existing resources; however, implementation of some of GAO's recommendations would require a revision of priorities, thus requiring a reallocation of present resources from one function to another. To the extent reallocations can be made without jeopardizing other functions or if additional resources are provided, the recommendations can be implemented.

The following comments are provided which we believe will clarify certain points and otherwise strengthen the report.

1. The "diagnostic" labels used in the report are indicative of the basic problem in collecting mental health data in general. Prison estimates are no more varied than those made of mental health needs for American society in general. Furthermore, the definitions used for psychosis, mental retardation, behavioral disorders, alcohol and drug abuse/addiction are so vague as to ensure data variance. For example, in our estimate of psychosis, we did not include "borderline" or "in remission" cases mentioned on page 12. Under behavioral disorders, we did include personality disorders; they were not listed on page 2. The terms are not consistent with the American Psychiatric Association Diagnostic and Statistical Manual II.
2. In the discussion of behavioral disorders on pages 7, 21 and elsewhere, the report seems to recommend coerced treatment. BOP is criticized for treating inmates only in crisis or upon request. Most published standards, DOJ, American Correctional Association (ACA), American Medical Association (AMA), and American Bar Association (ABA), list among inmates' rights the right to refuse treatment. The "medical model" seems to be pervasive throughout the report. It is considered outmoded by most mental health, correctional, and professional organizations and BOP.

3. The estimate of inmates who abused alcohol was reported as 6 percent. This is an inaccurate percentage for the following reasons:
  - the definition of inmates included in this category is not clear-cut;
  - BOP staff did not always have adequate background information at the time the data was recorded;
  - there is a tendency to not mark this category since the U.S. Parole Commission often bases parole considerations on alcohol abuse;
  - inmates who abused both alcohol and drugs were only counted in the drug abuse category.

In view of the above reporting problems, the percentage of inmates who abused alcohol could range from 6 percent to 42 percent.

4. The report contradicts itself in the discussion on estimates of mental retardation. On page 2, it reports a 1977 study showing 1 percent of Federal inmates were retarded (using only intelligence quotient (IQ) scores), but on pages 22 and 23, it states that no estimates were given. In fact, we surveyed all BOP psychologists at GAO's request, and found only 5 inmates, of the total inmate population, that essentially met their definition of an IQ below 70 combined with deficient adaptive behavior. All were under close supervision and post-release follow-up was being planned for those near release.
5. It should be noted on page 7 that the American Association of Correctional Psychologists has established a committee to develop psychological standards for prisons and jails rather than the American Psychological Association.
6. We believe the minimum requirements for screening that are mentioned on page 9 are simplistically narrow and are stated in psychoanalytic terms-- "coping mechanisms and ego strengths."

7. In the discussion of psychotropic medication usage (page 17) and the related recommendation (page 31), we disagree with some statements. We do agree that the lowest effective dosage, "drug holidays" and single medication therapy should be used whenever clinically possible. In fact, this has been discussed and encouraged at numerous regional and national meetings of BOP psychiatrists and during institution professional audits, although we have not yet so stated in any written national policy issuance. We believe, however, that this becomes a professional judgment decision for which the treating psychiatrist is responsible when considering medical management of a specific individual. We do know of patients on one medication therapy, lowest effective medication dosage, and "drug holiday" treatment regimes. Without reviewing the specific medical records that GAO reviewed and discussing with patients' prescribing physicians, we cannot comment on the specific therapeutic regimes of those individuals. We do concur with the recommendation.
8. On page 19, electro-shock therapy is mentioned as an example of an aversive behavior modification technique. We have some concern that this may be misinterpreted by someone if they confuse aversive electric stimulation (a type of aversive technique) with electro-convulsive therapy (sometimes referred to as electro-shock therapy) which is not aversive behavior modification but rather an accepted therapy with limited use in certain psychiatric disorders, such as, psychotic depression.

