Offender Needs and Assessment: Models and Approaches

National Institute of Corrections
Grant #EQ-8

Project Director

Carl B. Clements, Ph.D.
Department of Psychology
The University of Alabama

Project Associate

John M. McKee, Ph.D.
Rehabilitation Research Foundation

Research Assistant

Susan E. Jones, B.S.
Department of Psychology
The University of Alabama

TABLE OF CONTENTS

LIST OF ILLUSTRATIONS

Figures — Page

Exhibits

Tables

ACKNOWLEDGEMENTS

This project grew out of the National Institute of Corrections' technical assistance mandate and in response to the growing recognition of the importance of offender classification to humane and effective correctional management.

Conversations with NIC staff and several corrections administrators around the country stimulated many ideas developed in this volume. NIC also provided encouragement and the opportunity to interact with thoughtful professionals in the field through National Corrections Academy Training workshops. We are particularly grateful for this support.

We are especially indebted to Judith Friedman, the original project monitor, for helping to shape the scope of the work and for recognizing the existing void in classification. The contributions of NIC's Larry Solomon, who shares many of our beliefs regarding the impact of classification practices, and Aaron Brown, who facilitated the later stages of the project, are gratefully acknowledged.

Too numerous to thank individually are the many professionals in some 40 states who took the time to complete a cumbersome questionnaire. These contact persons are noted in an appendix. Several people did add an extra something to our work, either through supplying additional materials, discussing ideas, or making suggestions. These include:

Jack Alexander (New York)
Steve Berry (Kentucky)
Bob Buchanan (Correctional Services Group, Missouri)
Lou Cei (Virginia)
Cathey Farrey (Wisconsin)
Lonnie Fouty (Florida)
John Irion (Georgia)
Steve Kaiser (Oklahoma)
William Kime (Michigan)
Jim Patrick (Washington)
John Prelsnik (Michigan)
Chase Rive1 and (Co1orado)
Jim Thatcher (Washington)

Colleagues with unique expertise in the area of prisons and offenders also provided valuable consultation: psychologist Stanley L. Brodsky and attorney Ralph I. Knowles. Their review of early drafts of the material presented here provoked us to clarify and to deal with tough issues. We also wish to acknowledge the contributions of those involved in producing the document: Mary Colwick, Judy Giles, and our technical editor, Linda Dover, Ph.D.

This project was supported by a grant from the National Institute of Corrections, U.S. Department of Justice to the Rehabilitation Research Foundation, P.0. Box BV, University, Alabama, 35486.

FOREWORD

This volume seeks to accomplish eight objectives:

* define offender needs (or program) assessment in the context of prison classification.

* describe basic criteria or principles for providing a minimally effective needs assessment system.

* report the results of a national survey and describe the approaches and practices currently being used or developed in prison systems.

* review selected innovative approaches in use or under development.

* define and describe 10 needs-dimensions currently receiving attention and provide recommendations for assessment in each area.

* review special problems and issues associated with offender needs assessment.

* list published assessment instruments, tests, and related techniques applicable to offender needs assessment.

* provide references and resources easily accessible to correctional classification professionals.

By contrast, this report will <u>not</u>:

* review the history of offender classification and needs assessment.

* nor present lengthy legal or other mandates for needs assessment.

* nor review the problems of prison overcrowding and the often debilitating effects of prison environments.

* nor critically evaluate existing approaches to offender treatment or management.

Rather, we assume that the correctional professional will benefit most directly from a narrower conceptual focus and more specific technical information.

If readers are looking for an offender needs assessment package that can be transported intact, they may be disappointed. While the models and techniques used by several juris-

dictions are described in detail and favorably reviewed, no system yet deserves wholesale adoption. Many recent developments look promising, and systems which have given little systematic effort to offender classification may find much of interest in the work of others. However, innovators and users alike must judge for themselves the value of needs assessment systems on the basis of outcome evaluations. This critical step is too Often ignored.

If we don't fully endorse very narrow, specific techniques or instruments, we do endorse specific principles. Clearly, a number of routes can lead to the fulfillment of the needs assessment objective. We also believe that correctional professionals cherish their freedom to develop individualized approaches. While such differences may reflect the unique priorities or dilemmas of a given prison system, guiding elements raise the potential quality of any system of needs assessment. Moreover, many of these principles provide the basis for the eventual, necessary evaluation cited earlier. Thus, both short- and long-term purposes may be Served through adherence to basic principles.

1. INTRODUCTION

> We have to do too much for too many with too little and too few.
>
> A state prison classification coordinator, 1983

The steady press of new arrivals often forces prison personnel to receive and process offenders hastily. The acknowledged constraints of space and program availability, influence classification decisions related to both "risks" and "needs," as staffing and physical limitations routinely influence management and supervision practices. With few exceptions, officials systematically identify and meet only the most acute offender needs.

However, out of these conditions, efforts have recently been made to improve systems of resource allocation. The focus of these efforts has been the process of offender classification. If existing resources are to be appropriately matched to offenders, and if future resources are to be intelligently planned (i.e., based on system-wide profiles and projections), then classification data gathering, recording, and initial decision-making become critical. Existing technology and accumulated professional experience can make classification an effective tool of correctional management.

The failure to provide a reasonable level of "matching" of needs and programs has come under scrutiny both in prison conditions suits and in professional corrections. Court findings have addressed the harm that often results when offenders are indiscriminately housed in overly restrictive facilities and when needed services or special management are not provided. Correctional officials are also recognizing the financial and internal management implications of failing to assess realistically offender risk and special needs. For example, maximum security space, disproportionately costly, warrants very judicious use. The early identification of needs often can prevent deterioration--physical, psychological, and social--that may occur if left unchecked. From a humane point of view, deterioration is always costly. From a management perspective, unmet needs have widespread and predictable side effects.

One development in this critical area of corrections has been the model systems approach from which more objective and consistent decisions about offender placements and assignments can be made (Austin, 1983: Clements, 1984). The National Institute of Corrections (NIC), a principal catalyst in these developments, has provided technical assistance directly to states whose classification systems need improvement. In addition, NIC has sponsored the development of a classification approach currently being implemented on a trial basis in several states (see Prison Classification: A Model Systems Approach, NIC, 1982).

The NIC model is heavily weighted toward the area of risk (security/custody) assessment. This orientation reflects an overriding need to promote a rational allocation of housing, supervision and custody, and special management resources. The NIC approach, as well as recent independent efforts by several states and the Federal Prison System, provides both evidence of and a stimulus for increasingly well-defined, logical, and practical approaches to risk classification.

Parallel challenges exist in the areas of offender needs, management practices, and service provision not specifically related to custody and security. This relative inattention has been acknowledged in an introductory way in the current NIC model. However, neither the conceptual dialogue about the goals of offender "needs assessment" (sometimes called "program assessment") nor the development of a set of minimally adequate procedures and techniques exists. The purpose of this manual is to bring needs assessment concepts, models, and methods to professional attention and to promote recognition of guiding principles upon which needs assessment systems can be built.

The rationale for the program needs area has been particularly well expressed in the recent manual produced by the Washington Department of Corrections:

> Program Needs. It is recognized that one of the most important administrative problems to overcome in establishing a well-organized program delivery system is the development of objective screening instruments.
>
> With such instruments, institutional staff may periodically apply standardized criteria, uniformly weiqhted, to each inmate and identify the relative demands for services. Without this level of objectivity, it is less likely that all inmates who exhibit symptoms of need or deficiency would be uniformly recommended for program participation across the entire correctional system. Objective criteria are also necessary for development of relative scales of severity of need to be used systemwide in the effort to ensure the most efficient allocation of scarce resources to those inmates exhibitinq the greatest need.
>
> It should be noted that implementation of standard screening techniques is intended to ensure that the Department of Corrections is meeting its proper responsibility to provide each inmate with the opportunity for self-help in correcting identified deficiencies. The use of the Department's system of program screening is intended to improve the efficient delivery of services with the hope of intervening in a meaningful way to break the pattern of criminal behavior. At the least, improved delivery of correctional programs may offer the inmate an opportunity to address noted problems that are likely to make lawful adjustment upon release to a free society more difficult. (1984, p. vi)

II. NEEDS ASSESSMENT

A Basic Definition

Popularized terms often take on varied meanings. For purposes of clarity, a specific working definition of needs assessment is developed below.

Need is generally defined as follows:
- --a lack of something requisite, desirable, or useful.
- --a condition requiring relief.
- --a pressing lack of something essential.

Clearly, the definition of "need" is highly dependent on a criterion; that is, one has to decide ahead of time on the conditions, states or behaviors that are "requisite, desirable, useful, or essential" or that require "relief." In this context, "need" implies deficit. Such deficits may characterize an individual across a variety of settings or be problematic (or even recognizable) only in a highly particular situation.

Those identifying a need carry some obligation to respond to it--practically, socially, legally, or ethically. This sense of responsibility, and the sometimes elaborate structures that go with it (e.g., guidelines for hospital care), varies widely and reflects the degree of importance given to a particular need or set of needs.

Moreover, needs exist in degrees along a continuum from the barely perceptible to the glaringly obvious. One can have minor or monumental needs or deficits. The determination of the nature and degree of need arises from some type of assessment.

The term assessment is defined as:
- --appraisal; estimation.
- --a determination of importance, size or value.

Given these basic definitions, we can easily see how the term "needs assessment" has become so widely used. Without assessment, the concept of need remains highly abstract or becomes limited to only the most obvious, critical, and popular areas. We do not suggest that the idea of need should extend into every trivial dimension of human concern. Rather, the process of needs assessment must provide both the tools to determine a given need and a context in which to judge its importance.

Offender needs assessment, then, will be defined as those aspects of offender classification that seek to identify or determine the condition or state of individuals relative to some pre-established functional criteria. Those criteria may relate to more concrete attributes of adjustment (e.g., physical health), to behavioral skills that involve practical functioning (e.g., academic and vocational competence), or to even more

complex social situations in which deficits are measured relative to particular environments, conditions, or demands (e.g., vulnerability, personal-social skills).

As will be seen in subsequent chapters, needs assessment is a concept extending well beyond one-line summaries. Nevertheless, the basic working definition provides the starting point for the development of principles designed to improve the quality of offender needs assessment.

A Conceptual Overview

The levels of assessment. In considering needs appraisal, we distinguish among successively refined levels of assessment. Each assessment level involves a more specific focus and--presumably--a more highly individualized and detailed evaluation of the offender (see Table 1).

Table 1. Three Levels of Assessment

Level or Type	Scope	Decision Function
Intake screening	Basic needs	Initial assignment, management, and referral decisions
Dispositional assessment	Specific program areas	Group assignments, program decisions within a given intervention area
Intensive assessment	Identified priority areas	Individualized treatment plans

The refinement of the classification process correlates with the level of assessment. At a primary level, intake screening should result in a series of judgments sub-dividing offenders into broad categories of basic needs/deficits and potential intervention. Extending this first level of analysis, dispositional assessment provides additional information within one or more given need-dimensions regarding the specific program or treatment which would benefit the offender. Finally, more intensive assessment should result in highly detailed intervention plans within a priority need area. Each level of assessment may require, in turn, increased involvement of staff who are actually responsible for management, programs, or treatment delivery.

Another view of assessment levels sees the process as a "funnel" (Hawkins, 1979). Different techniques are required, depending on the stage of assessment.

> At a wide mouth of the funnel, screening procedures may be employed to determine which persons would profit from treatment. Since a large number of people usually undergo screening, these procedures should be relatively inexpensive in terms of both cost and time.... Once the client has been selected, a broad range of information should be gathered.. . . Interviewing, self-report questionnaires, ratings by others, and self-monitoring may be techniques particularly appropriate for this broad assessment. Eventually, the assessment funnel narrows and more specific information is sought... [through] techniques [which] may include observations in naturalistic situations, self-report questionnaires, self-monitoring, physiological measurement, intelligence or achievement testing, or behavioral by-products.
>
> (Nelson & Hayes, 1981, p. 20)

Obviously, needs assessment is not limited to any one time, place, or stage in an offender's passage through the corrections system. Although this report focuses on basic screening for incarcerated offenders, the principles of good assessment hold throughout.

The focus of assessment. Apparently, we assess offender needs for a variety of purposes:

* To detect critical needs that would be problematic in any setting, e.g., acute illness.
* To identify deficits or needs that may have influenced or been part of a pattern of law violation (criminality) or which may interfere with successful post-release adjustment (reintegration), e.g., drug abuse, impulse control, vocational deficits.
* To determine offenders' deficits, needs, traits, or behaviors which influence their adjustment or management while in prison, e.g., vulnerability, personal-social skills.
* To serve broader human needs, e.g., for structure, activity, support, privacy, etc., which have continuing implications for the operation of healthy correctional settings.

Each purpose is usually associated with a different approach to assessment and intervention. Typically, these diverse needs are addressed by different staff. Table 2 summarizes these differences. It would appear that most program needs that one could contemplate are subsumed in this model.

Table 2. A Functional Model of Needs Assessment and Intervention

	Focus of Assessment and Intervention		
	I. Critical Individual Needs	II. Barriers to Reintegration; Criminality	III. Institutional Adjustment
General Approach	Clinical/Diagnostic/ Treatment	Behavioral/Learning/ Programming	Community/Environmental/ Prevention
Assessment focus	Individualized needs	Sub-group deficits	Common, shared needs
Examples	Mental illness Retardation Acute medical Vulnerability	Drug/alcohol abuse Sexual adjustment Personal-social skills Academic/vocational Job Skills	Adaptability Coping Skills Behavioral traits 'Reactions to environment
Intervention focus	Specific, direct treatment	Multiple programs	Broad, indirect
Examples	Separation Specific handling Individual treatment plans	Skills training Targeted counseling Learning modules Time-limited groups	Unit management Stress reduction programs Differentiated units

Q-systems view. While the focus of needs assessment ordinarily is aimed at the individual offender's specific deficits and at potential remediation, a broader rationale also exists. Clearly the accumulation of prison-wide and system-wide information on offender needs is vital to the goal of orderly and timely assignments to programs and services. Resources may be shifted, strengthened, or developed in response to an overall analysis of offender characteristics and needs.

Decisions about resource allocation priorities relate primarily to judgments about the importance or value of the need area and to the assessed severity of a particular offender's need. For the individual, motivation, program availability, and time constraints also influence whether and how soon identified needs will be addressed. At the systems level, political and economic factors clearly influence the establishment of priorities--a fact that cannot be adequately addressed in this report, but which should be identified openly. The recognition of offender needs should not be distorted or minimized because of current system restraints (Clements, 1982).

Prevention versus treatment. Accumulating knowledge suggests strongly that stressful, unhealthy environments produce many of the casualties that later must be provided more expensive, individual care. Thus, the present needs assessment approach includes a prevention orientation in which shared human needs are met with activities, programs, or structure. Prison administrators readily agree, for example, that work programs and recreational activities meet some basic needs, and that without them, "adjustment" problems may rapidly increase.

We recognize also that many offenders have unique and critical problems calling for professional assessment and specific intervention. However, we point out that "normalization" is often a powerful treatment approach even, for example, for the offender diagnosed as mentally ill. More traditional activities, such as work and exercise, may be quite beneficial for these special groups.

Moreover, the model summarized in Table 2 is not meant to suggest that staff cannot or should not overlap in their responses. For example, physicians and other health providers, though spending time in supervising or providing direct treatment, can also contribute to health promotion, hygiene, and related prevention activities. Thus, in general, needs assessment and intervention need not be seen as a highly compartmentalized undertakings.

The range of needs assessment. How many offenders will be identified as having "needs"? Obviously, the proportions included depend greatly on definition. In most settings, serious, critical problems calling for immediate attention account for a small proportion of offenders. However, progressively greater numbers of offenders are encompassed under a broadening definition of needs.

As suggested by Figure 1, these target groups include:

* individual_acute_cases--for whom specific treatment and management is required to ameliorate immediate and serious problems, e.g., acute medical or mental illness.

* clinical_sub-groups--in which shared deficits or needs can be responded to with management, treatment, or maintenance programs, e.g., intermediate care units for aged and infirm, chronically vulnerable, retarded, or borderline adjusted.

* problem-oriented_sub-groups--in which common problems related to adjustment, criminality, or community reintegration can be addressed through training, psychological treatment programs, and skills development, e.g., job-skills, alcohol treatment, basic education, sexual adjustment.

* management_sub-groups--in which differential internal management approaches maybe directed at those who share similar characteristics and needs for structure, control, support, and confrontation, e.g., manipulators, passive-dependent, and non-career offenders.

* all_offenders--for whom basic shared needs require routine and yet flexible responses, e.g., housing, safety, physical and mental activity, social interaction, privacy, and involvement.

This graphic model also reemphasizes the premise that multiple levels of intervention are applicable to offender needs. The more pronounced and pervasive the need(s), the more important it is to harness all available resources.

Establishing_priorities. Needs areas (dimensions) accorded the highest value or priority should be accompanied by mandated services and programs. Second-level (but still important) needs areas also should be matched to required services, at least for those exhibiting the most severe deficits. Table 3 presents a possible framework for decision-making as jointly influenced by importance and level of need. (This model could just as easily have more than three "levels" of need, degrees of importance, or assignment code options.)

Almost by definition, those of fenders who have the most severe needs or deficits in the needs areas deemed most critical will require immediate attention. There can be no postponement or delay in providing the necessary treatment, programs, or services. By contrast, of fender needs assessed as low in those areas rated as only moderately important would be assigned to services only on a self-referred, space-available basis.

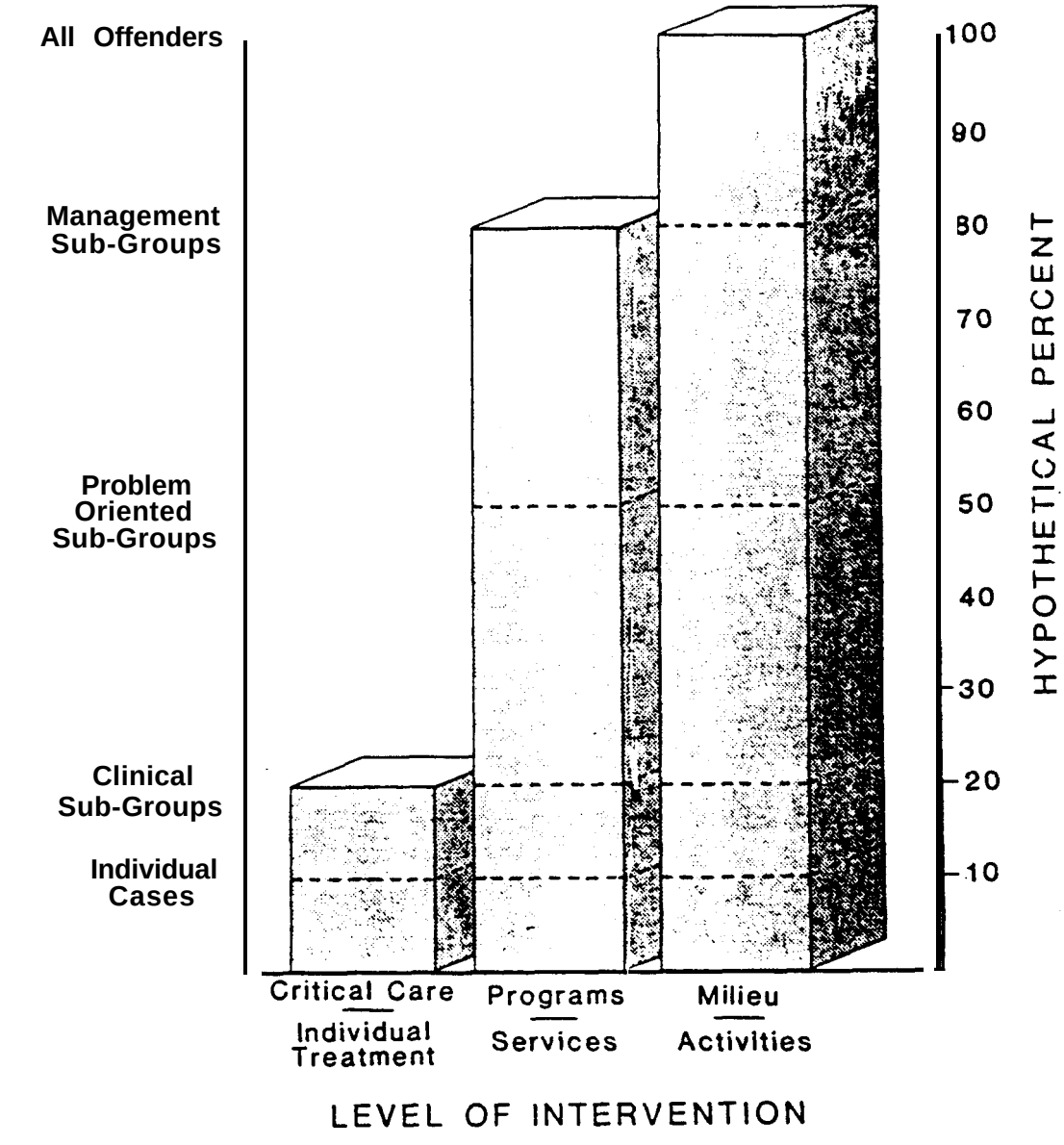


Fig. 1 A hypothetical model of intervention levels and target groups.

Note: Each level of intervention (left-to-right) is directed at successively increasing proportions of offender populations.

Between those two endpoints lies a range of options. While each correctional system should have the flexibility to construct its own model, it is important to present explicitly a basic decision-making framework of the kind suggested in Table 3.

Table 3

A Possible Model of Offender Assignments Eased on Importance and Level of Need

Level of Offender Need	Importance of Given Need-Dimension[a]		
	High (A)	Moderately High(B)	Moderate (C)
	[b]		
Severe	1	1	2
Moderate	1	2	2
Low or none		3	3

[a] Examples of Importance Rankings

(A) High medical: mental health; intellectual/adaptive

(B) Moderately High: drug/alcohol; vocational; educational; jobs skills; sexual adjustment

(C) Moderate: Family; economic; se1f-management

[b] Offender Assignments/Action Code

1 = required participation; immediate access to services and programs

2 = encouraged participation; priority access

3 = self-selected participation; space available

III. ESSENTIAL CRITERIA FOR AN EFFECTIVE NEEDS ASSESSMENT SYSTEM

While the general objectives of needs assessment may be met in a variety of ways, certain principles are desirable--perhaps essential--for the development and operation of an effective system. These principles include:

* those relating to the overall design or framework of the needs assessment system;

* those relating specifically to the techniques and quality of needs identification.

The principles presented below move from the general to the more specific and complement previously described principles of classification (NIC, 1982).

A. Principles Relating to the Overall Design of a Needs Assessment System.

A1. THE RATIONALE AND PURPOSES OF THE NEEDS ASSESSMENT SYSTEM SHOULD BE EXPLICITLY STATED IN WRITING.

This essential component has strong precedent in ACA and NIC classification standards and principles. The process of developing a written statement of purpose clarifies the agency's commitments and objectives. The general purpose statement can serve both as an action guide and as an evaluation benchmark. Multiple purposes may be envisioned; consensus and uniformity need not be achieved. Previous experience indicates, however, that inconsistent and poorly developed needs assessment systems are symptomatic of the failure to describe the overall purposes of needs assessment.

A2. EACH DIMENSION OR NEEDS AREA REQUIRING ASSESSMENT SHOULD BE SPECIFIED AND DEFINED IN WRITING.

Haphazard assessment practices grow in part from a failure to identify specific needs. Often, offender information is gathered without a clear regard for its potential use. By defining each needs dimension, agencies can select more efficient, relevant, and focused assessment practices. Definitions also help clarify whether a given needs dimension involves mainly a person-centered condition (e.g, medical), behavioral skills, or environmental interactions. The clearer the assessment target, the more valid the assessment is likely to be.

A3. PRIORITY OR IMPORTANCE RATINGS WITHIN THE NEEDS ASSESSMENT DIMENSIONS SHOULD BE DESIGNATED

Realistically, all offender needs are not equally important nor do they equally affect program decisions. Judgments of importance relate to many factors, some of them highly subjective. However, what now happens in practice is often an implicit ordering of priorities. A more explicit rating system has direct implications for meeting needs and deficits. A written statement of priorities can serve as a beginning point for planning and resource allocation decisions. Rankings of importance, however, should not influence the quality of the assessment.

A4. WITHIN EACH NEED DIMENSION, CRITERIA SHOULD DESIGNATE THE DEGREE OF NEED.

The specific components or particulars of an offender's needs in a given area (e.g., health) may not be easily summarized into convenient labels or categories. However, for management, planning, and resource allocation purposes, at any time officials should know which needs are most prominent for a given offender and how needs and deficits are distributed system-wide. In order to produce this information in an objective, reliable, and accurate way, they must develop and use well-standardized definitions and criteria.

A5. WHEN POSSIBLE OFFENDER ASSESSMENT SYSTEMS SHOULD ENCOMPASS DEFICITS AND PROGRAM NEEDS THAT SPAN BOTH THE INSTITUTIONAL AND COMMUNITY ENVIRONMENTS.

Although the institution is frequently the focus and the site of offender assessment, it need not be. As we will note in Principle B3, community-based sources may potentially provide the most accurate and valid information available. Furthermore, many offender needs may be equally disabling in both settings. Cooperative efforts in the gathering as well as in the sharing of important information by institutional and field staff may improve the quality, the efficiency, and the impact of offender assessment.

A6. A SYSTEM OF REFERRAL WHICH PROVIDES FOR MORE DETAILED ASSESSMENT, WHERE WARRANTED, SHOULD BE ESTABLISHED.

Initial assessment is designed to provide useful but not necessarily exhaustive information. However, routine assessment falls short in at least two situations. Principally, when screening information is equivocal, follow-up is required in order to clarify the existence or degree of need. Second, if a particular intervention is recommended, the screening assessment sometimes proves too crude for treatment planning purposes. Thus,

as part of intervention planning, additional detailed assessment might be required. In these instances, officials should decide ahead of time what the referral procedures are and under which circumstances additional assessment will be required.

A7. THE PERSON(S) OR SPECIFIC UNIT RESPONSIBLE FOR PERFORMING ASSESSMENTS ON EACH NEED DIMENSION SHOULD BE SPECIFIED.

The needs assessment manual should contain--in narrative form or by way of charts and tables--an assignment of responsibilities for each needs area. Multiple input may be desirable, but each contributing unit or person should be designated. This policy is designed to clarify roles and expectations.

A8. BROAD CATEGORIES OF INTERVENTION SHOULD BE SPECIFIED FOR EACH NEEDS AREA. INTERVENTION CATEGORIES SHOULD BE DEVELOPED IN CONCERT WITH SERVICE PROVIDERS AND LINE STAFF.

Within each needs area, several levels or types of intervention should be contemplated. An appropriate range of options must be available to match identified needs. Failure to translate needs assessment into recommendations and subsequently into action plans is a major deficiency, especially in critically overcrowded systems, where recommendations are vague, and when geographic, organizational, and--perhaps--philosophical distance exists between those who assess and those who provide potential services.

A9. EACH INSTITUTION OR CORRECTIONAL UNIT SHOULD BE IDENTIFIED AS TO ITS ABILITY TO PROVIDE PROGRAMS AND SERVICES FOR VARIOUS TYPES AND LEVELS OF ASSESSED NEEDS.

System-wide, the capability of each unit to deliver or provide for each need level should be charted. All units need not provide programs or services for all offender needs. Especially expensive services (such as acute medical care) could be concentrated in one location. Services can be distributed across a state system in a number of satisfactory ways.

A10. A SYSTEM OF ASSIGNMENT OR REFERRAL OF OFFENDERS TO PROGRAMS AND SERVICES SHOULD BE ADDRESSED IN WRITING AND DISCUSSED WITH INDIVIDUAL OFFENDERS AT INITIAL CLASSIFICATION.

The agency (or official) should specify the referral process, program options, waiting list procedures, etc., so that staff may carry out programs with some consistency and so that

offenders may be well-informed about decision processes. Vagueness in recommendations or assignments contributes greatly to inefficiency and to perceptions of insensitivity or arbitrariness. The use of forms and step-wise procedures will help standardize this important link in the needs assessment-intervention chain.

All. THE SYSTEM OF RECORDING NEEDS, LEVEL OF NEED, PROGRAM ASSIGNMENT, AND RELATED OFFENDER INFORMATION SHOULD BE DESIGNED TO FACILITATE QUICK RETRIEVAL AND EFFECTIVE MANAGEMENT USAGE.

A system of categories, codes, and the like should be developed so that aggregate information may be conveniently stored and retrieved. The information system should contain data useful both for individual offender planning (e.g., updated needs or enrollments) and for system-wide use (e.g., statistical information on needs, assignments, program completion). The increased access to computers appears to hold great promise for improving management information systems.

Al2. WRITTEN POLICY SHOULD PROVIDE FOR THE PERIODIC EVALUATION OF THE NEEDS ASSESSMENT

Based on the identified goals and objectives (Principle Al, evaluation of the current usefulness of the needs assessment system should be possible. Such factors as consistency, correspondence between needs and resource allocation, and the quality of assessment information are examples of needed feedback.

B. Principles Relating to the Quality of Needs Assessment Methods

These principles apply to assessment methods for each specified need area (see Chapter VI).

Bl. THE METHODS AND TECHNIQUES OF ASSESSMENT SHOULD BE SPECIFIED.

This principle does not mean to imply that every technique should be understandable by any interested party. Within a given need-area, some assessments may be sufficiently complex as to require specialized and/or professional training.. However, even within such areas the methods should be specified. Only through detailing of procedures can consistency and feedback be obtained.

B2. THE HIGHEST QUALITY ASSESSMENT TOOLS AND INFORMATION SOURCES AVAILABLE SHOULD BE USED INCLUDING, WHEN POSSIBLE, PRE-SENTENCE OR OTHER COMMUNITY-BASED INVESTIGATIONS.

The accuracy and usefulness of the appraisal of offender deficits depends greatly on the quality

of information obtained. No one assessment yields "true" information; different assessment approaches, e.g., tests, interviews, questionnaires, observations, yield different information for different purposes. Thus, multiple sources of information are often desirable. However, the assessment goal is to achieve valid data; sometimes, "more" is not "better." Particularly, the ability of paper-and-pencil (e.g., psychological) tests or informal, unstructured interviews to accurately reflect needs or deficits that are highly behavioral, skills-based, or situationally-dependent should not be overestimated. (See related principles, B4, B5, and B6.).

B3. ASSESSMENT APPROACHES SHOULD CONSIDER OFFENDER BEHAVIOR IN CONTEXT AND SHOULD RESULT IN DESCRIPTIONS THAT RELATE BEHAVIOR TO SITUATIONS.

Officials should avoid a narrow, exclusively person-centered approach to needs assessment. The concept of "need" is tied historically to the area of trait psychology and thereby shares some of its problems, e.g., that an individual's behavior is a permanent or static, determined principally by his "character." Such a view may be simply inaccurate--an offender 's current responses may be controlled more by specific environmental factors, e.g., overcrowding, provocation, reinforcement, than by any enduring trait or deficit (Clements, 1979; 1980). Likewise, needs can fluctuate as a function of the individual's socio-physical environment. Thus, some of our assessment approaches will be of limited value if they fail to examine this person-by-situation framework. A great deal of progress has been made recently in the techniques of behavioral assessment (Hersen & Bellack, 1981) --techniques that emphasize what the person does rather than what the person has or is. Behavioral assessment not only identifies problematic responses but also the situations in which the responses are most likely to occur.

B4. THE ASSESSMENT SYSTEM SHOULD USE HIGHLY RELIABLE INFORMATION, INSTRUMENTS, AND TECHNIQUES.

Any substantial investment of time and resources is best served by using only those techniques or instruments that can be consistently administered. The goal is to achieve a degree of uniformity that tends to yield comparable information from case to case. Moreover, officials, when relying on particular instruments or tests, must consider their inherent reliability characteristics. Finally, assessments should be conducted in settings and under conditions which are most conducive to obtaining full and accurate information.

B5. METHODS USED WHICH ARE SPECIFICALLY VALID FOR AND RELEVANT TO THE ASSESSMENTS AND DECISIONS BEING MADE SHOULD BE USED

A given instrument or method is not inherently valid. Its relevance must be established for each specific purpose for which it is to be used. Needs assessment must move away from "shotgun" approaches in which information of widely varying reliability and validity is all fed into the "black-box" of classification. In most instances, we need to limit sharply the generalization of information (or predictions) to those individual behaviors or conditions that have some known relationship to the assessment instrument or method.

B6. THE ESSENTIAL RESULTS OF A NEEDS EVALUATION SHOULD BE CLEARLY COMMUNICATED THROUGH AN "OUTPUT" FORMAT WHICH PROVIDES DIRECT IMPLICATIONS FOR MANAGEMENT OR TREATMENT.

The needs assessment process should result in readily understood conclusions and recommendations. This practice should allow for meaningful distinctions among sub-groups, increase the likelihood of specific actions for the individual offender, and improve the necessary accumulation of prison-wide and system-wide information. As more highly refined assessments are conducted, it becomes increasingly incumbent on evaluators to provide direct, useful statements on individualized needs and intervention plans. Such conclusions and recommendations should not be buried in long narratives or "clinical" reports, especially if results are being transmitted to line staff with dissimilar academic or professional backgrounds. (See related Principle A8.)

B7. ASSESSMENT APPROACHES MUST PROVIDE FOR THE POTENTIAL FOR CHANGE ACROSS TIME AND SETTINGS.

Some individual needs may be relatively static (e.g., physical disability) and may require a fairly constant response or management or environment. Still other needs can be seen as recurring (e.g., exercise), thus requiring a continuing leve1 of programming. Of more concern here, however, are those needs responsive to some degree of remediation or change. Since such changes should be measurable, follow-up assessments should be planned. Too, we must recognize that an individual's needs (especially in the interpersonal areas) may vary across settings. Clearly, then, descriptive labels should rarely be assigned to offenders on a permanent basis.

B8. THE COST OF THE NEEDS ASSESSMENT METHODS MUST BE REASONABLY BALANCED AGAINST THEIR PURPOSE AND VALUE.

Cost-effectiveness is a common-sense concern. A very expensive system or an approach yielding little useful information is an obvious, and thankfully rare, waste of resources. A reduction in costs can be accomplished, for example, by developing a referral system in which only selected offenders are given higher-level diagnostic assessments, e.g., for specific educational prescriptions. Effectiveness--often the forgotten side of the formula--can be enhanced through some of the principles cited above, for example, by selecting only reliable and valid assessment instruments. Moreover, the effectiveness of needs assessment becomes moot if inadequate and insufficient management and treatment options exist.

Summary of Principles

A. Design or Framework

- A1. Rationale and purpose stated in writing
- A2. Each need area defined
- A3. Priority of need areas established
- A4. Criteria for need severity specified
- A5. Institutional and community-based needs encompassed
- A6. System of referral for additional assessment established
- A7. Staff responsibilities specified
- A8. Intervention categories per need area designated
- A9. Institutional or unit capabilities identified
- A10. Referral system for intervention specified
- A11. Management information system designed
- A12. Periodic system evaluation required

B. Quality of Assessment

- B1. Methods and techniques specified
- B2. High quality information sources selected
- B3. Behavior considered in situational context
- B4. High reliability of instruments and techniques required
- B5. Validity of methods to specific decisions required
- B6. Implications for management and treatment communicated
- B7. Potential for change contemplated
- B8. Cost effectiveness assessed

IV. AN OVERVIEW OF CURRENT NATIONAL PRACTICES

Introduction

To increase the information base from which models and recommendations could be developed, we mailed a detailed six-page questionnaire to 52 directors of classification (or their nearest equivalent). The survey included the District of Columbia and the Federal Prison System. Thirty-eight surveys were returned, a return rate of 73%. Seven questionnaires were incomplete or otherwise considered unusable. Appendix E lists those states which replied, the reported size of their mid-1983 inmate populations, and the number of new inmates received in the previous 12 months.

Scope of Survey

The survey posed questions in three broad categories relating to assessment practices in ten identified needs areas:

1. **HEALTH:** Physical health, dental health, handicapping conditions, medical needs, fitness, and related health concerns.
2. **PSYCHOLOGICAL/MENTAL HEALTH:** Behavioral, cognitive, emotional, and/or interpersonal characteristics or patterns that influence adjustment and psychological well-being in either institutional or community settings.
3. **ALCOHOL/DRUG ABUSE:** The extent, nature, and patterns of alcohol consumption or drug use related to general functioning and crime pattern.
4. **INTELLECTUAL/ADAPTIVE:** On the basis of intellectual competencies, the ability to adapt to physical, educational, occupational, and social demands.
5. **ACADEMIC EDUCATION:** Academic competencies and achievement; grade-level functioning.
6. **VOCATIONAL APTITUDE AND INTERESTS:** The potential or demonstrated ability to perform successfully in one or more vocational areas (aptitude); the attraction to or preference for certain vocational or job areas (interests).
7. **JOB SKILLS:** The degree to which the individual possesses a marketable skill; his/her ability to obtain and hold a job.
8. **PERSONAL-SOCIAL SKILLS:** Interpersonal skills, self-management, money management, leisure time usage, personal hygiene and grooming.
9. **FAMILY AND FRIEND RELATIONSHIPS:** Interest and support of significant others, including parents, relatives, spouse, or peers.
10. **VICTIMIZATION POTENTIAL:** Factors related to the likelihood of being manipulated, taken advantage of, intimidated, or abused.

Each of the above listed areas of concern was subjectively rated by respondents as to:

* The importance of assessing each need-area
* The degree to which structured methods or procedures (e.g., tests, rating scales) are used in assessing a the need or deficit
* The scope (breadth and depth) of assessment during initial intake classification
* The quality of information resulting from the assessment
* The use of standard criteria (e.g., cut-off scores) for classifying or identifying presence/absence or degree of need

Within each need or deficit area, we asked respondents to specify how many levels of need were identified and by what descriptive names (e.g., “serious health deficit," “moderate health deficit,” "no health deficit"). Estimates of frequency of needs levels were also requested, as were the names and samples of instruments, forms, scales, and the like. Finally, we requested comments on issues such as offender amenability for programs and on the use of computers in program classification. The following section presents an overview of the survey results.

Results of Survey

Ratings. Each respondent provided subjective ratings of importance, structure, scope, quality, and standardization. Table 4 shows the mean ratings, on a five-point scale, that classification directors gave along each dimension. The following can be concluded from these ratings:

* Health and psychological needs assessment are the two top-ranking considerations across all descriptions. They are subject to the most structure in needs assessment and to the most specific standard decision criteria.
* Although victimization is ranked third in importance, it falls within the bottom third of the rankings on structured methods or standard criteria. Obviously, this factor is assessed somewhat subjectively.
* The second “cluster” of needs areas in terms of rank order of importance are: academic, intellectual/ adaptive, alcohol and drug use, and job skills. They received relatively consistent rankings across all five classification descriptors.
* At the bottom of the priority list are: vocational aptitude and interests, personal-social skills, and family and friend relationships. Assessment in these areas seems characterized by an absence of standard measures and decision criteria.

