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TOPICS IN COMMUNITY CORRECTIONS

Annual Issue 1994: *Mentally Ill Offenders in the Community*

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FOREWORD

This issue of *Topics in Community Corrections* focuses on supervising mentally ill offenders in the community. Mentally ill offenders have become a challenge to all levels of criminal justice. The problem of transitioning or diverting these offenders from secure confinement poses a particular challenge to community corrections agencies.

In an effort to help agencies meet this challenge, the NIC Community Corrections Division and the Center for Mental Health Services of the U.S. Department of Health and Human Services are formulating a cooperative agreement that will allow both organizations to provide technical assistance for mental health services in community corrections. Focusing on dually diagnosed and women offenders, the assistance will emphasize developing collaborative and coordinated working relations among corrections and mental health professionals as well as utilizing research data on effective treatment.

Other agencies throughout the U.S. are already dealing with the problem in a variety of ways. Joel Dvoskin, C. Terence McCormick, and Judith Cox from the New York State Office of Mental Health describe principles of effective mental health services for parolees and the work of their agency with the New York State Division of Parole. Douglas Weber of the Wisconsin Correctional Service discusses Milwaukee's Community Support Program. Dee Kifowit and Judy Briscoe of the Texas Council on Offenders with Mental Impairments outline a state-level approach to improve mental health service delivery throughout the Texas correctional system. Kyle Mickel from the Transitional Living Center in Maricopa County, Arizona, describes the services provided by the Center, and Linda Andresen discusses the role of the Center for Health Care Services in San Antonio, Texas, in keeping mentally impaired offenders in the community.

Bonita Veysey from Policy Research Associates, Inc., describes the special challenges posed by mentally ill offenders as well as practices that address those challenges. Grant Harris and Marnie Rice of the Ontario Ministry of Health inform us about the current research regarding mentally disordered offenders.

Beginning with this issue, publication of *Topics in Community Corrections* will be reduced from two issues per year to one. New is an update section highlighting some activities of the NIC Community Corrections Division.

We hope the present issue is helpful to agencies that are facing increasing numbers of mentally ill offenders on their caseloads.

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Challenges for the Future

by Bonita M. Veysey, Ph.D., Senior Research Associate, Policy Research Associates, Inc., Delmar, New York

Persons with mental illnesses who come into contact with the criminal justice system are a particularly vulnerable group. Combined with the stress and stigma associated with their mental disabilities, the burden resulting from their arrest and charges can exacerbate the isolation and distrust that often accompany their mental illnesses. Moreover, decreasing community resources, particularly the lack of available or accessible emergency mental health services, have increased the likelihood that persons with mental illnesses will come into contact with police and be arrested (CMHS, 1994).

The management of persons with mental illnesses is problematic at all levels of the criminal justice system, whether for police, jails, prisons, probation, or parole. Management problems arise because:

- Most corrections staff have not been trained in issues relating to mental illnesses or in managing people with serious psychiatric disorders;
- Individuals with acute psychiatric symptoms often have difficulty following directions and conforming their behavior to that required by corrections agencies; and
- Mental health resources are frequently insufficient to meet the many needs of persons with mental illnesses in jails and prisons and are often inaccessible to those under community supervision.

Persons with mental illnesses may come under probation supervision through standard criminal justice processing or through special mental health diversion programs. Torrey and colleagues (1992), in their report, "Criminalizing the Seriously Mentally Ill: The Abuse of Jails as Mental Hospitals," decried the state of U.S. jails, stating that jails are inappropriate places of detention for persons with mental illnesses whose crimes are more symptomatic of their illnesses than of criminal intent. Diversion from jail into mental health treatment has been presented as a key mechanism to reduce the unnecessary detention of persons with mental illnesses. Probation is an important component of many jail mental health diversion programs.

Estimates of Mental Health Needs

Like jails and prisons, probation and parole departments have experienced explosive growth over the past decade. On January 1, 1994, 2,216,880 adults were under active probation supervision, and 569,121 were under active parole supervision. This

represents a 25 percent increase in the population size just since 1989 (Camp and Camp, 1994). Although the percentage of persons on probation who have mental illnesses is unknown, jail and prison estimates are useful in understanding the magnitude of the population.

A recent study of a random sample of males admitted to the Cook County (Chicago) Jail found that 6.1 percent had a current psychotic illness and were in need of treatment services (Teplin, 1994). Among female Cook County detainees, the estimates of mental illness are even higher; 11.2 percent had a current diagnosable mental illness of schizophrenia or affective disorder (Teplin, unpublished).

Estimates of mental illnesses among prison populations are similar, generally ranging from 6 to 15 percent. A national survey of prisons and mental health facilities in 1978 found that 6.6 percent of offenders were designated as mentally disordered (Monahan and Steadman, 1983). In fact, a recent review of the literature noted that "surveys of facility administrators suggest that 6 to 8 percent of adjudicated felons are currently being *designated* as seriously mentally ill. A study of New York State prison inmates revealed that 8 percent had 'severe psychiatric and functional disabilities' that required mental health services, and an additional 16 percent had 'significant' disabilities that required periodic mental health services. Clinical studies, however, suggest that 10 to 15 percent of prison populations have a major DSM-III-R thought disorder or mood disorder and need the services usually associated with severe or chronic mental illness" (Steadman and Cocozza, 1993:6).

Based on the estimates of the prevalence of mental illnesses in jail and prison populations, which are typically two to three times those of the general population (Teplin, 1990), it is clear that a significant number of probationers are suffering from serious mental illnesses and are in need of mental health treatment in the community.

Probation and Mental Health Services

According to the NIC Community Corrections Division, the primary intent of probation supervision in most U.S. jurisdictions has changed from rehabilitation to risk reduction (USDJ, 1993). The main goal is the protection of the community. With growing corrections populations and the ever-increasing costs of incarceration, community corrections alternatives are gaining popularity. The increasing emphasis on innovative probation programs reflects "probation's growing role as a community sentencing option that offers control, treatment, and services outside an institutional placement" (USDJ, 1993:1).

Risk management can be understood as a two-pronged approach. Probation services can reduce risk by motivating offenders to refrain from criminal activities or—for those who cannot or will not refrain—by removing the offenders from the community. It is becoming clear that an emphasis on surveillance alone increases the probability of early detection of violations but does not reduce criminal behavior or aid in offender rehabilitation (Stroker, 1993). If the goal of probation is risk management, programs that are designed to reduce criminal activity or increase community participation should offer long-term solutions by intervening before recidivism occurs.

The reason that treatment conditions are imposed as part of probation sentences for some individuals is to guarantee that the individual will receive needed services and will remain in treatment. This increases the probability that the probationer will be stabilized and will receive emergency interventions, if they become necessary. The goal of mental health treatment is not to "cure" criminal behavior. However, treatment may reduce recidivism when an individual's criminal behavior is the direct result of his or her mental illness, if the array of services maximizes periods of stability and provides for timely intervention when symptoms are acute. Mental health treatment may also reduce criminal activity if the services provided include meaningful assistance to help individuals integrate into their communities.

The presence of a mental illness does not necessarily require probation to enforce mental health treatment. For individuals who have mental health treatment listed as one of the conditions of their probation, community supervision incurs the duty to ensure access to appropriate treatment and to supervise participation. In the case of refusal, the person may be returned to custodial care based on a technical violation of the conditions of release.

If mental health treatment is not a condition of probation, an individual's participation in mental health services is voluntary. Although persons under community supervision living in the community should have the same access to mental health resources as any other community member, their access is often restricted because of their status as probationers. Currently the subject of debate is whether probation officers should be advocates to assure that those who want to participate in generic community programs can do so when participation is not a condition of release.

Strategies for Meeting Special Needs

Special procedures and programs designed to address the needs of probationers with mental illnesses include: 1) mental health programs, either provided by a community mental health agency, the probation department, or jointly; 2) cross-training of probation officers in mental health issues, and of mental health staff in corrections issues; 3) special supervision practices; and 4) systems integration strategies, such as community planning boards and interagency memoranda of understanding. Comprehensive programs incorporate a combination of these elements.

Mental health programs

- *Community mental health services.* Individuals on probation who have mental illnesses, like other community members with similar disabilities, require the availability of a full range of mental health services that are accessible, appropriate, and relevant to their needs. Some probation agencies have developed standing contracts with community providers. These working agreements support the activities of both the probation and the mental health systems and the clients they jointly serve. Community agencies that work with individuals on probation tend to be familiar with corrections practices and to be receptive to non-voluntary clients (Cole et al., in press). Such arrangements may also allow probation officers to intervene at the mental health service provider site when emergencies involve persons under their supervision.

In other jurisdictions, probation departments or individual officers broker services as the need arises. In this case, probation identifies all necessary services and negotiates access for specific individuals. This process can be greatly enhanced if probation officers take advantage of mental health case management programs, particularly intensive case management programs. These programs typically provide support for many domains of living, including mental health, substance abuse treatment, housing, money management, and other support services. The funding and intensity of the services are flexible. Such programs appear to be effective in reducing the inappropriate use of psychiatric services and the number of days spent in hospitals and jails by some of the most difficult-to-serve clients (Dvoskin and Steadman, 1994).

While such arrangements ensure access to treatment for many individuals with mental illnesses, problems may arise when the mental health agency is not equipped to serve persons with varying levels of disability or with differing needs and interests. In addition, many community mental health service agencies are reluctant to provide treatment to persons with a criminal record or to individuals who are participating in services involuntarily.

- *Specialized probation programs.* Some probation departments provide their own treatment programs. Probationer resistance to participating in treatment programs against their will has been linked with higher rates of technical violation among those who receive services from generic community agencies (Wilson, 1978). In contrast, certain types of offenders involved in programs operated by probation agencies have demonstrated reduced recidivism rates (Gottfredson et al., 1977).

- *Jointly sponsored programs.* Some of the most comprehensive and promising programs for probationers with mental illnesses are those sponsored and developed jointly by community mental health and probation agencies. In such a program, a community mental health agency might provide traditional clinical services, housing, and case management for access to other needed supports, such as entitlements, while also providing close monitoring of participants through daily reporting. The probation department, in turn, might provide probation officers to oversee a small specialized caseload of probationers in the mental health program. Active collaboration and communication between the provider agency and probation are important to achieving the overall goals of the program: to reduce recidivism and to increase the individual's ability to live in the community.

Cross-training in mental health and corrections. Cross-training is an important component in all settings where criminal justice and mental health professionals work together. For community supervision of persons with mental illnesses to be effective, probation staff and mental health providers must understand each other's roles.

Cross-training is especially important for probation officers who will supervise specialized caseloads. In particular, community supervision staff need to understand:

- The characteristics of mental illnesses and the effects that these illnesses have on daily functioning;
- The mental health and other services available in the local area and how to access them;
- Confidentiality statutes and mental health law; and
- The goals and desired outcomes of treatment.

By the same token, community mental health providers need to be informed about the demands and nature of the criminal justice system and the need to work with offenders who have mental illnesses to help them meet the conditions of their probation. Clinicians and mental health staff should be trained in the specific procedures of corrections work, including conditions of release, violations, goals of supervision, and corrections' typically hierarchical organizational structure.

Special supervision practices. Persons with mental illnesses tend to have high rates of technical violation of their probation sentences. To accommodate their unique needs, many community supervision agencies have developed strategies to help them become successfully integrated into the community and meet their conditions of release.

Usually, technical violations of an individual's conditions of release result in immediate and prescribed sanctions. Alternative strategies developed for persons with mental illnesses allow for continuous monitoring, increased communication between community supervision and other provider agencies, greater client responsibility, and more flexible sanctions that allow for some mistakes without an immediate return to jail or prison. Alternative strategies include specialized caseloads, relapse prevention efforts, and systems of progressive sanctions.

- *Specialized caseloads.* Persons with mental illnesses on probation may be assigned to a specialized community supervision caseload. Such specialized caseloads tend to be smaller than regular caseloads. The probation officer in charge of these clients has special skills and knowledge that may facilitate the integration of the individual with mental illness into the community.

