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Psychology Treatment Programs

/s/
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1. PURPOSE AND SCOPE

To establish policy, procedures, and guidelines for the delivery of Psychology Treatment Programs within the Bureau of Prisons (Bureau). The Psychology Treatment Programs Manual is a plain-language, comprehensive set of operational guidelines for the programs operated by psychologists and treatment specialists in the Bureau.

The policy is designed to serve as a training device for psychologists and treatment specialists new to the Bureau. It is also a ready reference for more experienced Bureau psychologists and treatment specialists.

With the exception of the Sex Offender Treatment Program and the Sex Offender Management Program, the manual includes the following Executive Staff-approved programs:

- Drug Abuse Programs.
- Resolve trauma programs for women.
- Bureau Rehabilitation and Values Enhancement Program (BRAVE).
- Challenge Program (previously known as CODE).
- Mental Health Treatment Programs:
  - Habilitation Program.
  - Skills Program.
  - Axis II Program.
  - Mental Health Treatment Units (e.g., Step-Down Units).

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a. Summary of Changes

Policy Rescinded:
P5330.10 Inmate Drug Abuse Programs Manual (10/9/97)

The new Psychology Treatment Programs Manual is designed to describe Executive Staff-approved Psychology programs in the Bureau. Language has been simplified to make this policy easier to read and understand. Following are major changes to the manual, by chapter:

Chapter 1. EVIDENCE-BASED PROGRAMS. Introduces and describes the standardized clinical treatment programming for the Bureau's Psychology Treatment Programs. It includes the programs' foundation in evidence-based research and describes the required treatment philosophy, method, and administrative, operational, and clinical requirements.

Chapter 2. DRUG ABUSE PROGRAMS. Revises and describes Drug Abuse Treatment Programs in terms of evidence-based practices. It outlines changes in Drug Abuse Education, Non-residential Drug Treatment, and changes to the Residential Drug Abuse Program method of treatment (e.g., requiring inmate journaling, inmate assessment and evaluation, and building a program community).

Chapter 3. RESOLVE PROGRAM . Provides guidance on implementation of the national trauma program for female inmates. It describes both the psycho-educational course and the Non-residential Trauma Treatment for this population.

Chapter 4. BUREAU REHABILITATION AND VALUES ENHANCEMENT PROGRAM (BRAVE). Outlines policy, procedures, protocols, and methods for implementation of the BRAVE institution adjustment program.

Chapter 5. CHALLENGE PROGRAM. Outlines policy, procedures, protocols, and methods for implementation of the Challenge Program for high-security inmates who have substance problems and mental health disorders.

Chapter 6. MENTAL HEALTH TREATMENT PROGRAMS. Describes Mental Health Treatment Units in the Bureau – program history, targeted inmate population, and treatment for that population. Mental Health Treatment Programs include: Skills Program, Habilitation Program, Axis II Program, and Mental Health Treatment Units (Step-Down Units).

General Comment: SENTRY definitions and SENTRY assignments are on the Psychology Services Sallyport site, along with formats and examples of how to complete a Psychosocial Assessment, Treatment Plan, Treatment Progress Report, and Treatment Summary. Forms referenced in this policy are found on Sallyport (click Policy/Forms on the toolbar).

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b. Program Objectives. The expected results of this Program Statement are to establish:

- Procedures ensuring that inmates with mental health disorders receive appropriate treatment and clinical care from designation to release.
- Proven effective treatment practices throughout all Bureau Psychology Treatment Programs.
- Programs that meet the needs of the targeted population for which they were created (e.g., substance abusers, high security inmates, the seriously mentally ill).
- An effective mental health service delivery system that provides inmates the opportunity to change behaviors, reducing incident reports and lessening the burden of repetitive demands on staff.
- Effective psychological programs to reduce criminality and recidivism.
- Effective community transition.

c. Institution Supplement. Institutions with a Mental Health Treatment Program are required to have an Institution Supplement that includes specific details regarding the operation of their program, including:

- Any new evidence-based technologies in use.
- A description of the program's specific admission procedures.
- A description of the program's specific assessment procedures.
- A description of the program's specific treatment protocol.
- A description of the program's achievement awards and the criteria for earning each award.

REFERENCES

Program Statements

P1070.07 Research (5/12/99)
P1351.05 Release of Information (9/9/02)
P5100.08 Inmate Security Designation and Custody Classification (9/12/06)
P5331.02 Early Release Procedures Under 18 U.S.C. § 3621(e) (3/16/09)
P5380.08 Financial Responsibility Program, Inmate (8/15/05)

Federal Regulations

- Regulations cited in this Program Statement are contained in 28 CFR, Chapter 5.

Statutes

- 18 U.S.C. § 3621(e), The Violent Crime Control and Law Enforcement Act (VCCLEA).
- 18 U.S.C. § 3624(f), Mandatory functional literacy requirement.

ACA Standards

- Standards for Adult Correctional Institutions, 4th Edition: 4-4377, 4-4437, 4-4438, 4-4439, 4-4440, and 4-4441.

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- Performance Based Standards for Adult Local Detention Facilities, 4th Edition: 4-ALDF-4C-37, 4-ALDF-5A-04, 4-ALDF-5A-05, 4-ALDF-5A-06, 4-ALDF-5A-07, and 4-ALDF-5A-08.

Other Standards

- American Psychological Association (APA) Ethical Principles of the Psychologists and Code of Conduct, 8-21-02.
- APA Guidelines and Principles for Accreditation of Programs in Professional Psychology, 8-9-06.
- Association of Psychology Postdoctoral and Internship Centers membership criteria Predoctoral Psychology Internship Programs, 7-01.

- Association of Psychology Postdoctoral and Internship Centers membership criteria Postdoctoral Training Programs, 5-05.

Records Retention

Requirements and retention guidance for records and information applicable to this program are available in the Records and Information Disposition Schedule (RIDS) system in BOPDOCS and Sallyport.

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Chapter 1. EVIDENCE-BASED TREATMENT IN THE BUREAU OF PRISONS

1.1. The Bureau's Commitment. The Bureau is committed to providing high-quality, evidence-based psychology programs to all inmates in need of these services. Bureau Psychology Treatment Programs (PTP) are designed using the most recent research and evidence-based practices. These practices lead to:

- **Reduction** of inmate misconduct.
- **Reduction** of inmate mental illness and behavioral disorders.
- **Reduction** of substance abuse, relapse, and recidivism.
- **Reduction** of criminal activity.
- An **increase** in the level of the inmate's stake in societal norms.
- An **increase** in standardized community transition Treatment Programs. Transition treatment increases the likelihood of treatment success and increases the public's health and safety.

1.2. Cognitive Behavioral Therapy (CBT). The Bureau's PTPs are unified clinical services and activities organized to treat complex psychological and behavioral problems. The Bureau has chosen CBT as its theoretical model because of its proven effectiveness with inmate populations.

According to the CBT model, a person's feelings and behaviors are influenced by his or her perceptions and core beliefs. By helping inmates perceive events objectively and modify their irrational beliefs, they may become more successful in achieving pro-social goals.

CBT combines different treatment targets and specific conforming behaviors, focusing on an inmate's:

- Core beliefs.
- Intermediate beliefs.
- Current situation.
- Automatic thoughts, and the effects these thoughts and beliefs have on an emotional, behavioral, and psychological level.

As an example, inmates' ongoing criminal behavior is conceived, supported, and perpetuated by a set of habitual thinking errors: both criminal thinking and cognitive thinking errors. Using CBT, the Bureau is able to treat inmates by replacing those thinking errors with pro-social thinking. Such thinking supports behaviors that are consistent with the norms of a law-abiding community.

1.3. CBT Treatment Protocols. Using CBT underpinnings, the Bureau has created evidence-based treatment protocols (program journals, manuals, facilitator guides, etc.), for many of its PTPs. As treatment technologies change, there are opportunities to improve the Bureau's treatment programs. Therefore, staff are to use the most current journals, facilitators' guides, manuals, and resources developed by the Central Office.

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Other treatment protocols may be used *in addition to* the specified program protocols. These program additions must be CBT-based or compatible with CBT, and meet the goals of the treatment program (e.g., Motivational Interviewing, Cognitive Mapping, Dialectical Behavior Therapy, and 12-Step Programming). Additions must be approved by the PTP Coordinator, in consultation with the Regional Psychology Treatment Programs Coordinator (RPTP-C), formerly known as the Regional Drug Abuse Programs Coordinator.

While self-help programs such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Rational Recovery (RR) may be offered as part of an institution's drug abuse program effort, they are most often associated with non-residential (NR) treatment. While such programs are often powerful and important interventions in an inmate's recovery, they do not substitute for NR or residential treatment hours. They are considered a support to the Bureau's treatment protocols.

1.4. Program Support. Except in emergency situations (i.e., those for which institution emergency plans are written and other events such as assaults and body alarms where an immediate response is required), positions allocated and funded specifically to provide drug abuse treatment are assigned exclusively for providing this programming. These staff are not used for other duties (e.g., routine custody, unit, or case management functions).

All institution staff are to be informed of Residential Treatment Program operations, and play a role in support of them.

1.5. Residential Treatment Programs. Residential-based Treatment Programs in the Bureau follow the unit-based treatment model of a *modified* therapeutic community. This model has been proven effective in reducing inmate recidivism. A modified therapeutic community in a prison setting stresses pro-social values and behaviors that are needed in the outside community.

1.6. Core Program Elements. Prison Treatment Programs with successful outcomes apply specific *core elements***.** These elements are implemented in various ways, depending on the institutional environment and culture (e.g., physical layout, administrative support, allowable achievement awards). Sound security practices are strictly adhered to when performing treatment functions. The core elements in operating a Residential program call for:

1.6.1. Administrative Elements

a. **Separate Unit**. Residential Treatment Programs are to be separated from the general population in a separate treatment unit. A separate unit facilitates a positive peer culture and *reduces* negative peer influences.

b. **Unit Layout**. If allowed by the institution layout, the program staff and unit team will have offices on the treatment unit. Group sessions and meetings, when possible, are conducted on the unit. It is expected that the physical environment of the treatment unit reflects and supports the program concepts and goals. For example, the walls of the treatment unit should display signs,

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posters, paintings, etc., that reinforce key concepts, such as the Program Philosophy and Program Attitudes.

1.6.2 Clinical Elements

a. **Diagnoses**. The Treatment Program Coordinator will diagnose each inmate through an established assessment diagnostic process.

b. **Individual Treatment Plan**. Together with the inmate, treatment specialists will develop individual treatment plans for each inmate. In programs where there are no treatment specialists (e.g., the Habilitation program) the Psychologist will develop an individual treatment plan for each inmate, based on the CBT theory. Program activities will support the CBT theory and include the content of program journals. The treatment plan will be completed 30 working days from the inmate's admission into the residential program.

c. **Target Criminogenic Need**. Successful programs target criminogenic needs, such as antisocial attitudes and beliefs to reduce the likelihood of misconduct and recidivism.

d. **Therapeutic Activities.** All treatment staff will promote activities that have a therapeutic impact in the treatment community. Examples include promoting positive peer pressure and peer feedback, participants assisting one another in meeting their goals, changing negative attitudes to positive ones through activities such as attitude checks, conducting daily community meetings, etc.

e. **Program Monitoring**. All treatment staff will be knowledgeable about the treatment progress of all program participants. This diminishes inmate manipulation.

f. **Treatment Team**. All treatment staff are involved in discussing progress and commitment to the program of individual participants during treatment team meetings.

g. **Clinical Supervision**. The Treatment Program Coordinator is responsible for clinical supervision of Treatment Specialists. Supervision is conducted no less than one time a month and must be documented. Clinical supervision focuses on the development of the Treatment Specialist as an interpersonally effective clinician. Supervision includes instruction, supervisor modeling, direct observation, intervention by the supervisor in the actual process, and feedback. On occasion, clinical supervision may be offered in a group setting, such as a treatment team meeting.

1.6.3. Operational Elements

a. **Program Philosophy**. Each Residential Treatment Program develops a program philosophy that will become a permanent community ritual. An *example* of a program philosophy is written below.

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FCI XXXX, TREATMENT PROGRAM PHILOSOPHY:

Leader: We believe we have come together to share our common experiences and build positive, pro-social lifestyles together in our Modified Therapeutic Community (MTC).

Group Response:
- *We believe* (punctuated with volume) we together have much to offer.
- *We believe* (punctuated with volume) learning is most effective when it is experienced and shared.
- *We believe* (punctuated with volume) in the social experience as a catalyst for change.

(Emphasized with upbeat tone and volume) ***MTC, the Power of WE***.

b. **Rules and Consequences**. Treatment staff must establish clear, unambiguous rules and consequences for breaking the rules. Staff must ensure that inmates are aware of what they are agreeing to on the Agreement to Participate. For example, inmates are reminded that immediate expulsion will likely occur (and is mandatory in the Residential Drug Abuse Program) if the DHO finds that they have committed a prohibited act involving:

- Alcohol or substances.
- Violence or threats of violence.
- Escape or attempted escape.
- Any 100-level series incident.

Furthermore, an inmate is reviewed for immediate expulsion if he/she has been found to break confidentiality or his/her behavior is of such magnitude that his/her continued presence in programming would create an immediate and ongoing disruption for staff or other inmates.

