Looking at the BOP's Amended RDAP Rules

BY ALAN ELLIS AND TODD BUSSERT

The federal Bureau of Prisons (BOP) estimates that 40 percent of federal inmates have diagnosable, moderate-to-severe substance abuse problems. Yet, in recent years, the BOP has taken affirmative steps to curtail the availability of its widely lauded residential drug and alcohol abuse program (RDAP), a program that reduces relapse and recidivism rates while producing cost savings due to available sentence reductions. These efforts, which run contrary to clear congressional mandate, deny necessary substance abuse treatment to individuals just prior to their return to free society. Not only does the BOP's ill-conceived practice bear on courts' sentencing determinations, but, equally important, it negatively impacts on crime control while opening the door to litigation. This article looks at BOP's residential substance abuse treatment regulations and rules, particularly at Program Statements 5330.11 *Psychology Treatment Programs* (March 16, 2009), which governs RDAP.

What is RDAP?

Through the Violent Crime Control and Law Enforcement Act of 1994 (VCCLEA), Congress directed that the BOP "provide residential substance abuse treatment . . . for all eligible prisoners," defining "eligible prisoner" as one the BOP determines has "a substance abuse problem" and is "willing to participate in a residential substance abuse treatment program." (18 U.S.C. §§ 3621(e)(1)(C) and (e)(5)(B).) The BOP's "inpatient" 500-hour residential drug abuse program, in existence since 1989, employs cognitive behavioral therapy (CBT) to treat substance abuse. (28 C.F.R. § 550.53.)

> RDAP programs operate in 62 BOP institutions. . . . Inmates in these programs are housed together in a separate unit of the prison that is reserved for drug treatment, which consists of intensive half-day programming, five days a week. The remainder of the day is spent in education, work skills training, and/or other inmate programming. RDAP follows the CBT model of treatment wrapped into a modified therapeutic community model where inmates learn what it is like living in a pro-social community.
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> Upon completion of this portion of the treatment which lasts nine months, aftercare services are provided to the inmate while he/she is in the general population of the prison, and later at the residential reentry center (RRC). The program is open to all offenders diagnosed with a moderate to severe substance abuse problem (using the DSM criteria) who are able to complete all components of the program. A recent (March 19, 2009) BOP regulation adds treatment in a community corrections facility as a mandatory component of the program.
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> *A rigorous evaluation of RDAP demonstrated convincingly that offenders who participated in residential drug abuse treatment were 16 percent less likely to be re-arrested and to have their supervision revoked 3 years after release, compared to inmates who did not receive such treatment. This reduction in recidivism is coupled with a 15 percent reduction in drug use for treated subjects.*

(USDOJ-BOP, STATE OF THE BUREAU 2009 25 (emphasis added).)

Experience shows that parties to the federal criminal justice system (courts, probation, prosecutors) favor RDAP because it is one of the few avenues for mental health treatment available to prisoners not suffering from acute psychological problems. This, in turn, reduces substantially the risk of recidivism and of substance abuse relapse. (*See* B. Pelissier et al., *Triad Drug Treatment Evaluation Project*, 65 FED. PROBATION 3, 6 (2001).)

Most RDAP-eligible prisoners are aware of the congressionally incentivized, up-to-one-year reduction in

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sentence afforded successful, "nonviolent" graduates. (18 U.S.C. § 3621(e).) Indeed, with the closure of the Intensive Confinement Center (boot camp) program in 2005, RDAP is the only BOP program that provides an opportunity for sentence reduction. A consistently high number of prisoners seek RDAP admission each year. This is so notwithstanding the BOP's implementation of a sliding scale for section 3621(e) sentence reductions tied to sentence length. Those serving 30 months or less are ineligible for more than a six-month reduction; those serving 31–36 months are ineligible for more than a nine-month reduction; and those serving 37 months or longer are eligible for the full 12 months that the law allows.

Given the section 3621(e) incentive, and to ferret out malingering, RDAP eligibility interviews entail difficult questions designed to determine whether admission is sought in good faith to obtain treatment, or simply to secure a quicker return home. Applicants are routinely asked when they learned about the program and the section 3621(e) credit, whether attorneys advised them to exaggerate treatment needs when meeting with probation, and the details of their drug or alcohol use (e.g., when, how often, where, with whom, others' awareness, etc.). Notably, an applicant's chemical dependency does not need to be linked to his or her offense conduct to qualify for the program, nor does one's eligibility for the section 3621(e) reduction impact treatment eligibility. Once deemed RDAP-eligible, a prisoner is placed on a wait list that is ordered by projected release date (i.e., time remaining to serve, accounting for anticipated good time credit).

