MENTAL ILLNESS IN AMERICA'S PRISONS

NATIONAL COALITION FOR THE MENTALLY ILL
IN THE CRIMINAL JUSTICE SYSTEM

MENTAL ILLNESS

IN

AMERICA'S PRISONS

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and

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This monograph is being produced as part of a larger effort to address and improve the provision of mental health services to prison inmates. The overall project is being conducted by:

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FOREWORD

As Judge Robert Coate reminds us in his work, "A Street is Not a Home," there exists in the Western World a tradition of avoiding or denying unpleasant aspects of reality such as tragedy and illness. "The Clown," by George Rouault, a reproduction of which appears on this monograph's cover, captures in its dark shadowy figure some of this tendency. Rather than shedding the light necessary to face the reality, we often prefer the darkness, particularly when there is an uncertainty and complexity associated with it.

Yet is precisely because of the importance of confronting directly, seeing clearly and handling responsibly those in America's prisons who have mental illness that this monograph is written.

This monograph has been produced by The National Coalition for the Mentally Ill in the Criminal Justice System. The Coalition is a unique non-profit organization founded in 1989 to deal with the growing national crisis of increasing numbers of offenders who are mentally ill or dually-diagnosed and are in the custody of criminal justice and juvenile justice agencies. The Coalition is the only organization that has developed a national agenda focused on the mental health needs of this underserved and often ignored population. This agenda has the following objectives: to develop effective models for screening, diverting, and treating offenders who are mentally ill or dually diagnosed, and to establish comprehensive community-based systems of care to facilitate the rehabilitation of these individuals.

The coalition's mission is based on the premise that proper screening and handling by criminal justice agencies of offenders who are mentally ill or dually-diagnosed is a significant issue that has substantial public safety, health, economic, and moral implications. It is believed that problems related to offenders who are mentally ill or dually-diagnosed is a serious issue not only for criminal justice agencies but for a number of agencies at every level of government.

Through a series of innovative national forums, the Coalition seeks to build consensus and craft strategic solutions to impact the problems it addresses. Participants at these forums are stakeholders and experts from national organizations including corrections professionals, judges, court administrators, adolescent and adult treatment providers, legislative leaders, policy makers, families, clinical and policy researchers, and federal agencies involved in mental health, criminal justice, and drug and alcohol treatment. By enlisting top researchers, policy-makers and advocates who deal with these issues on a daily basis, the Coalition develops relevant literature that reflects the current status and realities of the corrections field. In calling on these leading experts, the Coalition is committed not simply to the growth and synthesis of knowledge in the field, but also to its dissemination and diffusion to those who can utilize the information within various sectors of society to strengthen our ability to respond to the mental health needs of those in the criminal and juvenile justice system.

In June 1993, the National Coalition for the Mentally Ill in the Criminal Justice System met in Austin, Texas for the National Work Session on "Mental Illness in America's Prisons." This represented the third "National Access Initiative." The Coalition's two other access initiatives focused on detainees in local jails who are mentally ill and on mentally ill youthful

offenders. All of the Coalition's initiatives aim to provide the best solutions for bringing about needed changes at the policy level for accessing health care for mental illness and related disorders in the justice system. For each initiative the Coalition systematically reviews, summarizes, and assesses in single documents what we know, and what we do not know, about mentally disordered offenders. These monographs comprise a comprehensive, state-of-the-art picture of the available body of research on these populations.

The Coalition, in the span of the past year, brought together a wide range and diversity of federal, state and local policy makers, administrators in criminal justice, and mental health and substance abuse, families, and national associations. This amalgam of people freely offered their time to help, through work and substance, because they believed we need to confront the barriers to accessing health care for those with mental illness and related disorders in prisons and the needed aftercare to prevent relapse and arrest for behavior most often contained with appropriate comprehensive health and supplemental services.

During the course of this effort, a quilt of emerging trends surfaced and should be seen as a starting point in the process of recasting the fragmented values of our current system. The following trends challenge us to develop new roles and relationships for public safety and mental health and to significantly increase the coordination between the prison, mental health providers, the community, victim and offender:

1. **Heighten Public Awareness** to be mindful to look at the offender as a whole person, part of the web of interconnectedness with his family and community. This whole system approach will require efforts in the public and private sectors, a variety of methods, and many years.

2. **Develop an Environment for Change** that allows for a broad vision that expresses the need for systematized, substantial, and significant change.

3. **Build Partnerships Between Prisons, Substance Abuse, and Mental Health Providers and the Communities** based on a practical vision, joint goals and objectives, and a unified view of high quality service delivery that includes shared outcomes and concern for recidivism rates.

4. **Consideration of Prevention Services for Adults at Risk for Relapse** should be an essential element when developing policies, highlighted by a more inclusiveness for adults. *(Prevention is not only for the young).* Prevention should become available for the vulnerable adult offenders in the criminal justice system who have health care needs for mental and related disorders and require support for crime-free living.

5. **Comprehensive Service Delivery** must include techniques to ensure these inmates actually receive services after leaving prison. Inter-Agency agreements and "one-stop shopping centers" can provide a wide range of services in a more effective fashion.

6. **Effectiveness of High Quality,** relapse prevention, supplemental services, and treatment services must be measured by the impact these interventions have on the lives of offenders in the community.

7. **From Double Talk to Plain Talk.** A strong communication and problem solving process and persistent efforts to avoid jargon and shorthand, clarify terms, and establish acceptable definitions can help partners in a comprehensive approach to services.

8. **High Quality Services Must Empower** the inmate or probationer and they should have a considerable voice in identifying and planning how best to meet these needs inside prisons and out in the community.

9. **Solutions Cannot be Restricted to Mental Health Services Alone.** Non-mental health services such as employment training and housing must be included as part of an integrated package to effectively meet the multiple needs of this population, particularly as they are reintegrated into the community.

10. **States Should Encourage Providers to Integrate their Services** and create a comprehensive offender - focused network aimed at the creation of an integrated delivery system. Regulations that impeded collaboration at the state and local levels should be eliminated and providers should be held accountable for how well offenders are being served.

There are no easy answers to the question of how we significantly improve the provision of mental health services to prison inmates and how we help to prevent their problems beforehand and reduce the likelihood that they will re-occur once released to the community. What we do know is that we will never succeed unless we try. The combination of the above trends and the body of knowledge provided in the following monograph provide us with the strong foundation needed to move forward.

There are two groups of people who have been crucial for this monograph: first, the researchers who wrote the chapters, and provided extensive knowledge, and extraordinary skills in working with the Coalition membership, bridging the gap between research and the community, and drafting policy recommendations; and second, the many stakeholders who generously shared information and ideas - some throughout several planning meetings.

The National Coalition is grateful to Tipper Gore for taking time out of her busy schedule to give the keynote address, by videotape, at the National Coalition's Plenary Session in Austin, Texas on Mental Illness in America's Prisons.

We also are grateful to our Program Manager, Nick Demos, of the Center for Substance Abuse Treatment, who provided guidance and continuous support for the project.

Our special thanks go to Henry J. Steadman, Ph.D. and Joseph J. Cocozza, Ph.D. of Policy Research Associates, our editors who provided the authors encouragement, and shared their knowledge and valuable critical commentary with the members of the coalition. Gratitude to the many others who helped plan the development and events around monograph: Mike Gatling from American Correctional Association; David Austin, Ph.D. Acting Dean and Smith Centennial Professor at the University of Texas at Austin; John Petrila, J.D., L.L.M. and Chairman and Associate Professor at the University of South Florida Department of Law and Mental Health.

Others who made important contributions to the monograph include: Cheryl Davidson, M.P.A., Community Action for the Mentally Ill Offender, Washington State; William O'Leary, J.D., Assistant Commissioner Forensic Mental Health, Executive Office of Health and Human Services and Mental Health, Boston, Massachusetts; Eric Trupin, Ph.D., Professor and Vice-Chair, Department of Psychiatry, Behavioral Science, University of Washington; Ted Wilson, M.S., Department of Corrections, Washington, State; and Joel Dvoskin, Associate Commissioner for Forensics, New York State Office of Mental Health, Bureau of Forensic Services who coached and guided carefully the small working groups at the National Work Session.

We are also thankful for all the helpful support from the state of Texas: Genevieve Hearon, First Vice-President, National Alliance for the Mentally Ill; Judy Culpepper-Briscoe, Director of Prevention, Texas Youth Commission; Wayne Scott, Deputy Director for Operations, Texas Department of Criminal Justice - Institute Division; Dee Kifowit, Director Texas Council on Offenders with Mental Impairments; and Dennis Jones, Commissioner, Texas Mental Health and Mental Retardation.

We were honored at the National Work Session for Mental Illness in America's Prisons to present the *Peggy Richardson Award* to Governor Ann Richards of Texas for her continued support for the Texas Council of Offenders with Mental Impairments, one of the most progressive state initiatives in the United States to find solutions for persons who have mental impairments and are caught up in the criminal justice system. The Distinguished Service Award was given to the Coalition's colleague and friend, Joel Dvoskin, Ph.D., Associate Commissioner for Forensics, New York State Office of Mental Health, for his boundless dedication to the field and his continued commitment to finding solutions for this population.

Lastly, we owe a great deal to the stakeholders listed in the Appendix from all the national associations, universities, criminal justice and substance abuse and mental health agencies, and the families that are graciously helping us see with new eyes. To all of the above we owe our heartfelt thanks.

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CHAPTER 1

INTRODUCTION

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Good advocacy demands that we have our facts straight. There are few things that more quickly compromise effective advocacy than asserting errors as fact. This need to confirm the facts before launching a major advocacy initiative has been at the core of the three major national conferences run by the National Coalition for the Mentally Ill in the Criminal Justice System over the past four years.

In 1990, the National Coalition sponsored a national conference, "Breaking Through the Barriers," focusing on mental health services for detainees in local jails and lock-ups. In 1992, the Coalition's national meeting, "Addressing the Mental Health Needs of Youth in the Juvenile Justice System," highlighted the mental health needs of juveniles. Most recently, in 1993, prison inmates' mental health needs were the Coalition's topic in its 3rd national work session, "Mental Illness in America's Prison."

At all three of the Coalition's meetings, the program activities were grounded in a series of research presentations. These presentations were developed by the leading researchers in the respective areas. Within each of the assigned topics, the researchers comprehensively reviewed all of the relevant research literature, interpreted the existing data in light of what level of services were available and how these services might best be developed, and then made suggestions for needed information from which even better recommendations might be developed.

After summary presentations of these reviews, the attendees at the national meetings were invited to vigorously critique the research reviews and the implications drawn from them. Based on these discussions, the authors then revised their chapters. The remainders of each of the Coalition's national meetings were geared towards developing an agenda for action with clearly articulated value statements, specific, attainable goals, and concrete action steps that could provide a road map for directed action.

This monograph includes the final versions of the research reviews plus a final chapter that reflects the deliberations of the conference attendees in identifying key issues for advocacy and the action steps that emerged from the discussions. These chapters represent the most thorough, up-to-date reviews of the empirical research on the prevalence of mental disorder among prison inmates and on prison mental health services. The final chapter is a comprehensive blueprint for needed action to improve mental health services to America's

jammed, oppressive prisons. They warrant the careful attention of researchers, clinicians, administrators, consumers, family members, legislators and the general public. The needs are great, but interest and attention spans are short.

SOME KEY TERMS

It must be clear from the outset that this monograph is about prisons. It does not focus on jails, except insofar as jails are usually the residences of prison inmates just prior to prison admission. With our focus on prisons, it means that we are dealing with state operated facilities housing persons convicted of crimes that have received sentences of one year or more. In those jurisdictions where state prisons also include pretrial detainees and inmates convicted of misdemeanors who are serving sentences of less than one year, their mental health service issues would have been covered in the Coalition's earlier monograph focused on jails (Steadman, 1990).

Consistent with the Coalition's earlier monographs, we are limiting the term mental disorder to "adults having a disabling mental illness, which includes schizophrenia and/or an affective disorder." These individuals can also have a secondary diagnosis, such as substance abuse disorders, personality disorders, or mental retardation.

Given the pervasiveness of substance abuse among prison inmates as discussed in Chapter 7, it is crucial for readers of this monograph to be equally clear about how we are including substance abuse disorders in our definition of disorder. To the extent that substance abuse disorders are co-morbid with DSM-IIIR Axis 1 disorders, they are included. To the extent that they are the sole diagnosis, they are not included. This is not to say that we do not think such substance abuse disorders are unimportant, but only that the treatment and management issues for them are distinctive and require special coverage which is beyond the scope of this monograph.

SHARED VALUES

In order to effectively advocate for any social change, it is important for advocates to have both shared information and shared values.

Shared values are important if advocates are to avoid seeing their influence scattered and diluted by internal disagreements. If ten organizations, each with some political power, ban together with focus upon one or two key changes, their chances of influencing public policy may be quite good. If these same ten organizations waste their efforts fighting about various details of changes they want, it becomes safe and easy for policymakers to simply do nothing.

The National Coalition has been, from its very inception, focused upon shared information and shared values. This monograph and the national work session which has informed it continues that tradition.

Listed below are several principles which have evolved from the work of the Coalition over the past several years. They were specifically reasserted via consensus at the planning meeting for the national work session, and met with wide acceptance at the Coalition's national work session in Austin, Texas in June, 1993. They are meant to be at once simple and robust and to provide a common platform from which advocates with different interests can join together to influence public policy.

Principle 1: Anyone who is in a prison and who has a serious mental illness or is experiencing a mental health crisis shall receive assessment, treatment planning, treatment, and exploration of all appropriate discharge planning services upon transfer or release.

Since its inception, the Coalition has consistently advocated for the principle that incarceration can never be an excuse for withdrawing essential mental health services. Despite the Coalition's strong advocacy of diversion programs aimed at removing many persons with mental illness from prisons, we believe that it is equally important to avoid abandoning those prisoners with mental illness who for a variety of reasons remain in prison. Aside from the Constitutional duty to provide mental health care in prison, we have elsewhere (Cohen and Dvoskin, 1992) asserted three additional reasons for such a policy:

1. to make the prison a safer place for all who live, work or visit there;

2. to reduce the unnecessary extremes of human suffering; and

3. to reduce the disabling effects of mental illness so that inmates can more fully participate in correctional rehabilitative programming.

To this list the Coalition has added a fourth reason to provide mental health services in prison:

4. to guarantee discharge planning so that mental health treatment continues after transfer or release.

Principle 2: While the models for treatment responsibility, organization and funding will vary from state to state, it is, nevertheless, essential that Departments of Mental Health and Corrections within each state share the responsibility for ensuring that adequate mental health services are planned, delivered, and monitored.

Some state have opted to provide mental health services to inmates exclusively by the Department of Corrections, while many other states have opted to provide all or part of such services by the Department of Mental health. Frankly, the Coalition has relatively little interest in which model is selected. What is crucial is an acceptance by both agencies of their fundamental responsibility to this group of people. Clearly, the Department of Corrections has a Constitutional duty to ensure that such services are available, though it need not be the actual service provider.

OVERVIEW OF THE MONOGRAPH

The rest of the monograph consists of six review chapters and a final chapter that presents recommendations for action. The six review chapters actually contain three different types of works. The first two provide an overview of prison inmates with mental disorders and the variety of issues that impinge upon their care and the provision of mental health services to meet their needs.

The next three chapters reflect the flow of the offender as he or she is: (1) screened and assessed; (2) provided with treatment during incarceration; and (3) transitioned back into the community. The last of the review chapters focuses on a particular sub-group of offenders with mental illness, those who are also substance abusers.

The authors of the six review chapters were given two general tasks. First, they were asked to systematically identify, review, and integrate the body of data and research findings related to their particular topic and to summarize what is known. Second, the authors were also requested to highlight what is not known, but is badly needed in order to better respond to the mental health needs of this population. Thus, each of these chapters represents a state-of-the-art review of our current knowledge of the needs of offenders with mental illness and the services and systems that attempt to meet their needs, and a road map for what else we need to learn and do.

The first of these chapters, by Ron Jemelka, Susan Rahman and Eric Trupin, provides an overview of some of the basic issues surrounding the provision of services to prison inmates with mental illness. The chapter begins with a review and analysis of the various studies and surveys that have attempted to assess the prevalence of mental disorders among the prison population. Based on their review of these works, they offer a best estimate as to the percentage of the prison population that is experiencing a major mental disorder and, therefore, in need of psychiatric services. Next, the authors provide a description of the current context of prisons with a primary emphasis on the components that constitute correctional mental health services. The final major area addressed focuses on the critical issue of the organization and administration of mental health services within prisons which must meet the dual needs of security and treatment posed by this population.

The aim of Chapter 3 is the same as the preceding one - to provide an overview and context. This chapter, however, focuses on the legal framework within which mental health issues are raised and mental health services are provided to prison inmates. The chapter, authored by Fred Cohen, starts with a very important and interesting discussion of the prisoner's legal identity. In the next several sections, the legal decisions regarding the right of prisoners to mental health care are examined in detail. The limits of these mandated rights and the importance and interpretation of the key concepts of "serious medical needs" and "deliberate indifference" are presented. The other side of this issue, the rights of prisoners to refuse treatment and medication, is examined next. The final major topic in this chapter relates to some of the organizational issues raised in the preceding chapter. Since a prisoner with mental illness may be served in a variety of mental health and correctional settings, what legal concerns and rights surround the transfer of prisoners.

Chapter 4 is the first of three chapters to deal with the issues and questions that confront this population as they move from being identified to receiving treatment while incarcerated to discharge and community reintegration. As documented in these chapters, there are gaps and needs surrounding each of these three stages as well as problems with the linkages and relationships across them. James Ogloff, Ronald Roesch and Stephen Hart review current screening and assessment models and specific methods for identifying mental health issues among prison inmates. This review follows a critical discussion by the authors about the nature and purposes of mental health screenings and evaluations in prisons. The chapter also includes a proposed model based on principles that stress the importance of providing all inmates with brief, effective mental health screening and linking assessment with treatment programming.

Marnie Rice and Grant Harris in Chapter 5 recognize that mental illness presents significant problems for the staff and other inmates in a system typically not equipped to deal with it. Within this context, they offer an approach that emphasizes the importance of focussing on symptoms and behaviors rather than diagnosis and on psychosocial rather than more traditional treatment modalities. Their review of the key issues and research findings are supplemented in their chapter by examples of successful treatment programs based on behavioral principles. The chapter also deals with some critical administrative issues, such as staffing, that are intertwined with treatment. In addition, it assesses whether special treatment procedures are required for specific sub-categories of offenders with mental disorders such as inmates with HIV.

Increasingly, professionals and researchers concerned with mental illness in prison are recognizing the transitional period between incarceration and reintegration into the community as one of the most critical areas for future research and program development. Chapter 6 by Todd Clear, James Byrne and Joel Dvoskin helps us to understand why by: (1) describing some of the recent changes in sentencing strategies, parole release policies and community supervision practices and (2) discussing the fundamental problems and conflicts affecting community supervision of mentally ill ex-offenders. The chapter, then, provides some practical suggestions for implementing and improving mental health services to ex-offenders in the community. These suggestions are framed within the context of core planning principles.

The last review chapter, Chapter 7 by Roger Peters and Holly Hills, focuses on a specific group of offenders - inmates with co-occurring mental health and substance abuse disorders. Because of the extremely high prevalence of a history of substance abuse among inmates, the co-occurrence of mental illness and substance abuse disorders in a significant proportion of offenders, and the problems and challenges surrounding their treatment, it was decided to devote a separate chapter to this population. The chapter mirrors for this sub-group most of the topics found in the earlier chapters. There is a review of prevalence studies, a discussion of the legal context of their treatment, a description of screening methods and assessment approaches, an analysis of treatment approaches, examples of specialized program models and a call for more effective linkages to aftercare treatment and community-based services. As such, it represents probably the most comprehensive compendium of information available on this dually diagnosed group of inmates.

All of the preceding chapters served as starting points for the development of the final chapter. As described by Deborah Dennis, the National Coalition sponsored a three-day National Work Session in June, 1993. The work session included experts from across the country. The attendees were asked to review the findings and information contained in earlier drafts of the prior chapters, identify key issues facing offenders with mental illness in prisons and the systems responsible for them, and, as a group, recommend a series of specific actions and strategies for more effectively responding to their needs. The final chapter represents a summary of the results of this three-day deliberation. Recommendations from the small work groups that were established to parallel the main topics of the monograph such as legal issues and assessment are provided. In addition, this final chapter presents suggestions made in an attempt to establish an overall action plan for improving the care of persons with severe mental illness in U.S. prisons.

COMMON THEMES

A major strength of the monograph is its diversity: different authors with different perspectives focussing on different topics. At the same time, one cannot avoid noticing certain common themes that are repeated over and over again across the chapters, frequently signifying both the consistency and criticalness of certain issues. These common themes include the following:

- Greater emphasis must be placed on clearly defining the targeted population and, then, establishing effective screening procedures for identifying those who need services.

- While there is significant variation across issues, in all cases there is a great need for further research.

- At the same time, as suggested in these chapters, there is enough information to at least begin re-orienting services and policies to conform with what we know works.

- Although research can provide guidance and legal decisions a framework, much of what may be desirable in treating offenders with mental illness requires strong advocacy by groups such as the National Coalition.

- There is a great need for increasing the coordination of agencies in all stages of the care and treatment of this population.

- The current programs and procedures for ensuing a successful transition back into the community and access to needed community-based services are totally inadequate and must become a priority.

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CHAPTER 2

PRISON MENTAL HEALTH: AN OVERVIEW

Ron P. Jemelka
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The United States has the highest incarceration rate in the world, with 420 prisoners per 100,000 population. The number of incarcerated persons has increased dramatically in the past five years, from 591,000 in 1987 to over 1 million (Mauer, 1991). Latest estimates indicate that the total cost of incarcerating the more than one million Americans in prisons and jails is now at least 16 billion dollars a year (Bureau of Justice Statistics, 1990). Incarceration costs range from $20,000 to over $60,000 per inmate per year, depending on the extent of specialized services offered (Mauer, 1991). Despite a national expenditure of 4 billion dollars for prison construction by the end of the 1980's, the increase in prison populations has prompted an even greater shortage of prison beds, so that projected space has been overfilled even before its construction (Mauer, 1991).

Criminal justice policy changes including mandatory sentencing laws for certain offenses, as now established in 46 states, and more stringent drug laws are expected to result in a 119% increase in the federal prison population from 1987 to 1997 (United States Sentencing Commission, 1987). There is evidence that the increased number of incarcerated is more a consequence of criminal justice policy rather than a direct result of rising crime. As an outcome of criminal justice policy, there is a greater proportion of offenders being sentenced to prison than 10 years ago. Amidst these burgeoning numbers, special concern has been voiced about the health needs of these inmates. In this chapter and this monograph, we are focusing on one especially underserved area of health services, mental health services.

EPIDEMIOLOGICAL STUDIES OF MENTAL DISORDER IN PRISONS

"Mentally ill offender" is a frequently used term. Despite this, there is little consensus as to its definition. A national survey of state and federal mental health and corrections facilities regarding offenders detained in 1978 found that 20,143 (6.6 percent of the total) were designated as mentally ill offenders. Of these, 8 percent were categorized as not guilty by reason of insanity, 32 percent were detained as incompetent to stand trial, 6 percent were mentally disordered sex offenders, and 54 percent were convicted prisoners who had been admitted to mental health facilities (Monahan & Steadman, 1983). Those found NGRI or IST were more likely to have been treated in a state hospital forensic unit and have been well studied, as have

sex offenders. Prisoners with mental disorders are the least understood and researched of these subgroups of mentally ill offenders despite the relatively large size of this group (Jemelka, Trupin & Chiles, 1989). Little is known about their diagnoses, their levels of functional disability, the duration and course of their illness, or the current prevalence of mental disorders in prisons. However, in the decade since the Monahan and Steadman article, some significant work has been done in these areas.

Some earlier studies of the prevalence of mental disorder in prisons have utilized a field survey approach in which key administrators in each prison system are asked to respond to a series of questions about inmates with mental disorders in their facilities. These surveys have found that 6 to 8 percent of state prison populations have a serious psychiatric illness (Steadman, Monahan, & Hartstone, 1982; McCarthy, 1985), while 15 to 20 percent of all prison inmates need psychiatric treatment at some point in their incarceration (Monahan & Steadman, 1984; Halleck, 1986). These data suggest that the rate of mental disorder among prison populations does not differ greatly from that found in groups of comparable social class in the community.

However, the methodologies utilized in these surveys of key informants have a number of flaws, including: a lack of clear criteria and definitions provided to respondents; variations in the way prisoners are classified, diagnosed, and tested in different prisons; and less formal designation of offenders as mentally ill in some jurisdictions. For these reasons, surveys of correctional administrators as key informants are likely to substantially underestimate the number of mentally ill offenders (Halleck, 1986). A recent review found that estimates of the number of inmates with mental disorders reported by prison administrators ranged from 0.1 percent to 22 percent. Such data support the conclusion that "most correctional systems do not have systems-level data necessary to support intelligent and informed planning" (Monahan & Steadman, 1984; McCarthy, 1985).

As an alternative to these surveys, several studies of the prevalence of mental illness in prisons have attempted to assess directly the mental status of individual prisoners. These studies have found higher rates of mental disorder, and have been able to provide better estimates of the number of individuals in more specific diagnostic subgroups. Steadman, Fabisiak, Dvoskin, et al. (1987) had counselors and mental health professionals complete a variety of rating scales on 3,332 prisoners. Eight percent were found to have severe psychiatric and functional disabilities requiring mental health service. An additional 16 percent had significant psychiatric and functional disabilities requiring periodic services.

James et al. (1980), using psychological test scores and psychiatric ratings, found that 10 percent of the inmates in one state prison were "in need of medication" and that 35 percent needed "a level of treatment above a minimum amount of crisis intervention for minor emotional problems." Thirty-five percent were diagnosed as having a personality disorder, 25 percent had a primary diagnosis of substance abuse, and 5 percent were schizophrenic (the authors did not indicate the diagnostic criteria used). Two percent were judged to need inpatient care, 5 percent needed day care, 29 percent needed outpatient care, and 31 percent needed short term crisis

intervention. They concluded that two-thirds of the prison population are in need of some form of psychiatric care.

Surveys of facility administrators suggest that 6 to 8 percent of adjudicated felons are currently being designated as seriously mentally ill. Clinical studies, however, suggest that 10 to 15 percent of prison populations have a major DSM- III-R thought disorder or mood disorder and need the services usually associated with severe or chronic mental illness: medications, day treatment, case management and specialized housing. In addition, one-third to one-half of the population are likely to need outpatient mental health services during their incarceration (James et. al 1980; Neighbors, 1987).

Wide differences in the methodology and results of existing studies have yielded conclusions of marginal utility for mental health planning or research. There have been a series of studies which have attempted to determine the prevalence of psychiatric disorder in state prison populations using a Diagnostic Interview Schedule (DIS), a standardized, widely accepted diagnostic research tool. Utilization of this methodology yields point prevalence for specific disorders. Studies utilizing this approach were reviewed from Washington, California, Ohio, and Alberta, Canada. In addition, Pallone (1991) derived point prevalence for specific disorders utilizing Megargee and Bohn's original MMPI research on a cohort of prisoners at the Federal Correctional Institution in Tallahassee, Florida. The results of these epidemiological studies are summarized in Table 1.

One study administered the DIS to 109 offenders (Jemelka, Wiegand, Walker & Trupin, 1992). The authors found prevalence rates of 4.4% for schizophrenia, 10% for depression, and 3.7% for mania. Cotten et al. (1989) found similar rates for California using the same methodology, as did Neighbors (1987) in Michigan, and Bland et al. (1990) in Alberta, Canada. Using the Structured Clinical Interview for DSM-III-R disorders, a modified form of the DIS for use by clinicians, Bean et al. (1988) found similar rates in Ohio. These prison prevalence rates are contrasted with those derived for the general population in the Epidemiological Catchment Area (ECA) studies conducted by the National Institute of Mental Health (Regier, 1988) in Table 1.

As can be seen from examination of the Table, prison prevalence rates for schizophrenia range from 1.5% to 4.4% (2.5 to 7.3 times the rate in the general population). Rates of 3.5% to 11.4% are reported for major depression (as high as 3.3 times the rate in the general population) and 0.7% to 3.9% for mania (2.3 to 13 times the rate in the general population. For these three major DSM-III- R disorders, it is clear that the best methodological studies suggest that at any given time 10 to 15% of state prison populations are suffering from a major mental disorder and are in need of the kinds of psychiatric services associated with these illnesses.

TABLE 1

Prevalence Rates for Specific DSM-III-R Disorders (Males Only)

Diagnosis	Correctional Populations					General Population
	WA n=109	CA n=413	OH[a] n=464	MI n=1,287	Alberta Canada n=180	Five ECA Sites n=7,618
Schizophrenia	4.4	3.1	1.5	2.9	2.2	0.6
Schizopreniform Disorder	1.9	0.3	0.2	---	---	0.1
Depression	10.0	3.5	6.7	11.4	3.9	3.5
Dysthymia	4.6	---	---	---	---	2.2
Mania	3.7	0.7	1.0	3.9	3.3	0.3
Antisocial Personality	44.0	---	---	50.9	7.8	0.8
Alcohol Abuse / Dependency	66.0	---	---	47.3	6.6	5.0
Drug Abuse / Dependency	61.0	---	---	---	24.4	1.8

[a] - Used the Structured Clinical Interview for DSM-III-R Disorders (SCID) rather than the DIS. the SCID is a DIS modified for use by trained clinicians.

THE CURRENT CONTEXT OF PRISONS

The problems and prospects for caring for inmates with mental illness within prisons must be approached with an understanding of the present context of corrections. Current funding shortfalls in the mental health system are well documented. Similar budgetary problems are being experienced in the corrections field but are less widely discussed. In addition to funding concerns and burgeoning populations, legal opinions have greatly influenced correctional administration in state and federal prison systems. As of 1987, there were 38 state prison systems operating under court orders or consent decrees (Stewart, 1987). As discussed in Chapter 3, in 1976, *Estelle v. Gamble* established a right to treatment for physical ailments for prisoners. One year later, *Bowring v. Godwin* (1977) asserted that there were no differences in the need for treatment of physical ills and the symptoms of serious mental illness (Cohen & Dvoskin, 1992). In 1980, in *Vitek v. Jones*, the court established procedural safeguards for the transfer of prisoners to facilities for the treatment of mental disorders so that movement of prisoners for mental health treatment would be subject to an administrative hearing similar to that for civil commitment. Also in 1980, *Ruiz v. Estelle*, a landmark case in general prison reform and in mental health care, established six basic components for a "minimally adequate mental health treatment program" for the Texas Department of Corrections.

These court decisions have led to a right-to-treatment posture by correctional administrators, who wish to avoid litigation but must convince reluctant state legislatures of the need for providing mental health care to mentally ill offenders. This is a difficult task because of the lack of sympathetic public sentiment for mentally ill offenders. There is little public or political support for rehabilitation of criminals, and some view mental illness as a volitional disorder, perhaps a deliberate attempt to avoid punishment (Perr, 1985, Johnson, 1985).

Advocacy for mentally ill offenders is just beginning to be organized, and often the only advocates for this group are corrections employees who provide correctional and mental health services for them. Persons with mental illness in prisons are almost entirely dependent on the courts for legal protection of constitutional rights to treatment and humane care, and on the ethicality and diligence of the correctional system charged with their care (Jemelka et al., 1989).

The Basic Components of Correctional Mental Health Services

There are a number of key elements that comprise the system of mental health services for corrections. They include the following:

A. Screening and Evaluation

APA guidelines define screening and evaluation in the following way:

a. Definitions

1. Receiving mental health screening consists of observation and structured inquiry designed to prevent newly arrived inmates, who may be acutely or chronically mentally ill, from being admitted to the facility's general population and to refer these inmates rapidly for a more full scale mental health evaluation.

2. Intake mental health screening is a component of the full scale admission workup and consists of a detailed medical and mental health examination.

3. Mental health evaluation is a comprehensive mental health examination which is appropriate to the particular, suspected level of disability and which is focused on the suspected mental illness or developmental disability.

B. Crisis intervention

There is a need to provide services on a short-term basis (up to 72 hours) in response to a psychiatric crisis in which an offender presents a serious risk of harm to self or others. Examples are suicide attempts, psychotic episodes, and other life threatening behaviors resulting from personal distress or mental illness. Responses to these incidents may include immediate and/or ongoing intervention by a mental health professional, segregation from the general population, special observation precautions, medications, and, if necessary to protect the offender, restraint. If emergency mental health care is required for more than 72 hours, the offender should be considered for a more thorough evaluation or for reassessment of the existing treatment plan.

C. Outpatient care

Some offenders may benefit from counseling, including routine assessment, individual and group therapy, psychoeducational programs, and medication management. These services may be provided to offenders who reside in the general population, as well as mentally ill offenders living in designated mental health service units. Outpatient services to general population offenders without major mental disorders should be limited so as to preserve these resources for the most seriously ill.

D. Day treatment

Mentally ill offenders need a structure for the delivery of specific rehabilitative activities in a group setting in a designated treatment area. This modality often follows an established curriculum which may include life skills training, psychoeducation, employment readiness or pre-vocational training, avocational skills training, and recreational activities. Day treatment services may be delivered over an extended period of time, usually from 2-4 hours per day. Day treatment services should be provided by a mental health professional or by staff clinically supervised by a mental health professional.

E. Special housing for inmates with mental disorders

Segregated housing in conjunction with mental health services is essential for the most severely disturbed prison inmates. Many of these offenders are too disruptive for general population placements and can better benefit from treatment services if segregated from the general prison environment. The prison environment and culture does not always support mental

health treatment and rehabilitation goals. Services provided should include routine assessment, case management, group therapy, psychoeducation, medication management, and day treatment activities. Residential care should be provided only to offenders who have been evaluated as acutely or chronically mentally ill, or seriously disturbed. The offenders level of functioning and diagnosis should constitute the criteria by which such placement decisions are made.

F. Case management

Mentally ill offenders are best managed by an identified mental health case manager who is responsible for activating and monitoring a continuum of treatment and classification services to a caseload of mentally ill offenders. The purpose of this approach is to monitor each offender's individualized mental health treatment plan, and to regularly evaluate the adequacy and appropriateness of the plan, making modifications where necessary. Effective case management will ensure consistency of service delivery, and will monitor mentally ill offenders' progress, including changes in levels of functioning and treatment needs.

The individualized service plan provides the case manager with a detailed account of the offender's programmatic needs. Specialized information system reports can assist the case manager in conducting ongoing evaluations of an offender's psychiatric diagnosis and medication, the appropriateness of custodial and housing assignments.

G. Mental health tracking

A system designed to ensure adequate information and accountability is critical in the delivery of mental health services. This system makes available pertinent information about mentally ill offenders to those with case management and mental health system coordination responsibilities within prisons on a timely, regular basis.

H. Transitional care and community reintegration

The primary goal of this service is to assist mentally ill offenders in adjusting from more restrictive environments to less restrictive environments such as the general population in an institution, minimum security facilities including camps and work release settings, and, ultimately, the community.

Transitional care emphasizes self reliance with less frequent and less intensive supervision. Areas stressed include independent living skills, self monitoring of medications, and recognition of medication side effects. These elements are included in revised treatment plans as offenders approach transfer to less restrictive institutional placements, work release settings, or to unsupervised release. The long term goal is to assist the offender in making the transition from an institutional to a community-based setting. As the offender nears release, case management will include liaison services with community-based mental health and financial support agencies to arrange a suitable community support plan for discharging offenders.

Efforts should be made to provide mentally disordered offenders with the same level of mental health care as is available to other persons with mental illness in the community. An individualized community support plan which juxtaposes the individual's strengths, weaknesses, and treatment needs with available resources is a necessary step in the process of integrating the mentally disordered offender back into the community. Case management, day treatment, and medication review are just as necessary. Housing alternatives, such as halfway houses, fairweather lodges, and supervised board-and-care homes are potentially as beneficial to this population of persons with mental illness.

CURRENT PRACTICE IN PROVIDING SERVICES TO PRISONERS WITH MENTAL ILLNESS

The Center for Mental Health Services has recently reported the results of the first national survey of mental health services provided in adult state correctional facilities (Morrisey, Swanson, Goldstrom, Rudolph, & Manderscheid, 1993; Swanson, Morrisey, Goldstrom, Rudolph, & Mandersheid, 1993a; and Swanson, Morrisey, Goldstrom, Rudolph, & Manderscheid, 1993b). These data, collected in 1988, provide a national overview of current practice in providing mental health services to correctional populations. Their results are summarized below.

Rates of treatment for twenty-four hour inpatient hospital care are highest for younger (those under the age of 18) and older (those over the age of 65) offenders, for females and for whites. Blacks appear to be under-represented in the population receiving inpatient care. For inpatient care, the primary diagnosis was a major psychotic disorder. However for residential care (as opposed to twenty- four hour inpatient care) a "comparatively small proportion...had major psychotic disorders and a comparatively large proportion had substance abuse and mental retardation diagnoses" (Swanson, et al. 1993b). Personality disorders were most commonly treated by counseling/therapy services. Numerous caveats apply to interpreting the data from this study.

Before proceeding, it is important to note limitations to the CMHS data. There was wide variation in the numbers reported from state to state, and in the numbers reported by different administrative auspices (whether services were provided by the state corrections department, the state mental health department, or by some combination of the two). Also, there were differences in what numbers were actually reported by different administrative auspices, making it impossible to distill national rates-under-treatment for the entire inmate population or for specific demographic or diagnostic subgroups. Nonetheless, these are the first national data available on these issues and when interpreted cautiously, they still provide guidance on what services are needed to address this under-served group.

Type and Amounts of Services Provided

As one moves from more intensive (twenty-four hour hospital care) to less intensive (counseling) services, the state department of corrections is more likely to be the service provider. Across all states, about 25 per 1,000 offenders are receiving either inpatient or residential psychiatric care. During September, 1988, nearly 10 percent of state prison inmates received some form of counseling from a nurse, physician, psychologist or social worker. About 5 percent received medication evaluations and 4 percent received psychiatric or psychological evaluation.

For twenty-four hour hospital care, the mean length of stay (LOS) was 85.4 days and the median LOS was 38.3 days. The average LOS ranged across all states from 5.0 to 684.5 days. For residential care, the average LOS across states was 14 to 1,050 days, with a mean of 234 days and a median of 165.8 days. The average number of counseling sessions for offenders receiving this service was 79.8 sessions (median was 45 sessions) (Morrisey, et al. 1993). The wide variation between states and the effect of outlier for these service categories complicates the interpretation of these data.

ORGANIZATION OF CORRECTIONAL MENTAL HEALTH SERVICES

The organization and administration of prison mental health services is an area just beginning to receive attention in the professional literature and technical assistance units of federal agencies. The following quotes indicate the "state-of-the-art" in planning and organizing these services:

> "...while the debate has raged over the abolition of the insanity defense and the creation of the verdict of guilty but mentally ill, little or no attention has been paid in the professional literature to administration of the actual provision of mental health services in prisons or to the treatment of those found not guilty by reason of insanity ." (Dvoskin, 1989)

> "Much more has been written about the legal issues in providing psychiatric treatment in jails and prisons than has been written about the treatment itself." (Jemelka, et al., 1989)

> "The lack of data and, even, descriptive information on state programs and systems make it difficult for state administrators to plan and develop programs that are responsive to the fears and concerns of the public at large and, at the same time, meet the needs of the offender population for mental health services." (Davis, 1983)

In general, mentally disordered offenders are treated in one of four organizational patterns: (1) in a correctional setting where corrections provides both security and treatment;

(2) in a correctional setting where corrections provides security but a mental health agency provides treatment; (3) in a mental health setting where the mental health agency provides both security and treatment; or (4) in a mental health setting where corrections provides security and the mental health agency provides treatment.

Nelson and Berger (1988) identify the following different advantages to providing mental health services in prisons or in mental health facilities:

Advantages to providing treatment in correctional settings:

1. Due to their current priority for state funding and rapid growth, correctional departments are currently able to obtain adequate resources more easily than are most mental health programs.

2. Correctional departments feel "ownership" of their own service programs.

3. Correctional departments theoretically provide better security.

4. Patients do not require transfer to a separate agency and, therefore, they can receive a more consistent treatment approach with fewer barriers to continuity of care.

Advantages to providing treatment in mental health agencies:

1. The mental health agency is more likely to develop and maintain a therapeutic environment.

2. Recruitment of treatment staff is generally easier for a mental health agency.

3. Resources will most frequently be channeled to treatment rather than focusing purely on security.

Numerous articles in the literature point to the need to develop an approach to prison mental health services that will mesh with the social, political, and organizational idiosyncrasies of the local context. Looking at the relative advantages of each alternate organizational structure, it is evident that a joint venture might represent the "best of both worlds" in that the advantages of both correctional management and management by a mental health division would accrue.

Further, the additional advantages of being able to present a unified front and rationale for funding to the legislature and governor's office would help to ensure the joint purposes of public safety, and the provision of constitutionally adequate care for the citizens of the state. As pointed out by Nelson and Berger (1989), decisions about how to organize forensic services "should focus on the organizational structure that maximizes the likelihood that appropriate

security and appropriate types, amounts, and quality of treatment will be provided." The joint governance and operations model are consistent with this position.

Dvoskin (1989) points out that there are often an exaggeration of distinctions between mental health and correctional auspices for mental health services, which is unfair to correctional and police roles by suggesting they are incompatible with humane care. We strongly believe that correctional and mental health values and perspectives are not inherently incompatible and can occur side-by-side in many jurisdictions. Proceeding with this dual mission will help to actualize the resources needed if this difficult societal problem is to be addressed.

Some data on the actual organizational patterns used by states are available for the first time from the recent national survey discussed earlier. In their study, Morrisey, et al. (1993) report that for 12 states, the state department of corrections was exclusively responsible for the provision of twenty-four hour hospital mental health care. This arrangement applied in 27.7 percent of the country's prisons and covered 23.1 percent of the inmate population. In another 6 states, this service was provided primarily by the department of corrections, with some of this service provided by another state agency, usually the state department of mental health. This arrangement applied to 12.7 percent of state prisons and covered 8.1 percent of the inmate population. In 13 states, the state department of mental health provided twenty-four hour hospital mental health care exclusively (16.1 percent of state prisons, 8.3 percent of the inmate population). In another 6 states hospital care was provided primarily by the state department of mental health with some provision by the department of corrections or other state agency (15.5 percent of state prisons, 19.4 percent of inmates). Thirteen states reported mixed responsibility for twenty-four hour mental health care (28 percent of state prisons, 41 percent of the inmate population).

The most notable trend in these data was that in the smaller states departments of mental health were more involved in the provision of mental health care. Also, as stated earlier, the less intensive modes of treatment (residential care, day care, counseling, and evaluation) were more often under the auspices of the state department of corrections.

SUMMARY AND RECOMMENDATION

We strongly recommend that efforts be made to provide mentally ill offenders with the same level of mental health care available to persons with mental illness in other institutions and in the community.

Regarding the care of prisoners with mental illness, we recommended that:

1. Departments of Corrections must be able to meet the six criteria necessary for a "minimally adequate mental health treatment program", established in the *Ruiz v. Estelle* decision.

2. Departments of Corrections need to develop mental health plans which emphasize continuity of care and placement of MIOs in facilities with appropriate treatment and rehabilitation options.

3. An individualized treatment plan needs to be developed for each identified MIO which is sensitive to the treatment needs of the individual and can be implemented in the offender's assigned institution.

4. Prisons need to adopt a case management approach to manage the care of MIOs within their jurisdictions.

5. Prisons need the capability to "track" their inmates with mental illness to provide information for case management and system coordination.

6. Procedures should be in place and corrections staff trained to ensure that MIOs in prison are not "penalized" because of their mental illness in decisions affecting program eligibility and release.

Regarding the transition of MIOs from the prison back to the community:

1. Persons with mental illness leaving prison have the same needs for care as a patient leaving a state hospital, including case management, day treatment, medication services and housing.

2. Case management by a service provider in the receiving community should begin well in advance of the offender's release.

3. An individualized community support plan, which juxtaposes the individual's strengths, weaknesses and treatment needs with available resources, is a necessary document in reintegrating the MIO back into the community.

4. Some form of post-release supervision would be beneficial to many MIOs leaving corrections facilities and should be mandatory for some.

In their study of county jail incarcerates, Lamb and Grant (1982) observed that "the lives of a large proportion of these inmates are characterized by chaos, dysphoria, and deprivation as they try to survive in a world for which they are ill prepared" (p. 22). Until Departments of Corrections and Departments of Mental Health begin to play a larger role in joint discharge planning and graduated post-release supervision, until disposition and continuity of care provisions are made possible, and until community-based care providers become more accepting of this sub-population, little will change (Jemelka, Trupin & Chiles, 1989).

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CHAPTER 3

THE LEGAL CONTEXT FOR MENTAL HEALTH SERVICES

Fred Cohen

INTRODUCTION

In this chapter we review the legal framework within which persons in U.S. prisons may exert a claim to mental health services. Most of the important litigation in this area has occurred in the federal courts with the plaintiffs bringing suit under a federal (civil rights) statute, 42 USC Sec. 1983. This statute allows persons to sue for damages, injunctive or declaratory relief where the defendants are shown to be acting "under color of state law" and are alleged to have violated the claimants' constitutional rights.

While this chapter focuses on prison inmates, it is important to note at the outset that the constitutional principles governing medical and mental health care are the same for the unconvicted detainee in jail and the convicted in jail or prison. There is a difference in the constitutional source, and there are obvious differences in the characteristics of the population, length of stay, resources and the like. Nonetheless, all persons in penal confinement in the U.S. have some basic rights to medical and mental health care.

Since the Supreme Court's decision in *Estelle v. Gamble*, 429 U.S. 97 (1976), it is clear that prison inmates have a constitutional right to treatment. Treatment is mandated, however, only for serious medical and mental health needs and the standard for assessing the availability and quality of such care is the elusive concept of deliberate indifference.

In this chapter, I first will broadly describe the overall legal identity of inmates and detainees and then explore in some detail the meaning of "serious need" and "deliberate indifference." We shall see that constitutional norms are not very demanding and there often is quite a gulf between the required and the desired.

After exploring claims of a right to appropriate treatment, I then examine the right to refuse treatment, in particular, recent decisions involving psychotropic medication. I then explore important issues related to due process requirements for transfers to mental hospitals and conclude with a personal perspective on the role of law in this area as well as a potpourri of issues -- consent being one -- briefly touched upon.

PRISONER'S LEGAL IDENTITY

The legal claims of inmates to mental health services exist within the larger framework of what might be termed the inmate's legal identity. That identity derives importantly from the United States Constitution and decisions of the various federal courts -- the Supreme Court, in particular -- interpreting the Constitution.

While federal constitutional rights are the most basic rights possessed by any person in this country, rights and duties also exist by virtue of federal treaties, statutes, and administrative regulations. States, of course, each have their own constitutions, statutes, and administrative regulations.

State court systems are open to persons in state and local confinement. Each state, then, has a set of written laws and procedures, as well as a state judiciary, open to persons captive in those jurisdictions. Tort remedies for damages claimed to be suffered as a result of inadequate or improper medical or psychiatric care may be sought in the state courts. Inmates seeking such relief may, however, encounter legal hurdles in the form of sovereign immunity and practical problems in the form of hostile courts and juries, caps on awards, and difficulty in obtaining counsel.[1]

On the other hand, medical malpractice -- actually a form of negligence applied to professionals -- may suffice for recovery in state courts while much higher standards of culpability (e.g., "deliberate indifference") apply in the federal courts.

Having stated this, limitations of space and judgments as to significance dictate that this section focus on the constitutionally based legal identity of an inmate and the constitutional claims available to all inmates whether in state or federal confinement. This is not to denigrate the availability of state remedies or ignore the increasing importance of state law in this area. Indeed, a new federalism is emerging where more and more individuals seeking damages or even injunctive relief are turning to state tribunals.

The federal constitutional rights of concern to us are not based on citizenship. Rather, they flow from the status of being a person. The Fourteenth Amendment provides "...nor shall any State deprive any person of life, liberty, or property, without due process of law, nor deny to any person within its jurisdiction the equal protection of the laws."[2]

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[1] See S.H. Nahmod, *Civil Rights and Civil Liberties Litigation: The Law of Section 1983* (2d ed. 1983).

[2] While there are some references to citizenship in the Constitution, the Bill of Rights is essentially based on "personhood" and not citizenship.

Inmates and detainees, without doubt and without reservation, are persons within the meaning of relevant constitutional safeguards. Upon conviction, and even with mere accusation and confinement, certain legal rights are lost or diluted while certain other rights actually are gained by virtue of official custody. One of those rights gained is a right to treatment, a right not possessed by those who are not in confinement.

The Supreme Court has recognized that prisoners and detainees have a First Amendment right to free speech including: access to written material and mail; the right to some religious freedom; the right to marry; a right of access to the courts; some procedural due process rights, particularly in prison disciplinary proceedings involving more serious charges and involuntary transfer to a mental hospital for treatment; and the right to be free from cruel and unusual punishment.[3]

One might think that pre-trial detainees have far greater rights than persons convicted of crime and imprisoned. In *Bell v. Wolfish*, 441 U.S. 520 (1979) the Supreme Court held that many of the rights of detainees emanate from the Due Process Clause of the Fourteenth Amendment and, as a consequence, this means that detainees may not be punished at all. The Eighth Amendment applies after conviction and by its express terms prohibits cruel and unusual punishment. In so doing, the amendment allows punishment so long as it is not cruel and unusual.

As we shall see, detainees and prisoners have a right to limited medical and mental health care with the detainees' rights based on freedom from punishment as a matter of due process and the prisoners' rights based on freedom from cruel and unusual punishment. The common feature here is the right to freedom from needless suffering and gratuitous pain.