The relative importance of a need area appears to be strongly and positively correlated to the degree to which

Table 4

Average Rank and Ratings of Ten Needs-Dimensions Across Five Descriptors

Average Rank	Importance of Assessment	Use of Structured Methods	Scope of Assessment	Quality of Assessment	Use of Standard Criteria
1	Health (4.65)	Health (4.18)	Health (4.15)	Health (4.21)	Health (3.83)
2	Psychological (4.60)	Psychological (4.10)	Psychological (3.71)	Psychological (3.96)	Psychological (3.54)
3	Victimization (4.27)	Academic (4.07)	Academic (3.50)	Academic (3.56)	Academic (3.53)
4	Academic (3.70)	Intellectual (3.93)	Intellectual (3.42)	Intellectual (3.36)	Intellectual (3.54)
5	Intellectual (3.50)	Vocational (3.29)	Victimization (3.42)	Victimization (3.18)	Alcohol (2.81)
6	Alcohol (3.46)	Alcohol (3.0)	Alcohol (3.12)	Vocational (2.93)	Vocational (2.77)
7	Job Skills (3.35)	Job Skills (2.60)	Vocational (2.74)	Alcohol (2.85)	Job Skills (2.51)
8	Vocational (3.11)	Victimization (2.54)	Job Skills (2.68)	Job Skills (2.46)	Victimization (2.51)
9	Personal-Social (3.09)	Personal-Social (2.25)	Personal-Social (2.35)	Personal-Social (2.45)	Personal-Social (2.12)

standard criteria and formalized, structured assessment procedures are employed. While this relationship is understandable, the overall trend in assessing many deficits and needs remains fairly non-objective.

Implications. Need or deficit areas that reflect the immediate welfare of offenders rank predictably high in importance. Not surprisingly, these areas (health, mental health, protection) have been repeatedly identified by courts as requiring scrutiny. The second "cluster" is composed of areas traditionally related to deficits often associated with criminality and community survival. Finally, it appears that importance ratings bear some relationship to the potential for structured intervention. That is, even though a given need-dimension might be theoretically important (e.g., family relationship, personal-social skills), its low rating may reflect the absence of practical programs or models designed to deal with it.

The use of structured assessment methods varies along similar lines. More structure exists where professional subgroups are involved and where published and/or standardized assessment instruments or protocols have been developed (e.g., medical, psychological, academic). Clearly, however, some fairly subjective approaches are being misidentified as structured, e.g., clinical interviews, while other more reliable and consistent assessment instruments are frequently ignored (see Chapter VI, Assessment of Specific Needs: Current Practices and Resources).

The use of standard criteria for determining the level or severity of a given need is characteristically weak, although again following a similar pattern in terms of rankings. For some dimensions (e.g., health, academic, intellectual) thresholds or cut-off points are logically identifiable. Such thresholds are virtually non-existent in other areas, where subjective judgments appear to be the rule. However, a few states have developed specific guidelines for determining the existence and severity of need in each relevant area (see Chapter V, Review of Selected Models).

Levels of need. The second broad area of inquiry addressed the number of levels and the descriptions of the various levels for each need-dimension. This topic will be detailed in the review of current practice for each need-dimension (Chapter VI). However, it warrants a few general comments. First, clearly "leve1s," i.e., the degree or severity of deficits, is not currently a well-thought-out or widely-used concept in needs assessment. In some instances, a "yes-no" decision is made; the off ● rider has or hasn't a need. Correctional practice tells us that considerably more variability exists. It demands that different degrees and strengths of need be identified. Otherwise, we will regularly over- or under-shoot our management or treatment responses.

When they actually identify levels, states appear to use three or four categories to distinguish them. A practice gaining some currency is the use of general descriptors such as "severe," "moderate," "low," and "none" to describe deficits or needs. However, in many states criteria do not exist for consistently assigning such descriptors. Selected models that approach this important principle are reviewed in Chapter V.

Assessment instruments. Finally, classification directors were asked to report on instruments used to assess the various needs-dimensions. A description of the instruments and their frequency of use will be reported separately in the review of current practice (Chapter VI). Briefly, the pattern that emerges is one of standardized instruments used to assess the following areas: health; psychological; intellectual/adaptive; academic; education; and vocational aptitude and interests.

In other areas (e.g., alcohol/drug abuse, job skills, personal-social skills, family and friend relationships, and victimization), assessment is often left to "clinical interviews" which vary considerably in depth and in the degree to which-they are formally structured, thus raising questions about reliability. A few states use suitable instruments for assessing these dimensions.

The Four Clusters of State Systems

In terms of our ten identified needs or deficit areas and the criteria for an effective needs assessment system (Chapter III), the current practices in state assessment programs can be divided into four broad clusters, based on similarity in their assessment approaches. The first three clusters reflect increasing levels of the breadth of assessment (number of areas assessed) and a beginning trend toward using more objective assessment models and approaches. The fourth group of systems combines the best of several approaches--breadth, use of structured assessment methods, and a clear, specified framework for decision-making. A number of the programs in this latter cluster are reviewed and critiqued in Chapter V.

Cluster 1. In this grouping, representing approximately one-fourth of the responding states, assessment is undertaken in four principal areas: health; psychological/mental health; intellectual; and academic education. With the exception of those in health, which are based on fairly standardized and commonplace practices, most assessment procedures rely on unstructured interviews to assess each need-dimension. In addition, these states use a "need present/need absent," all-or-none classification system. Clearly, such an approach does not meet our criteria put forth earlier.

Cluster 2. States representing 30% of those responding assess the four basic areas reported in Cluster 1, but, in addition, generally assess one or two other areas, e.g., alcohol/drug abuse and vocational aptitude and interest. These states tend to

rely somewhat more on standardized instruments for assessment and typically have established more than just two levels (present/absent) in their classifications. 'Prescriptive decisions based on levels assignments are generally lacking. However, one or two states appear to be developing decision models for a single area, typically academic assessment, wherein the assessed severity of deficit has direct program implications.

Cluster 3. Within this group, a few states assess inmate needs across a wide range of areas. These states evaluate seven, eight, and occasionally, nine, need-dimensions at intake. They typically use well-known standardized instruments in some categories (e.g., the Minnesota Multiphasic Personality Inventory (MMPI) for psychological/mental health) but rely on interviews for areas such as job skills, personal-social skills, and family and friend relationships. A mixture of needs-level descriptions can also be found. Those dimensions measured with standardized instruments seem to allow for finer distinctions across a wider range of needs levels (as opposed to yes/no categories). In this cluster, specific program recommendations are outlined for a few of the needs-dimensions based on the assessed severity level.

Cluster 4. Within this cluster are those systems which most closely approximate the principles discussed earlier. These states have established an assessment rationale, use specific assessment approaches and priority ratings for each dimension, have designated degrees of need, and assess a broad range of needs-dimensions. For each need area, they structure a response based upon the judged importance of the dimension and the offender's assessed level of need.

Because these programs have implemented, to varying degrees, more systematic and objective needs assessment programs, they will be described in greater detail in the following chapter.

V. REVIEW OF SELECTED MODELS

Several correctional systems have invested considerable effort in the development of a systematic approach to needs assessment. In some instances the National Institute of Corrections has provided technical assistance and/or preliminary guidelines for this undertaking. For example, states participating in the NIC Model Classification project (NIC, 1982) were provided with, and have since improved upon, a basic framework that anticipated several of the concepts described in Chapter III. Still other states have developed somewhat unique, yet apparently practical, approaches worthy of consideration. Characteristics of the alternative systems will be described below. Finally, at least one system--the Federal Prison System--deemphasizes highly structured needs assessment approaches, especially at intake, and focuses instead on unit management and program availability. Such an approach appears consistent with a major objective of needs assessment, namely, to promote timely allocation of resources that match offender needs.

The current review may not be exhaustive of possible worthy models. Information was difficult to obtain from some jurisdictions, some of which may be doing an entirely adequate job of needs assessment. This discussion of selected approaches is offered primarily to underscore the principles discussed in Chapter III and to provide a range of practical examples.

The NIC Model and Subsequent Developments

Early development. A basic working model was presented in Prison Classification: A Model Systems Approach (NIC, 1982) and via training workshops at The National Academy of Corrections in 1982-83. This beginning focused primarily on well-accepted needs-dimensions (e.g., health, intellectual ability), on distinguishing the level or severity of needs, and on the use of a coding scheme to enhance the development of a management information system. This important but rudimentary framework is portrayed in Exhibit 1 (p. 33). (Note: All exhibits are presented at the end of the chapter or section in which they are mentioned.)

As can be seen, classification decision makers are required to rate the offender on seven needs-dimensions. The levels of need (three in this example) are identified to reflect accurately the range of needs within a given dimension (versus yes-no ratings). A summary page (Exhibit 2, p. 34) elicits program and work recommendations. All information is codable to ease both offender record-keeping and system-wide analysis.

Structured systems of needs identification, including this one, do not necessarily simplify the actual assessment process. That is, completing various forms such as these is merely one step in a complex sequence. Arriving at an offender's "levels" of need may still require substantial assessment resources. NIC

has noted that pre-sentence investigations (PSI), high quality intake interviews, and health, psychological, and education appraisals constitute the core sources of information. The original NIC model provides a basic and necessary structure and is consistent with many of the principles developed in Chapter III. However, several limitations exist:

1. While levels of need are given brief attention, more extensive definitions and guidelines are required to achieve consistency in ratings. Without guidelines, one evaluator may rate a given pattern of drug abuse, for example, as "frequent," while another staff member may record the same behavior as "occasional abuse." Perfect agreement among raters is not always possible, but is always worth striving for.

2. No recommendations were provided regarding the overall structure of a needs assessment system (see Chapter IIIA), including referral practices, division of responsibilities, integration with field services, designation of intervention categories, or institutional mapping of programs and services.

3. The original NIC model was also silent or non-specific on many factors dealing with quality of assessment (see Chapter IIIB), e.g., selection of assessment instruments, reliability, validity, situational context, and communication of results.

From this basic context, however, increasingly sophisticated and creative applications have emerged. In each case, improvements have been overlaid upon the basic model and many of the shortcomings noted above have been addressed. The programs reviewed below represent but a sample of states which have systematically begun to address needs assessment.

Kentucky. The Commonwealth of Kentucky has introduced at least five improvements to the basic NIC model (see Exhibit 3 p. 35).

1. The number of needs categories has been expanded to 12. Additional dimensions include sexual behavior, job-related skills (distinguished from vocational status), living skills (distinguished from behavioral/emotional/mental health), marital/family, and companions. For the most part, these areas are associated with a social-learning approach to intervention. Concurrently, Kentucky has introduced a series of classes and modules to address many of the needs in these areas.

2. The sources of information are recorded directly on the needs assessment form. This step underscores the quality-of-data issue and promotes an information upgrade where possible. When PSI's are not available, the procedure calls for an automatic 60-day review.

3. Kentucky has also developed a Classification Manual (Kentucky Corrections Cabinet, 1983) that specifies in reasonable detail the definitions and criteria for both risk classification and needs assessment. Al though this step is not unique to Kentucky, it is seen as a critical component towards improving the objectivity and, ultimately, the functional utility of needs assessment.

4. Kentucky, as well as several other states, has now developed an institution-by-programs matrix in which the distribution of available resources for programs and services are specified (see Exhibit 4, p. 36). This is an invaluable aid for pinpointing resource availability and for comparing allocations with actual offender needs system-wide.

5. The latter is enhanced by a practical Management Information System (MIS) which Kentucky and other states have begun to use. Especially during transition from one classification system (or non-system) to another, states should be able to retain comparison figures and to acquire an overview of vital offender-based information, including needs for programs and services. MIS capability is an absolute must in offender classification.

Wisconsin. Improvements and developments similar to those cited above have been made in Wisconsin. Additionally, several other features are worth noting.

1. Explicit and detailed definitions and criteria have been developed for each of the needs-by-levels ratings. Although the needs assessment form (Exhibit 5 p. 37) contains abbreviated definitions, a 17-page set of instructions provides guidelines to increase the consistency and the meaningfulness of ratings. (See attached example regarding vocational definitions, Exhibit 6, pp. 38-39).

2. The Wisconsin model also describes criteria for assigning priority ratings to individual offenders (see Exhibit 7, p. 40). The ratings are a joint function of need level, motivation, amenability, and (when relevant) program timing. Motivation and amenability are complex concepts, and reliance on them may indicate an overly static, trait-centered model of behavior. However, it is important to specify the general basis on which programming decisions are made and to explicitly identify relevant factors.

3. Though not unique, Wisconsin has defined six activity levels correlated with medical status. Moreover, primary and secondary medical conditions are coded according to standard classifications of disease (Exhibit 8, pp. 41-42). More unusual is the seven-level classifications of dental needs/status (Exhibit 9, p. 43).

4. Using the definitions and criteria for needs categories cited earlier, Wisconsin has accumulated data that provide a meaningful profile of new admissions. Table 5 is a sample of the types of data that can be produced. Similar analyses have been done for current residents and for priority ratings.

Table 5

Percentages of New Admissions Having Needs at Each Severity Level

	Level-of-Need		
Need-Dimension	Low/None	Moderate	High
Emotional/Mental Health	80	16	4
Alcohol Abuse	46	22	32
Drug Abuse	60	24	16
Education	27	45	28
Vocational	17	39	44

Source: State of Wisconsin

5. Wisconsin has provided an organizational structure in which responsibilities for needs assessment are clearly specified. Additionally, the use of various tests is detailed as to purpose, responsibility, target population, etc. (see Exhibit 10, p. 44).

6. Wisconsin provides two specialized assessments--for Exceptional Educational Needs (EEN) and for Clinical (Psychological) Services. Both professional-level assessments are keyed, when necessary, to follow-up

services in local institutions and/or specialized treatment programs within the state system. This is an excellent example of an assessment-intervention link.

7. In addition to identifying needs in the seven selected areas (including medical and dental), Wisconsin has developed a learning-skills approach to address deficits within the everyday institutional environment. Time-limited "modules" are being designed to cover needs such as problem-solving, social skills, job-related skills, survival, etc. Wisconsin indicates further that it is attempting to structure institutional environments to promote the acquisition of such skills.

8. A recent experimental development is the creation of within-prison management sub-units. The program and management approaches are based on different offender characteristics (see Chapter VII). This effort follows a successful field application in the area of probation and parole case-load management.

Other Models

Several state systems have developed approaches which, while similar to NIC-type models in their intent, stand uniquely as to form. These models, however, also embody many of the principles described in Chapter III.

Washington. The State of Washington provides Inmate Program Screening (IPS) in nine areas, given in order of priority:

1. Health Care
2. Mental Health
3. Substance Abuse
4. Work Adjustment
5. Academic
6. Vocational
7. Personal Hygiene
8. Financial Management
9. Leisure Time

A final evaluation code for each area results from the combination of assessed severity and current program status (participation or amenability). Table 6 indicates the possible combinations of point values and their respective meanings. For practical purposes, Codes 1 and 5 (and probably 2 and 6) are not relevant to intake screening.

Each offender receives a nine-digit code reflecting his severity/status evaluation in each of the nine assessment areas. For example, 340033000 would indicate that offender John Doe has moderate needs/problems in the health (1st digit), academic, and vocational areas and that he is amenable to treatment and/or program participation. For his mental health problems, which are also of moderate severity, he has refused program participation.

The Health and Mental Health categories are somewhat uniquely constructed and, understandably, require professional con-

clusions as to severity of deficits and need for treatment (see Exhibits 11 and 12, pp. 45-47). However, the actual coding is consistent with the remainder of the system.

Table 6

An Evaluation Coding System Based on Problem Severity and Current Status

		Severity Assessment		
		No Problem	One Moderate Problem	Two or More Moderate Problems / One or More Serious Problems
Current Status	Point Value	0	1	5
	Numbers represent sum of row and column			
Program Completed	0	0	1 (problem persists)	5 (problem persists)
Participating or on Waiting List	1	X	2	6
Needs Program Is Amenable	2	X	3	7
Needs Program Not Amenable	3	X	4	8

Examples: Code 2 = person with one moderate problem; participating or on waiting list.
Code 7 = serious (or 2 or more moderate) problems; amenable to program enrollment.

A major positive component of the Washington model is the systematic use of criteria or check-offs to define each problem area. As suggested earlier, this approach provides for a consistent and comprehensive assessment. Some staff discretion is still required, however, in assessing each problem as "serious" or “moderate.”

The principal criterion for rating an area of deficit am a "serious" or "moderate"problem is the extent to which it has negatively affected the prisoner's institutional or community adjustment or performance. Such evidence may include the recommendation of the sentencing court or parole board. (High quality PSI's are usually available.) Also included in this determination is classification's concept of "an identified pressure situation." If the inmate is judged unable to cope with or control the situation, the problem will be scored "serious." Thus, the important environmental elements are incorporated. This approach coincides with principle B3 presented earlier, i.e., that behavior be judged in context. An example of this approach is indicated in the area of Vocational Screening (Exhibit 13, p. 48).

Following assessment, as Washington's guidelines indicate,

> the unit team and classification committee must turn their attention to establishing and recording recommended programs to address any problem area where a score of 8, 7, 6, 4, 3, or 2, is reported. Areas with scores of 7, 6, 3, or 2 should be given consideration for movement if recommended programs are not available at the inmate's current location.

In sum, Washington provides structured assessment of needs, guidelines for severity determinations, and a coding system which enhances fol1ow-through.

Oklahoma. Since January, 1983, Oklahoma has grouped its services and programs and the related assessments into six areas. In order of priority, these are:

1. Physical Health
2. Mental Health
3. Substance Abuse
4. Academic Deficiency
5. Vocational Deficiency
6. Social Skills Deficiency

If problems are noted in any needs area (at either a moderate or severe level), additional information is recorded regarding specified program options and participation status. Like Washington, Oklahoma specifies the criteria or check-off items for screening offenders in each needs area. However, some of the items are rather terse, e.g., "The inmate cannot speak English," or potentially ambiguous, e.g., "The inmate has reported a psychological problem within the last 120 days." To achieve consistency of ratings, staff must receive training and/or additional instructions regarding the assessment process.

The major positive feature of the Oklahoma system (over and above the features it shares with other states) is its systematic linkage of needs assessment to program recommendations. That is, each need area is keyed to currently available programs and services. As can be seen from the program summary (Exhibit 14, p. 49), both problems areas and program action are noted.

Second, the distribution of each of these program areas is represented on a facility-by-program matrix (Exhibit 15, p. 50). As previously discussed, this rather simple step has great utility in indicating current, and potentially needed, allocation of resources.

Finally, Oklahoma has defined by title, description, and eligibility criteria each offender program available in the system. In many cases, time-limited modules addressing specific problems are defined; in other areas, open-ended programs are available. An example of such programs in the Mental Health and Social Skills areas is noted on Exhibit 16 (pp. 51-54).

The Correctional Classification Profiles (CCP). A recent trend in several states follows a model developed by the Correctional Services Group (Buchanan & Irion, 1983). This model is similar to others previously discussed but includes the following additional features:

1. Offender needs are summarized on a visual display in which needs level or severity (CCP score) on each dimension is coded (see Figure 2 below).

2. The need-dimensions are ordered (left to right) in priority. That is, the factors that weigh most heavily in determining institutional placement are considered in a step-wise fashion. The CCP ratings, then, determine or limit institutional placement based on the capabilities and services offered at each facility.

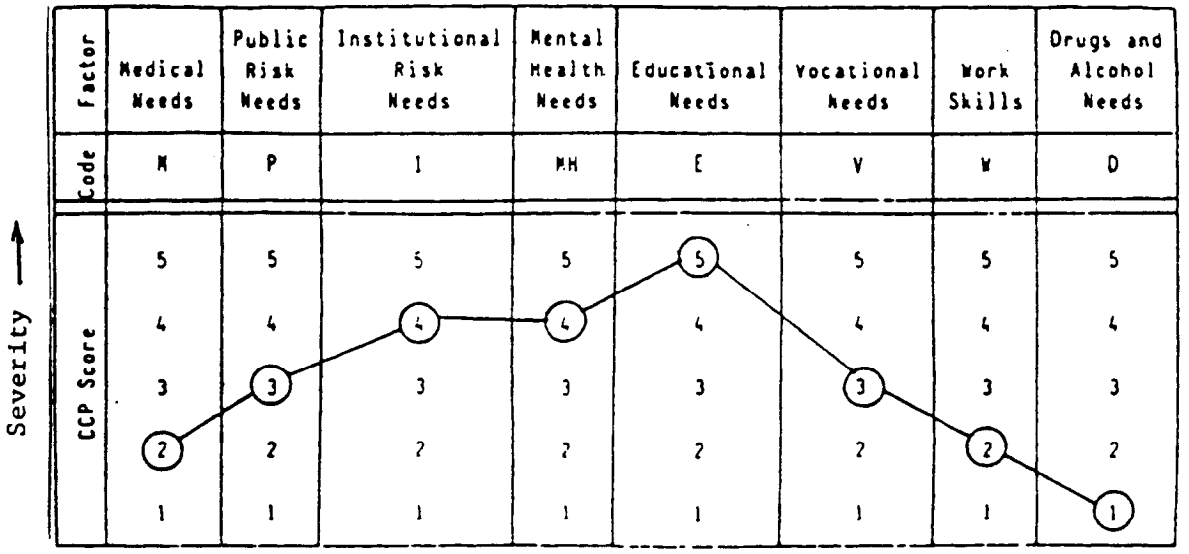


Figure 2. A correctional classification profile of a hypothetical inmate.

3. As can be noted on the profile, risk classification--both public (external) and institutional (internal)--are integrated into the "needs" framework. Such an approach may result in other needs areas' being given a balanced share of attention. For example, in Pennsylvania the needs profile is presented at the top of the offender classification summary (see Exhibit 17, p. 55). This format stands in contrast to those in jurisdictions in which program needs statements are often buried in the back pages of classification reports.

4. In some jurisdictions, e.g., Missouri, needs rising above the minimal or mild levels must be matched with treatment recommendations (see Exhibit 18, p. 56).

Offenders with low medical and risk scores will usually be afforded greater access to institutional options that provide services in other needs areas. When security and custody risk are somewhat higher--as in the hypothetical profile noted on page 31--placements that also address mental health and educational needs, for example, may be more restricted. However, the premise of this model is that the system-wide array of services (and security) will 'vary sufficiently to accommodate a wide range of profiles. Data analysis should reveal existing gaps in the system, for example, if large numbers of high risk offenders require vocational training. Institutional profiles indicating which needs-levels can be accommodated by each correctional facility have also been developed.

The value of the CCP is dependent on the adequacy of definitions, guidelines, and criteria used to determine needs scores in each area. Pennsylvania, Missouri, and Georgia, as principal users of this model, have developed detailed manuals with necessary guidelines. In some instances, however, the definitions of severity are mislabeled. They seem related more to services recommended, e.g., "medical observation seven days a week," than to the actual specification of an offender's need level.

Ideally, both assessment and prescription should receive parallel attention. That is, inmates are categorized, level 1 through 5, on each dimension. Within a given need area, say mental health, they would additionally be matched to a defined level, again 1 through 5, of treatment services. This parallel structure is one of the intended benefits of CCP. And it seems to provide the necessary flexibility so that a given state could effectively map both its offender population and its available (and needed) services.

Exh. 1

INITIAL INMATE CLASSIFICATION ASSESSMENT OF NEEDS

NAME _____ NUMBER _____
Last First MI

CLASSIFICATION CHAIRMAN _____ DATE ____ I ____ I ____

TEST SCORES:

_____ I.Q.

_____ Reading

_____ Math

NEEDS ASSESSMENT: Select the answer which best describes the Inmate.

HEALTH:

1 Sound physical health, seldom ill	2 Handicap or Illness which interferes with functioning on a recurrlng basis	3 Serious handicap or chronic illness, needs frequent medical care	_____ code

INTELLECTUAL ABILITY:

1 Normal intellectual ability, able to function independently	2 Mild retardation, some need for assistance	3 Moderate retardation, independent functioning severely limited	_____ code

BEHAVIORAL/EMOTIONAL PROBLEMS:

1 Exhibits appropriate emotional responses	2 Symptoms limit adequate functioning, requires counseling, may require medication	3 Symptoms prohibit adequate functioning, requires significant intervention, may require medication or separate housing	_____ code

ALCOHOL ABUSE:

1 No alcohol problem	2 Occasional abuse, some disruption of functioning	3 Frequent abuse, serious disruption, needs treatment	_____ code

DRUG ABUSE:

1 No drug problem	2 Occasional abuse, some disruption of functioning	3 Frequent abuse, serious disruption, needs treatment	_____ code

EDUCATIONAL STATUS:

1 Has high school diploma or GED	2 Some deficits, but potential for high school diploma or GED	3 Major deficits in math and/or reading, needs remedial programs	_____ code

VOCATIONAL STATUS:

1 Has sufficient skills to obtain and hold satisfactory employment	2 Minimal skill level, needs enhancement	3 Virtually unemployable, needs training	_____ code

Source : NIC

INITIAL CLASSIFICATION SUMMARY

1. Override Considerations-Custody Classification:

1. None
2. Inmate Needs Protection
3. Temporary Placement-Pending Investigation
4. Temporary Placement-Punitive Isolation
5. Temporary Placement-Suicide Threat
6. Other, Specify: _____

_____ code

_____ score

_____ I.Q.

2. Custody Level Assignment:

1. Community
2. Minimum
3. Medium
4. Close
5. Maximum
6. Protective Custody
7. Other, Specify: _____

_____ code

_____ score

_____ Reading

_____ Math

_____ code

_____ score

3. Facility Assignment:
(See attached Code List)

_____ code

_____ code

4. Program Recommendations:
(In order of priority)

_____ score

_____ code

	Program Code	Enrollment Code'

_____ code

5. Work Recommendations:

_____ score

_____ code

	Work Code	Inmate Skills	Skill Code

_____ score

_____ code

_____ score

_____ code

_____ score

TOTAL SCORE

'Enrollment Code
Program available = 1
Program currently at capacity/unavailable = 2
Program needed but does not exist at required custody level = 3
Inmate refuses program = 4

Source: NIC

ASSESSMENT OF NEEDS

NAME _____ AGE _____ NUMBER _____
Last First MI

CLASSIFICATION OFFICER _____ CODE _____ DATE _____

HEALTH:
1 Sound physical health; seldom ill | 2 Handicap or illness which interferes with functioning | 3 Serious handicap or chronic illness; needs frequent medical care — code

a. Observation b. Self-report c. Verified Medical History d. Medical Exam

ALCOHOL USAGE:
1 No apparent problem | 2 Occasional abuse,some disruption of functioning | 3 Frequent abuse,serious disruption; needs assistance — code

a. Observation b. PSI c. Self-report d. Other

OTHER SUBSTANCE USAGE:
1 No apparent problem | 2 Occasional abuse,some disruption of functioning | 3 Frequent abuse,serious disruption; needs assistance — code

a. Observation b. PSI c. Self-report d. Other

INTELLECTUAL ABILITY:
1 Normal intellectual ability; able to funcion independently | 2 Some need for assistance | 3 Independent functioning severely limited — code

a. Self-report b. Observation c. BETA _____ d. WAIS _____ e. Other

BEHAVIORAL/EMOTIONAL PROBLEMS:
1 Exhibits appropriate emotional responses | 2 Symptoms limit adequate functioning;requires counseling; may require medication | 3 Symptoms prohibit adequate functioning; requires significant intervention;may require medication or seperate housing — code

Self-report b. Observation c. PSI d. Psychological Evaluation e. Psychiatric Evaluation f. Other

SEXUAL BEHAVIOR:
1 No apparent dysfunction | 2 Situational or minor problems | 3 Real or perceived chronic or severe problems — code

a. Self-report b. Observation c. PSI d. Psychological Evaluation e. Psychiatric Evaluation

EDUCATIONAL STATUS:
1 Has High School diploma or GED | 2 Some deficits, but potential for GED | 3 Major deficits in math and/or reading; needs remedial programs — code

a. Self-report b. PSI c. Educational Record d. TABE ____: R____ M____ L____

VOCATIONAL STATUS:
1 Has sufficient skills to obtain satisfactory employment | 2 Minimal skill level; needs enhancement | 3 Virtually unemployable;needs training — code

a. Self-report b. PSI c. Employment Record d. Other

JOB RELATED SKILLS:
1 Has sufficient positive work to maintain employment | 2 Some deficits;needs program to develop positive work habits | 3 Work habits insufficient to maintain employment;needs strong work program — code

a. Self-report b. PSI c. Employment Record d. Other

LIVING SKILLS:
1 Presents and expresses self appropriately to social context | 2 Has mastered basic survival skills;needs enrichment | 3 Lacks skills necessary for social survival — code

a. Self-report b. Observation c. PSI d. Psychological Evaluation

MARITAL/FAMILY:
1 Relatively stable relationships | 2 Some disorganization or stress, but potential for improvement | 3 Major disorganization or stress — code

a. Observation b. Self-report c. PSI d. Report from family

COMPANIONS:
1 No adverse relationships | 2 Associations with occasional negative results | 3 Associations almost completely negative — code

a. Observation b. Self-report c. PSI

Source: Kentucky

Example of Program-by-Institution Matrix

Program and Program Code		KSP	KSR	LLCC	NP	KCTW	BCC	BCTC	FCTC	RPC	WKPC	
II.	VOCATIONAL PROGRAMS											
010	Auto Body	X	X									
011	Auto Mechanics		X									
012	Auto/Diesel Mechanics			X								
013	Business & Office					X						
014	Building Maint.					X						
015	Carpentry		X	X			X					
016	Drafting		X				X					
017	Electricity		X				X					
18	Heating & Air Cond.	X					X					
019	Home Economics					X						
020	Masonry	X	X	X		X						
021	Meat Cutting						X				X	
022	Printing		X									
023	Plumbing		X				X					
024	Radio & T.V.		X									
025	Small Engine	X	X									
026	Welding	X	X	X								
027	Upholstery		X									
028	Voc. Study Release					X		X				

Source: Kentucky

DEPARTMENT OF HEALTH & SOCIAL SERVICES
Division of Corrections
TEA: 62 (9/82)

STATE OF WISCONSIN

Exh. 5

INMATE NEEDS ASSESSMENT

Inmate Name - Last, First, MI (1-19)	Case Number (20-25)	Institution Code (26-27)	Date of Rating (28-33) Mo/Day/Yr	Type of Rating (34)
				1 ☐ A&E 2 ☐ PRC

INSTRUCTIONS: Check box to indicate appropriate response in Area of Need. Determine priority for each area based on assessment of motivation for treatment, amenability for treatment and urgency of need. Indicate priority by checking the appropriate box.

RATING	AREA OF NEED	PRIORITY
	EMOTIONAL/MENTAL HEALTH:	
1 ☐	Exhibits appropriate emotional responses.	1 ☐ High 2 ☐ Med 3 ☐ Low
2 ☐	Has some signs of mental health problems but not related to crime and would not lead to institutional adjustment problems.	
3 ☐ (35)	Severe problems affecting institutional adjustment or related to criminal pattern.	(36)
	ALCOHOL ABUSE:	
1 ☐	Adequately copes with alcohol consumption, related to social situation.	1 ☐ High 2 ☐ Med 3 ☐ Low
2 ☐	Use of alcohol predominant in most social and private situations. Consumption has negatively affected one or more major life areas.	
3 ☐ (37)	Heavy use of alcohol affecting several major life areas, may be psychologically or physically dependent. Consumption may have some relationship to crime.	(38)
	DRUG ABUSE:	
1 ☐	Does not use illicit drugs, adequately copes with prescription drugs.	1 ☐ High 2 ☐ Med 3 ☐ Low
2 ☐	Heavy user of marijuana, short term experimentation with hard drugs, or combination use of alcohol and drugs. Consumption negatively affects one or more major life areas.	
3 ☐ (39)	Heavy use of hard drugs affecting several major life areas, may be psychologically or physically dependent. Consumption may have some relationship to crime.	(40)
	EDUCATION:	
1 ☐	Has adequate education level with no negative effect on employment or ability to function in society.	1 ☐ High 2 ☐ Med 3 ☐ Low
2 ☐	Inadequate educational level to pursue vocational training. Needs GED or HED to enhance employment opportunities. May require refresher courses to bring education in line with vocational training. Desires college education to complete academic training.	
3 ☐ (41)	Illiterate or low academic ability, unable to communicate with others, prevents employment, needs academic training before acceptance into vocational programming.	(42)
	VOCATIONAL:	
1 ☐	Maintained employment with marketable skills, adequate financial status and education level.	1 ☐ High 2 ☐ Med 3 ☐ Low
2 ☐	Marginal work history, may have some work skills, results in marginal financial income.	
3 ☐ (43)	Unstable or no employment with no marketable skills, financially unstable.	(44)

Form 3 (45)

Vocational Definitions

VOCATIONAL:

INTRODUCTION: This guide defines three levels of need for vocational training: No Significant Need, Moderate Need, and Serious Need. These levels represent a scale of vocational needs from No Need to a Serious Need for vocational training. Although the final recommendation is subjective, the definitional guidelines presented for each of the three need levels can be used by staff as key areas which should be assessed. Assessment factors are also listed to help in determining vocational need level.

The assessment of vocational needs should be done following an interview(s) with an inmate, review of field and any other community information, and possibly contact with the supervising agent.

RATING: No Significant Need

DEFINITION:

1) Has maintained stable employment.
2) Has marketable job skills.
3) Adequate financial status.
4) Has achieved adequate educational level.

ASSESSMENT FACTORS:

Work History - Has maintained employment with the same employer for at least one year or more within the past one to three years.

Job Skills - Has successfully completed vocational training program(s) or has vocational certification(s); or has had considerable on-the-job experience in at least one job area.

Financial Status - Able to provide support for self and/or family without assistance from outside agencies.

Educational- Has high school diploma or GED; or lack of such has not had a negative impact on employment.

RATING: Moderate Need

DEFINITION:

1) Marginal work history.
2) May have some basic job skills.
3) Marginal economic status.
4) Interested in furthering present vocational education status through vocational technical school course or program.
5) Lack of GED or HED has hindered employment.

Source: Wisconsin

ASSESSMENT FACTORS:

Work History -- Has held employment but has not had any employment within the past year; held stable employment at some time during his life but not within the past one to three years; is usually able to find employment but is generally terminated from job after a short time; has held numerous short-term jobs.

Job Skills - May have sufficient skills to obtain employment; may need a refresher course for present vocational skills; may need to obtain a certification in an area of training in order to better chances of finding employment.

Medical Component -- May have had sufficient skills in the past but due to medical problems or illness, may be unable to return to past occupational area; may be permanently disabled or in need of exploration of a different occupational area with subsequent training.

Financial Status - Pattern of criminal activity does not relate to ability to provide for self through employment.

Educational- May have ability to obtain GED or HED but has not pursued this; lack of GED or High School Diploma may have had an effect on employer's willingness to hire the inmate.

Interest - Has interest in pursuing vocational/educational training through vocational technical school course(s) or program.

RATING: Serious Need

DEFINITION:

1) Unstable employment.
2) Does not have marketable job skills.
3) Is financially unstable.
4) Has need for remedial educational programming to become eligible for vocational programs.

ASSESSMENT FACTORS:

Work History - Has never held a job, has never had employment which lasted longer than six months; or has not held employment which has lasted more than six months during the past one to three years.

Job Skills - Has never had any type vocational or on-the-job training, or has never completed a vocational program to acquire skills.

Financial Status -- Has not been able to support self and/or family; has relied on outside agencies to help support self and/or family; or has relied on criminal or illegal activities to support self and/or family.

Educational- Low academic ability or lack of high school diploma or GED has made it difficult for inmate to obtain employment.

Source: Wisconsin

CRITERIA FOR ASSESSING NEED LEVEL AND PRIORITY:

Five areas of need are identified. Each area will have recorded a rating and priority. Rating for each area is located on the left margin and priority is rated on the right margin. Your rating response for each area should be based on the material prepared by the centralized Assessment and Evaluation committee and reported in the final report (May 19, 1982).

The rating of need should encompass the directions established for emotional/ mental health, alcohol abuse, drug abuse, education and vocational needs. In general, need level (low, moderate, serious) is the assessment of the extent to which a problem area affects an individual's social, personal, and legal status or functioning. Need assessment standards are as follows:

Serious need : Clearly document handicap, deficit, or problem area.

Moderate need: Occasional or symptomatic problem area - deficit areas secondary to others (may be related to other factors).

Low need: Problem area non-existent, not documented or demonstrated.

The rating of priority should encompass the requirements for treatment or services. Four factors are considered when establishing a priority level (low, medium, high) : motivation, amenability, immediacy of program Involvement, and need. These factors are defined as follows:

Motivation - Motivation level (low, medium, high) is the assessment of the inmate's current personal investment or willingness for investment in an identified area. Recognition of the problem or deficit area and investment for resolution are important considerations.

Amenability - Amenability level (low, moderate, high) refers to the anticipated ability of an inmate to benefit from a' program or intervention. This may be influenced by factors such as motivation, prior history of services, inmate's capability levels, etc.

Immediacy of program involvement - Anticipated program involvement will occur within designated time frames' or cannot occur due to short sentence structure.

The following requirements must be met in order to select priority level for each of the need areas.

High Priority:	Medium Priority:	Low Priority:
Need level - serious	Need level - serious or moderate	Need level - serious or moderate or low
Motivation - high	Motivation - low, medium, high	Motivation - low, medium
Amenability - high	Amenability - low, medium, high	Amenability - low, medium
Immediacy - within the next 2 years	Immediacy - within 2-5 years	Immediacy - over 5 years or not possible due to short sentence structure

Source : Wisconsin

BUREAU OF CORRECTIONAL HEALTH SERVICES
MEDICAL CLASSIFICATION REPORT

Reporting Source

A. REPORTING SOURCE

☐ Initial ☐ Revised

1. Name of Institution

2. Date of Report ___ ___ ___ (Mo Day Yr)

Case Identifications

B. CASE IDENTIFICATION

1. Inmate's Name

Last _____, First _____, Middle ____

2. Date of Birth ___ ___ ___ (Mo Day Yr)

Sex ☐ M ☐ F (1 2)

3. Case Number ___ ___ ___ ___ ___ ___

Special Conditions

C. SPECIAL CONDITION, DEFECT OR DISEASE CODE (refer to code on other side)

Primary _____ Secondary _____ Others _____

Activity Levels

D. ACTIVITY LEVEL

☐ 01 **Any Activity** - Subject is physically fit to perform any type work. Is also able to actively participate in strenuous sports such as football, basketball, wrestling and weightlifting.