#### Law Enforcement Assistance Administration

While LEAA generally concurs with the observations made in the report, GAO does little to display the positive accomplishments already undertaken by LEAA and other Federal agencies. Of further concern is the extent to which priorities should be revised and resources reallocated to act on GAO's recommendations. We also believe the report should have dealt with the problems of stigmatization surrounding mental health, responsibilities of States to provide adequate services (no mention is made of State departments of mental health) the risks of over-diagnosis, costs of treatment of services,

legal issues regarding right to treatment and right to be left alone, and emergent themes of deinstitutionalization and decentralization. Also the report displays little familiarity with available research literature or current operational priorities of LEAA in particular.

In addressing the major areas of the report, our comments first discuss some of the problems and issues of sensitivity that are encountered in the delivery of mental health corrections in Federal and State correctional institutions. These comments will be followed by specific responses to the recommendations directed to LEAA.

### Problems and Issues of Sensitivity

#### 1. Deinstitutionalization of Mental Health

The report fails to address the changing concepts of mental health care regarding the use of confinement for the mentally disordered. As a result of judicial and legislative intervention over the past decade, mental health confined populations have declined dramatically. The degree to which this phenomenon has affected correctional facilities is a subject of current research by the National Institute of Law Enforcement and Criminal Justice (NILECJ).

#### 2. Availability of Mental Health Diagnostic And Treatment Personnel

The report does not address the dearth of mental health personnel in rural and remote areas where prisons are principally located or how to attract such expertise given the relatively low salary structure of correctional employees. Also, the report does not address the substantial gains which have been made in State facilities over the past 20 years in the general area of treatment staff/inmate ratios. National Prisoners' Statistics indicate that in 1950 the ratio of "treaters" to inmates was 1:94.6 while in 1978 this proportion had shifted downward to 1:20.3. Regionally, this pattern has been most dramatic in the South where the 1950 ratio was (a) and the 1978 ratio was 1:28.5. We believe this progress should be recognized.

GAO note a: In a later phone call, Justice corrected this ratio to read 1:223.6.



### 3. Availability of Services

It has been established that no more than 50 full-time psychiatrists have been working in all Federal and State prisons during the 1960's and 70's (see Hospital and Community Psychiatry, 1979, Vol. 27, p. 15-17). The reason for this seemingly low interest on the part of psychiatrists in the confined offender may have little to do with the management strategies noted as deficient by the GAO report. Such lack of interest has more to do with such factors as salaries, geographic locations of prisons, and philosophical questions about the compatibility of treatment with coercive environments. The GAO report should note the kinds of social forces which influence and aggravate the delivery of treatment services in correctional environments.

### 4. Determination of Where Help Is Needed the Most

In a joint conference held in September 1978, by NILECJ, Bureau of Prisons' National Institute of Corrections (NIC), and Department of Health, Education, and Welfare's (HEW) National Institute of Mental Health (NIMH), panelists emphasized critical needs for mental health services in local jails. This conference pointed out that up to two-thirds of all individuals confined in local jails suffer emotional disorders which could be categorized in the American Psychiatric Association's DEM-II Classification scheme. Further, it was noted that there is a general dearth of empirical research available on methods for assessing the mental health status of short-term, relatively non-service offenders confined in local jails. The GAO report does not mention the mental health problems in local jails and remediation efforts which could be undertaken and are currently being planned by NIMH, NIC and NILECJ.

### 5. Efforts Past and Present

The report cites two studies undertaken by LEAA (Treatment Programs for Sex Offenders and Treatment Programs for the Mentally Retarded Offender) and then notes the lack of research. LEAA has sponsored numerous studies of treatment effectiveness, diagnostic

predictions, health care improvement, research on drug treatment (Methadone Treatment Manual, Drug Programs in Correctional Institutions, Treatment Alternatives to Street Crime and Treatment and Rehabilitation for Addicted Persons) and a study of diversion of the public inebriate. In addition, LEAA designated the Montgomery County, Pennsylvania Mental Health-Mental Retardation Emergency Service as an exemplary project. Currently, LEAA is planning to fund two studies of the flow of persons between the mental health system and the correctional system, a study of the use of psychiatric testimony in trials, and a study of screening and evaluation for mental health services by criminal justice agencies within FY 1979. Also, as noted previously, LEAA co-sponsored the workshop in September 1978, on mental health needs in local jails.

