Incarcerating the Mind: Mental Health Treatment In the Bureau of Prisons

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Research Question

What is the relationship between **BOP (Bureau of Prisons) Policies on Mental Health** and the **Actual Treatment of Mentally Ill Inmates?**

Abstract

This paper explores the relationship between Bureau of Prison (BOP) Policies on mental health and the actual treatment of prisoners with mental illness. Through analysis of written inmate correspondence and interviews, peer-reviewed academic articles, and mental health policies within the BOP, I reveal that while the policies themselves appeal well-intentioned, the conditional language used permits the BOP to largely ignore its own mental health guidelines. The majority of the data I analyze has been gathered from a database of thousands of tangible written letters between inmates and lawyers at a nonprofit legal agency in Washington, D.C. Throughout the paper, I use a representative sample letters of these letters to illustrate the punitive nature of our criminal justice policies and the detrimental impacts of this treatment of all federally incarcerated individuals. My findings reveal a pattern of systematic injustice perpetrated by conditional language, inadequate allocation of funds, a general misunderstanding of mental illness, and an antipathy toward mentally ill individuals perceived as criminals. The comparison between prisoner testimony and prison policies, overall, uncovers the BOP's lack of accountability for the prisons it oversees. After exposing the BOP's inability, or reluctance to provide adequate treatment in most facilities, I present a case study of one individual who has finally found relief after 15 years in solitary confinement in the form of adequate treatment, therapy, and freedom from segregation. This final case study informs my suggestions for policy reform and future research.

Background

Mental Health is consistently stigmatized as either an excuse, or an economic burden (Keyes 97). People find it difficult to talk about their illnesses, and even fewer seek treatment (Corrigan 614). Regardless of the stigma, an estimated one in five adults deals with mental illness on a daily basis. In prisons, individuals with mental illness are overrepresented, and this population inevitably receive less psychological treatment than those on the outside. **Of those who are incarcerated in the Federal Bureau of Prisons, experts have estimated that 45% have suffered with mental illness at least once in their lifetime (U.S. Dept. of Justice Office of the Inspector General, ii).**

Currently, there are more people with mental illness in prisons than in psychiatric hospitals. This is due, in large part, to a movement away from mass institutionalization of the mentally ill in the 1960s and 1970s, in recognition of the deplorable conditions in state mental health hospitals. However, promised federal support for community-based treatment never materialized, despite their potential benefits. People with mental illness were largely left untreated, with little to no resources for rehabilitation, leaving many poor, homeless, struggling with addiction, and subject to abuse in the community, leading to involvement in the criminal system of punishment, not treatment (Fellner 136, Gostin 907). We use this framework to understand the significance of mental health treatment within the Bureau of Prisons. **We are criminalizing mental illness, and, in the process, making it increasingly difficult for mentally ill prisoners to receive the treatment they need.**

Hypothesis & Approach

Hypothesis: The treatment of people with mental illness in the BOP worsens mental health, rather than helping to treat it.

Methodology: To answer this question, I used qualitative analysis to compare written correspondence from prisoners alongside the actual treatment policies within the Bureau of Prisons. For my analysis, I use correspondence from **20 inmates within the Federal BOP**, culminating in **one final case study**. The majority of these inmates are in solitary confinement. I divide my analysis into three major sections:

1. Care Levels and Evaluations: Each inmate is assigned a "Care Level", (CARE1-MH, CARE2-MH, CARE3-MH, or CARE4-MH) that determines the mental health treatment they will receive. CARE4-MH designates the highest amount of need and CARE1-MH designates the least amount of need.

2. Treatment: Every federal prison is expected to provide a basic level of mental health treatment for its incarcerated population. Some facilities are better equipped to care for people who are mentally ill than others.

3. Solitary Confinement: Solitary confinement is the isolation of an individual in a prison cell for 22-24 hours per day. As noted by Fellner, prisoners with mental illness receive higher rates of disciplinary infractions but are punished for these crimes equally, even when such actions that might have resulted from their mental illness.