At the risk of overgeneralizing and possibly obscuring some fine points, the claims of detainees and prisoners -- especially to medical and mental health care -- are evaluated by the same legal principles, decided similarly where the fact patterns are the same, and they have essentially the same remedies available.[4]

The constitutional rights listed above may seem fairly impressive. However, the real issue is their content and the remedies available to enforce such rights. It seems fair to say that all of the rights noted earlier are diluted versions of what we enjoy, some thinner than others.

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[3] For an excellent collection of cases on point see S. Krantz and L.S. Branham, *The Law of Sentencing, Corrections and Prisoners' Rights, Part Two* (4th ed. 1991).

[4] Prisoners will sue the state and detainees will likely sue the county or the municipality. The state may be able to raise immunity under the Eleventh Amendment where a municipality may not and problems of short-term and long-term captives obviously are different. The basic point in the text, however, is that detainees and inmates have a very similar set of constitutional rights and detainees' claims of right will rarely be found to exceed prisoners'.

In *Turner v. Safley*, 482 U.S. 78 (1987) the Supreme Court held that the deprivation of First Amendment rights -- correspondence here -- and fundamental rights -- the right to marry -- are not subject to any more rigorous judicial scrutiny than any other rights of prisoners. The Court announced a reasonableness test for such deprivations, overturning many lower court decisions which had, in effect, held that there was a hierarchy of constitutional rights even for captives, that it should be more difficult for government to impair First Amendment rights, and other rights deemed fundamental.[5]

More recently, in *Wilson v. Seiter*, 111 S.Ct. 2321 (1991) the Court dealt with the question of what test applies under the Eighth Amendment when inmates challenge the general conditions of confinement. By general conditions we refer to overcrowding, excessive heat or cold, noise levels, ventilation, toilet facilities, the housing mix, exercise, and the like.

The Court determined that not only must the challenged conditions be inhumane and involve the unnecessary and wanton infliction of pain, the needless suffering must be inflicted with the mental state of deliberate indifference. Where previously prisoners had to prove only, let us say, that conditions were very bad, they must now also prove a culpable mental state -- deliberate indifference -- on the part of correctional officials. As we shall see, deliberate indifference is also the culpable mental state required to show a constitutional violation as to medical or mental health care.

To sum up this section, we have seen that prisoners are not wholly without rights, that rights possessed by free persons may have the same constitutional source but they invariably are more expansive. Without doubt, jails and prisons have legitimate security concerns and it is those concerns which so often influence courts to defer to the judgment of correctional officials. Whether courts are unduly responsive to claims of security is yet another matter.

Security aside, having custody of a person creates rights on behalf of the kept and obligations imposed on the keeper. Two of the clearest of those obligations are:

1. To keep and hold safely, to provide a non-life threatening environment, and

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[5] The *Turner* reasonableness test includes the following questions:

1) Is there a rational connection between the regulation and a legitimate governmental interest. (The tougher test required an important governmental interest and the least depriving means for achieving it).
2) Are there alternate means still open to the inmate? (Can he or she still pray alone while being deprived of congregate worship, for example).
3) What would be the possible impact on staff or other inmates if the claim is accommodated?

As a general proposition, this test makes it far more difficult for inmates to win claims involving such religious issues as special diets, hair style, special type of worship (e.g., sweat lodges), as well as broader claims to correspondence and access to reading material.

2. To provide medical and mental health care to prevent needless suffering, avoidable deterioration, even death.

A captive is just that: unable to obtain life saving or life preserving care; unable to obtain relief from physical or mental suffering. That obligation falls to the captor and, regardless of the reason, the place, or duration of custody, and regardless of the cause of a medical or psychiatric condition, appropriate care for serious disorders is constitutionally mandated.

THE DIMENSIONS OF MANDATED CARE: THE DISEASE MODEL

It is sometimes difficult for persons outside a particular profession or discipline to grasp the meaning of language used by insiders. Not understanding a term unique to a profession is one type of problem; not understanding how a relatively common term has a special -- or term of art -- meaning and use is quite another problem. For us, such problems relate to the words "deliberate," "indifference" -- which when joined seem oxymoronic -- and "serious."

In *Estelle v. Gamble*, 429 U.S. 97 (1976), the Supreme Court, for the first time, held that the Eighth Amendment's proscription of cruel and unusual punishment established the government's obligation to provide medical care for those it convicts and incarcerates. "We therefore conclude that deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain' proscribed by the Eighth Amendment." The essential mandate for a legally mandated system of medical and mental health care is contained within this relatively briefly sentence.

"Serious medical needs" clearly is the threshold requirement and it is here that we first encounter terminological and conceptual confusion. Deliberate indifference, which will be discussed in some detail in the next section, is a legal term and, indeed, this is the first case in which the Supreme Court ever used the term. In Estelle, the Court indicated that deliberate indifference was not the same as negligence or malpractice, that it bespoke more than inadvertence or inattention.

The Supreme Court has not expressly extended the mandate of medical care to mental health care but every court which has spoken to the issue has equated the two. Thus, we turn now to the dimensions of mandated care and ask: what is a serious mental health need (or a serious mental illness) and by what criteria do the courts decide?

The most common judicial approach to answering these questions is known as the "obvious to a layman" test. Medical and mental health cases tend to borrow from each other here and the decisions from one area are used to resolve issues in the other.

Thus, in a case concerned with claims of physical injuries allegedly inflicted by police, the First Circuit Court of Appeals stated:

> A medical need is "serious" if it is one that has been diagnosed by a physician as mandating treatment, or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention.... The "seriousness" of an inmate's needs may also be determined by reference to the effect of the delay of treatment.[6]

This definition is flawed in that doctors regularly diagnose minor ailments and prescribe minimal care; doctors disagree about diagnoses all the time, and this seems especially true with mental disorders; and, finally, the court does not even mention a key ingredient from Estelle -- needless pain.

A more recent federal court decision spoke to "serious medical need" as follows:

> A "serious medical need" exists if the failure to treat a prisoner's condition could result in further significant injury or the "unnecessary and wanton infliction of pain".... Either result is not the type of "routine discomfort [that] is part of the penalty that criminal offenders pay for their offenses against society".... The existence of an injury that a doctor or patient would find important and worthy of comment or treatment, the presence of a medical condition that significantly affects an individual's daily activities, or the existence of chronic and substantial pain are examples of indications that a prisoner has a "serious" need for medical treatment.[7]

This description of "serious" by the Ninth Circuit, while flawed, is more detailed and a bit more useful than the more standard "obviousness" test adopted by the First Circuit and many other federal courts.

The word serious, of course, is an adjective and in our context it modifies "medical needs," consistently interpreted, as stated earlier, to include mental health needs. We are led, then, to ask what conditions, or diagnostic categories if you prefer, are encompassed by medical or mental health needs?

More particularly, do the courts include alcoholics? Drug addicts? Sexual psychopaths? At the risk of both oversimplifying the problem and surprising the reader, the answer is no.

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[6] *Gaudrealt v. Municipality of Salem, Mass.*, 923 F.2d 203, 208 (1st Cir. 1988).

[7] *McGukin v. Smith*, 974 F.2d 1050, 1059-60 (9th Cir. 1992).

As a general proposition, what is or is not a disease appears to vary with who asks the question, where, and for what purpose.[8] For example, it is clear that a doctor may choose to treat alcoholism or drug addiction while just as plainly these conditions may be included or excluded from insurance coverage. Sex offenders (or psychopaths) may be given individual or group treatment but the term sexual psychopath is discredited as a diagnostic tool and the term sex offender is virtually meaningless as even a short-hand for one who requires care.[9]

What is or is not a disease seems to vary over time. For example, with overly active children the diagnosis of hyperkinesis has surfaced and is used both as an explanation and as the rationale for prescribing the drug Ritalin as appropriate treatment. A drug, then, replaces the woodshed. On the other hand, homosexuality is formally no longer an illness following a vote by the American Psychiatric Association.[10]

In truth, there simply is no real definitional clarity on what is or is not a serious disorder for the purposes of mandated medical or mental health care. What poses as definitions tends to be descriptions. Whether or not something is an illness and, if so, serious will likely be the subject of a battle of expert witnesses; and the battle may actually be waged over whether the condition is a mental disease or not while the words employed may refer only to seriousness. In addition to the question of mental illness v. "mere conditions," there are conflicting views on whether certain dysfunctional states qualify as a mental disorder. This is so, for example, on whether a dysthymic disorder, or transsexualism, is a mental disorder.[11]

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[8] In my book, F.Cohen, *The Law of Deprivation of Liberty* 150-253 (1990), I present material from law, medicine, sociology, anthropology, and history on the disease concept. The material in this section is drawn from those sources. Peter D. Kramer in the bestselling Listening to Prozac (Viking, 1993) notes that scientists rely on medication response to infer the cause of disease or even if a disease exists. Thus, disease may be a conclusion arrived at after cure.

[9] Alcoholics and drug addicts may, indeed, suffer life threatening illnesses from an overdose or from withdrawal. These clearly are serious medical problems requiring appropriate care. It is the *condition* of alcoholism or addiction which is exempted from mandatory care and not life-threatening sequela from, say, overdosing or withdrawal.

[10] There is a particularly valuable collection of essays on point in *Dominant Issues in Medical Sociology* (Howard D. Schwartz, ed., 2d ed., 1987).

[11] See *Farmer v. Carlson*, 685 F. Supp. 1335, 1339 (M.D. Pa. 1988), where the argument was over estrogen treatment demanded by the inmate or the psychotherapy prescribed by the prison physicians. See also *Phillips v. Michigan Department of Corrections*, 731 F. Supp. 792, 800 (W.D. Mich. 1990), holding that transsexualism is a serious medical disorder regardless of cause and *White v. Farrier*, 849 F.2d 322, 325-27 (8th Cir. 1988) also finding transsexualism "serious."

If the condition is accepted as a mental disorder, the seriousness question then arises. Thereafter, the battle is raged over the modalities of treatment.

While the opinion of experts, now clearly validated by the Court in *Youngberg v. Romeo*,[12] is perhaps the single most important factor in the "serious/disease" decision, a few generalities may be distilled from the caselaw:

1. The diagnostic test is one of medical or psychiatric necessity.

2. Minor aches, pains, or distress will not establish such necessity.

3. A desire to achieve rehabilitation from alcohol or drug abuse, to lose weight to simply look or feel better, will not suffice.

4. A diagnosis based on professional judgment and resting on some acceptable diagnostic tool, e.g., DSM-III(R), is presumptively valid.[13]

5. By the same token, a decision by a mental health professional that mental illness is not present also is presumptively valid.

6. While "mere depression" or behavioral and emotional problems alone do not qualify as serious mental illness, acute depression, paranoid schizophrenia, "nervous collapse," and suicidal tendencies do qualify.[14]

With regard to the sixth point above, it is actually the clinicians' choice of the diagnostic terminology which will move these cases from no care to discretionary care or to mandated care.

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[12] 457 U.S. 307 (1982). The Court referred to the exercise of professional judgment by health care professionals as presumptively validating choices as to the "training" mandated for the institutionalized retarded.

[13] The following conditions have been held to be "serious": a broken arm (*Lee v. Armistead*, 582 F.2d 1291, 1296 (4th Cir. 1978)); a broken nose (*Smith-Bey v. Hospital Adm'r*, 841 F. 2d 751, 759-60 (7th Cir. 1988)); transsexualism (*White v. Farrier*, 849 F.2d 322, 325, 327 (8th Cir. 1988)); a hernia (*East v. Lemos*, 768 F.2d 1000, 1001 (8th Cir. 1985)); asthma coupled with allergy (*McDaniels v. Rhoades*, 512 F. Supp. 117, 120 (S.D. Ohio 1981). The following conditions were held not to be "serious": two infected toes along with filthy feet which the inmate refused to wash (*Andres v. Glenn*, 768 F. Supp. 668 (C.D. Ill. 1991)); denial of reading glasses for ten days and hair loss (*Harris v. Murray*, 758 F. Supp. 1114 (E.D. Va. 1991)); irritation due to shaving (*Shabazz v. Barnauskas*, 790 F.2d 1536, 1538 (11th Cir.) *cert. denied*, 479 U.S. 1011 (1986)); desire to lose weight (*Shaw v. Jones*, 81 N.C. App. 486, 588, 344 S.E.2d 321, 323 (1986)); desire for outdoor exercise (*Jones v. Diamond*, 594 F.2d 997, 1012 (5th Cir. 1979)); need for eyeglasses for minor visual problem (*Borrelli v. Askey*, 582 F. Supp. 512, 513 (E.D. Pa. 1), *aff'd*, 751 F.2d 375 (3d Cir. 1984)).

[14] See F. Cohen, *Legal Issues and the Mentally Disordered Prisoner* 59-60 (N.I.C., 2d ed., 1988).

A medical or mental health specialist who may wish to obtain care for an individual need only label the individual as schizophrenic with underlying alcoholism. In other words, the availability of primary and secondary diagnosis is a handy tool for obtaining or denying mental health services. A diagnosis in a custodial setting is likely to say as much about the availability of resources, security concerns, and a judgment about the captive's possible pursuit of secondary gain as about an objective diagnosis based on signs and symptoms. Even the cold look of epidemiological data may be significantly influenced by the availability of solutions. That is, the number of detainees or inmates identified as seriously mentally ill may well be responsive to the space and personnel available to deal with them as opposed to clinically sound assessments.

In accepting or rejecting various diagnostic categories, courts are strongly influenced by accounts of the inmate's behavior. For example, in a Massachusetts prison suicide case, a federal appeals court held that "the record contains sufficient evidence that Torraco had a serious mental health need."[15] In support of this conclusion, the court referred to an earlier suicide attempt while in confinement, assault on a prison official later attributed to impaired mental health, and overdosing on T.H.C. pills somewhat later.[16] Thus, clinical diagnosis supported by incidents supportive of those judgments are likely to be at the core in determining serious disorders.

If a detainee or an inmate remains labelled only, or primarily, as an alcoholic, drug addict or abuser, or as a sexual psychopath, then any claims to treatment are viewed legally as claims to rehabilitation. That is, serious illnesses or diseases require treatment while the above conditions (at times referred to as statuses) are dealt with as calling for rehabilitation.[17] In turn, the courts have consistently held that there is no constitutional right to rehabilitation.[18]

What we have seen in this section, then, is words having meanings and uses, with the latter actually more important. A captive's right to medical and mental health care begins with

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[15] *Torraco v. Maloney*, 923 F.2d 231, 235 (1st Cir. 1991).

[16] *Id.* at 235, n. 4.

[17] Any number of decisions reject inmate claims to community programs, educational programs, bilingual classes, even the continuation of methadone previously available to the detainee outside of jail. See cases collected in James J. Gobert & Neil P. Cohen, *Rights of Prisoners*, Sec. 11.11 (1989 and most recent Supplement).

[18] See F. Cohen, "The Right To Treatment" 155-162 in Barbara K. Schwartz, *A Practitioner's Guide to Treating the Incarcerated Male Sex Offender* (N.I.C. 1988).

See *Bailey v. Gardebring*, 940 F.2d 1150 (8th Cir. 1991) for a most restrictive analysis of sex psychopaths and treatment claims.

the fact of confinement but must then leap several hurdles. The cause of pain or suffering must be a recognized and serious disease and diagnosed as such by a mental health professional.

The disease must be serious and seriousness is importantly informed by the nature and degree of suffering and the consequences of delay or doing nothing. Minor depression, headaches, and sleeplessness by themselves will not mandate care. On the other hand, a full-blown depression with inattention to basic hygiene and inability to function will qualify.

Conditions such as alcoholism, drug addiction, and sex psychopathy while attaining disease/sickness status for certain purposes, are not *per se* viewed as diseases for constitutionally mandated care.

One major consequence of this is that when a prison is sued for having inadequate mental health services, the prison's programs for substance abusers and sex offenders -- and they proliferate, especially the inexpensive, self-help variety -- will not likely contribute to complying with essential *Estelle v. Gamble* mandates. On the other hand, as a matter of policy, it would be self-defeating to eliminate helpful programs simply because they were not constitutionally mandated.

We turn next to an examination of the culpable mental state of deliberate indifference as the second crucial prong in the constitutional formula.

DELIBERATE INDIFFERENCE[19]

In my effort to elaborate on the Court's meaning of deliberate indifference, we should again return to the original source, *Estelle v. Gamble*.

Deliberate indifference requires something more than poor judgment, inadvertence or failure to follow the acceptable norms for practice in a particular geographic area. Deliberate indifference is not, however, coextensive with the intentional infliction of needless pain and suffering. Looked at another way, deliberate indifference requires more culpability than malpractice but need not reach the more demanding criteria for intentional conduct; that is, consciously acting to achieve a preconceived result.

In the context of a suicide case, a federal court explained:

> The deliberate indifference standard implicitly requires assessment of states of mind in order to determine the constitutional adequacy of inmate medical care. Isolated negligence or malpractice is insufficient to state an *Estelle* claim.

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[19] Much of this section is derived from Fred Cohen & Joel Dvoskin, "Inmates With Mental Disorders: A Guide to Law and Practice," 16 *MPDLR* 339,342-45 (1992).

> Deliberate indifference exists when action is not taken in the face of a "strong likelihood, rather than a mere possibility" that failure to provide care would result in harm to the prisoner.[20]

The *Estelle* approach to deliberate indifference arose where the inmate claimed that the care he received was improper and inadequate. In the definition set out above, reference is to an omission, i.e., to a failure to provide care when there was a duty to do so.

The mental state of deliberate indifference, which typically is inferred from conduct, may apply to how treatment was provided or to a failure to provide treatment when it was mandated. The significance of the *Estelle* rule is that it creates a constitutional duty of care which is the *sine qua non* of a legal claim in this area of law. If a person does not have some legal duty to do something, the consequences of a failure to interrupt a course of events are not legally attributable to such a person.

A recent case involving a Nevada state prison inmate is instructive on the difference between deliberate indifference and mere negligence.[21] Inmate Wood arrived at the prison with a shoulder injury which had been repaired by inserting two pins in his damaged shoulder. The treating physician also prescribed a sling to prevent dislodging the pins. Over Wood's protests, without any access to Wood's medical file, a prison guard confiscated the sling as a security threat. Wood promptly broke one of the shoulder pins and experienced intense pain. After several days, the prison physician prescribed medication and recommended referral to an outside orthopedic specialist. Two months later, the orthopedic specialist removed the floating pin. The nub of Wood's complaint is deliberate indifference to his medical needs based in part on the unavailability of his medical records and an inadequate course of treatment over the two-month period.

The Court of Appeals for the Ninth Circuit stated:

> We agree with the district court that, while the prison officials' treatment of Wood may have been negligent, it did not rise to the level of deliberate indifference.
>
> Wood's strongest claim is that the prison officials failed to provide the inmate's medical records when he arrived at Nevada State Prison. This failure caused the confiscation of Wood's sling, which in turn caused the harm Wood complains of. This conduct, though apparently inexcusable, does not amount to deliberate indifference. While poor medical judgment will at a certain point rise to the level

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[20] *Guglielmoni v. Alexander*, 583 F. Supp. 821 (D. Conn. 1984) (citations omitted). Suicide cases almost always deal with the decedent's history and conduct just before the suicide.

[21] *Wood v. Housewright*, 900 F.2d 1332 (9th Cir. 1990).

> of constitutional violation, mere malpractice, or even gross negligence, does not suffice....
>
> Nor does the delay in treatment...constitute an eighth amendment violation, the delay must have caused substantial harm. Given the seriousness of his condition and the treatment Wood actually received such harm was not present here.[22]

This analysis creates a significant hurdle for inmates' claims. Consider, for example, the unavailability of Wood's medical records despite the fact that he injured his shoulder in jail just prior to being transported to prison. Inexcusable, says the court, but not deliberate indifference.[23]

In addition, courts have also disagreed as to whether gross negligence equates with deliberate indifference.[24] Without pretending that there is certainty in this area, gross negligence probably refers to an act or omission where there is a high degree of risk-creation (e.g., if a sling is not worn then a pin will likely break), with conscious realization of such risk ("My doctor said to tell you guys that if I didn't wear this sling, something bad would happen to my shoulder"). Gross negligence and deliberate indifference, after all, are hardly scientifically valid or objective terms.[25] They are descriptive and subjective and seem to be very close neighbors.

The final point from the *Wood* excerpt relates to the requirement that the delay cause substantial harm. In *McGuckin v. Smith*, another panel of the Ninth Circuit stated that "a finding that the defendant's activities resulted in 'substantial' harm is not necessary." The court noted that only one panel member had suggested that only if a delay in care caused substantial harm is there a violation of constitutional rights.[26]

Given the threshold requirement of a serious disorder and the difficult standard of deliberate indifference, the correct way to analyze the magnitude of harm is to find that serious harm is not a liability factor and that the extent and duration of the pain or loss is a factor relating only to damages.

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[22] *Id.* at 1334-35.

[23] Plainly, Wood could have retained the sling after it was closely examined and he could have been held in some special form of custody pending verification of his claim of medical necessity.

[24] See e.g., *Villante v. Department of Corrections of City of New York,* 786 F.2d 516, 519-20, 522 (2d Cir. 1986).

[25] See W.R. LaFave and A.W. Scott, Jr., *Criminal Law* 209 (1972).

[26] 900 F.2d 1332, 1334-35 (9th Cir. 1990).

The deliberate indifference standard may be invoked when an individual claims damages for denied, delayed, or inadequate care. It may also be invoked in class action suits for damages and injunctive relief where the claim is that an entire facility, or an entire correctional system, is so deficient that it regularly denies mandated care.

Langley v. Coughlin,[27] involved a claim by female inmates at New York's Bedford Hills facility that inmates with severe mental illness were regularly isolated without proper screening or care, and that the mix of inmates with mental illness with others violated the rights of those not mentally ill. In considering the possibility of damages -- the injunctive claims having been resolved -- the court clarified the meaning of deliberate indifference:

> [A]n isolated and inadvertent error in treating even a serious medical need would not constitute a violation since the Eighth Amendment does not constitutionalize the law of medical malpractice. On the other hand, a serious failure to provide needed medical attention when the defendants are fully aware of that need could well constitute deliberate indifference, even if they did not act with a punitive intent....
>
> [W]hile one isolated failure to treat, without more, is ordinarily not actionable it may in fact rise to the level of a constitutional violation if the surrounding circumstances suggest a degree of deliberateness rather than inadvertence, in the failure to render meaningful treatment. Moreover, the inference of such indifference may be based upon proof of a series of individual failures by the prison even if each such failure -- viewed in isolation -- might amount only to simple negligence.[28]

There are at least two interesting points made here. First, deliberate indifference may be shown by a series of negligent acts or omissions which then may cumulate to become a constitutional violation. According to *Langley*, no single act or omission need reach the level of deliberate indifference, but if seriously ill inmates are consistently made to wait for care while their condition deteriorates, or if diagnoses are haphazard and records minimally adequate then, over time, the mental state of deliberate indifference may be attributed to those in charge.

The court referred to being "fully aware" of the serious medical needs. Repeated acts of negligence or poor practice may also constitute the requisite proof of knowledge. Medical directors cannot turn their backs and then claim ignorance. And, the more often their backs may be turned, the more likely there may be a finding of deliberate indifference.

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[27] 715 F. Supp. 522 (S.D.N.Y. 1989), *aff'd* 888 F.2d 252 (2d Cir. 1989).

[28] 715 F. Supp. at 537.

Second, *Langley* carefully develops the professional judgment standard of care. In *Youngberg v. Romeo*, the Supreme Court dealt with the habilitation-training claims of state facility residents with mental retardation.[29] The Court stated that decisions regarding appropriate care (training, in this instance) would be presumptively valid if made by a mental health professional. Such decisions might be challenged, but only in the absence of reasonable professional judgment.[30]

While the Supreme Court did not state -- and as yet has not stated -- whether this extreme deference to professional judgment applies to all individuals in governmental custody, the *Langley* opinion cites a number of lower court decisions finding the rule applicable, and adopts this approach for itself.[31] The Court's general deference to the real or presumed expertise of correctional officials in general, and health care providers in particular, supports the *Langley* view that *Youngberg's* rule of "professional judgment" applies in the context of jail and prison cases which call for deliberate indifference analyses.[32] There is a touch of irony here, in that at a time when social trust and deference to doctors has seriously eroded, legal rules supportive of such deference are at a new high.[33]

Langley also provides a representative list of the type of specific claims indicative of constitutionally inadequate mental health care. Keep in mind that each of these items must be linked with deliberate indifference. Since it is clear that any mental element is knowable only by the actor's words or through inferences drawn from conduct -- acts or omissions -- these are the type of items that in practical effect may well establish or negate deliberate indifference:

1. Failure to take a complete medical (or psychiatric) record.

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[29] 457 U.S. 307 (1982).

[30] *Id.* at 321-23. See Ellen Saks, "The Use of mechanical Restraints in Psychiatric Hospitals," *95 Yale L. J.* 1836, 1949 (1986) finding that *Romeo* foreclosed use of federal constitutional law as a source for controlling use of restraints.

[31] 715 F. Supp. at 538.

[32] See *Jones v. North Carolina Prisoners' Labor Union,* 433 U.S. 119 (1977) requiring that correctional officers' opinions on security must be shown to be conclusively wrong.

See also Susan Stefan, "Leaving Civil Rights to the 'Experts': From Deference to Abdication Under the Professional Judgment Standard," 102 *Yale L. J.* 639 (1992) for a sharp critique of the expansive use of the professional judgment standard.

[33] On the general erosion of deference point see David Rothman's brilliant new book, *Strangers at the Bedside* 10 (1991).

2. Failure to keep adequate records.

3. Failure to respond to inmates' prior psychiatric history.

4. Failure to at least place under observation inmates suffering a mental health crisis.

5. Failure to properly diagnose mental conditions.

6. Failure to properly prescribe medications.

7. Failure to provide meaningful treatment other than drugs.

8. Failure to explain treatment refusals, diagnosis, and ending of treatment.

9. Seemingly cavalier refusals to consider bizarre behavior as mental illness even when a prior diagnosis existed.

10. Personnel doing things for which they are not trained.[34]

To the *Langley* list I would add:

11. Abrupt termination of medication, especially without prior records.[35]

12. Refusal by security staff to implement medical orders.[36]

Now that we have reviewed the threshold constitutional requirements needed to establish a duty to provide mental health care,[37] it is possible to address some policy issues.

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[34] 715 F. Supp. at 540-41.

[35] This is to be distinguished from mere disagreement among doctors or mental health professionals. Inmates will not prevail if all they can demonstrate is a difference in professional judgment.

[36] See *Arnold on behalf of H.B. v. Lewis*, 803 F. Supp. 245 (D. Ariz. 1992) for a particularly shocking narrative of a ten year failure to provide psychiatric care to a schizophrenic female inmate.

[37] In *Ruiz v. Estelle*, 503 F. Supp. 1265, 1339 (S.D. Tex. 1980), *aff'd in part* 679 F.2d 115 (5th Cir. 1982), *cert. denied*, 460 U.S. 1042 (1983), Judge Justice announced six basic components for a constitutionally acceptable prison mental health program. These factors may be a bit dated by now and are not as detailed as *Langley*. Nonetheless, they deserve study. First, there must be a systematic program for screening and evaluating inmates

First, it should now be clear that what mental health care is constitutionally mandated is minimal at best. Disorders must be serious and denials, delays, and the level of care are subject to the deliberate indifference test. While the role of the courts in stimulating, and in some cases having to supervise, reform should not be underestimated, advocates of mental health services that would approximate community standards must push beyond constitutional minima. Such advocates must not rely on the courts and while legislative-administrative relief may be chimerical, it may also be the only way to go.

Second, prison mental health is a tricky and complex affair. On the one hand, an inmate must be provided with the basic necessities of life -- food, clothing, shelter, and the like -- whereas a "street person" with mental illness may come to the attention of authorities precisely because of a public display of inability to provide for himself. On the other hand, an inmate's behavior which is suggestive of mental illness will often be viewed skeptically. Suicidal behavior is often labelled as manipulative while disorderly, manic behavior will be seen through the skeptical eyes of security and an effort to achieve "secondary gain."

Third, the role conflicts for mental health professionals are obvious and at times painful. Treatment decisions are nearly always made in the shadow of security concerns. Thus, the independence so prized by professionals may be compromised.

Fourth, inmates -- indeed, all captives -- have no choice concerning who treats them or where they are treated; and no choice as to the treatment modality, so long as the treatment chosen is within the range of professional judgment and remains above the benchmark of deliberate indifference.

> in order to identify those who require mental health treatment.... Second, as was underscored in both *Newman* and *Bowring*, treatment must entail more than segregation and close supervision of the inmate patients.... Third, treatment requires the participation of trained mental health professionals, who must be employed in sufficient numbers to identify and treat in an individualized manner those treatable inmates suffering from serious mental disorders.... Fourth, accurate, complete, and confidential records of the mental health treatment process must be maintained. Fifth, prescription and administration of behavior-altering medications in dangerous amounts, by dangerous methods, or without appropriate supervision and periodic evaluations, is an unacceptable method of treatment. Sixth, a basic program for the identification, treatment, and supervision of inmates with suicidal tendencies is a necessary component of any mental health treatment program.... TDC's mental health care program falls short of minimal adequacy in terms of each of these components and is, therefore, in violation of the eighth amendment.

Fifth, innovative claims such as a right not to deteriorate -- or a right to avoid "dehabilitation" -- tend to fall on judicial deaf ears. Claims by the marginally ill inmate, the inmate on the edge of a mental health crisis -- especially the quietly deteriorating type -- find little relief in the courts so long as overall prison conditions meet the requirements of the Eighth Amendment.

In the outside world if we have the resources we can define ourselves as ill, as becoming ill, as in need of spiritual guidance, as in need of respite, or as "doing okay." Inside prison, these definitions of self are made by others, sometimes generously and sometimes most grudgingly.

The constitutional minima created by the requirements of "seriousness" and "deliberate indifference" strongly argue for advocacy well beyond these constitutional floors. Those who speak for the inmate with mental illness need to insist on the minimum while arguing for the preferred.

THE RIGHT TO AVOID TREATMENT

To this point we have explored the constitutional basis for an inmate's or a detainee's right to insist on mental health treatment. Do such captives have the right to resist certain treatments? What arguments exist by which to resist unwanted, intrusive, possibly dangerous treatment modalities?

Psychosurgery and electro-convulsive shock aside, the most compelling area for analysis of the right to resist treatment involves the involuntary administration of antipsychotic medication. The various verbal therapies, even of the most aggressive sort, simply do not raise significant legal issues of consent. Courts are concerned with the degree of intrusiveness and the potential for harmful side effects. Thus, we simply may lay aside the various verbal therapies on the consent issue for these very reasons.

In *Washington v. Harper*,[38] the Supreme Court took on the questions of whether a competent inmate might constitutionally reject unwanted antipsychotic drugs and whether a judicial hearing was required or would administrative procedures suffice to determine the proper basis for involuntary medication.

The Court held that an inmate does have a liberty interest in avoiding such forced medication but that interest may be overridden even if the inmate is competent and without resort to judicial proceedings.

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[38] 110 S.Ct. 1028 (1990).

Washington's internal, administrative procedure was upheld as affording due process. The procedure called for notice, the right to be present at the adversary hearing, the right to present and cross-examine witnesses, and the right to an independent, lay advisor. The Court rejected claims of partiality in the tribunal, lack of counsel, rules of evidence, or a demanding burden of persuasion.

Thus, while inmates do have a constitutionally protected liberty interest in avoiding forced antipsychotic medication and this interest, in turn, requires due process, the inmate need not be incompetent, a judicial hearing is not required, and outside decisionmakers are not required. It is also clear that the Court was not endorsing forced medication as punishment or as a primary means to maintain security.

The Washington law at issue adopted the state's civil commitment laws' definition of mentally disordered, gravely disabled, and "dangerousness" as the requisite basis for forced medication. While the Court appears to have renounced security as a primary basis for forced medication, in accepting dangerousness to self, others, or property as a permissible basis it was, of course, allowing the dangerousness finding, in effect, to substitute for security.

One scholar was pleased that the Court relied on the *Turner* reasonableness standard in *Harper* instead of the more deferential standard of "professional judgment" announced in the earlier *Romeo* decision.[39] While the procedures endorsed in *Harper* are far less demanding than required by many lower courts, especially some state courts, reliance on a "professional judgment" standard would essentially require only that a doctor make the decision. By using the less-than-demanding *Turner* test, the Court did at least insist on a reasonable relationship between the prison's valid interests, which include inmate care and institutional safety, and the means adopted, forced medication.

I should remind the reader that decisions such as *Harper* establish constitutional minima and while every jurisdiction must meet these minimum standards, states can and, increasingly often, do impose more demanding state law requirements. In New York, for example, no captive who is competent can be forcibly medicated and a judicial hearing on competence or incompetence is required.[40]

While *Harper* is still a relatively new decision there are a number of post-*Harper* decisions, including one rendered by the Supreme Court,[41] which begin to give it additional

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[39] Susan Stefan, "Leaving Civil Rights to the 'Experts': From Deference to Abdication Under the Professional Judgment Standard," 102 *Yale L. J.* 639, 683-85 (1992).

[40] See *Rivers v. Katz*, 504 N.Y.S.2d 74, 495 N.E.2d 337 (1986) which found a four-layer administrative review process unacceptable to protect the protesting patient's due process rights.

[41] *Riggins v. Nevada*, 111 S.Ct. 1810 (1992).

shape. For example, in *Cochran v. Dysart*,[42] a federal inmate challenged his continued commitment beyond sentence expiration and forced medication with psychotropic drugs.

In remanding for reconsideration because of an inadequate record, the Court of Appeals stated that *Harper* does not support such forced medication for transfer to less restrictive quarters, participation in more programs, improvement of reality testing, and to make the inmate less agitated.

The court apparently was looking for a finding of dangerousness and that the treatment is in the inmate's medical interest. One might suppose that the prescribing physician believed that reduction in agitation and improvement in reality testing did relate to medical -- i.e., psychiatric -- best interests.

In *Washington v. Silber*[43] a Virginia inmate was transferred from a prison to the Marion Correctional Treatment Center in Virginia. The committing judge determined that the inmate was so seriously mentally ill as to be unable to care for himself, that he was incompetent and incapable of giving informed consent to treatment in his best interests. The supporting petitions sought commitment and authority to medicate.

Based on the petitions and order of commitment/transfer, the inmate was forcibly medicated but not until some two months had expired. The two interesting legal issues here are:

1. Is a separate medication hearing required under *Harper* or may the issues of commitability/transfer and medication be decided in a single hearing?

This court answers that one hearing may suffice so long as the requisite findings as to dangerousness and "best medical interest" are reached and decided.

2. Is due process violated when there is a two-month lapse between judicial (or, one supposes, administrative) authorization and the actual forced medication?

This court holds no, the doctor exercised professional judgment in delaying the authorized medication and in following a more conservative course did not violate the flexible requirements of due process.

The latter point raises some obvious questions. Is the authorization, then, a blank check to be exercised (or threatened?) any time during the commitment? In our case, the commitment was for 180 days but, presumably, it could be renewed.

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[42] 965 F.2d 649 (8th Cir. 1992).

[43] 805 F. Supp. 379 (W.D. Va. 1992).

Viewing forced medication as an interference with basic liberty interests, does it not follow that the required findings should at least be close in time to the point where the medication seems indicated? On the other hand, if that point is won, will doctors forego more conservative, less intrusive, treatment hoping to avoid the drugs but wanting their availability in reserve?[44]

In *Breads v. Moehrle*[45] we encounter one of the relatively few forcible medication cases involving a jail. Procedurally, the case involved motions for summary judgment which means there has not as yet been any live testimony and the matter is decided on the papers. The plaintiff alleged having been physically thrown to the floor, handcuffed and forcibly injected with drugs.

The jail's response was that the inmate was very difficult and that some unnamed psychiatrist authorized the drugs and they were administered by a qualified medical aide.

Finding that issues of fact remained, and thus summary judgment was not appropriate, the court did state:

> In regard to the procedural due process component of plaintiff's claim, there are material issues of fact whether any procedures existed at all to ensure that the substantive determination of need for the administration against plaintiff's will of antipsychotic drugs, would not be erroneous. For example, there is no proof that the decisionmaker was neutral and detached, and there is no indication of any patient access to the decision making process. Furthermore, there is no indication of a review process. As a separate matter, there is no proof in the record whether plaintiff was a sentenced inmate or a pre-trial detainee, nor is there any submissions on either side whether, if he was a pre-trial detainee, a different rule other than articulated in *Washington v. Harper* should apply.[46]

Although the judge here writes as though this is only a problem for the record, there is a strong suggestion that this jail had no procedures or substantive policies in place that comported with *Harper*. However that may be, it is foolhardy for jails to ignore *Harper* since

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[44] This is the type of analysis engendered by the new field of therapeutic jurisprudence pioneered by mental health legal expert David B. Wexler. See, e.g., *Therapeutic Jurisprudence: The law as a Therapeutic Agent* (1990) for a collection of Wexler's earliest scholarship on point.

[45] 781 F. Supp. 953 (W.D.N.Y. 1991). *Bee v. Greaves*, 910 F.2d 686 (10th Cir. 1990) is perhaps the best known jail case and it involved forcible medication in the Salt Lake City County Jail in 1980. Bee won money damages and attorney fees.

[46] 781 F. Supp. at 958-59.

it seems manifestly clear that its rules apply to jails. Indeed, it may well apply to detainees with special vigor.

There are a number of interesting decisions on forced medication that are beyond the purview of this chapter. For example, in *Riggins v. Nevada*,[47] the Supreme Court found it to be a constitutional error for a state trial judge to order the forcible administration of antipsychotic drugs to a murder defendant without finding there were no less intrusive alternatives; that the medication was medically appropriate; and that it was necessary either for defendant's safety or the safety of others. Other recent decisions deal with forcible medication of parolees[48] and the general issue of medicating to achieve trial competence.[49]

Moving from issues concerning drugs used in the treatment of captives, we may now ask if detainees or inmates may be forcibly medicated with antipsychotic drugs as a control measure in an emergency. Note that this question does not involve using drugs for punishment, which is clearly forbidden, but drugs used to achieve control under circumstances where physical force, restraints, or even disabling gas might otherwise be used.

In *Hudson v. McMillian*,[50] the Supreme Court held that whenever prison officials stand accused of using excessive force in violation of the Eighth Amendment the test is whether the force was applied in a good-faith effort to maintain or restore discipline, or maliciously and sadistically to cause harm. It would appear, then, that all force claims by prison inmates, including physical force, use of chemical agents, "stun guns" and drugs will now be measured by this standard.[51]

While this writer strongly believes that all use of force situations should be subject to "least intrusive" and "least potentially harmful" tests, the courts seem not to agree. Courts regularly uphold the use of tear gas and mace.[52]

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[47] 111 S.Ct. 1810 (1992).

[48] *Felce v. Fielder*, 974 F.2d 1484 (7th Cir. 1992).

[49] *Tran Van Khiem v. United States*, 612 A.2d 160 (D.C. Ct. App. 1992).

[50] 112 S.Ct. 995 (1992).

[51] Different standards may apply to detainees, see *Buckner v. Hollins*, 983 F.2d 119 (8th Cir. 1993) and the Fourth Amendment will apply to arrestees.

[52] See James J. Gobert & Neil P. Cohen, *Rights of Prisoners* Sec. 11.05 (1992 Supplement) for collected cases.

In *Soto v. Dickey*,[53] a comprehensive and limiting order by the district court concerning use of chemical agents was reversed. The court of appeals held that use of mace was not *per se* unconstitutional and that the judgment of correction officials on such matters is to be preferred to that of a trial judge.

Of course, with the use of medication to achieve temporary control of an inmate, undoubtedly a physician must authorize the procedure and a qualified person -- nurse or paramedical, for example -- would have to administer the medication.

In an earlier work, I reviewed a number of judicial decisions involving aversive behavior modification programs and token economies, programs that no longer seem in vogue in adult prisons.[54] The various cases involved use of anectine (a paralyzing, fright drug), apomorphine (causes vomiting), and various token economies operating on a punishment-reward basis.

The upshot of these decisions is that the drugs could not be administered as punishment *per se* but only within the framework of a treatment program to which the inmate had consented and from which he or she could withdraw.

The decisions relied on for these views are pre-*Harper* and *Harper* may well modify the earlier decisions' emphasis on consent.

The core legal issues on a right to refuse psychotropic medication have been addressed in some detail. Others should be noted here to complete the picture. For example, when consent is not required or put at issue then there are legal issues associated with the adequacy of the medical-drug records. It is vital that the nature of the drug, dosage, and drug mix be charted with care.

Continuity of care is the functional and legal concern here and decent records are an important factor on continuity.

Confidentiality of mental health records, and certainly medication records, is important and some -- but certainly not all -- courts will view this as of constitutional significance.

Finally, and perhaps ironically, many of the legal issues mentioned here deal with protecting the unwilling inmate. In my recent experiences as a legal consultant in a number of jurisdictions, and with varying degrees of emphasis, the problems I encountered were not so much with forcibly medicating the unwilling inmate, it was controlling the availability of all

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[53] 744 F.2d 1260 (7th Cir. 1984), *cert. denied*, 470 U.S. 1085 (1985).

[54] Fred Cohen, *Legal Issues and the Mentally Disordered Prisoner* 195-98 (N.I.C. 1988).

manner of pain-relieving, mind-altering drugs from all too willing inmates who desperately sought them.

Ethical doctors will try to prescribe psychotropic medication with care and based on diagnoses of specific and serious disorders, mindful of the ever-present threat of serious side effects. In the often stultifying, crowded, dangerous, world of the prison, captives often seek cognitive release, if only temporarily. If the price of such release is addiction or substance abuse, it may be too high a price.

TRANSFER TO MENTAL HOSPITALS: *VITEK* ISSUES[55]

There are, of course, a variety of mental health service delivery models available to government: reliance on private contractors, public employees, or a mix; a centralized psychiatric prison; small psychiatric units attached to prisons; regional psychiatric centers; security units within psychiatric hospitals; and/or a centralized psychiatric security hospital.[56] A state is not constitutionally mandated to adopt any of these models. So long as there is not deliberate indifference to serious mental health needs, then it is -- so to speak -- local option based on considerations of policy, economics and, presumably, effectiveness.[57]

Thus, where a prisoner (or detainee) is treated raises few legal issues. How an inmate is moved from place to place, in particular, from a penal setting to a mental hospital for treatment does create some significant legal issues. In *Vitek v. Jones*[58] the Supreme Court was asked to decide whether a Nebraska statute, or the Constitution itself, required some form of procedural due process before a nonconsenting inmate could be transferred for treatment from a prison to a mental hospital. The statute at issue in *Vitek* reads as follows:

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[55] Much of the material for this section is derived from Fred Cohen, *Legal Issues and the Mentally Disordered Prisoner* Ch. IV (N.I.C. 2d ed., 1988).

[56] Wardlaw, "Models for the Custody of Mentally Disordered Offenders," 6 *Int'l J. of Law and Psychiatry* 159 (1983).

[57] Interestingly, there appears to be no standards to judge relative effectiveness, Maier & Miller, "Models of Mental Health Service Delivery to Corrections," 32 *J. of Forensic Sciences* 225, 226 (1985), and almost no information available on point, Heilbrun et al., "The Treatment of Mentally Disordered Offenders: A National Survey of Psychiatrists," 20 *American Academy of Psychiatry and the Law* 475 (1992).

[58] 445 U.S. 480 (1980). In an earlier decision, the Court had decided that unless state law somehow created a liberty interest, a prison inmate could be transferred without any hearing to any other prison, regardless of increased security or difficulty in pursuing visits, rehabilitative goals, and so on. *Meachum v. Fano*, 427 U.S. 215 (1976).

> When a physician designated by the Director of Correctional Services finds that a person committed to the department suffers from a physical disease or defect, or when a physician or psychologist designated by the director finds that a person committed to the department suffers from a mental disease or defect, the chief executive officer may order such person to be segregated from other persons in the facility. If the physician or psychologist is of the opinion that the person cannot be given proper treatment in that facility, the director may arrange for his transfer for examination, study, and treatment at any medical-correctional facility, or to another institution in the Department of Public Institutions where proper treatment is available. A person who is so transferred shall remain subject to the jurisdiction and custody of the Department of Correctional Services and shall be returned to the department when, prior to the expiration of his sentence, treatment in such facility is no longer necessary.[59]

Justice White agreed with the lower courts that this statute created a liberty interest in the inmates.

> Section 83-180(1) provides that if a designated physician finds that a prisoner 'suffers from a mental disease or defect' that 'cannot be given proper treatment' in prison, the Director of Correctional Services may transfer a prisoner to a mental hospital. The District Court also found that in practice prisoners are transferred to a mental hospital only if it is determined that they suffer from a mental disease or defect that cannot adequately be treated within the penal complex. This 'objective expectation, firmly fixed in state law and official Penal Complex practice,' that a prisoner would not be transferred unless he suffered from a mental disease or defect that would not be adequately treated in the prison, gave Jones a liberty interest that entitled him to the benefits of appropriate procedures in connection with determining the conditions that warranted his transfer to a mental hospital. Under our cases, this conclusion of the District Court is unexceptional.[60]

This aspect of *Vitek* holds, in effect, that the very language of the Nebraska law created a right in the inmate to some sort of due process mechanism by which to resist the unwanted transfer. However, if this was the only source of the right -- the liberty interest -- then Nebraska would be free to change the law and, thus, remove the state law basis for challenging such a transfer. The Supreme Court, however, went further holding:

> None of our decisions holds that conviction for a crime entitles a State not only to confine the convicted person but also to determine that he has a mental illness

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[59] Neb. Rev. Stat. Sec. 83-180(1).

[60] *Vitek v. Jones*, 445 U.S. at 489-90.

> and to subject him involuntarily to institutional care in a mental hospital. Such consequences visited on the prisoner are qualitatively different from the punishment characteristically suffered by a person convicted of crime. Our cases recognize as much and reflect an understanding that involuntary commitment to a mental hospital is not within the range of conditions of confinement to which a prison sentence subjects an individual....
>
> A criminal conviction and sentence of imprisonment extinguish an individual's right to freedom from confinement for the term of his sentence, but they do not authorize the State to classify him as mentally ill and to subject him to involuntary psychiatric treatment without affording him additional due process protections.
>
> In light of the findings made by the District Court, Jones' involuntary transfer to the Lincoln Regional Center pursuant to Sec. 83-180, for the purpose of psychiatric treatment, implicated a liberty interest protected by the Due Process Clause. Many of the restrictions on the prisoner's freedom of action at the Lincoln Regional Center by themselves might not constitute the deprivation of a liberty interest retained by a prisoner.... But here, the stigmatizing consequences of a transfer to a mental hospital for involuntary psychiatric treatment, coupled with the subjection of the prisoner to mandatory behavior modification as a treatment for mental illness, constitute the kind of deprivation of liberty that requires procedural protections.[61]

Thus, regardless of state law, the combination of stigma, a drastic qualitative alteration in the conditions of confinement, and being subjected to involuntary psychiatric care and mandatory behavior modification programs combined to create a liberty interest traceable to the Fourteenth Amendment's Due Process Clause. This, of course, is not to say that a prison-to-mental hospital transfer cannot be done, only that certain minimal procedural safeguards apply.

The following minimal safeguards now must precede such a transfer:

1. Written notice to the prisoner that a transfer to a mental hospital is being considered.

2. A hearing, sufficiently after the notice to permit the prisoner to prepare, at which disclosure to the prisoner is made of the evidence being relied on for the transfer and at which the prisoner receives an opportunity to be heard in person and to present documentary evidence.

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[61] *Id.* at 493-94.

3. An opportunity at the hearing for the defense to present testimony of witnesses and to confront and cross-examine witnesses called by the state, except upon a finding, not arbitrarily made, of good cause for not permitting such presentation, confrontation, or cross-examination.

4. An independent decision-maker ("This person need not come from outside the prison or hospital administration.").

5. A written statement by the decision-maker as to the evidence relied on and the reasons for transferring the inmate.

6. Availability of "qualified and independent assistance," furnished by the state, if the inmate is financially unable to furnish his own.

7. Effective and timely notice of all the foregoing rights.[62]

A host of questions were left unanswered by *Vitek*, many of which now may be answered. I will proceed by setting out the particular question and then providing the best answer available, along with appropriate authority.

1. Does *Vitek* apply to transfers that are made for observation or diagnosis but not for treatment?

Every court which appears to have addressed this question finds that *Vitek* applies only to a transfer for treatment. For example, in *United States v. Jones*[63] a federal prisoner was transferred from the Marion prison to the Medical Center for Federal Prisoners in Springfield, Missouri. The transfer was done administratively and it was for a psychiatric evaluation.

In what is now a common basis for decision, the court held that *Vitek* does not apply to involuntary transfers for psychiatric evaluations. Such transfers are likened to prison-to-prison transfers for administrative reasons to which no due process attaches.[64]

While this court does not address it, there may be a question of subterfuge if a transfer ostensibly for assessment is unduly prolonged and mental health staff actually begin a treatment regimen. If such a situation were uncovered, the denial of *Vitek* rights could support a civil action for damages.

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[62] This procedural format resembles that which is constitutionally required for parole revocation.

[63] 811 F.2d 444 (8th Cir. 1987).

[64] 811 F.2d at 448.

2. Does *Vitek* apply only to mental health facilities operated or administered by a mental health agency or provider or does it apply as well to such programs administered by corrections?

It seems reasonably plain that the Court was concerned with the stigma of being labelled mentally ill and eligibility for enforced mental health care and not with administrative arrangements.

A very interesting decision involving the North Carolina prison system dealt with this and other related questions. In *Baugh v. Woodard* the court began its analysis of the problem by stating that "we do not distinguish, for the purpose of compliance with *Vitek*, inpatient mental treatment hospital facilities whether operated by the prison system, as in the case here, or by another state agency as in *Vitek*."[65]

Thus, *Vitek* is applicable regardless of which government agency provides mental health services and, indeed, even if the provider is a private vendor under contract with the government.

3. Does *Vitek* address such questions as the duration of the commitment, evidentiary standards, or transfer criteria?

Plainly, *Vitek* did not do so but there are some answers to these questions.