Ordinarily, the recommendation for expulsion is made by the treatment team. The Treatment Coordinator has the final authority to expel an inmate.

NOTE: In some instances a mentally ill inmate may be placed in a residential mental health treatment program (e.g., Challenge, Step Down) for management reasons. In these instances an Agreement to Participate is not required, but the inmate must be informed of program expectations. Before participation in any treatment group, the Agreement to Participate must be signed.

c. **Behavioral Contingencies**. All treatment staff stress a system of incentives and sanctions that foster desirable behaviors and deter undesirable ones.

d. **Program Rituals**. Each residential treatment community has program rituals to mark group and individual milestones.

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1.6.4. Caseload Organization. The Treatment Program Coordinator assigns caseloads to treatment staff. In programs with Treatment Specialists, each Specialist is assigned a caseload and provides the following documentation for each participant on his/her caseload:

- Initial screening for program admission.
- Assessment(s) (primarily the psychosocial assessment).
- Treatment plan.
- Progress reviews.
- Discharge note.
- Treatment summary.

Each Treatment Specialist is responsible for a caseload based on that program's staff-to-inmate ratio. Treatment Specialists should not oversee the treatment of a single group through the entire program; each Specialist facilitates a variety of groups.

Facilitating a variety of groups provides the opportunity for each Treatment Specialist to get to know all participants and treatment modules. Similarly, all participants are exposed to each member of the treatment team, allowing them to experience differing treatment styles.

Ordinarily, when conducting individual treatment, sessions are conducted by the participant's primary Treatment Specialist.

1.6.5. Community Meetings. All Residential Treatment Programs will conduct a daily community meeting (excluding non-program days, such as weekends and holidays). With a large program, two community meetings may be held.

All treatment staff will attend daily community meetings.

Inmates in the unit at the time of the meeting are required to attend and participate. If space is available, the community meeting is held on the unit; otherwise, an appropriate meeting space is identified.

The time of the community meeting is determined by the Treatment Coordinator, who considers the setting, schedule, and needs of the institution. The meeting is brief, generally 30-60 minutes, and supervised by the assigned Treatment Specialists.

The community meeting strives to motivate the participants to adopt a positive attitude. It also strengthens the awareness that they are in the change process together, as a community. To ensure program structure, meetings typically are held at the same time each day.

The general purpose of a community meeting is to discuss the activities of the day. Ordinarily, the agenda includes program philosophy, community business, the attitude of the day, the word of the day, reporting the news, sports and weather, and positive and negative community issues. Staff

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assign agenda items to participants to present during the meeting. However, in Mental Health Treatment Programs staff may take a more active role in facilitating the meeting.

1.6.6. More Than One Residential Treatment Program Coordinator. Institutions with two treatment Program Coordinators are encouraged to create two programs in consultation with and the approval of the Regional Psychology Treatment Program Coordinator.

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CHAPTER 2. DRUG ABUSE PROGRAMS

§ 550.50 PURPOSE AND SCOPE.
The purpose of this subpart is to describe the Bureau's drug abuse treatment programs. All Bureau institutions have a drug abuse treatment specialist who, under the Drug Abuse Program Coordinator's supervision, provides drug abuse education and non-residential drug abuse treatment services to the inmate population. Institutions with residential drug abuse treatment programs (RDAP) should have additional drug abuse treatment specialists to provide treatment services in the RDAP unit.

2.1. Structured Drug Abuse Treatment Program. The Bureau operates a structured Drug Abuse Treatment Program to identify inmates in need of substance abuse treatment upon entry and throughout their incarceration. This multi-pronged treatment delivery system accommodates the entire spectrum of inmates in need of substance abuse programs through the Drug Abuse Education Course, the Non-residential Treatment Program, Residential Drug Abuse Programs (RDAP), Follow-up Treatment in general population, and Community Transitional Drug Abuse Treatment (TDAT).

2.2. Treatment Protocols. Central Office Psychology Services Branch approves all required treatment protocols (e.g., clinical treatment modules, journals, and facilitator guides) used in substance abuse programs. A current list of required materials is available on the Psychology Services Sallyport site or through Drug Abuse Treatment Programs staff in Central Office. Field staff will be trained on the vital elements of substance treatment protocols as changes occur.

2.3. Drug Abuse Education Course

2.3.1. Purpose. **§ 550.51 DRUG ABUSE EDUCATION COURSE.**

(a) *Purpose of the drug abuse education course*. All institutions provide a drug abuse education course to:

(1) Inform inmates of the consequences of drug/alcohol abuse and addiction; and

(2) Motivate inmates needing drug abuse treatment to apply for further drug abuse treatment, both while incarcerated and after release.

The Drug Abuse Education course (DRUG ED) is available to all sentenced inmates at every institution.

2.3.2. Target Population. Inmates who meet the criteria outlined below and have been sentenced or returned to custody as a violator are required to take the DRUG ED course. These inmates are identified by the unit team through their initial file review.

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§ 550.51(b) *Course placement*.

(1) Inmates will get primary consideration for course placement if they were sentenced or returned to custody as a violator after September 30, 1991, when unit and/or drug abuse treatment staff determine, through interviews and file review that:

(i) There is evidence that alcohol or other drug use contributed to the commission of the offense;

(ii) Alcohol or other drug use was a reason for violation either of supervised release (including parole) or Bureau community status; that is, RRC placement for which the inmate is now incarcerated;

(iii) There was a recommendation (or evaluation) for drug programming during incarceration by the sentencing judge; or

(iv) There is evidence of a history of alcohol or other drug use. For example, the inmate's history of alcohol and/or drug use within the past 5 years is emphasized in the Presentence Investigation Report (PSR).

(2) Inmates may also be considered for course placement if they request to participate in the drug abuse education program but do not meet the criteria of paragraph (b)(1) of this section.

(3) Inmates may not be considered for course placement if they:

(i) Do not have enough time remaining to serve to complete the course; or

(ii) Volunteer for, enter or otherwise complete a RDAP;

(c) *Consent*. Inmates will only be admitted to the drug abuse education course if they agree to comply with all Bureau requirements for the program.

2.3.3. Volunteers. Inmates may volunteer for DRUG ED; however, inmates who are required to participate in the DRUG ED course are to receive priority placement.

NOTE: If an inmate who has been exempted from DRUG ED as noted in (ii) above, later fails, or withdraws from the RDAP without having completed the DRUG ED course, he or she must be placed back on the waiting list. This requires regular SENTRY monitoring by the Drug Abuse Program Coordinator (DAPC) or designee.

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2.3.4. Exemption. Inmates in an acute psychological crisis and/or experiencing chronic instability due to a diagnosis of a serious mental health disorder as determined by an institution psychologist or medical staff may be exempted from the drug abuse education course.

For inmates with cognitive limitations, see 2.3.6.

2.3.5. Procedures

a. **Screening**. The unit team reviews all inmates who are new commitments or violators to determine if the inmate meets the criteria for a referral to the DRUG ED course. Normally, the unit team enters the SENTRY DRG assignment of ED WAIT RV, ED WAIT RJ, ED WAIT RC, ED WAIT HX, or ED NONE within 45 days of the inmate's arrival at the institution. These ED assignments replace the DRG I assignments previously used.

b. **Monitoring Referrals**. The Drug Abuse Program Coordinator (DAPC) or designee will monitor the DRUG ED SENTRY ED WAIT rosters.

c. **Drug Abuse Education Course Process.** Inmates referred for participation in the DRUG ED course meet with the Drug Abuse Treatment Specialist (DTS) in either a group or an individual format. The specialist will:

- Inform the inmate of the reason they were identified for Drug Education.
- Inform the inmate of the sanctions for non-participation (see Section 2.3.6).
- Obtain the inmate's signature on the Agreement to Participate in the DRUG ED Course.
- Enter the appropriate DRUG ED SENTRY DRG assignment for the inmate.
- Notify appropriate staff of sanctions for non-participation.

d. **Enrollment Time Frame.** Because DRUG ED is intended to motivate inmates to volunteer for treatment interventions, it is essential that the DRUG ED course is provided at the beginning of the inmate's sentence, ordinarily within 12 months of his or her current commitment.

2.3.6. Drug Abuse Education Operation.

a. **Course Content**. The DRUG ED course is 12 to15 hours in duration. The course reviews personal drug use, the cycle of drug use and crime, and reviews additional program opportunities in the Bureau. As in other drug abuse program areas, a journal, facilitator guide, and resource materials have been developed for DRUG ED. Staff are to use the most current journals, facilitator guides, manuals, and resources developed by the Central Office.

b. **Testing and Security**. A bank of 50 test questions is available to staff through the Psychology Services Sallyport site (or using appropriate future technology). The DRUG ED exam will

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include 10 questions. The DAPC, or designee, is responsible for the selection of these 10 questions. The results of all DRUG ED test scores are to be entered into the Psychology Data System (PDS).

Under no circumstances are inmates permitted to engage in test administration or the handling of test materials. Any compromise in testing procedures must be reported immediately to the Regional Psychology Programs Coordinator via e-mail. The Regional Psychology Programs Coordinator will, in coordination with the institution DAPC and DTS staff, determine what, if any, changes in test security, testing procedures, or testing document must be made.

c. **Special Circumstances**. Inmates who volunteer for or are required to participate in the DRUG ED course and who experience cognitive impairment or a severe learning disability must be provided a reasonable accommodation toward completion of the DRUG ED course, including an alternate means of testing.

d. ***Completion*. § 550.51(d). To complete the drug abuse education course, inmates must attend and participate during course sessions and pass a final course exam. Inmates will ordinarily have at least three chances to pass the final course exam before they lose privileges or the effects of non-participation occur (see paragraph (e) of this section).** Completion of the DRUG ED course requires attendance of 12 to 15 hours, participation during sessions and successfully completing the course with 70% correct answers on the test. DRUG ED completions must be entered into SENTRY.

When an inmate is nearing completion of the DRUG ED course and it has been determined by the DTS, with input from the DAPC, that the inmate would benefit from additional treatment, he or she will be encouraged to volunteer for non-residential or residential treatment.

§ 550.51(e) *Effects of non-participation*.

(1) If inmates considered for placement under paragraph (b)(1) of this section refuse participation, withdraw, are expelled, or otherwise fail to meet attendance and examination requirements, such inmates:

(i) Are not eligible for performance pay above maintenance pay level, or for bonus pay, or vacation pay; and

(ii) Are not eligible for a Federal Prison Industries work program assignment (unless the Warden makes an exception on the basis of work program labor needs).

(2) The Warden may make exceptions to the provisions of this section for good cause.

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2.4. Non-residential Drug Abuse Treatment Programs

§ 550.52 Non-residential drug abuse treatment services. All institutions must have non-residential drug abuse treatment services, provided through the institution's Psychology Services department. These services are available to inmates who voluntarily decide to participate.

2.4.1. Purpose. The non-residential drug abuse treatment program (NR DAP) is available to inmates at every institution. The purpose of the NR DAP program is to afford all inmates with a drug problem the opportunity to receive drug treatment.

2.4.2. Target Population. NR DAP is targeted to inmates who:

- Are waiting to enter the RDAP.
- Do not meet the admission criteria for the RDAP, but who wish to benefit from less intensive drug abuse treatment services.
- Have been referred by other psychology or institution staff for drug abuse treatment.
- Have a judicial recommendation for drug treatment, but do not want or do not meet the criteria for the RDAP.
- Received detoxification from alcohol or drugs upon entering Bureau confinement.
- Have been found guilty of an incident report for use of alcohol or other drugs.

2.4.3. Programming. Treatment staff are required to use the most recent treatment journals, facilitator guides, manuals, and resource materials. As treatment technologies change, there are opportunities to improve the Bureau's treatment programs. Therefore, staff are to use the most current journals, facilitator guides, manuals and resources developed by the Central Office.

While self-help programs such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Rational Recovery (RR) may be offered as part of an institution's drug abuse program effort, they are most often associated with non-residential (NR) treatment. While such programs are often powerful and important interventions in an inmate's recovery, they do not substitute for NR DAP or residential treatment hours. They are considered a support to the Bureau's treatment protocols.

2.4.4. Duration. NR DAPs are conducted 90 to 120 minutes a week for a minimum of 12 weeks and a maximum of 24 weeks. Reasonable efforts will be made to foster a continuity of treatment by conducting weekly groups.

The 90 to 120 minutes may be broken up into more than one session per week.

2.4.5. Program Operations and Management. Under the administrative supervision of the DAPC, the DTS is responsible for identifying and treating inmates in NR DAP.

a**. Identification**. In addition to volunteers, inmates are identified for the NR DAP program through the Psychology Intake Screening interview.

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The psychologist conducting the Psychology Intake Screening will determine if the inmate is interested in participating in NR DAP. If so, the psychologist will select "NR DAP" in the "Program/Treatment Recommendations & Interest" section of the Intake Screening Report in PDS.

Monthly, the DAPC or designee will run a PDS report that lists those inmates who were identified as having an interest in NR DAP.

The DTS will interview the inmates. If there is a question as to whether the inmate is able to function at an 8th grade level, the DTS will notify the DAPC as to the reasons; e.g., has no cognitive impairment, cannot comprehend the English language, etc. (See 28 CFR §§ 544.40-544.44.)

The DAPC will refer the inmate to Education for testing. Education staff will notify the DAPC via email of the outcome of the testing. The DAPC will apprise the DTS.