For each, I asked: **1. What are the policies?, 2. Are the policies being followed?, and 3. What are the alternatives?**

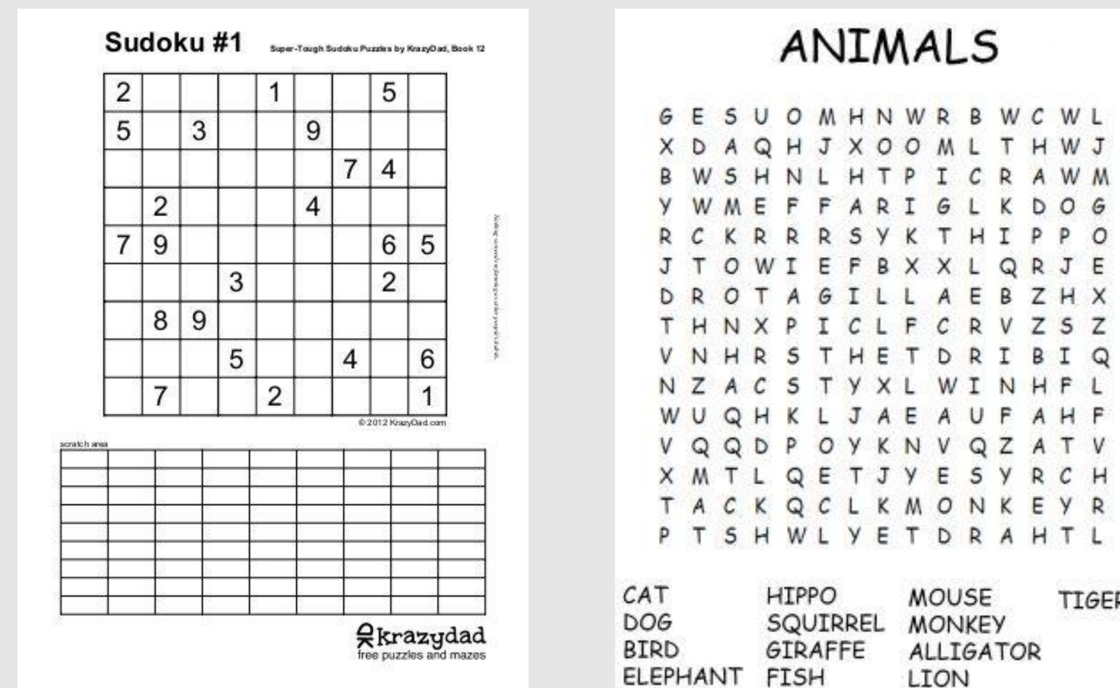

Figure 1

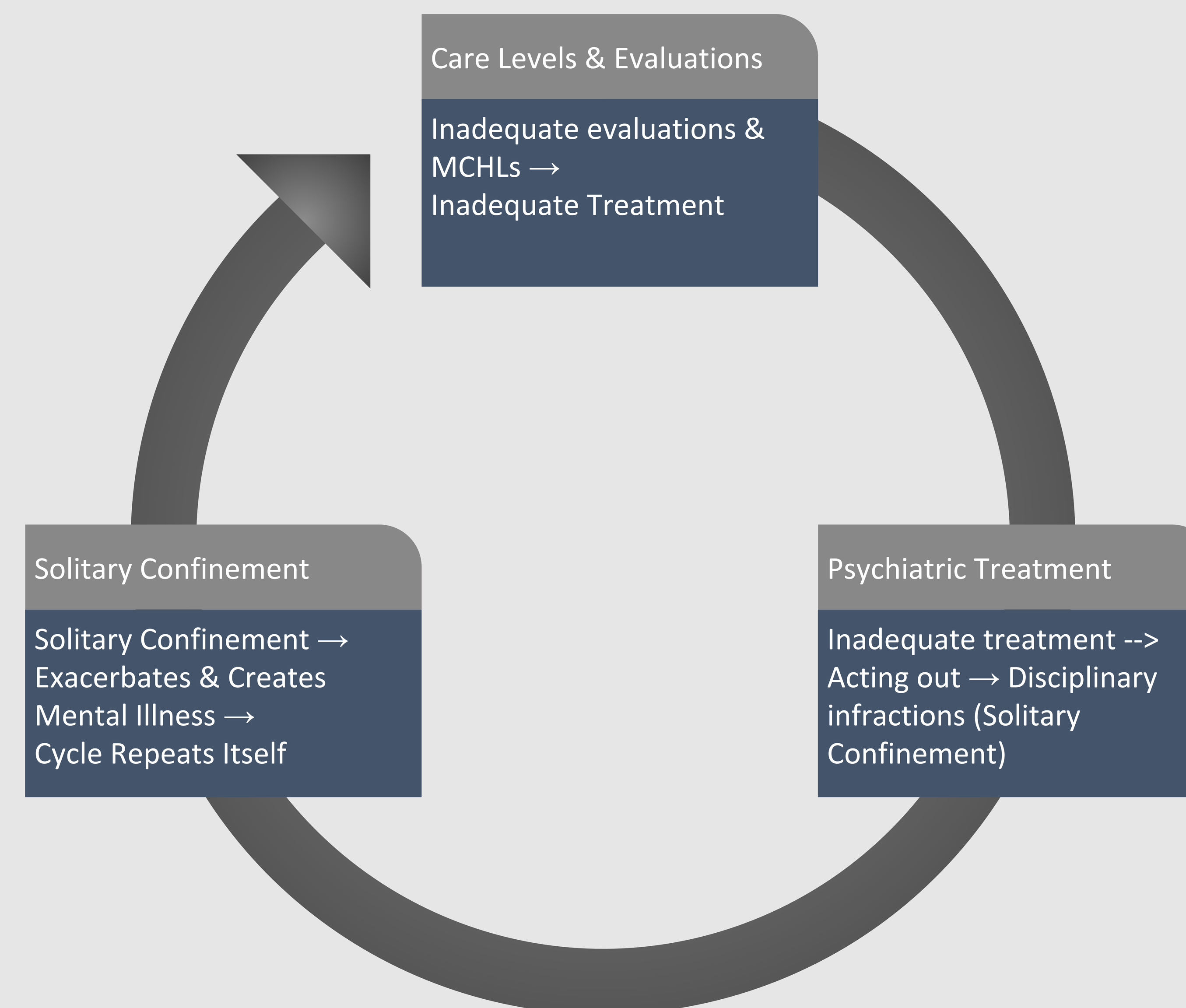

Figure 2

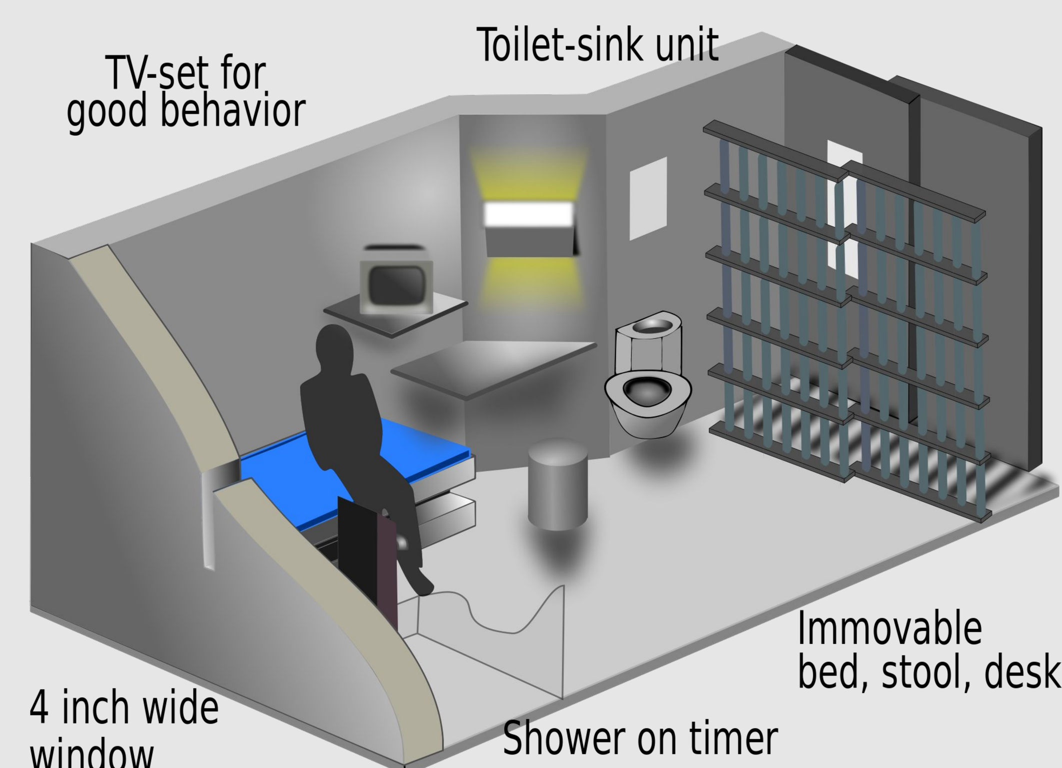

Figure 3

Findings

Note: The quotes listed below are representative of particular problems or pathologies.

Care Levels and Evaluations:

- "'I don't want to lower my threshold but I know that when staff are overwhelmed... there may have been sometime where people are reducing care levels in order to survive… There are just not enough bodies to carry out the policy'" - A BOP Chief Psychologist
- "Men who have been on suicide watch multiple times are often classified as CARE1-MH."

Treatment:

- "A lot of times when I would speak with the Psych at SMU Lewisburg about my suicidal thoughts they would tell me **'I don't believe you'll do it'** and often told me to 'just go read a book.'" - I/M G.
- "[the psychologists] come to everyone's door but just to pass out **puzzles**. It's on camera that they're only at the doors long enough to drop the puzzles off" - I/M D. (*Example: Figure 1*)

Solitary Confinement:

- "Prisoners with mental illness have higher rates of rule-breaking… **Yet they are punished for breaking the rules the same as other prisoners, even when their misconduct results from their mental illness. Even their acts of self-mutilation and suicide attempts are too often seen as "malingering" and are punished as rule violations.** As a result, mentally ill prisoners can accumulate extensive disciplinary histories." - Jamie Fellner, *Human Rights Watch*
- "Before I came to Lewisburg SMU there wasn't nothing wrong with me, but after being locked in a cell without receiving any outside recreation it has started to drive me crazy. I was evaluated and the prison stated that when I came to Lewisburg there wasn't anything wrong with me, but now I don't know what to do. I'm actually losing my mind" - I/M F.

Conclusion & Future Directions

The primary findings of this study are illustrated in Figure 2. The cycle of treatment within the Federal Bureau of Prisons begins and ends with Care Levels and Evaluations. If an inmate is inadequately assessed at his first visit, or does not have a visit at all, their mental illness may be exacerbated and many will act out. This "acting out" will result in a disciplinary infraction by the facility, typically solitary confinement. In solitary confinement, mental illness often intensifies. Those with preexisting conditions often feel worse, and those with no prior condition often develop a mental illness while incarcerated under such conditions (Figure 3 illustrates a layout of a solitary confinement cell).

I found, however, that the policies in place actually allow for the poor mental health treatment of inmates due to the conditional language of the policies. In one policy, there were 15 examples of conditional language - ordinarily alone was used ten times.

For example: *"To ensure Psychology Treatment Programs and mental health interventions prescribed in treatment plans **ordinarily** rely on evidence-based practices for the treatment of inmates with mental illness and rehabilitation needs" (BOP Policy on Treatment and Care of Inmates with Mental Illness).*

From this research, it becomes clear that there is an immediate need to **create stricter policies on mental health treatment** to increase accountability, **increase funding** for mental health treatment so facilities in need can hire additional psychiatric staff, and **train correctional officers** on signs of mental illness and ways to interact with inmates struggling with mental illness. In addition, we must think critically about the psycho-social impacts of solitary confinement and reconsider its usage as punishment in the criminal justice system.

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