On the duration issue, an inmate may not be hospitalized beyond the term of his or her criminal sentence unless there has been a separate, independently valid proceeding to support such an extension.

For example, if an inmate is, in fact, subjected to civil commitment proceedings as a way of complying with *Vitek*, and if the state law allows indefinite commitment, then at the expiration of the criminal sentence, the civil commitment provides a legal basis for an extended hold.[66]

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[65] 808 F.2d 333 (4th Cir. 1987).

[66] See *Bailey v. Gardebring*, 940 F.2d 1150, 1153 (98th Cir. 1991) upholding a Minnesota law that a civil commitment is not discharged as a result of transfer to the custody of the Department of Corrections. *Bailey* may well need to be reconsidered in light of *Foucha v. Louisiana*, 112 S.Ct. 1780 (1992) holding that an insanity acquittee may not be held on the basis of his antisocial personality and expert opinion that the acquittee may be dangerous.

Vitek, itself is silent on the burden of proof needed to transfer an inmate to a mental hospital. In *Addington v. Texas*[67] the Court held that due process required proof that is at least "clear and convincing" before a person may be civilly committed.

Vitek appears to equate a prison to mental hospital transfer with a civil commitment. While it is true that an inmate's basic liberty already is gone, the *Vitek* problem involves a qualitative alteration in confinement. Thus, while there are differences between civil commitment and prison-hospital transfers, "clear and convincing"[68] would appear to be the requisite burden of persuasion.

Finally, as to the criteria issue, the major question would seem to be whether mental illness and treatment needs suffice or is there some requirement as to dangerousness. Professor Churgin seems to be correct in arguing:

> Once a proper procedure is utilized and the individual inmate is found to be both mentally ill and in need of some treatment, any other requirement might be superfluous. The Supreme Court hinted as much in *Vitek* by repeated references to the determination required by the Nebraska statute, a finding of mental illness and a benefit in being transferred to the mental health facility.[69]

4. Does *Vitek* have any application when an inmate is transferred from one mental hospital to another, more secure hospital? No, seems to be the most reasonable answer.

If *Vitek* procedures have previously been complied with then the stigma of mental illness has attached as well as the potential for enforced mental health care. Thus, hospital-to-hospital transfers do not implicate *Vitek*.[70]

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[67] 441 U.s. 418 (1979).

[68] Clear and convincing is a notch above the preponderance standard applicable in non-liberty depriving civil cases and a notch below beyond the reasonable doubt standard applicable in criminal cases.

[69] Michael Churgin, "The Transfer of Inmates to Mental Health Facilities in Mentally Disordered Offenders." In Monahan, J. and Steadman, H.J. (eds.) *Mentally Disordered Offenders: Perspectives From Law and Social Science*. New York, NY: Plenum Press. (1983)

[70] By analogy, see *Savastano v. Nurnberg*, 567 N.Y. Supp. 2d 618 (Ct. of App. 1990). (Civil case.) *Maust v. Headley*, 959 F.2d 644 (7th Cir. 1992) after commitment as incompetent to be tried, no right to least secure hospital or to require hearing before transfer to a more secure hospital.

5. What is the relationship between *Vitek*, the transfer, and parole eligibility and release?

This is an important and highly practical issue. As a matter of policy, one would seek to encourage those inmates in need of mental health services to obtain it and to do so without penalty. Should a parole board, as a matter of practice, simply defer parole release because of a prior hospitalization, medication history, or deny good time credits during hospitalization this would seem to be an anti-therapeutic outcome.

With regard to good-time credits and parole eligibility, the ABA Standards are more clear and more to the point than the limited amount of recent case law. The Standards read:

> (a) A prisoner in a mental health or mental retardation facility is entitled to earn good time credits on the same terms as offenders in adult correctional facilities.
>
> (b) A prisoner in a mental health or mental retardation facility should be eligible for parole release consideration on the same terms as offenders in adult correctional facilities.
>
> (c) If otherwise qualified for parole, a prisoner should not be denied parole solely because the prisoner had or is receiving treatment or habilitation in a mental health or retardation facility.
>
> (d) If otherwise qualified for parole, a prisoner who would benefit from outpatient treatment or habilitation should not be denied parole for that reason.[71]

With few exceptions, the courts which have dealt with the good time credit issue have determined that prisoners may and do lose the opportunity to earn good-time credits after a determination of mental illness ("insanity" in the older cases) and some form of hospitalization. In *Bush v. Ciccone*, for example, the court dealt with federal law and determined that good-time credits are suspended for prisoners found "insane" by a Board of Examiners.[72]

Sawyer v. Sigler[73] is an important case which runs contrary to most other decisions. Nebraska apparently denied statutory good-time credits to prisoners found to be physically unable to work. This was viewed as forcing prisoners to choose between constitutionally required medical care and statutory good time. The judge concluded:

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[71] A.B.A., Criminal Justice Mental Health Standards 7-10.10 (1984).

[72] 325 F. Supp. 699 (W.D. Mo. 1971).

[73] 320 F. Supp. 690 (D. Neb. 1970), *aff'd*, 445 F.2d 818 (8th Cir. 1971).

> I am compelled to declare that the policy of denying statutory good time to persons physically unable to perform work, when that physical inability does not result from misconduct on the part of the prisoner, is contrary to the equal protection clause of the Fourteenth Amendment of the Constitution of the United States and to enjoin the enforcement of the policy to that extent.[74]

If we may interpolate this approach to mental disability -- and it is difficult to imagine why not -- then in a system where good time accrues either for good behavior or employment, an inmate undergoing mental health care should not be deprived of the opportunity to earn such credits.

There is, of course, no right to good time credits in the sense that a state must adopt such a system of rewards and sentence reduction. However, where good time laws exist, inmates cannot be prevented from earning credits on irrational or discriminatory grounds. That is the essence of the reasoning in *Sawyer v. Sigler*, which seems eminently sound in general and as applied to mentally disordered inmates undergoing treatment.

Finally, is it constitutionally permissible for a parole board to deny release because of a judgment about the inmate's mental condition and possible danger if released? Denying release on such a ground is plainly constitutional -- it is the sort of discretion virtually everywhere vested in parole -- although in so doing a board may create a right to treatment.

This is what occurred in *Bowring v. Godwin*.[75] The board found that the inmate was sufficiently mentally impaired to make release on parole problematic which enabled the court to then hold that the inmate was entitled to receive treatment to relieve the impairment. Since a parole board is not constitutionally required to state reasons for denial, this may be a victory that simply leads to silence.

Vitek is, of course, an important decision in its effort to provide inmates with some procedural safeguards by which to resist unwanted transfers for treatment to mental hospitals. In fastening on the label of mental illness as a stigma to be avoided, the Court may well have perpetuated what Professor Michael Perlin refers to as a form of "sanism;" as the often unwarranted, always negative stereotyping of persons with mental illness.

A *Vitek* hearing may well provide the basis for forced psychotropic medication and thus it is not to be taken lightly. That is, where forced medication is done in a hospital then the transfer hearing may also be the vehicle for compliance with *Harper*, forced medication mandates.

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[74] 320 F. Supp. at 699. The court went on to distinguish statutory good time from meritorious good time, finding no intent to discriminate as to the latter.

[75] 551 F.2d 44 (4th Cir. 1977).

Once again, what has been reviewed here are the most fundamental constitutional standards for prison-mental hospital transfers. Advocacy groups certainly may seek more in the form of legislation; for example, appointed counsel, ready access to independent psychiatrists, a higher standard of proof, regular review of treatment, and more. *Vitek*, however, and its progeny, does provide a reasonable set of protections for inmates wishing to resist transfer to a mental hospital for treatment.

DISCUSSION

As a matter of perspective, I believe the best approach to law is one that is preventive: one that includes knowledge of basic legal requirements -- such as discussed in this chapter -- and self-assessment which is regularly practiced. If it makes good sense to practice quality assurance with regard to treatment, it makes just as good sense to regularly review compliance with legal norms. Law suits are avoidable or easily dealt with when health care providers are able to demonstrate knowledge of the law and regularized efforts to maintain compliance.

As a thumbnail sketch to making an assessment of mental health services in prison or jail, I find that there are three crucial factors in such an assessment:

1. Physical resources. What type of space is available, where, to perform what type of services for the inmate who needs mental health care? What space is available for "out-patient," intermediate, longer-term chronic and acute care?

2. Human resources. How many people, with what kind of training, are available to do diagnosis, treatment, prognosis, and mental health programming in general?

3. Access. How do inmates find out about services and exactly how do they gain access?

These items are not exhaustive, but if all the questions raised in them are answered, one is well on the path to a basic legal evaluation of the prison or jail mental health services. If one supplements the basic outline with, for example, the standards utilized by the National Commission or Correctional Health Care then one is likely to attain a sense of both the required and the desired.

In addition to the critical topics discussed in this chapter, there are a number of other issues which deserve at least a brief review.

First, I wish to note the matter of epidemiology. A public system that involuntarily confines people and thereby owes such people, inter alia, medical and mental health care must have some knowledge of how many people in their custody are owed care. For example, when plaintiff's join in a class action and sue the State or local government for systemic failure -- that is, an alleged failure as to human and physical resources and denied or delayed access to

mandated care -- the plaintiff's attorneys will first ask: Do you have data on how many inmates or detainees are seriously mentally (or physically) ill?

The answer to this question requires a shared understanding of what is or is not "serious," and what is or is not viewed as an illness. This, in turn, requires some type of initial screening and assessment, some regular follow-up, and some type of decent record keeping. The epidemiological question is not satisfactorily answered by simply consulting medication lists since in many jurisdictions such lists include the dispensing of tranquillizers or sleep aides and, thus, are not parallel to a list of the seriously ill.

Second, the maintenance of complete and confidential medical and psychiatric records on individual patients is as important as the epidemiological data just discussed. The constitutional concern about completeness of medical and psychiatric records relates to a concern about assuring continuity of care. In other words, regular and somewhat detailed records are not a legal end in themselves. It is continuity of care, especially in a system where personnel regularly change and patients are moved about, that is of concern to the courts.

In the context of litigation, plaintiffs' counsel will obtain consent and discovery of their clients' records. Records that are materially incomplete as to diagnoses, prognosis, medication, and progress notes are highly suspect.

Confidentiality of medical and mental health records is a veritable labyrinth of professional ethics, statutes, various judicial decisions in the context of tort litigation, and constitutional law. Although the Supreme Court has not directly addressed the question, there is some consensus among the courts that there is a constitutional right to privacy as to one's personal affairs -- and that right extends to medical and mental health information.

In *Whalen v. Roe*, 429 v.s. 589 (1977), the Supreme Court upheld a New York law requiring the reporting by doctors of all prescriptions written for "dangerous drugs." In upholding the law, the court emphasized the protection given to the identity of the patients while hinting at a constitutional duty to avoid unwarranted disclosures.

To go from the less-than-clear constitutional right of medical privacy for free persons, to that same claim for captives involves something of a stretch.[76] Conceding that the claimed right is murky and that the demands of order and security in a confining facility must be recognized, I would argue that inmate - patient confidentiality should be the norm.

Exceptions should be considered only when there is a legitimate, if not important, governmental interest in the disclosure of such information that cannot be reasonably satisfied

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[76] Some courts have recognized the privacy rights of inmates suffering with AIDS. See e.g. *Doe v. Coughlin* 697 F.Supp. 1237 (N.D.N.Y. 1988); *Woods v. White*, 689 F. Supp. 874 (W.D. Wis. 1988).

through less invasive means. For example, there is a case to be made that some security staff should be aware of an inmate's psychotropic medication in order to monitor for compliance and deal with side-effects. Suicide relevant information should be shared as part of a preventive approach. An inmate's threat to inflict violence on an identifiable other, even if learned in the context of a privileged communication, must be disclosed in order to fulfill the duty to protect the potential victim. (This is known as the Tarasoff situation, named after a decision based on state law by the Supreme Court of California).

While the substance of confidentiality, as noted, remains fluid, it does seem clear that every jurisdiction should adopt policy and procedures in the area and train their personnel on how to comply.

A third issue, the use of seclusion and restraint, raises a number of legal and policy issues. As a foundation for this brief overview I should state that I know of no per se constitutional restriction on the use of seclusion or various forms of restraint. In other words, a captive with mental illness has no recognizable constitutional claim to be entirely free of seclusion or restraint.

On the other hand, the duration and conditions of seclusion as well as the technique and duration of restraint will be importantly influenced by the person's mental condition. What is marginally acceptable for relatively intact adults will likely be marginally unacceptable for persons with mental illness or the young.[77]

Clearly, those involved in providing mental health care must be aware of the state laws, regulations, and directives on seclusion and restraint. Policy and procedure on these practices should encompass the following matters:

1. Isolation and restraint are temporary measures to combat an individual's danger to self or others.

2. A properly trained clinician should authorize the measures using a "least intrusive means" approach, as well as previously articulated clinical criteria.

3. The time and frequency of use of these measures must be clearly articulated and of a relatively short duration.

4. There must be clear policy on monitoring, re-evaluation and documentation.

5. There must be staff training in all of these aspects of the process.

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[77] See e.g. *Santana vs. Collazo*, 714 F.2d 1172 (1st Cir. 1983).

Another set of issues related to custodial suicide also call for more detailed attention than is possible here.[78] Custodians clearly have a state law and constitutional duty to protect the lives of those in their custody. This duty to protect, of course, includes protection against acts of self-destruction.

At the constitutional level, whether this duty is viewed simply as insulation from harm or as a duty to provide medical or psychiatric care due to suicide threats or behavior, the liability requirements are the same. The custodian must be shown to have been "deliberately indifferent" to the threat of suicide.

The federal courts have taken a highly restrictive approach to liability for custodial suicide, requiring a credible, prior threat or an earlier attempt but not mandating that suicide-relevant information be developed. Thus, while I recognize that custodians may often escape liability for inmate or detainee suicide, I believe it is self-evident that a system or a facility should want to do all that it reasonably can to avoid these tragedies.

Suicide screening instruments are easily available through the National Center on Institutions and Alternatives[79] and just as easily used. Despite the fact that federal case law appears to put a premium on ignorance, responsible correctional officials should act to save lives, especially when the needed information and responsive measures are easy to obtain and easy to implement.

As a final point, readers should be aware that there are a number of standards, most recently those promulgated by the American Psychiatric Association, that provide valuable guidance in this area.[80] In addition, the recently published "Prison Health Care: Guidelines for the Management of an Adequate Delivery System," by B. Jaye Anno,[81] has very helpful, practical information.

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[78] See F. Cohen, Liability for Custodial Suicide: The Information Base Requirements. Jail Suicide Update 1 (Summer, 1992) for a fairly detailed analysis of this matter.

[79] 40 Lantern Lane, Mansfield, Massachusetts 02048.

[80] One writer puts the matter this way, "A court cannot impose a [medical/mental health] system simply because it may be desirable, nor can it rely on accepted standards promulgated by professional organizations to delineate minimally adequate prison health care provision." Susan L. Kay, *The Constitutional Dimensions for Inmates' Right to Health Care*, pg. 11, (National Commission on Correctional Care, 1991).

See Fred Cohen, Legal Issues and The Mentally Disordered Offender, Appendix A (22ed. 1988, N.I.C.) for a comparative review of such standards.

[81] (1991, N.I.C.)

A study of this chapter, and the materials noted, should provide a decent framework for understanding, and action to meet, the rights of detainees with mental illness and inmate. Do not wait for the legal papers to be served. Do your homework now, decide what is required and desired and - act.

CHAPTER 4

SCREENING, ASSESSMENT, AND IDENTIFICATION OF SERVICES FOR MENTALLY ILL OFFENDERS

James R. P. Ogloff
Ronald Roesch
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THE NEED FOR IDENTIFYING MENTALLY ILL OFFENDERS IN PRISONS

Although considerable attention has been paid to the issue of mentally ill offenders (MIO) in the criminal justice system within the past decade (e.g., Monahan & Steadman, 1983; Steadman & Monahan, 1984; Teplin, 1983, 1984), this certainly is not a new issue. Historically, people with mental illness or intellectual impairment were often incarcerated with offenders and "treated" by cruel methods similar to those used to punish offenders (e.g., physical restraint, starvation, and flogging; Ives, 1914). Monahan and Geis (1976) report that Benjamin Franklin was instrumental in establishing the first mental hospital in the American colonies because of his belief that persons with mental illness should be confined given their proclivity toward dangerousness. In many ways, then, the current attention that is being paid to mentally ill offenders is long overdue.

Several studies show that a small but significant number of inmates in prisons are mentally ill (see Chapter 2 in this monograph; see also, Daniel, Robins, Reid, & Wilfey, 1988; Dvoskin & Steadman, 1989; Hodgins & Cote, 1990; Roth, 1980; Steadman, Fabisiak, Dvoskin, & Holohean, 1987; Teplin, 1983, 1984, 1990). For example, Steadman, Dvoskin and their colleagues (Dvoskin & Steadman, 1989; Steadman et al., 1987) conducted a survey of the inmates in the New York State prison system to determine the extent of psychiatric disabilities among inmates. The results showed that 5% of inmates were "severely psychiatrically disabled," demonstrating psychopathology similar to that found in state psychiatric center acute inpatients. Another 10% were "significantly psychiatrically disabled," similar to patients in crisis beds in the community.

In addition to the research investigating the prevalence of MIOs in prisons, research shows that correctional officers perceive MIOs less favorably than other inmates, and the officers feel the need for training in the area of identifying and handling MIOs (Kropp, Cox, Roesch, & Eaves, 1989). Finally, MIOs have higher rates of institutional infractions and incidents of misconduct than other offenders (Adams, 1986).

As has been covered in Chapter 3 of this volume, a number of legal cases have mandated the evaluation of, and provision of limited mental health services for, MIOs in correctional facilities (see, e.g., *Bowring v. Godwin*, 1977; Churgin, 1983; Dix, 1985; *Inmates of Allegheny County Jail v. Pierce*, 1979; Leuchter, 1981; Melton, Petrila, Poythress, & Slobogin, 1987; Ogloff, Finkelman, Otto, & Bulling, 1990; Ogloff & Otto, 1989; *Robert E. v. Lane*, 1981; *Ruiz v. Estelle*, 1980). The legal standard for determining the adequacy of medical (including mental health) services in prisons is the level of care that is provided at no charge to people in the same locality (see *Newman v. Alabama*, 1977). Although the nature and quality of mental health services that are provided in prisons vary greatly among jurisdictions, systematic screening and evaluation of inmates for mental health problems is generally required. Therefore, given their presence in prisons, the legal mandate for providing treatment to MIOs, and the concern that correctional officers have about them, attention devoted to developing services for MIOs in prisons is warranted.

The terms jails and prisons are often used interchangeably; however, jails and prisons are very different types of facilities. Prisons typically house inmates who have been convicted and sentenced to serve one or more years in a correctional facility. By contrast, jails inmates generally are detained a) for relatively short periods of time prior to arraignment or trial, or b) if found guilty of a misdemeanor and sentenced to jail. Due to the very different mandates of jails and prisons, the type of mental health services that can be provided in them also varies considerably. Due to the short stay of most offenders in jails, mental health services in jails typically are limited to screening, classification, and diversion (Ogloff, Tien, Roesch, & Eaves, 1991). By contrast, mental health evaluation and treatment services in prisons are not as restricted by time. The focus of this chapter will be on mental health services for inmates in prisons as opposed to jails; however, where relevant we may rely on literature based on jails.

In this chapter, we review current screening and assessment models and methods used with MIOs in prisons. We then propose a model for screening inmates, conducting assessments, and providing mental health services in prisons. The philosophy that underlies our model is the importance of providing all inmates with brief, effective, mental health screening, and linking assessment and programming in prisons. We also emphasize the need for initial as well as ongoing screening and evaluation of mental health issues among inmates. Throughout the chapter, we note some of the specific problems inherent in these assessments, such as the disincentives or barriers to the provision and acceptance of mental health services in prisons, malingering and deception among prison inmates, lack of cooperation, scarce resources, volume of admissions, the transient nature of certain mental disorders, and co-morbidity.

THE NATURE AND PURPOSE OF MENTAL HEALTH SCREENING AND EVALUATIONS IN PRISONS

The need for identifying and providing services to MIOs is premised on the fact that mental disorder may hamper an inmate's ability to function in the prison. In addition, other

inmates may be disrupted, and the prison routine may be jeopardized, by MIOs. Therefore, it is important to identify inmates who are mentally ill. Given the large number of inmates that enter prisons, and the relatively small percentage of inmates who are mentally ill and in need of services, it is not necessary or cost effective to perform a complete mental health assessment of every inmate. Instead, as we discuss more fully in our model for the provision of mental health services in prisons, we recommend a two-tier mental health evaluation process. The first step involves a brief mental health screening for every inmate upon admission to the prison and occasionally during his or her sentence (see American Association of Correctional Psychologist, 1980). Second, those inmates who are identified during the screening as being mentally ill are referred to mental health professionals for a more complete mental health assessment.

Mental health assessments in prisons are performed for several general purposes: 1) to identify inmates who may be at risk for injurious behavior to themselves or others; 2) to determine whether an inmate is so mentally ill that he or she cannot participate in prison activities; 3) to determine whether an inmate is so mentally ill that he or she should be transferred to a mental health facility; and 4) to determine whether an inmate who is not so mentally ill as to be transferred to a mental health facility can benefit from treatment. These various types of assessments will be briefly discussed below.

According to Dvoskin and Steadman (1989), one of the "core principles" of providing mental health services to offenders is to "help make the prison a safer place for both inmates and staff" (p. 205). Suicide is one of the most severe threats to inmates' safety in prisons (Ramsey & Tanney, 1987). Therefore, any mental health evaluation program must attempt to identify those inmates who are at a risk for suicide. Unfortunately, due to the low base-rate of suicides in prisons, it is difficult to identify inmates who will likely attempt to take their own lives.

In order to determine whether an inmate is so mentally ill that he or she should be transferred to a mental health facility, the mental health professional generally conducts a rather routine psychological evaluation to identify the existence and severity of any psychopathology. If the clinician recommends to the institution that the inmate be transferred to a secure mental health institution, a transfer hearing may be held and the inmate may be transferred (see *Vitek v. Jones*, 1980).

In the case where an inmate apparently suffers from a mental disorder that is not serious enough to warrant transfer to another institution, the goal of the assessment should be to determine whether the inmate will benefit from a program that may be made available to the inmate within the prison system. Indeed, there is little need in conducting an assessment that identifies some minor psychopathology or "problem in living" for which the prison system offers no treatment program. Thus, it is essential to link mental health evaluations with programs that are available to inmates. Aside from providing information about the specific inmate being assessed, mental health evaluations may also be useful in identifying problems that should be addressed by treatment programs that do not currently exist.

As we discuss more fully below, most mental health evaluations in prisons are conducted at the time of admission or following a crisis in which an inmate displays acute psychological problems. These mental health services may be effective in identifying inmates who require services upon admission to the prison, or to identify the specific needs of inmates who have suffered an acute episode. However, many inmates, who develop mental health problems after being incarcerated, or whose problems become more severe under those circumstances, fall between the cracks left open by limiting mental health assessments to the time of admission and following crisis episodes. For this reason, it is important for prisons to implement a comprehensive screening and evaluation program, and to involve all personnel working with inmates in prisons in the process of continuously identifying inmates who may display symptoms of mental illness and who may require intervention.

REVIEW OF EXISTING ASSESSMENT MODELS TO IDENTIFY MENTAL HEALTH ISSUES AMONG INMATES

Front-End Mental Health Assessments

Most mental health assessments in prisons are conducted during the admission process. Virtually all standards that govern correctional facilities require that all inmates be given a medical examination upon admission to the facility. This examination must also include a screening for mental illness. As mentioned above, these examinations are to screen out inmates who are seriously mentally ill, and to identify those inmates who may require special placement or services in the institution.

From a practical perspective, the standards do not specify who must conduct the examination, or how it should be conducted. Typically, the mental health screening consists of asking inmates a few questions about their current functioning and whether they have had previous contact with the mental health system. Unfortunately, the efficacy of such informal assessment/screening procedures for identifying mental health problems is questionable. Indeed, there has been little research regarding the usefulness of standardized screening measures (e.g., Hart, Roesch, Corrado, & Cox, in press; Teplin & Swartz, 1989). To be most effective, a screening system should err on the side of false positives (i.e., correctly identify all the inmates with mental health needs, and incorrectly identify some inmates who really do not have such needs). By being over inclusive, it will be less likely to have MIOs fall through the cracks.

Those inmates who appear to be mentally ill during the screening generally are referred to the prison physician. In larger prisons, the inmate may be referred to a psychologist or other mental health professional. At that point, the inmate is given a more thorough mental health assessment. Such assessments typically involve having inmates complete psychological tests, be interviewed by a social worker and a psychologist and/or psychiatrist, and be observed by correctional officers or nursing staff.

It is common for prisons that employ more thorough mental health evaluations to use a standard battery of psychological tests to identify mental health problems. Most often, the psychological tests employed are of the self-report, personality inventory, nature. Later in this chapter we review some of the tests and clinical interviews that are used for assessments in prisons.

In general, more extensive psychological assessments can be useful in identifying mental health problems that may be missed during a routine screening. They also may be useful in identifying areas in which services should be provided. One important concern about using traditional mental health evaluations for all inmates entering a prison is that the assessments may reveal a number of relatively minor psychological problems with which the institution is not equipped to deal. Given our belief in the importance of linking mental health evaluations to services, there is little benefit in conducting thorough psychological evaluations that reveal relatively minor problems that will not be treated in the prison. In fact, given the stigma associated with mental disorder and psychological problems, it may be unfair to inmates to write information in their prison files about minor psychological problems that are quite inconsequential to their incarceration and will not be treated in the prison. Given the high cost of unnecessarily extensive psychological evaluations, it is important to reach a careful balance between using screening methods that do not identify important and relevant mental health issues and conducting extensive psychological evaluations that provide information that is not particularly relevant and is not linked to programs in the prison.

Furthermore, there is an implicit assumption that mental disorder is equated with an inmate's level of psychosocial functioning. This relationship is not always valid. Very often inmates with mental illness are not disruptive and will not harm themselves, while many disruptive inmates are not mentally ill. Therefore, rather than just focusing on identifying mental illness, it is important to consider inmates' psychosocial functioning.

Another model that is used in some jurisdictions makes use of "reception centers." Reception centers are centralized facilities within a jurisdiction where inmates are placed upon admission to the prison system. During their stay at the reception centers, inmates are evaluated for suitable placement in the prison system. Some attention is paid to inmates' psychological adjustment to prison and to their psychological functioning. Typically, inmates are given a rather thorough psychological assessment. Thus, the advantages and disadvantages of such assessments that we discussed above are relevant here. Although reception centers likely are useful for providing a smoother transition to prison, they are not particularly practical for all jurisdictions (e.g., small states).

Ongoing Observation and Monitoring of Offenders

Given the variable and sometimes lengthy sentences that inmates receive, it is crucial to continuously monitor inmates in order to identify those that may be demonstrating symptoms of mental illness. Some inmates will develop mental health problems while in prison, and the mental health status of inmates may change during their prison sentence (Hodgin, in press). All

staff who work with inmates in prisons should receive adequate training in identifying symptoms of mental illness and managing inmates with mental illness. Although corrections officers are likely to be the ones who have the most day-to-day contact with inmates, other personnel including teachers, librarians, nurses and others, should also receive this training.

In addition to training personnel in the identification and management of mental illness, it is important for mental health programs in prisons to include formal and informal mechanisms for personnel to make referrals to the programs. For example, corrections officers should be able to talk with mental health personnel about an inmate who they notice to have undergone serious changes in mood or behavior. Likewise, there should be a formal process for staff and duty officers to refer inmates to the mental health program.

Although the implementation of ongoing staff training and referral programs can be very effective in identifying inmates with signs of mental illness, it may also be useful to have a system of formally screening inmates at various times during their incarceration. Although such a system may be relatively costly, it is likely to reduce further the number of inmates with mental illnesses who fall between the cracks and do not receive treatment until a crisis occurs.

Post Crisis Mental Health Assessments

Unfortunately, in many prisons the only time an inmate is provided with psychological services after an initial admission screening or assessment is after an inmate experiences a crisis situation. Indeed, mental health professionals in prisons will find much of their work consisting of crisis intervention and crisis management (see Bonta, Cormier, Peters, Gendreau, & Marquis, 1983). It is reasonable to assume that absent difficulties or problems in the prison routine, corrections officers will be reluctant to consult mental health professionals. Regardless of the working relationships that may develop, involvement by "outsiders" constitutes a break with routine and procedure. This serves to discourage contact with clinicians except in cases where it is considered essential. And, intervening in crisis situations is the activity in which prison personnel likely see mental health professionals as being most useful.

The most obvious problem with limiting ongoing psychological evaluations and services to those which occur after a crisis has occurred is that, by then, the problems will have escalated to the point where intervention is extremely difficult. Also, other inmates and corrections officers will likely have been affected by the crisis, in which case the need for psychological services will have increased exponentially. Thus, in the multi-stage assessment program that we describe later in this chapter, we emphasize the need for ongoing screening or evaluation for psychological problems as a method for preventing crises from occurring.

Criminogenic Risk/Needs Assessment

In addition to front-end and post crisis assessments, mental health evaluations frequently are conducted to assess inmates for criminogenic risk and needs (e.g., level of security placement in the prison, suitability for gradual release programs, parole assessments). These

evaluations are generally focused on identifying factors that would place an offender at risk for criminal behavior. Some of the measures discussed later in this chapter have been found to be effective in aiding such evaluations (e.g., MMPI-2, Level of Supervision Inventory, Psychopathy Checklist). Generally speaking, criminogenic assessments are not conducted for the benefit of the inmate, per se, but rather to identify and reduce inmate misconduct (Berecochea & Gibbs, 1991; Levinson, 1988). Issues of security, overcrowding, and inmate control, rather than treatment, are the main objectives of these classification schemes (Bonta & Motiuk, 1992; Wright, 1988). Typically, all inmates are given criminogenic assessments, not just those who are mentally ill or in need of mental health services. Therefore, little attention will be paid to such assessments in this chapter. In the following section, we review the existing assessment methods that are employed to identify MIOs.

REVIEW OF CURRENT ASSESSMENT METHODS

Below, we review a number of procedures that are or can be used to assess prison inmates. One important issue to keep in mind is the degree to which they focus on psychosocial functioning (i.e., mental disorder) versus criminogenic risks and needs. In addition, as Hodgins (in press) argues, we need to move from a general methodology of simply identifying mental disorder among inmates, to exploring the relationship between mental illness and crime (Hodgins, in press). To this end, Hodgins notes that the reliability and validity of many of the methods that have been employed to assess mental illness among inmates is quite questionable.

Assessment of Psychosocial Functioning

When we speak of psychosocial functioning we are interested in whether or not the offender has some mental disorder that results in (a) personal distress, or (b) inability or unwillingness to function in a standard correctional setting. Note that this can be viewed as a medical model: Prisoners have "disorders" that are then "treated" according to professional standards. The "treatment" usually consists of medication and/or psychotherapy that is conducted through an outpatient clinical or inpatient unit. Assessments of psychosocial functioning are usually "clinical" in nature, that is, they are usually based on interviews and rely considerably on subjective judgments. As a result, they are generally conducted by mental health professionals.

Criminogenic Risks/Needs Assessments

Criminogenic risks/needs assessments are conducted to identify <u>risk factors</u>, static variables that are associated with increased likelihood of future offending, and <u>needs</u>, dynamic variables that, when properly addressed, can reduce the likelihood of future offending (e.g., Andrews & Friesen, 1987). Notice that here we are more interested in the protection of society (via desistence of offending) than in the reduction of the individual's distress (or the amelioration of his mental state), although in this model mental disorder may be construed as an important risk factor or need (Adams, 1986). The model is managerial: Prisoners have "risks" that are

"managed" according to system policies and procedures. The "management" usually consists of the establishment of rules or regulations that must be adhered to in order for the individual to obtain or retain privileges, specialized custodial or community placements, or the completion of educational, vocational, or counselling programs. Criminogenic risks and needs are typically assessed by paraprofessionals or correctional officers.

Adult Inmate Management System (AIMS)

The AIMS was developed by Quay for the U.S. Federal Bureau of Prisons to assist in the classification of adult male offenders (Quay, 1983). It is intended for use by correctional officers, who rate inmates on a number of specific items based on their institutional behavior. The item ratings are then used to assign inmates to one of five categories: Aggressive-Psychopathic, those who are hostile, violent, and anti-authority; Manipulative, those who engage in covert violations of institutional rules and regulations; Situational, those who are "normal" inmates and who infrequently engage in violence or other disciplinary problems; Inadequate-Dependent, those who are socially withdrawn, immature, and prone to victimization by others; and Neurotic-Anxious, those who are chronically distressed. The inmate categories are not based on psychodiagnostic nomenclature, but were identified in collaboration with correctional officers, which makes the AIMS "user-friendly." Another advantage of the AIMS is that it is based on current behavior, so that inmates whose behavior changes significantly over their period of incarceration can be re-assessed and re-classified.

Despite its apparent strengths, the AIMS has received relatively little attention from researchers. Thus, the generalizability of its reliability and validity are unknown. Recently, Cooke (1993) reported on his attempts to use the AIMS in a study of Scottish prisoners. In his statistical analyses, the Aggressive-Psychopathic and Manipulative categories collapsed into a single, large category; also, the Anxious-Neurotic category was not well-defined. Part of the problems with the AIMS seemed to stem from its use of a dichotomous (yes-no) rating format. Cooke therefore adapted the AIMS by adding items and changing the rating format to a 5-point scale (1 = never, 5 = all of the time). He called this new scale the Prison Behavior Rating Scale (PBRS). The PBRS was subsequently used in a sample of 890 prisoners from 7 different institutions. Analyses indicated that the PBRS yielded three distinct and reliable factors: Anti-Authority, corresponding to Quay's Aggressive-Psychopathic and Manipulative groups; Anxious-Depressed, corresponding to Quay's Neurotic-Anxious group; and Dull-Confused, corresponding to Quay's Inadequate-Dependent group. (Inmates with low scores on each factor would correspond to Quay's Situational, or normal, group.) PBRS scores were very stable across raters and time, and also were correlated with other measures, such as the Psychopathy Checklist (see below), and institutional misbehavior.

In light of their demonstrated reliability and validity, as well as their cost-effectiveness, correctional officer-administered rating scales deserve more study. The AIMS and PBRS could be easily incorporated into any correctional system with little cost in terms of training or administration.

Diagnostic Interviews

Diagnostic Interview Schedule (DIS)

The DIS is a structured psychodiagnostic interview designed for use in large-scale epidemiological surveys. It is designed for use by lay interviewers, although intensive training is required (40 hours of didactic and hands-on instruction is recommended). Several forms of the DIS are available. The original version was designed to yield current and lifetime diagnoses of a number of mental disorders made using DSM-III criteria; later versions were modified to conform to DSM-III-R criteria. Regardless of which version is used, the DIS comprises a large number of questions (more than 100), each designed to elicit diagnostically-relevant information. These questions are posed to every respondent in exactly the same manner, and responses are coded according to precise rules. Depending on how the response is coded, a number of follow-up questions ("probes") may be asked. Administration time is typically about 60 to 90 minutes. The DIS is generally scored by computer; hand-scoring is possible, but impractical due to the complexity of the answer form and the probability of errors. Research conducted with community residents and psychiatric patients suggests that the DIS has moderate but acceptable interrater and test-retest reliabilities; however, there is mixed evidence concerning its concurrent validity vis-a-vis clinical examination.

The DIS has been used extensively in research on the prevalence of mental disorder among correctional inmates (e.g., Bland & Newman, 1990; Cote & Hodgins, 1992; Hodgins, in press; Hodgins & Cote, 1990; Motiuk & Porporino, 1991; Neighbors, Williams, Gunnings, Lipscomb, Broman, & Lepowski, 1987; Wormith & Borzecki, 1985). In general, the findings suggest that a large majority of inmates (50% to 90%) meet the criteria for substance use disorders or antisocial personality disorder, and a significant minority (10% to 30%) meet the criteria for a serious, acute mental disorder such as a depressive, bipolar, schizophrenic, or organic disorder.

Due to the length of time it takes to administer, the DIS is not particularly useful for routine screening of inmates for mental illness on admission. However, the DIS has several features that make it attractive for use as a second level assessment tool once it has been determined that an inmate may be mentally ill. First, and perhaps most important, is the fact that the DIS does not have to be administered by professionals. This leaves open the possibility that correctional staff could use all or part of the DIS, flagging individuals who are diagnosed with certain "major" disorders for follow-up evaluation or treatment (Teplin & Swartz, 1989).[82] Such a procedure could reduce costs and improve service delivery in jurisdictions with limited

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[82] Teplin and Swartz derived a short form of the DIS, which they called the Referral Decision Scale, to predict major DIS/DMS-III disorders. However, there is evidence that the RDS, like any short form, is considerably less reliable than the full DIS, and that it may make too many prediction errors -- even in the hands of clinically-trained administrators -- to be of practical use (Hart, et al., in press).

access to mental health professionals. It would still be quite costly to train correctional staff to administer the DIS and computer score completed protocols, of course. Another problem is that the role of mental health evaluator may conflict with that of correctional officer. We have conducted several educational programs for corrections officers on the identification and management of mentally ill offenders. During these courses, officers have voiced concerns to us that focusing too much on the care of inmates might make them less able to enforce regulations or use physical force against inmates, at least in the eyes of their fellow officers.

A second positive feature of the DIS is that it yields diagnoses according to standard criteria. However, we should emphasize that symptoms of mental disorder, such as suicide risk, may be an important target for intervention even when the individual does not meet the criteria for a disorder. Also, the DIS does not assess every disorder that may be of interest to correctional systems. For example, it does not assess many organic mental disorders, most personality disorders, or any adjustment disorders. Finally, the DIS has only moderate concurrent validity. As a consequence of these problems, Thus, the DIS may "miss" important cases that should be referred for further evaluation or treatment.

Third, the DIS is highly structured. The practical consequence of this is that the quality and outcome of the assessment should not vary as a function of which specific person conducts the interview. This structure is a two-edged sword, however. It also means that the DIS requires considerable cooperation from respondents. Those unwilling to give complete or honest answers are likely to end up with either no diagnosis or a potentially serious misdiagnosis. Also, due to the structure of the DIS, it is not possible to incorporate collateral information into the assessment. This increases the interview's susceptibility to exaggeration or defensiveness on the part of the respondent. Finally, the DIS may be too complex for those who have poor English, thought form disorder, or limited intellectual skills.[83]

Structured Clinical Interview for DSM-III-R (SCID)

The SCID is a semi-structured psychodiagnostic interview designed for use in research and clinical practice. It is intended to be administered by qualified and experienced mental health professionals; formal training, typically lasting 1 or 2 days, is also recommended. The SCID actually comprises two major interviews: The SCID-I assesses current and lifetime major DSM-III-R Axis I disorders, including psychotic, mood, substance use, anxiety, somatoform, eating, and adjustment disorders; the SCID-II assesses current DSM-III-R personality disorders (with the exception of sadistic personality disorder). The first section of the SCID-I is devoted to obtaining a brief psychosocial history; the remainder consists of specific questions designed

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[83] The DIS has been translated into several different languages, including Spanish, French, and Chinese. However, some of these translations have not been fully validated; in addition, there may be insufficient evidence supporting the cross-cultural validity of the DSM-III-R disorders themselves. Finally, it is doubtful that many correctional facilities will be able to afford training staff to administer the DIS in several different languages.

to tap symptoms of psychopathology. Several versions are available; some are designed for use with nonpatients have a brief psychiatric history section, and others are designed to ignore the differential diagnosis of psychotic disorders. The SCID-II has no history section, and is designed to be administered after a full Axis I evaluation has been completed. A self-report inventory can be administered to respondents prior to the SCID-II interview to help focus the interview on salient symptoms. The SCID-I and -II are best described as semi-structured, because the questioning, probing, and coding are less rigid and require more judgement than do those on other interviews, such as the DIS. An important feature of the SCID is that collateral information and behavioral observations can be incorporated into the final scoring. Administration time varies from about 60 to 120 minutes for each form. Hand scoring is relatively simple, and aided by "skip to" and "skip out" questions. Research indicates that the SCID-I and -II yield diagnoses of good to excellent interrater reliability, test-retest reliability, and concurrent validity, at least for the major Axis I and II disorders. The SCID has been used in a small number of studies of correctional inmates.

The SCID has several advantages over the DIS: it offers a more thorough assessment of psychopathology; it has equal or greater reliability and validity; it is easier and more flexible to administer and score; and it may be less susceptible to distortion on the part of respondents. Also, note that the SCID is not used to screen inmates, but rather as the basis for ultimate professional judgments. These advantages come at a very high cost, however. The SCID requires considerable professional resources to administer. For this reason, routine administration of the SCID is impractical except in wealthy, large, urban facilities. The SCID, like the DIS, is also problematic for use with offenders from other linguistic or cultural groups.

Self-Report Inventories of Psychopathology

Minnesota Multiphasic Personality Inventory, Second Edition (MMPI-2)

The MMPI-2 contains 567 true-false items, all declarative statements phrased in the first person singular. The items yield scores on 10 basic clinical scales, 4 basic validity (response style) scales, and a number of supplementary scales. In the standard scoring procedure, raw scores are first adjusted for defensiveness (as measured by one of the validity scales, *K*) and then converted to T-scores; T-scores $\geq$ 65 are considered to be high. The target population of the MMPI-2 is adults (age 18 or older) who have Grade 8 reading ability or better. The entire MMPI-2 usually takes between 1 and 1½ hours to complete, although patients with serious psychopathology may take two hours or longer. Scoring and interpreting the MMPI-2 by hand can be a lengthy process, taking and hour or longer; fortunately, computer scoring and interpretation are available.

Routine use of the MMPI-2 as a screening instrument is economical and practical in most correctional facilities, as administration and scoring require supervision of a mental health professional but not necessarily much in the way of direct contact time. However, its has serious clinical limitations. First, while there is considerable research on the MMPI (see Zage, 1988 for a review), no norms for the MMPI-2 are available for correctional populations at the

present time (although they almost certainly will appear in the psychological literature over the next few years). Such data are critical in order to determine if the MMPI-2 is able to make meaningful discriminations among offenders. This is a concern, as reviews of the use of the MMPI in correctional settings have concluded that "the MMPI profiles of prisoners have seemed remarkably homogeneous. Numerous studies show that scale 4 usually is the most elevated scale in mean profiles of prisoners and identify the 4-2 and 4-9 code types as those most frequently occurring for prisoners" (Graham, 1990, p. 196). Second, the MMPI-2 is not very useful as an instrument to diagnose DSM-III-R-type disorders: it assesses only a limited range of psychopathology; it is very old, and the psychiatric constructs on which it was based have undergone extensive reformulation in recent decades; and the test employs cutoff scores can be used only to identify people with relative, rather than absolute, scale elevations. Third, the MMPI-2 requires considerable cooperation from respondents. It does provide a direct appraisal of deceitfulness and test-taking attitude via the validity scales. One form of deceitfulness--psychologically sophisticated defensiveness--is even corrected for during the scoring process. However, other forms (e.g., malingering, unsophisticated defensiveness) are not controlled; thus, valid completion of the MMPI-2 still requires considerable cooperation from subjects. The test is also inappropriate for those with literacy problems, poor English, or the intellectually impaired.

Millon Clinical Multiaxial Inventory, Second Edition (MCMI-II)

The MCMI-II is similar in format to the MMPI-2. It comprises 175 true-false items, all declarative statements phrased in the first person singular. It yields scores on 4 validity scales, 13 scales analogous to the DSM-III-R Axis II personality disorders, and 9 clinical syndrome scales analogous to DSM-III-R Axis I disorders. Each MCMI-II scale comprises a relatively small number of items (usually between 8 and 10) that are unique to that scale, as well as other items that are shared with other scales. Scale items are given a weight (1, 2, or 3) according to their theoretical importance and empirical validity. Raw scores on some scales are then adjusted according to scores on the validity scales and on two "hidden" (i.e., unreported) correction indexes. Finally, scale scores are transformed into base rate (BR) scores. The BR transformations are complex, and differ according to the sex and race of patients. Their interpretation is also complex: briefly, for the severe personality pathology scales and the clinical syndrome scales, BR scores $\geq$ 75 indicate that the disorder or syndrome measured by a scale is "present," and scores $\geq$ 85 that it is "prominent" (Millon, 1987). For the clinical personality pattern scales, Millon recommends a more sophisticated configural analysis that takes into account both absolute and relative scale elevations (although this procedure does not appears to improve significantly over the more simple cutoff method; Rennenberg, Chambless, Dowdall, Fauerbach, & Gracely, 1992). Not surprisingly, computer scoring and interpretation are available (and recommended; Millon, 1987) for the MCMI-II.

The MCMI-II has many of the same strengths and weaknesses as does the MMPI-2. One area in which the MCMI-II is superior concerns diagnostic assessment: It is consistent with current (DSM-III-R) nosology, covers a wider range of psychopathology, and uses cutoff scores to identify people with absolute (rather than relative) elevations. Despite this, the predictive

efficiency of the MCMI-II vis-a-vis DSM-III-R diagnoses may still be low (e.g., Hart et al., 1991; Rennenberg et al., 1992; Soldz et al., in press), and it still does not assess all possible symptoms and syndromes that might be problematic in correctional settings. Like the MMPI-2, the MCMI-II lacks correctional norms and requires considerable effort and cooperation from respondents.

Rating Scales

Brief Psychiatric Rating Scale (BPRS)

The BPRS (Overall & Gorham, 1962) was designed to assess the severity of specific psychopathological symptoms. In its most recent revision (Lukoff, Liberman, & Nuechterlein, 1986), it comprises 24 items that are rated on a 7-point scale according to their severity in the month preceding assessment (1 = not present, 7 = extremely severe). It was designed for use by both professionals and para-professionals in research and clinical settings. A semi-structured interview and review of collateral information are recommended, but not required, to assist in the rating process; assessment usually takes about 20 to 40 minutes. BPRS total scores, calculated by summing the individual items, are a highly reliable index of global symptomatology. In addition, the BPRS can be used to classify individuals into a number of different diagnostic "types" using more complex scoring algorithms (Overall & Gorham, 1962). The BPRS has been validated extensively in clinical populations (see Lukoff, Liberman, & Nuechterlein, 1986) and has also been used in a small number of studies of mentally ill offenders (e.g., Hart et al., in press; Neighbors et al., 1987).

The BPRS does not correspond with the DSM-III-R. This is both good and bad. On the down side, it means that further diagnostic assessment may still be required after the BPRS is completed. On the positive side, the BPRS assesses an extremely broad range of symptomatology, and its scores are not constrained by rigid and arbitrary diagnostic criteria.

In terms of ease and cost of administration, the BPRS probably lies somewhere between the structured interviews and the self-report inventories. It certainly requires some training or clinical experience to administer, although much less than the DIS or SCID. It can also be administered by any number of mental health professionals and para-professionals (psychiatrists, psychologists, psychiatric nurses, psychiatric social workers)--perhaps even by correctional officers. It is relatively flexible and easy to administer, even in cases where the individual refuses to cooperate, has poor English, thought disorder, or intellectual impairment, as ratings can be based on behavioral observations and informal contacts. In our own research, we have had good success using the BPRS as a screening device: inmates with high scores on the BPRS are very likely to be diagnosed with a major DSM-III-R diagnosis at follow-up, whereas those with low scores almost never receive such diagnoses (Hart et al., in press).

Referral Decision Scale (RDS)

The RDS (Teplin & Swartz, 1989) was designed to identify jail admissions who were likely to have a treatable serious mental disorder. The RDS comprises 18 questions taken from a structured diagnostic interview, the Diagnostic Interview Schedule (DIS), Version III (Robins, Helzer, Croughan, & Ratcliff, 1981). The questions were selected for their ability to predict DIS lifetime diagnoses of three major mental disorders: schizophrenia, bipolar disorder (mania), and major depressive disorder. Most of the questions focus on whether the respondents have experienced specific symptoms (e.g., loss of appetite, flight of ideas, persecutory thoughts) at some point in their life; one question concerns previous hospitalizations for mental disorder. Teplin and Swartz (1989) found that the RDS accurately predicted DIS major mental disorders in two different samples: jail admissions and sentenced inmates. Hart, Roesch, Corrado, and Cox (in press) found the RDS to be a useful screening measure, especially with some modifications to the recommended cutoff score for determining level of depression. One noteworthy feature of the RDS is that because the DIS was designed to be administered by lay interviewers, the RDS can be used by correctional officers rather than by mental health professionals. This could make the RDS particularly useful in jails with limited involvement of mental health professionals.

Computerized Assessment[84]

Over the past fifteen years there has been an increase in the number of computerized assessment systems (Matarazzo, 1986). As Jemalka, Wiegan, Walker, and Trupin (1992) note, the huge increase in admissions to jails and prisons makes it very difficult to adequately screen all inmates who are admitted. One solution to this problem is the development and implementation of computerized assessment techniques for offenders. The Offender Profile Report (OPR) is a computerized intake screening process that was developed by Jemalka and his colleagues for new admissions to state prison systems. The OPR was designed to specifically address major screening questions that arise in corrections, including an inmate's violence potential, risk of suicide, risk of victimization while incarcerated, vulnerability to substance abuse and need for substance abuse treatment, and identification of any emergent mental health issues for each inmate entering the prison system. Demographic data, personal and criminal history, and psychometric test data are combined in algorithms to yield rankings in each adjustment dimension addressed. Because a broad range of psychometric measures are used, the resulting assessments are based on a much broader data base than most current classification systems.

One of the primary goals of the OPR is to provide an initial indication of mental health problems for any given inmate. The screening battery developed contains a section listing the possible DSM-III-R diagnoses which may be applicable to the individual being screened. These are not intended as definitive diagnoses. Rather, they are tentative "rule out" diagnoses which

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[84] The authors are grateful to Ron Jemelka for his assistance with this section of the chapter.

should be confirmed or ruled out by a mental health professional following a more thorough evaluation. In the current version of the system, the MMPI is used almost exclusively in the algorithms for psychiatric diagnosis. Each possible diagnosis is "flagged" based on specific scale evaluations or combinations of elevations.