The Standard of Proof

One key area long contested in RDAP's administration is the level of proof necessary to substantiate a prisoner's substance abuse history, specifically to establish a disorder diagnosable under the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM). The BOP has historically placed primary reliance on a prisoner's self-reporting to the presentence report (PSR) writer. Whatever is contained in the PSR is presumptively valid, and any claim of a disorder that the PSR does not plainly substantiate is treated as suspect. That said, Program Statement 5330.11 confirms any prisoner's ability to validate the issue via "collateral documentation," including information from mental health or social service professionals "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 [*discussion below*]." This independent information must have been developed contemporaneous to the individual being seen and in connection to corresponding treatment, which begs the obvious question of why mere self-reporting to a clinician, as compared to a PSR writer, is insufficient.

For those individuals seeking admission to RDAP, the prudent course is to be fully forthcoming with one's PSR writer during the PSR interview. So, too, it is incumbent upon counsel to bring a client's abuse or dependence upon substances—be it illegal drugs, pharmaceuticals, or alcohol—to the PSR writer's attention as well as to document the abuse or dependency by information from an independent professional (e.g., physician, mental health professional, drug and alcohol counselor). If circumstances interfere with or prevent candor, counsel should refer clients to qualified independent providers for assessment and treatment as soon as practicable. The provider can, in turn, provide written corroboration of the client's issue(s) for disclosure to the BOP in conjunction with the client's RDAP application. Barring that, it is useful to find records that demonstrate the nature and extent of the client's substance abuse difficulties, such as certified copies of DUI judgments, hospital records noting blood alcohol level, and/or a primary physician's treatment notes with entries that substantiate the existence of the problem.

The 12-Month Rule

Although unstated in Pprogram Statement 5330.11, the so-called "12-month rule" derives from the BOP's disputed interpretation of "sustained remission," as provided for in the DSM. (*See* Beth Weinman, BOP Nat'l Drug Abuse Coordinator, Statement at the United States Sentencing Commission's Symposium on Alternatives to Incarceration 83–84 (July 14–15, 2008) [hereinafter Weinmman Statement] ("[W]e use the [DSM], and that's where all the information is regarding what we call court specifiers. Sustained remission is that you have not used drugs for over a year. . . . Because that's the standard in the [DSM] and that's what we follow.").) Thus, no matter the nature or extent of a prisoner's substance abuse problems, if the BOP cannot verify that the individual 's drug use rose to a level of a DSM diagnosis in the year prior to arrest, RDAP is denied.

Neither statute nor controlling Code of Federal Regulations provisions provide for the 12-month rule. Furthermore, courts have found that the "DSM-IV does not require documentation of substance abuse or dependency during the 12-month period *immediately preceding either a diagnostic interview, arrest, or incarceration.*" (Mitchell v. Andrews, 235 F. Supp. 2d 1085, 1090 (E.D. Cal. 2001) (emphasis in original); *see* Smith v. Vazquez, 491 F. Supp. 2d 1165 (S.D. Ga. 2007).) A simple hypothetical highlights the unsustainability of the artificial 12-month rule construct. Prisoner A and Prisoner B both abuse heroin similarly. Prisoner A last

used 11 months and 25 days (360 days) before his arrest but maintained sobriety thereafter, including during several years of pretrial supervision, before being sentenced to 25 years' imprisonment. Prisoner B last used 12 months and five days (370 days) before his arrest, but his case was resolved within five months and resulted in a 36-month sentence. According to the BOP, by the happenstance of a 10-day swing between last drug use and arrest, Prisoner A qualifies for the agency's only intensive residential treatment program while Prisoner B, who will return to the community after a significantly shorter period of (forced) abstinence, does not. The rule is thus properly seen as an arbitrary and capricious product of internal agency action, meaning it should be accorded little, if any, deference under *Chevron U.S.A., Inc. v. Natural Resourse Defense Council, Inc.*, 467 U.S. 837 (1984), and its progeny.

Challenges to the 12-month rule once in BOP custody, or to Program Statement 5330.11 generally, should be brought via a habeas corpus petition pursuant to 28 U.S.C. § 2241. Importantly, a commonly raised affirmative defense to such applications is the petitioner's failure to exhaust the BOP's administrative remedy process. (*See* 28 C.F.R. §§ 542.10–15.) Although there is a strong argument that exhaustion is not necessary, it is recommended that prisoners pursue the process when time permits, including during the pendency of litigation, if for no other reason than to avoid delays in reaching the merits of the litigation.