  Sometimes placement in a specialized caseload is transitional. For instance, persons with mental illnesses who are newly released from jail or prison may be assigned initially to a specialized caseload. Early, intensive supervision tailored to the specific needs of each person is important. Compared to other releasees, these individuals may have more difficulty adjusting to community living after incarceration, have fewer natural resources (e.g., employment, social supports, and housing), and require supervision of special conditions for treatment. Once the individual is stabilized in the community, he or she may be transferred to a generic probation caseload.

It is important to recognize that persons with mental illnesses may also require more intensive supervision at a later date. Probation departments should be able to monitor probationers frequently and reassign individuals based on their needs.

- *Relapse prevention efforts.* Relapse prevention has recently gained widespread support (Palmer, 1992). This approach focuses on the development of social and emotional supports that may reinforce an individual's resistance to further criminal behavior. The key to this effort is the probation officer, who acts as an intensive case manager, maintaining up-to-date information on the individual's progress in treatment programs and in employment, family, and social environments. Close monitoring allows the officer to anticipate periods of increased stress, exacerbation of symptoms, and possible criminal activity and to intervene to avoid recidivism. This approach incorporates and articulates the shared responsibilities of the client, community supervision staff, and service providers in achieving successful outcomes.

- *Progressive sanctions.* Imposing progressive sanctions for technical violations is another strategy that may be used alone or in conjunction with other approaches to reduce recidivism for persons with mental illnesses. This approach recognizes the fact that many persons with mental illnesses on probation are in a "catch-22" situation: probation conditions often mandate mental health treatment intended to increase the probability of success on probation, but an individual's refusal to cooperate with the treatment plan may result in a technical violation (Clear and O'Leary, 1983). Thus, if community supervision staff adhere to strict sanctions for technical violations based on treatment non-compliance, special needs clients—particularly those with mental illnesses—are likely to fail.

  Progressive sanctions can help avoid this problem. The essential component of this effort is to avoid an "all or nothing" approach to success or failure in treatment. For example, a probationer may be required both to report on a weekly basis and to receive psychiatric clinical services. If the individual fails to go to the clinic appointments, the probation officer might increase the frequency of contact to several times per week. Given the cyclical nature of many serious mental illnesses and the fact that probationers may be required to participate in services against their will, progressive sanctions allow the system to be responsive to individuals' changing needs and circumstances without necessarily returning the person to jail or prison (Clear et al., in press). For this strategy to be effective, open lines of communication and cooperation must be maintained between probation agencies and mental health and other service providers.

Systems integration. People who come into contact with the criminal justice system, particularly those with mental illnesses, have a high incidence of co-occurring substance abuse and physical health problems. In addition, they are likely to be impoverished and in need of housing or other social services. Helping individuals with multiple problems often requires systems-level integration, which ultimately supports and enhances the efforts of front-line probation staff and mental health personnel.

At a minimum, communities may want to consider developing a standing mental health/criminal justice planning committee or board, whose primary responsibility is

to clarify the responsibilities of each agency involved. Such a group should represent law enforcement, jail, and community corrections administrators; mental health services administrators; judges, public defenders, and district attorneys; local government officials; consumers and family advocates; and other relevant community service providers. The group may be supported by a formal memorandum of understanding and should have the authority to plan and implement a full array of integrated services to meet the needs of this population.

In particular, a joint planning group could develop streamlined procedures to facilitate appropriate inpatient and outpatient mental health treatment. In addition, such services as housing, health care, alcohol and drug treatment, entitlement assistance, and education and vocational training programs must be available and accessible. These approaches to developing effective criminal justice/mental health collaboration usually can be accomplished with little or no additional funding. Making maximum use of existing resources, in some cases by jointly funding cooperative efforts, can overcome many barriers among systems.

Information exchange and mutual support between participating agencies is critical. It is especially important to explore issues of client confidentiality. Although community supervision officers must be informed of an individual's non-participation in services when treatment is a condition of release, many mental health consumers object to the idea of complete information exchange between the mental health and criminal justice systems. Discussions with consumer advocacy groups may achieve a clearer understanding of the kinds of circumstances under which information may be exchanged.

Factors Important to Success

To date, there has been no systematic study of the need for specialized services for probationers with mental illnesses, nor has any study been conducted on the effectiveness of strategies probation departments have used to supervise persons with serious mental illnesses. The information presented here simply describes some approaches that have proven helpful to some probation departments.

Based on what is known, however, several important concepts are generalizable to all community corrections agencies:

- Cross-training of probation and mental health staff is crucial to develop understanding of the complex needs of individual probationers and of the systems involved in providing services.

- Probation programs that contract for or provide mental health services in conjunction with special revocation or supervision practices show great promise.

- Services integration is critical to meet the many needs of probationers with mental illnesses. Intensive case management programs that link mental health, substance abuse treatment, and other social support services with housing and entitlements are effective mechanisms to promote services integration.

- Mechanisms that encourage systems integration, such as community planning boards and memoranda of understanding, can be used to identify and overcome barriers to the provision of services, particularly fiscal and turf issues.

Fragmented services and poorly conceived treatment interventions can result in persons with mental illnesses receiving no services at all or receiving inappropriate treatment, including being hospitalized unnecessarily or re-arrested and returned to jail. Coordinated planning among probation, law enforcement and correctional personnel, mental health agencies, and social service providers can help meet the needs of all parties involved.

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What the Research Says About Effective Service

by Grant T. Harris and Marnie E. Rice, Research Department, Oak Ridge Division, Mental Health Centre, Ontario, Canada

Mentally disordered offenders (MDOs) are a heterogeneous group defined both by changing policies of the criminal justice systems over time and across jurisdictions and by the fluctuating practices of mental health professions over time and across disciplines. No services for MDOs have been implemented with sufficient rigor to permit one simply to copy a fully developed program with any guarantee of effectiveness. There are few data that inform us about how age, sex, ethnicity, offense severity, or language of origin influence the effectiveness of treatment for MDOs.

In evaluating the effectiveness of services for this group of offenders, the question of the appropriate outcome arises immediately. Appropriate indices of effectiveness are measures of criminal and violent behavior, symptom severity, social and vocational adjustment, and personal happiness. Two distinct empirical literatures inform us about what ought to be done for MDOs: research on the principles of effective intervention to reduce criminal recidivism among offenders, and research on psychosocial rehabilitation for persons with mental illness. The research base also suggests recommendations for appropriate services for mentally disordered offenders.

Reduction of Criminal Recidivism

Research on the criminal and violent recidivism of MDOs indicates, first, that the personal characteristics that predict further antisocial behavior among MDOs are the same as those that predict recidivism among criminal offenders in general. Mental illness (other than antisocial personality disorder or psychopathy) appears to be unrelated, or even negatively related, to recidivism among persons who have already committed a serious offense.

Second, the risk of criminal and violent recidivism among mentally disordered offenders can be appraised with reasonable accuracy using actuarial or statistical methods. This permits interventions to be targeted to persons of higher risk. Almost all MDOs, except those high in psychopathy and with lengthy criminal histories, would be determined on this basis as no worse than moderate risk.

Third, because the personal characteristics associated with recidivism among MDOs are the same as those for offenders in general, interventions known to reduce recidivism among offenders will, in all likelihood, be effective for MDOs.

Meta-analytic studies on reducing the recidivism of criminal offenders through treatment show that interventions are effective as long as they adhere to the following principles:

- *Interventions should focus on individual risk.* More intensive interventions should be targeted to individuals who present a higher risk. Targeting intensive service to low-risk offenders can increase recidivism.

- *Interventions should address criminogenic needs.* Interventions should target criminogenic needs—that is, changeable personal characteristics empirically related to antisocial conduct. Appropriate targets include social skills and interpersonal problem-solving ability; procriminal values and attitudes; antisocial peer groups; family cohesion and supervision; and substance abuse. Inappropriate targets for intervention include self-esteem and other vague intra-psychic forces or conflicts.

- *Interventions should be responsive.* The style or modality of service must match the learning style of offender clients. Appropriate therapeutic styles for most offenders include behavioral, cognitive-behavioral, and psycho-educational techniques. Harsher penalties, getting tough, manipulation of criminal sanctions, shock incarceration, the "scared straight" approach, boot camps, psychodynamic therapy, emotionally evocative treatment, and non-specific counseling are all among the styles of service that are not effective for most offenders.

Psychosocial Rehabilitation for Mental Patients

Research on the ability of mental health treatment to improve the quality of life of persons with serious mental disorders indicates that effective services are those that are clear about their purposes. Effective services are also described in the following ways:

- *They employ conservative medication practices combined with skills training to improve drug effectiveness and increase compliance.*

- *They emphasize teaching and learning.* Improved rehabilitative outcomes result from explicit step-by-step training with coaching practice and feedback in social skills, vocational skills, and symptom management, coupled with training for clients' families.

- *They ensure that clients share responsibility.* The negative effects of being a patient are minimized by having clients live in their communities and, when possible, participate in decisions that affect them.

- *They ensure program integrity.* Objective data on outcomes, clinical progress, and staff performance are essential for ensuring that services are delivered as specified.

- *They emphasize the importance of client contact with clinicians, especially in the context of community services.* Contacts are enhanced by staff training and assertive service delivery and by keeping client and clinician turnover low.

Implementation

Certain barriers can impede the implementation of psychosocial programs for MDOs, whether those programs are behavioral, cognitive-behavioral, or psychoeducational in approach. These barriers may be political, organizational, professional, or technical.

Ways to improve the adoption of psychosocial interventions have been identified, however. They include:

- Obtaining authoritative, personal consultation from outside experts.
- Developing detailed, step-by-step training packages for both clients and clinicians.
- Creating and using a system to monitor, report, and reward staff and managers in their performance of program duties.
- Ensuring that the implementation process has a committed, enthusiastic leader.
- Allowing for consequences, both positive and negative, both financial and nonmonetary, to accrue directly to the organization for successful or unsuccessful implementation.

The research bases for both offender treatment and rehabilitation of persons with serious mental disorders are completely compatible. Although the ideal program for MDOs may not have been identified empirically, it is possible to describe its essential features. They include conservative use of psychiatric medications with means to maximize compliance; behavioral or psychoeducational training in relevant skills targeted at criminogenic needs; assertively delivered service whose intensity is in proportion to clients' actuarially-determined risk; a staff selected, trained, monitored, and rewarded in a manner that reflects clarity of clinical purpose; and the objective measurement of outcomes, clinical progress, and clients' and clinicians' performance.

All of the key, essential features have already been implemented in one place or another. The knowledge to provide effective service for MDOs without greatly increasing costs already exists. All that is required is the will to use it.

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Services for Parolees with Serious Mental Illness

by Joel A. Dvoskin, C. Terence McCormick, and Judith Cox, New York State Office of Mental Health, Bureau of Forensic Services, Albany, New York

During the decade of the 1980s, parole populations in the United States more than doubled, to nearly half a million offenders. A significant proportion of individuals released on parole have serious mental illnesses. Even if persons with substance abuse disorders are not counted, a number of studies across the country have shown that state prison populations have significantly higher rates of mental illness than the general population. Our own studies here in New York indicate that at least 5 percent of state prison inmates suffer from severe psychiatric disabilities, and another 10 percent suffer from significant psychiatric disabilities.[1]

Barriers to Obtaining Community-Based Services

There are few empirical studies on the use of community mental health services by persons with mental illness on parole. Evidence suggests that community mental health providers—largely because of fears and assumptions of potential violence among "criminals"—create barriers that prevent many parolees from gaining access to services.[2] Parole officers report that they have often given up trying to obtain mental health services for their clients.

Though this phenomenon of rejecting parolees from mental health services has not been empirically documented, it is so consistently reported by parole officials that it must be taken quite seriously. It is also intuitively sensible. Consider that many mental health providers have extensive waiting lists. Upon release from prison, parolees must compete with other persons who have already requested services. The result is that the parolee is placed at the end of a long waiting list. Further, offenders, especially those who have endured long periods of incarceration, are unknown quantities—"criminals"—to mental health providers. Compounding this is the reality that many mental health community residences are specifically "sold" to communities with promises that they will house no "criminals." This leads to permanent discrimination against parolees, who will always be convicted felons.