The mental health screening battery consists of a series of pencil and paper tests and a brief mental health and personal history interview conducted at the time of the offender's arrival into the correctional system. The tests in the battery include the MMPI, the revised Beta IQ Exam, the Test of Adult Basic Education (TABE), the Suicide Probability Scale (SPS), the Buss-Durkee Hostility Inventory (BDHI), the Monroe Dyscontrol Scale (MDS), the Michigan Alcohol Screening Test (MAST), the Drug Abuse Screening Test (DAST), and the United States Employment Service Interest Inventory (USES). The battery also includes the responses from a structured, 31-item mental status examination administered by a correctional mental health worker.

Because of the large number of incoming inmates, the testing process has been automated as much as possible. To accommodate a wide range of reading abilities, an automated tape and slide presentation of all test items was prepared. Inmates record responses on custom-designed mark-sense answer sheets. Interview responses and other needed information are also recorded on machine readable forms.

Algorithms were developed to apply to each inmate's data set in order to decide which predictive statements best characterize that person. These algorithms utilize various test scale scores, specific test item responses, structured interview responses, and various personal and demographic data to produce rankings on five-point scales for each inmate's potential for violence and substance abuse, risk for suicide and victimization, and possible evaluation and treatment needs. These statements are synthesized into a written mental health screening report tailored to correctional settings and classification decisions using a computerized report generator. This process uses an optical scanner to read the mark sense forms and enters the data into a personal computer. Custom built software does all the scoring, data manipulation, and report generation. The system includes a printer to produce hard copy of all output and an internal hard disk drive for data storage and retrieval.

Although preliminary research with computerized assessments for inmates appears promising (Jemalka et al., 1992), further research is needed to replicate and extend those findings. Also, steps need to be taken to ensure that computerized testing systems are developed in languages other than English for areas with diverse populations.

Specialized Assessments

Psychopathy

Psychopathy is a key construct in psychological theories of criminal behavior. Traits of this personality disorder include glibness and superficial charm; callousness and a lack of

empathy; lack of guilt and anxiety; and irritability, impulsivity and irresponsibility. The most popular measure of psychopathy is Hare's Psychopathy Checklist-Revised (PCL-R) (Hare, 1980, 1991). The PCL-R is a 20-item symptom construct rating scale that is completed by clinicians on the basis of a semi-structured interview and a review of collateral information. It is intended for use only in forensic (i.e., criminal and forensic psychiatric) settings; it was originally validated in adult males, but it has also been used with adult females and young offenders (Hare, 1991). A large body of research conducted in North America and Europe indicates that the PCL-R has high interrater reliability, test-retest reliability, and internal consistency. In addition, PCL-R scores are a moderate but highly robust predictor of criminal recidivism, institutional misconducts, and response to institutional treatment programs. What makes the PCL-R particularly useful is that it is one of the few reliable predictors of future violence, both in and out of prison (see Hare, Forth, & Strachan, 1992; Hare & Hart, 1993). The PCL-R is starting to be used by several North American correctional and forensic mental health systems as a device for measuring static risk, with this information subsequently used to make institutional classification and community management decisions. One advantage of the PCL-R is that it yields both categorical diagnoses (psychopath versus nonpsychopath) and dimensional scores (ranging from 0 to 40); thus, it can be used to make useful discriminations even in groups of serious and persistent offenders.

Malingering and Deception

Although a great deal of stigma has been attached to inmates with mental illness, there are a variety of reasons inmates may malinger.[85] For example, inmates' cases may be on appeal and their mental state may be at issue, MIOs may be provided with segregated housing, they may receive special attention and care ("doing soft time"), and in some jurisdictions they may be transferred to a separate institution for MIOs.

Virtually no controlled experiments have been performed to investigate the usefulness of using traditional unstructured clinical interviews to identify malingering (Rogers, 1988; Ziskin, 1984). Given the vast literature regarding the frequency with which errors occur in human judgments (e.g., Arkes & Hammond, 1986; Kahneman & Tversky, 1973; Tversky & Kahneman, 1974), including those of clinicians (Arkes, 1986; Kleinmutz, 1986; Wiggins, 1981), it may be safe to say that unstructured clinical interviews are not very efficacious in identifying malingering in defendants. Similarly, projective techniques have not been subjected to much experimental rigor for assessing malingering and should probably not be relied upon exclusively to identify malingerers (for a review of projective techniques see, Schretlen, 1988; Stermac, 1988).

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[85] The Diagnositc and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM-III-R, American Psychiatric Association, 1987) defines malingering as the "intentional production of false or greatly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military conscription or duty, obtaining drugs, or securing better living conditions" (p. 360).

Rogers (1988) suggests that structured interview formats may have more promise in evaluating malingering. For example, the Structured Interview of Reported Symptoms (SIRS), was specifically designed to assess malingering (Rogers, 1984, 1986). Rogers and his colleagues have conducted studies which support the efficacy of the SIRS for identifying malingerers (Rogers, Gillis, & Bagby, 1990; Rogers, Gillis, Dickens, & Bagby, 1989).

Another structured interview format, the Schedule of Affective Disorders and Schizophrenia (SADS), shows some promise in differentiating malingerers from people with genuine mental disorders (Rogers, 1988; Rogers & Cunnien, 1986; Spitzer & Endicott, 1978).

Because of the psychometric rigor used to assess the validity and reliability of objective measures, they may be useful in accurately identifying clients who malinger. Both intelligence tests and personality inventories have been used to evaluate malingering. There is some disagreement whether examination of total IQ scores can accurately identify people who are malingering (e.g., Goebel, 1983; Schretlen, 1986; Heaton, Smith, Lehman, & Vogt, 1978). The literature discussing the identification of malingering using scatter analyses of performance on IQ tests is more promising. The underlying assumption of scatter analyses is that malingerers will fail items that people with an actual disorder will pass, and pass items that genuine patients fail (Schretlen, 1986, 1988).

The MMPI and MMPI-2 have, by far, received the most empirical attention regarding their ability to identify malingering and deception. Indeed, in developing the MMPI, Meehl and Hathaway (1946) noted the importance of identifying malingerers (those "faking-bad") and people who are defensive ("faking-good"). Although there is not sufficient space to review all of the relevant data investigating the efficacy of objective measures, including the MMPI, to correctly identify malingering and defensiveness, it is fair to say that these instruments are currently the most useful for doing so (see, R. L. Greene, 1988a & b; Schretlen, 1988). Both Greene (1988a) and Schretlen (1988) present tables which show the extent to which the MMPI is useful for correctly identifying malingering and defensiveness. The advent of the MMPI-2 has entailed the modification of the F scale and deletion of the Test-Retest index,[86] therefore more research is needed to assess the utility of the MMPI-2 for identifying malingering.

A PROPOSED MULTI-STAGE MENTAL HEALTH SERVICES PROGRAM FOR MIOs

Throughout this chapter, we have presented information about screening and evaluating inmates who may be mentally ill. As the information reveals, a variety of systems and methods have been employed across jurisdictions. In this section, we present and discuss a Multi-Stage Program for screening, assessing, and providing services to, MIOs (see Figure 1). We also

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[86] Shooter and Hall (1989) provide a table indicating the differences in the validity indicators between the MMPI and the MMPI-2.

discuss the need for including a research component of any model for screening, assessing, and delivering mental health services.

As mentioned in Chapter 3, in 1980, the Federal District Court for the Southern District of Texas specified six basic requirements of a constitutionally acceptable mental health treatment program for prisons in Texas (*Ruiz v. Estelle*, 1980):

1. The prisons must systematically screen and evaluate inmates to identify those who require mental health treatment;

2. Treatment of inmates must consist of more than the mere segregation and close supervision of MIOs;

3. The corrections system must employ sufficient mental health professionals to provide individualized treatment where necessary to inmates with serious mental disorders;

4. Providers of prison mental health services must maintain accurate, complete, and confidential records of treatment;

5. The use of behavior-altering drugs in dangerous amounts, by dangerous means, must be adequately supervised and reviewed;[87]

6. Provision must be made for the identification and treatment of inmates with suicidal tendencies.

The above requirements form a useful foundation for developing a useful multi-stage assessment and treatment program for MIOs. Although these minimum standards have not been mandated in other jurisdictions, they provide an indication of an by a court to apply the eighth amendment constitutional requirements derived from *Estelle v. Gamble* (1977).

Intake Screening

All inmates should be screened soon after admission to a prison. The screening should be relatively brief and could follow models developed in jails for screening for mental disorder. We suggest that the model we have developed in jails could be used in prisons as well (Ogloff, Tien, Roesch, & Eaves, 1991; Roesch, in press). This model begins with a screening interview of all persons entering the jail. We employ several senior graduate students from a clinical psychology doctoral program at a nearby university. The interviews are brief, approximately 20 minutes in length, but they provide sufficient information to make initial decisions about the

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[87] The Supreme Court has denied the right to refuse psychiatric treatment (i.e., by means of psychotropic medication) for offenders in prisons (*Washington vs. Harper*, 1990).

mental health needs of incoming inmates. The screening procedure includes a brief semistructured mental status interview, the Brief Psychiatric Rating Scale (Overall & Gorham, 1962), and the Global Assessment of Functioning Scale from the DSM-III-R (American Psychiatric Association, 1987). A semi-structured interview covers seven content areas: Personal/demographic information, suicide risk, orientation to time and space, criminal history, social adjustment during the past month, mental status in the past month, and mental health history.

We have found that the intake screening is useful as a means of identifying inmates who may need crisis intervention, particularly those who may be at risk for self-harm or suicide, but we suspect this will be less of an issue in prisons, at least at intake. Most of the jail inmates we assessed do not need further intervention because they do not have mental health problems, and we would expect that this would be equally or more true in prisons. Mental health professionals have a tendency to begin to see all inmates as in need of some form of mental health intervention, and we caution those involved in establishing a prison assessment program to avoid this pitfall. The majority of inmates do not need or desire mental health services, and for these inmates, the initial screening will be their last contact with the mental health program.

The initial screening should not be time-consuming as the daily admission rate in most prisons, in contrast to jails, is quite low. Further, suicides in prisons tend not to occur soon after admission, as they do in jails, so immediate screening is not a necessity. The screening should normally be completed within the first week of admission. The purpose of this screening is to detect serious mental disorder that requires rapid management, treatment, or further evaluation. In a system with few resources, this initial screening could be conducted by trained paraprofessionals or correctional officers. Larger systems should rely on mental health professionals, following the spirit of court decisions (e.g., *Ruiz v. Estelle*, 1976). It is desirable to minimize false negative errors at this screening stage (inmates whose mental disorder is not detected).

The intake screening should be designed to address immediate mental health needs of incoming inmates. Assessment for long-term intervention is inadvisable at this time. The more comprehensive assessment would take place at a later time (see section on Comprehensive Psychodiagnostic Assessment of MIOs). Inmates who may be good candidates for long-term intervention could be flagged at the initial screening stage and could then be monitored until there is an opportunity for the treatment assessment.

Ongoing Monitoring/Screening of Inmates

Our model places a heavy emphasis on prevention and early intervention. Some inmates will develop mental health problems while in prison, and the mental health status of inmates may change during their prison sentence (Hodgin, in press). Therefore, an essential component of our model is a formal process for ensuring that inmates are periodically assessed, both formally and informally. The system should encourage self-referrals as well in order to facilitate access to treatment services. In addition to formal assessment, we believe that it is important that

correctional officers, who have the most frequent contact with inmates, be trained to recognize signs of mental disorder (Lombardo, 1985). Correctional officers should be in a position to detect early signs of mental health problems and to initiate referral to mental health professionals so that appropriate services could be provided. Ongoing screening and evaluation is feasible in all prisons since it is relatively inexpensive to train correctional officers to identify symptoms of mental disorder (Dvoskin, 1990). Once detected, however, it will be necessary to have mental health professionals available for assessment and treatment.

Comprehensive Psychodiagnostic Assessments of MIOs

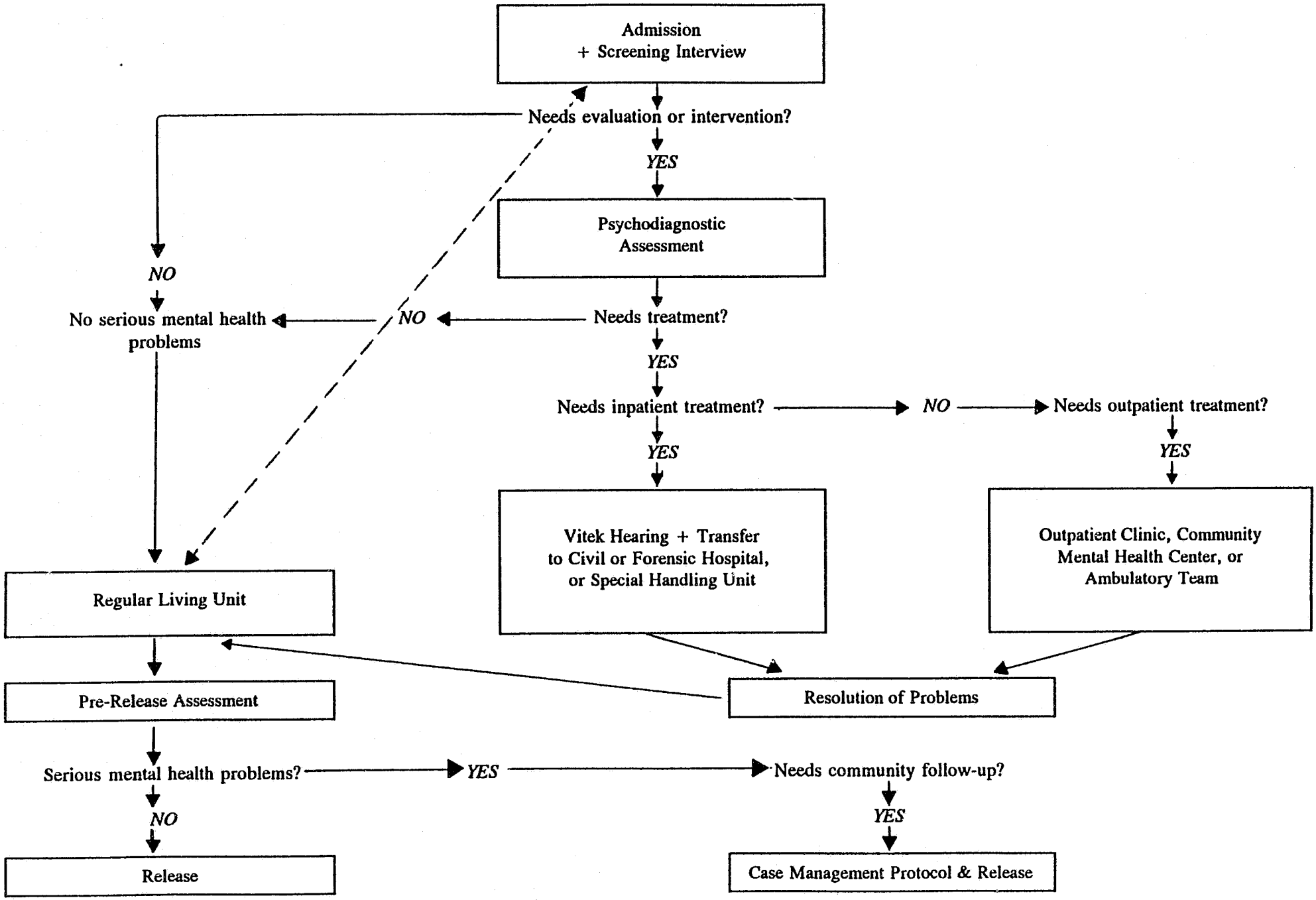
The purpose of the more comprehensive assessment is to determine mental status and treatment needs. Again, the emphasis of all mental health assessments is to obtain the information needed to make decisions about appropriate treatment services. In small systems, the psychodiagnostic assessment could be contracted out to mental health professionals. One alternative is to develop a contractual arrangement with a local community mental health center. This would be most desirable because the center could be involved in providing both assessment and treatment services while the inmate is in prison and perhaps could be involved following release if the inmate remains in the local community. An ambulatory team is another alternative, especially for systems comprised of two or more smaller facilities. This team would be employed fulltime by the correctional system and be available to all facilities in the system on an as-needed basis. Of course, larger prison systems would likely have one or more permanent mental health professional positions.

One of the central purposes of comprehensive psychodiagnostic examinations in prisons is to determine the threshold issue: Is the inmate mentally ill and should he or she receive treatment in the institution or should he or she be transferred to an inpatient or outpatient treatment facility? The measures we reviewed earlier in this chapter, particularly the SCID, should prove useful in providing more in-depth diagnostic information. While this diagnostic information is important, as it provides specific information on the nature and severity of mental health problems, it is not sufficient to assess an inmate's level of functioning or to develop a treatment plan. Specific treatment plans should be based on a more functional assessment of the individual inmate's specific problems. A diagnosis of schizophrenia, for example, provides little direction to treatment providers. However, knowledge that an inmate experiences delusions or has difficulty controlling aggressive impulses could lead to specific interventions designed to ameliorate these problems. The assessment battery for inmates referred from intake or ongoing screening, therefore, should include an assessment of the inmate's specific behavioral problems.

Gradual/Post-Release Monitoring/Supervision and Continuity of Services

Many treatment programs initiated in prisons terminate once the inmate is released. The transition back to the community is often a difficult one, and one need look no further than recidivism rates to find evidence of this reality. We believe that it is essential that the assessment and intervention process begun in prison continue after release in cases in which this

FIGURE 1
A proposed multi-stage mental health services program for MIOs



is deemed appropriate. Again, we emphasize the voluntary nature of participation in treatment but if the inmate is interested in continuing treatment post-release, efforts should be made to facilitate this.

Unfortunately, such continuity of treatment occurs all too infrequently. Based on his study of local jails, Steadman (1992) found that one consistent factor seemed to be associated with more effective jail/community programs, and that was the existence of a core position that was responsible for managing the interactions of mental health, jail, and judicial personnel. He uses the term boundary spanners to characterize these individuals, because they were able to cross over the boundaries of the separate systems and ensure that the needed services were being provided. The title of the position and professional qualifications varied from program to program, but for those interested in establishing a viable program, it may be essential that some individual have the responsibility of ensuring that the two systems interact effectively and efficiently. We believe that this model could be applied to the integration of prison and community services and could make continuity of treatment more likely. The difficulty in applying this to prisons is that inmates return to communities all over a state and sometime out-of-state, so many boundary spanners would need to be involved. In many states, mental health programs are organized by regions, so the integration of prison and community services could be facilitated if each region designated a person to work with returning inmates.

Research and Program Evaluation

In this final section, we want to emphasize the importance of a research component of any model for assessment and delivery of mental health services. Our model stresses the importance of linking assessment with treatment. Mental health professionals conducting the evaluations would typically make recommendations for treatment based on their assessment of the needs of an individual. These recommendations are based on perceived need but also on the availability of services. Often, especially in prisons with limited budgets for treatment, the most appropriate treatment might not be available so compromises often must be made. It is all the more important, then, that ongoing evaluations of the effectiveness of the assessment/treatment decisions be built into the system from the start. This evaluation could inform decision makers about the outcome of their decisions. Over time, this feedback could lead to improvements in the assessment, referral, and treatment phases of the model. Data on the base rates of mental disorder should also prove valuable in planning for future treatment needs.

CONCLUSION

Although it is by no means a new issue, increased attention is being paid to mentally ill offenders in the criminal justice system. Several studies show that a small but significant number of inmates in prisons are mentally ill. In addition, a number of legal cases have mandated the evaluation of, and provision of limited mental health services for, MIOs in correctional facilities. The need for identifying and providing services to MIOs is premised on the fact that mental disorder may hamper an inmate's ability to function in the prison. In

addition, other inmates may be disrupted, and the prison routine may be jeopardized, by MIOs. Therefore, it is important to identify inmates who are mentally ill.

Given the large number of inmates that enter prisons, and the relatively small percentage of inmates who are mentally ill and in need of services, it is not necessary or cost effective to perform a complete mental health assessment of every inmate. Instead, we recommend a two-tier mental health evaluation process. The first step involves a brief mental health screening for every inmate upon admission to the prison and occasionally during his or her sentence. Second, those inmates who are identified during the screening as being mentally ill are referred to mental health professionals for a more complete mental health assessment.

As discussed above, several psychometric instruments may be useful for screening and evaluating the mental health of inmates. Rather than using a number of traditional personality measures (e.g., the MMPI-2 or MCMI-II), we have found a screening system that we developed particularly useful (Ogloff, Tien, Roesch, & Eaves, 1991). This system begins with a screening interview of all persons entering the prison. The interviews are brief, approximately 20 minutes in length, but they provide sufficient information to make initial decisions about the mental health needs of incoming inmates. The screening procedure includes a brief semi-structured mental status interview, the Brief Psychiatric Rating Scale, and the Global Assessment of Functioning Scale from the DSM-III-R.

In addition to implementing a comprehensive screening and evaluation program, it is important for prisons to involve all personnel working with inmates in the process of identifying inmates who may display symptoms of mental illness and who may require intervention. Many inmates develop mental health problems after being incarcerated or have problems that become more severe during incarceration. Unfortunately, if their is no system or process for monitoring the mental health of inmates, some with mental illnesses may fall between the cracks left open by limiting mental health assessments to the time of admission and following crisis episodes. Because corrections officers have continuous contact with inmates, they are particularly useful for monitoring the mental health of inmates and providing referrals to a mental health program or mental health professional.

A vast majority of inmates return to the community following incarceration, most after a relatively short period of time. Therefore, it is important that mentally ill offenders are gradually released to the community with appropriate supports. Unfortunately, given the general dearth of community mental health services available, it is difficult to ensure that mentally ill offenders receive adequate care and supervision. Nonetheless, such care is critical for increasing the probability of the inmate succeeding in the community.

Finally, it is important that prison mental health programs incorporate an evaluative component that will enable them to monitor the progress of inmates who come into contact with the project. Such data are important for determining whether the program is successful, and are useful for helping to make any changes that are necessary to increase the program's efficacy.

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CHAPTER 5

TREATMENT FOR PRISONERS WITH MENTAL DISORDER[88]

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There are many seriously disturbed people in prisons. One might assume that the criminal justice system's laws about diminished capacity and insanity would ensure that offenders with mental disorder would be sent to hospitals instead of prisons. Experience and research show otherwise. Recent research shows that many persons with psychoses are convicted and sentenced (Rice & Harris, 1990; Teplin & Pruett, 1992). A surprisingly large proportion of prisoners, perhaps greater than 15%, qualify for some type of psychotic diagnosis (Hodgins & Coté, 1990; Motiuk & Porporino, 1991; Steadman, Fabisiak, Dvoskin, & Holohean, 1987; Teplin, 1990; Wormith & Borzecki, 1985).

There is accumulating evidence suggesting that persons currently experiencing psychotic symptoms (especially symptoms of schizophrenia) are at increased risk of violent behavior (Hodgins, 1992; Klassen & O'Connor, 1988; Monahan, 1992; Taylor et al., in press). There is also evidence that trends towards "deinstitutionalization" of mental hospitals have been accompanied by increased rates of incarceration for persons with serious mental illness (Palermo, Smith, & Liska, 1991; Penrose, 1939; see also Steadman, Monahan, Duffee, Hartstone, & Robbins, 1984). The characteristics that predict criminal recidivism among mentally disordered offenders are essentially the same as those that predict recidivism among offenders in general (Feder, 1992; Rice & Harris, 1992; Rice, Harris, Lang, & Bell, 1990; Rice, Quinsey, & Houghton, 1990).

Criminal justice systems do an inadequate job of screening and sorting their clients; many persons with psychoses end up in prison. This occurs partly as a deliberate result of social or institutional policy (e.g., persons who are psychotic but whose criminal act was minor or not seen as being a direct result of the psychosis are not usually considered for an insanity defense; Rice & Harris, 1990); partly because some persons are already in prison at the time their psychosis becomes apparent; and partly by accident (Teplin & Pruett, 1992; Toch, 1982; Toch & Adams, 1987). It is important to note, however, that the high incidence of psychosis in prison is not primarily directly caused by a cruel and unusual environment driving sane prisoners mad (Bonta & Gendreau, 1990; Wormith, 1984; Zamble

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& Porporino, 1988). The higher proportion of inmates with psychoses in segregation and special handling units is more likely due to the difficulties they present to staff and other inmates than to their mental disturbance being caused by segregation (Adams, 1986; Hodgins & Coté, 1991; Gendreau & Bonta, 1987).

Without question, the presence in prisons of inmates with mental disorder presents serious problems for institutional staff and other inmates. In addition, most prisons are profoundly ill-equipped to manage and treat psychotic disorders, and traditional methods of isolation, chemical restraint, and transfer may exacerbate symptoms (Toch, 1982; Toch & Adams, 1987; 1989). In this chapter, we discuss a psychosocial approach to the assessment and treatment of inmates with mental disorder. The approach we advocate meets all the desiderata for mental health services in prison described in *Ruiz v. Estelle* (see for example, Jemelka, Trupin, & Chiles, 1989). First, however, there are several key issues that should be addressed.

KEY ISSUES

Diagnosis versus Problems and Symptoms

Not all persons who qualify for a psychiatric diagnosis of major mental illness are disturbed or disruptive, in need of, or amenable to treatment. Conversely, not all disturbed, or disruptive inmates qualify for a diagnosis of psychosis. In this chapter we argue that all important clinical and administrative issues pertain to symptoms and other problems experienced by disturbed inmates and not to diagnosis per se. There are several bases for this assertion.

First, though persons with schizophrenia, for example, may exhibit slightly more violence than citizens or patients in general, characteristics that predict the occurrence of violence pertain to current symptomatology (Swanson, Holzer, Ganju, & Jono, 1990; Taylor et al., in press), and to history of aggression (Harris & Varney, 1986; Rice & Harris, 1992). Among mentally disordered offenders released to the community, severity of schizophrenic deficit and schizophrenic subtype were found to be unrelated to aggression (Rice & Harris, 1992).

Second, in several studies of psychiatric patients (Harris, Hilton, & Rice, 1993), forensic patients (Rice, Harris, Quinsey, Harris, & Lang, in press; Rice et al., in press) and prisoners with mental disorder (Sommers & Baskin, 1991) it has been shown that the type of psychiatric treatment delivered is, at best, weakly related to diagnosis and much more strongly related to presenting symptoms, other problems, and social factors.

Third, in several studies of psychiatric patients (Harris et al., 1993; Harris & Rice, 1990) and mentally disordered offenders (Quinsey, Cyr, & Lavallee, 1988; Rice & Harris, 1988), we examined subjects' clinical presentation with cluster analyses. In every case,

clinically useful (with respect to treatment and supervision needs) subgroups depended not upon psychiatric diagnosis but instead upon current interpersonal problems, skill deficits, criminal history, and current symptomatology. Thus, although a significant minority of prisoners qualify for psychiatric diagnoses, we conclude that treatment decisions cannot and should not be based solely or directly upon diagnosis.

Classification and Clinical Assessment

Classification of prisoners is a longstanding practice in corrections. Typically, inmates are sorted into institutions or areas within institutions based on security requirements. Levels range from maximum security for those judged to be the most likely to escape and the most dangerous to very open settings for inmates judged to be of low risk for escape and violence (Ekstedt & Griffiths, 1988). It has also been persuasively argued that, in addition to risk, classification should also reflect needs (Andrews, Bonta, & Hoge, 1990; Bonta & Gendreau, 1992). These authors assert that correctional classification should facilitate rehabilitation by targeting the criminogenic needs of relatively high risk offenders. In addition, we believe it is sensible to classify inmates based on their behavior within prison.

Our work on mentally disordered offenders (Rice & Harris, 1988; Rice et al., in press; see also Quinsey, Cyr, & Lavallee, 1988) suggests that several relevant subgroups emerge when the clinical presentations of offenders are examined in detail. These include:

1. Relatively low risk offenders who exhibit few problem behaviors in prison.

2. High risk offenders who exhibit few problem behaviors in prison.

3. High risk offenders who present significant management problems in prisons (e.g., violence, stealing, threatening, escape, noncompliance, insolence, lying, property destruction, etc.).

4. Inmates of varying levels of risk who exhibit psychotic symptoms (delusions, hallucinations, confusion, etc.) and social withdrawal (sometimes called negative symptoms of psychosis) while in prison.

5. A small group of inmates with serious mental disturbances who exhibit active psychotic symptoms, social withdrawal and severe management problems while in prison. This latter group is also likely to exhibit serious skill deficits (illiteracy, lack of vocational skills, etc.) and to appear depressed (and even suicidal; Bland, Newman, Dyck, & Orn, 1990; Florez & Holley, 1989).

The characterization of the latter two subgroups matches the case material provided by Toch (1982) and Toch & Adams (1987) on disturbed-nondisruptive and disturbed-disruptive inmates, respectively. We propose that correctional systems identify persons in

these latter two groups as the primary clientele of mental health services and provide specific treatment for them. In the remainder of this chapter we describe the assessment and treatment of the significant minority of inmates who exhibit such severe problems.

Before beginning, however, there are three points to make. First, treatment and rehabilitation aimed at reducing criminal recidivism are indicated for many offenders in the first three groups (Andrews, Zinger, Hoge, Bonta, Gendreau, & Cullen, 1990). Second, such rehabilitation is also indicated for the inmates in the latter two groups, but clinicians and prison administrators are likely to regard amelioration of the psychotic symptoms (and other problem behaviors) as a higher priority. As treatment improves such problems, one would expect an offender with mental disorder to be "reclassified" into his appropriate risk/needs category. Third, services for psychiatric patients are almost always directed towards the overarching goal of successful adjustment to the community. By analogy it has been argued that the goal of services for inmates with mental disorder should be successful adjustment to the "normal" prison population (Dvoskin & Steadman, 1989) to permit participation in rehabilitation programs and other activities. It goes almost without saying that this idea rests on the assumption that correctional institutions are safely and humanely run. No ethical clinician would assist in preparing inmate clients for reintegration into a "community" where they were likely to be the victims of violence and exploitation (Roth, 1980).

Just as diagnosis cannot be equated with assessment of clinical problems, assessment of clinical problems cannot be equated with correctional classification. Classification officers charged with sorting incoming prisoners can only be expected to make educated guesses about which inmates present significant clinical problems. There are several reasons for this: First, not all clinical problems are easily detected. For example, our research on subgroups of mentally disordered offenders (Rice & Harris, 1988; Rice et al., in press) and over a decade of combined experience on an admission ward for the most disturbed mentally disordered offenders in Ontario clearly show that many seriously disturbed inmates are not (or not always) disruptive. Rather, they are extremely withdrawn and seclusive. Second, much disturbed and disruptive behavior, no matter how pathological it seems, is profoundly controlled by the social environment (Rice et al., 1989). Third, as discussed below, many inmates exhibit some signs of disturbance or pathology on admission to prison, but that disturbance constitutes a "situational reaction" that quickly resolves itself (Zamble & Porporino, 1988).

CLINICAL SERVICES FOR INMATES WITH MENTAL DISORDER

To address these difficulties, a progressive system to providing service to inmates with mental disorder has been proposed (Cohen & Dvoskin, 1992; Dvoskin & Steadman, 1989; Greene, 1988; James & Gregory, 1980). Under such a system, inmates pass through increasingly selective screens (and increasingly intensive clinical services) starting with very liberal screening of inmates in the general population. Those assessed as likely to need

treatment become candidates for "outpatient" assessment and treatment. Outpatients in need of greater services are moved to crises or residential treatment beds and patients in need of the most intensive services move to the highly specialized services available in the "hospital". Most of the services can be located either within prisons or in separate institutions operated by public mental health agencies.

To us this approach makes good sense with the following provisos: 1. Especially at the early stages, extra care is needed to ensure that disturbed but nondisruptive inmates can receive services. At every stage, correctional staff (guards and clinicians) will be happy to see that the most disruptive inmates get transferred, but our research (Harris & Rice, 1992) and experience shows that withdrawn patients and inmates are often unnoticed or even preferred by institutional staff. 2. As much as possible, clinical services rather than patients should do the travelling. If the goal of service is successful adjustment to the prison environment, it is appropriate to evaluate the antecedents, problem behaviors and consequences in that environment (Kazdin, 1993). As discussed below, problems of generalization of treatment effects are minimized if that treatment occurs in the "home" environment. 3. Clinical services should be at least as much behavioral and psychosocial as pharmacological. There is abundant evidence, discussed below, that the resolution of the disturbed and disturbing behavior of mentally disordered offenders cannot come from exclusive reliance on drugs (Harris, 1989; Rice et al., in press; Rice, Harris, Quinsey, & Cyr, 1990).

Clinical Assessment

In this chapter, we take the strong view that traditional medical/psychiatric approaches to the treatment of offenders with mental disorder are inadequate. The problems inherent in basing policy and clinical decisions on psychiatric diagnosis have already been discussed. In assessing clinical needs and evaluating treatment, our position is the same: typical clinical observations are irrelevant (or nearly so). As we have discussed at length elsewhere (Rice et al., 1990; 1992), typical clinical observations as recorded in institutional files or noted in discussions among staff lack sufficient reliability and validity. Unfortunately, however, there is abundant evidence that clinically important behaviors are grossly underreported, that even highly qualified clinical staff do not agree about the meaning of clinical terms (e.g., delusional, depressed, disturbed, agitated) and that observations are not recorded in a sufficiently systematic (in time or context) fashion to permit useful comparability (Rice et al., 1990). Accurate decisions about who needs treatment, how much, and for what problems cannot be made using diagnoses or traditional clinical observations.

One response to these difficulties in traditional clinical practice was the rise of behavior therapy and behavioral assessment. We advocate the use of behavioral observation methods in the assessment of the clinical problems for mentally disturbed prisoners. Time sampling behavioral observation systems (e.g., Paul & Lentz, 1977) provide the highest quality data and can also be used to evaluate any intervention that is indicated in the treatment of inmates with mental disorder.

In addition to behavioral observation techniques, assessment of clinical problems can be informed by a number of paper and pencil questionnaires, checklists and rating scales completed by staff or patients. Some valuable general measures are the Psychotic Reaction Profile (Lorr, O'Connor, & Stafford, 1960)[89], the MACC Behavior Adjustment Scale (Ellsworth, 1971)[89], the Correctional Institutions Environment Scale (Moos, 1975)[90], and the Social Performance Survey Schedule (SPSS: Lowe & Cautela, 1978; Monti, 1983)[90]. Useful tools for the assessment of assaultiveness, anger and aggression include the Overt Aggression Scale (Yudofsky, Silver, Jackson, Endicott, & Williams, 1986)[89], the Special Hospitals Assessment of Personality and Socialization (SHAPS; Blackburn, 1987)[90] and several other self-report assessments of anger and temper control problems (Buss & Durkee, 1957; Novaco, 1975; Siegel, 1985; 198C; Spielberger, Johnson, Russell, Crane, Jacobs, & Warden, 1985)[90].

An expanded version of The Brief Psychiatric Rating Scale (BPRS; Lukoff, Liberman, & Nuechterlein, 1986; Overall & Gorham, 1962)[89] may be a useful supplement to behavioral observations in the assessment of positive psychotic symptoms. Finally, as discussed above, many persons suffering from schizophrenia or other serious disorders will exhibit only extreme social withdrawal as presenting problems. The SPSS (Miller & Funabiki, 1984)[90], MACC (Ellsworth, 1971; Helzel & Rice, 1985; Rice, 1983)[89], and NOSIE (Dvoskin & Steadman, 1989; Honigfeld, Gillis, & Klett, 1966)[89] have been shown to be useful with offenders with mental disorder. In addition, the Socialization Level Scale (Aumack, 1962; Rice, 1983)[89] and measures of assertion (Harris & Rice, 1984; McCormick, 1984)[90] may also be valuable.

Pharmacological Treatment

Many inmates with mental disturbances will be candidates for drug treatment. Of course, there is abundant and unequivocal evidence that neuroleptics reduce the positive symptoms of schizophrenia (agitation, hallucinations and delusions) and that lithium is the treatment of choice for bipolar disorder. The most revolutionary change in the history of the treatment of mental disorder was the advent of phenothiazine drugs. These drugs have profoundly altered the nature and duration of psychiatric hospitalization, and have greatly improved the quality of life for many persons diagnosed with schizophrenia (Rice, Harris, Quinsey, & Cyr, 1990). In addition, there is suggestive evidence that other psychotropic drugs reduce the aggression and agitation of other institutionalized individuals (Eichelman, 1988; Rice, Harris, Varney, & Quinsey, 1989).

Psychological treatments require institutional administration to engage in extensive planning and to have considerable control over the behavior of staff at all levels, while the

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[89] Measures completed by clinical staff.

[90] Self-report measures.

delivery of drugs alone rarely requires such a high degree of effective administrative control. Because drugs seem cheaper and easier to deliver than therapy programs; why do we so strongly advocate behavioral methods described below?

Neuroleptic drugs are completely effective neither for all psychotic symptoms nor for all patients. Harris (1989) showed that patients in a maximum security institution for mentally disordered offenders exhibited different responses to being admitted and receiving neuroleptic drugs. Many responded quickly and within a month or two were sufficiently stable to be considered for transfer. Many others, however, did not respond positively to drug administration and remained in the institution for many months or years. Neither increasing nor decreasing neuroleptic dose, nor changing to different drugs were associated with improvements in behavior or eventual transfer. Inevitably, any ward, unit or institution for disturbed and disruptive inmates would be populated by some who were partial or complete drug nonresponders.

Even when neuroleptic drugs have demonstrably positive effects, some patients resist taking them and initiate expensive legal battles in their efforts to resist. In fact, there is evidence that the best predictor of future drug refusal is the severity of some side effects (dysphoria and akasthesia) upon initial drug administration (VanPutten, May, & Marder, 1984). Drug refusal appears to be an especially common precursor to being identified as a mentally disordered inmate (Smith, 1989). Inmates might also be even less likely to take medication if they perceive that the drugs are offered to keep them quiet and compliant rather than to help them with their own serious personal difficulties. There are behavioral and cognitive-behavioral methods that improve medication compliance (Meichenbaum & Turk, 1987; Wittlin, 1988), but in the end, though an essential part of the clinical armentarium, it must be concluded that drugs will not suffice as the only clinical tool for prisoners with mental disorder (Harris, 1989; Rice et al., 1989; Rice, Harris, Quinsey, & Cyr, 1990). Thus, pharmacological approaches alone are not in fact as cheap and effective in treating offenders with mental disorder as they seem.

Behavioral Treatment

What other form(s) of therapy should be provided for inmates with mental disorder? Should it be psychotherapy, milieu therapy, cognitive therapy, cognitive-behavior therapy, or what? Whatever the value of other approaches in general, the empirical literature is unequivocal in supporting the use of behavioral treatment for inmates with mental disorder (Andrews et al., 1990; Harris & Rice, 1992; Rice et al., 1989; 1990; in press). It is commonplace to hear that treatment should be prescriptive. However, for the most part, the only form of prescriptiveness supported by empirical literature for the present population is attention to the antecedents, specific behaviors and consequences that characterizes behavior therapy. We propose a two-pronged behavioral approach. The first prong is the use of token economies and the second is the provision of skills training for specific behavioral deficits. Although therapeutic community or milieu programs are common in clinical settings, clinicians are unlikely to regard the most disturbed and disruptive inmates as

candidates for such a program. Furthermore, Paul and Lentz (1977) reported data showing that a token economy was more effective than an equally intensive therapeutic community program.

The existing literature strongly favors token economy programs as comprehensive systems to promote independent, prosocial, cooperative behavior; to extinguish (and sometimes penalize) dependent, antisocial behavior; to promote therapeutic client-staff interactions; to guide discharge and transfer decisions, and to encourage clients to participate in other skills teaching programs (Harris & Rice, 1992; Milan, 1987; Rice & Harris, in press; Rice et al., in press; Rice, Harris, Quinsey, & Cyr, 1990). Token economies can be individualized to target specific problem behaviors -- shaping and reinforcing desired prosocial conduct (being in a good mood, helping others, talking about realistic topics, leaving one's cell, etc.) and extinguishing or punishing undesirable conduct (assault, property destruction, threatening, yelling, etc.). Behavioral techniques designed to rapidly suppress self-injurious and assaultive behavior in institutions include differential reinforcement of incompatible behaviors, extinction, time-out, overcorrection-restitution, and contingent punishment. There is also evidence that suppression of these problem behaviors can be achieved through the use of contingent required relaxation and time-out plus response cost. Specific behavioral consequation can be accomplished without the use of a token economy, of course (Wong, Slama, & Liberman, 1987; Wong, Woolsey, Innocent, & Liberman, 1988), but a token economy is an invaluable tool when many or most inmates exhibit similar problem behaviors and deficits.

Token economy programs have been shown to improve and maintain many of the adaptive and prosocial behaviors of patients exhibiting a variety of problems in a variety of institutional settings (Rice et al., 1990). For example, the self care, life skills and social adjustment of institutionalized adolescents and delinquents, as well as the academic performance, work, life skills, and interpersonal behavior of adult and adolescent correctional inmates have all been reported to have been improved by token economy programs. Token economies also produce improvements in self-help behaviors, attendance at other programs, work, compliance, length of hospital stay, and recidivism in chronic psychiatric patients (Rice, Harris, Quinsey, & Cyr, 1990).

The overwhelming evidence on their effectiveness demands that clinicians planning therapeutic efforts in secure treatment institutions seriously consider the use of token economy programs (Rice, Harris, Quinsey, & Cyr, 1990). However, significant difficulties will face a clinician who proposes to implement a token economy program in an institution where staff are accustomed to a traditional custodial environment (Harris & Rice, 1992; Rice, Harris, Quinsey, & Cyr, 1990; see also Backer, Liberman, & Kuehnel, 1986). Appropriately trained and oriented staff are essential to the effective operation of a token economy. The effectiveness of a behavioral program can be undermined even when only a minority of staff fail to carry out program duties because customary staff practice is incompatible with effective behavioral treatment: deviant and dependent patient behaviors are reinforced and independent behaviors are extinguished. Laws (1974) asserted that

custodially-oriented ward staff should not operate a token economy and instead behaviorally trained staff should be specifically hired. As much as possible, one would seek an organization with staff specifically selected and trained for the program (Paul & Lentz, 1977).

Although it has been reported that token economy treatment can generalize to post-institutional environments (Paul & Lentz, 1977), such generalization is difficult to ensure (Rice, Quinsey & Houghton, 1990). Certain steps improve generalization (Kazdin, 1973), but whether behaviors acquired or strengthened in institutional reinforcement systems generalize or not, program managers require systems to monitor behavior, enforce reasonable rules, make security decisions and encourage patients in the specific skill building programs (for which there is evidence of generalization) that form the other part of our recommended behavioral approach. As discussed in the Inmates Rights section below, token economics have no serious rivals as management systems for offenders with mental disorder (Rice, Harris, Quinsey, & Cyr, 1990).

The second prong of our recommended behavioral approach is applicable to all inmates in need of mental health services and consists of specific skill training. This behavioral technology is usually provided for small groups of inmates at a time. The training methods comprise shaping, coaching, modelling, role-play practice, and feedback. The technology has been applied to general social skills associated with making and keeping friends (Rice, 1983; Rice & Josefowitz, 1983); heterosocial skills (Quinsey, Chaplin, Maguire, & Upfold, 1987), anger management or aggression replacement (Goldstein & Glick, 1987), assertion (Harris & Rice, 1992; Rice & Chaplin, 1979), interpersonal problem solving (Ross & Fabiano, 1985; Ross, Fabiano, & Ewles, 1988), conversation skills (Liberman, Mueser, & Wallace, 1986), and the management of positive psychotic symptoms (Liberman, 1988; MacKain & Streveler, 1990). Because patients with psychoses exhibit such obvious and gross deficits in interpersonal behavior, considerable effort has gone into teaching them social skills.

There is substantial evidence that social skill training produces lasting treatment effects and can increase community adjustment and reduce hospitalization (Benton & Schroeder, 1990; Corrigan, 1991). Although not specifically directed towards remediation of positive psychotic symptomatology (bizarre talk and actions, etc.), a common result of standard social skills training is that patients are reported, and report themselves, to have significant reductions in such psychotic symptoms (Rice, Harris, Quinsey, & Cyr, 1990). Liberman, Neuchterlein, and Wallace (1982) make a cogent argument for a concerted training effort aimed at teaching: basic cognitive/conversational skills such as staying on topic, focusing attention, ignoring distractions, handling stimulus overload, delaying responses, employing appropriate voice volume, and developing greater fluency; basic interpersonal social identification skills such as the accurate identification of others' emotions, predicting the impact of social behaviors, and the identification of others' social status; and coping strategies such as compromise, repeating requests, and refusing to comply (see also Wallace, 1982).

Other Treatment Issues

Seclusion and mechanical restraint are frequently used to reduce disruptive behavior (c.f. Harris, Rice, & Preston, 1989). However, their use often depends as much upon such factors such as staffing levels and the absence of structured activity as upon the nature of the problematic behavior itself. In addition, there is evidence that the use of behavioral treatments can drastically reduce the necessity for seclusion and restraint with no corresponding reductions in staff morale or safety (Davidson, Hemingway, & Wysocki, 1984).

It is important to note that disturbed disruptive inmates or patients can cause much friction within the ranks of institutional staff. Front line staff invariably seek to punish disruptive behaviors but frequently fail to reinforce appropriate responses. Even in token economy programs, there appears to be a continual tendency for front line staff to lobby for more and larger penalties for misbehaviors but to give fewer and fewer rewards (Bassett & Blanchard, 1977; Harris & Rice, 1992). There is a very real possibility that, in a general (non-token economy) ward environment, patients who exhibit management problems would live in a de facto program that was almost entirely aversive. That is, prosocial behaviors would largely be extinguished and there would be aversive consequences (in the form of restraint, seclusion, loss of privileges, scolding, etc.) for aggressive or disruptive behavior. Also, working with such patients can be stressful and frustrating for staff because of the effort required to effect patient improvement and because of the uncooperativeness and litigiousness of the patients. Staff are also at high risk for both real and specious charges of abuse and misconduct. In work with intrafamilial aggression, Patterson (1982; 1985) described an analogous phenomenon called coercive family process in which all family members attempt to control each others' behavior through an implicit process of exclusively negative reinforcement and punishment. Those who have worked on wards for the management of problem patients can recognize a nearly identical process in operation (Quinsey, 1981; Rice, 1985).

A final approach to the reduction of violent behavior in institutions is founded on quite a different understanding of the problem. It is based on the assumption that institutional violence is not solely the product of individual pathology but stems primarily, instead, from problems in the way patients and staff typically interact. That is, while staff regard their own behavior as reasonable, expected and "part of the job", patients often regard the same staff behaviors as provocative, insensitive and arbitrary. Thus, Rice and her colleagues (Rice et al., 1989; Rice, Helzel, Varney, & Quinsey, 1985) developed and evaluated a five day staff training course that emphasized early recognition of patients' disturbance, early verbal intervention to calm or defuse upset behavior and, as a last resort, safe and effective techniques for manual restraint and self defense. The course was positively received, reduced assaults, lowered workdays lost due to patient caused injuries, improved ward morale, and resulted in increased staffs' ratings of their own effectiveness and patients' ratings of self esteem.

ISN'T PRISON DEPRESSING?

So far, we have not addressed the assessment and treatment of the symptoms and other problems associated with depression. These problems include inactivity (psychomotor retardation); agitation; expressions of sadness, worthlessness, and hopelessness; threatened and attempted suicide; sleeplessness; anxiety; and sometimes anger. In a comprehensive and enlightening study, Zamble and Porporino (1988) showed that a very large number of prisoners report problems associated with depression and anger, especially early in their sentences. The authors point out that this is, to some extent, deliberate: prisoners are supposed to be unhappy about being in prison. In addition, depression can be the iotrogenic result of inconsistent and punitive staff behavior. Of course, some offenders have real and serious problems in other domains that cause them to be unhappy (marital discord, financial losses, addiction, etc.). Zamble and Porporino also showed that many of the most serious problems of depression resolve themselves relatively quickly with little or no intervention. Then, most prisoners "do their time" in what Zamble and Porporino term an intellectual and personal "deep freeze" in which they deal with problems much in the ways they do on the street: using avoidance, escape and, occasionally, impulsive antisocial conduct.

There will, however, be a significant minority of inmates whose problems of depression do not quickly resolve themselves. What clinical services should be provided for such persons? The treatment of major depression has received considerable scientific attention in recent years. There have also been efforts to distil those scientific data available in the public domain into useful advice for clinicians who treat unipolar depression (e.g., American Psychiatric Association, 1993). That advice seems sensible and fits traditional clinical lore: Supportive counselling is indicated for mild situational depression, psychotherapy is indicated for moderate depression and somatic therapy (drugs or ECT) combined with psychotherapy is required for moderate to severe depression.

In our view, a fair reading of the available literature, however, calls some of this advice into question. A comprehensive set of meta-analyses, narrative reviews, and multisite treatment evaluations (Elkin et al., 1989; Evans et al., 1992; Greenberg, Bornstein, Greenberg, & Fisher, 1992; Hollon, Shelton, & Loosen, 1991; Hollon, et al., 1992; Kupfer, 1992; Robinson, Berman, & Neimeyer, 1990; Shea et al., 1992; Shelton, Hollon, Purdon, & Loosen, 1991; Sotsky et al., 1991; Sweet & Loizeaux, 1991) leads to somewhat different conclusions: 1. Both cognitive-behavioral therapy and drugs (imipramine) are effective in the treatment acute depression. However, treatment effects are smaller when patients' (versus clinicians') ratings are used for the evaluation, and when greater efforts are made to control the effects of expectancies and the theoretical allegiance of the investigators. 2. Psychotherapies (usually in the form of cognitive, behavioral or cognitive-behavioral treatments) are equivalent to each other in effectiveness and to imipramine in the treatment of acute depression regardless of initial symptom severity or type of unipolar depression. 3. Cognitive-behavioral treatment during the acute phase of depression and continuing drug treatment are effective (and equally so) in reducing the likelihood of relapse regardless of initial severity. 4. The combination of cognitive behavioral therapy and drugs provided

during acute treatment is not much more effective than either alone, except that cognitive behavioral therapy (with or without drugs) appears to lower the risk of relapse. 5. The attrition rates for all forms of treatment are high (25-50%) and the personal characteristics that predict attrition and response to treatment are unknown. Also unknown are the mechanisms responsible for the positive effects of drugs and ECT and the specific features of interpersonal, cognitive, behavioral and cognitive-behavioral psychotherapy responsible for clinical improvement.