☐ 02 **Light Activity** - Subject is restricted from assignments requiring steady pace activity. Subject should be allowed to work at own pace. Should not be required to lift over 20 pounds. Limit recreational activities to walking, fishing, ping pong, pool, etc. *Examples of acceptable assignments:* sweeper, runner, ligh gardening. food preparation and serving, gatekeeper assistant, clerical or other sedentary assignments.

☐ 03 **Moderate Activity** - Subject is restricted from work involving heavy lifting over 50 pounds; tasks which demand prolonged physical exertion such as excessive running, climbing, walking or manual use of heavy machines.

Subject is restricted from active "full-time-game-time" participation in sports such as football or basketball. *Examples of acceptable assignments:* housekeeping, kitchen, laundry, daily livestock care, gardening, grass cutting, litter collection, bindery, cannery, most manufacturing areas, electrician, painter, finish carpenter.

☐ 04 **No Work Status** - Subject is in no condition to accept a work assignment under any circumstances due to serious health conditions such as heart disease, terminal cancer. Physical condition is such that subject will self-limit physical activity.

☐ 05 **Non-Hazardous** - Subject is subjected to significant visual or hearing impairment, epilepsy or other conditions causing frequent dizziness or vertigo.

Subject should not be assigned to work in dusty areas, scaffolding or ladder, use air compressor, or air drill or unguarded machinery. Avoid assigning subject to area where vehicle traffic is heavy.

☐ 06 **Medical Hold Status** - Subject is undergoing special medical workup or treatment or is in a recovery or convalescent phase of a medical condition which would be significantly disrupted if transferred to another facility.

Subject should not be transferred to another unit until hold status is removed. The hold status must be reviewed and either renewed or dropped every 30 days.

Special Instructions

E. ☐ 07 Special Instructions: _____

_____

Signature _____ Date ___ ___ ___ (Mo Day Yr)

(Refer to Code on Reverse Side)

Source: Wisconsin

MEDICAL CODE

Special Condition, Defect, or Disease; Whenever a special condition, defect or disease is noted in a subject, the medical classification will be so indicated. More than one classification can be used if indicated. While it is likely that activity level, *any activity* will not have a defect or condition to be noted, others will. All other activity levels must have a medical code listed as a reason for restricted assignments.

1. Age (60 or over) - Persons in this age group may need activity limitations.
2. Neurological - Includes epilepsy, muscular dystrophy, paralysis, etc.
3. Orthopedic - Includes tendonitis, fractures, arthritis, torn ligaments, etc.
4. Visual - Includes blindness, cataracts, glaucoma, etc.
5. Ear, Nose, Throat - Includes deafness, perforated eardrums, deviated septum, chronic tonsilitis, cleft palate, etc.
6. Hernia - Unrepaired ventral or inguinal.
7. Hematological - Includes leukemia, pernicious anemia, Sickle cell, etc.
8. Mental - Includes retardation, schizophrenia, depression, etc.
9. Coronary/Circulatory - Includes coronary artery disease, congestive failure, hypertension, arterioclerosis, etc.
10. Respiratory - Includes asthma, chronic bronchitis, emphysema, tuberculosis, etc.
11. Endrocrine - Includes diabetes, hyperthyroidism, Addison's, etc.
12. Gastrointestinal - Includes gastric ulcers, lye ingestion, Colostomy, etc.
13. Renal/Urological - Includes renal failure, hemodialysis, renal calculi, etc.
14. Malignacy - To include any malignancy not covered by other categories.
15. Dermatological/Gross - Includes severe skin diseases, facial disfigurement due to burns, GSW to face, etc.
16. Anaphylactic Reactions - Documented allergy to bee or wasp stings, etc.
17. Obstetrical/Gynecological - Pregnency, prolapsed uterus, endometriosis, etc.
18. Drug dependency/Alcoholism.
19. Other - Specify.

Source: Wisconsin

BUREAU OF CORRECTIONAL SERVICES
DENTAL CLASSIFICATION REPORT

Exh. 9

Source: Wisconsin

Reporting Source

A. REPORTING SOURCE

☐ Initial

1. Name of Institution

☐ Revised 2. Date of Report Mo Day Yr

Case Identification

B. CASE IDENTIFICATION

1. Inmate's Name

2. Date of Birth Mo Day Yr

3. Sex ☐ Male ☐ Female

Last First Middle

4. Case Number

Classification/treatment status

C. CLASSIFICATION/TREATMENT STATUS

☐ CATEGORY I (C-I)

01 Inmates with the following symptoms and conditions:

a. An oral condition if left untreated that would cause bleeding and/or pain in the immediate future.

b. An oral infection or oral condition which, if left untreated, would become acutely infectious.

c. An oral condition such as edentulousness or missing upper or lower anterior teeth which presents a psychological or physical problem to the inmate's sense of well being, confidence and adjustment.

d. An undiagnosed or suspected oral condition such as ulcerative lesion or growth tissue.

☐ CATEGORY II (C-II)

02 Inmates with the following symptoms and conditions:

a. The presence of medium to large non-painful carious lesions.

b. A localized gingival involvement.

c. Class II, class III, or class IV fractured anterior tooth or teeth.

d. The presence of temporary, sedative or intermediate restorations.

e. Broken or ill-fitting prosthetic appliance.

☐ CATEGORY III (C-III)

03 Inmates with the following symptoms and conditions:

a. Small carious lesions which radiographically present an imminent danger to the pulp.

b. The need for dental restorative procedures with significant laboratory costs involved, such as cast partial dentures.

c. The use of restorative procedures involving the use of precious metals.

d. Severe non-functional bite and malocclusion which involves social-psychological factors in the inmate's appearance and his/her potential for adjustment.

☐ CATEGORY IV (C-IV)

04 Inmates with the following symptoms and conditions:

a. Radiographical absence of carious lesions.

b. Lack of clinically visible gingival irritation.

☐ CATEGORY V (C-V)

05 Inmates with no symptoms or apparent need for dental treatment related to the type of assessment or inspection performed.

☐ CATEGORY VI (C-VI) Emergency Treatment

06 Conditions Requiring Emergency Treatment may include:

1. Bleeding and pain
2. Acute periapical abscess
3. Acute periodontitis
4. Vincents infection
5. Acute gingivitis
6. Acute stomatitis
7. Fractures of teeth
8. Fracture of jaw or jaws
9. Gaping wounds of lips and cheeks

☐ Dental Hold Status

07 Subject is undergoing special dental workup or treatment or is in a recovery or convalescent phase of a dental treatment which would be significantly disrupted if transferred to another facility.

Special Instructions

D. Special Instructions: _____

_____

Signature: _____ Date Mo Day Yr

CENTRAL ASSESSMENT AND EVALUATION BASIC SCREENING
BATTERY OF TESTS

Test Purpose	Test	Test Adm. Resp.	Population	Type of Admin.	Scoring/Output	Interpretation	Primary Use	Secondary Use
Screening for Intelligence Level	Wide-Range Vocabulary	Clinical Services	All Admissions	Group	CTR Section Machine	PSA	EEN; Educ. Clinical Services	Social Service Ed./Career Counselor
	Ravens Progressive Matrices	Clinical Services	All Admissions	Group	CTR Section Machine	PSA	EEN; Educ. Clinical Services	Social Service Ed./Career Counselor
Screening for Specific Cognitive Deficits	Oral and Written Language Samples	EEN Speech and Language Therapist	All Admissions Under age 21	Individual	Handscore or S/L Therapist	S/L Therapist	EEN; Educ., Ed./Career Counselor	Social Service Clinical Services
Screening for Achievement Level	Stanford Achievement Test (selected scales) 30 min.	Ed./Career Counselor	All Admissions	Group	Handscore or CTR Section Machine	Ed./Career Counselor	EEN; Educ., Ed./Career Counselor - Develop. Disabled Program	
Screening for Vocational Problems	Vocational Problems Checklist	Ed./Career Counselor	All Admissions	Group	Handscore or Ed./Career Counselor	Ed./Career Counselor	Ed./Career Counselor EEN	Social Service Education Staff
Screening for Vocational Interests	Wide Range Interest-Opinion Test (WRIOT) or	Ed./Career Counselor	All Admissions	Group	Handscore or CTR Section	Ed./Career Counselor	Ed./Career	Social Service

Exh. 11

HEALTH CARE SCREENING REPORT

IOTE IDENTIFY ONLY THE MOST SERIOUS PROBLEM OF THE INMATE

ITERIA/ASSESSMENT (CHECK/SCORE ONLY ONE):

1.	NO DIAGNOSED MEDICAL OR HEALTH PROBLEM AT THIS TIME.	____	0
2	CHRONIC ILLNESS RESULTING IN RECOMMENDATION FOR PLACEMENT IN COMMUNITY OR LONG-TERM-CARE FACILITY	____	1
3.	ACUTE OR CHRONIC, NOT LIFE-THREATENING, REQUIRING PERIODIC OUTPATIENT MEDICAL CARE.	____	1
4.	DIAGNOSED HISTORY OF SERIOUS RECURRING ILLNESS, REQUIRING PERIODIC OUTPATIENT MEDICAL CARE.	____	5
5.	DIAGNOSED ACUTE OR CHRONIC LIFE-THREATENING ILLNESS REQUIRING IMMEDIATE ATTENTION AND/OR INPATIENT TREATMENT.	____	5

CURRENT STATUS (IF THE SCORE FOR SECTION A IS GREATER THAN ZERO, CHECK ONE OF THE ITEMS BELOW. OTHERWISE, ENTER ZERO IN EVALUATION (SECTION C)):

1.	COMPLETED PRESCRIBED MEDICAL PROGRAM.	____	0
2.	RECEIVING TREATMENT, BUT HAS NOT COMPLETED PRESCRIBED MEDICAL PROGRAM.	____	1
3.	NOT INVOLVED IN MEDICAL PROGRAM AND IS AMENABLE TO PROGRAM AT THIS TIME.	____	2
4.	NOT INVOLVED IN MEDICAL PROGRAM AND IS NOT AMENABLE TO PROGRAM AT THIS TIME.	____	3

ALUATION (SECTION A + SECTION B):

OMMENTS:

REPARED BY: TITLE DATE

OC NUMBER | NAME: LAST FIRST MIDDLE

21 116 (2/83) OX A-116 DISTRIBUTION: WHITE—FACILITY CENTRAL FILE YELLOW—RESEARCH/DATA ENTRY
PINK—HEADQUARTERS CENTRAL FILE GOLDENROD—BOARD OF PRISON TERMS & PAROLES

Source: Washington

DEPARTMENT OF CORRECTIONS Exh. 12

MENTAL HEALTH SCREENING REPORT Source: Washington

A. HISTORY OF MENTAL ILLNESS (check all appropriate categories):

_____ HOSPITALIZATIONS
_____ OUTPATIENT TREATMENT
_____ PSYCHOTROPIC MEDICATION
_____ ATTEMPTED SUICIDE
_____ MENTAL ILLNESS IN FAMILY
_____ INSANITY/COMPETENCE EVALUATION
_____ SEXUAL ADJUSTMENT PROBLEM

B. MENTAL STATUS EXAMINATION (check all appropriate categories):

_____ BELOW AVERAGE INTELLIGENCE
_____ PERCEPTUAL DISTORTIONS—HALLUCINATIONS
_____ COGNITIVE DISTORTIONS—DELUSIONS
_____ REALITY/ORIENTATION DISTORTION
_____ MEMORY DEFICITS
_____ MOOD SWINGS
_____ SUICIDAL IDEATION

C. BEHAVIORAL OBSERVATIONS (Check all appropriate categories):

_____ TENSE
_____ HOSTILE
_____ ANXIOUS
_____ EXCITABLE
_____ LETHARGIC
_____ COOPERATIVE

D. PROVISIONAL DIAGNOSIS: DSM CODE

AXIS I _____ _____
AXIS II _____ _____
AXIS III _____ _____

E. ADAPTIVE FUNCTIONAL ASSESSMENT (ASSESS LEVEL OF ADAPTIVE FUNCTIONING IN THREE MAJOR AREAS: 1. SOCIAL, 2. OCCUPATIONAL AND 3. USE OF LEISURE TIME.)

_____ SUPERIOR/VERY GOOD (ENTER 0)
_____ GOOD (ENTER 0)
_____ FAIR (ENTER 1)
_____ POOR (ENTER 2)
_____ VERY POOR (ENTER 3)
_____ GROSS (ENTER 3)

F. MENTAL HEALTH NEEDS: _____

_____ ROUTINE (ENTER 1)
_____ CONTINUING (ENTER 3)
_____ EMERGENT (ENTER 5)

G. EVALUATION (TOTAL OF POINTS ASSIGNED TO SECTION E AND F): _____

COMMENTS:

PREPARED BY: TITLE DATE

DOC NUMBER: INMATE NAME: LAST FIRST MIDDLE

DOC 21 109 (REV 9/83) 588 DISTRIBUTION: WHITE—FACILITY CENTRAL FILE YELLOW—RESEARCH/DATA ENTRY
PINK—HEADQUARTERS CENTRAL FILE GOLDENROD—BOARD OF PRISON TERMS & PAROLES

Adaptive Functional Assessment

DSM Axis V permits the clinician to indicate his or her judgment of an individual's highest level of adaptive functioning (for at least a few months) during the past year. This information frequently has prognostic significance, because usually an individual returns lo his or her previous level of adaptive functioning after an episode of Illness.

As conceptualized here. adaptive functioning is a composite of three major areas: social relations, occupational functioning, and use of leisure time. These three areas are to be considered together, although there is evidence that social relations should be given greater weight because of their particularly great prognostic significance. An assessment of the use of leisure time will affect the overall judgment only when (here is no significant Impairment in social relations and occupational functioning or when occupational opportunities are limited or absent (e.g., the individual is retired or handicapped).

Social relations include all relations with people, with particular emphasis on family and friends. The breadth and quality of interpersonal relationships should be considered.

Occupational functioning refers to functioning as a worker, student, or homemaker. The amount, complexity, and quality of work accomplished should be considered. The highest levels of adaptive functioning should be used only when high occupational productivity is not associated with a high level of subjective discomfort.

Use of leisure time includes recreational activities or hobbies. The range and depth of involvement and the pleasure should be considered.

The level noted should be descriptive of the individual's functioning regardless of whether or not special circumstances, such as concurrent treatment, may have been necessary to sustain that level.

LEVELS

SUPERIOR:	Unusually effective functioning in social relations, occupational functioning, and use of leisure time.
VERY GOOD:	Better than average functioning in social relations, occupational functioning, and use of leisure time.
GOOD:	No more than slight impairment in either social or occupational functioning.
FAIR:	Moderate impairment in either social relations or occupational functioning, or some impairment in both.
POOR:	Marked impairment in either social relations or occupational functioning, or moderate impairment in both.
VERY POOR:	Marked impairment in both social relations and occupational functioning.
GROSS:	Gross impairment in virtually all areas of functioning.

Mental Health Needs

NEEDS

ROUTINE:	Screening testing, file review, intake interview.
CONTINUING:	Supportive counseling, outpatient appointment, referral for medication evaluation.
EMERGENT:	Referral to Special Offender Center, suicide prevention program, Special Needs Unit.

Source: Washington

DEPARTMENT OF CORRECTIONS Exh. 13

VOCATIONAL SCREENING REPORT

CRITERIA (CHECK ONLY THOSE WHICH APPLY).	SERIOUS	MODERATE
1 THREE OR MORE JOB-TYPE CHANGES IN THE LAST 12-MONTH PERIOD DUE TO INABILITY TO PERFORM	____	____
2 FIRED OR UNEMPLOYED MORE THAN 50 PERCENT OF THE TIME DURING THE PAST 12 MONTHS DUE TO LACK OF SKILLS	____	____
3 PHYSICALLY UNABLE TO APPLY ACCRUED WORK SKILLS	____	____
4 NO RECORD OF ANY EMPLOYMENT ABOVE THE UNSKILLED LEVEL	____	____
5. LACK OF SUFFICIENT VOCATIONAL TRAINING TO OBTAIN AND HOLD SUITABLE EMPLOYMENT.	____	____
6. COURT-RECOMMENDED VOCATIONAL PROGRAM (INITIAL ONLY).		____
7. INMATE ADMITS VOCATIONAL DEFICIENCY.	____	____
8. PAROLE BOARD-ORDERED VOCATIONAL PROGRAM.		____

B. OVERALL ASSESSMENT (CHECK ONLY ONE CATEGORY):

1. NO VOCATIONAL DEFICIENCY NOTED AT THIS TIME.	____	0	
2. ONE MODERATE PROBLEM NOTED ABOVE.	____	1	
3. TWO OR MORE MODERATE PROBLEMS NOTED ABOVE.	____	5	____
4. ONE OR MORE SERIOUS PROBLEMS NOTED ABOVE.	____	5	

C. CURRENT STATUS (IF THE SCORE FOR SECTION B IS GREATER THAN ZERO, CHECK ONE OF THE ITEMS BELOW. OTHERWISE, ENTER ZERO IN EVALUATION (SECTION D)):

1. COMPLETED ALL RECOMMENDED PROGRAMS.	____	0	
2. PARTICIPATING IN OR ON WAITING LIST FOR PROGRAM, BUT HAS NOT COMPLETED ALL RECOMMENDED ACTIVITIES.	____	1	
3. NEEDS PROGRAM, HAS NOT PARTICIPATED, AND IS AMENABLE TO PROGRAM PARTICIPATION AT THIS TIME.	____	2	____
4. NEEDS PROGRAM, HAS NOT PARTICIPATED, AND IS NOT AMENABLE TO PROGRAM PARTICIPATION AT THIS TIME.	____	3	

D. EVALUATION (SECTION B + SECTION C): ____

COMMENTS:

PARED BY	SIGNATURE	TITLE	DATE

DOC NUMBER	NAME LAST	FIRST	MIDDLE

DOC 21 121 (2 83) OX A 118

OKLAHOMA DEPARTMENT OF CORRECTIONS PROGRAM SUMMARY

INMATE NAME _____ (LAST) _____ (FIRST) _____ (M.I.) INMATE NUMBER _____

REPORT DATE	PROBLEM AREAS							PHYSICAL HEALTH 10		MENTAL HEALTH 20						SUBSTANCE ABUSE 30			ACADEMIC DEFICIENCY 40								VOCATIONAL DEFICIENCY 50	SOCIAL SKILLS DEFICIENCY 80					
	PHYSICAL HEALTH	MENTAL HEALTH	SUBSTANCE ABUSE	ACADEMIC DEFICIENCY	VOCATIONAL DEFICIENCY	SOCIAL SKILLS DEFICIENCY	CODES	IN-PATIENT TREATMENT	OUT-PATIENT TREATMENT	UMHU	EASTERN STATE HOSPITAL	SUPPORT THERAPY	SEX OFFENDER THERAPY	RATIONAL BEHAVIOR TRAINING	STRESS MANAGEMENT	SUBSTANCE ABUSE EDUCATION	CHEMICAL ABUSE PROGRAM	AADD	MENTALLY DISABLED PROGRAM	SPECIAL EDUCATION	ABE	GED	HIGH SCHOOL DIPLOMA	COLLEGE	SPECIAL INTEREST COURSE	STUDY RELEASE	SKILLS TRAINING	STRUCTURED LEISURE TIME PROGRAM	PARENT TRAINING	INTERPERSONAL SKILLS TRAINING	DAILY LIVING SKILLS	WORK RELEASE	RE-ENTRY PROGRAM
M/D/Y							FACILITY	11	12	21	22	23	24	25	26	31	32	33	41	42	43	44	45	46	47	48	51 - 74	81	82	83	84	85	86

PROBLEM AREA SCORE CODE

2 = SERIOUS PROBLEM

1 = MODERATE PROBLEM

0 = NO PROBLEM AT THIS TIME

PROGRAM PARTICIPATION CODES:

8 = PROGRAM IDENTIFIED AND RECOMMENDED

7 = PROGRAM IDENTIFIED BUT NOT AVAILABLE

6 = INMATE NOT PARTICIPATING IN AVAILABLE RECOMMENDED PROGRAM

5 = INMATE PARTICIPATING UNSATISFACTORILY IN RECOMMENDED PROGRAM

4 = INMATE PARTICIPATING SATISFACTORILY IN RECOMMENDED PROGRAM

3 = INMATE NOT ELIGIBLE FOR AVAILABLE PROGRAM

2 = INMATE UNSATISFACTORILY COMPLETED RECOMMENDED PROGRAM

1 = INMATE SATISFACTORILY COMPLETED RECOMMENDED PROGRAM

0 = NOT APPLICABLE

OKLAHOMA DEPARTMENT OF CORRECTIONS
FACILITY PROGRAM MATRIX

		PHYSICAL HEALTH 10		MENTAL HEALTH 20						SUBSTANCE ABUSE 30			ACADEMIC DEFICIENCY 40								VOCATIONAL DEFICIENCY 50		SOCIAL SKILLS DEFICIENCY 80					
		IN-PATIENT TREATMENT	OUT-PATIENT TREATMENT	IMMU	EASTERN STATE HOSPITAL	SUPPORT THERAPY	SEX OFFENDER THERAPY	RATIONAL BEHAVIOR TRAINING		SUBSTANCE ABUSE EDUCATION	CHEMICAL ABUSE PROGRAM	AIDD	MENTALLY DISABLED PROGRAM	SPECIAL EDUCATION	ABE	GED	HIGH SCHOOL DIPLOMA	COLLEGE/TALK BACK TV		STUDY RELEASE/ACADEMIC	STUDY RELEASE/ VOCATIONAL	SKILLS TRAINING	STRUCTURED LEISURE TIME PROGRAM	PARENTING TRAINING	INTERPERSONAL SKILLS TRAINING	DAILY LIVING SKILLS	WORK RELEASE	RE-ENTRY PROGRAM
		11	12	21	22	23	24	25		31	32	33	41	42	43	44	45	46		48	52	53 - 74	81	82	83	84	85	86
MALE																												
MAX	OSP	X	X			X	X	X		X					X	X	X						X		X	X		
MED	OSR		*			X		X		X				X	X	X	X	X				X	X		X	X		
	LCC	X	X			X	X	X		X					X	X	X	X				X	X		X	X		
	JHCC		*	X	X	X	X	X		X					X	X	X	X				X	X		X	X		
	CCC		X			X	X	X		X					X	X	X					X	X		X	X		
	SCC		*			X		X		X					X	X	X	X				X	X		X	X		
MIN	OSPTU		X			X		X		X					X	X	X	X				X	X		X	X		
	OCC		*			X		X		X					X	X	X	X				X	X		X	X		
	MCC		*			X	X	X		X					X	X	X					X	X		X	X		
	JDCC		*			X	X	X		X					X	X	X				X	X	X		X	X	X	X
	JCCC		*			X		X		X					X	X	X					X	X		X	X		
COM	KBCTC					X									X	X				X	X	X	X		X		X	
	HMCTC					X									X	X				X	X	X	X			X	X	
	OKCTC					X														X	X	X	X		X		X	
	MCTC					X						X 1								X	X		X				X	
	McCTC					X					X									X			X				X	
	ECTC											X 2								X	X	X	X				X	
	LCTC																			X	X	X	X				X	
FEMALE																												
MAX	MBCC					X		X		X					X	X	X	X					X	X	X	X		
COM	HMCTC					X									X	X				X	X	X	X			X	X	
	CWCTC					X						X 3			X	X				X	X	X	X		X		X	

50

Exh. 15

OKLAHOMA DEPARTMENT OF CORRECTIONS*
OFFENDER PROGRAMS

Mental Health Programs
Code Series 20

TITLE	DESCRIPTION	ELIGIBILITY CRITERIA
Intermediate Mental Health Code: 21	Provides structured psychiatric care for non-hospitalized inmates with psychiatric illness.	Must be referred by medical/psychological staff and have a DSM III diagnosis of psychotic behavior.
Support Therapy Code: 23	Short-term therapy for inmates showing acute emotional disturbance and intensive long-term therapy for chronic emotional illness. Employs multi-theraputic approach.	Must be referred to and accepted by the psychologist for treatment.
Sex Offender Therapy Code: 24	Evaluation: treatment focusing on issues from a cognitive behavioral standpoint: responsibility for own actions, coping skills, interpersonal relationships, and impulse control.	Must be referred to and accepted by the psychologist for treatment.

OKLAHOMA DEPARTMENT OF CORRECTIONS
OFFENDER PROGRAMS

Social Skills Programs
Code Series 80

TITLE	DESCRIPTION	ELIGIBILITY CRITERIA
Structured Leisure Time Code: 81		
Tournaments	At least 12 intra-facility tournaments are conducted yearly with activities of a sports/leisure time nature, to promote constructive use of free time.	None
Intramurals	Includes leisure time activities requiring moderate to low skill levels for the purpose of including all interested inmates in enjoyable recreational functions.	
Arts and Humanities	Promotes creative expression through a multi-disciplinary approach: theatre, dance, poetry, creative writing, the humanities, painting, sculpturing, macraine.	

OKLAHOMA DEPARTMENT OF CORRECTIONS
OFFENDER PROGRAMS

Social Skills Programs (Continued)
Code Series 80

TITLE	DESCRIPTION	ELIGIBILITY CRITERIA
Parenting Training Code: 82	Essential child care needs, stages of child development, stress, control problem-solving techniques, building a support system for parents.	Must have completed at least one of the following prerequisites. (1) Interpersonal skills. (2) RBT. (3) Substance Abuse Education Program.
Interpersonal Skills Training Code: 83	An intensive 80-hour program to maximize an individual's knowledge and use of interpersonal skills. Uses group format to teach and practice life skills: (1) Attending, (2) Responding, (3) Personalizing (4) Problem Solving, (5) Planning.	(1) Must be within 3 years but not less than 4 months of earliest possible release date. (2) IQ must be 70 or better as determined on revised Beta II. (3) Not actively psychotic. (4) Not neurologically impaired. (5) Not currently enrolled in a substance abuse education or RBT.
Daily Living Skills Code: 84	Teaches consumer education which includes: apartment/home buying or renting, advertising gimmicks, insurance buying, use of credit, good shopping habits, budgeting, income tax preparation, health, education, government and law, and employment education.	(1) Must be within 3 years but not less than 2 months from earliest possible release date.

OKLAHOMA DEPARTMENT OF CORRECTIONS
OFFENDER PROGRAMS

Social Skills Programs (Continued)

TITLE	DESCRIPTION	ELIGIBILITY CRITERIA
Work Release Code: 85	Structured program providing opportunity to work and provide family support while living in a Community Treatment Center.	Community Security and within one year of presumptive parole date. For further instructions regarding release date, see Air Conditioning/Home Appliance (Code: 55).
Re-Entry Code: 86	Intensive 90-day residential program for inmates near release date: prepares inmates to return to the community: includes counseling in areas of substance abuse, employment, religious and family living.	(1) Must be within 120 days but not less than 30 days from projected discharge date. (2) Classified as minimum security (3) Not actively psychotic. (4) Not enrolled in a vocational skills training program

BC-45A
Rev. 8/82

INITIAL CLASSIFICATION SCORE SHEET

Commonwealth Of Pennsylvania
Bureau Of Correction

BC NUMBER	COMMITMENT NAME	INSTITUTION	DATE

Correctional Classification Profile

MEDICAL PROFILE
PULHEST

FACTOR	Medical Needs	Public Risk Needs	Institutional Risk Needs	Mental Health Needs	Educational Needs	Vocational Needs	Work Skills	Drug and Alcohol Needs
Code	M	P	I	MH	E	V	W	D
CCP SCORE	5	5	5	5	5	5	5	5
	4	4	4	4	4	4	4	4
	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1
CODE								

INITIAL PROGRAM LEVEL _____

PUBLIC RISK SCORE

1. Extent of Violence in Current Offense: _____
2. Use of Weapon in Current Offense: _____
3. Escape History: _____
4. Prior Commitments: _____
5. Violence History: _____
6. Detainers: _____
7. Time to Expected Release: _____
8. Community Stability: _____

INSTITUTIONAL RISK SCORE

1. Community Stability: _____
2. Prior Institutional Adjustment: _____
3. Protection Considerations: _____
4. Psychological Stability: _____
5. Adjustment while on Probation/Parole: _____
6. Alcohol/Drug Use: _____

Public Risk Level: Institutional Risk Level: Overall Custody Score:

COMMUNITY SENSITIVITY

Other Considerations:

Notoriety of Crime(s) or Criminal: _____
Sophistication of Crime(s) or Criminal: _____
Gang Affiliation: _____
Separations: _____
Suicidal: _____
Other: _____ _____

Prison Preference Profile:

Privacy	_____	Emotional Feedback	_____
Safety	_____	Social Stimulation	_____
Structure	_____	Activity	_____
Support	_____	Freedom	_____

Need Scores

- = Low o = Average + = High

INITIAL CLASSIFICATION STAFF ACTION

Missouri Department of Corrections & Human Resources
DIVISION OF ADULT INSTITUTIONS

INITIAL CLASSIFICATION ANALYSIS (ICA)

NAME _____ NUMBER _____ DATE _____

FACTOR	CODE	ICA SCORE	JUSTIFICATION	TREATMENT
Medical and Health Care Needs	M	1 2 3 4 5		
Mental Health Care Needs	MH	1 2 3 4 5		
Security/ Public Risk Needs	P	1 2 3 4 5		
Custody/ Institutional Risk Needs	I	1 2 3 4 5		
Educational Needs	E	1 2 3 4 5		
Vocational Training Needs	V	1 2 3 4 5		
Work Skills	W	1 2 3 4 5		
Proximity to Release Residence/Family Ties	F	1 2 3 4 5		

PROTECTIVE CUSTODY _____

INMATE SIGNATURE _____ SCORED: _____
(Name and Title)

DATE REVIEWED _____ ASSIGNED TO _____

DAI - 0001 (1/83)

The Federal Prison System

The initial classification process in the U.S. Bureau of Prisons begins in a field setting. Within a given region of the country, an adult male inmate is initially assigned to an institution that matches his rated security level--Level 1 through 6--which reflects perimeter security and type of housing. Only in rare instances (e.g., medical, psychiatric) would other-than-security considerations play a major role in initial assignment. A comprehensive pre-sentence investigation (PSI) accompanying each offender provides an excellent beginning point for needs assessment.

The major classification assessment and decision-making takes place within a given institution. With some exceptions (e.g., community-based facilities and designated medical units), all federal institutions have a similar cross-section of programs and services available to offenders. Furthermore, within a given security-level institution, accommodation can be made for offenders requiring somewhat different levels or types of internal supervision. Thus, a given institution presumably can meet a wide range of offender needs. These features, in concert with less overcrowding (compared to many states), currently allow the federal system to limit the constant and rapid inmate turnover 60 prevalent in many state correctional systems.

Although field staff can refer an incoming offender directly to institutions offering specialized medical, psychological, or addiction programs, needs assessment occurs routinely at the resident's institution. Principal areas that assessment covers are health, psychological/intellectual, educational/vocational, and internal (unit) management. In the first three areas, standard appraisals are provided by the appropriate professional staff . Typically the assessment includes a full physical and lab work for health, an MMPI, Beta, and WAIS (on referral) for psychological/intellectual, and the Stanford Achievement Test (SAT) for educational status. Other tests and questionnaires are available for more specific assessment or referral issues.

Unit management decisions usually involve options regarding counseling, program activities, and internal supervision. The latter has especially been emphasized in a few selected locations in which more aggressive inmates are separated from more passive, dependent ones. Differential management approaches are also used and levels of violence have reportedly decreased (see Bohn, 1981). An example of this approach is summarized in Chapter VII.

The IPRS. The Federal Prison System has a fairly straightforward, objective approach to risk classification (e.g., security and custody) which has been reviewed elsewhere (Levinson, 1982a; NIC, 1982). Most systematic in the "program needs" area is an elaborate process known as the Inmate Programs Reporting System, or IPRS (Federal Prison System, 1991, revised). The IPRS is linked to a computer-based management information system that includes program recommendations, assignments, actual

enrollments, withdrawals, completions, and other offender information. The system does not record program needs per se, only recommended activities. However, theme recommendations proceed from a,. reasonably comprehensive analysis of the offender. Additionally, medical and psychiatric programs operate somewhat independently of this system. An overview of the IPRS can be gleaned from the forms on the following two pager. As can be seen, a coding system provides ready computer storage and retrieval (Exhibits 19 and 20, pp. 59, 60).

The IPRS manual also includes operational definitions of basic terms, constraints, and offender activities. Within broad treatment categories, e.g., Personal Development (code 67) , additional specification more clearly reflects the actual need and the recommended intervention. These definitions are presented on the following pages (Exhibits 21, 22, 23, and 24, pp. 61-68.

Not readily apparent is the process of determining the actual degree or severity of needs. Since no objective definitions or guidelines are available, consistency of program recommendations may be lacking. The Federal Prison system has seemingly Supported the development of an impressive array of programs and services but has left unstructured the means by which offenders needing these services are identified. Despite this limitation, a high level of program availability helps ensure a reasonable degree of “matching.”

The notion that offenders are “encouraged to participate" in Selected programs may be more than a euphemism in the Federal system. Because of the reliance on a unit management approach, unit staff become familiar with a relatively small number of residents. Additionally, representatives of the major programs, e.g., education, serve on unit teams and assist in the classification process. Such involvement stands in contrast to that in those systems which merely recommend services, on paper, without providing follow-up. That assessment and intervention are so closely linked is a very positive feature.

In sum, the Federal system provides an assessment of needs in several important areas, a rich variety of programs and services generally available on a voluntary basis, an excellent data system, and a unit management approach which seems to provide a knowledgeable basis for program referral. Unit management, decentralized assessment and classification, and program availability distinguish the Federal system from many of its state counterparts.

BUREAU OF PRISONS - PROGRAM PLAN

1. REGISTER NO.	2. NAME (LAST, FIRST, MIDDLE INIT.)	3. EFFECTIVE DATE ENTER MO. DAY, YR.
0 0 0 0 0 1 1 1	D O E J O H N	

4. INSTITUTION NAME

5. INSTITUTION CODE →

6. UNIT

7. ACTIVITIES

44 ADULT CONTINUING EDUCATION (ACE)
45 EXPLORATORY TRAINING (OE))
46 APPRENTICE TRAINING (OE)
47 EDUCATION-(PSE)
48 EDUCATION-SOCIAL
49 EDUCATION-(ABE)
50 EDUCATION-(GED)
51 RECREATION
52 VOCATIONAL TRAINING (OE)
53 ON-THE-JOB TRAINING (OE)
54 INDUSTRY
55 PSYCHOTHERAPY (INDIV)
56 PSYCHOTHERAPY (GROUP)
57 COUNSELING (INDIV)
58 COUNSELING (GROUP)
59 COUNSELING (CORR)
60 HEALTH SERVICES
61 VOLUNTARY GROUPS
62 WORK RELEASE
63 STUDY RELEASE
64 GENERAL MAINTENANCE
65 CTC
66 OTHER
67 PERSONAL DEVELOPMENT

8. CONSTRAINTS

01 CUSTODY REASONS
02 LACK PROGRAM
03 DECLINES PROGRAM
04 PROGRAM FILLED
05 TIME TOO SHORT
06 TEMPORARILY CLOSED
07 UNQUALIFIED
08 OTHER

9.

ACT 1	CNST 1	ACT 2	CNST 2	ACT 3	CNST 3	ACT 4	CNST 4	ACT 5	CNST 5	ACT 6	CNST 6	ACT 7	CNST 7	ACT 8	CNST 8	ACT 9	CNST 9	ACT 10	CNST 10

BP 6.1

(REV 12-78)

Exh. 20
Part 2
Page 12
5300.10
September 15, 1981

BUREAU OF PRISONS

INMATE ACTIVITY REPORT

INSTRUCTIONS

TO USE AS AN ENROLLMENT FORM ——— COMPLETE ITEMS 1-9 ONLY
TO USE AS A COMPLETION FORM ——— COMPLETE ITEMS 1-8 **AND** ITEMS 12 AND 14
TO USE AS A WITHDRAWAL FORM ——— COMPLETE ITEMS 1-8 **AND** ITEMS 12, 14 AND 15

COMPLETE ALL ITEMS IN THIS SECTION.

1. REGISTER NUMBER: 00000 1 1 1

2. INMATE NAME (LAST, FIRST, MIDDLE): DOE JOHN

3. INSTITUTION CODE (EXAMPLE: ATLANTA IS 131, LEAVENWORTH IS 132, ETC.)

4. TYPE OF REPORT 2 - ENROLLMENT 3 - COMPLETION 4 - WITHDRAWAL

5 DATE INMATE ENROLLED (MONTH, DAY, YEAR)

6. ACTIVITY NUMBER

44-ADULT CONTINUING EDUCATION (ACE)
45-EXPLORATORY TRAINING (OE)
46-APPRENTICE TRAINING (OE)
47-EDUCATION-PSE
48-EDUCATION-SOCIAL
49-EDUCATION-ABE
50-EDUCATION-GED
51-RECREATION
52-VOCATIONAL TRAINING (OE)
53-ON-THE-JOB TRAINING (OE)
54-INDUSTRY
55-PSYCHOTHERAPY (INDIV)
56-PSYCHOTHERAPY (GROUP)
57-COUNSELING (INDIV)
58-COUNSELING (GROUP)
59-COUNSELING (CORR.)
60-HEALTH SERVICES
61-VOLUNTARY GROUPS
62-WORK RELEASE
63-STUDY RELEASE
64-GENERAL MAINTENANCE
65-CTC
66-OTHER _____
67-PERSONAL DEVELOPMENT

7. PROGRAM SERVICES UTILIZED

01-EDUCATION
02-CORRECTIONAL SERVICES
03-CASE MANAGEMENT
04-CHAPLAINS
05-MEDICAL
06-PSYCHOLOGY
07-PSYCHIATRIC
08-BUSINESS OFFICE
09-MECHANICAL SERVICES
10-INDUSTRY
11-COMMUNITY VOLUNTEERS
12-FOOD SERVICES
13-OTHER_____

8. COURSE NUMBER

COMPLETE THIS SECTION FOR ENROLLMENTS ONLY

9. PROGRAM OR COURSE TITLE

10 (NOT TO BE USED)

11. (NOT TO BE USED)

COMPLETE THIS SECTION FOR COMPLETIONS OR WITHDRAWALS ONLY.