Ineligibility of inmates in correctional facilities for Medicaid has been identified as a barrier both to diverting persons with mental illness from incarceration and to providing pre-release planning for inmates leaving correctional facilities.[3] Prior to 1985, inmates were eligible for Medicaid during the first and last months of their incarceration. These funding windows gave mental health providers an opportunity to divert offenders when appropriate and to develop service linkages before inmates were released. Federal regulations that became effective in 1985[4] eliminated Medicaid coverage for any services provided to correctional inmates and created an

enormous additional barrier for local providers who attempted to assist clients in returning to the community.

As a result of these forces, many parole officers have felt forced to "go it alone" and provide only basic counselling to people who may need far more sophisticated clinical services, especially psychotropic medication. In addition, parole officers must attempt to broker a variety of other needed services for their clients.

Pepper[5] has referred to offenders with mental disorders as "multi-need, multi-agency clients." In addition to their mental illnesses, these clients are likely to have had problems with substance abuse, homelessness, poor health, and the myriad of social ills that often accompany poverty in America. They have dealt, often unsuccessfully, with a staggering array of human service and criminal justice agencies in their lifetimes, and many have come to view the government as their enemy. Strategies aimed at providing effective services to parolees with mental illness must therefore be creative and aggressive.

Core Principles for Effective Programming

There are at least nine core principles, many of which have been articulated elsewhere,[6] which should guide efforts to bring mental health services to parolees. Briefly summarized, the following characteristics are those that appear most important in developing effective programs:

- *Interagency effort.* Parole and mental health agencies are obviously at the core of this effort, but the multiplicity of social and human service needs of these clients may require the participation of a wide variety of agencies, including state and/or local departments responsible for parole, mental health, police, social services, health, child protective services, mental retardation and/or developmental disabilities, substance abuse, adult education, and vocational rehabilitation, as well as local clergy. Wherever possible, these relationships should be formalized in a memorandum of understanding.

- *Interagency cooperation and commitment.* Service agreements among the primary agencies, especially between parole and mental health, need to be developed as a first step in creating a responsive program for parolees. The role of other critical providers, such as social services agencies, also needs to be clear to ensure interagency commitment on even the most difficult-to-serve parolees. Cross-agency training is necessary to encourage communication and mutual understanding. In New York State, a three-day mental health training program has been developed to strengthen parole officers' skills in working with persons with mental illness and in accessing services. Equally important, mental health providers have been familiarized with the role of parole and ways to integrate their services effectively with those provided by parole officers.

- *Clear targeting of services and the population to be served.* Programs that attempt to serve every difficult parolee and do not identify the special service needs of this population are likely to fail. Later in this article we discuss two approaches being used in New York—for most mentally ill offenders, we pursue

early engagement in community-based services before offenders are paroled, while using intensive case management with the highest-risk individuals.

- *Cultural appropriateness.* Young men and women of color who grow up poor, witnessing or experiencing violence, with no hope, may need a very different type of human service provider than white, middle-class, young people who grow up believing that the system works for them. In addition, many people are reluctant to reveal personal issues to a person they perceive as quite different from themselves. Ideally, many of the case managers should come from the same cultures as the parolees. If this is not possible, then, at the very least case, managers must receive extensive training in the culturally competent provision of services.

- *Use of progressive sanctions.* Serious mental illness, especially among criminal justice populations, is seldom marked by an unbroken string of treatment successes. Clients of these programs are quite likely to refuse to participate in treatment or rebel against psychotropic medication. The goal of these programs is not to increase recidivism, so treatment resistance or relapses should not automatically result in revocation. Less dire consequences can include more frequent reporting, urine testing for drug use, and so forth. These choices should be developed ahead of time, in conjunction with treatment providers, as part of contingency planning.

- *A focus on residential stability.* Homelessness can disrupt every aspect of a person's life, increasing the likelihood of arrest[7] and making successful treatment of mental illness infinitely more difficult. Thus, advocacy efforts need to be targeted at obtaining and maintaining stable housing for the parolee. Parolees with mental illness who are too disabled to work after release require government supports such as Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI). Housing choice should be assessed individually. It is often assumed that people with mental illness leaving prison require congregate living. While this is true for some people, for others individual housing may in fact be safer and more appropriate. Programs such as supported apartments can provide support and structure without forcing a person into a congregate living arrangement he or she might find irritating, confusing, or frightening. For some people, the stress of congregate living could actually increase their risk of violence.

- *A focus on prevention of relapse of substance abuse.* Prevention of substance abuse relapse may be the single most important feature of the treatment plan of a person with these two disabilities. Although the primary problem may vary, both mental illness and substance abuse need to be addressed in an ongoing fashion by someone who understands the interaction between the two disabilities and their treatments. Fortunately, many of the social supports and treatments for mental illness are also very helpful to someone who is battling an addiction. Stable housing, good nutrition, sober friends, and a job are as valuable in treating one disability as the other. Unfortunately, people with mental illness and substance abuse diagnoses often report being given the choice of stopping their psychotropic medication or being thrown out of a substance abuse program, even one that has been mandated.

- *"Boundary spanners."*[8] Interagency collaboration relies heavily on staff who have familiarity, skill, and credibility in both systems. Although such staff often have little authority and receive little acknowledgement, their contributions are essential. Case managers can and should be boundary spanners. Case managers must also have the organizational authority to convene periodic meetings around individual clients or groups of clients served by a team of providers from various agencies. Further, these boundary spanners require organizational authority to refer their clients to publicly funded providers.

- *Effective parole officers.* The role of parole officers is crucial. Not surprisingly, parole officers are the major source of parolee referrals to mental health programs. They can also provide external structure for parolees, which may increase the chance that an individual will participate in treatment. This structure need not be coercive, but can come in the form of positive reinforcement, encouragement, or simple reminders about appointments. Parole officers also serve as an important safety net for mental health clinicians, who often ask, "What happens if this person becomes a problem in our clinic?" By providing external structure, information, clinician support, and even emergency response in the rare cases where it is required, parole officers can make mental health staff more at ease until the parolee is accepted as a person in need of treatment.

New York's Broad-Based Approach

In New York, there are currently more than 25,000 individuals on parole, at least 1,250 of whom have a compelling need for mental health services in the community. Collaborative efforts between the state's offices of mental health and parole to link these persons with mental health care were formalized in a 1994 interagency memorandum of understanding. Efforts have been initiated in several areas, emphasizing early engagement practices on-site in state correctional facilities.

- *Funding for parole transition services.* The New York State Office of Mental Health (OMH) in 1989 made its first comprehensive effort to integrate parolees into the generic community mental health system. This effort focused on the western New York region. OMH used money as in incentive, creating a fund that enabled a contractor to serve the mental health needs of parolees directly. To avoid an expectation that agencies would treat parolees only if they were paid extra, the state limited use of these funds to a period beginning shortly before offenders' release and extending only through their first few months in the community. During that time, it was reasoned, the contractor could help parolees to access entitlements such as SSI, SSDI, and food stamps and to establish Medicaid eligibility. Clients would then be able to "pay their own way."

  A second expectation was that during this period, the provider would come to know each individual as a person, instead of fearing him or her as a "parolee." Fortunately, the provider selected was a multi-faceted provider of substance abuse, retardation, and mental health services and was already committed to serving criminal justice clients. The program has been successful in helping clients make the transition from the forensic component into "regular" mental health care. Within the agency, access to service has improved for parolees served by the program.

- *Access to services in New York City.* Prior to 1991, OMH provided services to parolees in New York City solely through a small parole clinic. Because of its small size and the large number of parolees, the clinic limited these services to short-term assistance to parolees in crisis and evaluations for the Division of Parole (DOP) and/or the Parole Board. Though the clinic was able to provide mental health treatment for only a small percentage of parolees with mental illness, it was important to DOP as a resource for emergency evaluation and treatment, and also as a symbol of the mental health system's commitment to DOP clients. However, no special procedures were in place to help parolees with mental illness gain access to the community mental health system. Further, our prison mental health staff, already overloaded with prisoners in need of crisis help, had little time left over for extensive discharge planning.

  When the clinic was forced to close as a result of budget problems, the State of New York took the opportunity to revisit broad issues of parolees' access to mental health care. Fortunately, the New York City Department of Mental Health became strongly committed to improving parolees' access to services. A series of informational meetings familiarized prison mental health staff and parole supervisors with the referral system and how to access services. Parole officials in turn educated mental health providers about the support and structure they could provide and what would happen in the event of an episode of violence. At the same time, the DOP was working very hard to begin the process of making offenders eligible for Medicaid prior to release. Most importantly, each borough developed a contact point from which services could be accessed more efficiently. Parole officers have the option of calling programs directly or going through the offices of the five borough commissioners.

- *Comprehensive Outpatient Psychiatric System.* Access to the generic mental health system for parolees was greatly improved in New York State when OMH implemented a "Comprehensive Outpatient Psychiatric System" (COPS), which enhanced funding to mental health agencies for specific groups of persons with severe and persistent mental illness (SPMI). Persons with SPMI involved with the criminal justice system generally, and parolees in particular, were among the targeted groups. This mechanism improved the access to generic providers within the clients' communities.

- *Discharge planning initiative.* Concurrently, the Division of Parole embarked on a discharge planning initiative that included pre-release planning conducted jointly with mental health and medical services in the prison and improved referrals to substance abuse, medical, and mental health treatment in the community. Determining offenders' eligibility for SSI and SSDI benefits prior to their release made these clients more fiscally desirable customers to human service agencies.

This broad-based approach has clearly helped to reduce the service barriers experienced by parolees and their parole officers. It has also reduced mutual misunderstanding and cynicism. However, it has been a limited success. Medicaid eligibility is not achieved prior to release, Medicaid reimbursement is limited, and much stigma, fear, and discrimination remain. But the improvements noted have persisted over time for parolees with mental illness.

Intensive Case Management for High-Risk Parolees

A small number of individuals released on parole are at very high risk of bad outcomes, such as interpersonal violence, suicide, homelessness, psychiatric emergencies likely to result in expensive emergency room visits or hospitalizations, or criminal recidivism. The specific needs of these highest-risk individuals are addressed in New York through intensive case management. Dvoskin and Steadman[9] have described the ways in which intensive case management can reduce the risks of living with mental illness in the community, including the risks of violence, arrest, and days spent in jail. Although their article dealt with case management as a component of the overall community mental health system, the fit to the special needs of parolees is clear.

Though still rare, the concept of intensive case management for parolees with serious mental illness is not unique to New York. We are aware of at least one other program that is reporting similar success with this approach. The Texas Council on Offenders with Mental Impairments funds and coordinates a statewide program of case management for parolees with mental illness, mental retardation, head injury, and physical disabilities. *(See related article beginning on page 26.)*

OMH and the Division of Parole began serving parolees with concurrent mental illness and substance abuse disorders in 1993 through an intensive case management program. Parole officers are assigned special caseloads of approximately thirty-eight parolees, each with a serious mental illness. Further, through a direct contract with a local provider, OMH provides four intensive case managers who work in teams with each of two parole offices. Each case manager carries a caseload of ten parolees. Clients are rostered individually by name and assigned to specific case managers. Ongoing negotiations with other local human service providers are aimed at making staff available to the teams on at least a consultative and facilitative basis. However, whenever specific outside individuals play an important role in the services brought to each parolee, they are invited to team meetings to coordinate efforts, reduce waste, and enhance communication.

Whenever possible, case management staff meet the client prior to release and follow up by telephone contact to initiate the rapport that will be relied upon in the streets. To enhance this bond and also "hook" the client immediately into service, case management staff generally meet clients as they arrive in the community and assist them in their initial community transition problems, including treatment service appointments. Clinic appointments are scheduled well in advance of the offender's release, so that they occur as soon as possible, sometimes even the same day as the release.

Critical to the implementation of this type of program is educating the prison mental health staff in the identification, referral, and preparation of inmates with SPMI who are about to return to their communities. Frequent meetings are needed to screen each client for social, medical, clinical, and criminal justice factors that would place the client at risk of failing in his/her reintegration into the community. These meetings should occur both in prison and the community, should involve both parole and mental health, and should result in a transition plan that includes appointments for timely treatment services with specific providers.