Those inmates who qualify and agree to participate will be asked to sign the *Agreement to Participate in the Bureau of Prisons Non-Residential Drug Abuse Treatment* (BP-A0748). The DTS will then enter the appropriate SENTRY code.

b. RDAP Volunteers and Completers

(1) In institutions without RDAPs the procedures outlined in Chapter Two, section 2.5.8, RDAP Admissions and Screening Procedures will be followed.

(2) DTS's must identify inmates who have completed the RDAP and no later than the month following their arrival at the facility, these inmates must begin Follow-up treatment (see Section 2.7).

2.4.6. Program Documentation. Required documentation to be completed by the DTS for the NR DAP program includes:

- The approved psychosocial assessment on each inmate entering the NR DAP program to assist in the development of an individualized treatment plan.
- An individualized treatment plan for each NR DAP program participant will be completed within 30 days of entering the program, documenting the targeted problem areas, treatment goals, and treatment activities in PDS.
- The recording of an inmate's participation in group.
- Treatment contact notes when appropriate.
- A minimum of one progress review must be completed during the course of the inmates' treatment.
- Entering the NR DAP program assignments in SENTRY.

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- At the conclusion of the inmate's involvement in NR DAP, a brief account in the evaluation section of PDS noting how he or she left the program (e.g., "Mr. XXX was transferred to a lower security institution," "Mr. XXX successfully completed the treatment goals identified in his treatment plan," "Mr. XXX informed treatment staff he is no longer interested in participating in non-residential drug abuse treatment.").

2.4.7. Expulsion. Inmates may be removed from the program by the DAPC because of disruptive behavior related to the program or unsatisfactory progress in treatment.

2.4.8. Achievement Awards. In coordination with the Warden, the drug treatment team will determine program achievement awards to be offered at the institution. A non-exhaustive list of possible incentives are listed below.

a. **Limited Achievement Awards**. When the participant successfully completes a NR DAP program, he or she may be awarded $30. This award will be pro-rated based on the inmate's participation, but may never be adjusted higher. In determining the amount of the drug treatment award, the drug treatment staff must consider the following. The inmate must:

- Be on time for group.
- Have no unexcused absences.
- Obtain satisfactory work performance.
- Maintain satisfactory sanitation requirements for the institution.
- Be Financial Responsibility Program (FRP) compliant.
- Maintain clear conduct.
- Not leave group without permission from the DTS(s) overseeing the group.
- Not eat, drink, or sleep in group.
- Complete all assigned activities.
- Dress appropriately, (i.e., clean institutional clothing, shirttails tucked in, shoes tied, no headphones, properly fitting pants with belts, no sunglasses, no coats or jackets, and no head covering other than approved religious headwear).
- Participate and progress in treatment.

b. **Residential Reentry Center (RRC) Placement**. Each Warden is strongly encouraged to approve inmates who successfully complete the non-residential drug abuse program for the maximum period of RRC placement. On occasion, administrative factors (e.g., bedspace limitations at a RRC) or community safety concerns (i.e., exclusionary criteria) occur that require consideration for a RRC placement of more or less than the recommended number of days. When this occurs, the goal for both the Warden and Community Corrections Manager (CCM) is to seek the best possible placement for the RRC period without negatively impacting bedspace limitations in contract facilities or jeopardizing community safety.

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c. Tangible Incentives. If the Warden allows, incentives such as books, t-shirts, greeting cards, notebooks, pens, etc., may be presented to inmates participating in the non-residential drug abuse program.

2.5. § 550.53 Residential Drug Abuse Treatment Program (RDAP).

2.5.1. Target Population. The RDAP targets the inmate who volunteers for treatment and has a diagnosable and verifiable substance use disorder, and is able to participate in the entire RDAP.

(a) *RDAP*. To successfully complete the RDAP, inmates must complete each of the following components:

(1) *Unit-based component*. Inmates must complete a course of activities provided by drug abuse treatment specialists and the Drug Abuse Program Coordinator in a treatment unit set apart from the general prison population. This component must last at least six months. To ensure the Bureau provides evidence based treatment in its drug abuse treatment programs, the RDAP is a minimum of 500 hours. The RDAP has a duration of 9 to 12 months.

(2) *Follow-up services.* If time allows between completion of the unit-based component of the RDAP and transfer to a community-based program, inmates must participate in the follow-up services to the unit-based component of the RDAP.

(3) *Transitional drug abuse treatment (TDAT) component*. Inmates who have completed the unit-based program and (when appropriate) the follow-up treatment and are transferred to community confinement must successfully complete community-based drug abuse treatment in a community-based program to have successfully completed RDAP. The Warden, on the basis of his or her discretion, may find an inmate ineligible for participation in a community-based program.

(b) *Admission Criteria*. Inmates must meet all of the following criteria to be admitted into RDAP.

a. **(1) Inmates must have a verifiable substance use disorder.**

b. **(2) Inmates must sign an agreement acknowledging program responsibility.**

c. **(3) When beginning the program, the inmate must be able to complete all three components described in paragraph (a) of this section.** This includes the critical RRC or home confinement transfer to participate in the TDAT.

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Example 1: A deportable inmate is unqualified for the RDAP because he or she cannot participate in the transitional drug abuse treatment component because he or she is not eligible for RRC placement. The NR DAP program is available for these unqualified inmates.

An inmate previously determined DAP UNQUALIFIED due to his or her ineligibility for an RRC is responsible for notifying the drug abuse treatment staff if there is a change in the inmate's RRC status for reconsideration.

Example 2: If an inmate is found to be qualified for the RDAP and has begun to participate in the program, and then finds his or her RRC status to have changed; e.g., a detainer lodged, he or she may remain in treatment.

Inmates who are waiting for, or participating in the RDAP who are not eligible for transfer to an RRC, on or before the date of this policy's implementation, will remain qualified for RDAP participation; and

d. Ordinarily, have 24 months or more remaining on their sentence.

2.5.2. Staffing. With the exception of the co-occurring drug abuse treatment program as outlined in Section 2.5.3, DTSs will always maintain a caseload of 1:24.

Residential DAPC's are to manage no more than 120 RDAP participants. This will be implemented as new positions become available.

2.5.3. Co-occurring Populations. The Bureau also operates RDAPs for inmates with co-occurring substance use and serious mental health disorders. Questions and referrals for inmates with co-occurring disorders are directed to the Regional Psychology Programs Coordinator. RDAPs that include inmates with co-occurring disorders follow the same programming, policies, and practices of an RDAP with the following exceptions:

- There is an additional track for inmates with a co-occurring diagnosis that focuses on understanding one's disorder, issues with self-medicating and how to manage prescribed medications and medication compliance.
- There is a staff-to-inmate ratio of 1-to-8 for the DTSs who treat and manage these groups.

2.5.4. Physical/Medical Populations. Inmates who volunteer for RDAPs and have physical disabilities or medical conditions that require their assignment to a unit other than the RDAP unit to ensure handicap accessibility or medical monitoring may be qualified for the RDAP if the inmate is:

- Otherwise eligible for the RDAP, including eligibility for transitional drug abuse treatment; i.e., an RRC or home confinement placement.
- Able to fully participate in *all* aspects of the RDAP.

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- Able to be held accountable to the same standard of treatment and conduct as all other RDAP participants (e.g., complete homework, participate in all assigned groups, behavior consistent with treatment requirements).

Although Health Services staff are always the final decision-maker regarding an inmate's placement outside of the drug treatment unit for medical reasons, drug abuse treatment staff are responsible for identifying, monitoring, and documenting this exception in the inmate's DAP records. Ordinarily, these inmates are excused from residential drug treatment unit activities only for reasons of sleep and unit accountability purposes (special census counts, etc.).

2.5.5. Referral and Redesignation. An inmate's initial designation will be made by the Designation and Sentence Classification Center (DSCC) in Grand Prairie, Texas.

Institution DAP Coordinators and Regional Psychology Program Coordinators will monitor waiting lists to ensure inmates are transferred for RDAP with sufficient time to complete the entire RDAP program before their release from Bureau custody, ordinarily at 24 months.

Inmates are to be informed that they may be transferred to any suitable Bureau RDAP based on their release date. This notification is included in the Agreement to Participate for the RDAP.

Inmates waiting to enter the RDAP who are living on the treatment unit or on an adjacent unit are to adhere to the same unit rules and decorum as those inmates participating in the RDAP. Ordinarily, if these inmates do not follow the rules and decorum of the RDAP unit, (e.g., negatively impacting other RDAP participants and/or those waiting for RDAP), they will receive a warning of removal from the RDAP waiting list. This warning will be made during a treatment team meeting with all staff involved in the process. The DAPC, or designee, will document this warning in PDS.

If the inmate's behavior does not change, he or she will be removed from the RDAP waiting list. Treatment staff will change the inmate's appropriate SENTRY assignment and document the removal in PDS.

After six months, the inmate may formally reapply for RDAP, through an *Inmate Request to Staff* form (BP-A0148). The application will be considered in a treatment team meeting with the inmate. The goal of this meeting is to assess any changes in attitude or behavior that the applicant may have made while awaiting re-consideration for the RDAP. The treatment team will make the decision regarding the inmate's placement on the waiting list.

2.5.6. The RDAP Housing Unit. RDAPs are separated from the inmate general population. By living together in a unit where all inmates work together to create a community that supports pro-social attitudes and behaviors, the RDAP unit isolates program participants from the negative peer pressure of the larger prison environment.

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Further, the RDAP unit must be solely for RDAP participants, as required by 18 U.S.C. § 3621(e). Inmates living on the RDAP unit must be: waiting for admission into the program; participating in the program; or RDAP completers. Whenever possible, there should be more inmates who are participating in or who have completed RDAP in the treatment unit than those waiting to enter treatment. Any compromise of this defined unit purity will invalidate eligibility for early release of all inmates on the unit.

2.5.7. Urine Surveillance. Urine surveillance is a regular component of effective treatment programming. Urine surveillance provides information to staff on an RDAP participant's abstinence, coping mechanisms, and honesty. The Bureau's urine surveillance procedures allow for random testing, suspect testing, and testing after returning from a furlough. Therefore, inmates in the RDAP are subjected to the same urine surveillance procedures as the general population.

On rare occasions there may be a clinical reason to test individual program participants or the entire population of the program. On these infrequent occasions, and with the permission of the Regional Psychology Programs Coordinator, staff may use program funds for urinalysis testing. However, this is to be an extremely rare event and is the only situation where Drug Abuse Program funds may be used for urinalysis testing.

2.5.8. RDAP Program Admission. **§ 550.53(c) *Application to RDAP.* Inmates may apply for the RDAP by submitting requests to a staff member (ordinarily, a member of the unit team or the Drug Abuse Program Coordinator).**

(d) *Referral to RDAP*. Inmates will be identified for referral and evaluation for RDAP by unit or drug treatment staff. Typically, inmates are identified for referral to the RDAP by psychology staff or unit management staff.

(1) **Referral to DAPC**. Upon completion of the Psychology Intake Screening, the psychologist will refer inmates with a substance use history and an interest in treatment to the institution's DAPC. The DAPC will further screen the inmate for the RDAP or for referral to the non-residential drug abuse program or the drug education course.

Inmates may also apply for the program by submitting an *Inmate Request to Staff* form to the DAPC.

(2) **Screening**. Upon assignment of a RDAP referral by the DAPC, the DTS will review an inmate's Central File and other collateral sources of documentation to determine if:

- There is sufficient time remaining on the inmate's sentence, ordinarily 24 months.
- There is documentation available to verify the inmate's use of specific drugs, including alcohol.
- There is verification that can establish a pattern of substance abuse or dependence.

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- There has been consultation with the Education Department (see Section 2.4.5) and evidence is documented that the inmate cannot participate in the program; e.g., has a cognitive impairment or learning disability that precludes participation or is unable to participate in the program in the language in which it is conducted.
- The inmate can complete all of the components of the RDAP; e.g., is able to participate in community transition drug abuse treatment.

When seeking independent verification, examples of other collateral documentation that may be used include:

- Documentation to support a substance use disorder within the 12-month period before the inmate's arrest on his or her current offense.
- Documentation from a probation officer, parole officer, social service professional, etc., who has information that verifies the inmate's problem with substance(s) within the 12-month period before the inmate's arrest on his or her current offense.
- Documentation from a substance abuse treatment provider or medical provider who diagnosed and treated the inmate for a substance abuse disorder within the 12-month period before the inmate's arrest on his or her current offense.
- Multiple convictions (two or more) for Driving Under the Influence (DUI) or Driving While Intoxicated (DWI) in the 5 years prior to his or her most recent arrest.

The DTS will document a summary of the information gathered from the review and enter it into PDS.

NOTE: Recreational, social, or occasional use of alcohol and/or other drugs that does not rise to the level of excessive or abusive drinking does not provide the required verification of a substance use disorder. Any verifying documentation of alcohol or other drug use must indicate problematic use; i.e., consistent with the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Health Disorders (DSM) criteria.

(3) **No Verifying Documentation**. In the event there is *no* verifying documentation in the inmate's Presentence Investigation Report or other official documentation in the Central File, the DTS will meet with the inmate. The DTS will tell the inmate there is no verifying documentation and offer him or her the following information:

> As there is no substantiating documentation for a substance use diagnosis, you have the following options:
>
> 1. You may volunteer for the non-residential drug abuse program.
>
> 2. You may seek documentation from a substance abuse treatment provider where you previously received treatment. This document must have been written at the time services were provided and must demonstrate that a substance use diagnosis

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was completed at the time you were seen, and that treatment was provided for that documented substance abuse diagnosis.