12. DATE OF COMPLETION OR WITHDRAWAL (MONTH, DAY, YEAR)

13. (NOT TO BE USED)

14. TOTAL INMATE HOURS AND MINUTES INVOLVED — LIST HOURS FIRST

15. IF A WITHDRAWAL, INDICATE REASON

1-RELEASED
2-TRANSFERRED
3-PROGRAM CHANGE
4-INMATE REQUEST
5-PROGRAM DISCONTINUED
6-CONTROL PURPOSES
7-INSTITUTIONAL NEEDS
8-OTHER _____

BP-S 2 REV 12-78)

INMATE PROGRAMS REPORTING SYSTEM GLOSSARY

PROGRAMMING:	That aspect of the classification process in which programs are established by the inmate and unit team, among alternative program activities, to meet each inmate's individual needs.
ACTIVITIES:	The complete range of organized and structured programs and services that can be made available to meet each inmate's specific needs, including available community resources.
CONSTRAINTS:	Those conditions preventing or significantly delaying an enrollment into an activity.
PLANNED AND UNPLANNED ENROLLMENTS:	A planned enrollment is an entry into an activity that has been recorded on the 6.1 Program Sheet. An unplanned enrollment is an entry into an activity not recorded on the 6.1 Program Sheet.

Source: Federal Bureau of Prisons

INMATE PROGRAMS REPORTING SYSTEM

DEFINITIONS

CONSTRAINTS

1.	**CUSTODY REASONS:**	Offender's custody classification prevents being able to participate in an activity which might otherwise be utilized as a program activity.
2.	**LACK PROGRAM:**	An unavailable activity which the unit team identifies as being most appropriate for the inmate's needs; e.g., pyschotherapy when there are no mental health personnel on the staff.
3.	**INMATE DECLINES:**	A suggested activity which the inmate does not want.
4.	**PROGRAM FILLED:**	No space is available in the appropriate activity.
5.	**TIME TOO SHORT:**	Insufficient time remains on the sentence to permit the offender's completion of an activity which would otherwise be appropriate.
6.	**TEMPORARILY, CLOSED:**	An appropriate activity normally available has for some reason been temporarily discontinued. This happens on occasion because of the temporary unavailability of a staff person to conduct the activity.
7.	**UNQUALIFIED:**	Applies when an activity is programmed but the offender does not have appropriate attributes needed to take part in the activity.
8.	**OTHER:**	Should be used for only extremely unusual constraint reasons. "Other" should only be used for those rare situations when none of the above constraint reasons can be applied.

Source: Federal Bureau of Prisons

IPRS DEFINITIONS

NUMBER	ACTIVITY	DEFINITION
44.	ADULT CONTINUING EDUCATION (ACE):	Adult Continuing Education (ACE') is designed to accommodate those individuals who have a desire to expand their educational knowledge. This group will include those individuals who desire to "brush up" in a specific area or enroll in special interest courses. This area also includes those individuals who are taking English as a Second Language. Requirements for entry in any given course will be established by each institution. A BP-6.2 must be filled out on each course enrollment. A student will be judged to have completed an ACE course when he/she has completed the specific course requirements. Course numbers 4401-4499 will be used. These can be either sequential for each individual or assigned to specific courses. The amount of participation is measured in the number of inmate hours expended and the number of courses completed.
45.	EXPLORATORY TRAINING:	Exploratory Training is a program which involves an overview of industries, occupations and work experiences designed to provide a general knowledge of the world of work rather than specific skill development. This training is supplemented as required with related information and instruction.
46.	APPRENTICE TRAINING:	Apprentice Training is a program conducted under the direction of a journeyman who is responsible for instructing the apprentice in all facets of an occupation. Such programs are approved by the Bureau of Apprenticeship and Training at the state and/or national level and involve a minimum of 144 hours per year of related trades instruction.

Source : Federal Bureau of Prisons

NUMBER	ACTIVITY	DEFINITION
47.	POST-SECONDARY EDUCATION:	Post-Secondary Education (PSE) consists of courses designed to serve the individual's educational or vocational aspirations above the high school level, including any and all courses offered or approved for college level credit by community colleges or other institutions of higher learning.
48.	SOCIAL EDUCATION (SE):	Social Education consists of planned learning activities designed to assist students in their adjustment to the institution, their personal growth, and their ability to cope with problems encountered in society upon their release. Learning activities within the social education area are further characterized by the fact that they are not directly related to formal certification goals such as GED, college diploma or skill documentation. Nor are these activities thought of in terms of "academic level." They are designed to develop competence in "life skills" connected with family relationships, household management, locating a job, developing socially acceptable life styles, expressing responsible community citizenship, etc.
49.	ADULT BASIC EDUCATION (ABE):	Adult Basic Education (ABE) is designed to assist those adults whose communication and computation skills constitute difficulties in securing and retaining employment, or in otherwise pursuing satisfying life styles. A student will be judged to have completed the ABE program when a minimum of a sixth grade level as measured by a median score of at least 6.0 on the Intermediate Level SAT has been achieved.
50.	GENERAL EDUCATIONAL DEVELOPMENT (GED):	The General Educational Development program is designed to prepare students to successfully pass the General Education Development examination (GED). A student will be judged to have completed the GED program when each section of the GED examination has been passed at a minimum standard score as required by his state of residence.

NUMBER	ACTIVITY	DEFINITION
51.	RECREATION (LEISURE) ACTIVITIES (LA)	The definition of leisure time activities should be as follows. Leisure time activities include a wide ranqe of activities engaged in during "free time". For reporting purposes, these activities must be scheduled events in which participation is expected and attendance taken.
52.	VOCATIONAL TRAINING: (VT)	Vocational Training is the basic study of a trade or occupation and emphasizes training rather than institutional maintenance and/or productive work. It focuses on the maximum attainment of skill development in areas such as automotive repair, medical technology, computer programming, welding, etc., supplemented with related information.
53.	ON-THE-JOB TRAINING: (OJT)	OJT is planned instruction implemented through actual work in a variety of institutional services. The intent of the program is to develop an institutional maintenance cadre as well as to provide selected residents with a variety and quality of training (a minimum of two hours related instruction per week) which will enhance their chance for employment in trades and occupational positions upon release.
54.	INDUSTRIES:	Industries refers to Federal Prison Industries. Do not submit an IPRS 6.2 form for this activity. This is covered by the IEIS System.
55.	PSYCHOTHERAPY: (INDIVIDUAL)	Psychotherapy consists of formal treatment on a regular basis (a minimum of once a week) by a trained therapist (clinical psychologist, psychiatrist or MSW social worker) to help the inmate to make positive behavioral/emotional changes in himself/herself.
56.	PSYCHOTHERAPY: (GROUP)	Same as above except that the therapy is conducted within and through a group.
57.	COUNSELING: (INDIVIDUAL)	Regularly scheduled individual sessions (a minimum of once a week) with a staff person other than a Correctional Counselor.

NUMBER	ACTIVITY	DEFINITION
58.	COUNSELING (GROUP):	Same as the above but on a group basis.
59.	CORRECTIONAL COUNSELING:	For the purpose of this system, correctional counseling must be formalized. Correctional counseling refers to guidance provided by correctional counselors specifically assigned to provide such contact on a specified time basis (a minimum of once a week). For this activity the counseling may be individual or group. For example, a correctional counselor may be assigned to give an offender special attention for a specific reason, e.g., self-control. In any case, when this type of counseling has been programmed by the treatment team and/or classification committee an enrollment and completion form (BP-6.2) will be completed.
60.	HEALTH SERVICES:	Any medical, surgical or dental service as well as special services such as speech therapy, which directly relates to an attitudinal change and not routine physical hygiene such as filling cavities, etc.
61.	VOLUNTEER GROUPS:	Participation in such activities as Alcoholics Anonymous, Jaycees, Toastmasters, Drama Appreciation, etc.
62:	WORK RELEASE:	Paid employment in such activities as employment in the community requiring return to the institution after working hours.
63.	STUDY RELEASE:	Participation in a formal academic or vocational activity which is provided in the community.
64.	GENERAL MAINTENANCE:	This should be used only when the inmate is placed on a specific general maintenance job to assist him in adjusting to his institutional program. For example, he may be placed in the laundry in order to receive closer supervision as a first- step toward helping him to develop better self-control.

NUMBER	ACTIVITY	DEFINITION
65.	CTC's:	When an individual is programed for a Contract Center based in the community. This activity is entered on the 6.1 and then must be constrained for reason Unqualified (07). It does not require an enrollment (6.2).
66.	OTHER:	Should only be used for rare special activities not falling within the general meaning of the above listed.
67.	PERSONAL DEVELOPMENT:	These activities (or classes) are defined as instructional programs having the goal of obtaining knowledge to gain self-awareness and understanding of attitudes and behaviors. They differ from psychotherapy in that therapy inmates present problems on which they want to work, while in personal development the inmate is not required to participate in any way other than to listen to the presentation (and not disturb others in the class). These activities also differ from the social education class in that the social education relates more to "how to" objectives such as basic life skills of applying for jobs, etc.; Personal Development is related more to personal awareness and understanding (although in some institutions these activities may overlap somewhat in purpose and subject matter.)

PSYCHOLOGY ACTIVITY

COURSE NUMBERS

Standardized course numbers. The following standard course names and numbers should be used whenever appropriate. However, when an activity does not fit within these title descriptions, the institution staff can assign a number if it is not on the following list. The assigned number is 6751-6799, and such action is reported to the Central Office Psychology Administrator.

6701 - Assertiveness Training (AT)

6702 - Consciousness Raising

6703 - Erhart Seminar Training (EST)

6704 - Marriage Enrichment Workshops

6705 - Positive Mental Attitudes (PMA)

6706 - Rational Behavioral Training (RBT)

6707 - Rational Emotive Training (RET)

6708 - (TAI CHI)

6709 - Therapeutic Community

6710 - Transactional Analysis (TA)

6711 - Transcendental Meditation (TM)

6713 - Self-Awareness Seminar

6713 - Self-Image Seminar

6714 - Yoga

The special activity numbers for the Psychologist shall not limit use of others where appropriate.

Source: Federal Bureau of Prisons

I. ASSESSMENT OF SPECIFIC NEEDS: CURRENT PRACTICES AND RESOURCES

A. Health

Description. Physical health, handicapping conditions, medical needs, fitness, activity levels.

Rationale. Identifying and responding to fundamental health and medical needs has been consistently mandated by courts as part of the constitutional obligation of correctional systems. As in any microcosm of society, illness, disease, handicaps, and the like can be expected to occur with some predictable frequency. Moreover, given the social and demographic characteristics of the offender population and the nature of prison environments, certain health problems are likely to be more prevalent and their detection more difficult (Pointer & Kravitz, 1981a). Among deficiencies noted in a survey conducted by the U. S. Comptroller General (1978) were: inadequate diagnostic testing and follow-up; inadequate dental exams; poorly kept records; and a lack of qualified medical staff.

A number of current developments promise to overcome decades of inattention. Standards have been promulgated by public health, medical, and corrections organizations regarding health care in prisons (AMA, 1979, 1981; APHA, 1976; ACA, 1982). In each instance, initial medical screening has been given prominence as a cornerstone of adequate health care services.

Current Practice. This review does not assess the technical details of health screening. A number of sources are readily available to those systems or individuals who wish to compare specific procedures. However, several representative medical screening forms and related materials exemplifying current practice are attached (see Exhibits 25-27, pp. 71-77).

Every state in the present survey rates the determination of health needs as most important. Correspondingly, the necessary structure and comprehensiveness of health assessments--at least from survey reports--appear to have been achieved in most states.

All states report a basic set of assessment procedures: health screening interview, physical exam, chest x-ray, and standard laboratory analyses. Special assessments are instituted upon referral. Interestingly, only four states indicated that they provide dental screening; no doubt, more do. Physicians, nurses, and physician's assistants constitute the principal assessment staff , although para-professionals conduct some health screening. In at least two states, assessment is provided as part of a contract medical system.

Classification directors' estimates of health problems/needs range widely. Some states identify as many as 76% as having some kind of health-related problem. Given the severity categories of

"no problem/mild/moderate/severe," the rounded average estimates are 65%, 20%, 10% and 5%, respectively. For given subgroups, e.g., older inmates, these figures would no doubt show a shift toward a higher prevalence of health problems.

Because of its succinct presentation of the screening process, Michigan's guideline summary on health appraisal is attached (Exhibit 28, p. 78-83). Unlike most states, Michigan has a separate, and somewhat autonomous, Office of Health Care. This agency produces an annual health care utilization report which provides important information on distribution of services to the offender population.

Other examples of health screening may be noted in the additional exhibits. Pennsylvania, for instance, uses the PULHEST system. Within each physical area (Physical Capacity , Upper and Lower Extremeties, Hearing, Eyes, Stability [Mental], and Teeth) a five-tier rating system has been devised. Wisconsin, on the other hand, screens for 19 specific conditions and provides a primary and secondary medical code. Further, like many states, it provides an activity level code which indicates one of six different categories appropriate to the inmate's health status (see Exhibit 8, p. 41). Dental screening codes are also provided (see Exhibit 9, p. 43).

<u>Recommendations.</u> Apparently medical and health care standards are sufficiently well-developed to provide for adequate offender assessment. Barriers remain, however. Failure to provide sufficient and appropriate staff, increased intake, and inadequate work space all contribute to the marginal quality of health appraisals. As the current survey suggests, however, resources are increasingly being directed at such needs assessment. By implication, the entire spectrum of offender medical services deserves, and has begun to receive, the same emphasis.

CORRECTIONS DEPARTMENT
HEALTH SERVICES D. .SION

Exh. 25

INTAKE PHYSICAL EXAM

NAME: _____

ID# _____

MEASUREMENTS

PULSE: _____min.

☐ regular

☐ irregular

BP (rt. arm sitting) _____

TEMP. _____

WT: _____

HT: _____

HAIR COLOR: _____

EYE COLOR: _____

KEY: NORMAL = NL ABNORMAL = ABNL NOT EXAMINED = NE

SYSTEM	NL	ABNL	NE	REMARKS BY APPROPRIATE #
1. General appearance				
2. Head, Face, Scalp				
3. Skin (lesions, identifying marks, etc.)				
4. Eyes (a) pupils				
(b) conjuctiva, sclera, lids				
(c) ocular movements				
(d) fundi (if indicated)				
5. Ears (a) pinnae, canals, drums				
(b) gross hearing				
6. Nose, Mouth & Throat				
7. Neck (ROM, Thyroid)				
8. Lymph Nodes				
9. Breasts				
10. Lungs				
11. Heart(a) PMI				
(b) sounds/murmurs				
12. Abdomen				
13. Liver				
14. Spleen				
15. Groin (nodes, lesions, hernias)				
16. Back (tenderness, ROM, scoliosis)				
17. Peripheral Pulses				
18. Extremities (clubbing, edema)				
19. Joints (deformity, ROM)				
20. Neurologic (a) cranial nerves				
(b) reflexes				
(c) cerebellar (FTN)				
(d) grodd touch				
(e) gait				
(f) oriented				
(g) speech				
21. Recital				
22. ♂ Penis, Testes, Scrotum				
23. ♀ Pelvic, (a) vulva, vagina				
(b) cervix				
(c) uterus, adnexae				

VISUAL ACUITY

R /

L /

BOTH /

PROBLEMS IDENTIFIED BY HX & PX
(If None, Indicate Well)

PLANS: Data Collection & Treatment

Source: New Mexico

CORRECTIONS DEPART[illegible]NT
HEALTH SERVICES
DIVISION
INTAKE HISTORY

NAME: _____ _____
BIRTHDATE: _____ AGE: ____
A.K.A.: _____
ID#: _____

SIGNIFICANT PROBLEMS FROM SCREENING EXAM OR PAST RECORDS:

HOSPITALIZATIONS Physical & Mental	DATES	NAME OF HOSPITAL	REASON OR DIAGNOSIS

EDUCATION: _____ OCCUPATION: _____

SMOKING: ☐ Cigarettes___Packs per day___Years ☐ Cigars ☐ Pipe

TETANUS - Date of Last Immunization: _____

FAMILY HISTORY
(✓) disease and list family member

- ☐ Diabetes
- ☐ Cancer
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Seizures
- ☐ Tuberculosis

REVIEW OF SYSTEMS - Circle Positive Answers & Remark Below By Appropriate Number #

1. Tumor, Cancer
2. Thyroid Trouble or Goiter
3. Diabetes
4. Skin Trouble
5. Weight Loss/Gain
6. Frequent Headaches
7. Stab Wound or Gunshot Wound
8. Recent Head Injury
9. Broken Bones
10. Trouble with Vision
11. Trouble with Hearing
12. Ears, Nose or Throat Problem
13. Dentures
14. Toothaches
15. Gum Problems
16. Shortness of Breath
17. Cough
18. Sputum/Color/Amount
19. Asthma/Emphysema
20. Tuberculosis
21. Rheumatic Fever
22. Heart Murmur
23. High Blood Pressure
24. Chest Pain
25. Heart Attack
26. Skipping or racing Heart
27. Swelling of the Ankles
28. Phlebitis
29. Heart Valve Infection
30. Anemia - Low Blood
31. Bled A Lot After Injury
32. Frequent Heartburn or Indigestion
33. Ulcers
34. Stomach Pains
35. Constipation/Diarrhea
36. Laxative Use
37. Hernia
38. Hepatitis
39. Piles/Hemorrhoids
40. Swollen or Painful Joints
41. Back Pain
42. Foot Trouble
43. Frequent or Burning Urination
44. Kidney Stone or Blood in Urine
45. Kidney or Bladder Infection
46. Syphilis
47. Gonorrhea
48. Seizures
49. Periods of Unconsciousness
50. Bizarre Behavior or Manner
51. Delusuons or Hallucinations
52. Disorientation and/or Confusion
53. Serious Emotional Disturbances (anxiety, depression)
54. Previous Psychiatric OP Treatment

♂
55. Sore on Penis
56. Discharge from Penis
57. Prostate Trouble

♀
58. Lump in Breast
59. Discharge from Nipple
60. Vaginal Discharge
61. Pelvic or Tube Infection
62. Problems with period

Birth Control Used
Pregnancies___ Live Births___Abortions___

CORRECTIONS DEPARTMENT - HEALTH SERVICES DIVISION

Exh. 25-b

Receiving Screen:

DATE TIME

HAVE YOU BEEN HERE BEFORE? ☐ YES ☐ NO

HOW LONG ARE YOU SENTENCED?

NAME: _____

BIRTHDATE: _____ AGE: _____

A.K.A. _____

I.D.# _____

SUBJECTIVE:		NO	YES	COMMENTS For Positive Responses, Describe Details & Number According
1. Have you seen a doctor in the past month?				
2. Have you been hospitalized recently or had an operation?				
3. Have you been injured recently or have an injury now?				
4. Have you been treated for Syphillis? When?				
5. Have you been treated for Gonorrhea (clap)? When?				
6. Do you think you have V.D., Lice or Crabs now?				
7. Do you have:	Asthma/Emphysema			
	Tuberculos			
	Heart Trouble			
	High Blood pressure			
	Diabetes			
	Hepatitis or Jaundice			
	Epilepsy, Fits, Seizures			
8. Have you ever had a Skin Test for TB? When? Results?				
9. Are you allergic to any medications?				
10. Are you taking any medications?				
11. Have you ever been hospitalized for psychiatric reasons?				
12. Are you now under psychiatric care?				
13. Have you tried to commit suicide or hurt yourself?				
14. Do you have any other health problems? Describe				
15. For Women: Date of Last Menstrual Period: _____				

SUBSTANCE USED	NO	YES	HOW MUCH	WHEN LAST USED	LENGTH OF CURRENT USE	WITHDRAWAL COMPLAINTS
Alcohol						
Barbiturates						
Heroin						
Methadone						
Other:						

OBJECTIVE:	NL	ABN	DESCRIBE PERTINENT FINDINGS
Behavior-mood & affect alertness & orientation			
Body deformities			
Skin-trauma, scars, markings, tracks, jaundice, pallor, sweaty			
Gait			

TEMP: _____ oral

PULSE RATE: _____

☐ reg ☐ irreg

BLOOD PRESSURE: /

Rt Arm Sitting

ASSESSMENT AND PLANS:

HOUSING: _____ ACTIVITY: _____

LABORATORY TESTS TO BE DONE: Check appropriate boxes

☐ TB Skin Test ☐ Hematocrit ☐ Urinalysis ☐ Pregnancy Test

☐ Syphillis Serology ☐ SGPT ☐ Gonorrhea Culture ☐ PAP Smear

☐ Others (list)

☐ IMMEDIATE COMPLETE HISTORY & PHYSICAL

State of Ohio
Department of Rehabilitation and Correction
ADMISSION CENTER_____

MEDICAL HISTORY AND PHYSICAL EXAMINATION

Date Rec._____ Date of Exam._____ Soc. Sec._____ Religion_____
Birth: Date_____ Place_____ Age_____ Marital Status_____
FAMILY HISTORY: (/f/father, /m/mother, /sp/spouse, /b/brother, /s/sister, /c/child)
T.B._____ Diabetes_____ Hay Fever_____ Asthma_____ Epilepsy_____
V.D._____ Sickle Cell_____ Jaundice_____ Addiction_____
Cancer_____ Heart Disease_____ Mental Illness_____ Paralysis_____
Other_____
PERSONAL HISTORY: (Answer yes or no/give approximate date of experience)
T.B._____ Diabetes_____ Hay Fever_____ Asthma_____
Epilepsy_____ V.D._____ Sickle Cell_____ Jaundice_____
Addiction_____ Cancer_____
Heart Disease_____ Mental Illness_____ Paralysis_____
Mumps_____ Malaria_____ Whooping Cough_____ Arthritis_____
Drug (Reactions)_____ Chronic Cough_____
Alcoholism_____ Appendicitis_____ Rheumatic Fever_____
Medication Allergies_____ Injuries_____
Amputations_____ High/Low B.P._____
Operations_____
Hospitalizations_____
_____
Hernia_____ Skin Rashes_____ Kidney Trouble_____
Last Chest X-Ray_____ Other_____
PHYSICAL EXAMINATION: Temperature_____ Height_____ Weight_____
Pulse_____ Development_____ Nourishment_____
Posture_____ Gait_____ Blood Pressure_____
Eyes: near R20/_____ L20/_____ corr. to R20/_____ L20/_____
distant R20/_____ L20/_____ corr. to R20/_____ L20/_____
Accommodation:_____
Hearing: R_____
L_____
Gross Dental Defects:_____
CLINICAL: (✓: normal–X: abnormal)
Head and Scalp_____ Face and Neck_____ Nose_____
Sinuses_____ Mouth and Throat_____ Ears (general)_____
Ear Drums_____ Eyes (general)_____ Pupils_____
Ocular motility_____ Lungs and Chest_____
Heart_____ Vascular System_____
Hernia_____ Anus and Rectum_____ Feet_____
Lower extremities_____ Upper extremities_____
Spine, other musculoskeletal_____
Abdomen and Viscera_____ Endocrine system_____
Skin, lymphatics_____
Reflexes_____
Neurologic_____
Identifying body marks, scars_____
tattoos_____

NAME SERIAL NUMBER SEX RACE SUBJECT PAGE

State of Ohio
Department of Rehabilitation and Correction
ADMISSION CENTER_____

Exh. 26-a

LABORATORY: Serology_____ X-ray _____
70MM Urinalysis_____ Sugar_____
14 x 17_____ Albumin_____
Blood Chemistry_____
Clinic referrals_____
_____
Laboratory requests_____
_____
Immunization: Small-pox–date_____ Tuberculin--date _____
Tuberculin reading_____
Diptheria-Tetanus Toxoid–date_____ date _____
Polio vaccine–date_____ date_____ date _____
Boosters_____ Sickle Cell_____ date _____
Other vaccine _____
Blood type_____ Blood count _____
Additional laboratory indicated:_____
_____

FEMALE (additional information)
Breasts _____
Uterus _____
Cervix _____
Have you been pregnant:_____ Had a vaginal discharge:_____
Number of Past Pregnancies_____ Problems, if any:_____
Deliveries: Normal_____ Premature _____ Abortions_____ Miscarriages_____
Are you or have been recently on any type of birth control_____
Are you currently pregnant_____ Expected date of delivery_____
Treated for a female disorder:_____
Had a painful menstruation:_____
Had irregular menstruation:_____
Age at onset of menstruation:_____ Interval between periods:_____
Duration:_____ Date of last period: _____
Quantity: normal_____ excessive _____ scanty_____ other_____
Pelvic:_____ Vaginal smear:_____

Institutional Medical Status (Male and Female):_____Unlimited,_____Limited
If Limited: ___ Allergy or Astluma,_____Back Syndrome,_____Deafness,___ Geriatric/Age,
___ Hernia,_____Obesity,_____Vision,_____Epileptic,_____Diabetic
___ Other physical disability, specify_____
___ Other non physical disability, specify_____
___ Other prior injury_____

Other Notes and Summary:_____
_____
_____
_____
_____
_____
_____

_____ _____
Signature of Medical Examiner Signature of Approving Physician

NAME SERIAL NUMBER SEX RACE SUBJECT PAGE

STATE OF NEW YORK – DEPARTMENT OF CORRECTIONAL SERVICES Exh. 27

MEDICAL HISTORY

ADMISSION ☐ PAROLE VIOL. ☐
PRE-PAROLE ☐ OTHER (Specify) ☐

INMATE NO.	NAME	SHORT NAME	FACILITY NO.

BIRTH DATE	BIRTH PLACE	SEX	RACE	RELIGION
		MALE ☐ FEMALE ☐	BLACK ☐ HISPANIC ☐ WHITE ☐ OTHER ☐	

FAMILY HISTORY		AGE(S)	HEALTH STATUS – CAUSE OF DEATH SIGNIFICANT HEREDITARY DISEASES
FATHER	ALIVE ☐ DEAD ☐		
MOTHER	ALIVE ☐ DEAD ☐		
SIBLINGS TOTAL NO.	NO. LIVING ___ NO. DEAD ___		

PAST HISTORY

ILLNESSES, INJURIES, SURGERY, HOSPITALIZATIONS, MENTAL ILLNESS – DATES & DETAILS BELOW:

	YES	NO	DATE		YES	NO	DATE
EPILEPSY	☐	☐		GONORRHEA	☐	☐	
DIABETES	☐	☐		SYPHILLIS	☐	☐	
HYPERTENSION	☐	☐		MEASLES	☐	☐	
TUBERCULOSIS	☐	☐		MUMPS	☐	☐	
HEPATITUS	☐	☐		CHICKENPOX	☐	☐	
MENTAL	☐	☐		OTHER (LIST)	☐	☐	
'HMA	☐	☐					

IMMUNIZATIONS

	YES	NO	DATE
POLIO	☐	☐	
TETANUS	☐	☐	
DIPHTHERIA	☐	☐	
SMALLPOX	☐	☐	
OTHER (LIST)	☐	☐	

ALLERGIES

	YES	NO
PENICILLIN	☐	☐
OTHER (LIST)	☐	☐

DRUGS AND NARCOTICS PRIOR TO ADMISSION

	YES	NO	NEVER	DATE STOPPED	AMOUNT PER DAY
TOBACCO	☐	☐	☐		
ALCOHOL	☐	☐	☐		
NARCOTICS (LIST)	☐	☐	☐		

SERVICE IN ARMED FORCES

	YES	NO		YES	NO
MILITARY SERVICE	☐	☐	MEDICAL DISCHARGE	☐	☐
MEDICAL DEFERMENT	☐	☐	OTHER (SPECIFY)	☐	☐

PRESENT SYMPTOMS

CURRENT MEDICATIONS OR TREATMENTS
LIST DRUGS AND DOSAGES

PREVIOUS HEALTH RECORDS (NAME, ADDRESS)

NEAREST RELATIVE (RELATIONSHIP, NAME, ADDRESS)

SIGNATURE _____ DATE _____

STATE OF NEW YORK–DEPARTMENT OF CORRECTIONAL SERVICES Exh. 27-a

PHYSICAL EXAMINATION

ADMISSION ☐ PAROLE VIOL. ☐
PRE-PAROLE ☐ OTHER (Specify) ☐

INMATE NO.	NAME	SHORT NAME	FACILITY NO.

PULSE	TEMP.	WT. UNCLOTHED	HT. NO SHOES	SITTING B.P.	RESP.	DATE PERIODIC PHYSICAL DUE (TWO YEAR INTERVAL)

VISION	UNCORRECTED	CORRECTED
RIGHT	/	/
LEFT	/	/

COLOR TEST NORMAL ☐ ABNORMAL ☐ TEST USED

HEARING		
RIGHT	NORMAL ☐	ABNORMAL ☐
LEFT	NORMAL ☐	ABNORMAL ☐
HEARING AID	YES ☐	NO ☐

NORMAL ☑ ABNORMAL ☒ Leave blank if not examined

SKIN	☐	9. THROAT	☐	17. GENITALIA	☐	25. URINE	☐
GAIT	☐	10. MOUTH	☐	18. SPINE	☐	26. HCT	☐
SPEECH	☐	11. NECK	☐	19. RECTUM	☐	27. SEROLOGY	☐
SCALP	☐	12. CHEST	☐	20. PELVIC	☐	28. CHEST X-RAY	☐
EYES	☐	13. BREASTS	☐	21. NEUROLOGICAL	☐	29. LIVER FUNCTION	☐
FUNDI	☐	14. LUNGS	☐	22. EXTREMITIES	☐	30. SMA-12	☐
NOSE	☐	15. HEART	☐	23. LYMPH NODES	☐	31. E.K.G.	☐
EARS	☐	16. ABDOMEN	☐	24. MUSCULO-SKELETAL	☐	32. SICKLE CELL	☐
						33. G.C. CULTURE	☐
						34. PAP SMEAR	☐

LABORATORY TESTS (Check if ordered)

ABNORMAL FINDINGS (Refer to Number)

BEHAVIORAL ASSESSMENT

WORK CLASSIFICATION

No limitation ☐ Limitation ☐ (Describe)

SIGNATURE _____ DATE _____

MICHIGAN DEPT. OF CORRECTIONS	EFFECTIVE DATE	NUMBER
PROCEDURE	4-1-81	OP-SM1-64.11
	APPLICATION: SPSM-R&GC	SUPERSEDES: NO. OP-SM1-64.11
		DATED: 6/1/79
SUBJECT: INITIAL HEALTH APPRAISAL		PAGE 1 OF 6
	BUREAU/INSTITUTION NUMBER	SUPERSEDES: NO.

PURPOSE: To establish guidelines for health screening and documentation of new incoming residents and other appropriate returnees during the Reception and Guidance process.

INFORMATION: The Initial Health Appraisal is designed to comply with accepted standards of health care to protect the health and well-being of the individual and the correctional community and to establish base line health data for use in subsequent care and treatment; to provide data for appropriate classification and program planning.

All new incoming residents, correction center violators or appropriate returnees shall receive, prior to transfer, the following:

1. An initial screening at point of intake for urgent psychiatric and medical needs. It will include a visual inspection for signs of trauma, recent surgery, abscesses, open wounds, drug tracks, jaundice, pediculosis and communicable disease. Diphtheria and tetanus #1 and tuberculin skin test will be given where not contraindicated.

2. Self-administered health questionnaire with assistance available for questions.

3. Urine and blood analysis including syphilis screening.

4. Chest X-ray.

5. Dental screening.

6. Eye screening.

7. Hands-on physical examination with vital signs and description of all positive findings.

DOCUMENT TYPE	EFFECTIVE DATE	NUMBER	PAGE 2 OF 6
PROCEDURE	4-1-81	OP-SM1-64.11	
		BUREAU/INST. NUMBER	SUPERSEDES NO. OP-SM1-64.11 Dated 6/1/79

INFORMATION: (Cont'd)

8. Written summary of the above data with identification of problems, immediate plans, treatment, special needs, medical and work status.

Upon completion of any phase of the health screening, the responsible person will initial the appropriate documents and the control sheet indicating that the tests have been completed.

If a resident must be transferred prior to the completion of examination, it will be to a quarantine unit. Health care services (Clinic/Infirmary) will be notified of lock changes to insure rescheduling of the health screening.

Medical Sick call will be conducted in R&GC on a regularly scheduled basis twice a week. Dental sick call will be once a week on a regularly scheduled basis.

NOTE: Inquiries may be addressed to R&GC screening area.

Every effort shall be made to insure that all residents receive a complete health screening prior to transfer.

FORMS USED:

Intake Screening Form.
Immunology and TB Testing Record.
Laboratory Request Form.
Urinalysis Request and Report Form.
Initial Encounter Radiology, CRO-142A.
Outpatient Dental Record, CRO-134.
Optometric Vision Screening, CRO-144.
Initial Medical History.
Initial Physical Examination Assessment Plan.
Serology Reaction for Syphilis, F-1.
Health Screening Control Sheet.
Health Evaluation Request for Resident Transfer and Clearance CRO-150.

PROCEDURE:

WHO	DOES WHAT
R&GC Receiving Staff: (Bubble)	1. Refer all obvious or documented acute medical or psychiatric patients to the Infirmary for treatment.

DOCUMENT TYPE	EFFECTIVE DATE	NUMBER	PAGE 3 OF 6
PROCEDURE	4-1-81	OP-SH1-64.11	
		BUREAU/INST. NUMBER	SUPERSEDES NO.
			OP-SM1-64.11 Dated 6/1/79

WHO		DOES WHAT
Infirmary Medical Staff:	2.	Returns the resident to R&GC upon completion of evaluation and/or treatment to be scheduled for initial encounter health appraisal.
R&GC Staff Receiving (Bubble):	3.	Issues Quell shampoo and showers all new commitments, parole or correction center violators.
	4.	Visually observes all residents for health factors as noted on initial Intake Screening Form and completes the Intake Screening Form.
R&GC Block Nurse:	5.	Administers first diphtheria/tetanus shots and records them on Immunology and TB Testing Record.
	6.	Inquires of the resident if he has had a history of positive TB Skin Test or a history of treatment for TB.
	NOTE:	Residents with a previous history of a positive TB Skin Test or has a history of a diagnosis of TB and/or treatment for TB will *not* be administered the TB Skin Test. All other residents will be administered the TB Skin Test.
	7.	Administers the TB Skin Test and records it on the Immunology and TB Testing Record.
	NOTE:	All TB Skin Tests are to be read by the Medical Staff 48 to 72 hours after inoculation.
R&GC Desk Officer:	8.	Schedules residents for next available clinic no sooner than 48 hours and preferably no later than 72 hours after commitment, all new commits, parole or correction center violators for initial health screening. No more than forty residents will be scheduled for any one clinic.
R&GC Block Nurse:	9.	Assists the resident in completing the Initial Medical History Form.
	10.	Forwards all accumulated health records to the Top-6 Charge Nurse.

DOCUMENT TYPE	EFFECTIVE DATE	NUMBER	PAGE 4 OF 6
PROCEDURE	4-1-81	OP-SM1-64.11	
		BUREAU/INST. NUMBER	SUPERSEDES NO. OP-SM1-64.11 Dated 6/1/79

WHO		DOES WHAT
Top-6 Charge Nurse:	11.	Initiates laboratory requests for the following morning's processing, then forwards all accumulated health records to the Health Record Clerk for initiation of resident health record.
6-Block Officer:	12.	Assembles and escorts residents scheduled for initial health screening at 8:00 a.m. to the Top-6 Medical Waiting Room and performs other escort duties as necessary.
Top-6 Officer:	13.	Calls the residents out of the waiting room, one at a time.
	14.	Directs the resident to designated successive stations (TB Skin Testing Interpretation, Dip-Stick Urine Test, X-ray, Laboratory, Optometry, Dental and Medical Records clearance respectively). Each resident will carry his own processing papers and deliver them to the officer upon completion of screening for delivery to Health Records Clerk.
Medical Staff:	15.	Performs the appropriate examination and documentation, prepares indicated referrals, and upon completion directs the resident to the next station.
Health Records Clerk:	16.	Checks the Control Sheet and documents to verify that the resident has completed processing.
R&GC Officer:	17.	Directs the resident to the waiting room.
	18.	Returns the resident to R&GC upon completion of the health screening process.
X-ray and Laboratory Staff:	19.	Process X-rays and laboratory specimens per laboratory procedures for transfer by courier to designated facilities for examination and interpretation. Results are to be returned to R&GC Health Records for checking prior to scheduling for hands-on physical examination.
R&GC Staff:	20.	Schedules the residents who have completed initial medical testing for hands-on physical examination within seven to ten days.

DOCUMENT TYPE	EFFECTIVE DATE	NUMBER	PAGE 5 OF 6
PROCEDURE	4-1-81	OP-SM1-64.11	
		BUREAU/INST. NUMBER	SUPERSEDES NO. OP-SM1-64.11 Dated 6/1/79

WHO		DOES WHAT
R&GC Officer:	21.	Escorts the residents to Top-6 Medical Waiting Room at 12:30 p.m. daily.
Health Records Clerk:	22.	Pulls the records of all scheduled residents for health screening. Checks the record and control sheet to insure all documents are present and past testing completed.
	23.	Delivers the health record to the Charge Nurse.
Charge Nurse:	24.	Obtains and records patient's pulse and blood pressure and reviews patient's record prior to seeing the doctor or physician's assistant.
	25.	Escorts the resident with his records to the physician.
Physician OR Physician's Assistant:	26.	Completes and documents the hands-on physical examination and evaluates the patient for medical clearance.
	27.	Completes Referral Forms, where indicated, and notes the need to reschedule the resident for examination, treatment or follow-up.
	28.	Orders medical hold as necessary pending treatment and medical clearance to ensure that residents on medical holds will be retained at SPSM pending medical clearance.
	29.	Requests resident to return to block and delivers health record to Supervising Physician or Physician's Assistant.
Supervising Physician OR Physician's Assistant:	30.	Evaluates the resident with respect to medical hold and clearances and performs or initiates follow-up care.
Charge Nurse:	31.	Forwards all referrals to the proper medical department.
Health Records Staff:	32.	Screens the records to insure that all procedures are complete and documented and verifies that the patient has been medically cleared.

DOCUMENT TYPE	EFFECTIVE DATE	NUMBER	PAGE 6 OF 6
PROCEDURE	4-1-81	OP-SM1-64.11	
		BUREAU/INST. NUMBER	SUPERSEDES NO. OP-SM1-64.11 Dated 6/1/79

WHO	DOES WHAT
Health Records Staff: (Cont'd)	33. Forwards a medical clearance list to R&GC Classification.
	34. Follows Health Records Initiation Procedures OHC-HR-01 through 06.

AUTHORITY: PD-DWA-11.09, Office of Health Care

APPROVED:

Kenneth L. Cole, D.O., Medical Director (Date)

3-31-81

Barry Mintzes, Ph.D., Warden (Date)

HGS/mas

B. Psychological Health

Description. behavioral, cognitive, emotional, and/or interpersonal characteristics or patterns that influence adjustment and psychological well-being in either institutional or community settings.