Plans are in place to evaluate this program, but these efforts will be hampered by methodological problems, especially the absence of a randomly assigned control group. Because assignment to this program is specifically related to need, it will be necessary to use inferred control groups, such as similar parolees from boroughs that do not yet have this program. Despite the difficulties inherent in such evaluative efforts, however, the novelty of these approaches make such investigations essential.

Opportunities for Action

Providing mental health services to parolees requires an interagency commitment. The planning principles suggested in this paper have evolved from trial and error over time, and they have as yet not been tested empirically. Clearly, they must be tested.

The urgency of such research is clear. Even if the percentage of inmates with mental illness has remained constant, the explosion of prison populations in this country has created pressure in almost every area of state budgets. The absence of mental health treatment and planning keeps people with mental illness in prison longer, despite the lack of evidence that they present greater risk than other offenders. Creating programs that make mental health treatment systematically available to parolees is likely to increase their rate of release and may well keep them in the community longer and more safely.

For more information, contact Dr. Joel Dvoskin, Associate Commissioner, New York State Office of Mental Health, 44 Holland Ave, Albany, New York, 12229; (518) 474-3290.

Notes

1. H. J. Steadman, S. Fabisiak, J. A. Dvoskin, and E. J. Holohean, Jr., "Mental Disability Among State Prison Inmates: A Statewide Survey," *Hospital and Community Psychiatry* 38(10) (October 1987): p. 1086–1090.

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3. *ibid.*

4. 42 CFR Parts 435 & 436.

5. B. Pepper, N. Albert, and H. Ryglewicz, "The Multi-Need/Multi-System Client," in *Tie Lines* (New York: The Information Exchange, 1993), p. 1–6.

6. T. R. Clear, J. M. Byrne, and J. A. Dvoskin, "The Transition from Being an Inmate," in Steadman and Cocozza (eds.), *Mental Illness in America's Prisons* (Seattle, Washington: National Coalition for the Mentally Ill in the Criminal Justice System, 1993), p. 131–157.

7. L. Gelberg, L. Linn, and B. Leake, "Mental Health, Alcohol and Drug Use and Criminal History among Homeless Adults," *American Journal of Psychiatry* 145(2) (February 1988): p. 191–196.

8. H. Steadman, "Boundary Spanners: A Key Component for the Effective Interactions of the Justice and Mental Health Systems," *Law and Human Behavior* 16(1) (February 1992): p. 75–87.

9. J. A. Dvoskin and H. J. Steadman, "Using Intensive Case Management to Reduce Violence by Mentally Ill Persons in the Community," *Hospital and Community Psychiatry* 45(7) (July 1994): p. 679–684. ■

Helping Mentally Ill Offenders Develop Greater Self-Reliance

by Douglas W. Weber, Wisconsin Correctional Service, Milwaukee, Wisconsin

The goal of the Community Support Program (CSP), operated by Wisconsin Correctional Service (WCS), a private, not-for-profit agency based in Milwaukee, is to deliver intensive and extensive services to mentally ill offenders in the community while at the same time closely monitoring their behavior. Started in 1978, the CSP was created in response to the increasing number of chronically mentally ill people entering the courts and jails in Milwaukee.

WCS based its program on a community-based model rather than the more traditional—and costly—approach of incarcerating or institutionalizing mentally ill offenders. The CSP model includes five defining elements:

- *Medical and therapeutic services*—Medication is prescribed and administered five days a week. A pharmacy on the premises closely monitors the prescriptions. Psychotherapy and group sessions are also available. Case management services are provided to help clients obtain primary health care.

- *Money management*—The program arranges to be the legal recipient of each client's Social Security and other disability benefits. The client's fixed expenses, such as rent, are paid directly by the program. The remainder is given to the client in a daily allowance after the client has taken his/her medication.

- *Housing and other support services*—Intensive case work provides for clients' basic needs, either after arrest or upon release from jail or a hospital. The program provides referrals to other social service agencies, arranges housing, and monitors clients through periodic home visits.

- *Day reporting and close monitoring*—Most clients are required to report to the clinic daily, Monday through Friday. They can stay either for a brief period to take their medication and get their money or for longer periods. This daily observation and interaction with clients enables the staff to monitor behavior and to determine when changes in medications are needed. Failure to report is noted, and staff attempt to locate missing clients.

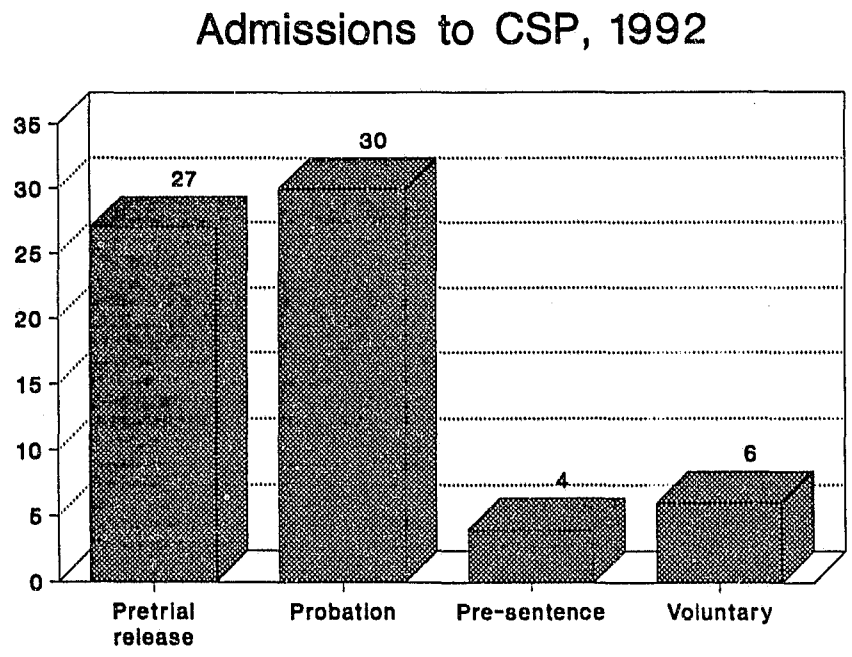
- *Participation in treatment*—Although clients must agree to enter the treatment program, their choice is constrained by other less desirable and more restrictive alternatives, including jail. Many mentally ill people are difficult to manage and often resist treatment instructions. However, the program's combination of supportive services backed by firm legal authority is effective in bringing them into and keeping them in treatment.

Referrals and Admission

The program can serve about 250 clients on an ongoing basis. Most clients enter the program through referral from WCS's Court Intervention Programs in Milwaukee, which operate out of the Milwaukee Municipal Court and the central intake unit of the Milwaukee Criminal Justice Facility and Jail. However, mentally ill people may enter the CSP at many points in their involvement in the justice system and through several different referral sources.

- The primary goal of the Milwaukee Municipal Court Intervention Program is to keep in the community people convicted of municipal ordinance violations and in need of mental health, alcohol, or drug treatment. The program provides a structured option to incarceration for these offenders.

- Central Intake Unit staff, located inside the Milwaukee Criminal Justice Facility and Jail, interview all people scheduled for arraignment in Milwaukee Circuit Courts. Staff conduct hundreds of interviews each day to obtain information for bail and custody decisions. Through this process, staff identify people who exhibit behaviors that indicate a need for treatment. These people are then interviewed in depth and referred to WCS programs or other community providers. Treatment needs and pending referral become part of the Central Intake Unit's release recommendation presented to the court. The court may then refer the defendant to CSP as a condition of pretrial release. An important advantage of this design is that defendants can move quickly from arrest and arraignment into treatment in the community. In many jurisdictions, the mentally ill offender must wait a long time for transfer from one facility to another. The defendant's mental and physical condition often worsens during the wait. WCS's Central Intake Unit works closely with the courts to minimize the time between arrest and treatment for mentally ill defendants.



- WCS's Pretrial Services, another referral source, continues to monitor local jail and House of Correction populations to identify inmates with treatment needs. WCS develops release plans that are presented to the court, followed by a referral to the CSP, if appropriate.

- Probation and parole officers provide yet another route to the CSP. The program's extensive services provide close monitoring for mentally ill offenders in the community, resulting in frequent contact between CSP staff and probation or parole staff. The relationship between probation and parole staff and the program have led to the formation of a consistent set of rules and expectations.

- Though nearly all CSP clients enter the program through a referral, a small percentage enter voluntarily. Although most clients are referred after contact or entry into the justice system, CSP can also accept mentally ill people whose behavior is deemed at risk for law enforcement intervention.

Clients entering the program are often homeless and have no means of support. As soon as someone is admitted to the program, staff move quickly to meet his/her basic needs, including housing, in addition to arranging for treatment and medication. Immediately meeting these basic needs motivates the client to continue in the program. Clients stay with the program and succeed through a combination of coercive elements, incentives, and encouragement. CSP enforces release conditions and rules, closely monitors behavior and medication, and regularly reports to the courts or other authorities. This model meets the concerns of law enforcement and the courts and instills confidence in the program.

Client Characteristics

Of the approximately 1,000 arrestees in Milwaukee County identified each year as being mentally ill, 700 to 800 had their charges dropped, re-entered programs where they had been previously enrolled, or were hospitalized. The remaining 200 to 300 are eligible for release and appropriate to enter CSP. However, due to demand, CSP treatment slots are not always available. In 1992, for example, CSP admitted sixty-seven new clients. Those who could not be admitted because no slots were available were referred to other county programs.

In recent years the number of clients admitted has remained steady. However, with the rise in cocaine use in the area, CSP has seen an increase in the number of dually diagnosed (mentally ill and drug-using) clients. The increase in cocaine use has also caused the re-arrest rate of CSP clients to climb from 10 to 25 percent.

The typical CSP client is male, never married, in his mid-thirties, has some secondary education, and is schizophrenic. More than half the clients have at least two prior arrests. Clients admitted in 1992 averaged seventy-five days in psychiatric hospitals during the previous two years. Data on 1992 admissions are presented on the following page.

Characteristics of Clients Admitted to the Community Support Program, 1992

Sex	Male	87 percent
	Female	13
Education	Did not finish high school	43
	High school graduate	28
	Post-secondary education	28
Race/Ethnicity	Black	46
	White	45
	Hispanic	8
	Native American	1
Illness	Schizophrenia	90
	Manic depression	9
	Other	1

The program often works with clients who have not complied with treatment elsewhere. In 1992, 39 percent of CSP's clients returned to the program, voluntarily or through referral, after having been discharged. The average length of stay is one and a half years, but this varies greatly from client to client. A few clients have been enrolled for fifteen years—as long as the program has existed.

Clients leave the program for many reasons. A total of eighty-four clients were discharged in 1992:

- Twenty-eight fulfilled their legal obligations and dropped out;
- Twenty completed their legal obligation and were referred to other, less structured outpatient programs;
- Six were found to need closer supervision and treatment and were placed in inpatient mental health facilities;
- Three were referred to hospitals for long-term treatment for physical illnesses;
- Three were sent to long-term residential drug treatment programs;
- Five moved to another state;
- Three died;
- One disappeared; and
- Fifteen were discharged after being jailed for having committed new offenses or violating their release terms.

Benefits of the CSP Program

Milwaukee's approach to working with mentally ill offenders is quite different from the methods of other jurisdictions. In cities where mentally ill offenders are commonly incarcerated, mentally ill individuals can comprise 15 to 20 percent of the jail's population. In Milwaukee, the CSP and other programs have helped to reduce jail populations; fewer than 3 percent of the jail population are diagnosed as mentally ill. As Milwaukee County District Attorney E. Michael McCann stated in

Federal Probation, "Jails are ill-suited for such prisoners as treatment is rarely provided and such prisoners can be disruptive and aggravating to other prisoners."[1]

At the core of CSP's success is its ability to provide service at a low cost. Cost per service slot is about $3,500 a year. That figure is one-quarter to one-third the cost of intensive outpatient treatment in the state and county mental health systems. To control costs, the program employs paraprofessionals—most of whom have a bachelor's degree—to provide services.