Consequently, our advice for treating problems of depression is little different than for other serious mental difficulties. Assessment should involve evaluation of the specific antecedents, behaviors and consequences of "depression." Some self-report measures may also be helpful (Beck & Beck, 1972; Hamilton, Stephens, & Allen, 1967; Rehm, 1981; Zung, 1969). Based on the meta-analyses and multisite studies cited above, inmates with persistent and acute depression should be offered a choice between cognitive-behavioral therapy (group or individual) or ongoing pharmacotherapy. Those who fail to respond to their first choice should be encouraged to try the alternate mode of treatment. ECT may be indicated for severely depressed inmates who fail to respond to both other forms of treatment.

SOME ILLUSTRATIVE TREATMENT PROGRAMS

By far the most powerful demonstration of the effects of behavioral treatment for psychiatric patients is that of Gordon Paul and his colleagues (Paul & Lentz, 1977). Working with very chronic and disturbed mental patients, Paul and his colleagues demonstrated that the specific behavioral techniques in a token economy were responsible for profound improvements in the severity of psychiatric symptoms, interpersonal skills and adaptive functioning. The token economy program was much more effective and less expensive than standard hospital care. The results of this study also showed that the behavioral improvements were maintained when the patients and programs were transferred to the community and resulted in very low rates of rehospitalization. Paul also developed a comprehensive technology to monitor patient and staff behaviors and demonstrated that the positive effects of the program occurred because the staff interacted with the patients in a manner very different from that found in a traditional hospital setting. Patients who participated in the program were maintained on far less medication (85% were drug-free). Although one might think such a program would be very costly, Paul and Lentz reported that the program (including the detailed behavioral observation methods described above) was effectively delivered with a staff that was no larger nor more highly qualified (though with much different training, of course) than that on traditional psychiatric wards. Paul's demonstration shows what is possible when an institution or service is specifically organized to deliver effective psychosocial treatment.

Milan and his colleagues (Milan, 1987) have convincingly demonstrated that behavioral programs can be effectively delivered in prisons. Using a cellblock token

economy for imprisoned felons, they demonstrated that contingent token reinforcement was responsible for increases in a variety of behaviors ranging from maintenance activities and personal hygiene to participation in educational programs. These improvements were achieved without deprivation of recreational opportunities or the imposition of other aversive consequences. Milan and his colleagues also demonstrated that response chaining could be used to develop behaviors that were otherwise never performed by the inmate participants. In a separate series of demonstrations, Ayllon and Milan (Milan, 1987) showed that behavioral programs in prison could produce large changes in academic and vocational skills compared to typical institutional routines. Furthermore, these investigators provided evidence that behavioral programs were acceptable to prisoners and that some skills generalized to the post-release community. Milan (1987) also examined legal judgments concerning the use of behavioral programs and concluded that the courts have never prohibited the use of effective and clinically sound behavioral programs. Rather, the courts have forbidden the use of some arbitrary, coercive and clinically unsound practices that skilled behaviorists would eschew anyway. Milan also noted the lack of behavioral work published since 1980, especially in institutions for mentally disordered offenders, and attributed this dearth to a host of professional, political, and administrative barriers to effective programming.

Finally, other investigators have shown that behavioral programs can be effectively delivered to prison inmates with mental disorder. Based on the work of Liberman (1988), MacKain and Streveler (1990) described a comprehensive psychosocial rehabilitation program for mentally ill offenders. The program was provided for both acutely disturbed "inpatients" and "day treatment" inmates who resided on regular prison ranges. Skills training (comprising modelling, shaping, role-play practice and videotaped feedback), was provided on such diverse topics as life skills, medication, self-management, communication skills, anger management, recreation, avoiding substance abuse, and stress management.

SPECIAL POPULATIONS

In this section, we consider whether special treatment procedures are required for three specific groups of offenders with mental disorder: HIV positive inmates, sex offenders, and females. Another group for whom special treatment is frequently recommended is substance-abusing inmates. This group is considered in a separate chapter.

Mentally Disordered HIV Positive Inmates

Both incarcerated individuals and persons with severe mental disorder are at higher risk for human immunodeficiency virus (HIV) infection and acquired immune deficiency syndrome (AIDS) than the general population (Cournos et al., 1991; Lurigio, 1989). Because of impaired judgment regarding drug injection and sexual behavior, as well as vulnerability to victimization, inmates suffering from major mental disorder may be at particularly high risk of infection by HIV both before and after incarceration. In addition,

psychiatric symptoms are common in HIV positive persons in all phases of HIV-related illness (Evans & Perkins, 1990). Dementia beginning with social withdrawal and impaired concentration, and then worsening gradually until there is severe poverty of speech, global cognitive impairment, and loss of muscle control occurs in a proportion of HIV positive individuals. Sometimes the dementia may be the only sign of AIDS. In other cases, there may be dementia secondary to acute infections. Suicide, suicidal ideation, depression and anxiety are common. There is some evidence that an HIV-related organic mood disorder may exist, and both major depression and manic syndromes have been reported (Evans & Perkins, 1990; Lyketsos et al., 1993).

There is some evidence that HIV-related mental disorders, especially major depression, respond to anti-viral treatments. In addition, traditional psychotropic medication including antidepressants, antianxiety agents, neuroleptics and psychostimulants can be used for symptomatic treatment. However, patients with HIV infection seem to be especially sensitive to many psychotropic drugs, so very low dosages are recommended (Evans & Perkins, 1990). Of course, all of the psychosocial treatments are applicable for HIV positive inmates just as they are for other inmates with mental disorder.

One of the most common concerns of staff who work with HIV-positive inmates is the possibility of infection via blood spills or bites during a violent altercation (Lurigio, 1989). Although there is no evidence that any correctional officer or person in any of a number of other occupations where contact through blood spills or bites is thought to be likely (e.g., police officers, paramedics or firefighters) has contacted HIV infection through the performance of their duties (Lurigio, 1989), it cannot be concluded that it is impossible (Belbot & del Carmen, 1991).

Because of the increasing numbers of cases of AIDs in prisons and the rapid pace of knowledge and laws about this topic, ongoing AIDs-related education should be an important topic for both inmates and staff who work with inmates. Although correctional officers mostly favor mandatory testing and the segregation of HIV positive inmates (Lurigio, 1989), the courts to this point have neither required nor forbidden either. Neither segregation nor mandatory testing is standard practice for both practical and humanitarian reasons (Belbot & del Carmen, 1991). At this point, then, universal precautions should be used with all inmates. Staff training in verbal methods to prevent and intervene in violent incidents (e.g., Rice et al., 1989) is especially important for staff who work with mentally disordered and other inmates at high risk for HIV infection. When physical intervention must be used with aggressive inmates known to be HIV positive, great caution is indicated and special equipment such as restraining blankets and retractable needles should be used (Cournos, Empfield, Horwath, & Schrage, 1990). Finally, AIDs education and protective devices (condoms and dental dams) and should be made available even though there may be explicit rules prohibiting sex (Cournos et al., 1990).

Mentally Disordered Sex Offenders

The idea that sex offenders, or many of them, at least, suffer from a mental disorder and therefore are in need of treatment has been debated at length. Until the late 1970s, the majority of U.S. states had statutes that allowed the indeterminate confinement of mentally disordered sex offenders (Monahan & Davis, 1983). Throughout the 1980s, the trend was towards repeal of these laws. Most recently, however, there has been a trend towards reenactment of special laws to indefinitely detain and treat the most serious sex offenders (usually child molesters, rapists and sexual murderers) who qualify for the label "sexual predator." Contrary to the earlier laws, which were viewed as a less severe sanction than prison (Monahan & Davis, 1983), the most recent laws are designed to detain the most serious offenders beyond the end of whatever sentence they received.

Only a minority of sex offenders, even within psychiatric settings, qualify for a diagnosis of major mental disorder as discussed in earlier parts of this chapter (Sturgeon & Taylor, 1980) and most sex offender treatment programs specifically exclude acutely psychotic offenders (Marques, Day, Nelson, & West, in press; Pithers, Martin, & Cumming, 1989). The diagnosis most commonly responsible for a designation as a "mentally disordered" sex offender is a paraphilia (almost always pedophilia or sexual sadism) in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R, American Psychiatric Association, 1987). Although a diagnosis of antisocial personality disorder is very common among sex offenders, it has often not been sufficient to qualify for a classification as a "mentally disordered" sex offender (Monahan & Davis, 1983).

In the rest of this chapter, we have approached treatment from the point of view of alleviating the suffering of the afflicted inmate so that he or she can live in the regular prison community. Although in some cases the treatment might have the effect of reducing the likelihood of recidivism, that has not been the explicit purpose of treatment. On the other hand, the purpose of treatment programs for sex offenders, whether labelled "mentally disordered" or not, is to reduce the likelihood of sexual recidivism. There is little question that the most popular current treatments for sex offenders are cognitive-behavioral and pharmacological (Becker, 1992; Bloom, Bradford, & Kofoed, 1988; Laws, 1989; Maletzky, 1991). There seems to be general agreement that other forms of group or individual therapy for sexual aggressors have not been shown to be effective (Furby, Weinrott, & Blackshaw, 1989; Marshall, Jones, Ward, Johnston, & Barbaree, 1991; Quinsey, 1984; Quinsey, Harris, Rice, & Lalumière, in press). Moreover, at least some outcome studies of treatment, including at least one behavioral treatment, done with the very serious offenders seen in most institutional programs for "mentally disordered" sex offenders have been failures (Frisbee & Dondis, 1965; Hanson, Steffy, & Gauthier, 1993; Rice, Quinsey, & Harris, 1991).

At the present time, a very ambitious program for incarcerated sex offenders is underway at Atascadero State Hospital (Marques, Day, Nelson, Miner, & West, 1992). The program is based upon relapse prevention, a cognitive-behavioral treatment strategy in which participants learn to recognize and interrupt the chain of events leading to relapse. The focus

of both assessment and treatment is the identification and alteration of the links in the chain, from broad lifestyle factors (such as substance abuse) and cognitive distortions to lack of specific skills (such as heterosocial skills, or anger management) and deviant sexual arousal patterns. The program is very intensive and lasts for two years during incarceration, followed by a one-year aftercare program designed to maintain treatment gains and reintegrate offenders into the community (Marques, Nelson, West, & Day, 1993). The program includes an evaluation of both in-treatment changes and long-term treatment effects using a design which includes volunteer subjects who are randomly assigned to treatment or control groups, as well as a matched non-volunteer control group. The project is not yet completed, but preliminary data are available on 108 men who completed at least one year of treatment, 9 men who began treatment but who dropped out before one year, 108 volunteer controls, and 110 nonvoluntary controls (Marques, Day, Nelson, & West, in press). The average time at risk is about three years. Unfortunately, the data so far are not encouraging inasmuch as reoffense rates among the groups are not significantly different.

There have been more encouraging results from less well-controlled (Marshall & Barbaree, 1988) and uncontrolled (Maletzky, 1991; Pithers & Cumming, 1989) studies of behavioral and cognitive-behavioral treatments for sex offenders, especially child molesters, treated in the community. However, the effectiveness of cognitive-behavioral programs, especially for serious offenders, remains to be demonstrated.

Pharmacologic treatments including antiandrogens (cyproterone acetate and medroxyproxgesterone acetate) and, more recently, fluoxetine, have been recommended as additions to cognitive-behavioral treatments for offenders who ruminate or masturbate excessively, or who have high plasma testosterone levels (Becker, 1992; Bloom, Bradford, & Kofoed, 1988). Although, there have been no controlled outcome studies of pharmacological or combined pharmacological and cognitive-behavioral treatments, very positive results have been reported for an uncontrolled evaluation of a combined behavioral, cognitive-behavioral, and pharmacological treatment program for offenders in the community (Maletzky, 1991).

Aside from the discouraging results so far about the effectiveness of any treatments for incarcerated sex offenders, much progress has been made in the prediction of which offenders are most likely to reoffend. Aside from factors known to predict recidivism (e.g., age, number of previous offenses) among offenders in general, some factors specific to sex offenders have been identified. Deviant sexual arousal, and level of psychopathy have been shown to predict recidivism among sex offenders (Quinsey, Rice, Harris, & Lalumière, in press; Rice, Harris, & Quinsey, 1990). Rapists have higher levels of recidivism than child molesters (Quinsey, Rice, Harris, & Lalumière, in press). Among child molesters, those who have male victims have higher recidivism rates (Quinsey, Rice, Harris, & Lalumière, in press; Rice, Quinsey, & Harris, 1991). Furthermore, it appears as though offenders who drop out of treatment have worse outcomes than both treated and unselected untreated offenders (Marques et al., in press).

Female Offenders with Mental Disorder

Although women form but a small fraction of persons held in prison, there are some data to suggest that they exhibit a higher rate of psychological disturbance than incarcerated men. Moreover, compared to men, they are more likely to be sent to secure hospitals than to prisons. There is also some evidence that although women respond better to prison and psychiatric hospitalization (in terms of recidivism) than men, they are harder to manage in the institution (Prins, 1980). Contrary to findings in society in general, there is little evidence among institutionalized persons with mental disorder that males are more violent (Rice et al., 1989).

Although high proportions of mental disorder have been found among female offenders, the disorders they exhibit fall mostly into the personality disorder category rather than into the category of psychosis or major mental disorder (Guze, 1976; Prins, 1980). Similar to the findings for male offenders, psychological distress seems to be highest upon admission to prison (Hurley & Dunne, 1991). When presence of major mental disorder is compared for male and female offenders (rarely done in the same study) the rates do not seem to be very different (Daniel, Robins, Reid, & Wilfley, 1988; Guze, 1976; Menzies, Chunn, & Webster, 1992) although there may be more affective disorder among women (Herjanic, Henn, & Vanderpearl, 1977). Similarly, studies of recidivism among female offenders have shown the best predictors to be similar to those for men - age, previous criminal history, marital status, education, and diagnosis of antisocial personality disorder and drug dependence (Cloniger & Guze, 1973; Martin, Cloninger, & Guze, 1978). Instruments designed to predict criminal recidivism among male offenders have also been found to work well for female offenders (Coulson, 1993).

Among psychiatric patients, there is considerable evidence that females are more likely than males to have been victims of abuse, especially sexual abuse (Carmen, Rieker, & Mills, 1984; Jacobson & Richardson, 1987). Diagnoses most commonly said to be associated with sexual abuse histories include post-traumatic stress disorder, borderline personality disorder, multiple personality disorder, substance abuse, and psychosis (Firsten, 1990), although in one study that compared diagnoses of abused and nonabused patients, no differences were found (Carmen et al., 1984). Sexual abuse histories are also common among female offenders, especially sex offenders (Travin, Cullen, & Potter, 1990), self-mutilators (Wilkins & Coid, 1991), and recidivist offenders (Long, Sultan, Kiefer, & Schrum, 1984). Although long-term psychotherapy, hypnotherapy, and pharmacotherapy are frequently recommended (Choy & Bossett, 1992; Kluft, 1987; Sonnenberg, 1988) there are few data to inform these recommendations. By contrast, there are promising data for short-term cognitive-behavioral treatments for victims of sexual or physical abuse (Foa, Rothbaum, Riggs, & Murdock, 1991; Sultan & Long, 1988).

At the present time, there is virtually no literature on the treatment of female offenders suffering from major mental disorder. However, based on the available literature concerning both female offenders and female psychiatric patients, there is little reason to

believe that the recommended treatments would be any different from those recommended for males.

ADMINISTRATIVE CONSIDERATIONS IN PROVIDING TREATMENT IN PRISONS

Staffing Issues

Although there are many strong opinions, and many sets of standards that address staffing issues in correctional institutions (e.g., the American Public Health Association's Standards for Health Services in Correctional Institutions, 1976; the American Association of Correctional Psychologists' Standards for Psychological Services in Adult Jails and Prisons, 1980), there are virtually no data to inform the selection of a staffing model for the provision of mental health services to incarcerated inmates. In studies that have attempted to identify the characteristics of effective psychiatric programs more generally (Collins, Ellsworth, Casey, Hickey, & Hyer, 1984; Ellsworth et al., 1979) none of the following had any relationship to program effectiveness: the staff/patient ratio, the qualifications or experience of the nursing staff, or the presence of a qualified psychiatrist. By contrast, stability of front-line ward staff shift assignments was related to program effectiveness. Obviously, there must be limits to the statement that numbers and qualifications of staff do not matter, and the authors urge caution in the interpretation of their results, but the findings lead us to question standards- and credentials-oriented approaches to measuring the quality of mental health services. Instead, we advocate a focus on measures of program integrity and program effectiveness as ways to evaluate the quality of services (e.g., Rice, Harris, Quinsey, & Cyr, 1990).

Social scientists who have studied the prison environment have argued strongly that greater interaction between guards and inmates can make the prison environment less stressful (e.g., Levinson, 1982). Similarly, in programs in which prison officers are encouraged to interact and develop relationships with prisoners, there is evidence of psychological and psychiatric improvement at least while inmates remain in that environment (Gunn & Robertson, 1982). In another study (Rice, Harris, & Cormier, 1992), it was found that men with psychoses involved in a highly intensive therapeutic community program in a maximum security hospital that relied heavily on patient-patient interaction with very low numbers of professional staff of any discipline had lower rates of criminal and violent recidivism upon release than did a similar group of men sentenced to prison (although the opposite was true for psychopaths). Similar to findings reported by Gunn and Robertson (1982) and Moos (1975) there was widespread agreement that the program eliminated the normal prison subculture and improved the attitudes and morale of both staff and patients (Barker, 1980), at least while they were in the program.

Because there is no evidence that high numbers of professional staff increase program effectiveness, because one goal of mental health treatment for inmates is to return them to a

regular prison environment, because there is evidence that positive effects can occur when front-line staff have combined treatment and security duties, and because it is likely to be less expensive, we advocate a staffing model in which staff assigned to a unit housing mentally disordered inmates have dual treatment and security functions. In such a unit, as in other units for mentally disordered offenders, tensions between treatment goals and security goals will be inevitable (Rice & Harris, 1993), but we believe that the advantages of such a model outweigh the disadvantages (Johnson & Price, 1981). Similarly, we believe that rather than relying primarily on one discipline (usually nursing) to provide the front-line staff of residential treatment units for mentally disordered offenders, consideration should be given to selecting front-line staff from disciplines that have the training most suited to the particular programs being offered. For example, in token economy programs, high proportions of persons with backgrounds in behavioral psychology might be most appropriate whereas in the skills training programs, high proportions of staff with backgrounds in occupational therapy might be appropriate. Of course, some staff with nursing backgrounds would be required in most programs, but the proportion could be much lower than is currently customary.

There has been considerable debate about whether inpatient treatment units for inmates with mental disorder should be located in institutions under the administration of health authorities or correctional authorities. We know of few data to inform this debate. Jurisdictions where mental health services are administered by correctional departments may be at greater risk for litigation about the quality of care (Metzner, Fryer, & Usery, 1990). On the other hand, it has been noted by others (Gearing, Heckel, & Matthey, 1980) that the transfer from prison to hospital, or indeed, even from one institution to another (Dell, 1980), often serves as an opportunity to screen out undesirable but deserving patients. It also leads to inter-institutional rivalries where the best interests of prospective patients gets lost; for example "blacklisting" institutions that refuse to take their clients back when treatment is deemed to have been successful.

Perhaps more important than whether the treatment unit is under the jurisdiction of health or correctional authorities is the question of the knowledge base of program managers and their supervisors. Unless they have some knowledge about mental health issues and psychosocial treatment approaches in the programs for which they are responsible, they are unlikely to recognize or reward desirable behaviors in their subordinates. Gendreau (1988) refers to the "MBA syndrome" in which managers are construed as a generic entity who need only know about how to manage. By contrast, managers who are familiar with something of the theory and practice of treatment will be much more likely to base promotional practices on treatment-relevant performance. Moreover, they will be able to model pro-treatment attitudes and values that are frequently not sufficiently valued in psychiatric settings for mentally disordered offenders.

Aside from the numbers and professional disciplines of the staff, how should staff be selected to work with mentally disordered inmates? Studies suggest that staff who are most likely to succeed with correctional or mentally disordered offender populations are those who use authority to enforce rules but in a nonconfrontational manner, who model prosocial (and

anticriminal) attitudes and behaviors, and who are at the same time empathic and interpersonally skilled (Andrews & Kiessling, 1980; Andrews et al., 1990). Unfortunately, typical institutional practice often selects for exactly the wrong characteristics (Johnson & Price, 1981).

Because of the power differences between inmates and staff in correctional and psychiatric settings, it has been argued that there is a tendency for staff to become more authoritarian and to treat the inmates or patients less humanely over time. This phenomenon was dramatically illustrated in the Stanford Prison Experiment (Zimbardo, 1973). In addition, as discussed above, there is good evidence that much of the violence that occurs in institutions is iatrogenic and that staff training can reduce the number of assaultive incidents. In fact, there is evidence that a staff training course that includes sections on interviewing and mediation skills, as well as safe physical techniques to be used when the situation requires them, can lead to increased staff and patient morale as well as reduce the level of institutional violence (Rice et al., 1989; Rice et al., 1985).

Inmate-Patient Rights Issues

The basic philosophy underlying various professional standards for the provision of mental health care in institutions is that it should be equivalent to that available in the community (Steadman, McCarty, & Morrissey, 1989). Furthermore, there is general agreement that inmates have a right to health care including mental health care while in prison (Ferguson, 1988; Fifth United Nations Congress on the Prevention of Crime and the Treatment of Offenders, 1975; Joliffe, 1984; Wishart & Dubler, 1983). At least part of the rationale for this right comes from the acknowledgement that mentally disordered offenders are particularly vulnerable in prisons, and there is substantial evidence that this is the case (Morrison, 1991).

Rights regarding treatment include both the right to treatment and the right to refuse treatment. Regarding first the right to treatment, in countries where there is no national health care program (and thus no specific entitlement to health care), it might seem that inmates are actually much better off than other citizens (Wishart & Dubler, 1983). Yet despite their constitutional right to adequate care, it is widely acknowledged that there are significant numbers of inmates suffering from major mental disorder who do not receive treatment while in prison (Hodgins & Coté, 1990; James, Gregory, Jones & Rundell, 1980). Part of the reason for this, as discussed earlier in this chapter, is that many of the inmates with severe mental disorder do not stand out to untrained observers; they are quiet and withdrawn and do not call attention to themselves or ask for treatment. For this reason, mental health professionals have an obligation to do more than passively accept referrals. A system such as that described by Condelli, Dvoskin, & Holanchock (1992) is a good example of an efficient system of identifying inmates in need of treatment.

Once identified as in need of treatment, there is little guidance in the literature as to what a patient's rights are regarding the nature of treatment. There have been occasional

legal rulings that have made some specific recommendations regarding treatment of psychiatric patients (e.g., *Wyatt v. Stickney*, 1972 described in Slovenko, 1973). There has also been a Canadian attempt to develop principles regarding quality of treatment for psychiatric patients that are sufficiently specific to guide practice and which were designed to include mentally disordered offenders held in secure treatment units (Rice, Harris, Sutherland, & Leveque, 1990).

Much has been written about the right of psychiatric patients to refuse treatment (e.g., Appelbaum, 1988) with heated debate on both sides of the issue. In most psychiatric settings, the issues regarding forced treatment pertain to pharmacological treatment only. However, in prisons, the right to refuse treatment has also encompassed nonpharmacological treatments, especially behavior modification (Friedman, 1975; Schwitzgebel, 1974; Martin, 1975; Law Reform Commission of Canada, 1985). One of the most difficult tasks facing mental health practitioners in corrections concerns what to do about those inmates who are obviously severely ill but who adamantly refuse all forms of treatment. James et al. (1980) have presented data suggesting that up to 20% of prisoners with severe mental disorder would require involuntary treatment.

Involuntary treatment issues in prison have commonly involved the question of transfer from prison to mental hospital and it has been argued that providing treatment on site in a prison would get around the requirement of a hearing before transfer. It has also been suggested that the standard for the prison equivalent of civil commitment should be somewhat higher than in non-prison society as the standard should refer to dangerousness within the prison rather than dangerousness within society at large (*Vitek v. Jones* discussed in Churgin, 1983).

In our view, many of the problems about forced treatment, especially behavioral treatments, arise because of a mistaken belief that there is a meaningful distinction between treatment and nontreatment environments. In fact, every institution has some form of management system in place in which consequences are applied to influence the behavior of the residents. The only choice program leaders have is how specific to be about which behaviors will be promoted and which will be discouraged. In most institutions, although the leaders make a set of rules and regulations, they do not make a coherent plan to influence the behaviors and attitudes of the inmates or patients. There is good reason to believe that in the absence of a coherent plan, individual staff members and other patients each apply their own consequences for behavior and much of this is inconsistent, disorganized and clinically destructive (Positano, Sanford, Elzinga, & James, 1990; Quinsey, Harris, & Rice, 1987). There is evidence that under these conditions, the institution will be more coercive, punitive and less therapeutic (Buehler, Patterson, & Furniss, 1966; Gelfand, Gelfand, & Dobson, 1967).

For ward-wide or institution-wide environments, there can be unplanned and/or unknown consequences of behavior, but that is not "no treatment" in the same sense that there can be a nontreatment alternative to drugs, ECT, or individual counselling. This view

seems to lead to a logical and ethical dilemma: 1. Unless a prison's administration employs a coherent, systematic, and noncoercive approach, the institutional environment will be dangerous and will make some inmates with mental disorder worse. 2. The more coherent, systematic and noncoercive is such an approach, the more closely it must embody the principles of psychosocial treatment or behavior therapy. 3. Behavior therapy is a recognized and effective form of clinical treatment. 4. An inmate with mental disorder has (as does everyone else) the right to decline unwanted treatment. This dilemma pits two ethical values against each other (Canadian Psychological Association, 1988); "respect for the dignity of individual persons" versus "responsible caring" and the Hippocratic injunction to "do no harm." There is no established way to resolve such a dilemma. However, elsewhere we have described a compromise in which the latter obligation (to do no harm) takes slight precedence. Thus, despite patients' rights to be free of unwanted therapy, we argued that an institution has an overriding obligation to have in place a system to discourage dangerous and destructive behavior and to promote cooperative safe, prosocial conduct. We argued further that such an obligation holds even though such a system might also alleviate psychological suffering and/or increase adaptation to regular prison or society in general (Quinsey et al., 1987; Rice, Harris, Sutherland, & Leveque, 1990).

What can be done, then, for patients who refuse all forms of treatment? We argue that there is little to be gained by entering into an extended legal battle in order to win the authority to treat a patient against his or her will. Rather, we would advocate the use of humane management techniques in such a case and turning the noncompliance issue into one of collaboration between the patient and the treatment providers wherein both take responsibility for producing a treatment program to which the patient can adhere (Appelbaum & Hoge, 1986; Corrigan, Liberman, & Engel, 1990). Although this may not be easy, it is the duty of treatment staff to continue to offer treatment even when it is unappreciated.

CONCLUSIONS

Although there is little evidence that prison causes much serious mental disorder, there is considerable evidence that serious mental disorder is much more prevalent in prisons than in society in general. In this chapter, we assert that the provision of mental health services to prisoners should be driven by inmates' interpersonal difficulties, skill deficits, criminal history and current symptoms. We identified two classes of consumers of such services: disturbed-disruptive inmates who exhibit active psychotic symptoms, anger, unhappiness, withdrawal, aggression and other institutional management problems; and disturbed-nondisruptive inmates who exhibit active psychotic symptoms, unhappiness, and withdrawal, but only rarely exhibit problems of institutional management. We advocate that services for inmates suffering from mental disturbance be provided via a series of successively more selective screens that ensure that disturbed-nondisruptive inmates are identified and treated, that services be delivered in an environment that most closely resembles the "normal" prison environment, and that services include behavioral and psychosocial treatments as well as pharmacological ones.

In this chapter, we take the view that behavioral assessment and treatment in the form of time sampling behavioral checklists, behavioral analysis, token economies and behavioral skills training are the treatments of choice for most mentally disordered inmates. A good example of the use of many aspects of this behavioral approach is the work of MacKain and Streveler (1990). Pharmacotherapy is a very useful adjunct in many cases.

For units devoted to the treatment of inmates with mental disorder, we advocate multidisciplinary teams that include behavioral technicians and correctional officers. Program standards should reflect measures of program integrity rather than professional credentials. Selection and training of staff should eschew confrontational, authoritarian personality styles and methods in favor of persons and methods that emphasize empathy, democratic techniques, and interpersonal skill. Inmates with mental disorder have moral and, in some jurisdictions, legal rights to treatment. They also have a right to decline unwanted treatment, but this cannot remove the obligation of administrators to provide an environment that promotes prosocial, independent, responsible, nonsymptomatic behavior. In considering several subgroups of inmates with mental disorder (those with HIV infection, sex offenders and female prisoners), we find no evidence to motivate a change in our overall advice: Triage and referral decisions should be based on interpersonal problems, skill deficits and current symptoms; assessment and treatment should be primarily behavioral.

FUTURE RESEARCH

Though we cite empirical work in support of most of the recommendations made in this chapter, there are many unanswered questions about the treatment of offenders with mental disorder. With few exceptions, there have been no studies of the effectiveness of treatments specifically for felon prisoners with mental disorder. It is unlikely that one program or therapy will prove effective in reducing all forms of criminal and psychiatric recidivism. Rather the appropriate question is, "What services, provided to offenders with which characteristics, in what settings yield reductions in which classes of recidivism?" There are a number of other important issues that also must be addressed by future research including: the treatment of female offenders with mental disorder, the role of clinical followup and community supervision, whether services that improve community adjustment and quality of life also reduce recidivism, and the cost-effectiveness of services for offenders with mental disorder.

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CHAPTER 6

THE TRANSITION FROM BEING AN INMATE: DISCHARGE PLANNING, PAROLE AND COMMUNITY-BASED SERVICES FOR OFFENDERS WITH MENTAL ILLNESS

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INTRODUCTION

The decade of the eighties was marked by changes in both the *number* and *type* of offenders placed under correctional control in the United States. The consequences of these changes for correctional policymakers and practitioners are two-fold: first, institutional crowding and larger caseloads for probation and parole officers challenge existing resources; and second, the increased proportion of the correctional population with multiple problems (e.g., drug abuse, alcohol abuse, mental illness) challenges existing offender management, control and intervention strategies. Consider for a moment the following data on the *growth* of corrections. Between 1980 and 1990, the state and federal prison population increased 129 percent, from 329,821 to 755,425 inmates. An additional 405,320 individuals were jailed in 1990, pushing the incarcerated offender population over the 1 million mark, where it remains today (Bureau of Justice Statistics, 1993). During this same period, the community-based correctional population increased at an even faster rate: between 1980 and 1990, "probation populations had grown by 126 percent to more than 2.5 million adults, while parole populations had increased 107 percent to nearly 457,000" (Edna McConnell Clark Foundation, 1992:1).

One reason for the expansion of our correctional population during this period was that the federal government decided to declare "war" on drugs, resulting in increased drug-related arrests (a 166.6% increase between 1981 and 1989), convictions and, of course, incarcerations (Bureau of Justice Statistics (BJS), 1992). According to a recent BJS report, "the increase in prisoners admitted for drug offenses accounted for more than half of the growth in the total admissions to state prisons (BJS, 1992:7). The criminal justice system also responded more punitively to two other groups of offenders - sex offenders and drunk drivers - during this same period (DiIulio, 1991). Consequently, there are significant differences in the 1980 and 1990 profile of the "typical" offender placed in either an institutional or community-based setting in this country. Not only do we have more offenders to control than ever before, but these offenders appear to have problems (e.g. drug addiction, alcohol-abuse, and/or mental illness) that challenge both the resources and expertise of corrections personnel.

In this chapter, we focus on a critical issue related to current offender control policies: how do we identify, treat and control the offender with mental illness as he/she makes the transition from an institutional setting to a community-based program? We begin by reviewing the available estimates of the size of this population in community-based settings, highlighting the limitations of current estimation procedures. We also review the research literature on the subsequent behavior of offenders with mental illness released from prison or jail. Current strategies for community supervision are highlighted, focusing on evidence of their effectiveness with this group of offenders. We identify three issues critical to the supervision of offenders with mental illness -- (1) *individual-level* role conflict, (2) *system-level* role conflict, and (3) *agency-level* role conflict -- and then discuss some practicual considerations in providing mental health services to parolees. We conclude by presenting an agenda for research on the treatment and control of offenders with mental illness in community settings.

ESTIMATING THE NUMBER OF OFFENDERS WITH MENTAL ILLNESS UNDER COMMUNITY SUPERVISION

Estimates of the number of people with mental illness under various forms of community supervision (i.e. probation, parole, furloughs) are typically derived from the prison and jail prevalence studies reviewed earlier in this monograph. The rationale for this strategy is simple: the necessary research on the prevalence of mental illness among various community corrections populations has not been conducted. Obviously, such basic research is needed for targeted planning and program development efforts. Although the prison and jail-based estimates are certainly suggestive, recent changes in sentence type, sentence length and the conditions/method of release to the community may have affected both the number and type of people with mental illness currently supervised in the community. As we note at the end of this chapter, direct assessments of probationers and parolees need to be completed using the standardized assessment procedures recommended by Steadman et al. (1987) and others (see, e.g. Shah, 1993). Until such basic research is completed, we can not offer an accurate estimate of the number of people with mental illness under community supervision.

TRANSITIONS FROM INSTITUTIONAL TO COMMUNITY CONTROL

Any discussion of the experience of offenders with mental illness in the institutional and community corrections systems must be grounded in a clear understanding of recent changes in sentencing strategies, parole release policies and community supervision practices. There are five major changes in sentencing and correctional control policies that can be identified: (1) the use of split sentencing, (2) the movement toward presumptive and mandatory sentencing, (3) the restructuring of parole release decisions, (4) the development of intermediate sanctions and the expanded use of conditions, and (5) tougher revocation policies for technical violators. The implications of each of these changes for the management, treatment and control of offenders with mental illness is discussed in the following section.

The Increased Use of Split Sentences

To begin, judges are using split sentences (a period of incarceration followed by a period of probation) much more often than in the past, which effectively has turned probation into a parole agency for these offenders (Byrne, 1993). According to a recent nationwide review of felons sentenced to state courts in 1986 (Dawson, 1990:2), "about 40% of probation cases - 21% of all convictions - were split sentence cases." The typical "split sentence" offender would serve the institutional portion of his/her sentence in a jail and then be supervised by probation. However, about one in four of these cases involved a prison sentence followed by probation supervision. Jail time for these offenders usually lasted about 6 months (median) followed by three years of probation, while prison time averaged four years (median), also followed by three years of probation (Dawson, 1990). Although no research has specifically addressed the issue, it appears that probation-agencies have much less expertise, experience and fewer resources than parole agencies in discharge planning, which could adversely affect offenders with mental illness. In 1986, split sentences were used for the following conviction offense categories: murder (5%), rape (17%), robbery (13%), aggravated assault (21%), burglary (25%), larceny (21%), drug trafficking (28%), and other felonies (20%). Both a straight prison sentence (33% of all convicted felons) and a straight probation sentence (16% of all convicted felons) are now much less popular among judges (Dawson, 1990). Unfortunately, we currently know very little about the impact of this change in sentencing strategy on offenders with mental illness.

Sentencing Reform Legislation

A second, related change in sentencing policy, which has direct implications for offenders with mental illness, is that the control of sentencing and release decisions is changing, reflecting both "classical" and desert-based assumptions (von Hirsch, 1976) about the need for an offense-based sentencing system with clearly defined punishments for specific illegal activities. Toward this end, presumptive sentencing statutes have been passed in over twenty states (Byrne, 1992). These statutes (and corresponding sentencing guidelines) effectively take much of the power over in/out sentencing decisions away from judges, placing it in the hands of the legislature. Evidence of certain categories of mental illness may still constitute an offense mitigating factor, but the weight given to mitigation is controlled by statutes rather than judicial discretion. Driven largely by such statutory reform, we doubled our prison population during the 1980's. We accomplished this feat by incarcerating a greater proportion of drug users, drunk drivers and sex offenders than at any point in the past.

Supervised Mandatory Release

Presumptive sentencing models also limit the ability of the executive branch (via parole release) to control the length of stay in institutions by establishing mandatory minimum terms for all offense categories. In jurisdictions with presumptive and/or determinate sentencing statutes, the process of parole release has changed in a manner that may directly (and adversely) effect offenders with mental illness.

> ... Inmates are conditionally released from prison when they have served their original sentence *minus time for good behavior or program participation*; this type of release is referred to as supervised mandatory release (Bureau of Justice Statistics *Bulletin*, 1991: 5).

In 1977, only 5.9% of the total releasees from prison were supervised mandatory release cases; by 1990, nearly 30% of the 394,682 releasees from prison were discharged in this manner. During this same period, the proportion of discretionary parole releases dropped from 71.9% (1977) to 40.5% (1990), while the proportion of unconditional releases (or "max-out" cases) remained fairly constant (Bureau of Justice Statistics *Bulletin*, 1991:5). This represents a fundamental change in the process of release from institutional control

Although no evidence was presented to support their position, Jemelka, Trupin and Chiles (1989:485) have asserted that offenders with mental illness "often serve the maximum length of their sentence, seldom qualifying for early-release options." They also argue that it is harder for them to earn good time credits, because of their location "in segregated housing, which may preclude participation in many programs" (Jemelka, Trupin & Chiles, 1989: 485). Recent research on psychiatric impairment and prison violence (e.g. Toch, 1982; Baskin, Sommers & Steadman, 1991), as well as research on disciplinary infraction rates in prison (e.g. Bonta & Motiuk, 1992; Tischler & Marquart, 1989), does seem to provide preliminary support for this contention. One inevitable consequence of the movement away from discretionary parole release may be that prisoners with mental illness remain incarcerated for longer periods than their counterparts who are not mentally ill.

Intermediate Sanctions and the Increased Use of Probation and Parole Conditions

A fourth change in sentencing/release policies can be identified: judges (and parole boards) are setting more and different types of probation and parole conditions than in the past (Taxman & Byrne, 1993; Cunniff & Shilton, 1991; Dawson, 1990). At the front-end of the corrections system, the use of multiple conditions (e.g. the use of house arrest, curfew, mandatory treatment, random testing for substance abuse, community service, fines) is often associated with the development of intermediate sanctions, which have been used in large part as a short-term solution to our prison and jail crowding problem (Byrne, Lurigio & Petersilia, 1992). These sanctions -- with names such as intensive supervision, electronic monitoring, and day reporting centers -- have been "sold" to the public as the latest correctional "panacea," with promises of lower recidivism, cost savings, and diversionary impact. Similar programs have also been developed at the back-end of the system by prison and jail administrators. Whether operating at the front-end or back-end of the corrections system, these programs share a common characteristic: an increased emphasis on offender lifestyle control, utilizing multiple conditions of supervision (e.g. contacts, drug tests, curfews, restitution/ community service).

Morris and Tonry (1990:188) have argued that intermediate punishments with conditions of treatment would

> ... seem particularly appropriate for addicted and mentally ill criminals, provided sufficient control of their behavior can be built into those programs to satisfy legitimate community anxieties - but there must be a sufficient nexus between the criminal's addiction or mental illness and his criminality to justify the provision of treatment services.

However, "treatment" has not been a central focus of the surveillance-oriented intermediate sanctions developed during the last decade (Clear & Byrne, 1992). Without equal attention to *both* treatment and control, it is difficult to envision these programs being appropriate for the types of multiple-problem offenders being discussed here.

In a recent review of felony sentencing in state courts, Dawson (1990) found that mandatory treatment (typically for drugs or alcohol abuse) was ordered in 17% of all felony probation cases (including both split sentence and non-split sentence cases). The use of mandatory treatment conditions varied by the type of conviction offense. For example, treatment was ordered for 47% of all rapists placed on probation, 24% of the aggravated assault cases, 22% of the drug trafficking offenders, 19% of burglaries, and 11% of all larcenies. Unfortunately, no specific breakdown of the use of mental health treatment was provided in this review. However, Cunniff and Shilton's recent examination of felony probation practices in 32 urban and suburban courts *did* examine a wide range of behavioral conditions ordered by the court, including the use of community residential placement (5%), alcohol treatment (14%), drug abuse treatment (23%) and mental health counseling (10%). Overall, "half of those receiving behavioral conditions are ordered to perform multiple conditions, with 30% receiving two conditions and another 20% receiving three or more" (Cunniff & Shilton, 1991:23). Not surprisingly, the authors identified considerable jurisdictional variation in the use of *all* behavioral conditions. For mental health counseling, the percentage of orders ranged from 2% to 62% of all probation cases reviewed. The authors note that "despite a network of community mental health facilities in metropolitan areas, the use of mental health treatment is limited" (Cunniff & Shilton, 1991:24).

Revocation Policy

A final area where more punitive court policies have affected probation and parole practice is revocation policy (Rhine, 1993). Courts appear to have increased the probability of a technical violation by setting more conditions of probation and then using formal revocation when a violation is detected. Paroling authorities have followed a similar strategy with both discretionary and mandatory releasees. Since it is estimated that up to half of all new prison admissions each year are probation and parole failures, the negative consequences of tougher violation/ revocation policies on institutional crowding should be apparent. Paradoxically, it appears that programs developed to reduce our reliance on prisons and jails (e.g. intermediate sanctions as direct sentence options and early release mechanisms) may actually have exacerbated the crowding problem (Byrne, Lurigio & Baird, 1989; Byrne, 1989). In 1979, 28,817 parolees or other conditional release violators (e.g. probationers and offenders on supervised mandatory release) were returned to prison, representing 15.8% of all new prison admissions in that year.

By comparison, 26.8% of the 379,742 new admissions to prison in 1988 were parole (or other conditional release) violators, a 68.4% increase. To date, no research has been conducted on whether mentally ill offenders are more (or less) likely to comply with conditions and/or be returned to prison/jail for a technical violation, but we do know that overall compliance rates with the multiple conditions of community supervision varied by the type of condition imposed (Cunniff & Shilton, 1991; and Dawson, 1990). For example, only 44% of the probationers ordered to undergo mental health counseling complied with this condition, while 60% of the probationers complied with the order to participate in day programming (Cunniff & Shilton, 1991). To the extent that offenders with mental illness on probation and parole are ordered to comply with more and/or different conditions than offenders who do not have some form of mental illness, variations in the rates of technical violations and subsequent return to prison/jail should be expected. In order to avoid this paradoxical and counter-therapeutic result, systems may need to devise new, progressive sets of sanctions for non-compliance. Once again, however, it appears that the basic research on the conditions of release and supervision of mentally ill offenders has not been conducted.

IDENTIFYING AND REDUCING THE RISK OF RECIDIVISM AMONG OFFENDERS WITH MENTAL ILLNESS IN THE CORRECTIONS SYSTEM

A number of researchers have examined the criminal behavior of offenders with various forms of mental illness (see, e.g. Hodgins, 1993; Taylor, 1993; Teplin, McClelland & Abram, 1993; Hare & Hart, 1993). Their general conclusion is that there is "clear, consistent, and convincing evidence of relationships between criminal and violent behaviors and certain major mental disorders" (Shah, 1993:306). Estimates of the number of inmates with mental illness in prison and jail vary widely (see, e.g. Monahan, 1993), while estimates of the size of the population with mental illness under various forms of community supervision (probation, parole, intermediate sanctions) are simply not available. Any attempts to summarize the research literature on the effectiveness of institutional and community corrections programs with offenders with mental illness are limited by this classification "shortfall." Evaluators of probation, parole, split sentencing, and various intermediate sanctions have ignored the question of how these programs "work" with offenders with mental illness (Byrne, Lurigio & Petersilia, 1992).

CONCEPTUAL ISSUES IN POST-RELEASE SERVICES

Before much headway can be made in improving the management of probationers and parolees with mental illness, attention must be paid to a fundamental problem afflicting the community supervision task: role conflict, at the individual, organizational/system, or agency level. Although our discussion in this next section focuses on "parole" officers, our comments apply also to probation officers supervising "split sentence" offenders and for officers in agencies with dual responsibilities for probationers and parolees.

Individual-Level Role Conflict - The Parole Officer's Dilemma

A major impediment to effective post-release supervision of offenders with mental illness occurs at the core of the supervision function. There is dispute about whether the primary purpose of supervision should be to provide help and support for the offender or to establish and enforce controls over the offender.

No consensus has ever existed about which function -- help or control -- is most appropriate in parole supervision. Recently the controversy has become even more heated. In most areas of the United States, the so-called "social work" function of parole has come under attack by insiders and outsiders alike. Critics of parole believe that the emphasis on "social work" functions has led to indefensible leniency with offenders, demeaning the credibility of the criminal law. For their own part, many parole officers stress the need for guns, self-defense training, and enhanced security on the job. Today there is a growing chorus of support for the "law enforcement" functions of the parole officer's job.

The debate about parole work is critical for the welfare of offenders with mental illness on parole. Whether it would be better to manage such offenders from a "helping" point of view or by "controlling" them would seem to be an empirical question. In practice, most parole agencies expect their staff to supervise offenders in ways that both "protect the public" and "support the offender's reintegration into society." It is frequently left to the parole officer to sort out how best to satisfy these two demands. The result is that parole officers face role conflict in the aims of "helping" and the requirements of "controlling."

Studies of Role Conflict

Perhaps the first scientists to speculate about role conflict in parole work were Ohlin, Pivan and Pappenfort (1956). They argued that the conflicting duties of the parole officer result in three main adaptations to the job: the "punitive officer," who is oriented toward rule enforcement; the "welfare worker," who responds to client needs; and the "protective agent," who mediates between the community and the client.

The first researcher to empirically document role conflict in parole supervision was Daniel Glaser (1964). He analyzed a survey of parole officer's attitudes using two Guttman scales, one for "treatment," and the other for "control." He found wide variations in the relative weight parole officers gave to these dimensions of parole work. Glaser also found that the two scales were orthogonal, and he used the theme to identify four "types" of parole officers: punitive, passive, paternal, and welfare.

Glaser's work has been widely interpreted as suggesting that the two aims of control and treatment are incompatible. His own choice of the term "paternal" to describe those who score high on both scales suggests his belief that the two demands could not be integrated. Klockars' (1972) extension of the Glaser model called the person scoring high on both dimensions "synthetic," again suggesting an uneasy combination of these functions.

The belief in the existence of a nearly impenetrable role conflict has been a hallmark of most discussions of the parole officer's job. It is felt to be so confusing for parole staff that reformers often argue one or the other role must be jettisoned (compare Barkdall, 1976; and Stanley, 1976). A minority voice exists that these roles are not so incompatible as they seem (Erwin & Clear, 1986) but to date the general consensus is that role conflict has a substantial, often damaging, impact on parole supervision.

Impact of Role Conflict on Supervision

A number of statistical studies of the importance of role conflict have followed in the Glaser tradition. These studies tend to support the robustness of the Glaser formulation, finding consistent patterns of parole officer belief and practice based on role perceptions. Dembo (1972) for example, has found the Glaser scales to be related to attitudes toward law and justice. Sigler and McGraw (1984) have shown the role perceptions relate to beliefs about more recent policy controversies, such as carrying guns. Clear and O'Leary (1983) demonstrated that the Glaser dimensions relate to strategic approaches officers take in supervising cases. Adding further support to the importance of role conflict is a string of studies using the Correctional Policy Inventory (O'Leary & Duffee, 1971) which also measures role perception. The CPI has been shown to relate to managerial styles (Duffee, 1989) revocation recommendations (Katz, 1982) and supervision strategies with clients (Clear & O'Leary, 1983).

It seems beyond question that role conflict is an important aspect of parole work. Whenever it is studied in a questionnaire format, significant patterns of parole officer beliefs are related to the role perception. As final support for the importance of this issue, some researchers have attributed a major degree of "burnout" precisely to the officer's perception that role expectations are incompatible (Whitehead & Lindquist, 1985).

Field research on role conflict is less conclusive about the issue. These approaches confirm the existence of role conflict, but sometimes downplay the importance of the problem. Studt's (1973) award winning study of "service and surveillance" in parole supervision described the struggle parole officers go through with conflicting role expectations. Yet she found that the best officers were able to balance these roles, sometimes emphasizing one, sometimes the other, depending upon the client's behavior. A similar study by McCleary (1993) found that most parole officers were eclectic in style, moving from one strategy to another based upon the circumstances of the case and the client's response to supervision. In a study of intensive probation, Erwin (1986) found little distinction in the supervision behaviors between staff assigned "control" roles and those asked to take "assistance" roles.

The question of role conflict could turn out to be quite important. There have been no studies of the effectiveness of different supervision styles in parole. The only such study in another setting -- juvenile probation -- indicated that some styles were more effective than others with certain kinds of clients (Brewster, 1993). This finding is consistent with treatment literature that shows a relationship between type of treatment and type of client (Palmer, 1992).

Ex-Offenders with Mental Illness

Role conflict is a central problem for the management of offenderss with mental illness in community settings because *both* helping and controlling can be appropriate tasks, depending on the situation. For example, offenders who are under medication may need to be monitored to be certain they are taking medication; resistant offenders may require more than casual enforcement. By contrast, recently released offenders who are adjusting to the strangeness of community will need help and understanding if the pressures of return are to be overcome.