Extensive contact between NILECJ, NIC, and NIMH is maintained on this particular topic. NIMH and NILECJ staffs have reciprocal agreements for reviewing proposals. There is a high level of coordination and discussion between NILECJ, NIC, NIMH, and the National Institute on Drug Abuse, HEW, contrary to the opinion offered by the GAO report.

#### 6. Recommendations

GAO recommended that LEAA:

- a. "Work with State criminal justice agencies to identify the extent of mental health problems in prisons and use the results of such efforts to consider establishing a discretionary grant program for the treatment of mental health problems in prisons. If such a program is established, require that State criminal justice agencies coordinate their actions with State health agencies receiving assistance under other Federal programs."

A review was made of the LEAA categorical grant awards which have been made in the specific area of mental health since 1969. This review revealed that 18 grants to 13 States in the amount of \$2,089,706 have been provided since 1969. In addition, a single grant in the amount of \$1,239,320 was awarded this year to continue the efforts of an LEAA program through the AMA.

The AMA program is expected to continue to have a significant impact on mental health. During the pilot program which produced the AMA Standards for the Accreditation of Medical Care And Health Services in Jails, and tested models for health care delivery in jails, the AMA experienced some very positive reactions and activities regarding mental health. In nearly all of the test sites, there was a great deal of community interest in the jail project. This, coupled with appropriate project coordination, led to the involvement of many mental health agencies and mental health boards. The results included letters of agreement between mental health agencies and jails, contracts for mental health services in jails, and the various ultimate results, such as correctional officer training.

The AMA Standards reflect a great deal of concern for mental health. The following information is based on Standards: 1004, 1011, 1012, 1024, 1025 and 1026, which make direct reference to mental health. However, all of the standards are in the interest of health in general.

The standards require screening, referral, and care for mentally ill and retarded inmates. They specifically require written standard operating procedures which have been approved by the responsible physician for all of these areas. Screening must be accomplished on all inmates upon admission to the facility with findings recorded on an approved form. A complete health appraisal including a psychiatric history is required within 14 days after admission. The standards require that facility personnel be trained regarding the recognition of the symptoms of mental illness and retardation. Mentally ill or retarded inmates whose adaptation to the jail environment is significantly impaired

must be referred for proper care. Special programs must be provided for inmates requiring close medical supervision. The current medical care health services program will adequately address mental health. This program in all of the 22 States involved is coordinated through the State Planning Agency and the State Medical Society.

We believe GAO's recommendation has already been implemented.

- b. "Strengthen procedures for review of State criminal justice agencies' comprehensive plans to insure that the plans adequately address the alcohol and drug treatment needs of prison inmates and provide for effective coordination with State substance abuse agencies in planning and program implementation actions."

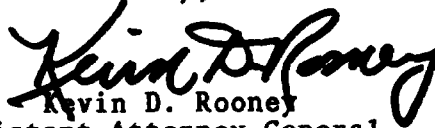
LEAA reviewed subgrant awards for mental health since 1969. This review revealed that 521 awards totalling \$34,671,832 have been provided since 1969 in the specific area of mental health. In addition, LEAA has provided 21 discretionary grants totalling nearly \$2.5 million in the past two years for the specific areas of Drug/Alcohol Treatment, under a Standards Implementation Program (SIP).

The SIP for both FY 1978 and FY 1979 required that correctional agencies applying for grants had to be co-applicants with the single State agency in their respective States.

We believe GAO's recommendation has already been implemented.

We appreciate the opportunity to comment on the draft report. Should you desire any additional information, please feel free to contact us.

Sincerely,



Kevin D. Rooney  
Assistant Attorney General  
for Administration



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE  
OFFICE OF THE SECRETARY  
WASHINGTON, D.C. 20201

AUG 22 1979

Mr. Gregory J. Ahart  
Director, Human Resources  
Division  
United States General  
Accounting Office  
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Prisons Are Not Providing Adequate Mental Health Care: Better Management and More Effective Federal Involvement Are Needed." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

A handwritten signature in cursive script that reads "Thomas D. Morris".