Nevertheless, the program did not gain immediate acceptance. Today, CSP is located in a mixed residential and business area. Business people were initially concerned about the effect the program's clients might have on local business. Program administrators took a proactive approach to this resistance and, through timely response to resident and business complaints, diffused tensions and resolved situations before they got out of hand. Judges, prosecutors, and defense attorneys have voiced their acceptance of the program. Many other court officials recognize the necessity of the program.

Providing treatment in the community "under one roof" has made possible more effective and efficient means of monitoring and responding to client needs. In turn, this supportive environment has helped clients learn to become more self-reliant. An incarcerated mentally ill offender may have had his/her needs met in the institution—but only until he or she is released. Back in the community, the person will find little support from the institution. The Community Support Program attends to the clients' basic needs, helping them to find housing and a means of financial support. The program continues to manage the client's money. With time and progress, the client will require less reliance on the program and, if possible, on public means of support.

CSP is funded through the Milwaukee County Department of Human Services, the United Way of Greater Milwaukee, the State of Wisconsin Community Options Program, and Medicare, Medicaid, and private insurance. Milwaukee County budget officials say that it is unlikely that the county would provide these services if it required creating additional government positions.

The Community Support Program is not based on conditions found only in Milwaukee. This model can be replicated, in whole or in part, elsewhere in the nation, although some aspects of our situation—including WCS's pretrial services and screening program and its status as a private organization—facilitated the development process.

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Notes

1. E. Michael McCann and Douglas W. Weber, "Pretrial Services: The Prosecutor's View," *Federal Probation* 57 (March 1993): p. 18–22. ■

A State-Level Approach to Special Needs Offenders

by Dee Kifowit, Director, Texas Council on Offenders with Mental Impairments, and Judy Briscoe, Council Member

One approach to improving the management of special needs offenders is to establish a central agency responsible for initiating change throughout the various levels and components of a state's correctional system. The Texas legislature responded to the unique challenges presented by special needs offenders —especially those with mental health disabilities—by creating a Council on Offenders with Mental Impairments, whose work affects all levels of the state's correctional system. This article describes how the council was formed and how it is attempting to carry out its leadership role in programming for special needs offenders.

How the Council Was Created

Recognizing the growing number of offenders with mental health and developmental disabilities, the Texas legislature nearly ten years ago called for a study on offenders with the following problems:

- Developmental disability
- Emotional disturbance
- Mental health disability
- Terminal illness
- Physical disability
- Advanced age.

The study identified a large number of these offenders within the criminal justice system and recommended increased cooperation and collaboration among mental health, law enforcement, and correctional agencies to deal with them. The legislature responded to this recommendation in 1987 by setting aside funds and drafting legislation to create the Texas Council on Offenders with Mental Impairments. The Council has since evolved into a centralized body that responds to an increasing variety of offenders' special needs, primarily by supporting innovative programming.

The Council is made up of nine appointed members with expertise in managing special needs offenders, plus representatives from various state agencies—including the Commission on Alcohol and Drug Abuse, the Department of Mental Health and Mental Retardation, and the Department on Aging. Advocacy groups involved with offenders with mental health disabilities are also represented. Every state agency and

advocacy group that has responsibility for, or interest in, offenders with mental health disabilities is a legislatively mandated member. This mandatory representation has encouraged broad-based cooperation and collaboration.

The Council's Leadership Role

The legislation also defined the Council's responsibility to identify offenders with mental health and developmental disabilities and the services these offenders need. The Council funds community-based alternatives to incarceration to deliver these services and also develops a state-wide plan for meeting the treatment, rehabilitative, and educational needs of offenders with mental health disabilities.

Organizations represented on the Council—

- Texas Commission on Alcohol and Drug Abuse
- Texas Council of Community Mental Health and Mental Retardation Centers, Inc.
- Texas Department of Mental Health and Mental Retardation
- Texas Department of Criminal Justice (Institutional Division, Pardons and Paroles, and Community Justice Assistance Division)
- Texas Education Agency
- Texas Commission on Jail Standards
- Texas Criminal Justice Policy Council
- Texas Rehabilitation Commission
- Association for Retarded Citizens
- Texas Department of Human Services
- Parents Association for the Retarded
- Mental Health Association
- Texas Youth Commission
- Texas Juvenile Probation Commission
- Texas Alliance for the Mentally Ill
- Texas Commission on Law Enforcement Officer Standards and Education
- Planning Council on Developmental Disabilities
- Texas Department on Aging.

Nine members-at-large are appointed by the governor.

Intensive case management pilot programs. The Council established its first pilot project, Project CHANCE, in 1988. Operated by the Association for Retarded Citizens, Project CHANCE is a diversion program that provides community-based, cost-effective alternatives to incarceration for offenders who have some level of mental retardation or developmental disability and have not committed aggravated offenses. Offenders remain in the program until they meet certain goals or are discharged from the criminal justice system. Case management services are provided for 100 offenders at a time, and approximately 175 offenders go through the program in a typical year.

Project CHANCE provides a vital and consistent link between the criminal justice and social service systems. In a nutshell, the project offers the offender the opportunity to obtain needed life skills while remaining in the community. Intensive case management helps participants identify their needs and establish goals. Staff help each offender to develop an individual justice plan that emphasizes community support services designed to help offenders master appropriate social behavior and improve their independent living skills.

In the 1993 fiscal year, 180 offenders participated in Project CHANCE. Most of these participants either successfully completed the program, are still involved in it, or were discharged from the criminal justice system. Project CHANCE's success is evaluated primarily in terms of recidivism, but participation in Project CHANCE improved the lives of virtually all participants, primarily because the program adapts all correctional programs and services to meet each offender's needs.

Project ACTION, also an intensive case-management program, was the Council's second pilot project. Like Project CHANCE, Project ACTION is designed to divert non-aggravated offenders with general mental health disabilities away from the criminal justice system and reduce their rate of recidivism. However, Project ACTION places a greater emphasis on programming than does Project CHANCE.

Project ACTION can serve no more than 120 offenders at a time, but it also provides ongoing technical assistance to other offenders or agencies. Thus far, almost 400 offenders have been involved in Project ACTION. The maximum length of stay in the program is two years. If an offender is stable for a significant period, case managers are encouraged to discharge them before the end of the two years.

Project ACTION reports quarterly to the Council on the recidivism rates of offenders in the program. Recidivism rates are measured by arrests, new convictions and/or incarcerations, and noncompliance with probation and parole conditions. Program success is measured by offenders' subsequent ability to obtain a job, secure income, re-establish social skills, maintain a stable home, and comply with medication requirements. A 1993 study by the Texas Criminal Justice Policy Council reviewed the pre- and post-program arrest rates of Project CHANCE and Project ACTION participants. The study revealed a 63 percent reduction in arrest rates for participants.

Projects similar to ACTION and CHANCE have now also been developed in the eight most populated counties in Texas. Unlike the initial projects, these programs serve both mentally retarded and mentally ill offenders. All programs are also responsible for providing screening and pre-release planning for offenders with mental impairments in county jails or prisons who are in need of aftercare treatment. *(See related article, page 33.)* This pre-release planning activity has recently been expanded to include juveniles with mental impairments who are committed to facilities operated by the Texas Youth Commission.

"Special needs" parole release. In addition to keeping offenders with special needs in the community, the two pilot projects attracted federal funding for eligible offenders. Partly in response to this funding success, the Texas legislature recently broadened the Council's responsibilities. Legislative changes were made to allow for the early release of special needs offenders in three new categories eligible to receive federal funds: the elderly, the terminally ill, and persons with physical disabilities. The Council established intensive case management and placement services for eligible inmates.

Target populations for this "special needs parole program" are inmates who have not been convicted of an aggravated offense and who are elderly, significantly or terminally ill, or physically disabled, and whose medical condition qualifies them for a nursing home, hospice, or other similar care. After being released from incarceration, the special needs parolee remains in the program for life or until he or she is re-incarcerated for a new offense. To date, 140 inmates have been approved for special needs parole.

The program is intended to reduce the state's correctional health care costs. Federal medical care funding reimburses nursing homes and other providers of health care services, and 80 percent of special needs parolees have been placed in their family homes. Since offenders incur no residential fees, state costs are reduced to case management and the state's share of Medicaid-reimbursed medications or treatments.

Outcomes of the Council's Efforts

A centralized approach to dealing with special needs offenders allows correctional systems to make programs that are already in place and known to be effective accessible and relevant to this previously excluded group. Independence and access to additional funding allow the central body to move beyond conventional treatment categories and to develop programs and policies that are more relevant to special needs offenders.

Cooperation among agencies has been significant in Council-funded programs. For example, the Pardons and Paroles Division of the Texas Department of Criminal Justice, the Texas Department of Human Services, and the Social Security Administration collaborated with private nursing homes and others in the special needs parole program. Further, although the pilot projects have been the main focal point for collaboration, there has been a subtle but significant increase in overall cooperation among the agencies and advocacy groups. In cooperation with the Texas Commission on Law Enforcement Officers Standards and Education, the Council recently helped develop a training curriculum for the Specialized Mental Health Deputies Program. The training increases participants' awareness of mental health disability and teaches them how to respond appropriately. Some sheriff's departments have created specialized mental health deputy positions.

The Texas legislature recently passed legislation requiring the criminal justice and mental health systems to plan and develop joint funding requests for special needs offenders. At the same time, the Pardons and Paroles and the Community Justice Assistance Divisions of the Texas Department of Criminal Justice have each created specialized caseloads of offenders with special needs.

Although these are some of the positive results of the work of the Council, the following statement, made 176 years ago, still rings true today:

> But the insane criminal has nowhere any home, no age or nation has provided a place for them. They are everywhere unwelcome and objectionable. The prisons thrust them out, the hospitals are unwilling to receive them, the law will not let them stay at home and the public will not permit them to go abroad. And yet, humanity and justice, the sense of common danger, and a tender regard for deeply degraded individuals all agree that something should be done—that some plan must be devised, different from and better than any that has yet been tried, by which they may be properly cared for, by which their malady may be healed, and their criminal propensity overcome.
>
> —E. Jarvis, *American Journal of Insanity* 13, 3 (1817).

We are still searching for answers. Jarvis' statement, meant to describe offenders with mental health disabilities, could apply today to any offender with special needs.

For additional information, contact Dee Kifowit, Director, Texas Council on Offenders with Mental Impairments, 8610 Shoal Creek Blvd, Austin, Texas, 78757; telephone (512) 406-5406; or Judy Briscoe, Council Member, P.O. Box 5260, 4900 North Lamar Blvd., Austin, Texas, 78765; (512) 483-5269. ■

A Little "TLC": Maricopa County's Transitional Living Center

by Kyle Mickel, Coordinator, Transitional Living Center, Maricopa County Adult Probation Department, Phoenix, Arizona

Alan is a twenty-nine-year-old construction worker recently released from jail after violating probation on burglary charges. He is typical of the 566 mentally ill offenders being supervised by the Maricopa County Adult Probation Department (MCAPD) in Phoenix, Arizona. Locating effective treatment options for Alan and other members of this challenging population is no easy task. Seriously mentally ill (SMI) defendants are often rejected for services by behavioral health agencies. Reasons for their rejection include offenders' active drug or alcohol abuse, changes in their diagnosis, loss of contact with case workers, or offenders' refusal of services.

When serious mentally ill offenders are in distress and need immediate intervention, probation officers need to find ways to tap a limited pool of resources. Maricopa County Probation currently employs six specialized mental health probation officers who work solely with SMI offenders, but whose caseloads are usually capped at forty clients. Offenders on the waiting list for specialized supervision may therefore lack appropriate intervention during times of psychiatric instability. The result may be that these offenders again come in contact with police, jails, and the criminal justice system.

All too often, our jails become the "treatment facilities" for the mentally ill only because there apparently is nowhere else to turn. To avoid the seemingly endless cycle of SMI recidivism, the standard probation officer needs additional skills and resources when the doors to successful supervision are closed. That's where the Transitional Living Center comes in.

Referrals Key to Transition Process

Funded through legislative appropriation since 1989, the Transitional Living Center (TLC) is a probation-operated residential program for psychiatric intervention. TLC is home to twenty-five SMI probationers who are awaiting appropriate community placement and is housed in the renovated Elsinore Baptist Church. The average length of stay at TLC is about sixty days, but this varies, depending on the time it takes to achieve linkages with community support services and facilities.