The complexity of issues surrounding different types of offenders with mental illness indicates that a simple "resolution" of the conflict cannot be achieved. Parole officers who are over-identified with one or another role will find themselves counterproductively firm with some offenders, or inappropriately unstructured with others. This suggests that some sort of informed role integration is needed for effective supervision of these offenders. However, in order for parole officers to be able to provide competent support to offenders with mental illness, they will need training and support. They will need to learn about mental illness, its treatment, and the clinical and social supports available to people with mental illness in the community.

Despite the fact that field studies find role integration is not uncommon, achieving full integration of roles may not be easy. A nationwide, multiple time series study of attitudes toward parole roles found that respondents had become less enamored of the traditional "helping" roles, and were more oriented toward the functions of "control" and authority in their work. Instead of integration, there may be a trend toward adoption of a unified view that the parole officer is a law enforcement agent.

System-Level Role Conflict: Mental Health Agencies and Community Corrections

The debate about the appropriate role for parole officers does not merely apply to their tasks, but it extends to the very mission and philosophy of parole. For the parole officer, the issue is role conflict; the parallel problem for the parole agency is goal conflict. There has always been debate about the "best" philosophy of parole, but thinking on this question has undergone considerable change in recent years. The advent of the determinate sentence has served to challenge thinking about the parole function. It has led some writers to argue that parole supervision should involve simply voluntary services (Stanley, 1976) and others to conclude that parole ought to be abolished altogether (von Hirsch, 1976).

High-minded philosophical thinking in the 1970s and 1980s about the function of parole has been replaced in the 1990s by a much more pragmatic set of concerns. With institutional crowding now grown well beyond any previous period in history, and with public concern about crime continuing to exist as a political pressure, tough-minded thinking about parole predominates (Flannagan & Maguire, 1992:178; Durham, 1993). However, the public's concern seems to be focussed more on current parole release policies than on the need for community supervision when an offender is released from prison. Since the majority of the public still

supports rehabilitation as the primary purpose of incarceration (The Gallup Poll, June, 1989, p.31), it certainly follows that this should also be a goal of parole supervision.

This "mixed message" from the public has significant implications for the future cooperation between mental health services agencies and parole, as they accept joint responsibility for the management of offenders with mental illness (Steadman, 1992). As parole becomes less a human service and more a law enforcement function, its identity diverges from that of the traditional mental health agencies. The question is whether this makes meaningful agency cooperation more difficult.

Problems in Conflicting Mission

The mission of a mental health agency working with people with mental illness is to help its clients achieve and retain effective functioning in the community. The mission of the parole agency is to protect the public. While these are not mutually exclusive aims, they are centered around different clients, clients whose interests may sometimes conflict. Simply stated, the mental health agency often seeks to find ways to keep its clients on the streets; the parole agency is often in search of reasons to remove them from the community. This frank difference in perspectives may explain a great deal about the conflicts in language and technique.

This is more than mere form. While many of us are used to mission statements that amount to eyewash, in this case, the mission can really matter. Parole agencies frequently devise their policies and procedures -- and their day-to-day paperwork -- in ways that are designed to justify (or facilitate) removing offenders from the community. Mental health agencies, by comparison, typically design their management systems to show the interventions they are taking and the basis for them.

This can mean that there may be basic incompatibility between the systems and processes of mental health and parole. When a parolee with mental illness starts having problems in the community, the mental health agency may be poised to "staff" a case to determine how best to intervene. Meanwhile, the parole agency may be reviewing the file to determine whether to revoke. Offenders recognize the distinction. With parole agencies, they are defensive; with mental health agencies, they are wary, but willing to listen.

Problems in Conflicting Practices

The differences in mission translate into differences in agency practice. The biggest problem for parole agencies is the continuing to struggle with goal conflict. This is illustrated by one recent comparative study of intensive probation in two agencies, one "service-oriented," the other "control-oriented" (Clear & Latessa, in press). The study found that officers who place a great deal of personal value in "control" were more likely to select authority-based responses to their clients in both settings. Officers oriented toward "help" were more likely to select assistance-oriented responses only in the organization that placed emphasis on "service" as a part of its programmatic mission and goals.

One reason for this is that agencies develop formal systems of accountability based on their mission, and these translate into supervision orientations of officers. A more significant explanation may be the development of informal office practice in line with dominant values defined by the mission. The importance of office traditions is widely described in research on community supervision of offenders (Lipsky, 1976; McCleary, 1993; Hardyman, 1988; Studt, 1973; Takagi, 1967).

Informal office practices develop as a sort of cultural sanctioning system for parole officers. For offenders with mental illness, this may translate into an expectation by staff that they will be "trouble" (McCleary, 1993) and a staff predisposition away from sympathetic, helping responses to their situations. "Odd" behavior by clients may be interpreted from an organizational viewpoint that emphasizes client compliance, rather than a clinical standpoint that seeks to interpret behavior in terms of need for intervention. This could result in higher revocation rates for offenders with mental illness, based not only on the offenders behavior, but also on the inadequate training of parole staff (Guynes, 1990).

Agency-Level Role Conflict: The Debate Over Supervision Strategies

Surprisingly little research has been done on the various parole supervision strategies. Mostly what is available in the literature is speculation on the kinds of strategies that might make sense, given what is known about supervision. There are, however, a number of different ways that offenders with mental illness might be handled by parole authorities, and each of these can be critiqued.

Direct Supervision Strategies

Parole officers have long worked effectively with offenders whose mental disabilities are not emotional in nature, but instead are intellectual or cognitive. Classification strategies identify the intellectually disadvantaged offender and proscribe direct supervision strategies that can be successfully employed with them (Arling, Lerner & Bemus, 1983). Recommended strategies include careful environmental structuring, systematic monitoring, and supportive intervention that is similar to social teaching. Offenders whose problems are cognitive and who are not seriously impaired can be managed with systematic techniques of "cognitive restructuring" (Ross & Fabiano, 1985). These approaches have received wide support in Canada and Great Britain, and are now being tried in the United States.

For the seriously emotionally disturbed offender, direct supervision by a parole officer is more problematic. Few parole officers have adequate training in the diagnosis of or intervention for these clients, and the chances of inappropriate case management are often quite high. This point is underscored in a recent national survey of probation and parole executives (Guynes, 1990). 87.7% of the directors of state probation and parole agencies indicated that staff training needs improvement in the area of "handling special problem offenders" (Guynes, 1990).

Specialization vs. Mainstreaming

For offenders facing serious behavior problems, most studies suggest that specialization is superior to traditional, generalist parole (Banks, et al., 1976; Palmer, 1992). The reasons for this are straightforward: complex problems faced by serious offenders are often lost in the midst of a generic parole caseload, and most parole officers do not possess the higher level of expertise needed to manage offenders with complex problems such as some forms of mental illness. For example, specialized sex offender programs for parolees are currently popular in this country, along with caseloads limited to drug and violent offenders. However, we could identify only two states (Texas and New York) that utilize specialized caseloads for parolees with mental illness.

Mainstreaming may be appropriate for some types of mental illness that are not predictive of a high risk of new offending or of violence. As indicated earlier, parole officers are able to manage these sorts of cases well, and the advantages of avoiding labeling (and resultant tendency toward technical revocation) might be important considerations in favor of mainstreaming.

A potential disadvantage of specialization is the problem of burnout (Whitehead & Lindquist, 1985). There is little systematic evidence on this question, but parole officials commonly discuss burnout as a problem of special services for troubled offenders. The amount of court work, crisis intervention and 24-hour availability needed to manage these offenders effectively is seen as the problem (though the special identity officers develop when given these assignments may balance the stress, at least for a while).

The ultimate decision as to specialization of services is both a classification and a management issue. Generalist caseloads are simple to manage, and workload accountability is not difficult when assignments are equal or equivalent. In contrast, management of a series of specialized caseloads is problematic, and thus should be undertaken when the benefits of improved supervision justify the increased organizational complexity. This is particularly true where parolees have a number of problems (e.g. drugs, violence, mental illness) that challenge existing single-problem oriented classification/supervision schemes.

Groups vs. Individualized Treatment

Similar issues are raised by comparing group to individual supervision strategies. The accountability of the parole officer for an individual caseload is easily managed; joint accountability for running clinical groups is less simple. Ordinarily, group supervision must be augmented by individual case management, making for even more complex staff accountability.

These limitations -- along with the movement away from clinical models associated with group treatment -- may be one reason why most parole systems have been reluctant to incorporate groups into their array of supervision methods. Another reason is the general failure of generic group-based methods to demonstrate benefits in terms of reductions in client failure (Lipton, Mattinson & Wilks, 1975; Andrews et al., 1990).

Two new circumstances have surfaced that serve to increase the interest of parole systems in group supervision strategies. First, group supervision can be a way to magnify resources for clients. When two staff see 8 clients for 90 minutes in a group, the quality of contact can be high, but in an efficient way, compared to the equivalent in individual contact. Second, current thinking about offender management has resurfaced the idea of groups as effective for some type of offenders under particular circumstances (Palmer, 1992). Whether this new emphasis on groups will be widely applicable to parole for offenders with mental illness is not yet known.

Contracting and Brokering

An obvious way to increase the diversity of case management of mentally ill offenders is to contract for or broker their mental health treatment services, perhaps by interagency agreement. This is an especially important strategy for the mentally ill offender, whose problems may be more complex than parole officers are equipped to handle. Improvement of mental health services was identified as a major need by over half of the probation and parole directors recently surveyed (Guynes, 1990), while one in three directors anticipated purchasing most or all of their mental health services from the private sector in the next three years (Guynes, 1990).

The main issue faced by contractual or brokered services is the maintenance of the interface between the correctional and treatment organizations. Because of workload issues, parole agencies will sometimes provide inadequate follow-up or support to the treatments for which they are contracting. Because treatment is often a condition of parole, there may be a class between the "voluntary" traditions of the treatment provider (especially when the contractor is a private service provider) and the authoritarian traditions of the parole system. Treatment providers often know little about the inner workings of parole, and the processes of treatment may seem mysterious to parole officers. A kind of mutual ignorance can develop in which both parties make unwarranted assumptions about the other's activities. When this happens, the offender can get caught in the middle -- or lost between the cracks. Studies of supervision systems based on brokering of services find high rates of technical failure by clients, often due to the client's failure to cooperate with the service provider (Clear & O'Leary, 1983).

It has become more common for parole to have standing service contracts with other government treatment agencies. These agencies can be more receptive to non-voluntary clients, and they often have a better understanding of parole and its procedures. Many parole administrators express concern about the quality of services they receive from public agencies, but the extent of the problem of quality in regard to parolees has not been studied systematically.

Relapse Prevention and Revocation Policy

A recent model for treatment of serious offenders, called "relapse prevention," has gained wide support (Palmer, 1992). The relapse prevention model is especially well-established as a supervision strategy for sex offenders, but it also has implications for management of other emotionally disturbed offenders. The relapse model views the offender as needing to develop

a web of social and emotional supports that reinforce resistance to new criminality. The offender is seen as residing in a system of forces that either tend to facilitate return to crime or to support resistance to crime. In the relapse prevention model, a network of forces is created to support crime-free living in the community. These will include treatment services, watchful family and (often) friends, lifestyle routines, and even medication. Parole functions as a manager of this network, insuring that the various supports are functioning effectively. Mainly, parole is a scanning system, looking for "cues" (changes in the offenders' behavior/situation) that indicate a risk of relapse.

Relapse prevention strategies have not been subjected to experimental evaluation, but non-experimental studies of this approach show promise in two ways. First, failure rates of clients may be lower under well-managed relapse prevention methods. Perhaps more important, the approach effectively articulates the shared responsibilities of parole agencies, service providers, and clients in the overall intervention system. The challenge for community corrections managers will be to integrate promising treatment strategies, such as relapse prevention, into existing early release programs and to apply the "lessons learned" from such programs to the larger question of revocation policy.

PRACTICAL CONSIDERATIONS IN PROVIDING MENTAL HEALTH SERVICES TO PAROLEES

Any state that wishes to implement a system of mental health services aimed at parolees should consider several core planning principles.[91] First, any attempt to provide services for parolees with mental illness must involve an interagency effort. A second principle involves clearly targeting the population to be served. Third, mental health services to parolees must be culturally appropriate. A fourth principle involves the use of progressive sanctions for parolees who do not participate in treatment. A fifth principle is to focus on residential stability. Finally, in light of the extraordinarily high incidence of substance abuse at the point of arrest in urban America, programs must focus on prevention of relapse of substance abuse.

Principle #1 - Interagency Collaboration

Obviously, providing mental health services to parolees requires the full cooperation of the state's department of parole. In New York[92], for example, our experience has shown the

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[91] The authors are indebted to Judy Cox and Terry McCormick of the New York State Office of Mental Health, who developed many of the principals contained herein. More importantly, they have played an important leadership role in the development of the programs described in this section.

[92] In New York, much of the credit for the design and success of this interagency collaboration must go to Chairman Raul Russi and Executive Deputy Martin Horne of the NY State Division of Parole.

Division of Parole to be enthusiastic advocates of mental health services for their clients. However, cooperation, collaboration, and communication must also include other state and local agencies. Parolees with mental illness often are excellent examples of "multi-need, multi-agency clients" (Pepper, Albert & Ryglewicz, 1993) whose problems may bring them into contact with a wide variety of public human service providers. The fragmentation of human service systems has been well documented. In order to efficiently provide services to multi-need, multi-agency clients, there must be a point at which systems come together to benefit clients. At the very least, parole officers will need to be trained in how to gain access to the generic mental health system, if possible with some organizational authority to refer their clients to publicly funded providers. In a targeted case management system, however, it is possible to do a great deal more. Dvoskin and Steadman (1993) have argued that the only sensible way to bring multiple agencies together to serve each client is by convening periodic meetings around individual clients or groups of clients served by a team of providers from various agencies.

In addition to departments of parole, a partial list of appropriate state and local departments would include: social services; child protective services; mental retardation and/or developmental disabilities; health; substance abuse services; adult education; and vocational rehabilitation. Equally important may be immediate or extended family members, clergy, local criminal justice agencies, and in the best of all circumstances, employers.

Division of Parole - Parole officers often report that they have given up in frustration at obtaining mental health services for persons under their supervision. Though this phenomenon of rejecting parolees from mental health services has not been empirically documented, it is so consistently reported by parole officials as to be taken quite seriously. It is also intuitively sensible. Consider that some mental health providers have waiting lists, sometimes quite long. Since parolees come from prison, they are typically entered last on these long waiting lists. Further, especially in cases of inmates completing long sentences, they are unknown quantities to mental health providers, leading to fear and stigmatization. Consider that many mental health community residences are specifically "sold" to communities with promises that they will house no "criminals," a more or less permanent stigma born by each parolee (one virtually never stops being a convicted felon.) Thus, parole officers have often been forced to "go it alone" and provide basic counselling to people who may need far more sophisticated clinical services, especially psychotropic medication.

Most importantly, parole officers are the best referral source for their clients to mental health programs. They can also provide external structure, which can increase the chances that an individual will engage in treatment. (This structure does not need to be coercive. Often, it can come in the form of positive reinforcement, encouragement, or simple reminders about appointments.) Parole officers also serve as an important safety net for the mental health clinicians, who will often ask "what happens if this person becomes a problem in our clinic?" By providing back-up, and even force in the rare cases where it is required, parole officers can make mental health providers more comfortable until they get to know each parolee as an individual.

Departments of Social Services - Even before going to prison, many parolees were unemployed and living in poverty. Upon leaving prison, they are at even higher risk of economic need. For those who are disabled by mental illness, their chances of surviving economically independently are quite slim. Due to their needs for mental health programming and special housing in prison, many inmates with mental illness are less able to attend vocational programming, educational classes, or otherwise gain job skills to prepare themselves for release. Further, our experience has shown that many inmates, but especially those with serious mental illness, have been cut off from their families and their communities, leaving them with few social supports upon release. Finally, economic stress can exacerbate existing mental illness.

Thus, the combination of poor pre-incarceration work history, lack of vocational skills, serious mental illness, lack of family and friends, create a very high likelihood that parolees with mental illness will require government supports such as social security disability insurance (SSDI) or supplemental secuity income (SSI) upon release.

Especially important is the attainment of a Medicaid card, which can increase the chances of a parolee receiving needed medical and mental health services upon release. The lack of Medicaid eligibility for inmates in correctional facilities has been identified as a barrier to both the diversion of persons with mental illness from incarceration and for pre-release planning for inmates leaving correctional facilities. Prior to 1985, inmates were eligible for Medicaid during the first and last month of their incarceration. These funding windows allowed mental health providers the opportunity to both divert when appropriate and perform service linkages prior to release. Federal regulations which became effective May 3, 1985 (42 CFR Parts 435 & 436) eliminated Medicaid coverage for any services provided to correctional inmates and created an additional barrier for local providers to assist clients in returning to the community.

Delay in obtaining entitlements to disability income and health care can prevent a parolee from obtaining needed services and exacerbate the already daunting stresses of reintegration into the community.

Health - People with mental illness frequently suffer from poor health care. Often, health care providers fail to take seriously the medical compliants of people who communicate in an unusual, or "crazy" manner. Reported symptoms may be assumed to be somatic delusions or exaggerations. Again, if some representative of the medical provider (e.g. a nurse from a medical clinic) can occasionally participate in interdisciplinary meetings, it could save the clinic staff a good deal of time which might otherwise be wasted on differential diagnosis, or even save money by treating illness or injury earlier in its course.

Substance abuse services - Substance abuse is of course a correlate of crime, both generally and for people with mental illness (Teplin & Schwartz, 1989) . Thus, gaining access to substance abuse treatment slots would seem self-evidently crucial for those parolees who need it. Investment in the treatment team is important, because many substance abuse programs allow no mind altering drugs. People with these two diagnoses often report being given the choice of stopping their psychotropic medication or being thrown out of a substance abuse program, even

one that has been mandated by departments of parole. If possible, these dually diagnosed parolees should be referred to programs with specific expertise in treating people with mental illness for substance abuse.

Child protective services - Especially for women leaving prison, the thoughtful cooperation of child protective services can help motivate a parolee into treatment, while fear of having one's children taken away could have exactly the opposite effect. Many female parolees fear that admission of a psychiatric crisis could lead to losing their children. Thus, they are tempted to try and go it alone, often with disastrous results. As part of the treatment team, and with the trust that comes from an ongoing relationship, a child protective worker can help the parolee invest in a plan that will house the children safely and temporarily until their mother is stabilized.

Mental retardation and/or developmental disabilities - For those parolees with dual diagnoses of mental illness and mental retardation, it is crucial that services be integrated. There is often a good deal of overlap between the services offered by these two agencies, and if uncoordinated, they can seem confusing or even contradictory to the client. Anyone, including parole officers, could be forgiven for some confusion about the respective roles of these two service delivery systems. It is unfair to expect parolees or parole officers to run back and forth trying to coordinate these two systems. Obviously, what is called for is a multi-agency plan to address the person's various symptoms and skill deficits.

Adult Education and Vocational Rehabilitation - Even parolees of normal intelligence may have large gaps in their academic and vocational educations, due to periods of drug abuse or mental illness which may have prevented attendance at school. Parolees who cannot read or who have no marketable job skills are at a tremendous disadvantage in trying to remain free. Vocational rehabilitation plays an essential role in the progress of people disabled by mental illness. By working toward, and eventually acheiving even partial or sheltered employment, people feel improved self image and increased hope for their futures.

Local Criminal Justice Agencies - Although they are, of course, not primarily a human service delivery system, in many communities the local police can be an invaluable resource in helping a parolee with mental illness to succeed. It is the police who are often the first to be called when a person with mental illness becomes angry or disruptive. If they are aware of an organized treatment approach and who to call (e.g. the parole officer or a case manager), it may be possible to avoid arrest as the only safe way to resolve a potential crisis.

Family members - Family members and other social support systems, such as the clergy, can be extremely valuable pieces of the puzzle. Part of the reason for high recidivism rates among parolees is a disconnectedness which leaves them alone and unsupported. This is especially difficult for people who, in addition to their stigma as ex-convicts, also have been ostracized for features of their mental illnesses. Family members may have been victims of violence in the past, and fear their relative's return to the community in the absence of

knowledge about other pieces of the treatment plan. When aware of the supports and structures which otherwise exist, they may be willing to try again.

Principle #2 - Targeting the population to be served

If services are aimed at broad participation by any parolee with serious mental illness, then the program must utilize strategies to dove-tail each parolee into the "generic" mental health sytem which serves the locality. It is unlikely that any government will, in these fiscally conservative times, agree to fund a mental health system for parolees which would exceed or take resources from the already inadequately funded community mental health systems available to the (non-offender) public.

In our opinion, the most efficient way to improve the ability of parolees to receive a fair shot at community mental health services is to make them fiscally desirable customers. Many programs now go out of their way to recruit medicaid eligible clients, since they bring some reimbursement with them. Parolees who leave prison without medicaid cards may wait weeks or months before they receive them. During that crucial early period of parole, they are thus beggars for service, and quite likely to be unsuccessful. What services they do receive are likely to be very short term crisis service, or commitment to involuntary hospitalization.

However, when they have in hand a Medicaid card, parolees may well be welcomed into clinics and treatment settings. It is of course unclear as yet how the nation's new health care package, when it arrives, will affect this aspect of the mental health care delivery system. But clearly, any broad strategy to improve access to service for all parolees with mental illness will have to focus on health and mental health care financing as a crucial piece of the solution.

Rather than attempting broad parolee participation, a state may instead choose to target a small number of individuals at very high risk of any of several bad outcomes. These outcomes include expensive psychiatric emergencies likely to result in emergency room visits or hospitalizations, criminal recidivism, acts of violence in the community, etc. In that case, a very different strategy will be selected.

This alternative strategy, though they are by no means mutually exclusive, is to focus resources on a small number of parolees whose mental illness is of an acuity to place them at high risk for violence or other disastrous outcome. As suggested above, in order to reach this small, "high-risk" group, one needs to find a way to integrate and focus care from a number of different agencies. We strongly recommend intensive case management as a cost effective means of accomplishing this integration of treatment resources (Dvoskin & Steadman, 1993).

Such high-risk programs need to roster clients specifically by name, and begin planning for their treatment prior to release. If possible, they should meet someone from their treatment team in person at least once, with perhaps additional phone contact prior to their actual release. Clinic appointments should be scheduled well in advance of release, so as to occur as soon as

possible, perhaps even the same day as release. It is important to "hook" the client into treartment as quickly and effectively as possible.

Principle #3 - Cultural Appropriateness

This is not meant as a "politically correct" buzzword. Ethnic minorities, especially African-American or Latino, are statistically overrepresented among prisoners and parolees. Young men who grow up poor, witnessing or experiencing violence, with no hope, may need a very different type of human service provider than middle-class young people who may have grown up believing that "the system" works for them. Also, many people will be far less likely to reveal personal issues to a person who they perceive as quite different from them. Finally, in order to serve a person's mental health and social needs effectively, it is important not to have unreasonable fears of them. To the extent that fear comes from cultural differences and ignorance of another person's culture, it can be minimized by having teams which are as culturally diverse as the parolees they serve. For broad-based systems of care, we advocate neighborhood-based providers, while targeted case management programs would do well to seek culturally a diverse work force to provide case management services to this population.

Principle #4 - Progressive Sanctions[93]

Parole boards will often choose to mandate mental health services for parolees with mental illness; which could lead to revocation for those who do not participate in treatment. This is an area of some potential controversy; since the purpose of a mental health program for parolees should be to decrease the chances of parole violation. Further, the current state of most state budgets has led to pressure on parole authorities to reduce revocations. Thus, rigid use of strict sanctions would of course set up clients for failure. However, the use of progressive sanctions allows for the provision of structure without increasing the chances of violation.

The Center for Addiction and Substance Abuse at Columbia University has argued for the use of progressive sanctions in mandated substance abuse programs, and the principal should be equally effective when dealing with mental illness. For example, clients might initially be required to check in with their parole officer weekly, but after failing to show up for several psychiatric clinic appointments, the parole officer might increase the frequency to several times per week. The essential component of this approach is to avoid an "all or nothing" approach to success or failure in treatment. It is the nature of serious mental illness to have periodic exacerbations and remissions, and progressive sanctions allow the system to provide responsive increases in structure without necessarily returning the person to prison.

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[93] For many of the ideas in this section and the section on substance abuse, we are indebted to Diane Baillargeon of the Center for Addiction and Substance Abuse at Columbia University.

Principle #5 - Residential Stability

No matter how thoughtful the treatment plan, or how good the other services may be; if a person is living on the street or in a shelter, their chances of success will severely diminish. It is hard enough for a person to live in fear for their physical safety without the added stress of mental illness and perhaps addiciton. Thus, in a focused program aimed at high risk parolees, it probably makes sense to serve fewer clients and include housing.

As noted above, entitlements are crucial. If a person is receiving SSI or SSDI payments, they may well be able to afford some type of stable housing. If these entitlements take weeks or months to achieve, then the person will be most disadvantaged during the early period which is already the most risky.

Frequently, mental health providers presume that the more severe a person's illness, the more likely they are to need congregate living arrangements such as community residences. Yet an inability to get along well with others could well argue for a private living arrangement, even a single room occupancy (SRO) situation, as preferable. Indeed, in prison those inmates who have the most problem getting along with others are typically housed in single cells, where they will have more privacy and avoid unwanted interaction with others. Programs such as supported apartments can provide some support and structure without forcing a person into a congregate living arrangement which they might find irritating, confusing, or frightening. In other words, housing choice should be assessed individually, based on the parolees preferences, strengths and assets, and ability to pay.

Principle #6 - Focus on Substance Abuse

As noted above, prevention of substance abuse relapse may be the single most important feature of the treament plan of a person with these two disabilities. Although the primary problem may vary from time to time, both mental illness and substance abuse need to be addressed in an ongoing fashion, by someone who understands the interaction between the two disabilities and their treatments.

Fortunately, many of the social supports and treatments for mental illness are also very helpful to someone who is battling an addiction. Stable housing, good nutrition, sober friends, and a job are as valuable in treating one disability as the other.

CONCLUSION: A RESEARCH AGENDA FOR OFFENDERS WITH MENTAL ILLNESS UNDER COMMUNITY SUPERVISION

Throughout this chapter, we have raised more questions about the identification, treatment and control of the mentally ill offender under community supervision than we have answered: Taken together, these questions suggest an agenda for future research on the mentally ill offender in the community.

1. What is the prevalence of (various types of) mental illness among probationers and parolees?

2. How reliable and valid are current classification procedures for identifying offenders with mental illness in these settings?

3. How have changes in sentencing practices (e.g. split sentencing, presumptive sentencing) affected the movement of offenders with mental illness to and from institutional control?

4. To what extent have offenders with mental illness been included in the current "intermediate sanctions" movement?

5. How have changes in parole release policies affected offenders with mental illness in prison?

6. How have recent changes in probation and parole supervision policies (i.e. number and type of conditions) affected offenders with mental illness?

7. How have recent changes in probation and parole revocation policies affected offenders with mental illness?

8. Which strategies appear to work best in reducing the individual, agency, and system-level conflict that inevitably arises when mental illness and crime control are combined?

9. Which intervention and/or sanctioning strategy works best as a general recidivism reduction mechanism with offenders with mental illness? Do some strategies work with one group but not others?

10. How should the correctional system prioritize (and respond to) the needs of offenders with multiple problems (e.g. drug abuse, alcohol abuse, other forms of mental illness)?

Given the *size* of our correctional system (over 4.2 million adult offenders at year end 1992) and the *proportion* of offenders currently supervised in the community (3 of every 4 offenders), it seems remarkable that more accurate estimates of both the *size and characteristics* of people with mental illness under various forms of correctional control are not available. Until these prevalence studies are completed, correctional policymakers and practitioners will continue to argue over whether mental illness is really a problem deserving immediate attention and little progress can be made on the rest of our proposed research agenda.

Providing mental health services to parolees requires an interagency commitment. The planning principals suggested in this chapter have evolved from trial and error over time, and

they have as yet been untested empirically. They are offered only as illustrations of the principals. Clearly, they must be tested.

The urgency of such research is clear. As noted elsewhere in this monograph, even if the percentage of inmates with mental illness has remained constant, the explosion of prison censuses in the United States have created pressure on almost every area of states budgets. The absence of mental health treatment and planning upon release quite likely keeps people with mental illness in prison longer, with no evidence that they present greater risk. Creating programs which make mental health treatment systematically available to parolees will likely increase their rate of release and may well keep them in the community longer and more safely.

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CHAPTER 7

INMATES WITH CO-OCCURRING SUBSTANCE ABUSE AND MENTAL HEALTH DISORDERS

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INTRODUCTION

The last decade has witnessed a rapid increase in U.S. correctional populations. Jail populations have risen from 223,000 in 1983 to over 405,000 in 1990 (Bureau of Justice Statistics, 1991a, 1991b). State and federal prison populations have grown from 329,000 to 804,000 between 1980 and 1991 (Bureau of Justice Statistics, 1992a). The most important factor contributing to the spiralling jail and prison populations in the past 15 years is the large number of drug law violators who have been arrested and incarcerated. The number of federal inmates committed to prison for drug charges nearly doubled between 1986 and 1991 (Bureau of Justice Statistics, 1992b). This trend has been accelerated by the availability of relatively inexpensive cocaine, intensified efforts by law enforcement to apprehend street drug users and sellers, increasingly punitive sentencing laws for drug offenses, and heightened levels of criminal behavior associated with drug use (Anglin & Speckart, 1988).

Results from the Epidemiologic Catchment Area (ECA) Study, conducted by National Institute of Mental Health (NIMH) from 1980-84 indicate that prison inmates are significantly more likely to have a diagnosable substance abuse disorder in comparison to the general population in the community (see Table 1). With the large influx of drug-offenders to state and federal prisons since 1984, it is likely that the proportion of inmates with diagnosable substance abuse disorders has increased dramatically. A Bureau of Justice Statistics survey (1993) found that 80% of state prisoners reported a history of substance abuse. This included 28% of prisoners who indicated a pattern of drug dependency. It is estimated that approximately one million individuals with mental illness and/or substance abuse are currently incarcerated in correctional institutions (Pepper & Massaro, 1992) - more than the number of clients who are receiving services in psychiatric hospitals throughout the country.

As described in Table 1, prevalence rates of affective disorders and schizophrenia among prison inmates are significantly higher than those detected in the general population (Keith, Regier, & Rae, 1992; Weissman, Bruce, Leaf, Floria, & Holzer, 1992). Rates of schizophrenia, and bipolar disorder among inmates are 4 to 5 times higher than comparable community samples. Studies conducted within prisons indicate that between 6 to 14 percent of inmates have a major psychiatric disorder (Government Accounting Office, 1991). The population of inmates

who are mentally ill within state and federal prisons has increased substantially since 1980 (Chiles, Von Cleve, Jemelka, & Trupin, 1990; Jemelka, Trupin, & Chiles, 1989). It is estimated that 123,000 prison inmates currently suffer from a major mental health disorder (National Commission on Correctional Health Care, 1992). Persons with mental illness tend to be arrested more frequently than non-psychiatric populations (Teplin, 1983), are frequently arrested for non-violent and misdemeanor offenses (Teplin, 1984; Torrey et al., 1992), and often cycle repeatedly through jails (Torrey, et al., 1992) and prisons. Given the above rates of mental illness and substance abuse disorders among correctional populations, and prevalence rates of dual disorders in community settings, it is estimated that from 3 to 11 percent of prison inmates are likely to manifest dual disorders. In the absence of epidemiological studies examining the prevalence of dual disorders within correctional settings, these estimates were generated by summing the prevalence rates of three major Axis I disorders in prisons (see Table 1), and positing a 50% rate of substance abuse/dependence disorder among correctional populations. Further research is needed to identify patterns of co-occurring disorders among prisoners.

As a result of the increasing confluence of persons with mental illness and/or substance abuse in jails and prisons, greater attention has been provided to the need for rehabilitation programs in correctional settings (Dvoskin, 1991; Inciardi, in press; Leukefeld & Tims, 1992), and for diversion of persons with mental illness and substance abuse from these settings (American Bar Association, 1992; National Institute on Corrections, 1991; State Justice Institute, 1991; Steadman, 1991; Steadman, McCarty, & Morrissey, 1989). Recent initiatives sponsored by the Center for Substance Abuse Treatment (CSAT), the National Institute on Drug Abuse (NIDA), the National Institute of Mental Health (NIMH), the Center for Mental Health Services (CMHS), and the National Institute of Corrections (NIC) reflect the need to develop specialized treatment interventions for mentally disordered and substance abusing offenders.

Research examining dually diagnosed clients in non-correctional settings indicates that lifetime prevalence rates of depression among drug abusers have exceeded 70% (Mirin, Weiss, & Michael, 1988), equivalent to co-morbidity rates found in psychiatric settings (Kay, Kalathara, & Meinzer, 1989). Among individuals in the community with a single personality disorder diagnosis, Regier et al. (1990) report that 64% of drug users seeking mental health treatment have a concurrent disorder. Concurrent mental illness has been observed in 37% of individuals who have a diagnosed alcohol disorder. When mental health populations are considered, it is estimated that 29% of all persons with a mental disorder will also achieve criteria for a substance abuse disorder in their lifetime. For persons diagnosed with schizophrenia, 47% will be diagnosed with a substance abuse or dependence disorder over the course of their lifetime. Substance abuse disorders are diagnosed in 56% of individuals with bipolar disorder.

Co-existing substance abuse and psychiatric disorders generally indicate a poor prognosis for involvement in treatment (McLellan, 1986; Weiss, 1992). Within substance abuse populations, the presence of mental health symptoms has been found to be associated with: (1) more rapid progression from initial use to drug dependence (Weiss, Mirin, Griffin, & Michael, 1988), (2) poor medication compliance (Drake, Osher, & Wallach, 1989), (3) decreased

Table 1

Prevalence of Substance Abuse/Dependence and Mental Illness Among Prisoners

	PRISONS[a]	GENERAL POPULATION
Alcohol Abuse/Dependence	26%[b]	5.9%[b]
Drug Abuse/Dependence	56%[c]	7.6%[c]
Schizophrenia	6.7%[c]	1.4%[c]
Major Depression	9.2%[b]	2.7%[b]
Bipolar Disorder	5.4%[b]	1.0%[b]

a. Statistics were compiled from results of the Epidemiological Catchment Area (ECA) study conducted by NIMH. Data was collected from 5 sites during 1980-1984. In 3 of the 5 sites, state correctional facilities were sampled. In the remaining 2 sites (New Haven, Connecticut; St. Louis, Missouri), samples included both jail and state prison inmates. Jail inmates in Connecticut are housed in state-operated correctional facilities. As a result, the state correctional facility sampled at the New Haven site included both jail and prison inmates. At the St. Louis site, 4 jails and 10 state correctional facilities were sampled.

b. One-year prevalence rate (Robins & Regier, 1991).

c. Lifetime prevalence rate (Robins & Regier, 1991).

likelihood for successful completion of treatment (Siddall & Conway, 1988; Zuckerman, Sola, Masters, & Angelone, 1975), (4) greater rates of hospitalization (Safer, 1987), (5) more frequent suicidal behavior (Caton, 1981), (6) difficulties in social functioning (Evans & Sullivan, 1990), and (7) shorter latency to remission of symptoms following release from treatment (Carpenter, Mulligan, Bader, & Meinzer, 1985; Kay, et al., 1989).

It is necessary to operationally define the term 'dual diagnosis', and to review several general issues related to the treatment of dually diagnosed prison inmates. Without a clear definition of diagnostic issues, the number of prison inmates who may be potentially labeled as 'dually disordered' is quite high. For the purposes of this discussion, dual disorders are conceptualized to describe individuals who have a DSM-III-R Axis I major mental disorder that co-exists with a substance abuse or dependence disorder. Individuals with concurrent mental retardation and mental illness are not included in this conceptualization. The issue of a 'dual

diagnosis' that involves a substance abuse and personality disorder remains more controversial, particularly among individuals diagnosed as having an antisocial personality disorder.

The 'dually diagnosed', or mentally disordered substance abusers within correctional settings have been identified as needing specialized treatment services (Pepper & Massaro, 1992; Peters, Kearns, Murrin, & Dolente, 1992). The Epidemiologic Catchment Area Study conducted by the National Institute of Mental Health (Regier et al., 1990) found that "strikingly high base rates of mental disorders in prison populations are coupled with addictive disorder comorbidity in about 90 percent of prisoners with schizophrenia, bipolar disorder, and antisocial personality disorder." Despite the high rates of comorbid disorders in prison, only a small proportion of inmates receiving mental health services have a primary substance abuse diagnosis (Goldstrom, Manderscheid, and Rudolph, 1992). Only 4% of inmates receiving services in a 24-hour mental health care hospital had a primary diagnosis of substance abuse/dependence, in contrast to approximately 20% of inmates receiving mental health counseling, and approximately 8% receiving residential treatment.

Clinical research has recently begun to focus on the needs of the mentally disordered substance abusing offender. Research conducted within a correctional setting indicates that approximately 26% of alcohol and drug abusers have a lifetime history of major depression, bipolar disorder, or atypical bipolar disorder, and 9% have a history of schizophrenia (Cote & Hodgins, 1990). In another recent study (Chiles, Von Cleve, Jemelka, & Trupin, 1990), state prison inmates were found to have lifetime prevalence rates of alcohol and drug abuse disorders, antisocial disorders, schizophrenia, and major depression that greatly exceeded those of the general population in the community. Diagnostic assessment of inmates in a metropolitan jail indicated that 44% had a lifetime prevalence of substance abuse disorders and either depression or antisocial personality disorder (Abram, 1990).

Dually diagnosed offenders present several distinct challenges to correctional staff assigned to develop treatment programs. Major issues in treatment of the dually diagnosed offender include frequent disturbance in psychosocial functioning that may interfere with involvement in clinical activities within the prison and during post-custody release. In one recent study (Peters et al., 1992), inmates referred for substance abuse treatment who manifested psychopathology were found to have more pronounced difficulties in employment, family and social relationships, and had more serious medical problems, in comparison to other inmates. Mentally disordered inmates involved in substance abuse treatment were also found to have lower 'baseline' skill levels in their knowledge of substance abuse treatment principles, and relapse prevention skills.

Accurate assessment of co-existing disorders also presents difficult challenges, due to the residual effects of addictive substances (e.g. withdrawal effects) that may mask or mimic psychiatric symptoms such as depression. Dually diagnosed individuals may also present acute psychiatric symptoms such as anxiety and depression that may interfere with traditional forms of substance abuse treatment, and more often require hospitalization or participation in intensive mental health services (Evans & Sullivan, 1990; Pensker, 1983). Involvement and retention of

dually diagnosed offenders in treatment is often difficult, due to rationalization and blaming others for their difficulties, distrust of service providers, and sudden changes in psychiatric symptoms.

Other difficulties in working with dually disordered offenders include the frequent lack of a followup support network, and identifiable family members who are willing to provide shelter and supervision of the offender. This population is also thought to be at greater risk for substance abuse relapse following release from custody (Weiss, 1992). One reason for the greater risk of relapse is the likelihood of medicating uncomfortable emotional states (e.g. depression, mania) through use of drugs. Mental illness may also impair the dually diagnosed offender from understanding the negative effects of drugs or alcohol on his/her behavior. A final difficulty in developing services for this population is associated with the coordination required between correctional mental health and substance abuse services. Due to the range of psychiatric and substance abuse problems, and to the use of psychotropic medications in treatment, dually diagnosed offenders are often excluded from participation in treatment programs.

The complicated clinical presentation of the dually diagnosed offender, the many challenges faced by correctional staff in encouraging participation and retention in treatment, and the difficulties in coordinating correctional and followup services are all factors that argue for the design of specialized approaches for this inmate population. This chapter will review several approaches for screening, assessment, and treatment of the dually diagnosed offender. A brief discussion of legal issues and professional standards of care related to correctional treatment of the dually diagnosed will be provided, followed by a discussion of clinical issues. The review of clinical issues is informed by the results of a national survey of correctional mental health directors.

LEGAL STANDARDS

Before examining screening, assessment, and treatment strategies for the dually diagnosed inmate, it is useful to review the legal context for providing correctional mental health and substance abuse services. Legal standards relevant to mental health care services provided within prisons are reviewed extensively in Chapter 3 of this monograph, and in several related surveys (Cohen & Dvoskin, 1992; Cohen, 1988). A brief discussion of legal issues related to the specialized treatment needs of dually disordered prison inmates will be presented here. An inmate's right to treatment has been supported by the Supreme Court in Estelle v. Gamble (1976), in which "deliberate indifference to the serious medical needs of prisoners" was found to be unconstitutional under the Eighth Amendment. The series of court decisions resulting from the Estelle decision indicate that a finding of "deliberate indifference" must be predicated on a substantial risk to an inmate's health (Cohen, 1988; 1992). In Bowring v. Godwin (1977), a federal court ruled that the right to correctional medical treatment was indistinguishable from the right to mental health treatment. The court concluded that an inmate was entitled to mental health treatment if a "physician or other health care provider" determined with reasonable

certainty that: (1) an inmate suffered from a serious mental disease or injury, (2) the symptoms reflected a "curable" disorder, or could be "substantially alleviated", and (3) potential harm to the inmate would result if treatment was withheld or delayed.

Although the parameters of required mental health care in prisons have been addressed by the court (Langley v. Coughlin, 1989; Cohen, 1992), an inmate's right to substance abuse treatment has not been clearly enumerated. The court in Marshall v. United States (1974) concluded that a convicted felon was not entitled to substance abuse treatment under the Narcotic Addict Rehabilitation Act of 1966. In Pace v. Fauver (1979) the court indicated that failure to provide alcoholism treatment did not violate an inmate's constitutional rights. The court held that a finding of deliberate indifference within the context of failure to provide correctional substance abuse treatment would require: (1) a serious medical need for treatment, and (2) that the inmate's condition would be easily recognizable by a lay person, or diagnosed by a physician. Within these guidelines, there appears to be no clear constitutional right to correctional substance abuse treatment in the absence of acute and life-threatening symptoms, such as those of withdrawal.

Although the court has not required the development of drug or alcohol treatment programs in prisons, several cases provide instruction regarding strategies for the design of such programs. In Langley v. Coughlin (1989), the court specified several constitutionally deficient aspects of correctional mental health care. These may also be useful in developing guidelines for the dually diagnosed offender. Among areas cited by the court were the following: failure to properly prescribe medications or to provide a proper diagnosis, the absence of meaningful treatment other than drugs, poor medical/psychiatric recordkeeping practices, and failure to provide observation of inmates experiencing acute mental health symptoms. In Ruiz v. Estelle (1980), the court indicated that prisons must adapt a "systematic program for screening and evaluating" inmates with mental illness. The court also observed the need for trained professional staff to maintain accurate and confidential treatment records.

Among dually diagnosed prisoners, legal standards support the need for systematic screening of mental illness, with particular attention to evidence of depression and suicide risk, and prior mental illness. Other affirmative obligations of correctional treatment programs include observation of suicidal inmates, and proper diagnosis of major mental disorders. Finally, legal standards indicate the need for accurate records of psychiatric diagnosis, participation in treatment (including refusal of treatment), and use of psychotropic medications.

PROFESSIONAL STANDARDS

Although standards developed by national correctional organizations do not specifically address the needs of dually diagnosed prisoners, they provide important guidance in designing specialized treatment services for this population. A range of increasingly explicit guidelines have been developed in areas of screening, assessment, and treatment services for inmates with both mental health and substance abuse problems. Standards for providing mental health and

substance services within prisons have recently been developed by the American Association of Correctional Psychologists (AACP; 1980), the American Bar Association (ABA; 1989), the American Correctional Association (ACA; 1990, 1993), the American Public Health Association (APHA; 1976), the National Commission on Correctional Health Care (NCCHC; 1992a,b), and the National Institute of Corrections (NIC; 1991). The majority of state correctional systems have also adopted standards for health services (Metzner & Dubovsky, 1986), although these are not always consistent with standards described above. Several reviews of professional mental health standards within correctional settings serve to highlight important commonalities in standards promulgated by these groups (Anno, 1991; Cohen, 1988; Cohen & Dvoskin, 1992; Steadman, McCarty, & Morrissey, 1989).

Professional standards developed by these national correctional organizations generally endorse the use of the following services among inmates with mental illness and substance abuse:

- Standardized screening for both mental health and substance abuse problems (ACA, 1990, 1993; NCCHC, 1992b) that includes a review of inmate records, an interview with the inmate, and observation to detect acute psychiatric symptoms (Steadman et al., 1989).

- Ongoing screening for suicide risk, psychopathology, and substance abuse, including abuse of psychotropic medications (AACP, 1980; ACA, 1990, 1993; NCCHC, 1992b; NIC, 1991).

- Comprehensive assessment within several weeks of referral (ACA, 1990, 1993; NCCHC, 1992b; NIC, 1991).

- Development of an individualized, multidisciplinary treatment plan (ACA, 1990; NCCHC, 1992b; NIC, 1991).

- Matching offenders with levels of treatment and supervision according to individual needs and risk levels (ACA, 1993; NIC, 1991).

- Crisis intervention services (AACP, 1980; Cohen & Dvoskin, 1992b).

- Relapse prevention strategies developed within the institution (ACA, 1993; NIC, 1991).

- Development of continuing care plans to assist in the transfer of inmates within the correctional system and to the community (AACP, 1980; ACA, 1990, 1993; NIC, 1991).

- Incentives and sanctions to increase motivation for treatment (ACA, 1993; NIC, 1991).

- Written policies and procedures regarding handling of receiving screening, handling of emergency situations, management of suicidal inmates, and other inmates placed in segregation or protective custody, confidentiality of records, and staff training (ACA, 1990; AACP, 1980; NCCHC, 1992b; NIC, 1991).

- Information provided to inmates describing basic mental health and substance services available in the institution (AACP, 1980; NCCHC, 1992b).

- Use of an integrated staffing approach to treatment services, and cross-training of staff (NIC, 1991).

- Specialized staff training in the area of substance abuse, coordination of institutional and community substance abuse programs, and development of a variety of treatment approaches to meet the diverse needs of inmates with a history of drug involvement (AACP, 1980; ABA, 1989; ACA, 1990; Cohen & Dvoskin, 1992b).

The ACA (1993) and NIC (1991) standards recommend that "targeted treatment programs" be developed for special needs populations, such as dually disordered prisoners. In recognition of the need for close supervision and continuity of care among these inmates, the NCCHC (1992b) suggests that "chronic clinics" be developed. Other administrative procedures for management of the 'special needs' inmate are recommended to assist correctional staff to quickly identify unique medical problems, medications, or other acute conditions. Cohen and Dvoskin (1992b) describe a model continuum of correctional treatment services that includes elements drawn from the community mental health system. Essential components of this system include crisis intervention services, intermediate and long-term residential treatment units for inmates who need an extended supportive and therapeutic environment, and outpatient clinic services. Standards recently developed by the ACA (1993) describe a range of "minimum", "primary treatment services" that should be provided for substance-abusing offenders. These services include: (1) diagnosis, (2) drug education, (3) counseling, (4) relapse prevention and management, (5) culturally sensitive treatment objectives, (5) self-help groups, (6) pre-release services, and (7) coordination with community supervision agencies.

Anno (1991) recommends that each correctional institution conduct a self-assessment to identify categories of inmates with special health needs. Once a special needs category (such as 'dually diagnosed inmates') has been established, a data collection instrument should be developed to describe the number of special needs inmates housed in a correctional system. Survey data should be used to assist correctional health care planners in developing an institutional or systems approach to treatment of the dually diagnosed inmate, and a tracking system to monitor this population.

SCREENING AND TRIAGE TO DUALLY DIAGNOSED PROGRAMS

Inmates admitted to state or federal prisons typically participate in a series of screening activities to identify health problems, psychiatric disorders, substance abuse problems, vocational and educational deficits, and other needs for program services. An additional classification screening may also be conducted to identify security risks (e.g. history of escape, past aggressive behavior within the institution), and to determine the type of institutional placement that provides a custody environment consistent with the level of risk. Substance abuse and mental health screening conducted in correctional settings is often quite brief (Peters, 1992a; 1992b), with items designed to identify self-reported psychiatric symptoms or substance abuse problems, and willingness to enter a treatment program. In some correctional systems, such as Florida, Oregon, and Wisconsin, evidence of substance abuse or mental health problems is used to 'flag' inmates who are in need of more extensive assessment to determine the type or intensity of treatment services (Peters, 1992b). This approach recognizes the need to provide general problem-oriented screening for all inmates, and the need to reserve scarce program resources for inmates who have more severe mental health and substance abuse problems.

Potential problems related to the use of dual diagnosis screening/admission criteria that are based solely on psychiatric diagnosis include the likelihood of not detecting many inmates whose symptoms are in temporary remission. It may be more relevant to evaluate the inmate's past history of mental health and substance abuse problems, and to determine the inmate's level of psychosocial functioning achieved over the past year. Nonclinical staff may also be able to help identify inmates who are experiencing significant psychosocial problems, such as self-destructive behaviors or difficulties in interacting with other inmates or with staff. Under conditions of scarce fiscal resources, inmates with acute symptomatology should receive priority for involvement in dually diagnosed treatment programs, although screening for program admission should also facilitate referral of eligible inmates who have more nonspecific functional deficits.

Screening Domains

Key areas to be assessed in mental health screening include acute mental health symptoms (depression, hallucinations, delusions); history of mental health treatment, including use of psychotropic medications; history of suicidal behavior, including current suicidal thoughts, and the perceived level of problems and need for treatment. Areas addressed in correctional screening of substance abuse should include patterns of recent drug and alcohol use, chronicity of use, the 'drug of choice', and motivations for using and for treatment. Initial screening efforts should focus on the individual's report of their current psychiatric symptoms and behaviors and should be completed at the earliest possible point after incarceration. This baseline information, collected in closest proximity to the inmate's most recent substance use, may be highly valuable in describing the symptom profile and the evolution of the dual disorders.