Rationale. Courts, corrections officials, civil rights activists, and informed citizens recognize the presence of and the difficulties associated with psychologically impaired individuals' being housed within the prison system. Moreover, a psychological relationship to many forms of criminal behavior has long been postulated--albeit to varying degrees and, frequently, in non-specific terms. Whether from a protection/management perspective or a treatment orientation, individuals with psychological needs constitute a sizable demand for resources.

Courts have been particularly insistent on procedures for the adequate identification of and response to such "special needs" offenders. The size of this group is apparently growing as social policies, such as stringent civil commitment procedures, guilty-but-mentally-ill statutes, etc. are instituted. It has also been suggested that certain prison practices, especially when exacerbated through pronounced overcrowding, might themselves increase psychological dysfunction (Clements, 1979).

Current Practice. The field of mental health is far from coherent. The application of mental health concepts and professional practice within corrections is no less poorly standardized. In most instances matters of definition, control, responsibility, and purpose have been inadequately resolved.

States recognizing degrees of dysfunction identify as many as 50% of the offender population as being psychologically impaired. Others, focusing only on severe disorders estimate less than 3 offenders per 1,000 as dysfunctional. Still others have not reached a working definition of mental health needs. These disparate views reflect idiosyncratic approaches to the definition of psychological functioning and mental health. This diversity ranges from a very narrow reliance on psychiatric diagnosis, e.g., Diagnostic and Statistical Manual (DSM III) of the American Psychiatric Association, to a broad-based behavioral/adjustment orientation. Assessment practices and subsequent allocation of treatment resources are obviously influenced by such basic assumptions. Narrow definitions require the commitment of fewer resources. As noted, typically only the most serious, acutely disturbed offenders receive attention (U.S. Comptroller General, 1979).

Several states employ a two-level screening process in which all offenders are evaluated through brief testing or interview. A portion of those, generally 25-40%, receives further individualized assessment, frequently conducted by a mental health professional. By states' reports, psychologists (master's or doctoral

level) are the predominant professional group engaged in these assessments, though paraprofessional s may conduct preliminary screenings. Psychiatrists are involved in a minority of jurisdictions and then only if hospitalization or inpatient care is contemplated.

For general psychological assessment purposes, the most frequently used tools are interviews and histories of widely varying quality, and the Minnesota Multiphasic Personality Inventory (MMPI). Beyond these basics, some states use additional testing, occasionally including projective tests or such scales am the Sixteen Personality Factor Scale (l6 PF).

Most of the assessment procedures reported result in clinical, somewhat subjective ratings of psychological status. Behavioral observations and assessments, potentially valuable sources of predictive data, are rarely conducted in any systematic way. Despite theme limitations, some states have devised a met of status categories which seem to reflect the range of psychological problems existing in correctional settings, for example, “no needs,” "out-patient, supportive care," "intermediate, protective environment,” and "inpatient, hospital care." The reliable and valid classification of offenders into theme (or similar) categories is more critical than the particular assessment technique used.

Some states, either by statute or policy, also identify certain sub-groups for whom psychologically oriented treatment must be provided. Theme determinations often relate more to criminal history and overt past behavior than to mental health evaluations. Examples include sex offenders, those considered "dangerous" or deficient in impulse control, drug abusers, and the like. Treatment is offered to these groups to influence their behavior upon their return to the community.

Recommendations. Despite the wide diversity of approaches in this assessment area, the fundamental question remains: Are individuals' psychological needs being adequately identified and met?.

A continuum of needs levels should be designated in the psychological and mental health realm. At the “severe” end of the spectrum (which, in some states, appears to be the only category requiring intervention), identification and programming should recognize offenders who require acute, immediate care, aftercare and reintegration, and/or chronic maintenance care. Too of ten, only acute care--frequently medication-bared--is provided. Moreover, there need not be a conflict between a "patient management” orientation and that of providing treatment to various clinical or problem-oriented sub-groups (e.g., sex offenders) . A minimally adequate system of assessment and intervention should embrace more than acute psychological crises.

Correctional mental health professionals have found useful the latest version of the DSM III (APA, 198O, especially in the

diagnosis of serious psychological impairment or dysfunctions. Using well-defined terms, the DSM III provides decision trees and cardinal symptoms which aid in differential diagnosis. Additionally, some states have found helpful DSM III's conceptualization of adaptive functioning levels which include social relations, occupational functioning, and use of leisure time.

Psychological testing am a vehicle for mental health assessment is a vast enterprise. While few studies documenting the applicability of various instruments to corrections exist, a rich literature addresses the basic reliability and validity of many well-known psychological tests. Of theme, the MMPI appears to hold the greatest promise for overall psychological assessment. Indeed, established prisoner norms and specific interpretive systems al low for comparisons of offender sub-groups, either for differential diagnosis and treatment (Fowler, 1979; see Exhibit 29, pp. 87-94, f Or sample report) or for internal management and supervision (Bohn, 1981; see Chapter VII).

Other tests available for psychological /mental health screening are numerous, but most have neither the broad base of research support nor have they been systematically applied to correctional populations. However, a few bear investigation. Theme include the recent Millon Clinical Multiaxial Inventory, the Psychological Screening Inventory, the Hoffer-Osmond Diagnostic (HOD) Test, and the Cornell Index. Each of these meets one or more of several criteria: development in the context of an existing mental health taxonomy; brief screening instrument with useful output categories; or ability to differentiate seriously disordered clients.

Beyond screening, a wealth of instruments can provide information regarding more specific components of psychological concern, e.g., depression, suicidal thoughts, and anxiety (see Appendix A-l). As treatment planning is developed for offenders, theme and related instruments may be used to gain a clearer picture of the individual. Such instruments show greater potential for answering referral or dispositional questions than for routine screening. Though few states noted it, we are aware from other sources that suicide potential is also frequently assessed. Since this area has such important implications, it is recommended that specific screening (and periodic reassessment) be provided.

PSYCHOLCGICAL ASSESSMENT SERVICE

MMPI REPORT

NUMBER: AGENCY:
AGE: 31 MALE JUNE 16, 1982

THE TEST RESULTS OF THIS PERSON APPEAR TO BE VALID. HE SEEMS TO HAVE MADE AN EFFORT TO ANSWER THE ITEMS TRUTHFULLY AND TO FOLLOW THE INSTRUCTIONS ACCURATELY. TO SCME EXTENT, THIS MAY BE REGARDED AS A FAVORABLE PROGNOSTIC SIGN SINCE IT INDICATES THAT HE IS CAPABLE OF FOLLOWING INSTRUCTIONS AND ABLE TO RESPOND RELEVANTLY AND TRUTHFULLY TO PERSONAL INQUIRY.

THIS PERSON TENDS TO BE ACTIVE AND IMPULSIVE. HE SEEKS EXCITEMENT AND AROUSAL AND IS CHARACTERIZED BY HIGH ENERGY LEVEL. HE MAY EXPEND GREAT EFFORT TO ACCOMPLISH HIS OWN DESIRES, BUT HE FINDS IT DIFFICULT TO STICK TO DUTIES IMPOSED BY OTHERS. HE MAY BE SOCIABLE AND OUTGOING, BUT HIS POOR JUDGMENT AND LACK OF CONSIDERATION TEND TO ALIENATE OTHERS. POOR WORK ADJUSTMENT AND EXCESSIVE DRINKING ARE LIKELY. AMONG ADOLESCENTS AND VARIOUS LOW SOCIOECONOMIC GROUPS, THIS PATTERN OCCURS FAIRLY FREQUENTLY AND MAY HAVE LESS SERIOUS IMPLICATIONS. HOWEVER, SOME IMPULSIVENESS MAY BE ANTICIPATED. THIS IS A PATTERN WHICH OCCURS QUITE FREQUENTLY AMONG PEOPLE WHOSE IMPULSIVENESS AND LACK OF INTERNALIZED RESTRAINTS CAUSE THEM TO COME INTO CONFLICT WITH THE LAW. CONTROLS WHICH ARE FIRM AND WELL DEFINED, ESPECIALLY WHEN ACCOMPANIED BY IMMEDIATE RECOGNITION AND REWARD OF APPROPRIATE BEHAVIOR, CAN BE HIGHLY EFFECTIVE IN BUILDING THE ABILITY TO ASSUME RESPONSIBILITY AND TO TOLERATE DELAY OF GRATIFICATION. HE NEEDS HELP IN DEVELOPING SOCIAL AND VOCATIONAL COMPETENCY.

HE UTILIZES REPRESSION AND DENIAL IN RESPONSE TO EMOTIONAL PROBLEMS. HE MAY RESPOND TO SUGGESTION AND REASSURANCE, BUT HE PROBABLY WILL RESIST A PSYCHOLOGICAL EXPLANATION OF HIS DIFFICULTIES. IN PERIODS OF PROLONGED EMOTIONAL STRESS SUCH AS LEGAL PROCEEDINGS OR INITIAL INCARCERATION, HE MAY DEVELOP ANXIETY ATTACKS AND FUNCTIONAL COMPLAINTS.

THERE ARE SOME UNUSUAL QUALITIES IN THIS PERSON'S THINKING WHICH MAY REPRESENT AN ORIGINAL OR INVENTIVE ORIENTATION OR PERHAPS SOME SCHIZOID TENDENCIES. FURTHER INFORMATION WOULD BE REQUIRED TO MAKE THIS DETERMINATION.

NOTE: THE MMPI CAN BE USED AS AN OBJECTIVE AID IN PLANNING REHABILITATION AND CUSTODY PROGRAMS. HOWEVER, IT SHOULD NOT BE USED AS THE SOLE BASIS FOR DECISIONS, AND RECOMMENDATIONS BASED ON THE TEST INFORMATION SHOULD BE SUPPORTED BY OTHER INDICES. THIS REPORT SHOULD BE REGARDED AS CONFIDENTIAL, AND ONLY PERSONS WITH APPROPRIATE PROFESSIONAL QUALIFICATIONS SHOULD HAVE ACCESS TO IT.

Source: Psychological Assessment Service

SCALE SCORES FOR MMPI

NUMBER: AGENCY:
AGE: 31 MALE JUNE 16, 1982

SCALE	?	L	F	K	HS	D	HY	PD	MF	PA	PT	SC	MA	SI
RAW	0	2	7	17	13	21	27	33	32	12	27	30	28	31
K-C					13			33			27	30	28	
T-C	OK	44	60	59	54	60	69	83	73	62	58	65	78	56

SCALE	A	R	ES	LB	CA	DY	DO	RE	PR	ST	CN	AT	SO-R	MT
RAW	11	23	46	12	10	21	19	16	15	25	31	18	29	11
T-C	49	65	53	61	51	52	62	40	56	67	65	57	36	58

SCALE	SCC	DEP	FEM	MOR	REL	AUT	PSY	ORG	FAM	MOS	PHO	HYP	HEA
RAW	10	7	14	5	4	15	16	5	5	6	8	17	5
T-C	53	50	64	44	42	64	64	49	56	43	56	62	50

WELSH CODE: *4 95'3862-701/:=

CRITICAL ITEMS (EXTENDED LIST)

THESE MMPI TEST ITEMS, WHICH WERE ANSWERED IN THE DIRECTION INDICATED, MAY REQUIRE FURTHER INVESTIGATION BY THE CLINICIAN. THE CLINICIAN IS CAUTIONED, HOWEVER, AGAINST OVERINTERPRETATION OF ISOLATED RESPONSES.

347 I HAVE NO ENEMIES WHO REALLY WISH TO HARM ME. (FALSE)

33 I HAVE HAD VERY PECULIAR AND STRANGE EXPERIENCES. (TRUE)

302 I HAVE NEVER BEEN IN TROUBLE BECAUSE OF MY SEX BEHAVIOR. (FALSE)
133 I HAVE NEVER INDULGED IN ANY UNUSUAL SEX PRACTICES. (FALSE)

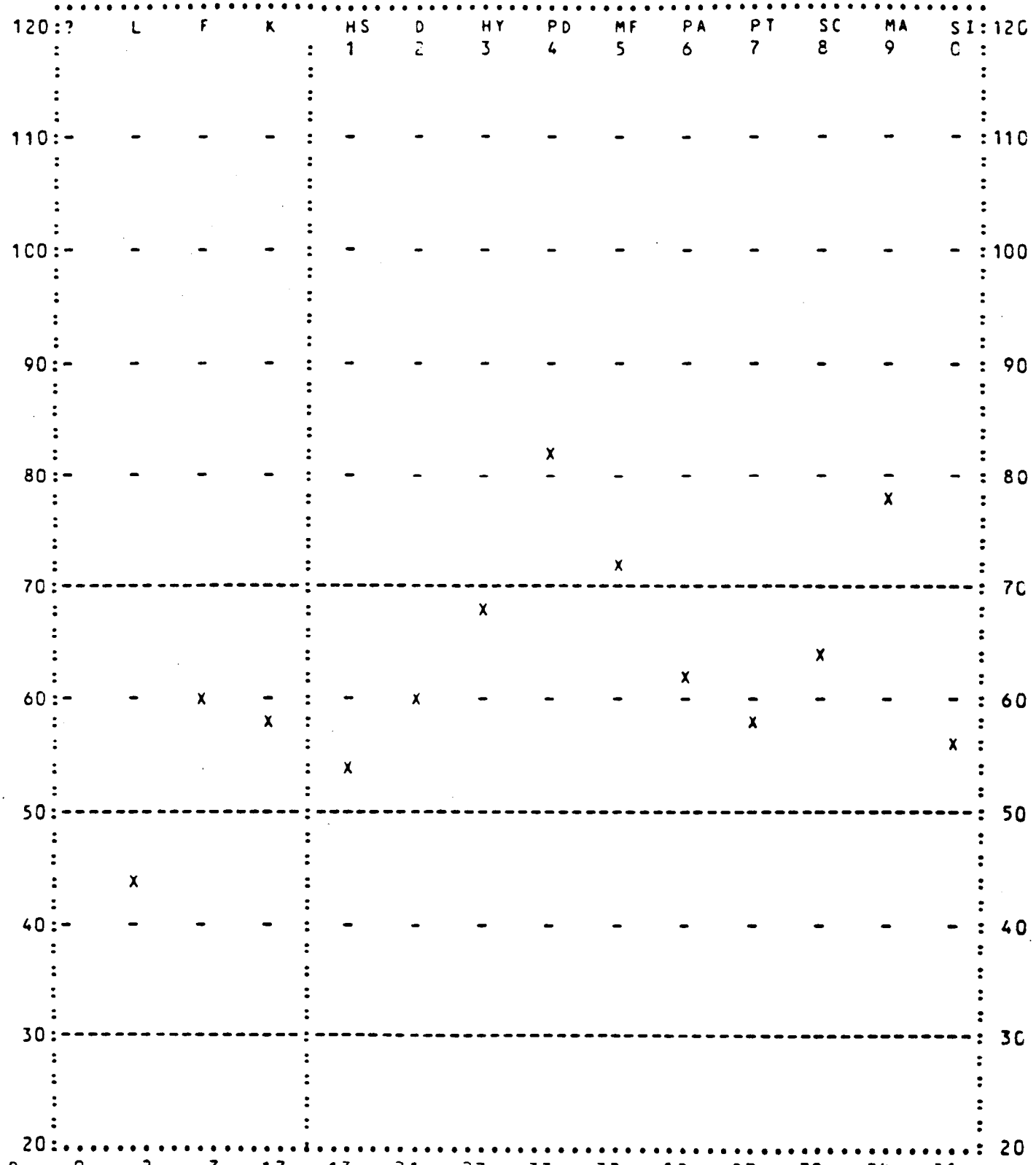
156 I HAVE HAD PERIODS IN WHICH I CARRIED ON ACTIVITIES WITHOUT KNOWING LATER WHAT I HAD BEEN DOING. (TRUE)
215 I HAVE USED ALCOHOL EXCESSIVELY. (TRUE)

152 MOST NIGHTS I GO TO SLEEP WITHOUT THOUGHTS OR IDEAS BOTHERING ME. (FALSE)

Exh. 29-b

NUMBER: MMPI PROFILE AGENCY:

AGE: 31 MALE JUNE 16, 19F



R	0	2	7	17	13	21	27	33	32	12	27	30	28	31
K-C					13			33			27	30	28	
T-C	OK	44	60	59	54	60	69	83	73	62	58	65	78	56

CONTENT SCALES

THE FOLLOWING STATEMENTS ARE BASED UPON AN ANALYSIS OF THE CONTENT OF THE SUBJECT'S RESPONSES TO THE MMPI ITEMS. THE CONTENT SCALES MAY BE REGARDED AS A MEASURE OF HOW THE SUBJECT VIEWS HIMSELF OR WISHES TO PRESENT HIMSELF IN THESE AREAS, AND THUS MAY DIFFER FROM THE DESCRIPTIONS FOUND IN THE NARRATIVE REPORT OR FROM THE CLINICAL IMPRESSION.

ABOVE EACH STATEMENT IS AN INDICATION OF WHETHER THE SUBJECT'S PROFESSED TENDENCY TOWARD THE CHARACTERISTICS DESCRIBED IS HIGH, (T SCORE 70 OR HIGHER), MODERATE, (60-69), OR LOW (40 OR LOWER). SCALE SCORES BETWEEN 40 AND 60 ARE NOTED AS AVERAGE.

1.	DEPRESSION (DEP)	AVERAGE	T= 50
2.	POOR MORALE (MOR)	AVERAGE	T= 44
3.	PSYCHOTICISM (PSY)	MODERATE	T= 64

HE ADMITS TO SOME SYMPTOMS WHICH ARE CHARACTERISTIC OF PSYCHOTIC THINKING. HE MAY HAVE FEELINGS OF UNREALITY, DELUSIONARY THOUGHT, AND STRANGE AND PUZZLING EXPERIENCES SUCH AS SEEING AND HEARING THINGS THAT OTHERS DO NOT.

4.	PHOBIAS (PHO)	AVERAGE	T= 56
5.	ORGANIC SYMPTOMS (ORG)	AVERAGE	T= 49
6.	AUTHORITY CONFLICT (AUT)	MODERATE	T= 64

HE IS CYNICAL AND DISTRUSTFUL OF PEOPLE IN AUTHORITY. HE SEES OTHER PEOPLE AS HYPOCRITICAL AND MOTIVATED PRIMARILY BY PERSONAL GAIN, EVEN IF UNFAIRLY OBTAINED. HE EXPECTS OTHERS TO TRY TO GET THE BEST OF HIM AND FEELS JUSTIFIED IN TRYING TO PROTECT HIMSELF BY WHATEVER MEANS ARE AVAILABLE.

7.	MANIFEST HOSTILITY (HOS)	AVERAGE	T= 43
8.	FAMILY PROBLEMS (FAM)	AVERAGE	T= 56
9.	HYPOMANIA (HYP)	MODERATE	T= 62

HE IS AN ENERGETIC ENTHUSIASTIC PERSON WITH BROAD INTERESTS AND A TENDENCY TO BECOME INVOLVED IN A VARIETY OF ACTIVITIES. HE IS RESTLESS, ENJOYS CHANGE, AND HAS LITTLE TOLERANCE FOR MONOTONY. HE MAKES UP HIS MIND FAST, CHANGES IT FREQUENTLY, GENERALLY MAINTAINS A HIGH LEVEL OF ACTIVITY, SOMETIMES TO THE POINT OF EXHAUSTION.

10.	SOCIAL MALADJUSTMENT (SOC)	AVERAGE	T= 53

ADDICTION PRONENESS MODERATE RAW SCORE= 25 T= 65

THIS PERSON HAS A BORDERLINE SCORE ON ADDICTION PRONENESS. ALCOHOLICS AND DRUG ABUSERS USUALLY HAVE HIGHER SCORES ON THIS SCALE.

MMPI SUMMARY DATA

NUMBER: AGENCY:
AGE: 31 MALE JUNE 16, 1982

SCALE	?	L	F	K	HS	D	HY	PD	MF	PA	PT	SC	MA	SI
RAW	0	2	7	17	13	21	27	33	32	12	27	30	28	31
K-C					13			33			27	30	28	
T-C	OK	44	60	59	54	60	69	83	73	62	58	65	78	56

SCALE	A	R	ES	LB	CA	DY	DO	RE	PR	ST	CN	AT	SO-R	MT
RAW	11	23	46	12	10	21	19	16	15	25	31	18	29	11
T-C	49	65	53	61	51	52	62	40	56	67	65	57	36	58

SCALE	SCC	DEP	FEM	MOR	REL	AUT	PSY	ORG	FAM	HOS	PHO	HYP	HEA
RAW	10	7	14	5	4	15	16	5	5	6	8	17	5
T-C	53	50	64	44	42	64	64	49	56	43	56	62	50

SCALE	AP	HC	HX	PV	EC	I	II	III	IV	V	VI	VII	VIII	IX
RAW	16	38	13	11	18	9	9	21	8	12	2	3	9	2
T-C	72	70	65	61	67	47	52	66	77	0	40	50	59	54

SCALE	O-H	ED	AM
RAW	20	8	25
T-C	74	65	65

INDICES: AI = 56 IR = .748 FT = 1.248 GI = 44 MFI = 27

WELSH CODE: *4 95'3862-701/:=

ANSWERS	10	20	30	40	50
1	FTTFF FFTTF	FFTFF FTTTT	FFFFF TFFFT	FFTFF TTTFT	FFFFT TFFFF
51	TFFTT FTFTT	TFTFT FFTFT	TFTFT FFTFF	FFTTF FFTTT	FFTFF TFFFF
101	FTTFT FTFFF	FTTFF TTTFT	FTFTF TTFFT	FFFTT FFFFT	FFTFF FFFFT
151	FFTTF TTFFF	FFTTT FTFTF	TFTFT FTTFF	TFFFF FTTFT	TTTFT TFFTF
201	FFFTF FTFFF	FFFFT FTFFT	TFFTT FFTTF	FTTFF FTTTF	FFTTF FFFFT
251	FTTFF FTTFF	FFFTF FFTTF	FTFTF TTTFT	FFFFT FTFFT	FFFFF TFFTF
301	FFTTT FFFTT	TTFFF TTTTF	TTTFF FTFFT	FFFFF FFTFT	FFFFF FFTFF
351	FTTFF FFFFF	FTFFF FTFFF	TTTFF FTFTT	TFTTF TFFTT	FFFTF FFFFT
401	TFTTT FFTTT	FFFFT FFTFT	FFTFF TFFTT	FTTFF TTTFT	TTTFT FFFFF
451	FFFTF TFFFT	FFFTT FFFFF	FFTTF FTFTF	FTFFF TFTTF	FFFFT TTTTT
501	FTFTF FFTFF	TFFFT FFFFT	TTTTT FFFFF	FFTTF FFFTT	FFFFF TFFFF
551	FFFTF TFFFF	FFTFF F			

CODE: 147 200 204 491 504 512 521 524 528 530 533 547 550 552
556 561 564 568 573 576 580 585 588 634 637 640 642 645 649
653 699

PSYCHOLOGICAL ASSESSMENT SERVICE

OFFENDER PROFILE AND RECOMMENDATIONS

NUMBER: AGENCY:
AGE: 31 MALE JUNE 16, 1982

TYPE IV (GROUP ABLE)

THIS INDIVIDUAL IS CLASSIFIED AS TYPE IV ON THE BASIS OF HIS MMPI. THE FOLLOWING REPORT DESCRIBES BEHAVIOR AND EXPERIENCES WHICH ARE TYPICAL OF TYPE IV INMATES. IT SHOULD BE KEPT IN MIND THAT THIS IS A GENERAL PICTURE AND NOT ALL TYPE IV CHARACTERISTICS WILL APPLY TO EVERY GROUP MEMBER.

SUMMARY

PSYCHOLOGICAL DESCRIPTION

.... CLEVER, OPPORTUNISTIC, DARING, AND SELF-ASSURED.

.... HIGH IN SOCIABILITY AND DOMINANCE.

.... OUTGOING, FORCEFUL, BUT NOT EXCESSIVELY AGGRESSIVE.

.... LACK THE PATIENCE TO ACHIEVE CONSTRUCTIVE GOALS OR TO RESIST IMPULSES.

.... WILL NOT SEEK FIGHTS BUT WILL RETALIATE AGGRESSIVELY IF ATTACKED.

TREATMENT AND MANAGEMENT CONSIDERATIONS

.... HIGH IN SELF-ACCEPTANCE; LITTLE DESIRE TO CHANGE.

.... MAY HAVE NEGATIVE EFFECT ON EASILY INFLUENCED INMATES.

.... DIFFICULT TO WORK WITH IN A COMMUNITY SETTING OR LOOSELY STRUCTURED SITUATION.

.... NEED DEFINITE STRUCTURE AND GUIDELINES.

.... MAY PROFIT FROM A DIRECT, CONFRONTIVE TREATMENT APPROACH.

.... CHANGES MADE IN TREATMENT ARE LIKELY TO BE SUPERFICIAL AND SHORT-LIVED AFTER RELEASE.

INTELLIGENCE AND ACHIEVEMENT

.... INTELLIGENCE:

.... READING LEVEL IS EQUIVALENT TO GRADE MONTH.

.... SPELLING LEVEL IS EQUIVALENT TO GRADE MONTH.

.... ARITHMETIC LEVEL IS EQUIVALENT TO GRADE MONTH.

PSYCHOLOGICAL ASSESSMENT SERVICE

OFFENDER PROFILE AND RECOMMENDATIONS

EXTENDED REPORT

Type IV [Group Able)

Inmates in this group tend to be clever, opportunistic, daring, and amoral people who risk taking illegal shortcuts to gratify their wants as soon as possible. They are significantly higher than other prison groups in sociability and social presence. They tend to be charming, popular, and manipulative. They have the ability to form good interpersonal relations with few conflicts, and are consistently evaluated as being one of the better adjusted groups in prison. They are active, forceful, and self-assured with a strong drive for dominance, coupled with imagination and smooth, persuasive verbal skills. Unfortunately, they lack the patience and achievement motivation necessary to achieve their goals through conventional means, as well as the social values and internal constraints that might inhibit their impulsive pleasure seeking. They give the impression of being a happy-go-lucky group, and, indeed, they seem to have less anxiety than any other prison groups. Over all, they are average in their history of violence and in their use of drugs. They are relatively high in the use of marijuana, but below average in the *use* of LSD. Although below average in their adjustment to prior incarcerations, they are quite optimistic about their ability to adjust to the present incarceration. They arc one of the more outgoing, dominant groups. They are not excessively aggressive, but they do little to avoid hostile interactions. Their aggressive encounters seem to be primarily' of a reactive type. They will not seek out fights, but they retaliate aggressively to attacks by others. They have generally good relations with authorities and are seen as friendly and adaptable.

Unfortunately, the men in this group *are* high in self-acceptance. They are charming, popular, and manipulative. Having little desire to change, they probably feel that the best way to cope with prison is to manipulate the staff and the parole board. They may appear contrite, but there are no signs of sincere remorse or guilt, and any changes they make arc apt to be superficial and short-lived once they are released. Given their social skills, the men in this group probably are frequently successful in their attempts to subvert the system and will be reluctant to abandon this habit.

Treatment and Management

Members of this group, being sociable, manipulative, and persuasive, will be difficult to work with without *some* external control over their coming *and* going. They would probably be difficult to treat in a community *or* loosely structured situation. It could be that incarceration for relatively short periods would get their attention and induce them to at least consider

consider alternative ways of gratifying their needs. Being interpersonally dominant and ascendant, these men influence other inmates within an institution. This relative strength could be used in a positive direction in considering the needs of the more disturbed groups. In dealing with relatively well adjusted but easily influenced groups, it could be that members of this group would have a negative influence.

Men in this group would not respond positively or be helped by warm, supportive, insight-oriented approach. They are not particularly interested in insight, and they tend to manipulate relationships for their own purposes. They may profit more from a direct confrontive approach which challenges them. They are not reluctant to get involved in stressful interpersonal interactions, and dealing in those terms would enable them to use some of the skills they have already mastered. Clear cut and definite structure and guidelines to any program would be required to place some boundaries on the extent of this group's manipulation. Staff members assigned to work with these individuals should be self-assured and comfortable in their own roles and personalities , with a good sense of humor, so that they do not over-react to situations in which manipulation is successful.

The men in this group can relate well in group settings, and it would not be surprising to see the men in this group emerge as leaders and pacesetters of a group. An approach with its own language, procedure, and stages, such as transactional analysis, would seem particularly appealing as an approach ***for*** this group.

The goal for this group is to get the men to live within values that they have been taught but which they have thus far elected to ignore or go around. If the men in this group could channel their interpersonal energy and talent into constructive legitimate activities, there is good indication that they could be leaders.

C. Alcohol/Drug Abuse

Description. The extent, nature, and patterns of alcohol consumption or drug use related to general functioning and crime pattern.

Rationale. Drug and alcohol abuse problems among inmates, and especially newly incarcerated inmates, is prevalent. A U.S. Department of Justice survey (Bureau of Justice Statistics, 1983a) indicates that one-third of all inmates reported that they were intoxicated at the time they committed their crimes; 25 percent had been drinking heavily for a full year prior to arrest. Drug abuse among offenders prior to incarceration is similarly high (Bureau of Justice Statistics, 1983b). The present survey found an even more ominous perception: classification directors reported to us that half to 95 percent of inmates have at least some problem with alcohol and drug abuse. Its relative rank of sixth in importance of assessment is surprising in light of the apparent extent of the problem. Perhaps this failure to recognize the problem explains the absence of systematic drug and alcohol treatment programs in most correctional settings.

Current Practice. The assessment of alcohol and drug abuse problems among inmates is undertaken largely in the absence of any meaningful criteria. Frequently used terms such am “no use,” “occasional use,” “moderate use,” and “severe use” have less utility than "abstinent," "social drinker," '*problem drinker," or "alcoholic" in accurately describing levels of alcoholism (or drug addiction). The latter have more common usage and are likely to have more direct prescriptive implications. In any event, terms should be anchored to specific behavioral criteria or other valid indicators so that consistent and meaningful descriptors will result. For example, Wisconsin has developed a set of criteria to describe three levels of drug abuse (see Exhibit 30, pp. 98-101).

By contrast, several states categorize drug abuse problems in an all-or-none fashion, e.g., as “no problem” or "addict." Such a dichotomy provides almost nothing in the way of treatment implications. A few states use levels descriptions such as: “no use,” "occasional use," "minor abuse problem,” “moderate abuse problem," or "addicted" and proceed to specify the drug (or drugs) involved. Such classification procedures seem far more useful .

In addition, assessment of this area is undertaken largely without the use of valid, reliable instruments. By far the most common assessment vehicle is reported to be an "interview" or "self-report history," taken either by drug and alcohol counselors, medical personnel, social workers, or psychologists. The breadth and depth of the interviews vary considerably from unstructured, broad questions about past drinking or drug abuse to more detailed, structured interviews. The latter hold some promise. However, the reliability and validity of these proce-

dures is clearly uncertain. Content-oriented interviews necessarily allow the client to distort, so collateral information from family or other agents seems desirable. Unfortunately, comprehensive pre-sentence investigations done at the community level are not regularly available to prison staff. Thus, a potentially valuable source of information regarding patterns of alcohol and drug abuse is lost.

A few states do report the use of standardized tests for alcohol assessment. The Michigan Alcoholism Screening Test (MAST), the Mortimer-Filkins Test, and the MacAndrew scale of the MMPI are all in use, albeit rarely. None of the states reported using standardized tests for assessing drug abuse. A few states assess substance abuse through other psychological tests, such as the Psychological Screening Test (PST); however, the appropriateness of such use is questionable. Finally, two states have developed their own substance abuse questionnaires; at this point, no information on the reliability or validity of the instruments is available (see Exhibits 31 and 32, pp. 102-110).

Recommendations. The generally poor quality of assessment in theme areas need not be the came, especially with regard to alcohol abuse. Several brief, easily administered instruments provide valid, reliable information (see Appendix B). For example, when the MMPI is routinely administered to new inmates, the scoring of 49 additional items on the MacAndrew scale taker only seconds and provides one of the most reliable measures available. The lack of face validity of the items is an added positive feature, protecting against deliberate distortion by an inmate.

In addition to the MMPI, the clinician has several options from which to choose; the decision basically involves time and personnel available. The Michigan Alcoholism Screening Test (MAST) is a sound instrument with considerable research support! however, it requires a structured, individual interview of up to 30 minutes. On the other hand, the Alcadd Test is a quick group test, but it is high in face validity and thus subject to possible distortion. This trade-off between convenience and acceptable degrees of reliability and validity is characteristic of the area. In general, the greater the face validity of an assessment instrument, the more uncertain the interpretation. Either denial or deliberate distortion (to gain special treatment) could motivate an individual to manipulate the diagnostic impression.

Instruments for assessing drug dependency are less readily available. The Drug and Alcohol Use Evaluation Scale (DUES/AUES) provides behavioral indices of maladjustment useful for assessing treatment outcome. DUES scores can range from 0 to 16; however, cut-off scores need to be developed to facilitate the screening and referral process.

Other community-based information (like that obtained from the DUES) should be systematically sought and evaluated. Information from family, friends, employers, etc. can provide an accurate and comprehensive picture of the offender ‘s alcohol and drug use. When this information is obtainable, it may lessen the need for other diagnostic procedures.

A general listing and brief description of these tests may be found in Appendix A-2. Because of the importance of assessing alcohol and drug abuse, and the apparent lack of familiarity with the available instruments, a detailed description of these instruments, including the development, advantages, disadvantages, reliability, and validity is provided in Appendix B.

Levels of Drug Abuse

DRUG ABUSE:

INTRODUCTION: This guide defines three (3) levels of drug usage: No Significant Problems; Moderate Problems; Serious Problems. These levels represent a continuum of drug usage from none to serious drug abuse. While the final rating recommendation is subjective, definitional guidelines are presented in each of the three Levels to be utilized by staff as key areas to be assessed and benchmarks to be considered in determining which level the inmate's drug usage history should be rated.

The assessment of drug usage level should be done following an interview(s) with an inmate, review of field and any other community information, and if possible contact with the agent.

DRUG USAGE LEVELS

RATING: No Significant Problem

DEFINITION:

Does not use drugs. Occasional use of marijuana, prescription drugs, etc., which has not negatively affected one or more major life areas (work/school, health, leisure activity, family, social relationships, financial, and/or legal).

ASSESSMENT FACTORS:

Motivation for Drug Use --	When does the inmate get "high," under what circumstances is the inmate likely to use drugs, and what drugs - infrequent use of drugs, situational use only, social/ peer pressure situations, etc.
Pattern of Drug Use --	Look for patterns of movement from experimentation with marijuana to other *'harder" drugs (LSD, speed, downers, cocaine, T's and blues, heroin) -- look for increase in involvement with street scene/drug subculture.
Educational-	Has stable school history; completed high school and received diploma; etc.
Work History --	Assess how individual supported himself/herself; has successfully held a job; has stable work history; etc.
Physical Appearance -	Males: look for longer hair, jewelry, pierced ears.
Leisure Time -	The inmate has leisure time interests and overall uses leisure time constructively.

Source: Wisconsin

social -- Assess inmate's family and social relationships - are they stable and/or positive; his/her drug usage has not had a negative impact on these.

Legal - Although illegal drug use obviously poses risks, the inmate has not had legal problems due to his/her use of drugs.

Health - Generally in good health with no problems caused by drug usage.

RATING: Moderate Problem

DEFINITION:

More Frequent use of Drugs that, has negatively affected one or more major life areas.

And/or

Heavy use of marijuana; short-term experimentation with harder drugs or occasional use of speed, downers, acid, cocaine; or use of combination of alcohol and harder drugs.

ASSESSMENT FACTORS:

Motivation for Drug Use - When does the inmate get "high," under what circumstances is the inmate likely to use drugs, and what drugs - more frequent use of drugs possibly including the use of harder drugs as a coping mechanism when under stress or as an escape from reality; increased usage not only in social situations but also a pattern of use when alone and an increasing frequency of the need to get "high." Perhaps the inmate has made a decision(s) not to use certain drugs, i.e., he/she decides can't handle acid, cocaine is too expensive, etc.

Pattern of Drug Use - Increased involvement in the street scene/drug subculture; more frequent and/or heavier use of drugs or combination of drugs and alcohol.

Educational- History of adjustment/achievement problems in school; school dropout (perhaps has subsequently gotten GED).

Work History - Drug usage has begun to interfere with ability to successfully maintain employment -- frequent tardiness and/or sick leave, poor job performance, occasionally goes to work "high."

Physical Appearance - Males: look for longer hair, jewelry, pierced ears that suggest drug subculture involvement.

Leisure Time - Has difficulty with management of leisure time; few recreational interests; has difficulty with boredom.

social - Drug usage has caused problems with relationships with family or friends -- family disapproval of friends; parents are critical of life style; friends have been arrested for possession and/or selling drugs.

Legal - The inmate may have had some contact with the legal system related to his/her drug usage (possession), resulting possibly In misdemeanor and/or felony convictions with probation and/or short county-jail sentences.

Health - Possibly some health problems related to drug usage but not physically dependent on drugs.

RATING: Serious Problems

DEFINITION:

Heavy use of drugs that has significantly negatively affected and/or disrupted several or more major life areas.

And/or

Heavy use of harder drugs with psychological end/or physical dependency.

ASSESSMENT FACTORS:

Motivation for Drug Use - When does the inmate get "high," under what circumstances is the inmate likely to use drugs, and what drugs -- inmate needs or wants to get "high" frequently; possibly psychologically and/or physically dependent on drugs.

Pattern of Drug Usage - Heavily involved in the street scene/drug subculture; frequent and/or heavy use of drugs possibly including heroin, T's and blues, and/or cocaine or combination of drugs and alcohol; possibly has overdosed on drugs one or more times: possibly involved in drug treatment which could include detox and/or methadone/nallene.

Educational- History of adjustment/achievement problems in school; school dropout.

Work History - Little or no evidence of legitimate job(s)/work history; questionable how inmate supported himself/herself; unable to maintain employment due to drug use related problem (poor job performance, excessive tardiness/sick leave, theft from employer, etc.)

Physical Appearance Males : look for longer hair, jewelry, pierced ears that suggest drug subculture involvement.

Leisure Time -- Few or no legitimate recreational/leisure time interests; leisure time use centers around drug-related activity or use.

Social -- Drug usage has caused problems with family/social relationships - poor or severed relationships with family; all or most friends are heavily involved in the use of drugs.

Legal - The inmate may have an offense history directly related to drugs, i.e., robbing a pharmacy, selling drugs, fraudulent prescriptions, etc., that could include convict fen of a felony and incarceration. May have property offense history related to drug usage (to obtain money for drugs).

Health - Possibly serious health problems related to drug usage - physically dependent, hepatitis, etc.

Other - "Fried brain syndrome" (rather slurred speech, slow in responding, sluggish body movements).