TLC's role is limited and well-defined. Falling far short of addressing all of its clients' psychiatric, personal, and legal needs, the program serves as a bridge toward independent living:

- Clients receive full medical and psychiatric evaluations. In most cases, appropriate dosages of psychotropic medications are prescribed.
- Staff initiate referrals for applicable benefits and entitlements.
- Initial and monthly case staffings identify follow-up placements and treatment strategies based on each probationer's needs.

Court-ordered terms of probation often dictate offenders' placement following their stay at TLC. However, input from interested parties helps locate ideal options. These options are discussed during regularly-scheduled staffings held the initial week of admission and every thirty days thereafter. TLC staff counselors report the results of an Addiction Severity Index, which identifies the client's medical, psychiatric, employment, family/social, legal and drug/alcohol treatment needs. Staffing participants include the probation officer, counselor, project coordinator, clinical director, psychiatric nurse, and case managers.

After the treatment plan is outlined, TLC's in-house case manager establishes community contacts to achieve placement at the desired treatment setting. The follow-up setting varies greatly from client to client. Relatively stable probationers may be placed at their homes and referred to outpatient services, while those in need of longer-term residential treatment may enter the most intensive therapeutic environments available.

Program Operations

Maricopa County contracts with a local non-profit agency, New Arizona Family, Inc. (AFI), for TLC's daily operations. The facility is staffed by a clinical director, project coordinator, three full-time counselors, six part-time counselor aides, a case manager, an independent living skills coordinator, an on-call psychiatrist, an on-call psychologist, and a psychiatric nurse.

TLC is one of three residential treatment programs administered in Phoenix by AFI. AFI also operates a drug treatment facility with a twelve- to eighteen-month program and a six-month program for dually diagnosed SMI clients who are also battling chemical dependency. These two facilities often serve as placement options for TLC graduates.

A TLC Coordinator is provided by MCAPD to screen cases and serve as department liaison. The program coordinator must be selective in approving clients for admission and rejecting those who might jeopardize the facility's safety and integrity.

Certain types of offenders are usually ineligible for TLC:

- Offenders with a significant history of violent criminal behavior;
- Offenders with non-SMI mental health problems, such as mental retardation or developmental disability; and
- Offenders needing extreme medical intervention, court competency evaluations, or treatment for mental problems resulting from long-term substance abuse.

TLC Successes

In statistical terms, TLC is a resounding success. Last year, 144 clients benefitted from TLC's unique services, with 63 percent achieving successful community placement.

More than 70 percent of those admitted to the program were released early from jail sentences into TLC under a specific court order to enter treatment. Had these offenders remained in jail to complete their sentences (and thus received no treatment), Maricopa County would have incurred an additional 5,428 total days of incarceration costs. The average daily cost of TLC treatment is about $60 per client, significantly less than the average daily cost of $75 to incarcerate an inmate in the Maricopa County jail's psychiatric unit. From July 1, 1993, through June 30, 1994, eighty-eight clients were released early through the TLC, for an estimated savings to the county of $81,420.

The true test of TLC's worth, however, is not as easily calculated. Perhaps the probationer's definition of success is the degree of insight he or she has gained about the specific complexities of his/her mental illness, its symptoms, and how these can be treated and controlled. This knowledge leads to self-understanding and confidence, which can enable SMI probationers to address the psychiatric obstacles that interfere with their transition to productive, independent living.

We witness success in the TLC beneficiary who maintains gainful employment; who remains clean and sober; who avoids further contact with the criminal justice system; who improves his/her own quality of life; and who contributes to the community by helping fellow Phoenix residents. This is the true test of success, for which there is no real measurement.

For additional information, contact Kyle Mickel, Coordinator, Transitional Living Center, Maricopa County Adult Probation Department, 6655 W. Glendale Avenue, Glendale, Arizona, 85301; (602) 435-6738. ■

Community-Based Forensic Case Management

by Linda Andresen, Forensic Unit Coordinator, Center for Health Care Services, San Antonio, Texas

The Center for Health Care Services in San Antonio, Texas, provides a unique approach to continuity of care for mentally impaired offenders in Bexar County. While also serving the mental health needs of the community at large, the Center operates a Forensic Unit that offers intensive treatment and support to offenders with serious mental disorders. The Forensic Unit works with the courts, jail, probation, and parole to assess the needs of mentally impaired offenders and link them with services in the community so that offenders can remain in non-institutional placements when appropriate.

Recommendations for individual clients may include services provided by the Center. For mentally impaired offenders receiving forensic clinical treatment from the Center, the program provides a combination of outpatient services and intensive case management, as well as crisis intervention services.

The Center's philosophy is to ensure that services delivered to persons with severe mental disabilities are tailored to individual needs so that these people can achieve the highest possible level of independent functioning in the community. Services for each client are constantly re-evaluated to be sure they meet the client's changing needs.

The Center's Service Matrix

The Center's Forensic Unit provides comprehensive services to improve the chances that mentally impaired offenders will adjust successfully in the community.

- *Assessment and evaluation.* Center staff provide screening, evaluation, and consultation for the courts, the Bexar County Detention Center, Bexar County Probation, and the Texas Department of Corrections. Staff may recommend that offenders be referred to programs provided by corrections agencies such as probation, by other community organizations, or by the Center itself. The Bexar County Adult Detention Center provides security badges for forensic case managers and the forensic psychiatrist so they can easily meet with offenders for this purpose.

- *Intensive case management.* Each offender receiving services from the Center is assigned a forensic case manager to provide overall coordination of mental health care, including care provided by the Center. The case manager also locates low-cost housing as needed and provides linkages to appropriate community resources. Other responsibilities include working closely with probation or

parole officers, the courts, and other criminal justice agencies on issues related to community supervision. The client ratio is one case manager to twenty clients. Clients are seen face-to-face five times a week and are in contact by phone the other two days a week during the first thirty days of case management. After that period, the treatment team determines an appropriate treatment level.

- *Forensic clinical services.* At the Center, Forensic Intensive Treatment Services staff have special skills needed to work with offenders with mental impairments. The staff includes a unit coordinator, a forensic psychiatrist, a registered nurse, forensic case managers, and a contracted psychologist who assists with research and outcome analysis. Psychiatry residents from the University of Texas Health Science Center at San Antonio also see clients regularly. A forensic psychiatrist and nurse based at the Center's outpatient clinic provide comprehensive clinical evaluations of offenders with complex presenting problems, specialized treatment for severe mental impairments and dual diagnosis with substance abuse, and medication management. Substance abuse treatment may be provided by the Center's substance abuse outpatient clinic.

- *Community referrals and living assistance.* Clients are referred to a range of community services and receive help with their basic needs. Case managers assist with transportation, leases, disability subsidies, and the acquisition of household items. Because supportive and drug-free housing is important to client success, a main goal is to establish more housing choices for severely mentally impaired offenders. The Center can have difficulty finding placements for clients who are offenders, despite providing twenty-four-hour crisis response, and sometimes pays providers an extra amount for the first month to help get these clients accepted as residents.

- *Crisis intervention.* In situations requiring clinical crisis intervention, the Center can admit offenders into its own crisis resolution residential unit or detox unit. Beds in these units are immediately accessible to offenders twenty-four hours a day, seven days a week.

Providing Services to Offender Populations

The Center's main target populations include detainees in the pretrial investigation and pre-sentencing stages who are being held at the Bexar County Detention Center, inmates sentenced to the Texas Department of Corrections but being held at the detention center, probationers, parolees, and persons found not guilty by reason of insanity under Texas law.

Jail/prison detainees. A close partnership exists between the Bexar County Detention Center's medical/psychiatric department and the Center's case management program. A specially trained Center caseworker works as part of the jail's mental health team and provides liaison between the detention center and the Center for Health Care Services. The caseworker screens and evaluates detainees for mental impairments including mental illness and the dual diagnosis of mental illness and substance abuse. The Center may provide diagnosis, medications, and treatment while the offender is at the detention center.

The case manager also works with detention center staff to develop a discharge plan for continuity of care after release, providing initial linkages to mental health service providers in the community. Approximately eighty jail detainees per year who are severely mentally impaired are referred to the Center for treatment on release from jail/prison. Those with mental disorders who do not meet the criteria for severe mental illness or who have special needs, such as sex offender treatment, are referred to other community resources.

Center staff also work with state inmates being held at the jail. Through its regular screening and service recommendation process, the Center is able to pull some of these offenders out of their intended institutional placements to receive community-based services coordinated by the Center.

Probationers. Staff conduct screenings for an estimated 1,000 mentally impaired potential probationers annually and submit recommendations to the sentencing court. Community management recommendations for offenders who are not severely mentally ill may include the use of probation department resources, such as electronic monitoring and Antabuse maintenance, rather than care provided by the Center. The Center's crisis intervention services are available to these probationers if needed.

Of the individuals who are screened for service needs on probation, approximately sixty per year will go on to receive clinical treatment and/or intensive case management services from the Center. Center caseworkers also provide consultation to probation officers on how to manage individuals and assist the probation department with offenders who are particularly difficult to manage.

Offenders found not guilty by reason of insanity. Center staff provide screening and evaluation for Bexar County's criminal law magistrate, who hears all cases involving competency and insanity. Eligible offenders judged not guilty by reason of insanity are placed on court-ordered outpatient commitments and released to the custody of the Center, which provides them with all regular services while they are in the community. Approximately twenty such cases are managed per year. Any failure to comply with treatment is immediately reported to the court, which may require the client to be incarcerated or hospitalized.

Parolees. A law passed by the Texas legislature in September 1994 requires the state prison system to notify local service providers before releasing mentally impaired individuals on parole. In Bexar County, the Center for Health Care Services is the designated site to receive this notification. This enables the Center to perform evaluations and recommend service plans for offenders before they are released. Previously, parolees were referred to the Center, but their contact was much less reliable. Offenders often did not receive needed services and were more likely to re-offend and be returned to prison.

Offenders at risk for probation or parole revocation. Center staff play a role in the revocation process by conducting assessments and making recommendations to the court or hearing officer. In most cases, the Center is successful in recommending continued community placement along with treatment services. However, limited availability of some services in the San Antonio area can lead to a recommendation

that offenders be incarcerated in order to receive needed treatment. For example, since only thirty- to ninety-day substance abuse treatment placements are available locally, mentally impaired offenders who need long-term substance abuse treatment in order to become stabilized must be sent to the state corrections system. Sex offenders are another population for whom adequate treatment is not presently available in the community.

Interagency Collaboration

Liaison between the Center and criminal justice agencies is integral to the Center's role. Center staff work out of the Bexar County Detention Center and Adult Probation offices, and staff of these agencies have offices on-site at the Center. For their work with parolees, staff maintain connections with the Texas Department of Corrections Institutional Division. The Center works with the maximum security unit at the Vernon State Hospital in matters relating to offenders not guilty by reason of insanity, and it maintains ties with the Texas Council on Offenders with Mental Impairments. This collaborative approach ensures that mentally impaired offenders receive the supervision and care they need to function independently.

In addition, cross-training contributes significantly to the effectiveness of the program and further exemplifies its interagency approach. Forensic Unit staff attend training provided by the state's parole academy, and the Center trains probation, parole, and jail staff on issues in mental illness and disability.

Since its inception in 1986 with one staff member, the program has grown to a staff of twelve. Funding is provided by the Texas Council on Offenders with Mental Impairments, the Texas Department of Mental Health and Mental Retardation, the Texas Criminal Justice Assistance Division, and through Medicaid and other third-party reimbursements.