Thomas D. Morris  
Inspector General

Enclosure

COMMENTS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON THE  
GENERAL ACCOUNTING OFFICE'S DRAFT REPORT ENTITLED "PRISONS ARE NOT  
PROVIDING ADEQUATE MENTAL HEALTH CARE: BETTER MANAGEMENT AND MORE  
EFFECTIVE FEDERAL INVOLVEMENT ARE NEEDED"

General Comments

While we agree with the general purport of this General Accounting Office (GAO) draft report, we believe it is important to recognize the fact that variation will be found in screening for or service delivery of mental health care in prisons. There may, of course, be many reasons for this. Perhaps the most notable reason is the very real conflict in penal philosophy between "punishment" and "corrections," and the operational contradictions which result and are thrust upon staff in correctional agencies. Therefore, the conclusions (1) that prisons do not always take the desirable actions vis-a-vis mental health care and (2) that what they do accomplish is sometimes questionable are truisms that provide little guidance in structuring actual improvements of the well-known deficiencies.

We feel the report could be strengthened by recognition of the political and structural factors that have kept and will continue to keep correctional programs at the bottom of social and political priorities. Given the severe competition for scarcer and scarcer tax revenues, prisons and related public facilities simply have not been able to obtain the resources and retain the skilled and dedicated personnel (e.g., physicians, psychiatrists, and other mental health professionals) to do many of the "complete" tasks that GAO recommends, and which correctional administrators themselves have for some time been aware would be desirable. Unfortunately, placing responsibility on correctional management ignores these social and political priorities.

The basic recommendation of the report is to improve mental health care through more effective administration. In this regard, the role of the Federal agencies (accurately assessed as having given only minor attention to prison mental health services) is seen as (1) direct improvement of management in Federal prisons by specific actions of the Bureau of Prisons (BOP), and (2) indirect improvement of management within State agencies by ensuring that various State planning efforts are coordinated and address the indicated deficiencies of mental health care of prisoners.

The recommendations do not address the fact that the lack of resources is not only a major cause of the problem, but also the result of longstanding structural and political dimensions to the problems identified by GAO. The recommendations also do not provide for initiatives at the State and local levels directed at specific program development. We believe the report user will have a better perspective on this problem area if these matters are considered in conjunction with the report's recommendations.

GAO Recommendation

We also recommend that the Secretary of Health, Education, and Welfare require the Administrator of ADAMHA to:

- "- Strengthen the procedures of its three institutes--NIMH, NIDA, and NIAAA--for review of State health and substance abuse agencies' comprehensive plans to insure that the plans adequately address the mental health, alcohol, and drug treatment needs of prison inmates and provide for effective coordination with State criminal justice agencies in planning and program implementation actions."  
(page 79)

Department Comment

We partially concur. ADAMHA's Institutes, where appropriate, will encourage the State agencies to include this area of underserved individuals in the State plans for formula grants. However, ADAMHA cannot insure through the mechanism of State plans that the needs of prison inmates will be adequately addressed. Legislation authorizing the programs does not provide for earmarking of funds for specific purposes or groups. The States may exercise their discretionary rights over formula monies and award funds to other priorities. We, therefore, cannot compel a State to consider in its planning the needs of prisoners or to earmark formula funds specifically for treating inmate populations. We can, however, encourage the State health agencies to address the mental health, alcohol, and drug treatment needs of prison inmates and provide for effective coordination with not only the criminal justice system but also with health, education, social service, and all other relevant agencies.

- "- Revise NIMH and NIAAA program guidelines for participating State mental health and alcohol abuse agencies to make clear that the agencies should address the needs of prison inmates."  
(page 79)

Department Comment

We concur. NIMH will revise its guidelines for participating mental health agencies to encourage the agencies to address the needs of prison inmates. Beginning in FY 1980, NIMH will offer technical assistance for development of guidelines and programs that will emphasize treatment services in prisons for States that request such assistance, within the limits of NIMH resources.