"Slick, manipulative con" (ingratiating generalizations to gain approval; uses lots of words but no substance and/or few or no specifics; of ten history of repeated property offenses - shoplifting, forgery, etc.)

COMMENTS :

As indicated previously, the preceding drug use ratings represent a continuum of drug usage. The assessment factors listed are intended as guidelines, key areas, and reference points to be assessed but are not intended to be either all inclusive or absolutely binding, i.e., an inmate meeting only one assessment factor description in a rating area should not automatically be rated in that area.

Rather, an assessment should be made considering the various key areas (the absence or presence of problems in the various areas, the degree of severity of those problems, and their inter-relationship).

Those offenders considered to have a serious or moderate level of need and who received treatment, based on programs provided by DOC or in the community during previous episodes of supervision, or had treatment provided in the community prior to their criminal activity, should have this treatment experience considered when assessing need level. If the person has been drug free or uses prescription drugs responsibly since this treatment for less than two years, (s)he should be rated one level lower than (s)he would have been prior to treatment . If the offender has been drug free or uses prescription drugs responsibly for over two years, the need level should be rated low.

CASEWORKER _____

The planning team needs to look at your past use of alcohol and drugs. We do this for three reasons:

___ One is to get accurate information on how widely alcohol and drugs were used by inmates when they were on the streets.
___ Another is to see if your chemical use makes you eligible for training or DVR funding.
___ Thirdly, you may need counseling or treatment.

You will need to make some important decisions about what you will do with your time here. It is important that you start planning for yourself from the very outset. Your answers to these questions will not add or substract any time from your sentence. They will contribute an important piece to your planning effort.

Answer Yes or No or fill in the blank.

If something doesn't apply to you, you can skip it.

You may write in whatever you wish to explain your response.

If you do not understand a question, say so or ask the counselor to clarify it for you.

	YES	NO
1. Have you used alcohol or drugs in the past?.....	___	___
If yes, mark yes behind the tings you have used, even if you just experimented with it:		
Alcohol, such as beer, wine, or hard liquor?.....	___	___
Marijuana, hashish?.....	___	___
Stimulants (uppers)?.....	___	___
Barbituates (downers)?.....	___	___
Cocaine?.....	___	___
PCP (Angel Dust)?.....	___	___
Heroin, morphine?.....	___	___
Inhalants, such as sniffing glue or paint thinner?.....	___	___
Hallucinogens, LSD, acid?.....	___	___
Other _____?.....	___	___

2. Which of the above do you find yourself using most?

1st choice _____

2nd choice _____

Source: Minnesota

Is there something else you use a lot of? _____

	YES	NO
3. Do you mix alcohol and drugs (i.e., use more than one thing at the same time?.....	___	___

If yes, what do you mix? _____

What percent of time do you mix (write in the %) _____%

4. What age did you first start using alcohol? _____

What age did you first start using drugs, including marijuana? _____

5. It is important to know if you have a recent problem with alcohol or drugs. By recent we mean the last 12 month period before you were put in jail. Write down what the 12 month period of time was before you were locked up. (For example, put down from July, 1981 to July, 1982)

From: _____ to _____ (this should be a 12 month period of time).

6. In the time period that you just wrote down, how often were you using to the point of getting intoxicated (drunk) or high? (For example, how many times per week or month).

Number of times _____ per week, or

Number of times _____ per month.

How far back in your life did this pattern of use go? _____
What age

Date of Birth _____ Today's Date _____

7. In your last year on the streets, what is the largest amount of alcohol you used, how long did it take to drink it? (For example, 12 beers in 3 hours). Largest amount of alcohol was:

_____ _____ and it took _____ hours
how much what kinds in how long

In your last year on the streets what is the largest amount of drugs you used and how long did it take to use it? (For example, 3 joints of pot in 1 hour). Largest amount of drugs was:

_____ _____ _____
how much what kinds in how long

Others? _____ _____ _____
how much what kinds in how long

8. In your last year on the streets, what is the longest period of time that you ever stayed high or drunk continuously? (For example, number of hours, days, or weeks) _____

YES NO

9. In your last year on the streets, what is the longest period of time that you went without getting drunk or high? _____

10. When you drink ***or*** use drugs, do you do it to get drunk or high? ___ ___

Ever use enough to pass out (become unconscious)?..... ___ ___

When you use, do you have trouble stopping before you get drunk or high?..... ___ ___

Some people can use moderately for awhile, but then they start getting drunk or high all the time. Did this happen to you?... ___ ___

When do you usually use? (Circle one or more answers or write in your own).

As soon as I wake up All day Evenings **Weekends**

Other _____

11. Do you think you have ever built up a significant tolerance to alcohol or drugs? (Tolerance means it takes more and more to get the same effect)..... ___ ___

If yes, did you have a tolerance to alcohol?..... ___ ___

Did you have a tolerance to drugs?..... ___ ___

If yes, what drugs? _____

If you did not have a tolerance to alcohol or drugs, then tell us this: Did you find that you were using alcohol or drugs regularly, but that you were getting a lot less high than you used to?..... ___ ___

If yes, what were you using? _____

12. Have you ever experienced withdrawal symptoms after you have stopped using for a time? (Withdrawal can be seen in dramatic physical or emotional changes in your system)..... ___ ___

Have you noticed physical symptoms? Circle all that apply:

The shakes Memory loss Hallucinations Other _____

Have you noticed emotional symptoms? Circle all that apply:

Crying jags Loneliness Depression Irritability

Paranoid Suicidal feelings Other _____

	YES	NO
The following questions have to do with problems that you may have had because of alcohol or drug use.		
1. Problems with the law associated with your use: Were you using before, during, or immediately after the offense that caused you to come here?.....	___	___
If yes, were you using (circle one) Before? During? Immediately after?		
What percent of the time have you been using when you get into trouble with the law? _____ %		
Did you ever commit offenses to get money to continue your use?	___	___
Do you drive?.....	___	___
If yes, do you drink or use drugs and then drive?.....	___	___
Have you ever been caught for this?.....	___	___
2. Problems with family associate with your use:		
Because of your use, have you had arguments with your parents?	___	___
Ever get into physical fights with your parents?.....	___	___
Ever get into physical fights with your brothers or sisters?..	___	___
Because of your use, have you had arguments with a girlfriend?	___	___
Because of your use, have you broken up with a girlfriend (or has she broken up with you)?.....	___	___
Are you married?.....	___	___
If yes, have you had trouble in your marriage because of your use?.....	___	___
3. Money problems associate with your use: How much per week were you spending on alcohol and drugs? $_____per week		
Was spending this much money on it a problem for you?.....	___	___
If not, was it because you had plenty of money?.....	___	___
4. Problems at work associated with your use:		
Ever use just before going to work?.....	___	___
Ever use during work?.....	___	___

	YES	NO
4. Problems at work associated with your use - continued:		
Ever come to work with a hangover?.....	___	___
Were you less effective on the job because of your use before or during work?.....	___	___
Ever show up late at work because of your use?.....	___	___
Ever not show up at work because of your use?.....	___	___
Ever have trouble with people on the job, such as other workers or supervisor because of your use?.....	___	___
Ever fired for something directly or indirectly related ot your use?.....	___	___
Did you ever quit a job because you would rather use?.....	___	___
Were there periods of time when you were <u>unemployed</u> that you didn't bother to look for work because you would rather use?....	___	___
5. Problems in school associated with your use:		
Did you skip out of school because of your use?.....	___	___
Did you come to school late because of your use?.....	___	___
Did you get poor grades because of your use?.....	___	___
Because of your use, did you have trouble with (circle one):		
Teachers? Counselors? Principal? Students?		
None of these?		
6. Physical problems associated with your use:		
I want you to understand what a blackout is if you don't already know. It is <u>not</u> the same as passing out. Rather it is a memory loss. For instance, you can't remember what happened last night when you were using. In the last year that you were on the streets have you had any blackouts?.....	___	___
If yes, how many? _____		
Does using cause you problems with eating?.....	___	___
Does using cause you problems with sleeping?.....	___	___

YES NO

If you have been using heavily for awhile and then stop using for 3 days or more, how does your body feel (Check all that apply):

___ feel good

___ feel tired

___ feel ornery

___ feel shaky

___ feel sweaty

___ feel a craving for alcohol or drugs

___ other _____

Ever had the dry heaves from drinking or using too much?..... ___ ___

Ever overdose?..... ___ ___

If yes, how many times? _____

Ever have any physical problems associated with your use, such as (check all that apply):

___ stomach trouble

___ ulcers

___ liver trouble

___ headaches

Does your behavior change when you are using?..... ___ ___

If yes, how does your behavior change? (Check those that apply)

___ I become more sociable __ Other _____

___ I get into arguments

___ I get into fights

___ I get into trouble with the law

___ I get lazy

___ I get depressed

___ I drive crazy

___ I have become dangerous to myself

___ I have become dangerous to others

YES NO

The last questions have to do with treatment.

1. Have you ever been in treatment?..... ___ ___

   If yes, where did you have treatment, how long were you there, how long was the program supposed to be, and did you complete it?

Where	How long did you stay?	How long was the program supposed to be?	Did you complete it?

YES NO

2. If you have been in treatment, do you feel a need for further treatment?..... ___ ___

   If you have never been in treatment, do you feel a need for it?..... ___ ___

3. If treatment is required by DVR in order to get financial services, would you agree to complete it?..... ___ ___

   If financial services are not at issue, would you agree to complete treatment?..... ___ ___

4. Are you alcoholic?..... ___ ___

   Are you chemically dependent?..... ___ ___

   If yes, on what drugs? _____

5. What are your goals as far as continuing to use alcohol or drugs in the future? (Check those that apply)

   ___ I haven't decided whether or not to quit using.

   ___ I want to quit using, but don't know if I can.

   ___ I want to quit using alcohol all together.

   ___ I want to quit using drugs all together.

   ___ I want to use in moderation. (This means never getting drunk or high but instead only having about a drink an hour)

   ___ I want to continue using pot occasionally.

   ___ Other _____

CHEMICAL DEPENDENCY DIAGNOSTIC FORM

In the following items, chemical use refers to the use of any mood-altering chemical including alcohol (beer, wine, liquor), sedatives, stimulants, marijuana, tranquilizers, and other drug

1. During the past year, how <u>often</u> did you typically use mood-altering chemicals? (Check one)

☐ (1) daily ☐ (2) several times a week ☐ (3) once a week

☐ (4) several times a month ☐ ( ) monthly or less ☐ (6) none

2. During the past year, how many drinks, capsules, tablets, joints, "hits", etc., of mood-altering chemicals did you typically take each day? (Check one)

☐ (1) less than one ☐ (2) 1 - 4 ☐ (3) 5 - 8

☐ (4) 9 - 12 ☐ (5) more than 12 ☐ (6) none

Which of the following problems have you experienced from the use of mood-altering chemicals? (Check all that apply)

Path. Patt. 3. ☐ Intoxicated throughout the day.

☐ Path. Patt. 4. ☐ Unable to cut down or stop use.

Path. Patt. 5. ☐ Use producing impairment/disruption in body's functioning (e.g. blackouts, loss of memory, impaired breathing, loss of consciousness, false beliefs, delirium)

Harm. Cons. 6. ☐ Social problems (e.g., fights/violence, arguments with family, loss of friends)

☐ Harm. Cons. 7. ☐ Occupational problems (e.g., absence from work, loss of job, poor job performance)

Harm. Cons. 8. ☐ Legal difficulties (e.g., traffic arrests or police problems; not including single arrest for possession, purchase or sale of substance)

☐ Phys. Dep. 9. ☐ Development of withdrawal symptoms after cessation of or reduction in substance us (anxiety, restlessness, irritability, insomnia, impaired attention, the "shakes")

☐ Tolerance 10. ☐ Tolerance (need for markedly increased amounts of substance to achieve desired effect with regular use)

11. For how long have you experienced these problems from the use of chemicals?

☐ (1) less than 1 month ☐ (2) 1 - 3 months ☐ (3) 4 - 12 months

☐ (4) 1 - 2 years ☐ (5) 3 - 5 years ☐ (6) over 5 years

12. Have you previously undergone treatment for a problem associated with your chemical use?

☐ (1) no ☐ (2) once ☐ (3) twice

☐ (4) 3 - 4 times ☐ (5) 5 - 6 times ☐ (6) 7 or more times

FJG/8-11-82

DEPARTMENT OF CORRECTIONS

Exh. 32
Source: Washington

SUBSTANCE ABUSE SCREENING REPORT

TERIA (CHECK ONLY THOSE WHICH APPLY):	SERIOUS	MODERATE
1. ONE OR MORE PRIOR CONVICTIONS OR CRIMINAL ACTS COMMITTED WHILE UNDER INFLUENCE OF ALCOHOL OR DRUGS (INITIAL ONLY).	____	____
2 COURT-RECOMMENDED SUBSTANCE ABUSE PROGRAM (INITIAL ONLY)		____
3 COMMITMENT OFFENSE IS SUBSTANCE-ABUSE RELATED (INITIAL ONLY).	____	____
4. BACKGROUND REPORTS CONTAIN REFERENCES TO INCIDENTS OR INDICATORS OF SUBSTANCE ABUSE (INITIAL ONLY).	____	____
5. ONE OR MORE MISCONDUCT REPORTS RELATED TO SUBSTANCE ABUSE.	____	____
6 EVALUATIONS WITHIN LAST SIX MONTHS REFLECT INCIDENTS OF SUBSTANCE ABUSE.	____	____
7. PHYSICAL EVIDENCE SUGGESTING INVOLVEMENT IN SUBSTANCE ABUSE.	____	____
8. INMATE ADMITS TO HAVING A SUBSTANCE ABUSE PROBLEM.	____	____
9. PAROLE BOARD-ORDERED SUBSTANCE ABUSE PROGRAM.		____

COMMENTS:

9ALL ASSESSMENT (CHECK ONLY ONE CATEGORY):

.. NO SUBSTANCE ABUSE PROBLEM HAS BEEN NOTED.	____ 0	
2. ONE MODERATE PROBLEM NOTED ABOVE.	____ 1	
3. TWO OR MORE MODERATE PROBLEMS NOTED ABOVE.	____ 5	[ ]
4. ONE OR MORE SERIOUS PROBLEMS NOTED ABOVE.	____ 6	

CURRENT STATUS (IF THE SCORE FOR SECTION B IS GREATER THAN ZERO, CHECK ONE OF THE ITEMS BELOW. OTHERWISE, ENTER ZERO IN EVALUATION (SECTION D)):

1. COMPLETED ALL RECOMMENDED PROGRAMS.	____ 0	
2. PARTICIPATING IN OR ON WAITING LIST FOR PROGRAM, BUT HAS NOT COMPLETED ALL RECOMMENDED ACTIVITIES.	____ 1	
3. NEEDS PROGRAM, HAS NOT PARTICIPATED, AND IS AMENABLE TO PROGRAM PARTICIPATION AT THIS TIME.	____ 2	[ ]
4. NEEDS PROGRAM, HAS NOT PARTICIPATED, AND IS NOT AMENABLE TO PROGRAM PARTICIPATION AT THIS TIME.	____ 3	

EVALUATION (SECTION B + SECTION C): [ ]

MENTS:

) BY: TITLE DATE

NUMBER	NAME: LAST	FIRST	MIDDLE

D. Intellectual/Adaptive

Description. On the basis of intellectual competencies, the ability to adapt to physical, educational, occupational, and social demands.

Rationale. Inmates at the lower range of intellectual/ adaptive functioning present serious correctional management problems. The naive or retarded inmate is particularly vulnerable to exploitation. In addition, his/her intellectual capacity may severely limit the potential benefit of academic and vocational training programs.

The concept of mental retardation includes a combination of measured deficits in intellectual functioning and in adaptive behavior. As the American Association of Mental Deficiency notes (AAMD, 1983), intellectual impairment can be associated with varying degrees of adaptive deficits in the areas of personal independence and socially responsible behavior. Almost by definition, then, an offender who has a measured IQ of 70 or below may be classified as retarded. For assessment and treatment planning purposes, it may be more important to assess specific components of adaptive functioning than to focus exclusively on an IQ score (Lomastrol, 1977).

The scope of the "mentally retarded offender" problem is substantial (Kennedy, Goodman, Day & Griffin, 1982; Pointer & Kravits, 1981b; Santamour & West, 1979). Proportionally, more retarded persons reside in prisons and jails than in the general population. Estimates range from nine percent nationally to over 20 percent in some states. If both intelligence "scores" and adaptive functioning are considered, the percentages may be less. But few states have taken seriously the need to assess adaptive ability. Whatever the actual figures, a substantial sub-group requiring attention and special management exists. Moreover , intellectual/adaptive limitations and needs must be considered in academic and vocational decisions.

Current Practice. Results of the national survey indicate that over half of the states use either the Wechsler Adult Intelligence Scale - Revised (WAIS-R) or the Revised Beta for intellectual evaluation. A few isolated reports show use of the Peabody Picture Vocabulary Test, Culture-Fair Intelligence Test, Slosson Intelligence Test, and Raven Progressive Matrices.

All of these instruments are considered reasonably valid tests of intellectual functioning, although reliability and validity suffer when a quick, group screen instrument, such as the Revised Beta, is used. Such tests should be adequate when used for screening purposes, if more thorough subsequent evaluation is provided for those in the borderline range.

Very few states assess adaptive functioning for inmates scoring in the retarded range on intellectual testing. In the absence of more detailed information on adaptive functioning,

intelligence test scores are of limited value in planning for management or educational or vocational training.

In describing intellectual levels, most states seem to follow a similar pattern. The classifications used are "superior," "above average," "average," "borderline," "mildly retarded," "moderately retarded," etc., employing the DSM III or AAMD criteria for diagnosis. Unfortunately, many states have no specific treatment or educational/vocational programs geared to match special offender needs in this area. The absence of a systematic approach dealing with the retarded offender is one of the most common deficiencies in modern correctional practice.

Recommendations. As emphasized earlier in this manual, a structured approach to definition and assessment can yield extremely valuable information for individual and system-wide planning. This point is underscored by the AAMD (1983) in its most recent Classification in Mental Retardation. This excellent book should guide the development of an assessment program in this area.

Given this backdrop, some specific recommendations can be made. When time and staff permit, WAIS-R is the assessment instrument of choice for measuring intellectual functioning down to the range of moderate retardation. The WAIS-R is a valid, reliable measure, and in the hands of a skilled clinician, provides excellent, useful information.

When group screening for intellectual ability is required, tests which minimize the effects of verbal fluency, cultural background, and educational level should be considered. For those with a minimal reading ability, the Raven Progressive Matrices or Peabody Picture Vocabulary Test-Revised will provide adequate intellectual assessment, although the latter tends to overestimate WAIS-R or Stanford-Binet scores. Another measure of mental ability, The Ohio Classification Test, was specifically developed for use with penal populations.

Several tests (e.g., WAIS-R) are available in Spanish versions. In addition, two tests have been specifically developed for use with Spanish-speaking inmates: the Pruebas de Habilidad General and the Barranquilla Rapid Survey Intelligence Test (BARSIT). The latter requires the examiner to speak Spanish.

Other tests currently available are listed in Appendix A-3. The selection of the instrument will depend upon the need for cursory intellectual screening or more comprehensive measurement, and the verbal capacity and English fluency of the inmate.

Several assessment tools measure adaptive functioning of inmates (e.g. , AAMD Adaptive Behavior Scale, Vinel and Social Maturity Scale, Vocational Adaptation Rating Scale), although most require direct observation or interviews with a primary caregiver--that is, a family member or someone who has closely

observed the individual in a variety of settings. In a related area are instruments using a variety of work samples to assess adaptive functioning. These assessments (e.g., Vocational Information and Evaluation Work Samples-VIEWS) are generally expensive and time-consuming. However, they are especially relevant to assessing vocational aptitude.

An excellent review of the measurement of adaptive behavior is provided by Myers et al. (1979), who describe the several skills and competencies that comprise the concept of adaptive behavior. These include: self-help, physical development, communication, basic cognitive skills, domestic and occupational activities, self-direction and responsibility, and socialization. The Myers article also reviews the specific characteristics of a wide range of assessment instruments, most of which are presented in Appendix A-4. The reader should note the overlap of this assessment area with personal-social skills (Section H of this Chapter).

Most authorities recommend that the assessment of intellectual and adaptive functioning be performed (or supervised) by trained professionals. Special testing or interview situations may also be required. The retarded individual is of ten distractable; a quiet environment and simple directions will be necessary. Inmates' tendencies to overly comply or give quick answers should be handled by avoiding leading questions. A summary of other techniques is provided in Kennedy et al. (1982).

E. Academic Education

Description. Academic competencies and achievement; grade-level functioning.

Rationale. Every state system gives academic education high visibility as part of its program of services. Moreover, states that have analyzed their offender population report from 40 to 70 percent of inmates as having moderate to serious educational needs, i.e., deficits which limit current functioning or prevent vocational readiness.

Current Practice. As most classification personnel recognize, reported grade level may provide an inaccurate estimate of actual functioning level. Fortunately, a variety of straightforward instruments and measures are available. The Test of Adult Basic Education (TABE) and the Wide Range Achievement Test (WRAT) are the most frequently used tests for assessment of academic skills in correctional settings,. The California Achievement Test (CAT) and the Stanford Achievement Test (SAT) receive occasional use.

Levels descriptions in the area of academic education, like intellectual assessment, seem to be fairly uniform. Assessment is made based upon highest level of education completed and

tested achievement level. Each level usually has a prescriptive alternative available. A typical classification scheme delineates the following levels: college degree, post secondary, secondary, intermediate, and elementary education. When adjectives are used, "serious need" usually denotes a tested grade level of 6.0 and below, while "moderate" encompasses pre-GED achievement levels.

Recommendations. Assessments leading to clearly defined placements (e.g., remedial education) are the most appropriate and useful . Many tests in current use (e.g., WRAT) provide only rough diagnostic assessment and cannot be expected to portray accurately a client's specific deficits. Tests offering more detailed information regarding academic deficits are far more useful in developing focused prescriptive remedies. The TABE, for example, meshes nicely with instructional programs that are skills based. That is, in addition to providing grade level scores in reading, language, and arithmetic, the TABE identifies specific skills deficits within each area. Several states have adopted individually prescribed instructional systems based on such an analysis (Ayllon & Milan, 1979). Other investigators have noted the importance of skills testing in establishing basic reading programs.

While many tests are available, the decision regarding the appropriateness of a particular instrument for an individual inmate will need to consider the inmate's age, formal education, the depth of assessment sought (rough screening, or diagnostic-prescriptive), and the normative sample upon which the test is based. Within these guidelines, the educator or clinician has considerable choice regarding needed administration time and the suitability of test for group administration. As can be seen from Appendix A-5, a wide range of options exists.

F. Vocational Aptitude and Interests

Description. The potential or demonstrated ability to perform successfully in one or more occupational areas (aptitude); attraction to or preference for certain vocational or job areas (interests).

Rationale. Vocational or occupational training holds lofty status as a major correctional tool. Every prison system in the U.S. provides vocational training to portions of its population. Efforts range from informal on-the-job experiences to formal, accredited courses. Besides providing ongoing , meaningful activities for inmates, vocational training is also presumed to address widely-noted offender deficiencies in employability. Lack of occupational skills has been a factor frequently thought to be associated with criminality, and satisfactory employment has consistently been shown to influence community reintegration.

Vocational training may have the greatest impact when: (1) offenders are selected on the basis of aptitude and interest; (2) when training programs match the community job market; and (3) when generalized job skills (see next section) are taught prior to or as part of the vocational sequence. An accurate assessment of offender skills and deficits in these areas should help improve resource utilization and indicate areas in which training could be productively offered.

Unfortunately, vocational opportunities in many systems are quite limited. In such situations, elaborate assessment would seem to be relatively unproductive, perhaps even hypocritical. However, the creation of occupational training efforts--even relatively simple work programs--may receive higher priority if the existence of wide spread offender deficits is clearly documented.

Current Practice. Vocational aptitude and interest is one of the most frequently assessed areas in corrections, although the quality of assessment varies widely. Many states use a simple two-level system of "need/no need," or a three-tier system with levels such as "sufficient," "minimal," "no skills." These broad terms alert decision-makers to the existence of a need but provide little concrete intervention implications. From these descriptors one cannot be sure what specific skills are deficient, what strengths the inmate may possess, nor what his vocational interests are. A more refined assessment usually occurs, if at all, when an offender is actually placed on a vocational track.

On the average, states report 80 percent of their inmates lack vocational skills, with some states identifying as many as 95-99 percent of their populations as deficient in this area. The sources of these data must be viewed as fairly subjective, however, since so few states systematically assess vocational aptitude and skills as part of the classification process.

The most frequently used instrument reported is the U.S. Employment Service General Aptitude Test Battery (GATB). More rarely used are the Strong-Campbell Interest Inventory, the Wide Range Interest-Opinion Test (WRIOT), the Differential Aptitude Test (DAT) , and a variety of inhouse work history interviews and self -reports.

Recommendations. The instruments available fall into two broad categories: paper 'and pencil self-report, or hands-on work performance samples. The time and administrative resources required for testing vary considerably also. As the reader can note in Appendices A-6 and A-7, a wide range of options exists.

Aptitude. The GATE is a well-known instrument and is in relatively wide use. It provides both paper and pencil self-report information and several performance measures. Administration time is somewhat high (2.5 hours), but the test yields a wealth of quality information. An especially important feature of the GATB is the nonreading adaptation of the test.

The Differential Aptitude Test is another comprehensive alternative. Although it yields fewer measures than the GATB, it takes equally as long to administer. However, it can be administered in groups, whereas the GATB requires individual administration, at least in part. A few shorter paper and pencil surveys which may be administered to large groups are available (e.g., the Employee Aptitude Survey).

At the other extreme are the newer test batteries which provide hands-on work samples in a variety of areas (Wide Range Employability Scale-WREST; Vocational Evaluation System-Occupational Assessment; Vocational Information and Evaluation Work Samples-VIEWS). These packages are expensive and lengthy, yet they provide considerable concrete data on aptitudes. Of special note is that two of these tests (WREST and VIEWS) are suitable for use with disadvantaged and mentally retarded offenders.

Interests. A number of instruments are available for measuring vocational interests. Most are paper and pencil, self-administered inventories that take about 30-40 minutes. Instruments do vary considerably in the number of occupations tapped and the type of occupations explored; some strictly assess interest in trade skills, others explore interest in professions requiring some college education. The Strong-Campbell Interest Inventory, the Ohio Vocational Interest Survey II, and the Wide Range Interest-Opinion Test (WRIOT) are all popular instruments measuring a broad range of occupational interests. Selection of an instrument for a particular inmate will also need to consider his reading level. The Self-Directed Search and the Gordon Occupational Checklist II, for instance, are both tests requiring minimal reading levels.

Ultimately, it may not be cost-effective to assess routinely occupational interests at intake, especially if specific program placement decisions are likely to be postponed for a year or more. Interest assessment may be most realistically done at the institutional level where the inmate can identify interests within the range of appropriate options. On the other hand, aptitude and interest patterns could productively be considered in making basic institutional work assignments.

G. Job Skills

Description. The degree to which the individual possesses a marketable skill; his/her ability to obtain and hold a job.

Rationale. This category obviously interacts with the issue of vocational aptitude, and deficiencies in both areas have been addressed through common programs. However, actual work history and performance should be distinguished from aptitude and interest. The actual possession of both job-specific skills and job-related behaviors may be critical to community reintegration. Offenders who have never been employed may particularly need basic work experiences that allow for the dignified acquisition of both skills and work habits. Obviously , specific vocational and/or academic training will be required in some instances. Thus, assessment of job skills is necessarily linked to these other areas.

Current Practice. Several states employ some variation of a three-level diagnostic system in which the inmate is evaluated as "skilled," "semi-skilled," or "unskilled." These categories indicate more vocational preparedness than the presence or absence of skills necessary to find and maintain a job, such as getting to work on time, carrying out responsibilities, etc. One state reports an interesting two-factor system which evaluates an inmate as "skilled, dependable;" "skilled, undependable;" "unskilled, dependable;" "unskilled, undependable."

Washington assesses job skills deficits using a four-level system similar to its assessment levels for personal-social skills (see following section). The offender is evaluated on several criteria, such as ability to cooperate with co-workers, tardiness, etc., and then is given an overall assessment rating, which in turn specifies remedial programs. A copy of the criteria and assessment levels is provided in Exhibit 33 (p. 119). Another instrument, the Maladaptive Behavior Record (see following section on personal-social skills), has items which include work attendance, interaction with employer, etc. Only one state--Idaho--reports using this scale.

There was wide variability in the reports of inmate needs in the job skills areas. Most states estimated between 70 and 80 percent of inmates need job skills training, although the range was from a low of 30 percent to a high of 95 percent.

Though reported need levels are high, actual assessment rarely goes beyond interviews regarding work history. Only two states use any systematic measures. One state has developed its own in-house problems checklist; the other utilizes a commercially available assessment package which includes assessment of job skills.

Recommendations. Job skill information about an inmate should be integrated into an overall employability development plan (EDP). This plan would contain vital information, such as an

analysis of employment barriers, objective occupational goal statements, those activities essential to achieving the goals, and a time frame for their achievement. A model EDP system, developed by Rehabilitation Research Foundation (McKee, Pirhalla & Burkhalter, 1982) for juvenile clients, can be applied to an offender population with little modification (Employment Barrier Identification Scale). This system contains a "master form" which integrates all employment information and makes employment planning and decision making easier. A sample page is presented in Exhibit 34, p. 120.

Clearly, only a limited number of instruments specifically measuring job skills exist; however, these instruments appear to be solid tests yielding a wealth of information. From among the instruments listed in Appendix A-8, the evaluator has great flexibility in terms Of the length of time required for administration and the depth of the information provided.

Two of the tests (Temperament and Values Inventory, and Adult Performance Level Program-Occupational Knowledge) are self-report, multiple choice tests ranging from 42 to 230 items. Other instruments require individual interviews, and the Occupational Skills Assessment Instrument requires some role-playing on the inmate's part.

DEPARTMENT OF CORRECTIONS

Exh. 33
Source: Washington

WORK ADJUSTMENT SCREENING REPORT

ERIA (CHECK ONLY THOSE WHICH APPLY):	SERIOUS	MO'	E
1. FIRED OR REMOVED FROM A WORK ASSIGNMENT IN LAST YEAR DUE TO IMPROPER ADJUSTMENT.	____	____	
2 FAILED TO MAINTAIN QUALITY/QUANTITY OF WORK PRODUCTS WITHOUT CONTINUOUS SUPERVISION.	____	____	
3 REPEATED FAILURE TO COOPERATE WITH CO-WORKERS OR SUPERVISORS.	____	____	
4 MAINTAINED UNSATISFACTORY WORK RATING DURING THE LAST SIX MONTHS.	____	____	
5. GUILTY OF SUBSTANCE ABUSE ON THE JOB DURING THE LAST SIX MONTHS.	____	____	
6. AVERAGED ONE OR MORE UNEXCUSED TARDINESS OR ABSENCE PER MONTH FROM WORK ASSIGNMENTS DURING THE LAST SIX MONTHS.	____	____	
7. RECORD REFLECTS DEFICIENCIES IN WORK HISTORY (INITIAL ONLY).	____	____	

VERALL ASSESSMENT (CHECK ONLY ONE CATEGORY):

1. NO WORK ADJUSTMENT PROBLEM NOTED ABOVE.	____	0	
2. ONE MODERATE PROBLEM NOTED ABOVE.	____	1	
3. TWO OR MORE MODERATE PROBLEMS NOTED ABOVE.	____	5	____
4 ONE OR MORE SERIOUS PROBLEMS NOTED ABOVE.	____	5	

URRENT STATUS (IF THE SCORE FOR SECTION B IS GREATER THAN ZERO, CHECK ONE OF THE ITEMS BELOW. OTHERWISE, ENTER ZERO IN EVALUATION (SECTION D)):

1. COMPLETED ALL RECOMMENDED PROGRAMS.	____	0	
2. PARTICIPATING IN OR ON WAITING LIST FOR PROGRAM, BUT HAS NOT COMPLETED ALL RECOMMENDED ACTIVITIES.	____	1	
3. NEEDS PROGRAM, HAS NOT PARTICIPATED, AND IS AMENABLE TO PROGRAM PARTICIPATION AT THIS TIME.	____	2	____
4. NEEDS PROGRAM, HAS NOT PARTICIPATED, AND IS NOT AMENABLE TO PROGRAM PARTICIPATION AT THIS TIME.	____	3	

VALUATION (SECTION B + SECTION C): ____

IENTS:

ARED BY:	TITLE	DATE

NUMBER	NAME: LAST	FIRST	MIDDLE

DISTRIBUTION: WHITE—FACILITY CENTRAL FILE YELLOW—RESEARCH/DATA ENTRY
PINK—HEADQUARTERS CENTRAL FILE GOLDENROD—BOARD OF PRISON TERMS & PAROLES

118 (Rev 9/83) OX A 118

The EBIS

WORK

Item 1. **Work Experience**

This item is easy to introduce and is straightforward. It allows for direct questioning and the information obtained is relatively simple to score. It is designed to reflect the nature of work experience. You seek information regarding the duration, frequency, quality, and efficiency of the client's work performance. If the participant has a good work history - consisting of stable jobs, positive job references, and long periods of employment—record an "0" for this item.

If any of the following conditions occurs, put a check mark beside it.

Score this item "1" if the participant:

Check:

_____ Is entering the work force or has not worked for the past 5 years.

_____ Cannot cite or show positive job references.

_____ Has history of job-hopping without increases in pay, status, or responsibility.

_____ Admits to having been fired or having quit more than once with no justifiable excuse.

_____ **Work Experience.** Give a rating (1) if the participant does not have a positive job history.

Specify: _____

_____

Item 2. **Job Skills**

This item addresses the participant's work history and training. If you can determine that skill training is sufficient for the participant to qualify for an entry job as a skilled worker in a particular field, score this "0". If the client cites a skilled work history or was taught through an apprenticeship program or on-the-job training, score this "0". Beware of claims of skill *without sufficient training and supervision*. For example, working at a service station and doing minor auto repairs, changing oil and filters, would not qualify a person as an auto mechanic. Also, a general degree, such as a B A., does not represent a skill.

Score this item "1" if the participant:

Check

_____ Has no marketable skill obtained through experience or formal training.

_____ Has no marketable skill in this geographic area and is unwilling to relocate.

_____ **Job Skills.** Rate "1" if participant has no marketable skill.

Specify: _____

_____

Item 3. **Job Survival**

This item is concerned with a person's retention of a job and those factors that affected retention. Confronted with a poor work history, ask about interactions with employers or supervisors. Ask why he/she was fired, laid off, or quit. Inquire about disagreements with the boss - their nature and their resolution. Ask if any disciplinary actions were ever taken against the participant, the last time he was late, and what happened.

Score this item "1" if the participant:

Check:

_____ Has a history of being frequently late for work or has lost a job because of tardiness.

_____ Requires constant or frequent supervision at work.

_____ Has had problems with supervisors or co-workers that interfered with performing or keeping job or getting raises or promotions.

Source: Rehabilitation Research Foundation
(page 1 of 7)

H. Personal-Social Skills

Description. Interpersonal skills, self-management, money management, leisure time usage, personal hygiene and grooming.

Rationale. Clearly, a collection of "personal habit" skills exists in which deficiencies, either singly or collectively, may interfere with both institutional and community adjustment. These factors may not rise to the level of mental disturbance, though they have strong psychological components. Rather, they represent a cluster of behaviors or skills that influence how the individual is perceived by others and how the person copes with ordinary societal demands. These deficiencies lend themselves to behavioral skills programs which have been successfully implemented within correctional as well as other institutional and community settings.

Current Practice. Most states surveyed reported that they did not directly assess inmates' personal-social skills. The few states assessing this dimension report level descriptors such as "no need," "limited," and "major need." Interviews are the most common tool used to establish these need levels, along with information obtained from a thorough pre-sentence investigation. There were also isolated reports of use of the MMPI, 16PF or CPI. Apparently these states are assessing personal-social skills under the general heading of psychological functioning rather than as a separate dimension. Another issue complicating assessment is the apparent lack of uniformity across states in the definitions of personal-social skills. Interestingly, the classification directors rather consistently reported 70-75 percent of the inmates were deficient in this area.

However, exceptions to this general lack of systematic evaluation exist. Washington State, for example, evaluates personal hygiene, financial management, and leisure time usage separately, assessing each inmate on a series of specified criteria and then assigning an overall rating of "no problem," "one moderate problem," "two or more moderate problems," or "one or more serious problems." Importantly, each level has specified remedial alternatives. Copies of Washington's screening reports on these factors are presented in Exhibits 35-37 (pp. 123-125).

Recommendations. Several instruments are available to assess the skills necessary for everyday functioning. Most of the instruments, listed in Appendix A-9, are easily administered, self-report inventories of various lengths; they provide valuable treatment-planning information. A few tests used for psychological screening (e.g., 16PF) also have a sub-scale measuring inter-personal skills and, in the interest of time, such tests could be used for both purposes. However, several other factors (e.g., self-management, leisure time usage, etc.) still aren't tapped by these personality inventories and need further assessment. Examples of instruments in these latter areas are included in Appendix A-9.

One instrument worth noting is the Maladaptive Behavior Record (Jenkins, deValera, & Muller, 1977). The MBR, though based on behavioral adaptation in the community and thus requiring some ingenuity in obtaining accurate information, has been shown to correlate with recidivism. Important behavioral dimensions assessed by the MBR include money management, job behaviors, and interpersonal encounters. This instrument and its companion measures--the Environmental Deprivation Scale, the previously noted Drug Use Evaluation Scale, and others--represent a systematic approach to behavioral data gathering that has excellent potential for intervention planning.