For additional information, contact Linda Andresen, Forensic Unit Coordinator, Center for Health Care Services, 1407 N. Main St., San Antonio, Texas, 78212; phone (210) 299-1071. ■

Hints on Developing a Continuity of Service System for Offenders with Mental Illness and Mental Retardation

- Involve the highest level officials from each participating agency.
- Involve all agencies and consumers in the service area in the strategic planning process.
- Establish a liaison system between the mental health system and all facilities/agencies involved.
- Cross-train staff of all organizations.
- Establish an information exchange among all agencies.
- Establish collaborative, on-going communication on a daily basis among agency staff.
- Establish a mechanism whereby the highest level officials and key staff of all organizations meet at intervals to work through implementation strategies. ■

Accessing Federal Disability Resources

by Kyle A. Matting, M.S., Mental Health Therapist/Case Manager, Adams Community Mental Health Center, Commerce City, Colorado

People who are unable to work or engage in gainful activity because they are mentally ill may be eligible for disability benefits provided through the Social Security Administration (SSA). Two types of disability benefits are available: a monthly cash benefit for obtaining food and housing, and disability insurance that covers psychiatric evaluation, medications, and mental health therapy. These supports help a disabled individual start a course of recovery, and they are key to accessing mental health and other rehabilitation resources in the community.

The application process is initiated with a phone call to a local or national SSA office. Information will be requested, including the person's name, Social Security number, date of birth, diagnosis, and an address to which the follow-up formal application should be sent. Because the time between application and final review can be lengthy, it is important to start the process early and to provide complete and accurate information. It may be advisable to assign a responsible person as the disabled applicant's representative payee—a probation department, community corrections facility, mental health center, or a family member. The payee agrees to manage the disability income and ensure that the funds are used as intended.

Publication no. SSA 64-039, "Disability Evaluation Under Social Security," defines the criteria for disabling mental disorders. The law defines a disability as "the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to last for a continuous period of not less than twelve months." Based on this definition, the Social Security Administration evaluates an application based on the following specific criteria:

- *Clinical signs and symptoms of mental disorder.* Clinical signs are "medically demonstrable phenomena which reflect specific abnormalities of behavior, affect, thought, memory, orientation, or contact with reality." They may include auditory hallucinations or other perception disturbances, delusions or other thought disturbances, and depression or other significant mood disturbances.

- *A description of the individual's functional impairment that is a direct result of the mental disorder.* A functional impairment may be a neglect of personal care or an inability to perform activities of daily living.

- *Evidence of the person's inability to function outside of a structured setting or evidence of repeated deterioration or exacerbation of symptoms under stress.* Examples could include the inability to find housing, employment or food.

The application must document the ways in which the disabled person meets each criterion. His or her status in the correctional system is also important in determining eligibility: an offender currently in prison serving a sentence for a felony is ineligible until he/she is on parole. In most cases, a person engaged in a work release program is also ineligible for disability benefits. ■

The national toll-free number for the Social Security Administration is (800) 772-1213.

NIC COMMUNITY CORRECTIONS DIVISION UPDATE

by Eduardo Barajas, Jr., Correctional Program Specialist, NIC Community Corrections Division, Washington, D.C.

The NIC Community Corrections Division has taken initial steps in promoting the establishment of linkages among probation and parole agencies, the police, and the community.

A new paradigm of criminal justice is emerging. Spearheaded by community or "problem-oriented" policing, criminal justice is initiating new approaches that conceive of the community as both the ultimate customer and a business partner. Elements of this trend can be seen in the community justice and restorative justice movements and in such practical applications as "beat" or neighborhood probation.

By hosting two meetings, the Community Corrections Division has begun to help frame the conceptual and practical implications of this movement and to establish a dialogue between police and probation/parole agencies.

Community response to crime. The first of these meetings was held on October 20, 1994. At this meeting, community corrections practitioners and criminal justice researchers came together to plan a spring 1995 conference on violent offenders. The planning meeting was co-convened by the Communitarian Network, a group founded by professor Amitai Etzioni of George Washington University. The group's purpose is to build or strengthen communities and community institutions, restore the "moral voice" to those institutions, and establish a balance between individual rights and individual responsibilities.

One product of the meeting was the formulation of four guiding principles for community corrections as it works in partnership with communities to address crime and violence. These principles emphasize that community corrections must:

- *Provide value.* The value of community corrections must be in contributing to safe, secure, and just communities.
- *Be responsive to community demands.* Community corrections must work collaboratively so that capabilities available in the community are used.
- *Enhance the capacity of the community to be responsive.* Crime control should not exact such a high price that it reduces the community's ability to respond responsibly to crime and violence.
- *Hold the community responsible for its work as co-producers of justice.* Community corrections must urge the larger community to provide the necessary resources to respond responsibly to crime and violence.

The context of the 1995 meeting on violent offenders will be framed within this general structure, and participants will focus on formulating coordinated responses to the harm inflicted by violent offenders. Participants also will discuss effective treatment interventions based on the principles of limited risk management.

Linking police with probation and parole. On November 2, 1994, the Community Corrections Division co-sponsored a meeting among chiefs of police and probation and parole executives. The purpose of the meeting was to establish a dialogue and better cooperation and collaboration between law enforcement and community corrections. This meeting was cosponsored by the Police Foundation, an organization that conducts research on police practices and provides technical assistance to police agencies.

Those attending the meeting agreed that the timing was right for police and community corrections to work together toward the common goal of creating safer communities. This meeting was the first step in establishing a working relationship between NIC and the Police Foundation to carry this effort forward.

Symposium on Female Offender Issues

NIC and the Community Corrections Division have received a growing number of requests for assistance on issues related to female offenders. As a result, the Community Corrections Division is working with the National Association of Women Judges to study the possibility of holding a national symposium on female offenders. The project is in the very early stages of conception at this time. NIC will keep agencies informed as things develop. ■

RECOMMENDED READING

Abstracts of Currently Utilized Substance Abuse Assessment Instruments.
National Institute of Corrections Academy (Longmont, CO), 1993. 10 p.
This document briefly describes ten substance abuse assessment instruments in use throughout the United States. Each abstract describes the instrument's purpose, target population, validity and reliability data, administration/scoring, training requirements, source, and cost.

A Comprehensive Review of State-By-State Probation and Parole Drug Testing Case Law.
Council of State Governments (Lexington, KY); American Probation and Parole Assn. (Washington, DC), 1992. Sponsored by U.S. Bureau of Justice Assistance (Washington, DC). 27 p.
This document provides an overview of the available drug testing case laws among the states as they relate to urinalysis, fourth and fifteenth amendment issues, and legal challenges. Issues covered include: testing as a condition of probation and parole; confidentiality; right against reasonable search and seizure; right to due process; and admissibility of test results.

Correctional Technology: A User's Guide.
Kichen, Carol Cole; Murphy, James; Levinson, Robert B. American Correctional Association (Laurel, MD); National Institute of Corrections (Washington, DC), 1993. 278 p.
Meant to provide corrections administrators with a nonbiased, objective source for evaluating different correctional technologies, this guide is divided into seven chapters: 1) Perimeter Security Systems; 2) Locks and Locking Systems; 3) Internal Detection Systems; 4) Monitoring and Surveillance Systems; 5) Fire Safety Systems; 6) Communication Systems; and 7) Management Information Systems. Each chapter includes an abstract, table of contents, executive summary, and sections containing sample characteristics, survey findings, conclusions and issues, and questionnaire data.

Development of Hawaii Paroling Authority Case Management Classification System.
Hawaii Paroling Authority (Honolulu, HI); Hawaii Dept. of Public Safety (Honolulu, HI), 1993. Sponsored by National Institute of Corrections (Washington, DC). 97 p.
The Hawaii Paroling Authority re-structured the way cases are managed by implementing an offender classification and workload management system based on a model developed by the National Institute of Corrections. This packet represents the summary documents and working papers of the Authority.

Mentally Retarded and Mentally Ill Criminal Offenders: Effectiveness of Community Intervention Programs.
Eisenberg, Michael. Criminal Justice Policy Council (Austin, TX), 1993. 4 p.
This report discusses two pilot projects developed by the Texas Council on Offenders with Mental Impairments and reports on preliminary outcome evaluations of their impact on the recidivism rates of mentally ill and mentally retarded offenders. Preliminary program evaluations show significant reductions in recidivism rates for project participants.

Materials listed are among those cataloged into the NIC Information Center collection between September 1993 and January 1994. Single copies of these titles may be requested from the NIC Information Center by calling (800) 877-1461.

Multisite Evaluation of Shock Incarceration.
MacKenzie, Doris Layton; Souryal, Claire. University of Maryland. Dept. of Criminal Justice and Criminology (College Park, MD); National Institute of Justice (Washington, DC), 1994. Sponsored by National Institute of Justice (Washington, DC). 45 p.
This study examines eight boot camp prison programs. The examination focuses on: the development and implementation of the programs; the attitude changes of offenders during the in-prison phase of the program; the impact of the programs on recidivism; the impact of the programs on the positive activities of graduates during community supervision; and the effect of the program on prison crowding.

New Approaches to Staff Safety.
Thornton, Robert L.; Shireman, John H. Personal Development Consultants, Inc. (Tacoma, WA); National Institute of Corrections (Washington, DC), 1993. 73 p.
This document is designed to assist community corrections agencies and trainers in evaluating their training needs relating to staff safety. The monograph specifies specific safety training needs areas, legal issues in safety training, research on the most effective training techniques, and resources in the respective safety training areas. Topics covered include: use of force, crisis prevention, firearms training, canine use, transporting offenders, self-defense training, handcuffing, contraband management, and electronic monitoring.

Pro-Active Press: Developing and Implementing a Media Strategy for Probation Image Enhancing, Constituency Building and Damage Control.
Migliore, Gerry. New York (N.Y.). Dept. of Probation (New York, NY); Massachusetts Trial Court. Office of Commissioner of Probation (Boston, MA), 1993. Sponsored by National Institute of Corrections (Washington, DC). 155 p.
Migliore advocates using the media to educate the public and market the mission of community corrections. His pro-active press policy is divided into 177 statements categorized under numerous major headings and sub-headings. They include: the mission statement, define your constituencies, the probation story, probation's commitment to the community, projecting the image of leadership, letters to the editor, public safety: the primary concern of John Q. Public, meeting with editorial boards, insuring media participation, holding a press conference, working with reporters, rights of probationers, damage control, and managing crisis situations. The exhibit section provides examples of newspaper articles that tell the probation story.

Responding to Probation and Parole Violations.
Parent, Dale G. Abt Associates (Cambridge, MA); National Institute of Justice (Washington, DC), 1994. 50 p.
This report examines recent trends in violations of conditions of community supervision as reported by probation and parole practitioners. It also discusses the policies being developed by different jurisdictions in response to problems associated with these trends. Areas discussed include: conditions of supervision; administrative review of revocations; enhances casework responsibilities; revocation guidelines; information gathering; privatization of absconder-apprehension services; limited sanctions; and policy issues.

A State-By-State Sampling of State Legislation on the Use of Intermediate Sanctions by Probation and Parole.
Council of State Governments (Lexington, KY); American Probation and Parole Association (Lexington, KY), 1992. Sponsored by U.S. Bureau of Justice Assistance (Washington, DC). 61 p.
This report summarizes the results of a survey of state legislators and legislative staff concerning legislation on intermediate sanctions as incorporated by probation and parole. This compilation by sanction provides a sampling of each states legislation on community-based sanctions, sentencing alternatives, intermediate sanctions, and alternatives to incarceration. For further information, the Appendix contains the name, address, and telephone number of each contact person, providing that states information. ■

STATE OF CONNECTICUT
DEPARTMENT OF CORRECTION

ADMINISTRATIVE DIRECTIVE

APPROVED BY:

DIRECTIVE NO.	EFFECTIVE DATE:	PAGE 1 OF
6.14	December 10, 1993	10

SUPERSEDES
Security Risk Groups - 4/13/92

TITLE
Security Risk Groups

1. Policy. The Department of Correction shall identify, monitor and control security risk groups and their members.

2. Authority and Reference.

   A. Connecticut General Statutes, Section 18-81.
   B. Administrative Directives 6.10, Inmate Property; 9.2, Inmate Classification; 9.4, Restrictive Housing; 9.5, Code of Penal Discipline; and 10.7 Inmate Communications.