For example, the documentation may not state that the substance abuse treatment provider thought you had an alcohol or other drug problem when he or she saw you for a medical or psychological problem. Documentation must be sent to, and received by, the drug abuse treatment staff in the institution. It is not to be sent to you for you to provide to the drug abuse treatment staff. If the documentation is acceptable, you will be referred to the DAPC for a diagnostic interview.

3. You may seek documentation from a probation officer, a parole officer, a social services professional, etc., who has information that verifies your problem with illegal or illicit substances. Documentation must be sent to, and received by, the drug abuse treatment staff in the institution. It is not to be sent to you for you to provide to the drug abuse treatment staff. If the documentation is acceptable, you will be referred to the DAPC for a diagnostic interview.

4. If you have physical proof of your substance use that may be examined by medical staff to prove an addiction, e.g., track marks, abscesses, etc., you may sign a consent form allowing the drug treatment staff to receive the results of such examination from Health Services. If the documentation is acceptable, you will be referred to the DAPC for a diagnostic interview.

5. If you received substance detoxification as you entered the Bureau, you may sign a consent form for the drug treatment staff to verify your detoxification with Health Services.

6. Upon obtaining accepted documentation, you will be referred to the DAPC for a diagnostic interview.

2.5.9. The Clinical Interview. **§ 550.53(e)** ***Placement in RDAP*****. The Drug Abuse Program Coordinator decides whether to place inmates in RDAP based on the criteria set forth in paragraph (b) of this section.**

If verifying documentation is found or produced, and only then, inmates who volunteer for the RDAP will be personally interviewed by the DAPC. Interviews will be conducted based on the inmate's proximity to release, ordinarily no less than 24 months from release.

The DAPC will conduct the personal interview and use his or her psychological training to form a clinical judgment to determine if an inmate has a substance use diagnosis (i.e., substance dependence and/or substance abuse) in accordance with the American Psychiatric Association's

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Diagnostic and Statistical Manual of Mental Health Disorders, (DSM). All verifying documentation used is to be consistent in time, intensity, and duration with the inmate's self-report.

On the basis of the clinical interview, the DAPC may conclude that the inmate either does or does not have a diagnosis of a substance use disorder. In some instances, the DAPC may find the inmate does not have a diagnosis, even if there is substantiating documentation.

The DAPC must also determine if the inmate can fully engage in treatment; i.e., communicate in English and/or comprehend treatment expectations. An example of those who may not comprehend treatment expectations is an inmate who is cognitively impaired or has a severe learning disability. In some instances, the DAPC may find the inmate cannot fully engage in treatment and does not qualify for the program, even if there is substantiating documentation (see 18 U.S.C. § 3624(f)(4) and 28 CFR §§ 544.40 - 544.44).

The DAPC will document the result of the clinical interview in PDS, including the substance use diagnosis and the diagnostic criteria used to formulate the diagnosis and notify the inmate of the outcome. The DAPC will also ensure the appropriate SENTRY code(s) are entered and the appropriate documents are signed. Appropriate documentation includes the *Agreement to Participate in the Bureau of Prisons Residential Drug Abuse Treatment Program* form (BP-A0749) and the waiver of hearing to modify the court order (modification of the court order is completed on an inmate with a condition of supervised release that does not include a treatment stipulation).

The DAPC will ensure that the appropriate SENTRY code(s) are entered and the appropriate documents are signed. Appropriate documentation includes the *Agreement to Participate in the Bureau of Prisons Residential Drug Abuse Treatment Program* form (BP-A0749) and the waiver of hearing to modify the court order (modification of the court order is completed on an inmate with a condition of supervised release that does not include a treatment stipulation).
Note: Inmates with a diagnosis of a substance use disorder are qualified for the RDAP whether or not they are eligible for the early release incentive.

2.5.10. Program Operations. The RDAP treatment modules direct the treatment program. Programming consists of a minimum of 500 *contact* hours; i.e., face to face contact between treatment staff and inmate participants, over no less than 9 months of half-day programming. To facilitate the modified therapeutic community, RDAP programming is conducted daily during day watch hours (excluding non-programming days, such as weekends and holidays) for half of the inmate's work day. Supplemental treatment activities may occur during weekday evenings; however, evening treatment activities cannot be used to replace treatment during day watch hours. Treatment begins as soon as the inmate is in DAP PART status in SENTRY.

Treatment staff are required to use the RDAP treatment journals, facilitator guides, manuals, and resource materials. As effective treatment technologies advance, treatment materials may be

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revised. Therefore, only the most current drug program materials, journals, facilitator guides, etc., are to be used.

Additional programming may be used in the RDAP as approved by the DAPC in consultation with the Regional Psychology Treatment Program Coordinator (R-PTPC). The added treatment programming must be Cognitive Behavioral Therapy-based (CBT) or consistent with CBT and meet the goals stated within each of the RDAP treatment phases and modules.

2.5.11. Treatment Phases. All Bureau RDAPs are to be organized in phases. Each RDAP phase follows a clearly defined structure. Inmate movement through phases is based on his/her progress as determined by the inmate's treatment team. In the Bureau's RDAP, phases are organized as follows:

Phase I - The Orientation Phase.
Institutions are to provide an orientation packet that outlines the Bureau treatment program. In addition, any rules and/or expectations required by the RDAP in the institution will also be documented in the orientation packet.

During the Orientation Phase of treatment a thorough psychosocial assessment is conducted by the Treatment Specialist (see Sallyport).

During the Orientation Phase of treatment, DTS's are to:

- Strive to build rapport and motivate the inmate to engage in treatment.
- Conduct the psychosocial assessment (this guides the development of the treatment plan). The treatment assessment must be conducted with the inmate. It is not a self-assessment instrument (see Sallyport).
- Present the inmate's case at a treatment team meeting. These meetings are scheduled and conducted by the DAPC. The treatment team meeting is to assist with the development of the inmate's treatment plan.
- Attend additional team meetings. These meetings provide the opportunity for staff to discuss each individual inmate. These discussions are to review the inmate's progress in treatment and commitment to the program; for example, willingness to conform to the norms of the program, participate fully in groups, demonstrate positive attitudes, complete a statement that outlines his or her readiness for treatment, complete a realistic treatment plan, and learn to accept feedback from staff and peers.

The Treatment Coordinator will develop a schedule to conduct, at a minimum, at least one weekly team meeting to bring together the entire treatment team. The Treatment Coordinator will invite unit management staff for input into updating progress reports, training, and addressing any related issues.

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In addition, the DTS must complete an individualized progress report on each program participant every 60 days. The first progress report is due 60 days from the completion of the treatment plan.

Phase I duration - Ordinarily, Phase I should not last more than two months.

Phase II - The Core Treatment Phase.
In the Core Treatment Phase, the inmate is expected to build positive relationships in group, on the treatment unit, with family/significant others, with institution staff, etc.

Using the treatment journals and facilitator guides developed for the program, staff facilitate the inmate's acquisition of thought processes and pro-social skills required to live a substance-free, crime-free, and well-managed life.

Treatment progress reviews are to be completed every 60 days and documented in PDS. In addition, treatment staff are to observe program participants regularly on and off the unit (e.g., at work, during main line). This is done to determine if the inmate's behavior in the program is consistent with his or her behavior throughout the institution.

Phase II duration - Ordinarily, the Core Treatment Phase will last no more than five months. Staff will monitor the participants' behavior, personal insights, motivation, and commitment to treatment daily. Changes in behavior (positive or negative) are to be documented in the participants' progress reviews.

Phase III - The Transition Phase.
Phase III focuses on the inmate practice of pro-social skills acquired in treatment while developing realistic expectations for exiting the program.

Phase III duration - Ordinarily the Transition Phase will last no more than two months. Inmates are not to complete the program until they have mastered the expected behaviors of Phase III. See (a) Completion, below.

2.5.12. Program Outcomes. How an inmate leaves a RDAP is based on the inmate's behavior.

(a) Successful Completion. **§ 550.53(f)** ***Completing the unit-based component of RDAP*. To complete the unit-based component of RDAP, inmates must:**

(1) Have satisfactory attendance and participation in all RDAP activities; and

(2) Pass each RDAP testing procedure. Ordinarily, we will allow inmates who fail any RDAP exam to retest one time.

Testing procedures for completion of any Phase of treatment are to be behavioral in nature. Completion is determined by the inmate's behavior within the program and on the compound. An

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inmate is not to be moved from Phase to Phase in the RDAP without demonstrating that he or she has:

- Accepted and acknowledged his or her diagnosis.
- Taken on the responsibilities of the community.
- Made a commitment to positive change, as evidenced by observed positive behavior in his or her daily interactions.
- Expressed him- or herself in group, demonstrating the ability to give and receive appropriate feedback from other staff and inmates.
- Mastery of phase-related concepts.

Inmates who do not demonstrate these behavioral changes are not ready for RDAP completion.

(b) RDAP Treatment Summary. Two weeks prior to the inmate's scheduled date for RDAP completion, the DAPC will ensure the RDAP Treatment Summary is sent to the Unit Team and Transitional Drug Abuse Program Coordinator (T-DATC) in the region of release (see example on Sallyport). The DAPC should review the Treatment Summary for accuracy and completeness, and sign it prior to forwarding it to the unit team and T-DATC.

(c) Withdrawal/Incomplete. An inmate may withdraw voluntarily from the program. Withdrawals must be documented on the *Change in RDAP and § 3621(e) Status* form (BP-A0767) and forwarded to the Unit Team. If the inmate was previously determined ELIGIBLE, the DAPC, or designee, must change SENTRY to reflect ELIGIBLE to INELIGIBLE, change DAP PART to the applicable removal code, and forward the *Change in RDAP and § 3621(e) Status* form to the DSCC.

An inmate may also be moved to incomplete status for many reasons: placement in the Special Housing Unit (SHU), removed from the institution on a writ, unforseen redesignation, etc. An incomplete does not mean the inmate is automatically a failure. The DAPC and the treatment team will make the decision on the inmate's final treatment determination depending on the reason for his or her incomplete status. Inmates who do not complete the RDAP for reasons other than expulsion also require a Discharge Note with the reason(s) for non-completion documented in the Evaluation section of PDS. At that time the DAPC, or designee, is to make the appropriate changes to the inmate's SENTRY assignment(s).

(d) Intervention and § 550.53(g) *Expulsion from RDAP*.

(1) Inmates may be removed from the program by the Drug Abuse Program Coordinator because of disruptive behavior related to the program or unsatisfactory progress in treatment.

(2) Ordinarily, inmates must be given at least one formal warning before removal from RDAP. A formal warning is not necessary when the documented lack of

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compliance with program standards is of such magnitude that an inmate's continued presence would create an immediate and ongoing problem for staff and other inmates.

(a) **Circumstances for an Intervention.** Ordinarily, staff will provide the inmate with at least one treatment intervention prior to removal. However, in response to disruptive behavior or unsatisfactory progress, treatment staff will:

- Meet with the inmate to discuss his or her behavior or lack of progress.

- Assign the treatment intervention(s) chosen to reduce or eliminate the behavior, or to improve progress.
- Warn the inmate of the consequences of failure to alter his/her behavior.
- Properly document in PDS the meeting and treatment intervention(s) assigned.
- Properly document in PDS changes to the inmate's treatment plan, and ensure that both staff and the inmate sign the amended treatment plan.
- When appropriate, require the inmate to discuss his or her targeted behavior in the community.

(b) **Circumstances for Expulsion.** In the event repeated treatment interventions are required in response to inappropriate behaviors or unsatisfactory progress the treatment team will meet to decide if the inmate will be removed from the program.

Within two working days after a decision has been made to expel an inmate, the DAPC will:

- Verbally notify the inmate of his/her expulsion status.
- Notify the inmate and appropriate staff in writing of the reason for expulsion through the *Change in RDAP and § 3621(e) Status* form.
- Update the pertinent SENTRY DRG assignments.
- Ensure proper documentation of the expulsion has been entered into PDS.

An inmate may not ordinarily be removed immediately by the DAPC without a treatment intervention unless the inmate has committed a prohibited act that jeopardizes the institution and other inmates.

(3) § 550.53(g)(3) Inmates will be removed from RDAP immediately if the Discipline Hearing Officer (DHO) finds that they have committed a prohibited act involving:

(i) Alcohol or drugs;
(ii) Violence or threats of violence;
(iii) Escape or attempted escape; or
(iv) Any 100-level series incident.

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An inmate may also be expelled from the program without a formal intervention if the inmate is determined to have violated confidentiality.

(4) **§ 550.53(g)(4) We may return an inmate who withdraws or is removed from RDAP to his/her prior institution (if we had transferred the inmate specifically to participate in RDAP).**

2.5.13. Discharge Note. Whenever an inmate leaves the RDAP for reasons other than completion, treatment staff will document the circumstance(s) concerning the inmate's discharge in the evaluation section of PDS.