DEPARTMENT OF CORRECTIONS

PERSONAL HYGIENE SCREENING REPORT

Exh. 35
Source: Washington

TERIA (CHECK ONLY THOSE WHICH APPLY):	SERIOUS	M	ATI
1 REPORTS INDICATE CONTINUAL FAILURE TO MEET MINIMUM STANDARDS OF CLEANLINESS.	____		____
2 RECORD REFLECTS FREQUENT INCIDENTS OF ILLNESS OR ACCIDENTAL INJURY IN LAST SIX MONTHS.	____		____
3 INMATE ADMITS TO A PERSONAL HYGIENE PROBLEM.	____		____

OVERALL ASSESSMENT (CHECK ONLY ONE CATEGORY):

1. NO PERSONAL HYGIENE PROBLEM NOTED.	____	0	
2. ONE MODERATE PROBLEM NOTED ABOVE.	____	1	
3. TWO OR MORE MODERATE PROBLEMS NOTED ABOVE.	____	5	[ ]
4. ONE OR MORE SERIOUS PROBLEMS NOTED ABOVE.	____	5	

CURRENT STATUS (IF THE SCORE FOR SECTION B IS GREATER THAN ZERO, CHECK ONE OF THE ITEMS BELOW. OTHERWISE, ENTER ZERO IN EVALUATION (SECTION D)):

1. COMPLETED ALL RECOMMENDED PROGRAMS.	____	0	
2. PARTICIPATING IN OR ON WAITING LIST FOR PROGRAM, BUT HAS NOT COMPLETED ALL RECOMMENDED ACTIVITIES.	____	1	
NEEDS PROGRAM, HAS NOT PARTICIPATED, AND IS AMENABLE TO PROGRAM PARTICIPATION AT THIS TIME.	____	2	[ ]
4. NEEDS PROGRAM, HAS NOT PARTICIPATED, AND IS NOT AMENABLE TO PROGRAM PARTICIPATION AT THIS TIME.	____	3	

EVALUATION (SECTION B + SECTION C): [ ]

MENTS:

EPARED BY: | TITLE | DATE

IC NUMBER | NAME: LAST | FIRST | MIDDLE

DISTRIBUTION WHITE—FACILITY CENTRAL FILE YELLOW—RESEARCH/DATA ENTRY
PINK—HEADQUARTERS CENTRAL FILE GOLDENROD—BOARD OF PRISON TERMS & PAROLES

DEPARTMENT OF CORRECTIONS

Exh. 36
Source: Washington

FINANCIAL MANAGEMENT SCREENING REPORT

ERIA (CHECK ONLY THOSE WHICH APPLY):	SERIOUS	MODERATE
1. CONVICTION OFFENSE(S) REFLECT A FINANCIAL MANAGEMENT PROBLEM; E.G., EMBEZZLEMENT (INITIAL ONLY).	____	____
2. PRE-SENTENCE INVESTIGATION REFLECTS FAILURE TO MEET MONETARY OBLIGATIONS; E.G., CHILD SUPPORT (INITIAL ONLY).	____	____
3. INCARCERATION HAS EXCEEDED TWO YEARS, HAS NOT HAD INSTRUCTION/COUNSELING ADDRESSED TO FINANCIAL MANAGEMENT, AND EXPECTS RELEASE WITHIN SIX MONTHS.	____	____
4. SELF-REPORTED FINANCIAL MANAGEMENT PROBLEM.	____	____

OVERALL ASSESSMENT (CHECK ONLY ONE CATEGORY):

1. NO APPARENT FINANCIAL MANAGEMENT PROBLEM NOTED.	____	0	
2. ONE MODERATE PROBLEM NOTED ABOVE.	____	1	
3. TWO OR MORE MODERATE PROBLEMS NOTED ABOVE.	____	5	____
4. ONE OR MORE SERIOUS PROBLEMS NOTED ABOVE.	____	5	

CURRENT STATUS (IF THE SCORE FOR SECTION B IS GREATER THAN ZERO, CHECK ONE OF THE ITEMS BELOW. OTHERWISE, ENTER ZERO IN EVALUATION (SECTION D)):

COMPLETED ALL RECOMMENDED PROGRAMS.	____	0	
PARTICIPATING IN OR ON WAITING LIST FOR PROGRAM, BUT HAS NOT COMPLETED ALL RECOMMENDED ACTIVITIES.	____	1	
3. NEEDS PROGRAM, HAS NOT PARTICIPATED, AND IS AMENABLE TO PROGRAM PARTICIPATION AT THIS TIME.	____	2	____
4. NEEDS PROGRAM, HAS NOT PARTICIPATED, AND IS NOT AMENABLE TO PROGRAM PARTICIPATION AT THIS TIME.	____	3	

EVALUATION (SECTION B + SECTION C): ____

MENTS:

PARED BY: | TITLE | DATE

: NUMBER | NAME: LAST | FIRST | MIDDLE

1127 (Rev. 9/83) OX A 118

DISTRIBUTION: WHITE—FACILITY CENTRAL FILE YELLOW—RESEARCH/DATA ENTRY
PINK—HEADQUARTERS CENTRAL FILE GOLDENROD—BOARD OF PRISON TERMS & PAROLES

Exh. 37
Source: Washington

DEPARTMENT OF CORRECTIONS

LEISURE TIME SCREENING REPORT

CRITERIA (CHECK ONLY THOSE WHICH APPLY):	SERIOUS	MODERATE
1. RECEIVED NO VISITS DURING THE LAST SIX MONTHS.		____
2. DOES NOT PARTICIPATE IN RECOMMENDED TREATMENT PROGRAMS OR IN AVAILABLE GROUP ACTIVITIES.		____
3. CONTINUALLY SEEKS ISOLATION.		____
4. REPEATEDLY DEMONSTRATED ANTI-SOCIAL OR SELF-DESTRUCTIVE BEHAVIOR WHEN PRESENTED WITH UNSTRUCTURED TIME.	____	____
5. ADMITS TO LEISURE TIME PROBLEMS.		____

OVERALL ASSESSMENT (CHECK ONLY ONE CATEGORY):

1. NO LEISURE TIME PROBLEM NOTED.	____ 0	
2. ONE MODERATE PROBLEM NOTED ABOVE.	____ 1	
3. TWO OR MORE MODERATE PROBLEMS NOTED ABOVE.	____ 5	____
4. ONE OR MORE SERIOUS PROBLEMS NOTED ABOVE.	____ 5	

;RENT STATUS (IF THE SCORE FOR SECTION B IS GREATER THAN ZERO, CHECK ONE OF THE ITEMS BELOW. OTHERWISE, ENTER ZERO IN EVALUATION (SECTION D)):

1. PARTICIPATING IN LEISURE TIME PROGRAMS AT THIS TIME.	____ 0	
2. NEEDS PROGRAM AND IS AMENABLE TO PARTICIPATION AT THIS TIME.	____ 2	____
3. NEEDS PROGRAM AND IS NOT AMENABLE TO PARTICIPATION AT THIS TIME.	____ 3	

EVALUATION (SECTION B + SECTION C): ____

MMENTS:

EPARED BY: | TITLE | DATE

DC NUMBER | NAME: LAST | FIRST | MIDDLE

DISTRIBUTION: WHITE—FACILITY CENTRAL FILE YELLOW—RESEARCH/DATA ENTRY

I Family and Friend Relationships

Description. Interest and support of significant others, including parents, relatives, spouse, or peers.

Rationale. Incarceration imposes a separation from family and friends. In some instances, these relationships may not have been particularly supportive or pro-social. Moreover, this separation experience does not always weaken existing relationships. However, clearly the degree of institutionalization, the level of demoralization, and the ability to reenter the community successfully are influenced by this social support network (Brodsky, 1975).

Current Practice. Consistent with the low priority rating given it by survey respondents, assessment of family and friend relationships is rarely undertaken. Those few states assessing this need dimension rely primarily on interviews, or on the MMPI, PSI, CPI, or 16PF, all instruments having subscaler measuring deficits or problems in this area. Unfortunately, the results of such evaluations lose meaningfulness when, as is commonly practiced, they are collapsed into a two-level rating system of "adequate/ inadequate," "or stable/unstable." Interestingly, wide disparity exists among states in the reported percentage of the inmate population needing assistance. A small cluster of states reported 80-95% of the population as having stable relationships. By contrast, most states estimated between 70 and 80 percent of the population as having unstable or inadequate resources in this area. This estimate is more consistent with research in the field suggesting that as many as half of incarcerated offenders have virtually no outside contacts while in prison (Brodsky, 1975).

Recommendations. Several instruments have been developed specifically for assessing interest and support of significant others. Some are designed for intact couples in which each partner responds to a problem checklist. Their use will obviously be limited by the proximity of spouses and their willingness to cooperate. Other tests are self-report measures of the inmates' perceived problems in relationships with significant others (principally family). The MMPI has a separate, reliable scale for measuring family problems. Where the MMPI is routinely administered , scoring and interpreting the Family Problems Content Scale could provide a source of information. The Mooney Problem Checklist also specifically addresses family problems as a separate dimension and could provide useful data (see Appendix A-10). Unfortunately, almost no instruments measure the existence and nature (positive or negative) of peer relationships, although the Environmental Deprivation Scale (EDS) taps this dimension in a limited way.

Overall assessment efforts in this area are consistent with the general inattention to this aspect of prison life. A decade ago, Chaiklin (1972) asserted:

> ... the offender's family affects all phases of his life, and vice versa. Unless one considers the network of important social relationships the offender is involved in, it is probable that every rehabilitation program is compromised in some way. People do not change in limbo.. . . No correctional program can succeed if it does not include those whom the offender will live with after prison. (p. 786)

Assessment efforts will continue to have low priority until this aspect of correctional programming is treated seriously.

J Victimization Potential

Description. Factors related to the likelihood of being manipulated, taken advantage of, intimidated, or abused.

Rationale. Victimization is no less a problem in prison than in the non-prison environment. Indeed, certain prison conditions may foster a high rate of aggression and its natural by-product, victimization. The temptation to identify and perhaps isolate or, in other ways, to protect potential victims in no way reduces the obligation of corrections to promote safe environments for al 1 offenders. However, one step in this process may be to identify individuals who are--because of behavioral, physical , or intellectual factors--more likely than others to become victims.

Current Practice. Most state systems reported that this dimension is an important one. Missing, however, are systematic approaches to screening individuals who may be vulnerable. Self-identification, no doubt a critical part of this dimension, is used almost exclusively. Similarly, protective custody is often the only intervention or management strategy available or considered.

Staff judgment, history, and interviews are the principal reported sources of decision-making. Apparently many states simply sub-divide offenders into two groups, e.g., "no problem" vs. "protective custody," while others contemplate two or three types of vulnerability. Some few states (and at least one federal institution) put offenders on a continuum ranging from predatory to victim-prone. This practice is somewhat consistent with the view that such groups need separation and special supervision. However, the more predatory of fender may well be identified through routine risk classification (i.e., for custody purposes) , while the victim-prone is less systematically identified.

Some jurisdictions identify over half of the prison population as being potentially at risk for victimization, while the typical figures run between 10 and 30 percent. Overall, however,, many states simply have no quantitative data reflecting the

degree of need in this dimension. The number of offenders in protective custody (special housing) constitutes a kind of de facto estimate.

Recommendations. Because victimization (and its counter-part-aggression) is so interactive with the prison environment and management practices, it is unrealistic to expect any particular technique of identification to reduce greatly the problem. As yet no psychological scale reliably predicts either end of this continuum. An "average" offender can be a victim one day, aggressor the next.

However, some approaches promise inroads in these areas. For example, Toch (1979) developed a Prison Preference Inventory now used in several jurisdictions to solicit offenders' perceived needs for factors such as privacy, safety, support, etc. Also promising is the approach discussed in Chapter VII, Section C, wherein predators and victim-prone individuals are provided differential supervision and housing within a fairly open setting (i.e., without resorting to lock-down situations).

Methods following the outline suggested by Monahan (1981) for identifying individuals who may be dangerous are also worth considering. While recognizing the limitations of pure predictions, Monahan has pointed out that by considering factors such previous circumstances under which aggression took place, we may come nearer specifying future aggressive episodes. Victimization, though perhaps an even more complex phenomenon, is worth pursuing within this same model.

VII. ADDITIONAL ISSUES IN OFFENDER NEEDS ASSESSMENT

A. Needs Assessment for Female Offenders

Background. Female offenders have a long history of neglect in the criminology literature, probably in part due to their smaller numbers and less visible locations. However, the existence of needs and deficits highlighted in this volume are no less pronounced for female offenders (Jones, 1982; Sarri, 1983; Warren, 1981).

Women account for a significantly smaller proportion of the incarcerated population (approximately four percent) than do men. Consequently, most states provide only one facility for all incarcerated women, regardless of custody needs, age differences, variability in offenses, levels of psychological adjustment , or sentence length. One writer (Adler, 1975) further suggests that program funds are allocated to women's institutions on the "four percent plan." Such a backdrop may explain why assessment frequently receives low priority. Meaningful assignments are often directly influenced by the limitations of the institution's functional units. Classification decisions made at this level often become subjective decisions of institutional staff, a practice increasingly being tested in the courts (NIC, 1982).

It can be safely asserted that the models and principles developed in this volume provide a framework for assessing the needs of all offenders--male and female. However, the National Institute of Corrections report on Prison Classification (NIC, 1982) correctly argues that classification and needs assessment systems for women cannot simply be mirror images of those systems designed and developed for men. Characteristics of the populations, the facilities, and the differing institutional options make merely superimposing the classification policies developed for men onto the female offender impractical and, as noted, constitutionally questionable.

The principles described in Chapter III should be useful in developing an appropriate needs assessment program for women. This approach should lead to a clearer, more objective picture of the actual needs and deficits of women prisoners, both individual 1 y and system-wide. Although women prisoners' needs are not totally unique, some tailoring and sensitivity is required. Otherwise, errors in treatment assignments, allocation of scarce resources, and in future planning will continue.

Special Assessment Issues. Female inmates should be assessed on each dimension, even when suitable placement or programs may be unavailable at the institution. Many programs, such as training in traditionally male dominated vocational areas, presently do not exist in prison facilities for women. Their absence is often justified by the assertion that women do

not have the required skills or interests. No concrete data verifies such a position. Compiling of data in each assessment area can shed light on need, interest, and entrance skills which may affect future programming decisions and, ultimately, result in a broader range of programs being available for women.

In addition, care should be taken in the selection of assessment instruments and techniques. In the earlier sections of this volume reviewing each need-dimension, a range of applicable instruments was noted (also see Appendix A). Many of these have been adequately standardized on women and provide data for this population. Others provide no such assurances. For assessment approaches relying less on normative data, e.g., behavioral checklists, no particular cautions are required. However, the clinician or evaluator should monitor the literature and select tests and methods appropriate for use with female offenders.

B. Ethical Issues Associated with Psychological Assessment in Corrections

The ethical conflicts for psychologists involved in the criminal justice system, and suggestions for their resolution, have been detailed elsewhere (APA, 1978). By implementing a needs assessment approach within the guidelines developed in Chapter III, the psychologist and psychological support staff will concurrently fulfill many of the obligations outlined by the American Psychological Association's Board of Social and Ethical Responsibility. In addition, they will be meeting many of the standards established by the American Association of Correctional Psychologists (AACP, 1980).

The recommendations and standards described below represent only those that specifically address assessment. However, the broader ethical context should also be considered. The following brief summaries are presented in order to highlight the convergence of ethical obligations and the use of a systematic needs assessment system.

The Task Force Report on the Role of Psychology in the Criminal Justice System (APA, 1978) notes the following:

> Recommendation 3: Other than for legitimate research purposes, psychological assessments of offenders should be performed only when the psychologist has a reasonable expectation that such assessments will serve therapeutic or dispositional function.
>
> Recommendation 10: Psychologists should be strongly encouraged to offer treatment services to offenders who request them.

The intent of these recommendations is consistent with systematic needs assessment. When such a program is implemented,

inmates are evaluated only on relevant need dimensions which have been clearly defined in advance. The model endorsed in this volume further requires that specific dispositional implications be designated for each level of need. The net result is the more prudent use of time and staff resources, the elimination of unnecessary testing, and the more efficient use of institutional resources. When inappropriate placements are reduced, more placements are available to offenders who require or request services.

In a similar vein, the American Association of Correctional Psychologists has adopted standards of psychological practice in corrections. Three of these, from Standards for Psychology Services in Adult Jails and Prisons (AACP, 1980) are relevant to psychological needs assessment:

> Standard 23. Receiving screening is performed on all inmates upon admission to facility before being placed in the general population or housing area. The findings are recorded on a printed screening form. Inmates identified as having mental problems are referred for a more comprehensive psychological evaluation. Screening includes inquiry into: (a) past and present history of mental disturbance, and (b) current mental state, including behavioral observations.

Standard 23 describes a systematic needs assessment program in its most basic form. However, the systematic approach presented in this volume urges that intake screening go beyond merely describing inmates as "having mental problems," and instead suggests that the degree or level or type of disturbance be identified so that follow-up evaluation and intervention can be more clearly specified.

> Standard 26. The individual assessment of all inmates referred for a special, comprehensive psychological appraisal is completed within 14 days after the date of the referral.
>
> This standard as applied in a prison setting includes:
>
> A. Reviewing earlier screening information and psychological evaluation data
> B. Collecting and reviewing any additional data to complete the individual's mental health history
> C. Collecting behavioral data from observations by correctional staff
> D. Administering tests which assess levels of cognitive and emotional functioning and the adequacy of coping mechanisms
> E. Writing a report describing the results of the assessment procedures, including an outline of a recommended plan of treatment which mentions any indication by the inmate of a desire for help
> F. Communicating results to referral source

G. Writing and filing a report of findings and recommendations

Standard 26 describes the appropriate follow-up for inmates identified at intake screening as needing further psychological evaluation. The standard provides an excellent model for assessing other needs as well. A number of similarities with principles advanced in this volume can be seen, e.g., use of behavioral data, selection of appropriate instruments, clear communication of intervention plan.

> Standard 25. Collection of psychological evaluation data is performed only by psychological services staff personnel or facility staff trained by them. Review of and written reports based on the results of the examination, testing, and developing a plan of treatment is done by, or under the supervision of, a qualified psychologist. Al 1 such information is recorded on data forms approved by the chief psychologist and in accordance with headquarters policy in multifacility systems. At *no* time is the responsibility for test administration, scoring, or the filing of psychological data given to inmate workers.

Standard 25 requires the use of appropriate personnel whose functions are to be specified in a written policy statement. A caution is also provided to control the disposition of testing data.

In sum, as can be *seen* from these examples (and others equally apply), the standards and ethical guidelines developed by the psychological profession can be integrated into an offender needs assessment system. As such systems are increasingly implemented, fundamental standards in each well-defined professional area, (e.g., medicine, education), should be examined and utilized as a basis for supporting a responsible approach to needs assessment.

C. Assessment for Internal Management Classification

Offenders and the staff who supervise them spend large proportions of time in correctional living/housing environments. Thus, classification decisions could productively address those offender/environment/management interactions that, within obvious limits, lead to the most harmonious living climate.

Within a given group of offenders sharing the same level of security/custody classification, temperaments, interaction characteristics, skills, and needs *may* vary widely. Some of these differences will be provided for through the system of needs assessment and interventions described at length in this report. However, little attention is typically given to differential, day-to-day management approaches within the living unit. We

cannot expect one custody designation, say "medium," or one offense category, e.g., robbery, to tell us how to supervise effectively the large numbers who fall within such a category. Moreover, even the availability of quality educational, mental health, or similar programs--typically offered outside the living unit--does not necessarily solve all offender management issues.

Institutional staff cannot be expected to gauge their approaches and responses on a moment-to-moment basis for each individual offender. Moreover, the natural levels of friction generated by housing incompatible groups cannot be sufficiently counteracted by applying supervisory muscle. Thus, it would be highly desirable to classify offenders into. management sub-groups--groups sharing certain salient characteristics and for whom general management prescriptions could be devised.

The technology of such differential classification and management is not yet well-developed in adult institutions. Two such reported attempts, one at the Federal Correctional Institution in Tallahassee, Florida, and the other in the Wisconsin prison system, are reviewed briefly below. A parallel and earlier literature in the juvenile delinquency area (e.g., I-level classification) is also available (Sullivan, Grant, & Grant, 1957), as is the pioneering work by Quay (1973; 1983). A few states have also begun to use Toch's (1979) Prison Preference Inventory as a means of matching prisoners to living environments and of classifying them into more homogeneous groups.

Wisconsin's Client Management Classification (CMC) System Originally developed in 1975 for use by probation and parole staff , Wisconsin's CMC has recently been extended to an institutional setting (Wisconsin, 1982). Consistent with many of the classification principles described earlier, the CMC is based on accurate information gathering, specific decision guidelines, and particular intervention strategies.

The CMC is an attempt--following custody and other program needs determinations--to provide additional qualitative information. The CMC uses semi-structured interviews, (which require some skill and flexibility on the part of the interviewer), and detailed scoring guides. As a result, the offender is placed in one of four management categories. These, in turn, are matched to supervision strategies and treatment outlines. The four categories cut across offense types and are used in addition to risk determinations and needs assessment.

The interview contains 45 items dealing with "attitude" toward prior and current offense, offense patterns, family, interpersonal relationships, current problems, and future plans. In addition, 11 objective items dealing with background are provided, followed by eight behavior ratings, and seven agent impression categories. both items and scoring guides are well-specified.

The CMC identifies four treatment groups. They are:

1. Selective Intervention
   a. Situational sub-type
   b. Treatment sub-type
2. Casework/Control
3. Environmental Structure
4. Limit Setting

For each group--emphasizing differences rather than similarities --several specific hallmarks are developed: description; goals; client-staff relationship; security; housing/peer relationships; school/vocation programs; social/clinical services; auxiliary services; and readjustment expectations.

The interrater reliability of the interview/scoring system is reportedly high. Retained items differentiate offenders into the four groups. Applicability and usefulness in the field setting has been established by a survey of parole agents. Almost without exception, field staff ranked as "improved" their knowledge and understanding of clients, case planning, referrals, anticipation of client problems, and interviewing skills. Feedback on institutional applicability is not yet completed.

However, the information collected during the interview seems sufficiently valuable to warrant its use. Scoring the interview and arriving at treatment grouping is a straightforward second step. Setting up management environments and training staff in differential supervision is obviously more involved, but, among current modalities, this approach seems quite attractive.

Management Classification at FCI Tallahassee. Given an essentially medium security institution with four large open dormitories serving as principal housing, the management of 550 young adult offenders, including many with histories of violence, is no small challenge. Such was the task faced at the Federal Correctional Institution at Tallahassee in the late 1970's. One of the dorms (units) served as a voluntary, more intense programming unit; the three other units received and housed newly admitted offenders on a rotating basis. Thus, units housed comparable proportions of trouble-makers, potential victims, difficult cases, etc. Prior to the initiation of a management classification system, rates of program participation and disciplinaries were approximately equivalent for each unit (Bohn, 1979; 1981). Improvements on both dimensions were sought.

A basic operating premise of FCI Tallahassee's new management classification system was that "predators" and "potential victims" constituted a minority of the total population and that "average" inmates could be expected to live reasonably harmoniously with either group. Separation of the two extreme groups, then, was a major consideration. Second, staff were selected and management styles developed to best match the particular group of offenders assigned to a specific living unit. One dorm was comprised of predators plus average offenders, one of potential

victims plus average offenders, and a third of average offenders.

The division of offenders into these groups flows from a classification scheme based on two major data sources: the MMPI, and a behavior rating and record review checklist. The MMPI typology recently developed by Megargee and associates (Megargee & Bohn, 1979) provided a promising basis for distinguishing among predator, stable, and victim subgroups. In addition, correctional officers completed behavioral checklists (Quay, 1973) during the offender's two-week stay in an admissions and orientation unit. Salient items from the pre-sentence investigation were also coded. Additional information included intellectual and educational data, physical characteristics, and other officer observations.

One- and two-year follow-ups of this classification approach have been undertaken. Overall assault rates have decreased, as have incident reports. Moreover, infractions involving aggression have been isolated largely to the unit housing more predatory inmates. The unit housing "average" offenders saw an almost complete elimination of violence--despite the fact that staffing ratios were decreased in order to utilize personnel in the other living units. Bohn (1981) concludes:

> . . . the management classification system, based primarily on the Megargee MMPI typology of offenders in conjunction with systematic ratings of inmate behavior and records, has played a major role in the reduction of institution violence in the Federal Correctional Institution, Tallahassee, Florida . . . . It would seem reasonable to conclude that the system could be generalized to other similar settings. (p. 10)

REFERENCES

Adler, F. (1975). Sisters in crime. New York: McGraw-Hill.

American Correctional Association. (1982). Classification as a management tool: Theories models for decision-makers. College Park, MD: Author.

American Association of Correctional Psychologists. (1980). Standards for psychology services in adult jails and prisons. Criminal Justice and Behavior, 7, 81-127.

American Association of Mental Deficiency. (1983). Classification in mental retardation. Washington, DC: Author.

American Medical Association. (1979). Standards for health services in prisons. Chicago: Author.

American Medical Association. (1981). Standards for health services in jails. Chicago: Author.

American Psychiatric Association. (1980). Diagnostic and statistical manual of mental disorders (3rd ed.). Washington, DC: Author.

American Psychological Association. (1978). Report of the task force on the role of psychology in the criminal justice system. American Psychologist, 33(12), 1099-1113.

American Public Health Association. (1976). Standards for health services in correctional institutions. Washington, DC: Author.

Austin, J. (1983). Assessing the new generation of prison classification models. Crime & Delinquency, 29(4), 561-576.

Ayllon, T., & Milan, M. A. (1979). Correctional rehabilitation and management: A psychological approach. New York: John Wiley & Sons.

Ballard, K. B., Jr., Fosen, R. H., Neiswonger, J., Fowler, R., Belasco, J., & Taylor, R. (1966). Interpersonal personality inventory manual. Vacaville, CA: Institute for the Study of Crime and Delinquency.

Beck, A. T. (1972). Depression: Causes and treatment. Philadelphia: University of Pennsylvania Press.

Bohn, M. J. (1979). Management classification for young adult inmates. Federal Probation, 43(4), 53-59.

REFERENCES

Adler, F. (1975). Sisters in crime. New York: McGraw-Hill.

American Correctional Association. (1982). Classification as a management tool: Theories models for decision-makers. College Park, MD: Author.

American Association of Correctional Psychologists. (1980). Standards for psychology services in adult jails and prisons. Criminal Justice and Behavior, 7, 81-127.

American Association of Mental Deficiency. (1983). Classification in mental retardation. Washington, DC: Author.

American Medical Association. (1979). Standards for health services in prisons. Chicago: Author.

American Medical Association. (1981). Standards for health services in jails. Chicago: Author.

American Psychiatric Association. (1980). Diagnostic and statistical manual of mental disorders (3rd ed.). Washington, DC: Author.

American Psychological Association. (1978). Report of the task force on the role of psychology in the criminal justice system. American Psychologist, 33(12), 1099-1113.

American Public Health Association. (1976). Standards for health services in correctional institutions. Washington, DC: Author.

Austin, J. (1983). Assessing the new generation of prison classification models. Crime & Delinquency, 29(4), 561-576.

Ayllon, T., & Milan, M. A. (1979). Correctional rehabilitation and management: A psychological approach. New York: John Wiley & Sons.

Ballard, K. B., Jr., Fosen, R. H., Neiswonger, J., Fowler, R., Belasco, J., & Taylor, R. (1966). Interpersonal personality inventory manual. Vacaville, CA: Institute for the Study of Crime and Delinquency.

Beck, A. T. (1972). Depression: Causes and treatment. Philadelphia: University of Pennsylvania Press.

Bohn, M. J. (1979). Management classification for young adult inmates. Federal Probation, 43(4), 53-59.

Bohn, M. J. (1981). Inmate classification and the reduction of institutional violence. In American Correctional Association (Ed.), Classification (pp. 5-12). College Park, MD: Author.

Brodsky, S. L. (1975). Family and friends of men in prison. Lexington, MA: Lexington Books.

Buchanan, R. A., & Irion, J. G. (1983). The correctional classification profile. Paper presented at the annual meeting of the American Correctional Association, Chicago.

Bureau of Justice Statistics. (1983a, January). Prisoners and alcohol. Washington, DC: U.S. Department of Justice.

Bureau of Justice Statistics. (1983b, March). Prisoners and drugs. Washington, DC: U.S. Department of Justice.

Buros, O. K. (Ed.). (1978). The eighth mental measurements yearbook. Highland Park, NJ: Gryphon.

Carlson, K. A. (1972). Classes of adult offenders: A multivariate approach. Journal of Abnormal Behavior, 79, 84-93.

Chaiklin, H. (1972). Integrating correctional and family systems. American Journal of Orthopsychiatry, 42, 784-91.

Clements, C. B. (1979). Crowded prisons: A review of psychological and environmental effects. Law and Human Behavior, 3, 217-225.

Clements, C. B. (1980). Test-trait fallacies: Prison style. American Psychologist, 35, 476-478.

Clements, C. B. (1981). The future of offender classification: Some cautions and prospects. Criminal Justice and Behavior, 8, 15-38.

Clements, C. B. (1982). The relationship of offender classification to the problems of prison overcrowding. Crime & Delinquency, 28, 72-81.

Clements, C. B. (1984). Towards an objective approach to offender classification. Law & Psychology Review, 9.

Curran, J. P., Corriveau, D. P., Monti, P. M., & Hagerman, S. (1980). Social skill and social anxiety: Self-report measurement in a psychiatric population, Behavior Modification, 4, 493-512.

Derogatis, L. R. (1977). SCL-90 administration, scoring and procedures manual. New York: Johns Hopkins University.

Federal Prison System. (1981). Inmate programs reporting system. Washington, DC: U.S. Department of Justice.

Fowler, R. D. (1979). Use of the computerized MMPI in correctional decisions. In J. N. Butcher (Ed.), New developments in the use of the MMPI. Minneapolis: University of Minnesota Press.

Gay, M., Hollandsworth, J., & Galassi, J. (1975). An assertiveness inventory for adults. Journal of Counseling Psychology, 22, 340-344.

Grossman, H. Manual of terminology and classification in mental retardation (1977 rev.). Washington, DC: AAMD.

Gunn, J., Robertson, G., Dell, S., & Way, C. (1978). Psychiatric aspects of imprisonment. London: Academic.

Guze, S. B., & Goodwin, D. W. (1972). Consistency of drinking history and diagnosis of alcoholism. Quarterly Journal of Studies on Alcoholism, 33, 111-116.

Guze, S. B., Tuason, V. B., Gatfield, P. D., Stewart, M. A., & Picken, B. (1962). Psychiatric illness and crime with particular reference to alcoholism: A study of 223 criminals. Journal of Nervous Mental Disorders, 134, 512-521.

Hawkins, R. P. (1979). The functions of assessment: Implications for selection and development of devices for assessing repertoires in clinical, educational, and other settings. Journal of Applied Behavioral Analysis, 12, 501-516.

Hersen, M., & Bellack, A. S. (1981). Behavioral assessment: A practical handbook. New York: Pergamon.

Jacobson, G. R. (1980). Diagnosis and assessment of alcohol abuse and alcoholism: A report to the National Institute on Alcohol Abuse and Alcoholism (DHEW Pub. No. ADM 80-228). Washington, DC: U.S. Government Printing Office.

Jenkins, W. O., deValera, E. K., & Muller, J. B. (1977). The Behavioral Evaluation Treatment and Analysis (BETA) System in the prediction of criminal and delinquent behavior. Quarterly Journal of Corrections, 1, 44-50.

Jenkins, W. O., Muller, J. B., deValera, E. D., & Kelly, J. V. (1977). An evaluative follow-up study of the Birmingham treatment alternatives to street crime (TASC) drug program. University, AL: Rehabilitation Research Foundation.

Jones, S. E. (1982). An exploratory study of alternate sources of vocational training for incarcerated women. Unpublished manuscript, University of Alabama.

Kennedy, M., Goodman, M., Day, E., & Griffin, B. W. (1982). Mentally retarded offenders: A handbook for criminal justice personnel. Cleveland, OH: Federation for Community Planning.

Kentucky Corrections Cabinet. (1983). Classification manual. Frankfort, KY: Author.

Kerlan, M. W. (1971). Court procedures for identifying problem drinkers, Volume I: Manual (U.S. Department of Transportation Publication No. DOT-HS-uoo-632). Ann Arbor, MI: Highway Safety Research Institute.

Kissin, B., & Begleiter, H. (1977). Treatment and rehabilitation of the chronic alcoholic. New York: Plenum Press.

Levinson, R. B. (1982a). The federal prison system's security designation/custody classification approach. In American Correctional Association (Ed.), Classification as a management tool: Theories and models for decision-makers. College Park, MD: Author.

Levinson, R. B. (1982b). Guest editorial: A clarification of classification. Criminal Justice and Behavior, 9(2), 133-142.

Lomastrol, J. F. (1977). Classifying retarded offenders. American Archives of Rehabilitation Therapy, 25(2), 8-11.

Lowe, M. R., & Cautela, J. R. (1978). A self-report measure of social skill. Behavior Therapy, 9, 535-544.

MacAndrew, C. (1965). The differentiation of male alcoholic outpatients from nonalcoholic psychiatric patients by means of the MMPI. Quarterly Journal of Studies on Alcohol, 26, 238-246.

Manson, M. P. (1949). A psychometric determination of alcohol addiction. American Journal of Psychiatry, 106, 199-205.

Mathews, R. M., Whang, P. L., & Fawcett, S. B. (1980). Development and validation of an occupational skills assessment instrument. Behavioral Assessment, 2, 71-85.

Mathews, R. M., Whang, P. L., & Fawcett, S. B. (1981). Behavioral assessment of job-related skills. Journal of Employment Counseling, 18, 3-11.

Mathews, R. M., Whang, P. L., & Fawcett, S. B. (1982). Occupational skills assessment instrument. University of Kansas: Research and Training Center on Independent Living.

Mathews, R. M., Whang, P. L., & Fawcett, S. B. (1982). Behavioral assessment of occupational skills in learning-disabled adolescents. Journal of Learning Disabilities, 15, 38-41.

McKee, J. M., Pirhalla, S. M., & Burkhalter, B. B. (1982). A system for preparing an employability development plan for CETA participants. University, AL: Rehabilitation Research Foundation.

Megargee, E. I., & Bohn, M. J., Jr., with Myer, J., Jr., & Sink, F. (1979). Classifying criminal offenders: A new system based on the MMPI. Beverly Hills, CA: Sage Publications.

Monahan, J. (1981). Predicting violent behavior: An assessment of clinical techniques. Beverly Hills, CA: Sage Publications.

National Institute of Corrections. (1982). Prison classification: A model systems approach. Washington, DC: U.S. Department of Justice.

Nelson, R. O., & Hayes, S. C. (1981). Nature of behavioral assessment. In M. Hersen & A. S. Bellack (Eds.), Behavioral assessment: A practical handbook. New York: Pergamon.

Pointer, W. D., & Kravits, M. (1981a). Prison and jail health care: A selected bibliography (Contract No. J-LEAA-023-77). Washington, DC: U.S. Department of Justice.

Pointer, W. D., & Kravits, M. (1981b). The handicapped offender: A selected bibliography (Contract No. J-LEAA-013-81). Washington, DC: U.S. Department of Justice.

Quay, H. C. (1973). The differential behavioral classification of the adult male offender: Interim results and procedures (Report No. J-Ic-22-253). Washington, DC: U.S. Department of Justice, Bureau of Prisons.

Quay, H. C. (1983). Technical manual for the behavioral classification system for adult offenders (Grant No. FB-6). Washington, DC: National Institute of Corrections.

Richardson, F. C., & Tasto, D. L. (1976). Development and factor analysis of a social anxiety inventory. Behavior Therapy, 7, 453-462.

Santamour, M. B., & West, B. (1979). Retardation and criminal justice: A training manual for criminal justice personnel (Contract No. A-A; 3-217-77). Washington, DC: President's Committee on Mental Retardation.

Sarri, R. C. (1983). Gender issues in juvenile justice. Crime & Delinquency, 29(3), 381-397.

Selzer, M. L. (1971). The Michigan Alcoholism Screening Test: The quest for a new diagnostic instrument. American Journal of Psychiatry, 127, 89-94.

Sullivan, C., Grant, M., & Grant, J. (1957). The development of interpersonal maturity: Applications to delinquency. Psychiatry, 20, 373-385.

Sweetland, R. C., & Keyser, D. J. (Eds.). (1983). Tests: A comprehensive reference for assessments in psychology, education and business. Kansas City: Test Corporation of America.

Toch, H. (1979). Living in prison: The ecology of survival. New York: Free Press.

Trower, P., Bryant, B., & Argyle, M. (1978). Social skills and health. London: Methven.

U.S. Comptroller General. (1978). Federal strategy is needed to help improve medical and dental care in prisons and jails. Washington, DC: U.S. General Accounting Office.

U.S. Comptroller General. (1979). Prison mental health care can be improved by better management and more effective federal aid. Washington, DC: U.S. General Accounting Office.

U.S. Department of Justice. (1982). Prisoners and alcohol. Rockville, MD: Bureau of Justice Statistics.

U.S. Department of Justice. (1982). Prisoners and drugs. Rockville, MD: Bureau of Justice Statistics.

Warren, M. (Ed.). (1981). Comparing female and male offenders. Beverly Hills, CA: Sage Publications.

Washington Department of Corrections (1984). User's manual for inmate classification. Olympia, WA: Author.

Watson, D., & Firend, R. (1969). Measurement of social-evaluative anxiety. Journal of Consulting and Clinical Psychology, 33, 448-457.

Weissman, M. M., & Bothwell, S. (1976). Assessment of social adjustment by patient self-report. Archives of General Psychiatry, 33, 1111-1115.

Wisconsin Bureau of Corrections (1982). Client management classification: Institution treatment outline. Madison, WI: Author.

Wolpe, J., & Lazarus, A. A. (1966). Behavior therapy techniques. New York: Pergamon.

APPENDIX A

Tests and Instruments for

Offender Assessment

The instruments listed on the following sections are by no means intended to represent all of the available tests and measures, but rather they are provided as a representative sample of the options available. Many popular tests were omitted from the listings because they did not meet minimal reliability or validity criteria or did not appear to be suitable for use with an inmate population. For example, many instruments have been standardized only on students or require testing circumstances that are clearly unavailable in the prison environment.

Some instruments are listed which, while not previously researched with offender populations, offer information of potential value. The reader is cautioned, however, that their use must conform to the principles outlined in this manual. The reader should consult the narrative section on the relevant need-dimension for recommendations and additional discussion.

Further information, including detailed descriptions and critiques of most instruments, can be found in the Eighth Annual Mental Measurements Yearbook (Buros, 1978) and Tests: A Comprehensive Reference for Assessments in Psychology, Education and Business (Sweetland & Keyser, 1983), or by writing directly to the publishers.

Readers aware of other instruments useful in correctional settings are invited to communicate with NIC or directly with the authors of this volume.

A-1 PSYCHOLOGICAL/MENTAL HEALTH: GENERAL

Instrument	Time in Minutes	Admin.	Publisher/Availability
Minnesota Multiphasic Personality Inventory (MMPI) Interpretive Scoring	45-120	Indiv. or group	University of Minnesota Press--distributed exclusively by NCS Interpretive Scoring Systems

Comments: 566 items, 6th grade reading, less with tape recorded items. Prisoner norms and other research-based information widely available.