Although legal and professional standards identify the importance of providing standardized screening for all prisoners, the depth of material included in the screening and 'decision rules' guiding referral for subsequent assessment will be determined to a large extent by the available services in the institution. As few highly individualized dual diagnosis programs currently exist, screening decisions within the majority of prisons are likely to be concerned with whether an inmate will be treated in a substance abuse treatment program or a mental health treatment program. Within prisons having both substance abuse and mental health services, screening should attempt to the severity of both disorders, the need for stabilization of acute symptoms, and the effects of current symptoms on the inmate's response to treatment.

The symptom history is often useful in shaping treatment recommendations for the dually diagnosed client. If the history of acute psychiatric symptoms has coincided with the onset of a substance abuse disorder, then substance abuse treatment may take precedence. Continued assessment during an extended period of abstinence may reveal whether affective or psychotic symptoms were substance-induced. If these symptoms become exacerbated during a period of abstinence, psychiatric treatment is indicated. Though lengthy observation and deferral of diagnosis is recommended until a period of sobriety can be established, Kofoed (1991) suggests that "evidence of significant psychiatric comorbidity soon after detoxification" should be used as an important indicator to guide assessment and treatment planning. Continued abstinence will likely diminish the severity of an independent mood or psychotic spectrum disorder. For example, many affective symptoms are thought to remit quickly with sobriety (Kofoed, 1991; Schuckit, 1989). Examination of current symptoms will often take precedence over the development of specific diagnoses. For example, suicidal behavior should be addressed and monitored as a primary concern, regardless of the competing diagnoses that may be under consideration. This is of particular concern among the dually diagnosed, who have higher rates of suicide in comparison to other psychiatric populations.

Prisons that operate specialized dual diagnosis programs should develop an integrated screening approach that examines critical indicators of both mental health and substance abuse problems. Screening and assessment should be conducted by persons who are experienced in the use of DSM-III-R diagnostic criteria. Training may be needed to assist staff in detecting signs of mental illness and substance abuse disorders, and to initiate referral to dually diagnosed prison services. Staff training should be provided to assist in determining whether a symptom developed as a result of mental illness or substance abuse. As described above, this requires that assessment staff are able to obtain a coherent, longitudinal symptom history. The diagnostician must be cautious, however, in relating historical information to the current episode, and must consider psychopathology within the context of an evolving symptom presentation (Kofoed, 1991).

Screening Instruments and Procedures

A range of screening and assessment instruments that address mental health and substance abuse problems are described in Table 2. Several mental health screening instruments that have been used successfully in correctional settings are reviewed by Jemelka (1991) and Dvoskin

(1991). These include the Referral Decision Scale (RDS; Teplin & Schwartz, 1989), a 14-item instrument derived from the Diagnostic Interview Schedule (DIS), which has been empirically validated within a jail setting. Other mental health screening instruments that may be useful in identifying dually diagnosed inmates include the Beck Depression Inventory (Beck, Rush, Shaw, & Emery, 1979), the Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983), and the Symptom Checklist (SCL-90R; Derogatis, Rickels, & Rock, 1976). Dvoskin (1991) indicates that mental health screening is one of the most important correctional mental health services, and recommends liberal referral to more comprehensive assessment.

Substance abuse screening measures include the four-item CAGE Questionnaire (Mayfield, McCleod, & Hall, 1974) and the Michigan Alcoholism Screening Test (MAST; Selzer, 1971), which have been used extensively in screening for alcohol dependence. The Drug Abuse Screening Test (DAST; Skinner, 1982) provides a similar screening for drug abuse. The Alcohol/Drug Use section of the Addiction Severity Index (ASI; McLellan, Luborsky, O'Brien, & Woody, 1980) has also been used successfully as a preliminary substance abuse screening instrument within correctional settings. Each of these screening instruments may also contribute to a more structured diagnostic assessment of dually disordered inmates.

It may be difficult to determine the etiology of mental health or substance abuse symptoms at the time of initial screening, due to the potential effects of acute abuse or withdrawal on psychiatric symptoms. Dual diagnosis screening and referral to specialized treatment services should be provided for individuals who are reporting symptoms of either an acute or past history of substance abuse, and who manifest psychiatric symptoms consistent with a major mental illness. In the absence of intoxication or withdrawal effects, inmates may still report a significant history of substance abuse or dependence that has occurred in their past. Despite recognizing that the cyclical nature of their psychiatric symptoms may precipitate an increase in their substance use, these individuals may not understand the severity of their substance abuse disorder.

Inmates who do not initially acknowledge a mental health or substance abuse problem may later refer themselves to treatment after learning more about correctional program services, or experiencing psychiatric symptoms while incarcerated. This may occur in reception/ admissions units, or following placement within a general correctional institution. Dual disorders may be identified by a range of correctional staff during the course of an inmate's admissions screening, reception, or subsequent incarceration, by intake screening counselors, mental health or substance abuse counselors, classification or correctional officers. A flexible screening system should be developed that allows for ongoing identification of mental health and substance abuse problems during the course of incarceration, and multiple points of entry to programs serving the dually diagnosed inmate.

In addition to the need for ongoing identification of individuals who experience a recurrence of mental health symptoms or develop motivation to enter substance abuse treatment, consideration must be given to the likelihood of acute effects of substance abuse. For inmates screened in the first several days of incarceration, staff should carefully examine the presence

of acute substance intoxication, and the interactive effects of drug/alcohol use on psychiatric symptoms. As the length of abstinence from substance abuse increases, correctional staff will be more concerned with the presentation of withdrawal symptoms or chronic residual effects of drugs. Although acute withdrawal effects for most substances of abuse typically resolve within 2 weeks, chronic residual effects, though not well understood, may exert their effects over a period of several months (Sederer. 1990).

ASSESSMENT OF INMATES WHO ARE DUALLY DIAGNOSED

Following screening and triage, a more comprehensive assessment is required to determine the level of skill deficits, the need for psychotropic medications, and various forms of psychotherapeutic intervention. This will allow the clinician to develop an individualized treatment plan and reentry/followup plan for the inmate who is dually diagnosed. As indicated within professional standards (National Institute of Corrections, 1991), standardized assessment methods should be implemented at an early stage of incarceration, and should be available for dually diagnosed offenders throughout the period of incarceration.

Kofoed (1991) recommends that assessment of the dually diagnosed client should first attempt to determine the presence of a substance abuse disorder. This is thought to be of preeminent importance because substance abuse disorders are more reliably diagnosed, can cause serious complications if missed, and can have a significant impact on early treatment planning (i.e. sobriety). There is some controversy regarding the need to declare one or the other disorder as primary, however, Kofoed (1991) suggests that there is little evidence to support use of 'primary' and 'secondary' diagnostic schemas in the assessment of the dually disordered. Even among clients for whom the substance abuse is considered secondary to another psychiatric disorder, this distinction quickly becomes irrelevant. Drug use itself is inherently reinforcing and can quickly become an independent disorder among dually diagnosed populations.

An important component of dual diagnosis assessment involves the self-report of symptoms. This information is useful in describing the sequence and history of symptoms, the individual's conceptualization of their mental health and substance abuse problems, and their level of motivation for changing maladaptive behaviors. Increasingly, the process of changing addictive behavior is thought to occur in stages, through which individuals may pass on several occasions before successfully achieving abstinence (Prochaska, DiClemente, & Norcross, 1992). These 'stages of change' begin with only minimal awareness of substance abuse problems. In later stages, awareness of problems may increase, and the individual may begin to consider making lifestyle changes towards the goal of abstinence, and may proceed to modify addictive behaviors, and to consolidate gains made in previous stages. Due to the chronic relapsing nature of addictive disorders, gradual movement through various stages of recovery is often punctuated by regression to earlier stages of motivation and commitment to behavior change.

Table 2
Available Screening and Assessment Instruments for Dually Diagnosed Inmates

Structured Diagnostic Interviews	Global Symptom Measures
▸ Composite International Diagnositc Interview Substance Abuse Module (CIDI-SAM)	▸ Minnesota Multiphasic Personality Inventory-2 (MMPI-2)
▸ Diagnostic Interview Schedule (DIS)	▸ Millon Clinical Multiaxial Inventory (MCMI-II)
▸ Structured Clinical Interview for DSM-III-R (SCID)	▸ Symptom Checklist (SCL-90-R)
	▸ Brief Psychiatric Rating Scale (BPRS)
	▸ Referral Decision Scale (RDS)
Single Disorder Measures	
Mental Illness	**Substance Abuse**
▸ Profile of Mood States (POMS)	▸ Addiction Severity Index (ASI)
▸ Schedule for Affective Disorders and Schizophrenia (SADS)	▸ Alcohol Use Questionnaire (AUQ)
▸ Beck Depression Inventory (BDI)	▸ Michigan Alcohol Screening Test (MAST)
▸ Beck Hopelessness Scale (BHS)	▸ Alcohol Use Inventory (AUI)
▸ Beck Anxiety Scale (BAS)	▸ CAGE
▸ Brief Symptom Inventory (BSI)	▸ Drug Use Index (DUI)
▸ Hamilton Depression Scale (HDS)	▸ Drug Abuse Screening Test (DAST)

Dual diagnosis assessment should also examine factors related to the initiation and maintenance of addictive behavior. Early etiological theories describing co-occurring disorders posited that the selection of a particular drug of abuse was driven by the effects it had on underlying symptoms (McLellan, Woody, & O'Brien, 1979). This 'self-medication' model promotes the importance of specific alcohol and drug effects, rather than more general motivational variables, in explaining the development of substance abuse. For example,

Khantzian (1985) indicates that individuals may abuse specific substances to reduce depression and rage. More recent studies shave shown that individuals do not always select drugs that reduce negative symptoms, and that the drug of choice is more often influenced by other psychosocial factors such as conformity with peer group norms (Dixon et al., 1991).

Symptom Interaction

A thorough assessment of dual disorders should be predicated on a knowledge of mental health and substance abuse symptom interactions. Terms used to describe the way in which symptoms interact include 'mask', 'precipitate', 'exacerbate', and 'mimic'. Masking, in this context indicates that one disorder is hidden by the presence of the other disorder. For example, many drugs are thought to exacerbate psychiatric symptoms. Marijuana and alcohol are often thought to mask the presence of bipolar disorder, whereas alcohol has been hypothesized to mask the presence of schizophrenia (DeVito et al., 1970). Among a group of individuals suffering from major depression, Ablon and Goodwin (1974) demonstrated that dysphoric reactions occurred after ingesting even moderate amounts of THC, the active ingredient in marijuana.

High doses of cocaine were found to produce intense anxiety and crying in another investigation (Post, Kotin, and Goodwin, 1974). Numerous reports indicate that alcohol and drug abuse are associated with exacerbation of bipolar disorder (Goodwin and Jamison, 1992). Drake, Osher, and Wallach (1989) found that alcohol and drug abuse were associated with greater expression of psychiatric symptoms, including threatening and hostile behavior, and disorganized and incoherent speech.

Assessment of dually disordered inmates should also consider the potential confounding effects of drug and alcohol abuse on psychiatric symptoms. Acute effects of withdrawal and of chronic use can produce symptoms largely indistinguishable from those seen in inmates with major mental illnesses. Several authors have suggested that substance abuse may elicit symptoms of major mental illness among individuals who are predisposed or vulnerable through either environmental or genetic risk factors. Rounsaville et al. (1982) found that the lifetime prevalence rate of depression in opioid addicts was 48%, with most patients reporting a history of depression following the onset of opioid abuse. The previously cited ECA findings (Regier et al., 1990) indicate a somewhat different trend. The vast majority of dually disordered individuals identified by the study reported an onset of psychiatric symptoms prior to that of substance abuse. Freed (1975) hypothesized that the onset of schizophrenia is sometimes precipitated by substance abuse. Substance abuse has also been thought to mimic the presence of mental illness. Chronic use of depressants has been demonstrated to produce organic affective symptoms which usually resolve after a period of abstinence.

Use of an Extended Assessment Baseline

Given the complex symptom interactions between substance abuse and mental disorders, there is a need for an extended baseline in the assessment of dually diagnosed inmates. Current guidelines under consideration for inclusion in DSM-IV criteria indicate that individuals should

be "drug free for between 4 and 6 weeks before they can be reliably diagnosed as having a psychiatric disorder". There is some controversy regarding the duration of abstinence required to rule out the effects of alcohol or drugs. Although most drugs are not detectable in urine or blood after 1-2 weeks, sustained release from fatty tissue storage for some substances has been hypothesized (Dackis, et al., 1982). Schuckit (1989) and others have stated that symptoms of a secondary mood disorder among individuals with a primary substance abuse disorder should remit after 2-4 weeks of abstinence.

Use of psychotropic medication for individuals whose mood or cognitive symptoms will attenuate with abstinence is thought to be inappropriate, although staff must also consider the risks of not treating an active psychiatric disorder. Most dually diagnosed inmates referred to correctional treatment will be detoxified prior to the prison admission, although chronic residual side effects of drug use may continue to confuse the symptom picture. Given the likelihood of symptomatic change among dually diagnosed inmates over an extended period of treatment, early diagnostic indicators should be continually readdressed. A general strategy for assessing the longitudinal presentation of symptoms is presented in Table 3.

The reliance on historical interview data and self-report measures within dual diagnosis settings also support the use of an extended assessment baseline. The accuracy of self-report information has been a concern in the assessment of substance abusing inmates. Among dually disordered inmates, for example, self-report information is used to document the relationship between prior substance abuse and the current symptom presentation. The issue of denial has, perhaps, achieved folklore status in the assessment and treatment of individuals who are substance abusers. Several investigations (Donovan, Rohsenow, Schau, & O'Leary, 1977; Skinner & Allen, 1983) indicate that the trait of 'denial' does not distinguish alcoholics from nonalcoholics. In at least one investigation, trait denial has been found to increase across the course of treatment (Baumann, Obitz & Reich, 1982). Miller & Rollnick (1991) conclude: "it has not been shown that individuals with alcohol and other drug problems display pathological lying or an abnormal level of self-deception".

Among dually disordered inmates, the effects of acute intoxication or withdrawal from substances, or the evolving symptoms of a major depression or psychotic spectrum disorder, may limit the individual's ability to accurately report the frequency and amount of substance use. There is no evidence, however, that inmates who are dually diagnosed are likely to purposely disguise the effects of substance abuse on psychiatric symptoms. The detection of denial among inmates may be both clarified and complicated by the history of criminal justice involvement. If there is a history of drug-related offenses, for example, denial of substance abuse problems is less likely, unless an inmate reports involvement in drug sales without a pattern of use. Following release from custody, offenders with dual disorders who receive regular urinalysis as a function of community supervision may be less likely to deny their substance abuse involvement.

Table 3
Assessment of the Dually Disordered Inmate:
Identifying the Chronological Effects of Each Disorder

1. Assess the significance of the alcohol or drug (AOD) disorder
   - ✓ Obtain longitudinal history of mental health and AOD symptom onset
   - ✓ Analyze whether mental health symptoms occur only in the context of AOD abuse
   - ✓ Determine whether sustained abstinence leads to rapid and full remission of mental health symptoms

2. Determine the length of current abstinence
   - ✓ If not 4-6 weeks in duration, delay diagnosis until this has been achieved

3. Reassess mental health symptoms at the end of 4-6 weeks abstinence

4. If mental health symptoms remit fully, potential referral for AOD or dual diagnosis (DD) services; if not, potential referral for mental health or DD services

Assessment Domains

Assessment of the inmates who are dually diagnosed should examine a broad range of psychosocial problems in order to identify contributing factors and sequela of dual diagnoses (TIE, 1992). A highly comprehensive assessment will provide a description of an inmate's developmental history, including birth complications and, in utero substance exposure. Though the longitudinal effects of the latter are not known, this information may be relevant to evaluating the person's biological predisposition and their learning history.

The inmate's psychiatric history, and their report of the course and outcome of any mental health treatment will provide extremely useful information for current treatment planning. In addition, the history of substance abuse treatment, and factors that have promoted and maintained an inmate's abstinence, or return to drug use, are highly relevant. While it is important to identify the type of substances used in order to evaluate their potential effects on symptom presentation, the theories attempting to link motivation for choosing specific drugs to psychiatric diagnoses have not been confirmed (Lehmann, Myers & Corty, 1989). In general, motivation to abuse drugs or alcohol among the dually diagnosed is not well understood (Dixon et al., 1990).

The inmate's criminal history, including drug-related offenses, may also reveal information regarding the expression of psychiatric and substance abuse problems in aggressive and erratic behavior. This information may help to identify the need for supervised reentry, case

management services, and placement in structured residential programs following release from custody. A detailed criminal justice history may also help to identify potential relapse prevention strategies that involve avoidance of high risk situations that may elicit a return to criminal behavior and symptoms expression. An inmate's educational and vocational background may also reveal special needs that should be considered (e.g. retardation) in planning verbal psychotherapeutic interventions or post-release vocational activities. The inmate's relationships with significant others, and the family history of psychiatric illness and substance abuse/dependence also are important areas of assessment that will assist in treatment planning. Other areas of assessment recommended by TIE (1992) for use with offenders include academic achievement testing, intellectual (IQ) testing, memory screening, and inventories to assess self-esteem, anxiety, depression, and problem solving. Measures of client progress in didactic and skills groups are also recommended.

Assessment Instruments

Although several instruments are commonly used to assess aspects of mental illness and substance abuse, no single assessment measure has been designed specifically for the dually disordered (see Table 2). Structured clinical interviews that address both substance abuse and mental illness include the Structured Clinical Interview for the DSM-III-R (SCID), and the Diagnostic Interview Schedule (DIS). Although these instruments are diagnostically precise, their utility in a prison setting is limited due to the length of administration and staff training requirements. The Addiction Severity Index (ASI) is perhaps the most common psychosocial assessment instrument employed with substance abuse populations, and has been found to be useful with both dually diagnosed clients (McLellan, et. al, 1983; Woody et al., 1984) and with offenders (McLellan, et al., 1993, Peters et al., 1992). ASI norms for substance abusing offenders have recently been developed (McLellan et al., 1993).

The ASI examines 7 functional domains related to substance abuse. Alcohol and drug abuse domains include a survey of recent and lifetime use, treatment history, and other indicators of substance abuse severity. The ASI also reviews major psychiatric symptoms and the history of mental health treatment. Within the context of assessing the inmate with dual disorders, the ASI or other structured interview instruments may be most useful in identifying clusters of mental health symptoms, or substance abuse problems at the time of intake/admission to a mental health, substance abuse, or dual diagnosis program. This assessment would serve to identify areas (e.g. depression, cocaine abuse, employment problems) in which additional interview and test data are needed, yielding a more precise diagnostic picture and allowing staff to begin the process of treatment and aftercare planning. The ASI however, does not produce diagnostic conclusions (Kofoed, 1991) and it should always be supported by the use of mental health measures. Longitudinal client history data and collateral reports may be more sensitive and specific to dual disorders than use of research interviews (Drake et al., 1990).

Brief substance abuse measures that may be used to supplement other assessment instruments in a diagnostic battery or interview include the CAGE (Mayfield, McLeod, & Hall, 1974), and the MAST (Selzer, 1971) . Drake et al. (1990) examined the use of the CAGE

among persons with schizophrenia, and demonstrated a sensitivity of 97 percent in persons with a lifetime alcoholism diagnosis, and sensitivity of 73 percent in persons with a current diagnosis of alcoholism. The MAST has been tested in individuals with comorbid mental illness and alcoholism disorders, and was found to generally have high sensitivity (> 80%), but variable consistency (36% - 89%). Others (Toland & Moss, 1989) have discovered that the MAST produced false positives both by individuals who could not differentiate the effects of alcohol versus schizophrenia on their symptoms, and by those who could not accurately place their symptoms in a historical context. Even a focused interview with the MAST did not detect 25% of alcoholics. Assessment may be confounded in these individuals who experience an exacerbation of their symptoms at relatively low levels of alcohol consumption (Drake, Osher, & Wallach, 1989). Both the CAGE and the MAST require little time to administer or score and could be used in routine screening, or in a formal assessment within a treatment program. An evaluation of depressive symptomatology in persons entering alcoholism treatment found that of several measures, the Hamilton Depression Scale was the most strongly correlated with the DSM-III-R diagnosis (Willenbring, 1986). Scores were found to substantially improve when the measure was readministered after twenty-one days, suggesting that the instrument has low specificity in identifying major depressive disorders.

Few standard batteries of psychological tests that are currently in use have been validated with dually disordered clients. Drake et al. (1990) report that most standard alcohol assessment measures have not been validated for use with substance abusing clients with schizophrenia. Given the heterogeneity of symptoms presented by dually diagnosed inmates, it is unlikely that a single instrument will be developed to accurately distinguish inmates with dual disorders from others with mixed Axis I psychological disorders (Osher & Kofoed, 1989).

An innovative assessment approach developed by Project Shift (TIE, 1992), and used successfully with offenders includes a three-step process: (1) review of the client's history and current treatment information, (2) collection of objective test data, (3) observation and collection of subjective data. This process yields an assessment of the inmate's current functioning and skill levels, which is used to develop a treatment plan. A key element of the assessment is an examination of readiness and motivation to participate in treatment. This assessment is conducted through an interview at the time of intake, through review of the previous record of treatment compliance, and through evaluation of the inmate's involvement in introductory treatment sessions.

In summary, assessment of dually diagnosed inmates should include a comprehensive review of substance abuse history and psychiatric symptoms consistent with a major mental disorder. The initial assessment should be extended for a period well beyond the last active period of substance abuse, as established by drug testing and self-report information. Use of psychosocial assessment instruments provide valuable information regarding mental health symptoms, substance abuse history, and other areas of functioning that require more intensive scrutiny. Diagnostic evaluation, including the examination of the genetic and environmental contributors to the person's presentation of the symptoms, may then proceed. Continued review

of the inmate's clinical presentation should be conducted throughout the course of treatment, due to the protracted and episodic course of the disorders.

TREATMENT OF INMATES WHO ARE DUALLY DIAGNOSED

To date, few guidelines have been established for development of dual diagnosis treatment programs (Lehman et al., 1989). Minkoff and Drake (1991) summarize several emergent themes in the clinical literature, including an emphasis on the integration of mental health and substance abuse, at a systems, program, and individual level. This concept has been realized in "hybrid" programs that integrate the treatment of both disorders within the same treatment group or within the same treatment program. Other methods to achieve integration have included attempts to link substance abuse and mental health treatment programs through intensive case management.

Minkoff and Drake (1991) discuss the need for comprehensive services within the context of the vast array of clinical symptoms manifested by dually diagnosed clients. The authors address the need for assessment of relevant diagnoses and level of problem severity, potential vocational, physical, or cognitive disabilities, and the motivation for treatment. This analysis may involve assessment of the individual's specific treatment needs in the current phase of their illness. Treatment needs may include acute stabilization, development of motivation to engage in treatment process, full participation in a dually diagnosed treatment program, relapse prevention, and rehabilitation.

The transition from an addictions model of treatment to encompass the treatment of dual disorders involves numerous difficulties (Mueser, Bellack, & Blanchard, 1992). Traditional addictions programs contain elements of confrontation, emphasize the role of personal responsibility, and require abstinence as a precondition for participation. Often the use of prescriptive medications is looked on unfavorably in a correctional environment. Among dually diagnosed inmates who have cognitive deficits and may be particularly vulnerable to interpersonal stress, these strategies may be largely untenable. These individuals may also be impaired in their ability to admit problems, and to develop conceptual links between their behaviors, symptoms, and life situations (Mueser, Bellack, & Blanchard, 1992). Similarly, psychiatric treatment programs that do not provide an emphasis on accountability for behavior and utilize only supportive techniques may not be effective in reducing alcohol or drug abuse.

Treatment Approaches

The biopsychosocial model is increasingly being applied in the treatment of persons with dual disorders. Biogenetic issues include the evaluation of the family history and vulnerability for the dual disorders. Results from a study by Ingraham and Wender (1992) indicate that the incidence of both substance abuse and affective disorders is significantly greater in biological relatives when compared to adoptive relatives. This study provides evidence for genetically

transmitted liability of both substance abuse and affective disorder in relatives of individuals with a history of affective disorder.

Common neurotransmitter systems have been implicated as the link in the relationship between the substance abuse disorders and mental illnesses. Dopamine and serotonin neurotransmitter systems have been implicated in the etiology of schizophrenia and depression for many years and have recently been investigated for the role that they play in the reinforcement systems involved in substance dependence (Regier et al., 1990). Psychopharmacological interventions are routinely provided for individuals with serious affective and psychotic spectrum disorders, and have been highly effective in remediating acute symptomatology (Donaldson, Gelenberg, & Baldessarini, 1983; Pi & Simpson, 1985) that would otherwise inhibit participation in correctional substance abuse treatment programs. Among individuals who have dual disorders, pharmacological interventions have been used successfully to decrease drug cravings, to reduce the reinforcing effects of drugs, and to assist in acute withdrawal. Several medications (anxiolytics, tricyclic antidepressants) which have traditionally been used in the treatment of major mental illness are currently being evaluated for their effectiveness in reducing cravings and the reinforcement effects of addictive substances.

Psychopharmacological interventions for dually disordered individuals that are based on models of biogenetic vulnerability are extremely complicated. The decision to prescribe medication in this dually diagnosed population is tempered by the fact that the abuse of nonprescription drugs can significantly impair their action. This can occur through enhanced liver activity which causes the prescribed medication to be more quickly metabolized. Toxic and life-threatening conditions can occur if the individual uses alcohol or illicit drugs while taking lithium, tricyclic antidepressants, or monoamine oxidase inhibitors (Sederer, 1990). Drug interaction complications are also a major concern among clients who may potentially experience a substance abuse relapse. Other relevant considerations include caution in prescribing medication with a potential for abuse with individuals who have a history of addiction. A further complication exists in that participants in substance abuse self-help interventions are also sometimes challenged by other group members for their use of prescribed psychiatric medications.

Psychotherapeutic interventions most commonly provided for dually disordered clients include interventions determined to have efficacy in the treatment of both classes of disorders. Miller and Hester (1986) in their review of the alcoholism treatment literature found that the most effective interventions for individuals with concurrent mental illness are strategies and techniques employed in the treatment of major mental illness. These include instruction in stress management techniques, social skills training, behavioral self-control, marital and family therapy, and community reinforcement - a broad spectrum approach which is designed to restructure family, social, and vocational reinforcers. Recent interest has been demonstrated in the application of cognitive-behavioral therapies to the treatment of substance abuse and dually disordered populations. These strategies were originally developed for the treatment of depression (Beck et al., 1979), and have found to be useful in the treatment of addictive disorders (Laws, 1989; Peters & Dolente, 1990).

Social support interventions in the treatment of persons who are dually diagnosed include the application of self-help groups such as Alcoholics Anonymous. The twelve-step model has been adapted within many "dual diagnosis" treatment programs (McGloughlin & Pepper, 1991). However, spiritually-based services have not always meshed well with treatment programs conceptualized from a mental health perspective. Offering alternative self-help options (National Depressive-Manic-Depressive Association) that are consistent with the client's conceptualization of their disorder(s) is likely to enhance participation in supportive services during an extended period of rehabilitation.

Acute Residential Care

Minkoff (1989) proposed a model for an integrated treatment facility that would incorporate both substance abuse and mental health treatment philosophies. This program is located in a general hospital psychiatric unit and provides treatment for clients who have both a major psychosis and a substance abuse/dependence disorder. This integrated model is based on the 12-step AA model, and a biopsychosocial illness-and-rehabilitation model for the treatment of the psychiatric disorder. This program was developed with the assumption that both the addiction and psychiatric models are considered equally valid when applied independently to clients, with either mental health or substance abuse diagnoses, but must be used in an integrated format with clients who are dually diagnosed.

According to this integrated model, the addiction is seen as the primary disorder, separate from the symptoms for which relief was originally sought. This model also holds that the primary disease (addiction) requires specific interventions, and is not remediated through simply relieving "underlying" symptoms. Four phases of parallel-process recovery are briefly described: acute stabilization - detoxification and treatment of psychotic symptoms; engagement - establishment of treatment relationship; prolonged stabilization - maintaining complete abstinence from the drug causing the problem; and rehabilitation - continued participation in the program and self-growth. This process often includes stabilizing one illness while treatment efforts focus on the other disorder.

Therapeutic Communities

Therapeutic communities (TC's) have been adapted successfully for dually diagnosed clients, and may be particularly useful for inmates requiring a supportive yet structured treatment setting. Although TC's have been used to treat psychiatric disorders, their use is most widely associated with drug treatment (McGloughlin & Pepper, 1991). Residential TC's are developed based on the belief that recovery from addiction is a long-term process, involving major lifestyle changes. The treatment focus is on basic habilitation in areas of social, vocational, and psychological functioning. The TC provides a heavily regimented environment that includes strict community norms regulating participant behavior, positive and negative sanctions for behavior, and a wide range of client involvement in community management.

De Leon (1989) describes the TC model as it relates to the treatment of dual disorders. Therapeutic communities treat drug abuse as a holistic disorder, reflecting problems in numerous psychosocial areas such as conduct, attitudes, emotional management, and social skills. Treatment goals are to change the negative behavior patterns and cognitive processes that lead to drug abuse. A highly structured treatment program includes work, recreational, and community activities conducted over a period of approximately eighteen months. An additional 6 months of continuing care are provided, during which time clients are placed in an independent living setting. Symptom reduction has been noted during the course of TC treatment, although there is less evidence of change in client's character traits. The degree of client improvement during followup is associated with the length of treatment, with residents involved in 9-12 months of TC treatment having a better prognosis.

DeLeon (1989) describes 3 different diagnostic groups: 1) mentally ill chemical abusers (MICA), whose primary problem is a psychiatric disorder with a superimposed drug abuse problem; 2) chemical abusers with mental illnesses (CAMI), involving a primary drug problem and a secondary psychiatric disorder; and 3) chemical abusers (CA), with a primary drug problem and an Axis II personality disorder. TC's have traditionally excluded the first group, but newer treatments are being developed which have been adapted for severely disturbed patients (DeLeon, 1989). DeLeon (1989) believes that the holistic TC approach is successful in treating clients who are dually diagnosed and facilitates recovery by emphasizing comprehensive treatment and community aftercare programs.

The Harbor House program in New York is an example of a TC program that has been developed for dually diagnosed clients (McGloughlin & Pepper, 1991). An interdisciplinary treatment staff includes substance abuse counselors, a part-time psychiatrist and psychologist, and a full-time nurse and social worker. Specialized training is provided to all staff in efforts to enhance and understanding of the psychosocial needs of the dually disordered client, and staff are involved in cross-training to understand the roles of other treatment team members. The Harbor House TC does not rely on verbal confrontation or harsh behavioral techniques that typified several of the earlier TCs developed for substance abusers (DeLeon & Zeigenfuss, 1986). Mental health staff participate in group treatment sessions conducted by substance abuse counselors. Regular staff conferences are held to review difficult clinical cases, and are attended by an external consultant with a specialty in dual diagnosis treatment. Participants in the TC program are provided regular peer support through attendance in 12-step recovery groups within the residential facility and in the community.

Outpatient Treatment

Peterson, Irvin, and Penk (1991) present a model of outpatient treatment for persons with dual disorders. Clients are involved in thirty, weekly appointments focused on "skill units" which utilize 7 learning activities. These include an introduction to the skill area, a videotape of correct skills performance, role playing, resource management (determining what is needed to perform a particular skill), and problem-solving. Additionally, participants are asked to practice these skills in the community and are given homework assignments. The content of

these skill units focuses on symptom management (identifying and managing relapse, coping with symptoms, avoiding alcohol and street drugs), and medication management (information, administration, side effects). A clinical research investigation of this treatment program is currently underway.

Project Shift is an example of a cognitive-behavioral treatment program that has been implemented with both offender and non-offender populations. Developed in New York by The Information Exchange (TIE, 1992), the program was designed to address specific psychological and educational deficits manifested by a young dually diagnosed population. In addition to an extensive assessment of cognitive skills, and readiness and motivation for treatment, the program features a series of nine treatment modules. These include 4 "Cognitive-Behavioral" modules, and 5 "Cognitive-Educational" modules (TIE, 1992). Cognitive-Behavioral modules provided during the program are as follows: (1) anxiety reduction, (2) mood elevation, (3) problem solving, and (4) affect identification and expression. Cognitive-Educational modules provides in the program include: (1) language skills, (2) arithmetic skills, (3) attention/concentration, (4) visual-spatial skills, and (5) reasoning.

Within each of the cognitive-behavioral modules, attempts are made to establish rapport with the client, including discussion of interests in the program, individual treatment goals and objectives, and the client's roles and responsibilities within the treatment module. A second phase of the module is largely psychoeducational, involving a review of the importance of the topic area (e.g. problem solving) in assisting the client to sustain recovery from mental health and substance abuse problems. This activity is designed to enhance individual motivation to learn and develop coping skills within the program, and to appraise the client's understanding of the topic area. A third phase of each module involves presentation and rehearsal of cognitive-behavioral techniques (e.g. stress management). Clients are assigned regular homework to practice self-monitoring and self-management strategies. Treatment counselors are then able to evaluate use of these skills in group treatment sessions. A final phase of each module involves a review of client progress in developing cognitive-behavioral skills. Program counselors assume an active role in providing feedback to clients regarding use of coping skills, and evaluate current skill levels to determine whether additional treatment services are necessary.

Hellerstein and Meehan (1987) describe the difficulties in treating persons with concurrent serious mental illness and substance abuse disorders. This population is described as difficult, noncompliant, and resistant to approaches from both psychiatric treatment and substance abuse programs, leading to their exclusion from both types of outpatient care. As a result, these individuals are frequently admitted to emergency rooms, inpatient psychiatric facilities, and substance detoxification programs. Hellerstein and Meehan (1987) developed an outpatient group for persons presenting with comorbid schizophrenia and substance abuse. Their aim was to treat patients with histories of multiple hospitalizations and poor compliance with outpatient follow-up. Admission criteria included a diagnosis of chronic schizophrenia and a history of significant substance abuse. The groups were highly unstructured with few initial demands, except for the participants acknowledged desire to decrease their substance abuse. The clinical approach was divided into phases: 1) engagement - in which patients are taught to

identify their mutual problems, particularly psychotic symptoms, chronic suicidality, and drug abuse, 2) interpersonal skill development - focused on learning to listen and respond effectively to others, 3) problem solving - addressing family issues, time management, housing, and work. Self-help (AA/NA) was also encouraged. The authors found an overall decrease in the amount of days spent hospitalized. A statistically significant decrease in the mean number of days of hospitalization for the time from one year pretreatment to one year posttreatment was observed.

Kofoed et al. (1989) describe a pilot program for the treatment of psychiatrically impaired substance abusers (PISA) that was developed within a VA alcohol/drug dependence treatment program, and that offers residential and outpatient treatment in an abstinence-oriented setting. The program was situated in a substance abuse program to emphasize the importance of sobriety. The initial focus of treatment is on symptom control, abstention from the addictive substance, and administration of appropriate psychiatric medication. Research findings from this program indicate that clients who remained in treatment experienced a reduction in the number of days hospitalized. A history of previous hospitalizations or of psychiatric symptoms did not influence retention in the program.

Nigam, Schottenfeld, and Kosten (1992) describe the use of adjunctive group therapy with clients with diverse comorbid disorders, utilizing weekly, hour-long psychoeducational group meetings focused primarily on recovery from substance abuse. The groups focused on an open discussion of lapses, and used abstinence as a goal rather than as a criterion for success. Group members were not allowed to come to group "high" in an effort to increase the comfort and safety of those attending. This guideline is particularly important for use with dually diagnosed clients, who are easily exploited by non-psychiatrically impaired drug users and dealers (Nigam, Schottenfeld, & Kosten, 1992). Substance abuse relapse was handled in a "nonjudgmental, supportive manner". Successful program components included an emphasis on education and skill building.

Adapting dually diagnosed treatment approaches for offenders

Programs developed for clients with co-existing mental health and substance abuse disorders should consider the impact of emotional and psychiatric problems, poor problem solving skills, limited attention span, diminished verbal skills, and organic deficits on participation in treatment (Daley, Moss, & Campbell, 1987; Evans & Sullivan, 1990; Peters, et al., 1992; TIE, 1992). Each of these factors should be weighed in developing decisions regarding the content and format of treatment interventions (e.g. therapy groups, community meetings), and coordination of dual diagnosis programs with other correctional services. Diminished reality testing and self-esteem, poor judgment, inadequate stress coping skills, reduced self-care skills, and the lack of a social support network creates additional difficulties in development of post-release treatment plans among this population (TIE, 1992). Within the correctional environment, in which administrators have often perceived the goals of security and rehabilitation to be in conflict, even traditional mental health services (e.g. outpatient clinics, crisis units) are sometimes constructed on a tenuous foundation. Development of specialized

interventions for the dually diagnosed inmate presents further challenges to program staff and administrators.

Depending on the constraints of the correctional facility and the length of incarceration among dually diagnosed inmates placed in treatment, elements from the several previously described treatment models might be implemented within existing mental health or substance abuse treatment programs. It appears necessary, however, to develop an integrated treatment approach with this population, based on models developed in community settings. In addition to involvement in 'core' treatment activities, inmates who are dually diagnosed may also benefit from self-help groups that are focused on the interaction between the dual disorders, and that are accepting of the individual's need to take appropriate psychotropic medications.

Inmates with dual disorders appear to benefit from a structured, psychoeducational approach. Didactic approaches have been found to be particularly useful in assisting these inmates in understanding and managing their mental illness, and in understanding the biological aspects of mental illness and drug abuse (Friesen, 1993). A supportive treatment environment should be developed that allows for inmates who are dually diagnosed to move at a slower pace than would be expected in traditional substance abuse programs. Education should be provided to inmates who are not involved in dual diagnosis treatment, regarding means of positively interacting with program participants.

Following a comprehensive assessment, dually diagnosed inmates referred for acute care may be involved in group therapy to assist in development of psychosocial and life skills, and relapse prevention strategies. Since the potential for substance abuse relapse during incarceration may be limited in some institutions, treatment activities will need to focus on identifying historical patterns of high risk situations (e.g. isolation from family and friends, interpersonal conflict, exposure to active drug users) that have precipitated past drug or alcohol use, and the related effects of psychiatric symptoms. Individualized strategies should be developed to deal with high risk situations, maladaptive thoughts, excessive emotions, cues, and urges that serve as precursors to substance abuse. Educational and role playing strategies may be particularly useful in developing relapse prevention and social skills for this population. Training should also be provided in means of accessing community treatment services following release from prison, including strategies for locating treatment services, setting appointments, and for effectively participating in treatment.

Family involvement in correctional dual diagnosis programs should be encouraged whenever possible. Institutional policies regarding family visitation may need to be reviewed to examine the potential for more lengthy therapeutic visitations, including seminars on co-dependency, and relapse prevention strategies. Family members should be educated about the treatment program, and involved in structured activities with their relative who is dually diagnosed as well as with families of other program participants. Family members should also be encouraged to join Al-Anon or other community support groups, and to participate in followup treatment planning activities.

Positive incentives should be provided to encourage participation of dually diagnosed inmates in correctional treatment programs. These incentives should be communicated to inmates at the time of orientation during the reception/admission process. Specific consequences related to non-participation in treatment should also be identified. For example, mechanisms for providing information regarding participation in dually diagnosed treatment to parole boards, or other agencies involved in developing plans for post-release supervision should be described to inmates. Participation in treatment should not prevent inmates from receiving institutional 'good time', or early release. Specific incentives for compliance with treatment plan goals may be provided through development of token economy programs or other similar behavioral interventions.

Development of a therapeutic community for dually diagnosed inmates would require ongoing support from correctional administrators, and a considerable commitment of staff resources. Correctional TC programs include 24-hour clinical services, and are designed to provide a range of supportive activities. Specialized TC's relying on confrontative techniques may be appropriate for inmates with antisocial characteristics, and have been successfully implemented in Oregon and Wisconsin (Field, 1992; Willoughby, 1990). However, use of frequent confrontative techniques are thought to be countertherapeutic for inmates who have Axis I psychiatric disorders (Friesen, 1993; Vigdal, 1993), and may promote premature dropout from treatment. These techniques have been found to be countertherapeutic for individuals who are intolerant of interpersonal stress (Meuser, Bellack, & Blanchard, 1992).

Among prison inmates who have been dually diagnosed, the high risk for return to drugs and alcohol, and for reemergence of psychiatric symptoms is compounded by a history of criminal behavior, marked by poor impulse control, low frustration tolerance, and aggressive behavior. The association between substance abuse and criminal behavior is synergistic, in which drug use accelerates involvement in crime (Anglin & Speckart, 1988). A recent analysis of data from the National Institute of Mental Health's Epidemiological Catchment Area Study (Robins & Regier, 1991) revealed that the prevalence rate of violence among individuals diagnosed as alcoholic was 12 times that of non-alcoholics (Monahan, 1992). Similarly, the prevalence rate of violence among individuals diagnosed as drug abusers was 16 times that of non-drug abusers. In addition to a diagnosis of substance abuse, other potent predictors of violence included diagnoses of major mental illness. The study concluded: "Violence was most likely to occur among young, lower class men, among those with a substance abuse diagnosis, and among those with a diagnosis of major mental disorder". The heightened risk for substance abuse relapse, return of psychiatric symptoms, and reinvolvement in criminal behavior indicate the need for ongoing case management of the dually diagnosed offender following release from prison.

Critical issues in program development

Staff training

There are often shortages of well-trained staff to work with special inmate populations. Identification of an interdisciplinary team of professional staff is likely to enhance the effectiveness of dual diagnosis programs, and will encourage consideration of multiple treatment perspectives. Conflict may be reduced between interdisciplinary treatment staff working in a correctional dual diagnosis program through involvement in specialized training activities, and regular case staffings. Training is useful in developing a consensus regarding the array of dually diagnosed treatment goals, and an awareness of the roles and responsibilities of treatment team members.

A significant number of correctional substance abuse treatment staff do not have extensive experience or training in working with inmates with mental illness. Similarly, correctional mental health staff have infrequently received specialized training in substance abuse issues. As a result, staff with expertise in substance abuse treatment should be assigned to train colleagues with primary experience in mental health in the stages of recovery among addicted inmates, the effects of drugs and alcohol on psychiatric symptoms, and the residual effects of chronic substance abuse observed during treatment. Staff who have both mental health and substance abuse treatment expertise should be assigned to train colleagues in techniques for working with inmates who have cognitive impairment, depression, or other psychiatric symptoms, and in major modalities of substance abuse treatment. Involvement in this training may be particularly valuable for program staff who have primary experience in substance abuse. Correctional officers who are responsible for supervising dually diagnosed program activities should also be involved in specialized training.

Reviews of dually diagnosed treatment programs conducted by Brown and Backer (1988) and The Information Exchange (TIE; 1993) recommend that cross-training and team teaching should be provided by staff from differing backgrounds. Suggested topics for staff training within dually diagnosed programs are summarized in each of these reviews, and include the following:

- Providing instruction in evaluating a person's substance abuse history, understanding the fast-paced spread of new street drugs, and understanding that even a small amount of drugs can be dangerous

- Cross training and team teaching among staff from both mental health and substance abuse treatment backgrounds

- Including in training curricula, information on dual disorders, including drug and alcohol effects on psychotropic medications, the role of the family, assessment strategies, information about multiple addictions, and disease or "self-help" models of treatment

- Participation of staff members in self-help or support groups
- Information about different treatment models, including detoxification, therapeutic communities, recovery homes, methadone maintenance, 12-step programs, as well as inpatient and outpatient settings
- Evaluation of negative attitudes around these issues and clients (i.e., are they seen as unmanageable, manipulative, etc.)
- Information regarding special client populations, including women, the homeless, and the HIV-positive
- Use of relapse prevention approaches in treatment
- Developing a network of community resources
- Therapeutic approaches to working with 'family systems'
- Working with the involuntary client
- Overview of treatment within community corrections and prison settings

Program location

As in-prison treatment programs for the dually diagnosed inmate are developed, consideration will need to be given to whether they are best placed in an existing mental health or substance abuse program, or whether a separate unit should be identified for this purpose. Given the need for extensive screening and ongoing assessment to examine the symptom history and their current symptom profile, dually diagnosed inmates should be located in program areas with skilled diagnosticians. The level of staff experience and training in working with inmates with mental illness and substance abuse is of paramount importance in siting a program, and may be the most useful factor in determining whether a program is located in a mental health or substance abuse setting (Friesen, 1993).

Participants in dually diagnosed programs should be isolated from inmates who are not receiving mental health or substance abuse services (Peters, 1992a), particularly during the initial involvement in treatment (Friesen, 1993; Keogh, 1993). This will insulate participants from the corrosive influences of non-program inmates on attitudes and norms developed within the treatment program, and will prevent difficulties encountered in mixing emotionally and cognitively impaired inmates with more predatory 'general population' inmates. As acute cognitive symptoms subside, dually diagnosed inmates are better able to cope with interpersonal stressors and can effectively share in meals, recreational, and other group activities within the general prison compound (Friesen, 1993; Keogh, 1993). Although many prisons will not be able to fully isolate dually diagnosed program participants from other inmates, attempts should be

made to provide treatment services in an area that is secure, quiet, and accessible to medical, mental health, and substance abuse services. Location of treatment programs in maximum security facilities may reduce opportunities to provide graduated inmate involvement in recreational and social activities, or in mental health or substance abuse treatment services in less restrictive settings.

Perhaps the optimal setting for a correctional dual diagnosis program is within a specialized mental health or substance abuse facility, in which a continuum of outpatient, acute care, transitional care, and extended care services are available. This setting would provide ample time for screening and assessment, and a range of alternative supervised settings for inmates who experience remission of mental health symptoms, and who complete initial stages of dual diagnosis treatment. A continuum of prison treatment services for the dually diagnosed would assist in managing inmates who experience cyclical psychiatric decompensation (Evans & Sullivan, 1990), and would be particularly useful for those who require graduated levels of supervision and monitoring in educational, vocational, social, and treatment activities.

For many prison systems that lack the facilities or resources to develop dually diagnosed programs within a larger continuum of mental health or substance abuse treatment, efforts should be made to develop a coordinated network of existing correctional services. For example, it may be feasible for mental health or substance abuse programs to incorporate elements of other correctional services, such as detoxification, drug education, medication monitoring, or individual counseling. Within prisons that lack specialized dual diagnosis services, cooperative agreements may be developed with community mental health and substance abuse agencies to assist in providing staff training, treatment planning, and linkage with followup treatment services.

Sequence of program interventions

Prison overcrowding has had a significant impact in reducing the average length of incarceration, thus reducing the amount of time available to provide dually diagnosed treatment services for many inmates. For inmates who are incarcerated for less than 6 months, interventions should be adapted to focus on orientation and commitment to treatment, pre-release planning, and community linkage issues. Education should also be provided regarding the interaction of psychiatric symptoms with alcohol or other substances, and relapse prevention strategies that may be used in the first several months following release. An extended assessment baseline can be initiated to evaluate the need for psychopharmacological interventions. A medication trial may also be initiated if it appears that the inmate plans to continue in treatment following release from prison. It may be useful to develop a separate treatment 'track' for inmates with an expected sentence length of less than 6 months. For those inmates who have an expected sentence length of more than a year, treatment services should initially address acute psychiatric or substance abuse symptoms, with the goal of adjustment to the institution. More comprehensive dual diagnosis treatment interventions should be provided for this group within the last year of incarceration.

Integration of treatment services

In a review of dual diagnosis approaches for criminal justice populations, Pepper and Massaro (1992) describe the complex problems of offenders with mental illness and substance abuse, and the need for a "coordinated and integrated" treatment strategy. A biopsychosocial approach is endorsed that addresses needs for vocational training and employment, housing, education, and development of a family support network, in addition to more traditional mental health and drug abuse treatment counseling. The authors also recommend use of concurrent substance abuse and mental health treatment services for dually diagnosed offenders. A range of interventions are proposed for the dually diagnosed offender, including: (1) assessment of cognitive and neuropsychological impairment, (2) psychoeducational approaches, (3) cognitive-behavioral techniques, (4) use of therapeutic communities that are adapted for mentally ill offenders, (5) relapse prevention activities, and (6) long-term community supervision coupled with ongoing involvement in treatment.

Development of rigid program boundaries between mental health and substance abuse agencies/divisions has prevented dually diagnosed offenders from receiving comprehensive services while in prison, and during reentry in the community. Separation of mental health and substance abuse programs and funding streams within state and federal prison systems have inhibited development of integrated and comprehensive service delivery models. Few joint treatment initiatives have been developed within states that have separate mental health and substance abuse divisions within the correctional system.

State human service agencies are also frequently divided into separate mental health and substance abuse divisions. This has created additional barriers to the development of comprehensive integrated services for dually diagnosed offenders released from prison. It is increasingly recognized that splitting these services among separate divisions is somewhat arbitrary, and has resulted in negative consequences for dually diagnosed individuals. Separate funding mechanisms for community mental health and substance abuse treatment services have fostered the development of a network of programs with narrowly defined 'target populations' (e.g. chronically mentally ill or heroin addicts), that are often ill-equipped, due to limitations in staff training or experience, to diagnose or treat the range of psychosocial problems manifested by the dually diagnosed offender. The absence of integrated dually diagnosed programs in the community has sometimes led to an overdependence on either mental health or substance abuse services, resulting in a failure to address key issues such as monitoring of psychotropic medication or identification of patterns of symptom interaction. For example, the lack of specialized treatment programs in the community has often prevented dually diagnosed offenders from simultaneous involvement in mental health and substance abuse services, and has excluded these individuals from services due to restrictive admission eligibility criteria (e.g. the absence of psychopathology).

Community mental health centers (CMHC's) provide an optimal location to develop post-release dual diagnosis services for offenders because of the greater likelihood of both trained mental health and substance abuse treatment professionals within a single agency, use of an

interdisciplinary team approach to treatment, and availability of specialized case management services. Staff within CMHC's are frequently experienced in working with forensic and correctional populations, and clients with multiple psychosocial problems. Many CMHC's also embrace the biopsychosocial treatment model, which is thought to provide the most effective approach for use with dually diagnosed offenders. However, CMHC's often receive a relatively small share of state substance abuse funds, and may not receive incentives for developing integrated dually diagnosed treatment programs. Both correctional and state human service agencies need to recognize the need for combined efforts in the treatment of the dually disordered offender, and for development of specialized programs for this population.