2.5.14. Re-application to the RDAP. An inmate who previously declined, withdrew, or failed RDAP may reapply for readmission to the program after 90 days through an *Inmate Request to Staff* form to the DAPC. The treatment team, in consultation *when appropriate* with the unit team, will decide on readmission. Considerations may include the inmate's participation in the NR DAP program or DRUG ED, at the discretion of the DAPC. The DAPC will provide the treatment team's decision to the inmate in person and in writing. If readmitted to the same or to a different RDAP, the inmate will not receive any credit for prior treatment participation.

2.5.15. Program Achievement Awards. § 550.54 Incentives for RDAP participation.

(a) An inmate may receive incentives for his or her satisfactory participation in the RDAP. Institutions may offer the basic incentives described in paragraph (a)(1) of this section. Bureau-authorized institutions may also offer enhanced incentives as described in paragraph (a)(2) of this section.

(1) *Basic incentives*.

(i) Limited financial awards, based upon the inmate's achievement/completion of program phases.

(ii) Consideration for the maximum period of time in a community-based treatment program, if the inmate is otherwise eligible.

(iii) Local institution incentives such as preferred living quarters or special recognition privileges.

(iv) Early release, if eligible under § 550.55. See the Program Statement **Early Release Procedures Under 18 U.S.C. § 3621(e)**.

(2) *Enhanced incentives*. For those institutions notified that they are to use the Enhanced Incentives, following is a list of those incentives.

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(i) Tangible achievement awards as permitted by the Warden and allowed by the regulations governing personal property (see 28 CFR part 553).

(ii) Photographs of treatment ceremonies may be sent to the inmate's family.

(iii) Formal consideration for a nearer release transfer for medium and low security inmates.

(b) An inmate must meet his/her financial program responsibility obligations (see 28 CFR part 545) and GED responsibilities (see 28 CFR part 544) before being able to receive an incentive for his/her RDAP participation.

(c) If an inmate withdraws from or is otherwise removed from RDAP, that inmate may lose incentives he/she previously achieved.

Most psychology treatment programs offer achievement awards for inmates who participate. (Programs that do not offer achievement awards are noted within the specific program's description.) Achievement awards for RDAP are offered to participants who demonstrate the behaviors that reflect the Attitudes of Change, a commitment to treatment, conformity with program norms, progress on treatment plan goals, and behaviors that are expected in the general society.

(a) **Earning Program Achievement Awards**. Inmates must:

- Be on time for group.
- Have no unexcused absences.
- Not leave group without approval from the Treatment Specialist.
- Not eat, drink, or sleep in group.
- Complete all assigned activities.
- Dress appropriately: clean institutional clothing, shirts tucked in, shoes tied, no headphones, no jackets, no coats, properly fitting pants, no sunglasses, and no head covering other than approved religious headwear.
- Be active in group.
- Put forth positive efforts in accomplishing treatment goals, as determined by the treatment team within the treatment plan.
- Comply with education, Financial Responsibility Program (FRP) obligations, and pre-release preparation programs.

(b) **Specific Achievement Awards**.

- *Limited Financial Awards*. An inmate may earn a financial award to offset time lost from work. The amount of this award is $40 for each phase of treatment. However, a financial

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award may be reduced by the treatment team based upon the inmate's participation and progress. A financial award is never to be increased.

- *Nearer Release Transfer*. Formal consideration may be given for a nearer release transfer for medium and low security inmates.
- *Local Incentives*. Institutions may offer incentives such as preferred living quarters, "early chow," washer/dryer on unit, etc.
- *Tangible Incentives*. With the Warden's approval, tangible incentives may be given, (e.g., books, t-shirts, notebooks, pencil pouches, mugs with program logo).
- *Commencement Ceremony/Ritual*. For the completion of RDAP, institutions may offer a structured commencement ceremony for the inmates. Pictures of individual inmates or of the treatment group may be allowed for inmates to send to family.
- *Early Release*. Details regarding the early release criteria may be found in the Program Statement **Early Release Procedures Under 18 U.S.C. § 3621(e)**.
- *Residential Re-entry Center (RRC) Placement*. Consideration may be given for up to the maximum period of placement in an RRC to include home confinement. The RRC placement allows for the completion of the Community TDAT component of RDAP. Program completion in the community is a critical component of the RDAP.

Each Warden is strongly encouraged to approve inmates who successfully complete the RDAP for the RRC placement. Similarly, CCMs must, when possible, ensure that inmates required to participate in TDAT are placed in an RRC for the maximum time recommended by the Warden.

On occasion, administrative factors (e.g., bedspace limitations at a RRC) or community safety concerns (e.g., exclusionary criteria) occur that require consideration for RRC placement of less than the recommended maximum days. When this occurs, the goal for both the Warden and CCM is to seek possible placement for the maximum period without negatively impacting bedspace limitations in contract facilities or jeopardizing community safety.

Bureau experience and drug abuse treatment research demonstrate that successful community treatment cannot be completed in less than 120 days. Therefore, inmates who are approved for less than a 120-day RRC placement or home confinement cannot ordinarily complete the final component of the RDAP, and are, therefore, ineligible for early release. For inmates who would otherwise be eligible for early release, but who are approved for less than a 120-day RRC placement, the appropriate SENTRY assignment must be changed from ELIGIBLE to INELIGIBLE.

3. **Effects of Non-participation**. In those institutions authorized, inmates may feel the effects of non-participation if they fail to apply for the RDAP.

§ 550.53(h) *Effects of non-participation.*

(1) If inmates refuse to participate in RDAP, withdraw, or are otherwise removed, they are not eligible for:

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(i) A furlough (other than possibly an emergency furlough);

(ii) Performance pay above maintenance pay level, bonus pay, or vacation pay; and/or

(iii) A Federal Prison Industries work program assignment (unless the Warden makes an exception on the basis of work program labor needs).

(2) Refusal, withdrawal, and/or expulsion will be a factor to consider in determining length of community confinement.

(3) Where applicable, staff will notify the United States Parole Commission of inmates' needs for treatment and any failure to participate in the RDAP.

2.6. Follow-up Treatment

2.6.1. Follow-up to the RDAP: Target Population. This is the second component of the RDAP. Treatment continues for inmates who complete the unit-based component of the RDAP and return to general population. An inmate must remain in Follow-Up Treatment (FOL PART) for 12 months or until he/she is transferred to a RRC.

Inmates are to be identified for FOL PART by running DAP COMP rosters. These rosters are to determine if any DAP completers have transferred to the institution without FOL PART.

2.6.2. Follow-up Admission. Inmates enter follow-up treatment within the first month after their return to general population. The treatment protocol is designed so that inmates may enter the monthly group at any time. Each group will be no less than 60 minutes. If FOL PART is conducted individually, the DTS may start with any of the 12 treatment sessions and complete the entire cycle as described below.

2.6.3. Follow-up Treatment Refuse or Failure. Any RDAP participant who refuses to participate in follow-up treatment is an RDAP failure and is disqualified from receiving additional achievement awards, (e.g. early release). His or her failure may result in the inmate's re-designation. The primary DTS is responsible for entering the appropriate SENTRY assignment and entering the discharge note into PDS.

2.6.4. Treatment Protocol. Inmates identified for follow-up treatment are provided with a standardized treatment protocol. The protocol is required and is designed to review the treatment components of the RDAP.

As treatment technologies change, there are opportunities to improve the Bureau's treatment programs. Therefore, staff are to use the most current journals, facilitator guides, manuals, and resources developed by the Central Office.

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2.6.5. Treatment Operations and Documentation. The DTS responsible for FOL PART is to:

- Be the authority in the content of the RDAP modules and facilitator guides.
- Correctly enter the appropriate SENTRY assignment(s).
- Enter a progress note on the inmate's participation in FOL PART in PDS within 60 days of beginning FOL PART and every 60 days thereafter. For example:

  "The inmate has developed the skills to identify most of his own Criminal Thinking Errors. He still struggles with Power Orientation as demonstrated by monopolizing group discussions and not letting other group members comment. It is important for him to control the group. He has been confronted about this behavior by the staff and group members. Using Walters, Samenow, and Yohleson's materials, he has been assigned an essay describing how behaviors of power orientation increase the chance for re-offending and reduce the chance for recovery. The essay will be delivered in group at a podium with feedback."

- Enter a discharge note (when the inmate leaves the program) in PDS and the appropriate SENTRY assignment. Additionally, when applicable, the DTS is to replace ELIGIBLE with INELIGIBLE.

2.7. § 550.56 Community Transitional Drug Abuse Treatment Program (TDAT).

2.7.1. Target Population. TDAT is the third component of the RDAP. TDAT is appropriate for the following groups of inmates:

(a) For inmates to successfully complete all components of RDAP, they must participate in TDAT in the community. If inmates refuse or fail to complete TDAT, they fail the RDAP and are disqualified for any additional incentives.

(b) Inmates with a documented drug abuse problem who did not choose to volunteer for RDAP may be required to participate in TDAT as a condition of participation in a community-based program, with the approval of the Transitional Drug Abuse Program Coordinator.

(c) Inmates who successfully complete RDAP and who participate in transitional treatment programming at an institution must participate in such programming for at least one hour per month.

2.7.2. RRC Placement. Ordinarily, inmates who participate in the TDAT must receive no less than a 120-day placement in an RRC. It is not always possible to complete transitional drug abuse treatment in less than 120 days.

2.8. § 550.57 Inmate Appeals.

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Inmates may seek formal review of complaints regarding the operation of the drug abuse treatment program by using administrative remedy procedures in 28 CFR part 542.

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CHAPTER 3. THE RESOLVE PROGRAM: A TRAUMA TREATMENT PROGRAM FOR FEMALE INMATES

3.1. The Resolve Program. In 1993, the Bureau's Executive Staff approved a model to ensure parity of program opportunities for female inmates. This model included the implementation of a trauma treatment program at each female institution. Each institution developed its program independently with limited direction from Central Office, leading to tremendous variability in program structure and content.

In 2004, Executive Staff requested that a single model for trauma treatment be developed and implemented Bureau-wide. After extensive research and consultation with subject matter experts, the Resolve Program was prepared for Bureau-wide implementation in 2007. The Resolve Program consists of two primary components: a psycho-educational workshop and a non-residential program for inmates with trauma-related disorders.

As in all Bureau Psychology Treatment Programs, the Resolve Program is conducted through the use of specific manuals, journals, facilitator guides, and/or other identified resource materials. These Resolve Program materials are drawn from research and practice and are proven effective for use in the treatment of trauma-related disorders. Their use in the program is required.

3.2. Staffing. The Resolve Program is staffed by a psychologist who serves as the Resolve Program Coordinator. The role of Resolve Program Coordinator will be a full-time position.

3.3. The Trauma in Life Workshop

3.3.1. Purpose. The Trauma in Life Workshop will be provided at all female institutions, excluding Federal Transfer Centers (FTCs), Federal Detention Centers (FDCs), and Metropolitan Detention Centers (MDCs). However, FTCs, FDCs, and MDCs may choose to implement this program element, subject to available resources. It is a psycho-educational workshop that provides female inmates with information on trauma and its potential impact in their lives. The workshop also functions to identify and motivate inmates who need treatment to participate in the Resolve Program's non-residential protocol during their incarceration.

3.3.2. Target Population. The Trauma in Life Workshop is designed for inmates who meet any of the following three criteria:

- There is evidence that the inmate has a history of traumatic life events, such as childhood abuse or neglect, rape, or domestic violence.
- There is evidence that the inmate suffers from an Axis I or Axis II disorder that may be associated with a traumatic life event.
- The inmate expresses an interest in learning more about trauma and its potential impact; e.g., an inmate who physically abused her children wants to learn more about the potential impact of her actions.

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The Trauma in Life Workshop is voluntary. While inmates may be encouraged to enroll in the workshop, they are not required to participate.

3.3.3. Admission Procedures.

a. **Program Referral.** Psychology Services will ensure inmates receive information about the Trauma in Life Workshop. This information is to be offered in a group format during Admission and Orientation. In addition, inmates who are appropriate for the workshop should be identified during their Psychology Services Intake Interview and provided with information about the workshop.

Inmates who express a willingness to participate in the Trauma in Life Workshop will be referred to the Resolve Program Coordinator for placement on the SENTRY waiting list for the workshop (RRW WAIT).

b. **Enrollment Time Frame**. Because the Trauma in Life Workshop is intended to motivate inmates to volunteer for the Resolve non-residential program, it is essential that the workshop is provided at the beginning of the inmate's sentence, ordinarily within 12 months of her current commitment.

c. **Agreement to Participate.** At the time of the first workshop meeting, the Resolve Program Coordinator will obtain the offender's signature on the *Agreement to Participate in the Resolve Psychology Treatment Program* form (BP-A0946) and enter the appropriate SENTRY assignment.

3.3.4. Treatment Protocol.

a. **Course Structure.** The required workshop resources are the participant journal and facilitator's guide, titled *Trauma in Life*. Use of these materials is required; however, use of additional supplemental materials is acceptable if the content is consistent with the *Trauma in Life* materials. Ordinarily, the workshop will consist of four two-hour sessions. A certificate of completion may be awarded to inmates who complete the program. The Resolve Program Coordinator is responsible for conducting the workshop.

b. **Course Completion**. At the conclusion of the workshop, all participants will complete a brief self-assessment. The purpose of the assessment is to allow inmates to make an informed decision about their potential need for additional trauma-related treatment. The Resolve Program Coordinator will encourage participants with ongoing treatment needs to enroll in the Resolve non-residential Program.