Millon Clinical Multiaxial Inventory	25	Indiv. or group	NCS Interpretive Scoring Systems

Comments: 175 items, 8th grade reading level. Coordinated with DSM-III, providing Axis I and Axis II diagnosis. Screening for psychopathology and assessment of personality dynamics. Scales: Basic Personality Patterns (DSM-III, Axis II), Pathological Personality Disorders (DSM-III, Axis II), Clinical Symptom Syndromes (DSM-III, Axis I). Validity Scales.

Hoffer-Osmond Diagnostic (HOD) Test	25-30	Indiv. or group	Behavior Science Press

Comments: 145 statements to be answered either "True" or "False." Designed to survey and assess the range of an individual's sensory perceptions and mood changes which may be associated with schizophrenic disorders. The results produce six scores: a Total Score, Perceptual Score, Paranoid Score, Depression Score, Thought Disorder Score, and a Ratio Score.

Cornell Index	5-15	Indiv. or group	Psychological Corporation

Comments: 101 items. Rapid screening instruments for psychosomatic disturbances. Has been used as an index of general maladjustment among new penitentiary inmates.

Instrument	Time in Minutes	Admin.	Publisher/Availability
Psychological Inventory (PSI)	15	Indiv. or group	Research Psychologists Press

Comments: 130 items. Brief mental health screening instrument. Five scores: alienation, social nonconformity, discomfort, expression, defensiveness.

California Psychological Inventory	45-60	Indiv. or group	Consulting Psychologists

Comments: High school and adult. 480 items assess personality factors important for social living and interaction. Scales: poise, ascendancy, self-assurance, interpersonal adequacy, socialization, responsibility, interpersonal values, character, achievement potential, intellectual efficiency,intellectual/ interest modes. Spanish version available.

Clinical Analysis Questionnaire (CAQ)	2 hours	Indiv or group	Institute for Personality and Ability Testing

Comments: 272 items. Measures both normal personality (using 16 PF) plus 12 scales measuring psychopathology.

The Personality Inventory	25	Indiv.	Consulting Psychologists

Comments: 125 items, 6 scores: neurotic tendency, self-sufficiency, introversion-extroversion, dominance-submission, sociability, confidence.

Sixteen Personality Factor Questionnaire (16PF)	45-60	Indiv. or group	Institute for Personality and Ability Testing

Comments: 187 items (Forms A & B), 105 (Forms C & D, more elementary reading level). Scales: reserved/warm-hearted, dull/bright, low/high ego strength, submissive/dominant, serious/ happy-go-lucky, weak/strong ego strength, shy/venturesome, tough/ tenderminded, trusting/ suspicious, practical/imaginative, forthright/shrewd, assured/ apprehensive, conservative/radical, group-oriented/self-sufficient, undisciplined/controlled, relaxed/tense. Spanish version available.

Instrument	Time in Minutes	Admin.	Publisher/Availability
Eysenck Personality Questionnaire	10-15	Indiv. or group	Educational and Industrial Testing Service
Comments: Three dimensions of personality: Psychoticism, Extroversion, Neuroticism.			
Mooney Problem Check List	30-50	Indiv.	Psychological Corporation
Comments: 288 items measure concerns in the areas of health, economic security, self-improvement, personality, home and family, courtship, sex, religion, and occupation.			
Edwards Personal Preference Schedule	40-45	Indiv. or group	Psychological Corporation
Comments: 225 items measuring needs that motivate individuals. Scales: achievement, dominance, endurance, order, intraception, nurturance, affiliation, heterosexuality, exhibition, autonomy, aggression, change, succorance, abasement, deference.			
Adjective Check List	15-20	Indiv. or group	Consulting Psychologists
Comments: 300-adjective list, 37 possible scales. Self-perception regarding Edwards' needs. Clinical scales: counseling readiness, self-control, self-confidence, personal adjustment, ideal self, creative personality, military leadership, masculine attributes, feminine attributes, critical parent, nurturing parent, adult, free child, adopted child. Available in Spanish.			
Profile of Mood States	3-5	Indiv. or group	Educational and Industrial Testing Service
Comments: 65 adjectives. Rating scale tension-anixety, depression-dejection, anger-hostility, vigor-activity, fatigue-inertia confusion-bewilderment.			

A-1 PSYCHOLOGICAL/MENTAL HEALTH: GENERAL (continued)

Instrument	Time in Minutes	Admin.	Publisher/Availability
SCL-90	10-20	Indiv. or group	Derogatis (1977)
Comments: 90 items, nine scales: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism.			
Interpersonal Personality Inventory	20-30	Indiv. or group	Ballard, Fosen, Neiswonger, Fowler, Belasco, and Taylor (1966)
Comments: Objective means of classifying inmates as "high" or "low" on levels of integration (I-levels) of interpersonal maturity. 93 items.			

A-1 PSYCHOLOGICAL/MENTAL HEALTH: DEPRESSION

Instrument	Time in Minutes	Admin.	Publisher/Availability
IPAT Depression Scale	10	Indiv. or group	Institute for Personality and Ability Testing
Comments: 40 items. Brief estimate of depression normed on prison population.			
Depression Adjective Check List (DACL)	5	Indiv. or group	Educational and Industrial Testing Service
Comments: 34 items, measure of transient state of depression. Seven alternate forms. Four forms for women, three for men. Positive and negative adjectives. Extensive normative data available. Alternate forms for rapid retesting.			

A-1 PSYCHOLOGICAL/MENTAL HEALTH: DEPRESSION (continued)

Instrument	Time in Minutes	Admin.	Publisher/Availability
Beck Depression Inventory	2-3	Indiv. or group	Beck (1972)
Comments: 21 items (13 item short form available) relating to symptomatology of depression, including cognitive, affect, overt behavior, somatic symptoms, and interpersonal symptoms.			
Center for Epidemiological Studies of NIMH (CES-D)	203	Indiv. or group	Center for Epidemiological Studies
Comments: 20 items to measure "current level of depressive symptomatology with emphasis on the affective component, depressed need."			
MMPI-D Scale	5-10	Indiv. or group	University of Minnesota, distributed by NCS Interpretive Scoring System
Comments: 60 items. Most frequently used depression index. May not discriminate from anxiety.			

A-1 PSYCHOLOGICAL/MENTAL HEALTH: SUICIDE

Instrument	Time in Minutes	Admin.	Publisher/Availability
S-D Proneness Checklist	5-15	Indiv. or group	Psychologists and Educators, Inc.
Comments: 30 item inventory measure of suicidal feelings and behavior. (No reliability or validity data available.)			
Suicide Probability Scale (SPS)	5-10	Indiv. or group	Western Psychological Services
Comments: 36 statements, yields probability index of engaging in suicidal behavior.			

A-2 ALCOHOL AND DRUG ABUSE *

Instrument	Time in Minutes	Admin.	Publisher/Availability
MacAndrew Alcoholism Scale (ALC)	90 min	Indiv. or group	Psychological Corporation
Comments: ACL is one of the special scales of the MMPI. Can administer 49 items separately or as part of routine administration.			
Michigan Alcoholism Screening Test (MAST)	20-30 min.	Individual	Selzer (1971)
Comments: Individual, structured interview which can be administered by trained clerical staff.			
Mortimer-Filkins Test	60 min.	Part I: indiv. or group	National Technical Information Service U.S. Department of Commerce
Comments: Part I is self-administering questionnaire. Part II is a brief, structured interview.			
Guze and Goodwin's 17 Item Drinking History Questionnaire	15-30 min.	Indiv.	Guze, Tuason, Gatfield, Stewart, and Picken (1962)
Comments: Quick, simple structured interview.			
Alcadd Test	10-15 min.	indiv. or group	Western Psychological Services
Comments: 60 item, yes/no questionnaire.			
Drug & Alcohol Use Evaluation Scale (DUES/AUES)	varies 20 min. average	Indiv.	Rehabilitation Research Foundation
Comments: Structured behavioral interview. Good for getting pre- and posttreatment measures for evaluating treatment outcome.			

* See also Appendix B

A-3 INTELLECTUAL ASSESSMENT

Instrument	Verbal/ Nonverbal	Time	Publisher
Individual Administration			
Wechsler Adult Intelligence Scale-Revised (WAIS-R)	both	40-75	Psychological Corp.
Comments: Spanish version available.			
Stanford-Binet Intelligence Scale	both	45-90	Riverside Publishing Co.
Comments: Presupposes language, lower floor than WAIS-R.			
Standard Progressive Matrices	nonverbal	45	Psychological Corp.
Comments: Nonverbal test of intellectual efficiency.			
Slosson Intelligence Test (SIT)	verbal	10-20	Slosson Educational Publications, Inc.
Comments: Can be administered by clerical staff. Quick screening instrument.			
Full Range Picture Vocabulary Test	verbal	10-15	Psychological Test Specialists
Comments: Good with individuals with physical handicaps or communication difficulties.			
Quick Test	nonverbal	3-9	Psychological Test Specialists
Comments: 50 items, 3 forms; brief, provides rough estimate. Can be administered by clerical staff. Requires no verbal abilities, examinee need only point to correct answer.			

A-3 INTELLECTUAL ASSESSMENT (continued)

Instrument	Verbal/ Nonverbal	Time	Publisher
Ohio Classification Test	verbal	20	Psychometric Affiliates
Comments: Specifically developed as a group test for mental ability screening with penal populations. Intended as a culture-fair test.			
The Immediate Test (IT)	Verbal	5	Sheridan Psychological Services
Comments: 66 items. Rapid estimate of mental age and IQ. Designed for emergency use, rough screening only.			
Spanish Speaking			
Pruebas de Habilidad General	both		Guidance Testing
Comments: Test of general ability. 6 levels preschool through level 5 (adult). Yields verbal-numerical, non-verbal and total score.			
Barranquilla Rapid Survey Intelligence Test (BARSIT)	verbal	15	Psychological Corp.
Comments: Test of mental ability in Spanish; verbal and numerical scores; examiner must speak Spanish.			
Group Administration			
Culture Fair Intelligence Test Scale II (3 forms)	nonverbal	15-30	Institute for Personality and Ability Testing
Comments: Individual or group test designed to minimize importance of verbal fluency, cultural influence, and educational level.			

A-3 INTELLECTUAL ASSESSMENT (continued)

Instrument	Verbal/ Nonverbal	Time	Publisher
Revised Beta Examination-Second Edition (Beta-II)	nonverbal	15-30	Psychological Corp.
Comments: Measure of general intellectual ability of relatively illiterate or non-English speaking. Rough screening only.			
Otis-Lennon Mental Ability Test (replaces Otis Quick Scoring Mental Ability Test)	verbal	30-45	Psychological Corp.
Comments: Assesses mental ability and scholastic aptitude; optional scoring services available.			
Henmon-Nelson Tests of Mental Ability	verbal	40-50	Houghton Mifflin Company
Comments: Single factor measure of mental ability. 4 levels, college level now out of print.			

A-4 ADAPTIVE FUNCTIONING

Instrument	Verbal/ Nonverbal	Time	Publisher
AAMD Adaptive Behavior Scale	nonverbal	30	AAMD
Comments: Use as a content base for assessment. Observational rating scale of 95 items.			
Vineland Social Maturity Scale	nonverbal	20-30	American Guidance Service
Comments: Requires interview with primary caregiver. 8 categories: Self-help general, self-help eating, locomotion, self-help dressing, occupation, communication, self-direction, socialization.			
Vocational Adaptation Rating Scale (VARS)	verbal	20-30	Western Psychological Services
Comments: Measure of maladaptive behavior in MR's that would interfere with vocational training. Must be completed by an individual who knows inmate well. Not a screening instrument.			
Vocational Information and Evaluation Work Samples (VIEWS)	nonverbal	varies	Vocational Research Institute
Comments: 16 work samples for assessment of mentally retarded. Expensive, beyond screening level.			

A-5 ACADEMIC EDUCATION

Instrument	Time in Minutes	Admin.	Publisher/Availability
Tests of Adult Basic Education (TABE)	120 per level	Indiv. or group	CTB/McGraw-Hill
Comments: 3 levels: easy, medium, and difficult. Locator test for identifying starting level. Measures adult proficiency in reading, mathematics and language.			
Wide Range Achievement Test (WRAT)	15-30	1 part Indiv./ 2 parts group	Jastak Associates
Comments: Spelling, arithmetic, reading. Two levels available.			
California Achievement Test (CAT)	varies 180-240	Indiv. or group	CTB/McGraw-Hill
Comments: 10 levels. Measures reading, mathematics, language, spelling and reference skills.			
Comprehensive Test of Basic Skills (CTBS)	5 hours 35 min.	Indiv. or group	CTB/McGraw-Hill
Comments: Locator tests. Measures reading, mathematics, language, spelling and reference skills.			
Adult Basic Learning Examination (ABLE)	varies 25-180	Indiv. or group	Psychological Corp.
Comments: Screening test also provided to select appropriate assessment level (3 levels available). Basic educational achievement of adults who have not completed a formal 8th grade education.			

A-5 ACADEMIC EDUCATION (continued)

Instrument	Time in Minutes	Admin.	Publisher/Availability
Stanford Achievement Test Test (SAT) 7th edition	3 hours 40 min.	Indiv. or group	Psychological Corp.
Comments: Assessment of skills in all major academic areas. 10 levels: K through college entry. Computer scored.			
Basic Achievement Skills Individual Screener (BASIS)	60	Indiv.	Psychological Corp.
Comments: Diagnostic assessment of academic strengths and weaknesses. Hand scored.			
Metropolitan Achievement Tests 5th edition Survey Battery	1 hour 55 min. average	Indiv. or group	Psychological Corp.
Comments: 8 battery levels.			
Stanford Test of Academic Skills 1st edition (TASK)	2 hours 15 min.	Indiv. or group	Psychological Corp.
Comments: Assessment in reading, English, and mathematics.			
Life Skills: Tests of Functional Competencies in Reading and Math	80	Indiv. or group	Riverside Publishing Company
Comments: Everyday skills in reading and mathematics.			
Minimal Essentials Test	90	Indiv. or group	Scott, Foresman Lifelong Learning
Comments: Measures basic skills in academic areas and general life skills.			

Instrument	Time in Minutes	Admin.	Publisher/Availability
Peabody Individual Achievement Test (PIAT)	30-50	Indiv.	American Guidance Service
Comments: Wide-range screening measure of achievement in mathematics, reading, spelling and general information.			
Diagnostic Pre-test for GED Instruction	varies with test given	Indiv. or group	Contemporary Books
Comments: 5 separate tests--writing skills, social studies, science, reading skills, mathematics.			
GED Practice Tests	3 hours	Indiv. or group	Contemporary Books
Comments: Rough prescriptive function, 300 items.			

A-6 VOCATIONAL APTITUDE

Instrument	Time in Minutes	Admin.	Publisher
United States Employment Service General Aptitude Test Battery (GATB) B-1002	2.5 hrs	Indiv.	U.S. Department of Labor
Comments: 434 items, 12 tests; 8 paper and pencil, 4 performance. 9 scores: intelligence, verbal, numerical, spatial, form perception, clerical perception, motor coordination, manual dexterity. Spanish version available.			
Nonreading Aptitude Test Battery (NATB)	3 hrs	Indiv.	U.S. Department of Labor
Comments: 10 paper and pencil, 4 performance. Nonreading adaptation of GATB.			
GATB-NATB Screening Device	15-20	Indiv. or group	Intran Corporation
Comments: Used to identify examinees who are deficient in reading skills and should be tested with nonreading adaptation.			
Differential Aptitude Tests (DAT)	3 hrs.	Indiv. or group	Psychological Corp.
Comments: Comprehensive, measures 6 basic aptitudes; computer scoring available. Yields 9 scores: verbal reasoning, numerical ability, VT and NA, abstract reasoning, clerical speed and accuracy, mechanical reasoning, space relations, spelling, language usage.			
Employee Aptitude Survey	60	Indiv. or group	Educational and Industrial Testing Service
Comments: 10 part battery measures aptitudes for 52 occupational and educational groups from file clerk to manager.			

A-6 VOCATIONAL APTITUDE (continued)

Instrument	Time in Minutes	Admin.	Publisher
Short Occupational Knowledge Tests	10-15	Indiv. or group	Science Research Associates

Comments: Series of separate tests designed to determine an applicant's current skills and proficiency in a certain area. Areas include: auto mechanic, bookkeeper, carpenter, draftsman, electrician, machinist, office machine operator, plumber, secretary, tool and die maker, truck driver, welder. Cassette version available.

Wide Range Employability Sample (WREST)	1.5 hrs.	Indiv.	Jastak Associates

Comments: Expensive; hands-on work samples. For normal and mentally or physically handicapped adults.

Vocational Information & Evaluation Work Samples (VIEWS)	varies	Indiv.	Vocational Research Institute

Comments: Vocational evaluation for mentally retarded. Provides 16 work samples. Expensive. Appropriate for more thorough assessment, beyond screening level. Can be used to assess interests.

Vocational Interest Temperament and Aptitude System (VITAS)	varies	Indiv.	Vocational Research Institute

Comments: 29 work samples. Expensive. More thorough assessment, beyond screening level. Can be used to assess interests.

Vocational Evaluation System Occupational Assessment	varies	Indiv.	Singer Company

Comments: Extensive but expensive. Also used to assess interests.

Note: Aptitude tests for very specific occupations, e.g., clerical, mechanical, computer programming, typing, etc. are available; however, these tests go well beyond the initial screening assessment level, and are therefore beyond the scope of the present review.

A-7 VOCATIONAL INTERESTS

Instrument	Time in Minutes	Admin.	Publisher
California Occupational Preference System Interest Inventory	30-40	Indiv. or group	Educational and Industrial Testing Service
Comments: Provides job activity interest scores related to large number of occupational clusters. 168 items. High school and college.			
Kuder Occupational Interest Survey-Revised (Form DD)	30-40	Indiv. or group	Science Research Associates
Comments: 114 occupations; 48 college majors.			
Career Assessment Inventory	20-35	Indiv. or group	NCS Interpretive Scoring Systems
Comments: Written at 6th grade reading level. For individuals interested in immediate career entry or in occupations requiring some post-secondary education, but not 4-year degree.			
Vocational Preference Inventory	15-30	Indiv. or group	Consulting Psychologists
Comments: 11 scales: realistic, intellectual, social, conventional, enterprising, artistic, self-control, masculinity, status, infrequency, acquiescence.			
Geist Picture Interest Inventory	30	Indiv. or group	Western Psychological Services
Comments: Also has a motivation questionnaire that can be administered. Form for deaf; separate forms for males and females.			
Gordon Occupational Checklist II	20-25	Indiv. or group	Psychological Corp.
Comments: Can be used with individuals with low reading levels. Aimed toward those seeking job training below the college level.			

A-7 VOCATIONAL INTERESTS (continued)

Instrument	Time in Minutes	Admin.	Publisher
Self-Directed Search: A Guide to Educational and Vocational Planning Form E	40-60	Indiv. or group	Consulting Psychologists
Comments: Form E for inmates requiring easier reading level (4th grade vocabulary required). Gives measure of interest for a specific occupational cluster and corresponding educational requirements. Male/female norms.			
Strong-Campbell Interest Inventory	30-45	Indiv. or group	Stanford University Press
Comments: 325 items. 8th grade reading level. Requires computer scoring. 6 general occupational themes, 23 basic interest scales, 162 occupational scales, 11 administrative indexes. Male/female norms.			
Ohio Vocational Interest Survey II (OVIS)	45	Indiv. or group	Psychological Corp.
Comments: 253 items tapping 23 occupational interest clusters. Male/female norms.			
Wide Range Interest Opinion Test (WRIOT)	40	Indiv. or group	Jastak Associates
Comments: Provides 25 scores, 18 occupational interests and 7 vocational aptitudes. Male/female norms.			
Occ-U-Sort	varies	Indiv. or group	CTB/McGraw-Hill
Comments: 3 levels, high school through college.			

Instrument	Time in Minutes	Admin.	Publisher
Temperament and Values Inventory (TVI)	20-30	Indiv. or group	NCS Interpretive Scoring System

Comments: 230 items, measures personality and motivational characteristics for getting along on the job. 8th grade reading level. Personal Characteristics Scales: routine/flexible, consistent/ changeable, quiet/active, attentive/distractible, reticent/persuasive, reserved/sociable, serious/cheerful. Reward Values Scales: philosophical curiosity, work independence, leadership, managerial/ sales benefits, social recognition, task specificity, social service.

Adult Performance Level Program (APL)	varies 90-120	Indiv. or group	American College Testing Program

Comments: 42 items set in context of everyday problems relating to finding and keeping a job. Reading level at 4th grade. Very practical problems posed by questions.

Occupational Skills Assessment Instrument	40	Indiv. or small groups	Matthews, Whang, and Fawcett (1982)

Comments: Behavioral assessment of individuals' actual level of occupational skills. Uses a series of analogue employment situations that relate to finding, securing, and keeping a job. Uses role playing and a written sample.

Employment Barrier Identification Scale	varies 20-45	Indiv.	Rehabilitation Research Foundation

Comments: Structured interview assessing 19 barriers to getting and holding suitable job. Assesses operative behavioral patterns and environmental factors. Originally developed for use with CETA program participants.

Job Search Assessment	varies	Indiv.	Prep Inc.

Comments: Audio-visual assessment of individual's knowledge of job search topics (20 topics in all), including letter writing, employment agencies, interviewing, etc. Expensive, beyond screening, more diagnostic than other tests.

A-9 PERSONAL-SOCIAL SKILLS

Instrument	Time in Minutes	Admin.	Publisher
Interpersonal Skills			
Fundamental Interpersonal Relations Orientation Behavior (FIRO-B)	varies, brief	Indiv. or group	Consulting Psychologists
Comments: 54 items, six scales, measuring characteristic behavior toward other people in the areas of inclusion, control, and affection. Useful in measuring people's relationships as well as individual characteristics.			
Social Performance Survey Schedule (SPSS)	not timed	Indiv. or group	Lowe & Cautela (1978)
Comments: 100 item, behaviorally specific self-report. Behavior tests/situations of several kinds to be used as part of treatment planning.			
Social Avoidance & Distress Scale	not timed	Indiv. or group	Watson & Firend (1969)
Comments: Nondiagnostic but overall index of social anxiety. Self-report.			
Social Situations Questionnaire	--	--	Trower, Bryant, & Argyle (1978)
Comments: Wide range of social situations; difficulty as well as frequency of occurrence.			
Social Adjustment Scale	15	Indiv. or group	Weissman & Bothwell (1976)
Comments: 42 item, self-report. Covers social-interpersonal factors, including those of depression.			

Instrument	Time in Minutes	Admin.	Publisher
Social Anxiety Inventory	20-30	Indiv. or group	Richardson & Tasto (1976) Curran, Corriveau, Monti, & Hagerman (1980)

Comments: 100 items (plus a modified version), 7 factors: fear of disapproval or negative evaluation; social assertiveness and visibility; confrontation and anger; heterosexual contact; intimacy and interpersonal warmth; conflict with or rejection by parents; and interpersonal loss. Modified version adds social skill assessment in addition to social anxiety.

Wolpe-Lazarus Assertiveness Scale	brief	Indiv. or group	Wolpe & Lazarus (1966)

Comments: Assertiveness measure in general adult population.

Adult Self-Expression Scale	brief	Indiv. or group	Gay, Hollandsworth, & Galassi (1975)

Comments: Assertiveness measure.

Interpersonal Personality Inventory	20-30	Indiv. or group	Ballard, Fosen, Neiswonger, Fowler, Belasco & Taylor (1966)

Comments: Objective means of classifying inmates as "high" or "low" in levels of integration (I-levels) of interpersonal maturity. 93 items.

Self-Management, Money Management

Adult Performance Program (APL) Form AA-1	varies, approx. 2.5 hrs.	Indiv. or group	American College Testing Program

Comments: Test battery assesses life skills necessary for minimal levels of educational and economic success. Emphasis is on functional skills relevant to everyday living. Five content areas: community resources, occupational knowledge, consumer economics, health, government and law, and five skills areas: identification of facts and terms, reading, writing, computation, problem solving. Requires only 6th grade reading level.

Instrument	Time in Minutes	Admin.	Publisher
Comprehensive Occupational Assessment and Training System-Living Skills	varies	Indiv.	Prep, Inc.

Comments: Assesses skills and knowledge necessary for an individual to function successfully on a day-to-day basis. Similar to APL, in fact, developed based on studies of APL. Minimal reading required due to use of audio visual presentation. Lengthy, expensive. Beyond screening level.

Minimum Essentials Test (MET)	90	Indiv.	Scott, Foresman Lifelong Learning Division

Comments: Two parts: Basic Skills (reading, language, and mathematics) and Life Skills (nutrition, occupation, etc.)

Leisure Time Usage

Leisure Activities Blank (LAB)	15-30	Indiv. or group	Consulting Psychologists

Comments: 120 items, 16 scores: past and future participation.

Leisure Interest Inventory	20-25	Indiv. or group	Hubert, Edwina E.

Comments: Five scores: games, art, sociability, mobility, immobility.

A-10 FAMILY AND FRIEND RELATIONSHIPS

Instrument	Time in Minutes	Admin.	Publisher
Marital Satisfaction Inventory	30-40	Indiv. or couple	Western Psychological Services
Comments: 280 items self-report that measures each spouse's marital distress along 9 dimensions: affective communication, problem solving communication, time together, disagreement about finances, sexual dissatisfaction, role orientation, family history of distress, dissatisfaction with children, conflict over children.			
Marriage Adjustment Inventory	10-20	Each spouse separately	Western Psychological Services
Comments: 157 items. Rapid assessment of 12 most common problem areas. Provides self-appraisal by each partner.			
Marital Diagnostic Inventory	30	Each spouse separately	Western Psychological Services
Comments: Provides intake information relevant to marriage counseling.			
MMPI--Family Problems Content Scale (FAM)	90	Indiv. or group	Psychological Assessment Services
Comments: Content scales of MMPI, items can be administered separately or scored from full test.			
Mooney Problem Checklist	30-50	Indiv. or group	Psychological Corp.
Comments: One of 9 scores taps home and family problems.			
A Familism Scale	10	Indiv. or group	Bardis (Panos D.)
Comments: 16 items, assesses inmates' attitudes toward nuclear and extended family.			

A-10 FAMILY AND FRIEND RELATIONSHIPS (continued)

Instrument	Time in Minutes	Admin.	Publisher
Family Environment Scale	20	Indiv. or group	Consulting Psychologists
Comments: 90 items--characteristics of family environment: cohesion, expressiveness, conflict, independence, achievement orientation, intellectual-cultural orientation, active-recreational orientation, moral-religious emphasis, organization and control.			
Interpersonal Conflict Scale	30	Indiv. or group	Family Life Publications
Comments: 80 items--conflict level within primary relationship.			
Marital Communications Inventory	20	Indiv. or group	Family Life Publications
Comments: Communication difficulties in problem marriages.			

APPENDIX B

Detailed Descriptions of Alcohol and Drug Abuse Screening Instruments*

*Jacobson (1980) is the general reference source used in the discussion of the alcohol assessment instruments reported in this section.

MacAndrew Alcoholism Scale (ALC)

Development

The MacAndrew Scale (ALC) (MacAndrew, 1965) was derived from the Minnesota Multiphasic Personality Inventory (MMPI) by selecting items that reliably differentiate alcoholic from nonalcoholic patients. The scale has undergone extensive study and revision over fifteen years, and the current form clearly represents a well-established alcoholism scale.

Description

The MacAndrew Alcoholism Scale consists of 49 true/false items from the MMPI answered by the inmate: Thus scoring necessitates only the addition of one scoring template, making the scale essentially self-administering. The ALC scale can be easily scored by clerical help or via computer. Interpretation of the ALC involves the application of a cutoff score, generally regarded as 24, although higher cutoff scores have been proposed with mixed research results. Although interpretation may be made on this basis alone, it is generally more appropriate to view the ALC in light of the F scale score on the MMPI (generally regarded as a measure of "faking bad" or "faking good"). This interpretation should be made by someone knowledgeable in the interpretation of the MMPI.

Reliability and Validity

The MacAndrew Alcoholism Scale has received a tremendous amount of research attention, particularly surrounding the appropriate cutoff score. However, research on special populations, e.g., prison populations, is rare. Normative data on women is also sparse. Although research continues, the consensus regards the ALC as a strong instrument, one of the best currently available, and a valid screening device when used cautiously as a detection or identification scale for alcoholism.

Advantages

1. Self-administering.
2. Easily scored.
3. Generally routinely given.
4. Can be given to inmates with reading levels above elementary school.
5. This scale is not a test employing face validity, (that is, the items don't appear to measure what they are in fact measuring; it is a "disguised" test). Thus, among inmate populations who may perceive a need to distort their alcoholism, the test may still render valid results.

Disadvantages

1. The length of time required to administer the entire MMPI (minimum of 90 minutes) is seen as a drawback by some; however, since routine administration of the MMPI is quite frequent, scoring the MacAndrew Scale essentially adds little difficulty. Some investigation is being done on the possibility of administering only the ALC, F, K, and L scale items, but the validity of this approach has yet to be determined.

Michigan Alcoholism Screen Test

Development

The Michigan Alcoholism Screening Test (MAST) was originally developed as a quick, simply structured interview instrument for detecting alcoholism. Importantly, the MAST has been studied among prison populations and appears to be a successful tool for identifying alcoholic inmates with the reservations noted below. A brief version of the test (10 items) has been recently developed, but little is known concerning its discriminative validity.

Desriptions

The MAST consists of 25 simple interview questions (e.g., "Are you always able to stop drinking when you want to?" "Have you gotten into fights when drinking?"). It can be administered in 10-15 minutes by trained clerical staff. Some investigations are exploring the possibility of group administration of the MAST, but for the present, this procedure is not recommended. Instead, the MAST should be used as an individually administered test. Scoring directions and cutoff points are easily understood.

Current Use

The MAST is a widely used instrument in a variety of settings from hospitals to prisons and is considered an efficient, inexpensive screening instrument. It has been tested on white, black, Mexican-American, and American Indian males, white females, and psychiatric patients, all with positive results. Its only major limitation is its inappropriateness for screening teenage populations.

Reliability and Validity

The bulk of current studies indicates overall acceptable levels of validity, but little investigation has been undertaken concerning the test reliability. The high face validity of the test items raises the issue that the test may be of questionable validity when examinees purposefully attempt to distort or deny alcohol problems in an effort to avoid detection or overstate their problems. The test itself provides no control or correction for this test-taking attitude. Al 1 possible arrangements should be made to elicit the maximum amount of cooperation from examinee, e.g., assurances of confidentiality where appropriate.

Advantages

1. Quick, simple interview test.
2. Can be administered and scored by clerical personnel.
3. Cutoff scores clearly established, making diagnosis easier.
4. Test has been validated on prison populations and a wide variety of ethnic groups. Test appears appropriate for use with women.

Disadvantages

1. High face validity of test allows for exaggeration or "faking good."
2. Unacceptable for use with youthful population.
3. Must be administered in an individual , structured interview.

Mortimer-Filkins Test

Development

The Mortimer-Filkins Test (Kerlan, 1971) was developed to screen for alcoholism among drivers brought to court for drinking-driving offenses. The test is considered to be one of the most well-developed and thoroughly field-tested instruments available.

Description

The test is divided into two parts. Part one consists of 58 items answered true/false by the individual. The format allows the test to be self-administering and completed in 15 minutes. A minimal amount of training is necessary to administer or score the test; thus this part can be handled by clerical help. Part one is scored for two separate dimensions, a problem-drinking measure and a neuroticism measure.

Part two is a structured interview which can be completed in approximately 30 minutes. The 70 questions, most requiring relatively brief answers, are then scored based on criteria provided in the accompanying manual. More experienced personnel are required for conducting the structured interview, as a third part of the assessment consists of a subjective evaluation by the examiner based on the interviewee's behavior during the interview. Clear guidelines are provided for interpreting cutoff scores for problem drinkers and alcoholics.

The test has been standardized on inmate populations, both male and female, across a wide age range. In addition, the test is also available in a Spanish version, an important feature for many prison intake centers. Finally, the test is not overly dependent on content validity and, therefore, would be suitable as a detection instrument for those attempting to disguise or deny alcohol-related problems.

Current Use:

The Mortimer-Filkins test reportedly enjoys widespread use among court-related evaluations. Its current use in prison intake assessment is unknown.

Reliability and Validity

Empirical studies on the Mortimer-Filkins test yield acceptable levels or reliability and validity, although the test was designed to be highly conservative to avoid falsely identifying an individual as an alcoholic; thus the test may miss more true alcoholics than is desirable. However, current cutoff scores are shown to identify correctly 89.6% of social drinkers and 83.1% of problem drinkers with no false positives.

Advantages

1. Part one administered and scored by clerical help.
2. Total administration time approximately one hour.
3. Spanish version available.
4. Test items are not obvious, so test distortion is minimized.

Disadvantages

1. Part two requires structured interview conducted by more highly trained personnel.
2. Conservative cutoff scores may result in missing some alcoholics.

Guze and_ Goodwin's 17 Item Drinking History Questionnaire

Development

The authors were interested in developing a brief alcoholism screening instrument which provided maximum accuracy at follow-up. The instrument allows one to screen the individual for alcoholism and to monitor stability of diagnosis by repeated administration.

Description

The Drinking History Questionnaire is a 17-item structured interview scored for yes or no responses. Given the simplicity of the items, it appears that the questionnaire could be self-administered and scored by clerical help. Items are divided into four groups. A diagnosis of definite alcoholism is made if positive responses occur in a minimum of three groups; if positive answers are found in two groups, alcoholism is seen as a plausible diagnosis.

Current Use

There are no data available on current use: however, reviewers (e.g., Kissin and Begleiter, 1977) evaluate the instrument very positively, indicating that it is efficient, simple, reliable, and valid.

Reliability and Validity

In the original study, the Drinking History Questionnaire correctly identified 38 out of 39 alcoholic felons out of a group of 40, an impressive hit rate (Guze, Tuason, Gatfield, Steward, & Picken, 1962). A follow-up study on another group of 176 alcoholic felons indicated that the instrument correctly identified 75 percent of the alcoholics after eight and nine years (Guze & Goodwin, 1972). The group for which the instrument proved inconsistent was found to represent mild or borderline alcoholism diagnoses.

Advantages

1. Simplicity, efficiency.
2. Reliability, validity.
3. Tested on a criminal population.

Disadvantages

1. No apparent drawbacks for use as a screening instrument.

The Alcadd Test

Development

The Alcadd is one of the oldest screening instruments for alcoholism (Manson, 1949). The test was developed by choosing commonly endorsed statements made by alcoholics regarding their behavior and then administering these items to groups of alcoholics and non-alcoholics to establish a series of statements which reliably differentiate the two groups. Factor analysis yielded five dimensions: drinking consistency; attitudes toward drinking over other activities; rationalization of alcohol use; loss of control over drinking; and emotionality.

Description

The Alcadd consists of 60 questions answered yes or no by the inmate. The test can be self-administered, administered individually, or administered in groups by having inmates record answers on the answer form provided. Such flexibility allows for administration to low reading level inmates. The test can be administered in approximately 10-15 minutes and scored in 2 or 3 minutes. The scores are then plotted on a supplied profile sheet, which reflects scores on the five dimensions of the test. The test manual provides norms and diagnostic cutting scores for both sexes, thus assisting the clinician in interpreting the test.

Current Use

The Alcadd is a widely used test, especially in busy screening services that need a self-administered instrument. It is a quick, simple test.

Reliability and Validity

The Alcadd received early attention, and results of testing with middle and low-income whites indicated high reliability and validity coefficients. Studies reported accurate identification of 96% of male alcoholics and 93% of the nonalcoholic males. For women the figures were 97% and 96%, respectively.

The major drawback, however, is that the test is less valid when used with populations who wish to deny or distort their alcoholism. Moreover, since the test was standardized on only middle- and low-income whites, little information is available about use with other populations. The consensus regarding the test is that it may be valid when assessing middle- to low-income white males and females in the community, but that its validity may be questionable when used with incarcerated populations. Some writers have even suggested that the Alcadd is more appropriately seen as an overall measure of maladjustment, rather than as a reliable method of detecting alcoholics.

Advantages

1. Rapidly administered.
2. Can be self-administered, individually administered, or administered in groups (10-15 minutes).
3. Easily administered and scored by clerical personnel (2-3 minutes), although interpretation must be by clinician.
4. Clear cutoff scores provided for diagnosis.

Disadvantages

1. Test has not been validated on incarcerated populations, only on middle- and low-income white males and females.
2. Test is high on face validity, and therefore individuals who want to deny or distort their alcoholism may be able to do so.

The Drug/Alcohol Use Evaluation Scale_ (DUES/AUES)

Development

The Drug/Alcohol Use Evaluation Scale (DUES) was developed as a means of evaluating the effectiveness of drug and alcohol treatment intervention programs. It provides a thorough assessment of pre- and post-treatment behavior for systematic comparison.

Description

The DUES is a behavioral interview which taps ten areas of assessment: variety, frequency, conditions, concurrent behavioral changes, immediate after-effects, l ong-range consequences, duration, amount, intensity and appropriateness of the drug-taking (or alcohol) behavior. For each dimension the practitioner

assesses the level of adjustment. The behavior- is viewed as maladaptive (scored ong point) when physical, psychological or social damage to the individual is evident. Absence of any of these disruptions on a dimension is scored a zero. Thus, at intake,. the practitioner- has a data base of behavioral information about the individual's drug or alcohol abuse with which to compare outcome data.'- The authors contend that when drug treatment programs are effecti ve, a follow-up interview with DUES will show -a considerable drop in overall score, in other words, a decrease in maladaptive behaviors.

Reliability and Validity

Available studies appear to offer strong support for the reliability and -validity of the Drug Use Evaluation Scale (e.g., Jenkins, Huller, deValera, & Kelly, 1977; Jenkins, Muller, deValera, Lindley, Walker, & Williams, 1977). In a twelve 'and eighteen month follow-up study of 134 subjects, divided into three conditions2 treatment completion (N = 40), partial treatment completion (N = 46), and nontreatment controls (N = 48), the investigators found significant decreases in posttreatment- DUES scores. All groups began with scores averaging approximately 9, but at foll ow-up ,' those in the treatment completion. group dropped to 0.7, a 92 percent pre- to post-test decrease.' Similarly, the partial treatment group dropped to 5.1, a 45 percent decrease, and the nontreatment group showed a slight gain, or a 1 percent increase- in DUES scores. In a second study with a sample of 116, subjects showed a similar pattern or pre- to post-treatment DUES scores, providing evidence for treatment effectiveness.

Overal1, the Drug/Alcohol Evaluation Scale appears to be a valid, reliable instrument for the evaluation of treatment programs.

Advantages

1. Simple, structured interview.
2. Can be administered in short period of time once familiarity is developed. However, some interview training may be required to enhance reliability.
3. Simple scoring criteria.

Disadvantages

1. Not self-administering.