Program Models

A mail survey was developed at the University of South Florida, Florida Mental Health Institute in March, 1993, to examine the treatment needs of dually diagnosed prison inmate. This survey was mailed to the chief administrator of the Federal Bureau of Prisons, and of each state department of corrections. Surveys requested information regarding substance abuse and mental health characteristics of the current correctional population, sources of data used to identify these inmate characteristics, specialized services developed for the dually diagnosed inmate, and specific treatment needs of the dually diagnosed population. Follow-up phone interviews were used to obtain more detailed information regarding programs providing specialized services for dually diagnosed inmates. The following sections discuss results from this survey of state and federal prisons, and describe two model correctional programs identified by the survey that provide specialized dual diagnosis services.

Survey results

Of 51 surveys mailed, a total of 34 surveys were completed (67%). Four respondents indicated that no information was available regarding the dually diagnosed offender. Survey respondents included mental health directors and other mental health staff (33%), program administrators or assistants to the chief correctional officer (23%), substance abuse services directors (13%), medical directors (10%), treatment services directors (10%), chief correctional officers (3%), quality assurance specialists (3%), and classification staff (3%). All geographic regions were represented by survey respondents. Correctional systems represented by respondents averaged 19,600 inmates (range: 600 - 113,000).

Survey respondents indicated that an average of 87% of prison inmates had a history of substance abuse (range: 50 - 93%). When asked to describe the source of substance abuse history data, 73% of survey respondents indicated that this information was obtained through an initial screening conducted by mental health or classification staff. In 13% of cases, this information was obtained through more comprehensive assessment. The substance abuse history obtained during screening and assessment was presumably based on an inmate's self-report. Survey respondents indicated that an average of 9% of inmates had a DSM Axis I mental disorder (range: 3 - 20%). This mental health information was most frequently derived from classification or tracking records (38%) and from medical records (38%).

Only 3 survey respondents were able to identify the number of dually diagnosed inmates within their correctional system. These respondents estimated that the proportion of dually 2diagnosed inmates within the correctional system ranged from 2.2% to 10%, with an average of 5.2%. Dual diagnosis problems are typically identified by correctional mental health staff (43% of respondents), by intake screening staff (38%), by substance abuse staff (5%), and by both substance abuse and mental health staff (14%).

Only two states (Alabama, Delaware) reported specialized program services for the dually diagnosed prison inmate; these two programs are described below. Three states (Illinois, Maryland, Oklahoma) indicated that plans were underway to develop a dually diagnosed program, and 2 other states (Rhode Island and Wisconsin) had established goals of developing services for this population. Survey results indicate that few post-release services are currently available for dually diagnosed offenders. Substance abuse services in halfway houses and outpatient settings were available for this population in only 5 states, and residential programs and case management services were available in only 4 states. Outpatient mental health services for dually diagnosed offenders were reported in 3 states, and halfway house and case management services for offenders with mental illness were available to dually diagnosed offenders in 2 states.

Ventress Correctional Facility - Alabama

The specialized dual diagnosis programs in Alabama and Delaware prisons that were identified through the survey are organized very differently (Friesen, 1993; Keogh, 1993). The program developed by the Alabama Department of Corrections includes a 62-bed unit located within the Ventress Correctional Facility (VCF). This prison has been designated to incarcerate and provide treatment to substance-abusing offenders. The program in the Delaware correctional system was developed by a private medical services contractor, Correctional Medical Systems, Inc. This program was originally designed to provide services for inmates with chronic mental illness and retardation, but has recently been expanded to focus on the needs of the dually diagnosed.

Dually diagnosed inmates at the VCF prison in Alabama are initially screened and referred for treatment by a classification review committee, and then receive further screening by an intake psychologist. Dually diagnosed inmates are placed in a separate dormitory within the prison, originally developed as a result of verbal abuse directed at dually diagnosed program participants by other substance-abusing inmates. As the program developed, efforts were made to 'mainstream' inmates over the course of treatment to participate in meals, recreation yard, laundry, and pharmacy activities, sick call, family visits, and other group activities with the general inmate population.

Dually diagnosed inmates receive approximately 30 hours of treatment services per week over an average of 18 weeks. Treatment interventions include comprehensive psychosocial assessment, group therapy, psychoeducational groups, 12-step groups, AIDS prevention and

education activities, use of psychiatric medications, relapse prevention, and community reentry services. Drug testing of program participants is also conducted.

Mental illness and substance abuse issues are provided equal attention within the dually diagnosed program. The program includes several 'core' modules that are drawn from the 8-week treatment program received by other inmates enrolled in substance abuse treatment at VCF. An additional 10 weeks of treatment services were added to this program to address management of emotional problems, interactions of substance abuse and mental health symptoms, medication compliance, and aftercare issues. The dually diagnosed program also provides Emotions Anonymous (EA) groups, based on the 12-step model.

The program offers a highly regimented schedule of activities, similar to other substance abuse treatment services offered within the prison. In comparison to other treatment offered at VCF, dually diagnosed services start slightly later in the morning, and provide somewhat less intensive homework requirements due to the limited cognitive abilities of inmate participants. In comparison to other institutional substance abuse programs, the dually diagnosed program provides more informal group interaction to allow for processing of emotional and interpersonal problems that may arise in the unit, and provides more of an emphasis on psychoeducational approaches.

An aftercare treatment plan is developed for all inmates in the dually diagnosed program. Following completion of the program, inmates are eligible for placement in other correctional substance abuse programs, that include TCs and modified TCs. Inmates may also be transferred to correctional institutions that do not have substance abuse treatment programs, or may be placed in a work release program in the community. Efforts are currently underway by the Alabama Department of Corrections to identify 12-step resources in the community and to provide staff training within community work release settings. In comparison to other inmates, the dually diagnosed have experienced more difficulty in securing legal and institutional advocacy to support their release from prison through parole board hearings (Friesen, 1993).

The dually diagnosed program is staffed by 2 drug treatment counselors, and one clinical supervisor. Several inmate 'dorm leaders' who have completed the 18-week treatment program assist counselors in treatment activities. The program is funded through a grant received by the Center for Substance Abuse Treatment. Although the specialized dually diagnosed program at VCF has only been operating for one year, preliminary evaluation results indicate that only 5 of 62 inmates have been transferred out of the program, including 2 that were sent to more intensive psychiatric hospital units (Friesen, 1993).

Delaware Department of Corrections - Chronic Care Program

Dually diagnosed inmates in the Delaware correctional system are referred for treatment to the Chronic Care Program, a 25-bed unit located in the Sussex Correctional Institution (SCI). Treatment services are provided through contract by Corrections Medical Services, Inc. Although this program was originally designed for inmates with mental retardation and mental

illness, specialized services for the dually diagnosed offender were developed as greater numbers of substance abusers were placed in this program. Specialized dually diagnosed services have been provided in the Chronic Care Program for the past 2 years. Corrections administrators were initially somewhat hesitant to develop a specialized dually diagnosed program at SCI due to concerns regarding behavior management of this population. Staff training during the first year of program operations was useful in generating support for the program.

Inmates are identified for the Chronic Care Program through mental health screening following detoxification, and through referral by correctional officers or correctional counselors during incarceration. Upon referral, program staff provide a clinical interview and chart review to determine eligibility for admission. The length of involvement in treatment varies considerably, although inmates may remain in treatment for the duration of their sentence.

Treatment services are provided 7 days a week by a staff of 2 mental health counselors, a correctional counselor, and a consulting psychiatrist and part-time activity therapist. Medical services are located in an adjacent unit, and provide crisis care and other monitoring of health care needs. The Chronic Care Program unit is separated from other institutional programs, and is located within a maximum security facility. Program participants currently share meals, recreation yard, and religious activities with other inmates. Staff report the need for greater isolation from other inmates, particularly during initial involvement in treatment. Following this initial orientation period, program participants would then be gradually involved in shared activities with other inmates.

Treatment services include a comprehensive psychosocial assessment, individual and group therapy, drug education, medication monitoring, psychoeducational groups, AIDs prevention/education, relapse prevention, and individual case management and planning for community reentry. All inmates are involved in a 'Family Systems Group', which meets twice weekly for 12 weeks to review the history of mental illness and addictions and to explore developmental correlates (e.g. emotional/physical abuse, parental substance abuse) of the dual disorders. Inmates also participate for 8 weeks in a 'Medication/Mental Illness' group designed to assist inmates in understanding their mental illness and psychotropic medications. Psychoeducational groups are provided on topics of addictions, management of anger and aggressive behavior, and sexuality.

A 'Focused Group' is provided once weekly in the Chronic Care Program for a small group of inmates who have limited cognitive abilities. Inmates spend approximately 20 minutes in this group reviewing topics from the 'Medication/Mental Illness' group, and involved in structured skills-building exercises, such as learning to effectively communicate side effects of medication, and how to fill out a commissary form. A tutoring program is provided for the vast majority of inmates in the Chronic Care Program who lack basic literacy skills. These services are provided several hours per week by tutors selected from the general inmate population. Inmates also have opportunities to participate in a variety of arts and crafts activities within the program.

Behavioral reinforcement is provided by the program through use of a level system, in which inmates progress to higher levels of responsibility and privileges based on compliance with treatment goals and community rules and regulations. The program provides 4 levels, with inmates at the highest level afforded privileges such as commissary, family visits, and yard activities. New admissions to the program are generally given a range of privileges, unless they exhibit inappropriate behavior or experience difficulties in cognitive functioning or self-care activities.

Inmates completing the program may receive continuing dual diagnosis services in aftercare groups provided within SCI. Inmates placed in other correctional institutions are eligible to receive outpatient services and psychiatric monitoring. A few program graduates have been placed in work release settings. Following release from prison, dually diagnosed inmates are also eligible for placement in mental health and substance abuse halfway houses, and in a variety of outpatient services.

The Chronic Care Program offers a range of reentry services for dually diagnosed inmates. County mental health agency staff 'reach in' to SCI to meet with inmates and staff prior to the planned release date, and conduct an assessment of followup treatment needs. A pre-release treatment plan is established for each inmate in the program. County mental health staff coordinate with mental health and substance abuse agencies in the community to set an initial appointment for followup treatment; and through the Mobile Crisis Unit, provide transportation to insure that the dually diagnosed offender attends these treatment sessions. In some cases, county mental health staff have met program participants at the prison at the time of release, for this purpose. County mental health agencies also provide case management services to secure supervised housing, placement in sheltered vocational workshops, and assistance to obtain SSI and other entitlements.

COMMUNITY LINKAGE AND REFERRAL

The need for development of effective linkages to aftercare treatment and support services is consistently described within standards developed by professional correctional organizations. The need for aftercare linkages is also firmly articulated within the 1989 American Psychiatric Association Task Force Report on "Psychiatric Services in Jails and Prisons" (Griffin, 1991). Pre-release planning to promote continuity of treatment for the dually diagnosed inmate presents considerable challenges. Developing continuity of care among dually diagnosed clients diagnosis is complicated by the undulating course of psychosocial functioning, marked by symptom exacerbation and substance abuse relapse (Minkoff & Drake, 1990). In the same way that dually diagnosed inmates are not easily integrated with existing prison mental health or substance abuse programs, they may not be universally accepted in community-based programs. These individuals bear the triple stigma of active mental illness, substance abuse problems, and a recent criminal justice history; any one of which may serve to disqualify them from involvement in community treatment services. There is some evidence that mental health programs may be

more receptive than drug treatment programs to involvement of dually diagnosed offenders who are returning to the community (Wilson, 1993).

Linkage to community mental health and substance abuse treatment is further complicated by the limited availability of community resources for dually disordered clients. Correctional programs should attempt to enlist the support of community mental health and substance abuse agencies in providing assessment for post-release treatment needs, and developing a continuing care plan. The National Commission on Correctional Health Care (1992a) recommends that prisons develop cooperative arrangements (e.g. 'no-decline agreements') with community mental health systems to expedite the process of followup referral and placement. Several correctional programs have also found it useful to develop resource directories that may help familiarize inmates with community treatment, vocational, educational, and other support services.

An individualized pre-release, or followup treatment plan for dually diagnosed inmates should be developed well in advance of release (Griffin, 1991; Jemelka, Trupin, & Chiles, 1989), that involves community treatment staff, the inmate, correctional program staff, and available family members. The pre-release plan should anticipate the need for continuing psychotropic medication, and participation in mental health counseling. Griffin (1991) recommends that arrangements be made for renewal of prescriptions, and provision of an interim supply of medication prior to release to the community. Pre-release treatment activities should also be designed to assist dually diagnosed inmates to prepare for stressors and high risk situations that might be faced during the first few weeks after release. Role play activities and modeling may be useful in developing strategies to avoid active drug users, to resist social pressures to use drugs or alcohol, and to cope with interpersonal conflict.

Effective linkages with followup treatment agencies are largely dependent on the ability to communicate information regarding the dually diagnosed offender's participation in institutional treatment services, the course of mental health and substance abuse symptoms, and deficits in psychosocial functioning that should be addressed following release from prison. Policies and procedures should be developed within each institution to insure that cumulative treatment information follows the offender throughout the correctional system, and is routed to community-based treatment programs following release (ACA, 1993). Federal confidentiality regulations (42 CFR - Part II) require that informed consent be completed by each inmate, authorizing release of correctional treatment information to other community, state, or federal agencies. Follow-up treatment counselors within the prison should attempt to develop 'qualified networks' with community agencies to expedite this process. Procedures also should be established to routinely send a copy of the pre-release treatment plan, the discharge summary, assessment data, and other relevant clinical information to follow-up treatment agencies. Similar procedures should be developed and implemented at the time of program admission, in order to obtain relevant clinical records from community treatment agencies.

An accurate inmate self-appraisal of their symptoms and conceptualization of their illness is important in developing recommendations for post-incarceration treatment. If an inmate understands and supports the need for followup treatment, the referral and linkage process may

be less complicated. However, if an inmate has not fully participated in correctional mental health or substance abuse treatment programs (including development of treatment and post-release plans), or associated support and self-help groups, opportunities for successful referral are likely to be compromised.

Involvement of available family members in institutional treatment and followup care will increase the likelihood of successful reintegration to the community. Family members should be encouraged to participate in the development of a treatment and aftercare plan, and in discussion of the optimal post-release placement of the dually disordered inmate. Family members should also be consulted during the initial assessment, and should be invited to participate in periodic staff reviews of inmate progress. These efforts are designed to provide information to the family about the treatment needs of the dually disordered inmate, to reduce isolation of family members from the community of allied mental health professionals, and to mobilize hope and willingness to become involved with the offender's recovery following release from prison.

For those inmates who have few contacts outside the institution, attempts should be made to contact family members, and to enlist their support in the treatment and recovery process. Meetings involving available family members should be held within the institution prior to an inmate's release, in order to discuss the role of the family in the recovery process. It may be useful to designate staff within the prison to coordinate family services, including therapeutic family sessions, visitations, and family support groups. The National Alliance for the Mentally Ill (NAMI) has established a forensic network in each state. In the past, this network has provided training to coordinators of family activities within the prison, and has also developed community support groups for families of dually disordered inmates.

Family members having regular contact with the offender in the community are often the first to observe difficulties in psychosocial functioning, and should be trained to identify relapse warning signs that may precede psychiatric decompensation or resumption of drug or alcohol use. Although family members are often unable or unwilling to serve as the primary care provider in the community, the family can provide ongoing support in development and implementation of the followup treatment plan. Involvement of the family in follow-up treatment can also serve to strengthen the offender's motivation and commitment to recovery goals.

Dually diagnosed inmates may require referral to a variety of ancillary services, in addition to mental health and substance abuse treatment. These include placement in sheltered housing, job training, life skills programs, GED programs, self-help groups, and assistance in applying for entitlements. The likelihood for successful reintegration to the community will be enhanced by involvement in structured living programs that provide an opportunity for regular interaction with drug-free peers. Recommendations developed by the National Commission on Correctional Health Care (1992a) regarding comprehensive followup services for inmates with mental illness are also useful in guiding post-release plans for dually diagnosed inmates. Key areas of followup services recommended by the NCCHC include: (1) outreach programs, (2) psychiatric consultation and monitoring, (3) detoxification services, (4) individual and group

psychotherapy, (5) family therapy, (6) self-help groups, (7) residential treatment services, (8) diversion programs, and (9) assistance to meet financial, housing, and legal needs.

Specialized community case management services are needed to help coordinate reentry activities for the dually diagnosed offender. Case managers may assist these individuals in developing a structured daily schedule, to monitor compliance with medication, and to identify early warning signs of substance abuse or depression. The case manager may be of critical importance in promoting continued involvement in substance abuse and mental health treatment. Due to the multiple problems experienced by dually diagnosed offenders during community reentry, and the high rate of relapse, the size of caseloads supervised by case managers should be quite small.

Research indicates that criminal justice supervision following release from treatment encourages retention in followup treatment, and reduces the likelihood for rearrest (Hubbard et al., 1989). Criminal justice supervision of dually diagnosed offenders will assist to monitor involvement in mental health and substance abuse treatment, to provide drug testing to strengthen commitment to abstinence and to detect early signs of substance abuse, and to identify other potential precursors of relapse. Criminal justice supervision may be particularly useful in providing monitoring of aftercare treatment goals during the first three months of community reentry, when a significant number of relapses can be expected to occur. Dually diagnosed inmates should be provided access to work furlough, controlled release, or parole programs, so that enhanced supervision can be provided during this critical period of reentry.

PROGRAM EVALUATION

Several recent evaluation studies have documented the effectiveness of correctional substance abuse programs in reducing drug use and criminal recidivism among prison inmates (Field, 1992; Wexler, Falkin, & Lipton, 1990; Willoughby, 1990). Few comprehensive evaluations have examined the effectiveness of correctional mental health programs, or programs for dually disordered inmates. Within the context of scarce institutional resources and an increasingly diverse inmate population with varied needs for program services, the importance of evaluation and monitoring is augmented. As prisons begin to develop specialized programs for dually disordered inmates, there is an acute need for evaluation and research to identify: (1) the effectiveness of various approaches and interventions for inmates with differing levels of psychopathology and substance abuse involvement, (2) the optimal length of program interventions, and (3) strategies to enhance retention in community treatment and supportive services following release from custody. Results from these evaluation efforts may be used to modify ineffective program procedures or treatment interventions, and to justify continuation or expansion of existing programs. Standards recently developed by ACA (1993) indicate the need to conduct annual "process and program evaluation" activities by qualified professional staff.

Planning for evaluation activities should begin in the early stages of program implementation, reflecting the need to provide a coordinated data collection strategy and the

significant duration of time required to obtain outcome results. Key prison administrators should be consulted in determining the range of issues to be addressed in the evaluation, including ongoing needs for program-level information. Several important evaluation questions that may be addressed include the following:

(1) What are the characteristics of inmates participating in the dually diagnosed treatment program?

(2) What are the defining characteristics/elements of the treatment program?

(3) Has the correctional program been implemented as intended?

(4) Have dually diagnosed inmates made progress towards program goals and objectives, as measured by cognitive and behavioral changes related to psychosocial functioning, and utilization of prison resources?

(5) Is the investment of treatment program resources justified by the program outcomes obtained?

The evaluation design is strengthened by the inclusion of a comparison group of untreated inmates. Although it is frequently impractical to provide random assignment of inmates to correctional programs, several 'quasi-experimental' designs may be used to identify comparison groups of inmates eligible for participation in the dually disordered treatment program but who are placed in an institution without available treatment services. Other types of comparison groups include inmates who have not completed the full regimen of dually disordered treatment services, or who have received less intensive interventions (e.g. outpatient mental health services).

A variety of important evaluation data may already exist within prison records, such as reception mental health and substance abuse screening, classification records, and other aspects of the inmate record that reflect institutional adjustment and utilization of mental health or substance abuse services. Evaluation of dually diagnosed programs may be strengthened through use of an integrated psychosocial interview instrument that includes both substance abuse and mental health domains. In addition to profiling the inmate population receiving services, this information is useful in identifying factors associated with program dropout, response to specific treatment interventions, and post-treatment outcomes. Examples of instruments that examine mental health, substance abuse, and other psychosocial variables are the Addiction Severity Index (ASI; McLellan, Luborsky, O'Brien, & Woody, 1980), and the Clinical Intake Assessment Instrument (Center for Substance Abuse Treatment, 1992).

Another important area of evaluation examines the level of inmate participation in treatment. Information obtained may include dates of program admission and discharge, the type, frequency, and duration of treatment interventions and ancillary services received, the response to treatment, and discharge status. Efforts should be made to routinely monitor and

evaluate dually diagnosed inmate's abilities to understand materials presented in treatment sessions, to practice skills learned in these sessions, and to complete homework assignments. Difficulties in participating in treatment may signal the need for adjustments to the pace or content of treatment groups.

Measures of inmate progress during treatment may include changes in psychiatric symptoms, counselor ratings of mental health functioning or progress in treatment, or objective measures of skills acquired during treatment. Examples of instruments examining changes in psychiatric symptoms include the Beck Depression Inventory, the Brief Symptom Inventory, and the Symptom Checklist. Measurement of inmates' skills may be obtained through use of counselor ratings (TIE, 1992), skills tests such as situational competency instruments (Hawkins, Catalano, & Wells, 1986), or other objective tests reviewing specific content areas covered within treatment modules.

These measures may help to determine whether an inmate should continue to work on a specific treatment module, whether the inmate is able to begin work in another area of treatment, or whether involvement in treatment should be discontinued. An integrated evaluation of client progress is used within some programs (TIE, 1992), that includes readministration of skills tests in specific modules, weekly evaluation of program participation and progress, monthly evaluation to examine retention of skills, and post-treatment evaluation to assess changes in cognitive and educational abilities.

Several outcome evaluation measures that may be useful in determining the effectiveness of dual diagnosis programs include: the frequency of psychotropic medications prescribed and received, type and frequency of outpatient services prescribed, compliance with outpatient or other treatment modalities, disciplinary incidents and use of isolation management, changes in psychiatric symptoms, and readmissions to intensive mental health services (e.g. acute care, transition care, or other residential programs). Although there are currently no evaluation results reported from correctional settings, preliminary evaluation results from dual diagnosis programs in the community are encouraging, and indicate fewer post-treatment days of hospitalization (Hellerstein, & Meehan, 1987; Kofoed, Kania, Walsh, & Atkinson, 1986). Clients completing 12 sessions of treatment in Project Shift (TIE, 1992) were rated by counselors as significantly improved in 8 of 10 assessed problem areas. Both clients and counselors reported a significant improvement in the overall level of adaptive functioning, following participation in this program.

SUMMARY

American correctional populations are characterized by high rates of mental health and substance abuse disorders. Despite the significant number of prisoners with comorbid disorders, few correctional substance abuse or dually disordered treatment programs are currently available. While budgets for state and federal correctional systems have increased substantially in the last 5 years to support construction of new facilities, per capita health care expenditures for prisoners

have actually declined (Boodman, 1992; Goldstrom, Manderscheid, & Rudolph, 1992). Although the influx of substance-involved offenders committed to prisons during this period has precipitated much of the new prison construction, this group clearly has not been the beneficiary of significantly augmented treatment services that might ultimately reduce criminal recidivism.

Dually disordered prison inmates represent one of several growing 'special needs' populations that would benefit from additional correctional services. This population presents several unique challenges in areas of screening, assessment, treatment, and linkage to post-release services. In addition to difficulties in disentangling the often complex array of substance abuse and mental health symptoms, dually diagnosed inmates have a multi-problem lifestyle that has often evolved over a period of many years. Other major barriers to treatment involvement and community reentry include poorly developed social, daily living, and coping skills, cognitive deficits, and an inadequate social support network.

Dually diagnosed inmates are typically poor consumers of treatment or of other social services, and are often resistant or non-compliant within traditional therapeutic programs. The dually disordered inmate is also at higher risk for substance abuse relapse and psychiatric decompensation in comparison to other inmates, and is characterized by several important risk factors that have been found to be associated with violence in the community. Within the framework of a multi-problem lifestyle and significant impairment in psychosocial functioning, the development of dually diagnosed correctional treatment programs may appear to represent a daunting task. However, this challenge should be embraced by correctional systems in efforts to meet the critical need for acute and long-term services, to prevent further penetration to the criminal justice and correctional systems, and to reduce the need for subsequent use of treatment services in the community.

Although there is not a clear constitutionally protected right to dually disordered treatment within correctional settings, the court has indicated the need for provision of basic mental health treatment; particularly in the presence of acute symptoms or an apparent risk of self-injurious behavior. Legal standards also support the use of systematic screening and assessment of mental illness and (to a lesser extent) substance abuse problems. Professional standards more explicitly describe the need for standardized screening and assessment of inmates with mental illness who are substance-involved, development of individualized treatment plans, and for matching these offenders to treatment according to demonstrated needs. Professional standards also describe the need to develop policies and procedures regarding management and treatment of special populations. There are currently few guidelines that specifically address standards of care related to screening, assessment, and treatment of dually diagnosed inmates.

The significant rates of both mental health and substance abuse disorders in correctional populations indicate the need for careful dual diagnosis screening among all prison commitments. Many dually diagnosed inmates will be identified through brief mental health or substance abuse screening, or through other interaction with correctional mental health, health services, or program staff. Use of an integrated screening approach is recommended, that examines both mental health and substance abuse symptoms. The accuracy of screening and subsequent

assessment is contingent upon a sustained period of abstinence, and the ability to accurately evaluate the etiology of the symptoms. Screening and assessment is likely to be conducted after a period of prior incarceration, thus reducing the confounding effects of acute intoxication. The scope of initial screening or of assessment may also be limited to the extent that information regarding the inmate's past behavior may not be revealed during early interviews, particularly if there are concerns about confidentiality or about disclosing prior criminal activities.

Screening and assessment should be accomplished soon after commitment to prison, and should be available to inmates throughout the course of incarceration. The initial assessment will focus on the current stage of the dual disorders, needs for acute stabilization, and for education regarding symptom identification. This information will be used to develop individual treatment plan goals. Comprehensive assessment of dually diagnosed inmates requires a knowledge of mental health and substance abuse symptom interaction. Due to the limitations of self-report information and to the anticipated gradual resolution of symptoms of acute substance exposure, assessment should continue over a period of several weeks. Ongoing assessment will address differential symptom presentation, increased awareness of the interrelationship between symptoms, the history of psychosocial functioning, and the need for continued treatment in a focused areas (e.g. psychosocial skill development).

Opportunities for screening, assessment, and treatment services should not be restricted to inmates experiencing acute symptoms, but should include those with a history of mental health and substance abuse symptom interaction, and a history of substance abuse or dependence that significantly impairs psychosocial functioning. The decision to refer to either a mental health or substance abuse program may ultimately hinge on the severity of the inmate's presenting symptoms and the availability of institutional resources.

A variety of instruments may be administered in an attempt to examine the inmate's symptom presentation and motivation. These may be presented through structured interviews or written self-report. Several currently available measures address both substance abuse and mental illness, although no single measure has yet been developed that examines the complex symptom history of dually disordered individuals. Inmates with a history of chronic substance abuse who also have documented psychiatric symptoms should be referred for more comprehensive assessment.

The application of standardized assessment measures for use with dually disordered individuals has not been fully validated. Structured diagnostic interviews are thought to be the most comprehensive form of assessment, but have not yet been tailored to address the presence of dual disorders. These interviews have significant limitations in correctional settings due to the lengthy time of administration and staff training requirements. Comprehensive inmate history data and collateral reports obtained during interviews are thought to be extremely valuable components of a dual diagnosis assessment.

At present, few clear guidelines exist for the treatment of dual disorders in correctional settings. Several community treatment approaches appear to hold considerable promise,

including integration of dual diagnosis treatment interventions within a single treatment setting. Many treatment programs for the dually diagnosed have also embraced a biopsychosocial treatment model. Treatment interventions found to be effective with dually diagnosed populations overlap significantly with those employed in the treatment of major mental illness. These include stress management, social skills training, and other methods of behavioral reinforcement and self-control. The twelve-step (AA) model has been employed with dual diagnosis populations, but has not yet been demonstrated to be effective. Psychopharmacological interventions present unique challenges within this population, given the likelihood for interactive effects between substance abuse and psychiatric symptoms.

Although the treatment model developed for dually diagnosed inmates will be determined in large part by the range of available services within a facility, it is apparent that this population will require longer and more intensive therapeutic contact than is typically provided within correctional mental health or substance abuse programs. Model therapeutic programs have attempted to provide dually diagnosed services within a wide spectrum of treatment settings. Acute care, therapeutic community, and outpatient service models for dual disorders have all been used effectively for this population. For prisons that are unable to provide separate programs for the dually diagnosed inmate, specialized groups may be developed within residential or therapeutic community programs.

Dually disordered inmates may have limited cognitive resources, as manifested by impaired attention, poor problem-solving skills, and organic deficits. These cognitive deficits limit the pace at which this population is able to participate in psychotherapeutic interventions, and to apply related skills. Diminished abilities to tolerate interpersonal stress may also render this group particularly vulnerable to inmates in the general population that have better developed social skills, superior verbal communication abilities, and more aggressive tendencies. Confrontational techniques, while effective for certain substance-involved inmate populations, may be countertherapeutic for the dually diagnosed.

Staff training should be provided to assist in accurate identification of dually disordered inmates, patterns of symptom interaction, and in biopsychosocial treatment approaches. Cross-training should be developed for substance abuse and mental health staff, and correctional officers and administrators to review relevant characteristics of dually diagnosed inmates, goals of the treatment program, and security/management issues. The location of a dually diagnosed program within a prison system should consider the availability of skilled diagnosticians, and of mental health and/or substance abuse staff who have training and experience with dually disordered populations. The need for ongoing monitoring of psychotropic medication among dually disordered inmates also requires the accessibility of psychiatric staff. Proximity to a continuum of mental health and substance abuse services within less restrictive settings is also desirable.

Offenders released from prison often face many difficulties in readjusting to a less structured daily schedule, reinvolvement in relationships and employment, and in some cases, to ongoing criminal justice supervision. Dually diagnosed offenders face the additional stigma

of mental illness and substance abuse problems, the absence of family or peer support, and eligibility criteria for community social services that often exclude this group from participation in mental health or substance abuse treatment. Development of linkages to community services will be an extremely important component of any correctional dually diagnosed program.

A pre-release plan developed with involvement of the inmate, community agencies, and available family members provides a critical foundation for continued involvement in treatment and adjunctive services. Initial appointments at community mental health and substance abuse agencies should be planned well in advance of release, and provisions made for continuation of psychotropic medication. Specialized community case management services are also needed to address the multiple needs of this population, and to 'broker' and monitor utilization of treatment, educational, vocational, housing, transportation, and other areas of service needs.

Relatively few dually diagnosed treatment models currently exist within state and federal correctional systems. In most states, dually diagnosed inmates receive treatment services in either mental health or substance abuse programs. Specialized programs for this population have been developed in only 2 states. Although these programs vary in their placement within either a larger network of mental health or substance abuse services, both have received administrative support, have developed a comprehensive level of interdisciplinary services, and are able to successfully provide services throughout the course of incarceration. Support is urgently needed to develop additional program models through agencies such as the Center for Substance Abuse Treatment, the Center for Mental Health Services, and the Bureau of Justice Assistance. Research examining the effectiveness of various dually diagnosed treatment interventions within corrections settings is also needed. In addition to examining the application of dually diagnosed treatment models developed in non-correctional settings, research is needed to identify the optimal length of treatment interventions, the optimal sequence of substance abuse and mental health activities, and the effectiveness of various community linkage strategies.

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CHAPTER 8

THE NATIONAL WORK SESSION: RECOMMENDATIONS FOR ACTION

Deborah L. Dennis

INTRODUCTION

In June 1993, the National Coalition for the Mentally Ill in the Criminal Justice System sponsored a three-day National Work Session in Austin, Texas to discuss the key issues facing persons with severe mental illness in the nation's prisons and to recommend actions to address the needs of this population. More than 70 experts from across the country participated, representing researchers, mental health and criminal justice administrators and direct service staff, family members of persons with severe mental illnesses, national associations, and advocacy organizations.

Plans for the National Work Session began nearly a year earlier with the commissioning of the papers comprising the prior six chapters in this monograph. The papers were compiled in draft form and distributed to each participant prior to the meeting. Participants were asked to read all chapters and come prepared to develop a national agenda for addressing the needs of persons with severe mental illnesses in U.S. prisons.

Presentations by the authors of each chapter provided a context for the deliberations of small work groups that focused on each chapter topic. Participants were assigned to a work group which included a facilitator, a researcher (typically the author of the chapter), two recorders, and 10-15 other participants.

Each group was charged with three specific tasks. For each topic, the groups were asked to develop **a vision statement** that was compelling enough to bring about change in state and local systems, specific in outcome orientation, broad enough to encompass the diversity of the population, reflect a set of principles, and be easily understood. Second, they were to identify **the major problems** or issues raised in the context of each topic. Finally, each group was asked to recommend **strategies for responding to the needs of** offenders with mental illness in prison.

From these small group interactions came the policy discussions and recommendations that were reported back to the full conference at a series of large group meetings. Three products resulted from these efforts: (1) authors were given feedback on their draft chapters, (2) small groups hammered out policy recommendations to put forward around the assigned small

group issues, and (3) the group as a whole discussed these recommendations to build a national agenda for reforming the care of mentally ill offenders in the prison system.

In this final chapter, the recommendations of the small work groups are summarized and cross-cutting issues and recommendations are identified. While no format could fully capture the range of ideas and the discussion that ensued, the following summary is intended to convey the essence of these deliberations and their importance and relevance for creating change.

RECOMMENDATIONS FROM WORK GROUPS

Legal Strategies for Addressing Severe Mental Illness in Prisons

Since 1976, it has been clear that prison inmates have a constitutional right to treatment for serious medical and mental health needs (see Chapter 3, p. 1). However, the assessment of need for and the availability and quality of mental health care remain at issue. The Legal Work Group focused on the use of the law -- including legislative and administrative changes as well as the courts -- to move from the **"required to the desired."**

The Work Group agreed that the goal of such efforts was to provide clinically adequate and humane mental health services to prisoners with serious mental illness and to prisoners in mental health crisis. To accomplish this goal, multiple strategies are necessary, including: preventive law audits and corrective action, advocacy, standards development and implementation, training and education, legislation and regulation, and litigation. They recommended that the Coalition focus its efforts on the following:

- **Adopt standards** for: (1) confidentiality as it related to the transmittal of records among agencies; (2) conflict of interest between evaluation and treatment; (3) the clinical autonomy of mental health professionals in prison settings (i.e., address role conflict); (4) use of isolation, restraints, and segregated housing (clinically appropriate and conforming to civil standards); (5) mandatory screening for suicide prevention; and (6) discharge planning that includes a patient's rights statement and access to non-discriminatory services.

- **Audit legal status** regarding confidentiality, conflict of interest, informed consent, clinical autonomy, use of isolation/restraints/ segregated housing, screening, and discharge planning.

- **Reach out to culturally and gender diverse organizations.**

- **Educate**: (1) families and consumers about the legal process, (2) justice about mental health, and (3) the bar and law schools about mental health and correctional law.

- **Commit to continuous process review** of mental health service systems.

Identifying Severely Mentally Ill Offenders in Prison

The most methodologically rigorous studies suggest that 10-15% of prison inmates have a severe mental illness and that perhaps as many as another 15-50% need outpatient mental health services at some point during their incarceration (see Chapter 4). Persons with severe mental illness often do not function well in prison. They may be particularly vulnerable or they may disrupt prison routine. Thus, identifying inmates who have a severe mental illness is essential to maintaining a prison environment that is safe for both inmates and staff.

The Screening Work Group emphasized the importance of conducting initial and ongoing mental health screening as well as the need for a pre-sentance evaluation that is transmitted with the inmate to prison. The Work Group made three major recommendations related to initial screening, follow-up assessment, and ongoing monitoring and referral for treatment once the offender is in prison.

Initial screening. All inmates should be given a brief, initial screening for severe mental illness immediately upon admission to prison that includes: (1) evaluation of dangerousness to self or others, (2) presence of psychotic symptoms and/or extreme emotional states, (3) information about any medication the inmate is taking for psychiatric symptoms, (4) a brief psychiatric history, (5) cognitive functioning, and (6) impairments of psychosocial functioning that interfere with the admission process.

- Screening should be conducted in a **setting respectful of the privacy** and dignity of the inmate, and where sensitive and valid information may be obtained. Inmates should be informed about the nature, purpose, and results of the screening and assessment process.

- Screening is best accomplished using **a semi-structured interview with a standardized measure** (see Chapter 4). Wherever possible, relevant ancillary information should be incorporated (e.g., medical records, presentence reports, previous custodial records, information from family members). This may require obtaining informed consent releases from the inmate.

- **Screeners must be trained** to identify symptoms of mental disorder and to competently administer the screening instrument(s). The screening and screeners need to be culturally competent and the screening must be conducted in a language the offender understands.

- If a mental health concern is identified or if screening information cannot be obtained for any reason, the screener should make a **referral** for a follow-up assessment or, if indicated, arrange for immediate intervention.

Follow-up assessment. A follow-up assessment by a mental health professional is desirable for all inmates, but it is essential when a mental health concern is identified during screening or when the screener is unable to obtain screening information.

- The purpose of the follow-up assessment is to verify the results of the initial screening, to determine whether, and to what extent, mental health services are required, and to make a referral, if indicated, to the appropriate treatment units and/or programs.

- If no serious mental health needs are identified in this assessment, the inmate should be returned to the general population, and the decision documented.

- Inmates referred for follow-up assessment because screening information could not be obtained should receive an assessment that is culturally sensitive and in a language that the inmate can understand.

Ongoing monitoring and referral for treatment. Because an inmate's mental health needs may change during incarceration, prisons need to have mechanisms and training to ensure that ongoing monitoring and referral occurs for mental health problems as they emerge.

- All staff working with inmates in prisons should be trained to identify the symptoms and signs of mental illness and to understand the appropriate contact person and mechanisms for referral. The referrals must be acted upon appropriately. Training is the responsibility of the department of corrections and should be ongoing.

- As part of the prison orientation procedure, inmates should be made aware of available mental health resources in the event that he or she needs them.

- Inmates who are found to have ongoing or emergent mental health problems should be referred to a treatment unit for a more comprehensive evaluation and development of a treatment plan.

Creating Effective Prison Treatment Programs

The Treatment Work Group defined an effective prison treatment program as safe, individualized, culturally and community competent, and measurable. They stressed that creating a good prison treatment program requires a multidisciplinary approach, adequate funding, political will, redefining agency roles and responsibilities, the identification and acknowledgement of special population groups, and behavioral support to ensure that desired changes are reinforced through an established system.

The Work Group made four major sets of recommendations designed to: (1) ensure safety, (2) develop individualized assessments and treatment programs, (3) create culturally and community competent treatment programs, and (4) support effective programs. These recommendations are presented below.

Ensure safety. Ensure the safety of both mentally ill offenders and staff by training staff, orienting inmates, and developing clear program guidelines with behavior support.

- Provide team cross-training for all staff and let inmates know that staff are cross-trained.
- Create normalized physical environments to the extent possible.
- Teach conflict resolution techniques to inmates and staff.
- Provide initial and on-going inmate orientation.
- Develop clear, but fair and flexible, program guidelines with behavioral support.
- Teach inmates skills and responsibilities and provide the behavioral support to encourage safety in prison.

Develop individualized assessments and treatment programs. Assessments and treatment plans should be individualized; they should be implemented using specific skills training treatment modules that are time limited and periodically reassessed.

- Conduct individualized assessments of inmate skills, skill deficits, and symptoms and develop individualized treatment plans based on the individualized assessments.
- Implement individual treatment plans using specific skills training treatment modules that: (1) are time limited and periodically reassessed, (2) are designed to be delivered by all staff, (3) are driven by client desires and needs, (4) are disseminated to every U.S. correctional system, (5) value small therapeutic gains, (6) are based on the context of an individual's ultimate discharge plan and within other aspects of his or her life (both within and outside the prison environment, (7) provide for both group and individual interventions, and (8) are inclusive regardless of offense, security classification, or other characteristic.

Create culturally and community competent treatment programs. Training and education in cultural and community competency should be increased, models for culturally and community competent treatment programs should be identified, and a national resource center on cultural competency should be established to disseminate existing information, generate new knowledge, and provide technical assistance in this area.

Support effective programs. Treatment programs need to be accountable to inmates who receive services, to administrators who fund them, and to others who want to develop new programs or new approaches to prison mental health treatment. Research needs to be conducted on treatment outcomes and efficacy and technical assistance must be available to disseminate information on effective approaches.

- Develop feedback mechanisms on the individual level so that inmates can measure his or her own success and so that the treatment plan can be adjusted when indicated.

- Make technical assistance on developing information systems and on mechanisms for exchanging information among agencies widely available.

- Expand program evaluation/research to assess program implementation and client outcomes.

- Track the impact of treatment within the prison (e.g., transfer from mental health unit back to general prison population) and through community release and integration (e.g., linkage to community-based care).

Assuring Substance Abuse Treatment for Persons with Co-Occurring Disorders

The Work Group on Substance Abuse Treatment focused specifically on the treatment needs of individuals who have co-occurring mental and substance use disorders. At least half of all persons with severe mental illnesses are estimated to have an alcohol or other drug problem and even higher rates have been found among persons with severe mental illness in prison (see Chapter 7).

The Work Group agreed that persons with dual disorders should be provided access to a full range of treatment services offered by a staff of competent, cross-trained professionals. Services for dually diagnosed inmates should be provided in the least restrictive setting in order to maximize participation in prison programs and continuity of care upon discharge to the community. The Work Group's recommendations were to:

- Increase corrections administrations' awareness of the dually diagnosed population's needs, treatment programs, and implementation methods by: (1) providing opportunities to visit model programs, (2) developing a proposal for technical assistance, (3) disseminate information at professional and trade meetings, (4) developing new and refining existing standards, and (5) developing a program implementation manual.

- Reduce stigma by including dual diagnosis information in conferences and special population workshops, developing public service announcements featuring public officials, and establishing state-level mental health consumer affairs offices.

- Develop training curriculum and fund technical assistance on dual diagnosis for prison staff.

- Establish a common definitions and identify core treatment components as part of the development of a program implementation manual for dual diagnosis treatment.

- Encourage joint planning and funding of treatment and research by corrections, mental health, and alcohol and drug agencies with a focus on identifying effective approaches to treating co-occurring mental and substance use disorders.

- Increase cross-training of mental health and substance abuse treatment professionals by: (1) encouraging clinical staff rotation, (2) providing opportunities for joint staff training, (3) supporting National Alliance for the Mentally Ill's development of a university training curriculum, and (4) encouraging adoption or expansion of cross-training by state department of corrections, mental health, and alcohol/drug agencies.

- Increase awareness of existing mechanisms for information exchange among state and local agencies while still meeting confidentiality requirements.

Planning for Discharge and Parole

Assuring continuity of care upon release from prison and reducing recidivism was the focus of the Discharge Planning Work Group. Although the specific approaches will vary by state and local jurisdictions, it is essential that discharge planning for offenders with mental illness in prison be an interagency process for individual treatment and supervision that maximizes public safety and improves the quality of life for the mentally ill offender.

Ideally, an interagency discharge plan: (1) is holistic, related to diagnosis, offense, and behavior patterns; (2) assigns a single case manager; (3) includes a flexible budget for each individual with case manager discretion; and (4) has clearly defined and linked roles for interdisciplinary team members, including family members. It is essential that conditions of release are clear and that violation policies are consistently applied and include intermediate sanctions. Supervised residential facilities and other essential support services must be available for those who need them.

Discharge plans must be culturally and gender sensitive. Victims and other stakeholders must be informed and involved in plans for release. At the same time, however, the general public must be educated to reduce the stigma created by the dual labels of mental illnesses and ex-offender.

Recommendations for achieving these goals include:

- Support comprehensive mental health benefits for mentally ill offenders as part of a national system of health care reform and with coverage beginning prior to discharge.

- Create an interagency treatment plan beginning at the initial contact with the criminal justice system, and following the offender through discharge into the community.

- Conduct new and review existing demonstration research on the most promising approaches by: (1) examining existing models/research, (2) examining existing research literature in other contexts, (3) studying model programs, (4) establishing baseline information to test the effectiveness of interventions, and (5) conducting analyses of the legal context for model programs. These studies should be linked to policy development. They should be funded by federal and/or state agencies and conducted by broad base of researchers including, but not limited to university-based researchers.

- Develop national, state, and local standards for effective discharge planning for transition to community supervision and treatment.

- Review existing community services and conduct local needs assessment.

- Bring together local stakeholders to design and develop a collaborative model that is most workable for the local community.

- Encourage the implementation of model programs by: (1) creating action steps to build in additional "buy-in" and collaboration between agencies involved; (2) seeking additional funding and/or reorganizing agencies to allow for tailored funding for the mentally ill offender; and (3) holding frequent team meetings to discuss staffing, role definition of team members, etc.

- Monitor and evaluate programs at the individual and systems levels.

TOWARD A NATIONAL PLAN FOR ACTION

The entire group came together at the end of the National Work Session to hear the reports and recommendations of the smaller work groups. From the individual work groups and the larger group discussions came specific suggestions and recommendations to the National Coalition for the Mentally Ill in the Criminal Justice System.

A Mission Statement

The need to develop a mission statement to guide the Coalition's advocacy work in prison mental health was considered essential. During the large group discussion key elements of a mission statement were proposed and agreed to by a majority of participants. In the weeks that followed, a mission statement was developed that reflected these key elements and the set a context for the National Work Group's recommendations for action.

> Mission statement. The Coalition affirms every prisoner's constitutional right to treatment for severe mental illness and mental health crises by working to:
>
> 1. Provide clinically adequate and humane mental health services to prisoners with serious mental illness and to prisoners in mental health crisis;
>
> 2. Reduce human suffering and enhance severely mentally disordered offenders' ability to function in prison and in the community by ensuring universal access to treatment, including: screening and assessment, treatment planning, clinically appropriate levels of care in cost effective settings, exploration of appropriate alternatives, and discharge planning; and
>
> 3. Ensure that the policies and practices which govern prisons, including those relating to classification, discipline and segregation are clinically sensitive, informed by, and responsive to the current functional capabilities of the mentally disordered offender.

Recommendations for Action

The group as a whole and several of the small work groups helped to identify the initial steps that should be taken as part of an overall action plan for the National Coalition for the Mentally Ill in the Criminal Justice System to improve the care of persons with severe mental illnesses in U.S. prisons. These steps include lobbying, developing new or promoting existing standards for care, disseminating information on effective programs and approaches, and promoting culturally and community competent programs and staff in prisons. Specifically, the Coalition should:

Foster new partnerships and interagency teams and agreements

- Reach out to culturally and gender diverse organizations.
- Promote the participation of mentally ill offenders in setting the agenda for mental health care in prisons.

- Encourage the development of partnerships between local mental health authorities and state prisons in order to obtain mental health services in prisons and to facilitate their reintegration in communities upon release fostering interagency response.

- Support comprehensive mental health benefits for mentally ill offenders as part of a national system of health care reform.

Develop new and promote existing standards

- Work to assure that existing professional standards for the treatment and care of mentally ill offenders are widely known and that they are met in all states and localities, and encourage the revision of existing standards to incorporate goals that facilities can strive to attain and against which their performance can be measured.

- Convene those involved in setting professional standards with the goal of coming to mutual consensus around direction for action.

- Conduct a national audit of state policies, legislation, and regulations with regard to persons with severe mental illness in prisons.

Train staff

- Support the development and wide dissemination of training curriculum on screening and assessment, individualized treatment planning, conflict resolution, and discharge planning.

- Encourage cross-training of criminal justice and mental health staff in prisons, and mental health and substance abuse treatment staff.

Disseminate information

- Educate mental health professionals, families and consumers about the legal process; and criminal justice professionals about mental health.

- Advocate for the federal government to take a leadership role in providing a focus on issues of persons with severe mental illness in prisons, including the establishment of a national resource center for information collection and dissemination.

- Advocate with agencies such as the Center for Mental Health Services, the National Institute of Justice and the National Institute of Corrections to fund the creation and promulgation of tools necessary to create the individual assessment and treatment programs outlined above.

- Reduce stigma by disseminating information on programs for mentally ill offenders at conferences, developing public service announcements featuring public officials, and supporting the establishment of state-level mental health consumer affairs offices.

- Develop specific proposals for technical assistance needed within the mental health and criminal justice systems.

- Make technical assistance on developing information systems and on mechanisms for exchanging information among agencies widely available.

Facilitate cultural and community competency

- Increase training and education in cultural and community competency.

- Identify models for culturally and community competent treatment programs.

- Advocate for a national resource center on cultural competency to disseminate existing information, generate new knowledge, and provide technical assistance in this area.

Encourage research

- Expand program evaluation to assess program implementation and client outcomes.

- Review existing research and conduct new demonstration research on the most promising approaches to providing mental health treatment and rehabilitation in prison and to providing continuity of care for offenders with severe mental illness who are being discharged from prison.

- Track the impact of treatment within the prison (e.g., transfer from mental health unit back to general prison population) and through community release and integration (e.g., linkage to community-based care).

- Encourage joint planning and funding of research by corrections, mental health, and alcohol and drug agencies with a focus on identifying effective approaches to treating co-occurring mental and substance use disorders.

CONCLUSION

The National Coalition for the Mentally Ill in the Criminal Justice System has taken an important first step on the way to improving the care of persons with severe mental illnesses in prison. Bringing together a broad spectrum of mental health and criminal justice professionals,

representatives of national organizations, and advocates, the Coalition has focused a wealth of national expertise on an issue that has been too long ignored and about which there was no consensus.

By creating the opportunity to build consensus and to make recommendations that cut across disciplines and interest groups, the Coalition has broke new ground and increased the potential for change. Future efforts in prison mental health will be measured against the standard set by the Coalition in this monograph. However, there is much that remains to be done and the recommendations for action contained in this chapter will require the collective efforts of all who are concerned about these issues.

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