Completion of the Trauma in Life Workshop requires attendance and participation during all course sessions. When an inmate completes the workshop, the appropriate entry will be made in SENTRY (RRW COMP).

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3.4. The Resolve Non-residential Treatment Program. The Resolve Non-residential Treatment Program is a collection of evidenced-based, cognitive-behavioral treatment (CBT) protocols tailored to the needs of individual inmates. Specific treatment manuals and resource materials are required for use in the program. Additional CBT, or CBT-compatible, interventions may be utilized after completion of the required protocols.

The Resolve Non-residential Treatment Program is available at all female institutions with a full-time Resolve Program Coordinator.

3.4.1. Purpose. The purpose of the Resolve Non-residential Treatment Program is to address the treatment needs of a significant segment of the female inmate population: individuals with psychological and interpersonal difficulties precipitated by traumatic life experiences.

3.4.2. Target Population. The Resolve Non-residential Treatment Program is designed for inmates with a history of trauma *and* a related psychological disorder. Potential program participants must:

- Report a history of a traumatic life event as documented in the screening instrument (e.g., the Stressful Life Experiences Screening).
- Present with an Axis I or Axis II disorder that is related to the traumatic life event.
- Complete the Trauma in Life Workshop.

3.4.3. Admission Procedures

a. **Program Referral**. Inmates who complete the Trauma in Life Workshop and express an interest in additional treatment will be referred for participation in the Resolve Non-residential Treatment Program.

b. **Assessment of Treatment Needs.** Prior to enrollment in the Resolve Non-residential Treatment Program, inmates will complete a psychosocial assessment interview that includes a review of the inmate's Trauma in Life journal. As a prerequisite for participation in the program, the inmate must have an Axis I or Axis II disorder related to a traumatic life event. The Resolve Program Coordinator is responsible for conducting a thorough assessment and providing a diagnosis consistent with this prerequisite. Suggested diagnostic tools include the Stressful Life Experiences Screening (SLES), a supplemental questionnaire to identify traumatic life experiences not included in the SLES, and the Personality Assessment Inventory (PAI).

c. **Agreement to Participate**. At the time of the first treatment group, the Resolve Program Coordinator will obtain the inmate's signature on the *Agreement to Participate in the Resolve Psychology Treatment Program* form and place them in participation status in SENTRY (RR1 PART, RR2 PART).

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3.4.4. Treatment Protocol. Inmates who participate in the Resolve Non-residential Treatment Program will be provided services in a group format, utilizing standardized evidence-based, cognitive-behavioral treatment protocols. The current protocols are located on the Psychology Services Branch Sallyport site. The protocols are divided into two phases:

a. **Phase I.** Phase I emphasizes the acquisition of basic skills, with a focus on coping skills and interpersonal skills. The required protocol is delivered in a group format, with a minimum of 12 group sessions meeting weekly for at least 60 minutes per session.

b. **Phase II.** Phase II of the program consists of specialized groups designed to meet the additional treatment needs of three distinct populations as described below. Inmates must complete Phase I of the program before enrolling in Phase II groups.

(1) **Maintenance Skills Group.** Maintenance Skills Group is for inmates who remain interested in treatment, but whose symptoms, if present, no longer interfere with daily functioning. This group utilizes a supportive and educational orientation to maintain treatment gains. The group is an open-ended, continuous group. The group meets at least monthly for 60-90 minutes.

(2) **Cognitive Processing Therapy Group**. Cognitive Processing Therapy Group is for inmates who remain symptomatic after completion of Phase I with a primary diagnosis of an Axis I disorder (e.g., Post Traumatic Stress Disorder (PTSD), major depression, substance use disorder). This group utilizes a highly structured, 12-session treatment protocol combining cognitive techniques with written exposure therapy to address negative affect, intrusive images, dysfunctional thoughts, and avoidance behavior. The group meets weekly for 60 to 90 minutes per session. In special cases, Cognitive Processing Therapy may also be offered in an individual format.

(3) **Dialectical Behavior Therapy Skills Training Group**. Dialectical Behavior Therapy Skills Training Group is for inmates who remain symptomatic after completion of Phase I with a primary diagnosis of an Axis II disorder; e.g., Borderline Personality Disorder. This treatment intervention utilizes cognitive-behavioral skills training in emotional regulation, distress tolerance, interpersonal effectiveness, and core mindfulness. Typically the group meets weekly for 60 to 90 minutes per session. In special cases, Dialectical Behavior Therapy skills may be offered in an individual treatment format.

As treatment technologies change, there are opportunities to improve the Bureau's treatment programs. Therefore, staff are to use the most recent manuals, journals, facilitator's guides, and resources developed by the Central Office.

3.4.5. Program Documentation. Required documentation for the Resolve Non-residential Treatment Program includes:

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- A documented psychological diagnosis in PDS related to a history of trauma or traumatic life experiences.
- An Agreement to Participate in the program, signed by the inmate at the time of the first treatment session.
- A psychosocial assessment on each inmate entering Non-residential treatment to assist in the development of an individualized treatment plan;
- An individualized treatment plan for each non-residential program participant, documenting the targeted problem areas, treatment goals, and treatment activities in PDS.
- Group attendance (via PDS).
- Treatment contact notes when appropriate.
- 60-day progress reviews noting progress toward treatment goals.
- Non-residential Resolve treatment assignments in SENTRY.
- At the conclusion of the inmate's involvement in Non-residential treatment, a brief account in the evaluation section of PDS noting how he or she left the program; e.g., "Ms. XXX was transferred to a lower security institution," "Ms. XXX successfully completed the treatment goals identified in her treatment plan," "Ms. XXX informed treatment staff she is no longer interested in participating in non-residential treatment."

3.4.6. Program Expulsion. Inmates may be removed from the program by the Resolve Coordinator because of disruptive behavior related to the program or unsatisfactory progress in treatment.

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CHAPTER 4. THE BUREAU REHABILITATION AND VALUES ENHANCEMENT (BRAVE) PROGRAM

4.1. The BRAVE Program. In 1995, following a series of institutional disturbances, Executive Staff sought to identify the inmates most likely to engage in disturbances and to develop an appropriate intervention. Young, newly committed inmates serving long sentences were identified as the group most likely to engage in both disturbances and general institutional misconduct. In 1998, the Bureau Rehabilitation and Values Enhancement (BRAVE) Program was implemented as an intensive, cognitive-behavioral, residential rehabilitation program for medium security inmates.

4.1.1. Purpose. The BRAVE Program is designed to facilitate favorable institutional adjustment and reduce incidents of misconduct. In addition, the program encourages inmates to interact positively with staff members and take advantage of opportunities to engage in self-improvement activities throughout their incarceration.

4.1.2. Residential Treatment Unit. BRAVE Program participants are to be housed together on a unit, separate from general population inmates. Living together in a unit allows all inmates to work together to create a community that supports prosocial attitudes and behaviors. The BRAVE Unit isolates program participants from the negative peer-pressure of the larger prison environment.

Further, the BRAVE Unit must also be solely for BRAVE participants. Inmates living on the unit must be waiting for admission into the program, participating in the program, or have completed the program. Whenever possible, there should be more inmates who are participating in or who have completed BRAVE in the treatment unit than those waiting to enter treatment.

4.1.3. Staffing. The BRAVE Program is staffed with a psychologist who serves as the BRAVE Program Coordinator and a minimum of three BRAVE Program Treatment Specialists. The program has a 1:20 Treatment Specialist-to-inmate ratio.

4.2. Target Population. The BRAVE Program is designed to address the treatment needs of inmates:

- 32 years of age or younger.
- With a sentence of at least 60 months.
- A first-time Bureau commitment.

4.3. Admission Procedures

4.3.1. Program Referrals. Inmates are identified for placement in the BRAVE Program by the Designator and/or BRAVE Program Treatment Staff. Designators may directly designate inmates

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to the BRAVE program if they meet the target population criteria. New arrivals to the institution may be screened and accepted into the BRAVE Program if they meet the admission criteria.

On occasion, inmates who have poor institutional adjustment may be allowed to participate in the BRAVE Program at the Coordinator's discretion. Inmates who meet all the admission criteria are to be given priority placement in the program and should always make up the vast majority of program participants.

4.3.2. Program Placement. Inmates designated or selected for placement in the BRAVE Program should be placed directly on the BRAVE Program Treatment Unit upon arrival at the institution. Inmates are strongly encouraged to participate in the program; however, the program is voluntary. Inmates who agree to participate in the program must sign the *Agreement to Participate in Psychology Treatment Programs* form (BP-A0940) before they are placed in participation status. Inmates may decline to participate in the program. Inmates who decline to participate in the program should be removed from the BRAVE Program Treatment Unit as soon as possible.

4.3.3. Enrollment Time Frame. As the BRAVE Program is designed to facilitate a favorable *initial* adjustment to incarceration, program participants should be assigned to the program at the start of their sentence, upon their first designation to a Bureau institution.

4.4. Assessment of Treatment Needs. A psychosocial assessment of the inmate's treatment needs is conducted during the Orientation Phase of the program. The information gathered during this face-to-face interview will become a part of the inmate's treatment plan. This assessment is available on Sallyport.

4.5. Treatment Protocol

4.5.1. BRAVE Treatment Modules. The BRAVE Program treatment modules direct the treatment program. The program is a six-month, 350-hour program. Ordinarily, programming is conducted daily (excluding non-program days, such as weekends and holidays) for half of the inmate's work day. Treatment begins as soon as the inmate is in BRV PART status in SENTRY.

The current BRAVE treatment journals and facilitator guides are identified on Sallyport.

As evidence-based treatment technologies advance, treatment materials will be revised. Therefore, only the most current BRAVE materials, journals, facilitator guides, etc., are to be used.

4.5.2. Treatment Phases. The BRAVE Program is offered in three distinct Phases with each phase following a clearly defined structure. The BRAVE Program phases are organized as follows:

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a. **Phase I – The Orientation Phase.** During the Orientation Phase of treatment, BRAVE Program Treatment Specialists are to perform the following duties related to inmates assigned to their caseload:

- Strive to build rapport and motivate the inmate to engage in treatment.
- Conduct the psychosocial assessment. This guides the development of the treatment plan. The treatment assessment must be conducted with the inmate. It is not a self-assessment instrument.
- Present the inmate's case at a treatment team meeting. These meetings are scheduled and conducted by the BRAVE Program Coordinator. The treatment team meeting is to assist with the development of the inmate's treatment plan.
- Attend treatment team meetings. These meetings provide the opportunity for staff to discuss each individual inmate. These discussions are to review the inmate's progress in treatment and commitment to the program.

Phase I will ordinarily last one month. If the treatment team is in agreement that the inmate is not ready to move on to Phase II, Phase I may be repeated until the inmate is ready to move on, withdraws, or is expelled.

b. **Phase II – The Core Treatment Phase**. In the Core Treatment Phase, the inmate is expected to build positive relationships in group, on the treatment unit, with family/significant others, with institution staff, etc.

Using the treatment journals and facilitator guides developed for the program, staff will facilitate an environment for inmates to acquire the thought processes and prosocial skills required to live a drug-free, crime-free, and well-managed life.

Treatment progress reviews are to be completed every 60 days and are to be documented in PDS. In addition, treatment staff are to observe program participants regularly (e.g., at work, during main line, in the unit) to ascertain if the inmate's behaviors demonstrated around the treatment staff are constant, or if the inmate's behavior changes outside of the treatment environment.

Ordinarily, the Core Treatment Phase will last four months. Staff should monitor the participants' behaviors, personal insights, motivation, and commitment to treatment daily. Changes in behavior (positive or negative) are to be documented in the participants' progress reviews.

If the treatment team does not believe the inmate has made significant progress at the end of the core treatment phase, staff may require the inmate to repeat all or part of the core treatment phase. Failure to progress in treatment will be documented in the Psychology Data System (PDS).

c. **Phase III – The Transition Phase.** The Transition Phase focuses on the inmate continuing to practice the prosocial skills acquired in treatment. In addition, the inmate must demonstrate realistic expectations and living skills to function in a prison environment.

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Ordinarily the Transition Phase lasts one month. If the treatment team finds the inmate has not made adequate progress, he may be held back until he completes, withdraws, or is expelled from the program.

4.6. BRAVE Program Achievement Awards. The BRAVE Program offers achievement awards for inmates who participate appropriately in the program. The BRAVE Program treatment team will determine if an inmate is eligible to receive an achievement award.

4.6.1. Earning Program Achievement Awards. In order to earn program achievement awards, inmates must:

- Be on time for group.
- Have no unexcused absences.
- Not leave group without approval from the Treatment Specialist.
- Not eat, drink, or sleep in group.
- Complete all assigned activities.
- Dress appropriately: clean institutional clothing, shirts tucked in, no jackets or coats, shoes tied, no headphones, properly fitting pants with belts, no sunglasses and no head covering other than approved religious headgear.
- Be active in group.
- Put forth positive efforts in accomplishing treatment goals, as determined by the treatment team within the treatment plan.
- Comply with education and FRP obligations.