NIAAA's guidelines presently encourage the coordination of planning efforts with judicial and correctional agencies. Following the process of renewal legislation for NIAAA, the Institute will revise its guidelines to encourage the State alcohol abuse agencies to address the needs of prison inmates.

"- Direct NIDA to remove its present restriction on the use of Drug Abuse Office and Treatment Act funds for treatment of inmates in correctional institutions." (page 79)

Department Comment

We do not concur. Removal of restrictions or modifications of present policy on prison inmates would seriously threaten the provision of services to individuals whose needs are currently met under NIDA's mandate. NIDA's mandate is the establishment and maintenance of a nationwide community-based treatment network for treating individuals residing in the general community. This mandate, initiated by the Special Action Office for Drug Abuse Prevention (SAODAP), is consistent with, and has been reiterated in, past and current Federal strategy. Federal policy separates responsibilities between the criminal justice system (i.e., the Law Enforcement Assistance Agency, the Bureau of Prisons, and State criminal justice agencies) and NIDA. NIDA's policy on treating prison inmates, is, therefore, consistent with overall Federal policy in this area.

An additional consideration is funding. We understand that a joint Law Enforcement Assistance Agency - Bureau of Census study made in 1974 showed that potentially over 118,000 inmates needed treatment. By comparison, NIDA's current total of treatment slots available for community-based services is 95,700. A considerable, additional effort would be required to meet the inmates' needs. Such an effort would be beneficial and humane. We encourage that the provision of necessary support for such an undertaking, however, be made available to the criminal justice system which is responsible for providing treatment services for incarcerated individuals. Although the Department can and will continue to collaborate with the criminal justice system, it should not support or duplicate their efforts.

"- Direct NIMH and NIAAA to assist State and local agencies in identifying or developing means by which community mental health centers and alcoholism projects could be reimbursed for services provided to prison inmates." (page 80)

Department Comment

We concur. ADAMHA's Institutes are currently developing strategies for continued funding of projects as Federal financial assistance declines. The Institutes would be willing to coordinate their efforts with BOP to work with State and local agencies through the Regional Offices to identify reimbursement mechanisms for services provided.



Technical Comment

We would also like to offer the following technical comment:

After discussing how "Mental Health Care Could be Improved Through Better Management", Chapter 3 concludes with a series of recommendations. Some of these are directed to the BOP. In light of discussions and recommendations that follow in a later chapter relating to other Federal programs, we suggest including a recommendation that BOP, and its local institutions, initiate contact with local community-based mental health service providers for provision of the specific services which seem most appropriate for a particular institution. This recommendation should also include a recommendation that BOP develop mechanisms whereby BOP could help compensate those service providers for services they might render just as they might compensate any other providers of service. Action on such a recommendation could make it easier for CMHC's to become involved in areas of specific need rather than attempting to penetrate a closed system to provide services for which there may not be a clearly perceived need. Clear mechanisms for reimbursement would make such an arrangement even more attractive to mental health service providers.

STATE AND FEDERALINSTITUTIONS VISITEDSTATE INSTITUTIONS VISITED

<u>States</u>	<u>Institutions</u>
California	California Medical Facility
Michigan	State Prison of Southern Michigan Riverside Correctional Facility
New York	Clinton Correctional Institution and Annex
North Carolina	Central Prison McCain Prison Unit Scotland Prison Unit
South Carolina	Kirkland Correctional Institution

BOP REGIONS AND INSTITUTIONS VISITEDNORTH CENTRAL REGION

U.S. Penitentiary	Marion, Ill.
Medical Center for Federal Prisoners	Springfield, Mo.

NORTHEAST REGION

U.S. Penitentiary	Lewisburg, Penn.
Federal Correctional Institution	Petersburg, Va.

SOUTHEAST REGION

Federal Correctional Institution	Butner, N.C.
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WESTERN REGION

Federal Correctional Institution	Lompoc, Calif.
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