The 24-Month Cutoff

As noted above, Congress requires that the BOP provide residential substance abuse treatment for each inmate determined to have a substance abuse problem. Moreover, Congress intends that the BOP administer RDAP so as to maximize each eligible inmate's sentence reduction. (*See Conf. Rep. to Consolidated Appropriations Act of 2010*, 155 Cong. Rec. H13631-03, at H13887 (daily ed. Dec. 8, 2009), Pub. L. No. 111-117, 123 Stat. 3034 (Dec. 16, 2009).) However, as the BOP's national drug abuse coordinator acknowledged in July 2008, "[Fiscal Year] 2007 was the first year that the Bureau was unable to meet its mandate to provide treatment for all inmates who volunteer for and are qualified for treatment before they are released from the Bureau of Prisons." (Weinman Statement, *supra*, at 72.) Soon thereafter BOP eliminated its handful of RDAPs for Spanish-speaking prisoners; in order to participate in the program, a prisoner must now be able to speak and understand English. Although the authors suspect that budgetary pressures contributed to this action, a larger consideration may well have been an agency interest in being able to tell Congress that it is in compliance with its mandate. (*See* USDOJ-BOP, The Federal Bureau of Prisons Annual Report on Substance Abuse Treatment Programs Fiscal Year 2010 at 9 (2010) ("In FY 2010, the BOP met the requirement [of the VCCLEA] to treat 100 percent of the eligible inmate population. . . .").)

Along these lines, Program Statement 5330.11, which was promulgated in 2009, directs that otherwise eligible prisoners must "ordinarily" be within 24 months of release to qualify for admittance to RDAP. There is no known basis for this 24-month cutoff date, which is troubling since, inter alia, the program can be completed in as little to 15 months. (*See* Scott v. FCI Fairton, 407 Fed. Appx. 612 (3rd Cir. 2011) (citing BOP submissions).) Accounting for customary good time credits, the 24-month cutoff means that a defendant with a diagnosable disorder and no pretrial jail credit must receive a sentence of 27.6 months or greater to even be considered for the program. Notably, BOP officials have stated publicly that the 24-month cutoff has shifted to 27 months, which means a sentence of at least 31 months (if no pretrial jail credit).

Feedback the authors have received indicates most judges, and the probation officers who advise them, are unaware that defendants sentenced to less than 27 months' imprisonment do not qualify for RDAP, regardless of the severity of their addictions. Courts cannot increase a defendant's sentence to facilitate RDAP participation. (Tapia v. United States, 131 S. Ct. 2382 (2011) (under 18 U.S.C. § 3582(a), rehabilitation is not to be considered in terms of the need for or length of a term of imprisonment).) They can, however, consider this conundrum relative to the propriety of imposing a non-guidelines sentence. Support for such an approach, at least by analogy, is found in the 2010 amendments to the *Guidelines Manual*, specifically Application Note 6 to Guideline section 5C1.2. If anything, the unavailability of RDAP in this circumstance speaks to judges' need to structure sentences consistent with their statutory authority, for instance, through the imposition of a mitigated term of imprisonment (e.g., one year and a day) followed by a term of supervised release conditioned on the completion of an inpatient treatment program. Another option in those districts with reentry/support courts is a mitigated term of imprisonment followed by admission into that community-based, court-supervised program. Such an approach has the added effect of shifting the cost burden to the offender.

Like the 12-month rule, the 24-month cutoff, which is inconsistent with the agency's historic administration of RDAP, is properly seen as arbitrary and capricious and not meriting *Chevron* deference. Similarly, for those in custody, the rule can be challenged by way of a section 2241 petition.

Conclusion

A growing body of empirical data rejects the dated claim that "nothing works" when it comes to rehabilitating prisoners. Indeed, there is strong evidence that cognitive behavioral treatment models, liked those used in RDAP, work to substantially reduce relapse and recidivism. Given the high incidence of substance abuse disorders within correctional systems, including the BOP, every effort should be made to facilitate, rather than deny, treatment. The BOP's approach to RDAP, namely the adoption of arbitrary and unwarranted standards and time limits, must be addressed both to ensure prisoners receive appropriate care and to ensure compliance with 18 U.S.C. § 3621. In particular, the BOP must eliminate the 12-month rule and replace it with an interview by a trained and licensed psychologist or similarly qualified mental health professional to determine who is a substance abuser who would benefit from the program; restore the Spanish-speaking RDAP classes; and eliminate the baseless cut-off date for RDAP eligibility since the program can be completed in 15 months. Only by taking such appropriate steps will the BOP truly meet its statutory mandate. ■

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