4.6.2. Specific Achievement Awards

- **Limited Financial Awards**. An inmate may earn a financial award to offset time lost from work. The amount of this award is $40 for each phase of treatment. A financial award may be paid in whole or in part, based upon the inmate's participation and progress. A financial award is never to be increased.
- **Local Incentives**. Institutions may offer incentives such as preferred living quarters, early mainline, exercise equipment on the unit, a program library, a movie night, etc.
- **Tangible Incentives**. With the Warden's approval, tangible incentives (e.g., books, t-shirts, notebooks, mugs with program logo) may be offered.
- **Graduation Ceremony/Ritual**. For the completion of the BRAVE program, institutions may offer a structured completion/graduation ceremony for the inmates. Photographs of individual participants or the treatment group may be allowed. Inmates may mail a photograph of themselves or the group to family.

4.7. Program Documentation. Required documentation for the BRAVE Program includes:

- An Agreement to Participate in the program, signed by the inmate at the time of the first treatment session.

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- A psychosocial assessment on each inmate entering the program to assist in the development of an individualized treatment plan.
- An individualized treatment plan for each participant, documenting the targeted problem areas, treatment goals, and treatment activities in PDS.
- Recording in PDS a participant's attendance in group.
- Treatment contact notes, when appropriate.
- 60-day progress reviews noting progress toward treatment goals.
- BRAVE Program treatment assignments in SENTRY, including the appropriate DRUG ED assignment.
- At the conclusion of the inmate's involvement in the program, a treatment summary and brief account in the evaluation section of PDS noting how he left the program; e.g., "Mr. XXX was transferred to a lower security institution," "Mr. XXX successfully completed the treatment goals identified in his treatment plan," "Mr. XXX informed treatment staff he is no longer interested in participating in the program."

Inmates who do not complete the BRAVE Program for reasons other than expulsion require a discharge note with the reason(s) for non-completion documented in the Evaluation section of PDS. At that time the BRAVE Coordinator, or designee, is to change the inmate's SENTRY assignment from BRV PART to BRV INCOMP.

4.8. BRAVE Outcomes. How an inmate leaves a Residential program is based on the inmate's behavior.

4.8.1. Completion. Completion of any Phase of treatment is determined by the inmate's behavior within the program and on the compound. Inmates are not to be moved from Phase to Phase without demonstrating they have:

- Taken on the responsibilities of the community.
- Made a commitment to positive change as evidenced by observed positive behavior in his or her daily interactions.
- Expressed him or herself in group demonstrating the ability to give and receive appropriate feedback from other staff and inmates.
- Mastered phase-related concepts.

Inmates who do not demonstrate these, and other, behavioral changes are not ready for completion.

4.8.2. Withdrawal/Incomplete. An inmate may withdraw voluntarily from the program. Withdrawals must be documented in PDS and a memorandum forwarded to the Unit Team.

An inmate may also be moved to Incomplete status for many reasons: placement in the Special Housing Unit (SHU), removed from the institution on a writ, unforseen redesignation, etc. An incomplete does not mean the inmate is automatically a failure. The Treatment Coordinator and

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the treatment team will make the decision on the inmate's final treatment determination, depending on the reason for his or her incomplete status. The Treatment Coordinator will ensure proper documentation of the meeting in PDS and SENTRY.

4.8.3. Expulsion. Inmates may be removed from the program by the coordinator because of disruptive behavior related to the program or unsatisfactory progress in treatment. Ordinarily, staff will provide the inmate with at least one treatment intervention prior to removal. In response to disruptive behavior or unsatisfactory progress, treatment staff will:

- Meet with the inmate to discuss his or her behavior or lack of progress.
- Assign the treatment intervention(s) chosen to reduce or eliminate the behavior, or to improve progress.
- Warn the inmate of the consequences of failure to alter his/her behavior.
- Properly document in PDS the meeting and treatment intervention(s) assigned.
- Properly document in PDS changes to the inmate's treatment plan, and ensure that both staff and the inmate sign the amended treatment plan.
- When appropriate, require the inmate to discuss his or her targeted behavior in the community.

In the event repeated treatment interventions are required in response to inappropriate behaviors or unsatisfactory progress, the treatment team will meet to decide if the inmate will be removed from the program.

Within two working days after a decision has been made to expel an inmate, the Program Coordinator will:

- Verbally notify the inmate of his/her expulsion status.
- Update the pertinent SENTRY PTP assignments.
- Ensure proper documentation of the expulsion has been entered into PDS.

An inmate may not ordinarily be removed immediately by the Program Coordinator without a treatment intervention unless the inmate, pursuant to an incident report, is found by the DHO to have committed a prohibited act involving:

- Alcohol or drugs.
- Violence or threats of violence.
- Escape or attempted escape.
- Any 100-level series incident.

An inmate may be expelled from the program without a formal intervention if the inmate is determined to have violated confidentiality.

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In limited circumstances, an inmate may be expelled from the program without a formal intervention if the inmate's behavior is of such magnitude that an inmate's continued presence in programming would create an immediate and ongoing problem for staff and/or other inmates.

Whenever immediate expulsion is necessary the program coordinator, or designee, will:

- Inform the inmate of his or her expulsion.
- Ensure proper documentation of the meeting and expulsion are entered into PDS.

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CHAPTER 5. THE CHALLENGE PROGRAM

5.1. The Challenge Program. In 1997, Executive Staff approved the implementation of Residential Treatment Programs, termed CODE Programs, in the Bureau's high security institutions. In 2004, Executive Staff refocused the penitentiary programs with the mission of providing treatment for inmates with drug abuse and/or mental health disorders. Now known as the Challenge Program, the Bureau began a slow conversion of all CODE programs to Challenge Programs. The Challenge Program is a residential, evidence-based, cognitive-behavioral treatment program.

5.1.1. Purpose. The Challenge Program is an intensive Residential Treatment Program for high security inmates. It is designed to facilitate both favorable institutional adjustment and successful reintegration to the community through the elimination of drug abuse and the elimination/management of mental illnesses. The program consists of a core program and two specialized treatment tracks: the drug abuse track and the mental illness track.

5.1.2. Residential Treatment Unit. The Challenge Unit is to be separated from the general population. Living together in a unit allows all inmates to work together to create a community that supports prosocial attitudes and behaviors. The Challenge Unit isolates program participants from the negative peer pressure of the larger prison environment. Further, the Challenge Unit must be solely for Challenge participants. Inmates living on the unit must be: waiting for admission into the program (CHG WAIT); participating in the program (CHG PART); or Challenge complete (CHG COMP). Whenever possible, there should be more inmates who are participating in or who have completed Challenge in the treatment unit than those waiting to enter treatment.

5.1.3. Staffing. The Challenge Program is staffed by a psychologist who serves as the Challenge Program Coordinator and a minimum of three Challenge Program Treatment Specialists. The program has a 1:20 Treatment Specialist-to-inmate ratio.

5.2. Target Population. An inmate must meet one of the following criteria to be admitted into the Challenge Program:

- A history of drug abuse as evidenced by self-report, Presentence Investigation Report (PSR) documentation, or incident reports for use of alcohol or drugs.
- A major mental illness as evidenced by a current diagnosis of a psychotic disorder, mood disorder, anxiety disorder, or personality disorder.

5.3. Admission Procedures

5.3.1. Program Placement. Inmates are identified for placement in the program by the Challenge Program Coordinator or designee. There are a variety of potential indicators for program placement. These indicators must include at least one of the following: a CMA

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assignment of PSY ALERT, an MDS assignment of MEN ILL, a Sensitive Medical Data (SMD) assignment of MNTL HLTH, apparent symptoms of a major mental illness, recent placement on Suicide Watch, the need for detoxification upon entrance into Bureau custody, a DRG I REQ or DAP WAIT assignment, the receipt of an incident report for use of alcohol or drugs, or a history of substance abuse noted in the inmate's PSR. Mentally ill inmates may be placed directly in the Challenge unit after screening.

5.3.2. Program Referrals. Inmates may self-refer for the program, provided they meet the admission criteria. To request placement in the Challenge program, inmates must submit an *Inmate Request to Staff* form (BP-A0148) to the Challenge Coordinator. The Challenge Coordinator will determine the appropriateness of the inmate's placement in the program. A waiting list of inmates approved for voluntary placement in the program will be maintained in SENTRY. The inmate will sign the *Agreement to Participate in Psychology Treatment Programs* form (BP-A0940) when he is notified of his acceptance to the program.

5.3.3. Enrollment Time Frame. The Challenge Program is designed to facilitate both a favorable adjustment to incarceration and a successful release to the community. Participants may enroll in the program at any time during the course of their sentence, provided they have sufficient time to complete the program. Priority placement should be given to inmates at the beginning of their sentence in order to maximize the program's impact on the inmate's behavior while incarcerated.

5.4. Assessment of Need. A psychosocial assessment of the inmate's treatment needs is conducted during the Orientation Phase of the program. The information gathered during this face-to-face interview will become a part of the case conceptualization for the treatment plan. This assessment format is available in the Psychology Data System (PDS). Other assessments or testing will be conducted as needed, based on the inmate's behaviors.

5.5. Treatment Protocol

5.5.1. Treatment Modules. The Challenge Program treatment modules direct the treatment program. In the Drug Abuse Track, programming is 500 *contact* hours; i.e., face-to-face contact between treatment staff and inmate participants, over no less than 9 months of half-day programming. Ordinarily, programming is conducted daily (excluding non-program days, such as weekends and holidays) for half of the inmate's work day. In the Mental Illness Track, programming is based on a clinical case management model, with contact hours based on need. Treatment begins as soon as the inmate is in CHG PART status in SENTRY.

The developed Challenge Treatment journals, facilitator guides, and manuals are required for the Challenge Program. The current treatment journals and facilitator guides are identified on Sallyport.

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As evidence-based treatment technologies advance, treatment materials will be revised. Therefore, only the most current Challenge materials, journals, facilitator guides, etc., are to be used.

5.5.2. Treatment Phases. The Challenge Program is organized in Phases. Each Phase follows a clearly defined structure. The Phases are organized as follows:

a. **Phase I – The Orientation Phase**. During the Orientation Phase of treatment, Challenge Program Treatment Specialists are to perform the following duties related to inmates assigned to their caseload:

- Strive to build rapport and motivate the inmate to engage in treatment.
- Conduct the psychosocial assessment. This guides the development of the treatment plan. The treatment assessment must be conducted with the inmate. It is not a self-assessment instrument.
- Present the inmate's case at a treatment team meeting. These meetings are scheduled and conducted by the Challenge Program Coordinator. The treatment team meeting is to assist with the development of the inmate's treatment plan.
- Attend treatment team meetings. These meetings provide the opportunity for staff to discuss each individual inmate. These discussions are to review the inmate's progress in treatment and commitment to the program.

Phase I will ordinarily last one month. If the treatment team is in agreement that the inmate is not ready to move on to Phase II, Phase I may be repeated until the inmate is ready to move on, withdraws, or is expelled.

b. **Phase II – The Core Treatment Phase**. In the Core Treatment Phase, the inmate is expected to build positive relationships in group, on the treatment unit, with family/significant others, with institution staff, etc.

Using the treatment journals and facilitator guides developed for the program, staff will facilitate an environment for inmates to acquire the thought processes and prosocial skills required to live a drug-free, crime-free, and well-managed life.

Treatment progress reviews are to be completed every 60 days and are to be documented in PDS. In addition, treatment staff are to observe program participants regularly (e.g., at work, during main line, in the unit) to ascertain if the inmate's behaviors demonstrated around the treatment staff are constant, or if the inmate's behavior changes outside of the treatment environment.

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Ordinarily, the core treatment phase will last six months. Staff should monitor the participants' behaviors, personal insights, motivation, and commitment to treatment daily. Changes in behavior (positive or negative) are to be documented in the participants' progress reviews.

If the treatment team does not believe the inmate has made significant progress at the end of the core treatment phase, staff may require the inmate to repeat all or part of the Core Treatment Phase. Failure to progress in treatment will be documented in PDS.

c. **Phase III – The Transition Phase**. The Transition Phase focuses on the inmate continuing to practice the prosocial skills acquired in treatment. In addition, the inmate must demonstrate realistic expectations and living skills to function in a prison environment.

Ordinarily the Transition Phase lasts two months. If the treatment team finds the inmate has not made adequate progress, he may be held back until he or she completes, withdraws, or is expelled from the program.

5.6. Challenge Program Achievement Awards. The Challenge Program offers achievement awards for inmates who participate appropriately in the program. The Challenge Program treatment team will determine if an inmate is eligible to receive an achievement award.

5.6.1. Earning Program Achievement Awards. In order to earn program achievement awards, inmates must:

- Be on time for group.
- Have no unexcused absences.
- Not leave group without approval from the Treatment Specialist.
- Not eat, drink, or sleep in group.
- Complete all assigned activities.
- Dress appropriately: clean institutional clothing, shirts tucked in, no jackets or coats, shoes tied, no headphones, properly fitting pants with belts, no sunglasses and no head covering other than approved religious headgear.
- Be active in group.
- Put forth positive efforts in accomplishing treatment goals, as determined by the treatment team within the treatment plan.
- Comply with education and FRP obligations.

5.6.2. Specific Achievement Awards.

- **Limited Financial Awards**. An inmate may earn a financial award to offset time lost from work. The amount of this award is $40 for each phase of treatment. A financial award may

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be paid in whole or in part based upon the inmate's participation and progress. A financial award is never to be increased.

- **Local Incentives.** Institutions may offer incentives such as preferred living quarters, early mainline, exercise equipment on the unit, a program library, a movie night, etc.

- **Tangible Incentives**. With the Warden's approval, tangible incentives (e.g., books, t-shirts, notebooks, mugs with program logo) may be offered.
- **Graduation Ceremony/Ritual**. For the completion of the Challenge Program, institutions may offer a structured completion/graduation ceremony for the inmates. Photographs of individual participants or the treatment group may be allowed. Inmates may mail a photograph of themselves or the group to family.

5.7. Program Documentation. Required documentation for the Challenge Program includes:

- A documented psychological diagnosis in PDS related to a drug abuse and/or mental health disorder.
- An Agreement to Participate in the program, signed by the inmate at the time of the first treatment session.
- A psycho-social assessment on each inmate entering the program to assist in the development of an individualized treatment plan.
- An individualized treatment plan for each participant, documenting the targeted problem areas, treatment goals, and treatment activities in PDS.
- Recording in PDS a participant's attendance in group.
- Treatment contact notes, when appropriate.
- 60-day progress reviews noting progress toward treatment goals.
- Challenge treatment assignments in SENTRY.
- At the conclusion of the inmate's involvement in the program, a treatment summary and a brief account in the evaluation section of PDS noting how he left the program; e.g., "Mr. XXX was transferred to a lower security institution," "Mr. XXX successfully completed the treatment goals identified in his treatment plan," "Mr. XXX informed treatment staff he is no longer interested in participating in the program."

Inmates who do not complete the Challenge Program for reasons other than expulsion require a discharge note with the reason(s) for non-completion documented in the Evaluation section of PDS. At that time the Challenge Coordinator, or designee, is to change the inmate's SENTRY assignment from CHG PART to CHG INCOMP.

5.8. Challenge Outcomes. How an inmate leaves a residential program is based on the inmate's behavior.

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5.8.1. Completion. Completion of any Phase of treatment is determined by the inmate's behavior within the program and on the compound. An inmate is not to be moved from Phase to Phase without demonstrating he or she has:

- Taken on the responsibilities of the community.
- Made a commitment to positive change as evidenced by observed positive behavior in his or her daily interactions.
- Expressed him- or herself in group, demonstrating the ability to give and receive appropriate feedback from other staff and inmates.
- Mastered phase-related concepts.

Inmates who do not demonstrate these and other behavioral changes are not ready for Challenge completion.

5.8.2. Withdrawal/Incomplete. An inmate may withdraw voluntarily from the program. Withdrawals must be documented in PDS and a memorandum forwarded to the Unit Team.

An inmate may also be moved to Incomplete status for many reasons: placement in the Special Housing Unit (SHU), removed from the institution on a writ, unforseen redesignation, etc. An incomplete does not mean the inmate is automatically a failure. The Treatment Coordinator and the treatment team will make the decision on the inmate's final treatment determination, depending on the reason for his or her incomplete status. The Treatment Coordinator will ensure proper documentation of the meeting in PDS and SENTRY.

5.8.3. Expulsion. Inmates may be removed from the program by the coordinator because of disruptive behavior related to the program or unsatisfactory progress in treatment. Ordinarily, staff will provide the inmate with at least one treatment intervention prior to removal. In response to disruptive behavior or unsatisfactory progress, treatment staff will:

- Meet with the inmate to discuss his or her behavior or lack of progress.
- Assign the treatment intervention(s) chosen to reduce or eliminate the behavior, or to improve progress.
- Warn the inmate of the consequences of failure to alter his/her behavior.
- Properly document in PDS the meeting and treatment intervention(s) assigned.
- Properly document in PDS changes to the inmate's treatment plan, and ensure that both staff and the inmate sign the amended treatment plan.
- When appropriate, require the inmate to discuss his or her targeted behavior in the community.

In the event repeated treatment interventions are required in response to inappropriate behaviors or unsatisfactory progress, the treatment team will meet to decide if the inmate will be removed from the program.

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Within two working days after a decision has been made to expel an inmate, the Program Coordinator will:

- Verbally notify the inmate of his/her expulsion status.
- Update the pertinent SENTRY DRG assignments.
- Ensure proper documentation of the expulsion has been entered into PDS.

An inmate may not ordinarily be removed immediately by the program coordinator without a treatment intervention unless the inmate, pursuant to an incident report, is found by the DHO to have committed a prohibited act involving:

- Alcohol or drugs.
- Violence or threats of violence.
- Escape or attempted escape.
- Any 100-level series incident.

An inmate may be expelled from the program without a formal intervention if the inmate is determined to have violated confidentiality.

In limited circumstances, an inmate may be expelled from the program without a formal intervention if the inmate's behavior is of such magnitude that an inmate's continued presence in programming would create an immediate and ongoing problem for staff and/or other inmates.

Whenever immediate expulsion is necessary the program coordinator, or designee, will:

- Inform the inmate of his or her expulsion.
- Ensure proper documentation of the meeting and expulsion are entered into PDS.

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CHAPTER 6. MENTAL HEALTH TREATMENT PROGRAMS

6.1. The Mental Health Treatment Programs. Mental Health Treatment Programs are a series of programs dedicated to management and treatment of the Bureau's seriously mentally ill and behaviorally disordered inmates. Current Mental Health Treatment Programs include:

- The Habilitation Program.
- The Skills Program.
- The Axis II Program.
- Mental Health Treatment Units (e.g., Step-Down Units).

Additional Mental Health Treatment Programs may be implemented by Central Office.

Each Mental Health Treatment Program Coordinator is responsible for preparation of an Institution Supplement that provides specific details regarding the operation of their program. As evidence-based treatment technologies advance, Coordinators will be responsible for inclusion of these technologies in their programs and their Institution Supplement. Central Office will serve as a resource in this process.

6.1.1. Purpose. Mental Health Treatment Programs are designed to effectively manage and treat the Bureau's seriously mentally ill and behaviorally disordered inmates. Specifically, the programs are designed to reduce psychological symptoms, improve functioning, facilitate institutional adjustment, and reduce incidents of misconduct.

6.1.2. Residential Treatment Unit. Mental Health Treatment Program participants are to be housed together on a unit, separate from general population inmates. Living together in a unit allows all inmates to work together to create a community that supports prosocial attitudes and behaviors. The treatment unit isolates program participants from the negative peer pressure of the larger prison environment. In addition, the treatment unit offers mentally ill inmates an environment where they are less likely to be victimized by other inmates.

The Mental Health Treatment Program unit must be solely for program participants. Inmates living on the unit must be waiting for admission into the program, participating in the program, or program completers. Whenever possible, there should be more inmates who are participating and have completed the treatment program in the treatment unit than those waiting to enter treatment.

6.1.3. Staffing. Mental Health Treatment Programs are staffed by a psychologist who serves as the Program Coordinator. Additional program staff may include psychologists, Treatment Specialists, social workers, teachers, and psychiatrists, depending on the needs of the individual programs.

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Staffing complements for Mental Health Treatment Programs are established by Executive Staff at the time of program implementation. The staffing complements for current programs are listed below:

- The Habilitation Program has a capacity of 16 inmates and is staffed by a psychologist.
- The Skills Program has a capacity of 44 inmates and is staffed by a psychologist, a Treatment Specialist, and a teacher.
- The Axis II Program has a capacity of 48 inmates and is staffed by a psychologist, two Treatment Specialists, and a correctional counselor.
- The female Step-Down Unit has a capacity of 72 and is staffed by a psychologist.
- The male Step-Down Unit has a capacity of 84 and is staffed by a psychologist, a social worker, and a half-time psychologist.

Any changes to these staffing complements require Central Office approval.

6.2. Target Population. An inmate must meet all the following criteria to be admitted into a Mental Health Treatment Program:

- The inmate must have a serious mental illness or behavioral disorder, including psychotic disorders, mood disorders, anxiety disorders, personality disorders, or significant cognitive impairment.
- The inmate has a need for intensive treatment services, as evidenced by:
  - Multiple psychiatric hospitalizations.
  - Complex psychotropic treatment.
  - Major mental health-related functional impairment.
  - Repeated instances of severe behavioral problems.

Note: In some instances a mentally ill inmate may be placed in a residential mental health treatment program for management reasons. In these instances an Agreement to Participate is not required. However, in these instances an inmate must be informed of program expectations. Prior to participation in any treatment group the *Agreement to Participate in Psychology Treatment Programs* form (BP-A0940) must be signed.

The target populations for current Mental Health Treatment Programs are noted below:

6.2.1. The Habilitation Program. The Habilitation Program targets high security, low functioning inmates who cannot successfully adapt to a penitentiary environment, but who may have the ability to function well at medium security level institutions.

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6.2.2. The Skills Program. The Skills Program is designed for inmates with significant cognitive limitations and psychological difficulties that create adaptive problems in prison and in the community.

6.2.3. The Axis II Program. The Axis II Program targets inmates with severe personality disorders, typically Borderline Personality Disorder, who have a history of behavioral problems in the institution and who are amenable to treatment.

6.2.4. Mental Health Treatment Units. Mental Health Treatment Units, including Step-Down Units, provide an intermediate level of mental health care for seriously mentally ill inmates. Typically Mental Health Treatment Units are located in Care Level 3 institutions. Step-Down Units provide intensive treatment for inmates releasing from psychiatric hospitalization and may also function as Step-Up Units to intervene before an inmate requires hospitalization.

Note: Mental Health Treatment Program Step-Down Units are not to be confused with custodial Step-Down Units.

6.3. Admission Procedures. Inmates are identified for placement in Mental Health Treatment Programs by the Program Coordinators. In addition, Chief Psychologists throughout the Bureau may refer seriously mentally ill inmates to Mental Health Treatment Programs, provided they meet the program admission criteria. The Program Coordinator is responsible for screening these referrals and making recommendations regarding the inmates' appropriateness for the program. Each program's Institution Supplement will include a description of the program's specific admission procedures.

6.4. Assessment of Treatment Needs. At a minimum, a psychosocial assessment of the inmate's treatment needs is conducted during the Orientation Phase of the program. The information gathered during this face-to-face interview will become part of the inmate's treatment plan. The assessment may also include other evaluation measures specific to the needs of the program and the individual inmate.

Each program's Institution Supplement will include a description of the program's specific assessment procedures.

6.5. Treatment Protocol. Treatment protocols for the Mental Health Treatment Programs will vary, based on the focus of the individual programs. However, all treatment protocols will utilize evidence-based interventions, with an emphasis on cognitive and behavioral treatment strategies. At a minimum, these interventions will include: psycho-educational courses related to mental illness and its management, skills training groups, and clinical case management. As evidence-based treatment technologies advance, treatment materials will be revised. Therefore, only the most current Mental Health materials are to be used. Central Office staff will provide guidance regarding appropriate treatment protocols.

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Mental Health Treatment Programs are intensive treatment interventions, with most participants remaining active in the program for at least six months. Treatment staff are responsible for actively treating and managing program participants on a daily basis. Each program's Institution Supplement will include a description of the program's specific treatment protocol.

6.6. Program Achievement Awards. Although used with less frequency than in other psychology treatment programs, Mental Health Treatment Programs may make use of program achievement awards. Any program achievement awards must be approved by the Warden and the Regional Psychology Services Administrator. For example:

- **Local Incentives.** Institutions may offer incentives such as preferred living quarters, early mainline, exercise equipment on the unit, a program library, a movie night, etc.
- **Tangible Incentives**. With the Warden's approval, tangible incentives (e.g., books, t-shirts, notebooks, mugs with program logo) may be offered.
- **Graduation Ceremony/Ritual**. For the completion of the Mental Health Treatment Programs, institution staff may offer a structured completion/graduation ceremony for the inmates. Photographs of individual participants or the treatment group may be allowed. Inmates may mail a photograph of themselves or the group to family.

Each program's Institution Supplement will include a description of the specific program achievement awards and criteria for earning each achievement award.

6.7. Program Documentation. Required documentation for Mental Health Treatment Programs includes:

- A documented psychological diagnosis in PDS of a serious mental illness or behavioral disorder.
- An *Agreement to Participate in Psychology Treatment Programs* form (BP-A0940), signed by the inmate at the time of the first treatment session. NOTE: In some instances a mentally ill inmate may be placed in a residential mental health treatment program for management reasons. In these instances an Agreement to Participate is not required. However, in these instances an inmate must be informed of program expectations. Prior to participation in any treatment group the Agreement to Participate must be signed.
- A psychosocial assessment on each inmate entering the program to assist in the development of an individualized treatment plan.
- An individualized treatment plan for each participant, documenting the targeted problem areas, treatment goals, and treatment activities in PDS.
- Recording in PDS a participant's attendance in individual and group sessions.
- Clinical case management notes, when appropriate.
- 60-day progress reviews noting progress toward treatment goals.
- Mental Health Treatment Program assignments in SENTRY. Specific SENTRY codes will be provided by Central Office.

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- At the conclusion of the inmate's involvement in the program, a treatment summary and a brief account in the evaluation section of PDS noting how he or she left the program; e.g., "Mr. XXX was transferred to a lower security institution," "Mr. XXX successfully completed the treatment goals identified in his treatment plan," "Mr. XXX informed treatment staff he is no longer interested in participating in the program."

6.8. Program Expulsions. As soon as possible after a decision has been made to expel an inmate from the program, the Program Coordinator, or designee, must:

- Notify the inmate verbally of his/her expulsion status.
- Remove the inmate from the program housing unit.
- Update the SENTRY assignment(s).