3. Definition. For the purposes stated herein, the following definitions apply:

   A. Close Custody Unit. An inmate housing area located at designated facilities wherein Security Risk Group Safety Threat Members are placed.
   B. Reviewer. A person assigned by the Unit Administrator to assess all information relating to alleged security risk activity.
   C. Security Risk Group. A specifically designated group of inmates possessing common characteristics which serve to distinguish them from other inmates or groups of inmates and which as a discrete entity poses a threat to the safety of staff, the facility, other inmates or the community.
   D. Security Risk Group Member. An inmate specifically determined to be a member of a security risk group in accordance with this directive.
   E. Security Risk Group Safety Threat Member. A member of a security risk group and whose behavior or status has been determined in accordance with this directive to be a threat to the safety of staff, the facility, inmates or the community or the order of the department.

4. Security Risk Group Identification. The Unit Administrator shall report any incident, activity or information which suggests the existence of a Security Risk Group to the Director of Security. The Director of Security shall assess the activities of inmates who may constitute a Security Risk Group. The Director of Security shall control the collection, maintenance and dissemination of information regarding Security Risk Groups.

A. Recommendation Factors. The Director of Security shall consider the following factors when recommending designation of a Security Risk Group. These factors include, but are not limited to: (1) history and purpose of the group; (2) organizational structure of the group; (3) propensity for violence by the group; (4) specific violent acts or intended acts of violence that can be reasonably attributed to the group as an entity; (5) specific illegal or prohibited acts, to include the intention or conspiracy to commit such acts, that can be associated with the group as an entity; (6) demographics of the group to include group size, location, patterns of expansion or decline of group membership; and (7) the degree of threat to facility security.

B. Designation. The Director of Security shall evaluate all information suggesting the existence of a Security Risk Group. When sufficient information suggests the existence of a Security Risk Group, the Director of Security shall present the findings and supporting documentation to the Commissioner. The Commissioner shall be the approving authority to designate a Security Risk Group in accordance with the factors set forth in Section 4(A) above.

5. Group Monitoring. The Unit Administrator shall ensure the ongoing monitoring and reporting of Security Risk Group activities to the Director of Security. Such monitoring and reporting shall include organizational structure, chain of command, bylaws, creed, names and titles of individual inmates connected with Security Risk Groups as and identifying colors, tattoos or other common identification. Monitoring shall include information on the relationships of Security Risk Group members both within the unit and the Department as well as reports on all factors listed in Section 4(A) above.

6. Designation of a Security Risk Group Member. Upon reasonable belief that an inmate is a member of a Security Risk Group, the inmate shall be so notified and allowed to present any objection(s). If the Unit Administrator, in consultation with the Director of Security, determines the inmate is a member of a Security Risk Group, the Unit Administrator shall designate the inmate as a Security Risk Group member and notify the inmate in writing. The Unit Administrator shall notify the Director of Security by completing and forwarding the Inmate Security Risk Group Membership Form, CN 61401, along with all documentation

indicating security risk group membership. A photocopy of the inmate's picture and visiting list shall be attached. The Director of Security shall ensure the designation is noted on the RT46 and RT50 computer screens.

7. Management. An inmate designated as a Security Risk Group member shall be managed as follows:

   A. Classification. The inmate shall be classified Level 3 or higher in accordance with Administrative Directive 9.2, Inmate Classification.
   B. Work or Program Assignments. An inmate assigned to a worksite or program must be in a specific location under ongoing supervision. Assignments to a maintenance crew, industries job, seven day job or an assignment outside the secure perimeter shall be prohibited.
   C. Extended Family Visiting. Extended family visiting shall be prohibited .
   D. Outstanding Meritorious Good Time (OMGT). OMGT awards shall not be granted;
   E. Good Time Restoration. Restoration of forfeited good time shall not be permitted in accordance with Administrative Directive 9.5, Code of Penal Discipline.

8. Appeal. An inmate designated as a Security Risk Group member may appeal the designation in writing to the Commissioner (or designee).

9. Designation of Inmate as a Security Risk Group Safety Threat Member. When it is reasonably determined that the behavior, or status as a recognized leader, of a Security Risk Group member is a threat to the safety of staff, the facility, other inmates, the community or the order of the Department, the Unit Administrator or higher authority shall initiate a review. Any inmate housed in a Level 3 facility or below shall be transferred to a Level 4 or 5 facility and/or shall be placed on Administrative Detention in accordance with Administrative Directive 9.4, Restrictive Housing, upon initiation of the review. If the inmate is determined not to be a Security Risk Group Safety Threat Member, the inmate shall be returned to a facility of the inmate's original level unless reclassified under Administrative Directive 9.2, Inmate Classification. The Reviewer shall complete Sections 1 and 2 of the Inmate Security Risk Group Safety Threat Determination Form, CN 61402. Upon completion of the review a hearing shall be conducted as follows:

A. Notification. The inmate shall receive a copy of the Security Risk Group Safety Threat Member Hearing Notification Form, CN 61403, and Sections 1 and 2 of Form, CN 61402, notifying the inmate of the hearing and the reason(s) for possible designation as a security risk group safety threat member. The written notification shall be delivered to the inmate at least 48 hours prior to the scheduled hearing. The Unit Administrator shall ensure that the Hearing Officer and advocate, if applicable, is notified of the scheduled hearing and is provided with Sections 1 and 2 of form CN 61402, and supporting documentation, except as provided in Section 9(D) below, at least 48 hours prior to the hearing. Specific information which could reasonably jeopardize the identity of informants shall not be given to nor shared with the inmate or Advocate.

B. Representation. The Reviewer shall determine if the accused inmate desires an Advocate and shall inform the inmate of the choices. The choices shall be any of the Advocate(s) scheduled to be on duty at the time of the hearing. The Reviewer shall indicate the inmate's decision on form CN 61402 and, if an Advocate is selected, shall promptly notify the Advocate. The Advocate shall meet with the inmate at least 24 hours prior to the hearing, conduct a thorough review independently of the Reviewer, assist the inmate in preparing a defense, and assist in making a presentation at the hearing. Each Unit Administrator shall appoint advocates in accordance with Administrative Directive 9.5. The names of the Advocates shall be made known to all staff and inmates through appropriate notice. If the inmate elects to be represented by an Advocate, an Advocate shall be present at the hearing. If an Advocate assigned to a given case becomes ill or otherwise is unable to be present for the hearing, a substitute Advocate shall be appointed by the Hearing Officer. In such a case, the inmate may choose to proceed with the present hearing or continue the hearing to a later designated time so that the substitute Advocate can become familiar with the case.

C. Witnesses. An accused inmate shall have an opportunity to present witness testimony at a hearing. Witness testimony must be relevant, freely given and not redundant. To appear at a hearing, an individual must be present at the unit and pose no threat to an orderly

hearing or to personal safety. If an otherwise qualified witness is unable to appear, written testimony may be submitted.

1. Identification. The Reviewer shall ascertain whether the inmate wants to call witnesses. If so, the Reviewer shall record the names on Form, CN 61402. The inmate's failure to identify witnesses to the Reviewer shall make any subsequent request for a witness subject to the Hearing Officer's discretion.
2. Testimony. The Reviewer shall interview prospective witnesses; list the witnesses and the nature of the testimony on Form, CN 61402; and schedule the admissible witnesses for the hearing. No inmate witness shall be compelled to testify.
3. Staff Witness. A staff member, called upon for testimony, may submit such testimony in writing or in person at the discretion of the Hearing Officer. No shaff member shall be compelled to testify in person.

D. Hearing. Following notification to the inmate, a hearing shall be conducted by a Department Hearing Officer within five (5) business days. The inmate shall normally be allowed to be present during the hearing, present testimony/evidence and call witnesses. Information which is material to the purpose of the hearing may be exempted from disclosure if it places the informant in jeopardy. If the Reviewer believes that documentary or testimonial information should be exempted from disclosure, the Reviewer shall present the information and an assessment of its credibility to the Hearing Officer outside the presence of the inmate and the inmate's Advocate. The Hearing Officer shall decide if the information should be exempt from disclosure and, if so, shall inform the inmate that there is exempted information. If the inmate is found to be a Security Risk Group Safety Threat Member, the Hearing Officer shall state, in writing, a summary of the information, an assessment of its reliability and why it was exempted. This statement shall be maintained in a file which is not accessible to any inmate. If the Hearing Officer determines information is not confidential, the Hearing Officer may proceed with the hearing or may continue the hearing to permit

the inmate time to prepare a defense. The inmate and/or witnesses may be denied access to the hearing when a threat to facility safety, security, or order exists.

E. Unit Administrator Review Procedures. The Hearing Officer shall complete Section 3 of Form, CN 61402, and forward it to the Unit Administrator for review within three (3) business days of the hearing. The Unit Administrator shall review all materials and make a recommendation within three (3) business days by completing Section 4 of Form, CN 61402. All supporting documentation shall be attached to the Unit Administrator's recommendation. The recommendation shall be forwarded to the Director of Security who shall review and develop the materials for presentation to the Commissioner.

F. Decision. Only the Commissioner may designate an inmate as a Security Risk Group Safety Threat Member. Such designation shall be based upon the personal discretion of the Commissioner, sound correctional practice, the Commissioner's training and experience, and a review of all available materials.

G. Notification of the Commissioner's Action. The inmate shall be notified of a Security Risk Group Safety Threat Member designation in writing within 10 business days by receiving a completed copy of Form, CN 61402. The notification shall inform the inmate of the right to request a reconsideration by the Commissioner. The Offender Classification Administrator shall be notified when an inmate has been designated as a Security Risk Group Safety Threat Member and shall arrange transfer to a Level 4 Close Custody Unit.

10. Automatic Designation as a Security Risk Group Safety Threat Member. An inmate who has been verified as a Security Risk Group member in accordance with Section 6 of this Directive and is found guilty of any of the following disciplinary offenses in accordance with Administrative Directive 9.5, Code of Penal Discipline shall be automatically designated as a Security Risk Group Safety Threat Member and be classified Level 4 in accordance with Administrative Directive 9.2, Inmate Classification and placed in a Close Custody Unit:

A. Level 2 Assault on Staff;
B. Creating a Disturbance;

C. Assault;
D. Fighting;
E. Contraband A (Possessing a Dangerous Instrument).

The provisions set forth in Section 9 above shall be waived when an inmate who is a Security Risk Group Member is found guilty of one of the above offenses.

Placement of an inmate in a Close Custody Unit shall not preclude placement in Administrative Segregation in accordance with Administrative Directives 9.2, Inmate Classification, and 9.4, Restrictive Housing.

11. Inmate Records. An inmate's designation as a Security Risk Group member or as a Security Risk Group Safety Threat Member shall be recorded in the inmate's Master file and identified on the RT46 and RT50 computer screens.

12. Readmitted Inmate. An inmate discharged from the Department while designated as a Security Risk Group Safety Threat Member shall be readmitted in the same status. The inmate's status shall be reviewed within 90 days of readmission. The Unit Administrator shall notify the Director of Security and the Offender Classification Administrator of any Security Risk Group Safety Threat Member's readmission. The Director of Security shall review the case, and make a recommendation to the Commissioner to determine whether the inmate should remain in such status.

13. Management Of a Security Risk Group Safety Threat Member. An inmate designated as a Security Risk Group Safety Threat Member shall be managed as follows:

A. Housing. Placed in a Level 4 Close Custody Unit;
B. Movement.

1. Out of cell or secured area within housing unit - not more than eight inmates including janitors/tierman allowed out of cell at one time.
2. Out of cell or secured area when on restraint status - restraints shall not be authorized unless for movement to Restrictive Housing.
3. Out of unit other than to adjacent recreation area - inmate shall be escorted, at a minimum, by one (1) staff member for every three (3) inmates.

C. Searches. Cell and living area searches shall be conducted at least once every seven (7) days.

D. In Cell Observation. Direct observation by a Correctional Officer shall not be less frequently than every 30 minutes. Living breathing flesh shall be observed.

E. In Cell Restraint Status. In cell restraints shall not be allowed.

F. Mail. All mail shall be handled in accordance with Administrative Directives 6.10, Inmate Property and 10.7, Inmate Communications. No more than five (5) letters may be retained per inmate in the cell.

G. Telephone. All inmate telephone calls shall be in accordance with Administrative Directive 10.7, Inmate Communication. A maximum of three (3) 15 minute telephone calls per week may be allowed, exclusive of privileged communication. All calls must be approved by a supervisor. Phone calls shall be recorded and may be listened to directly. Upon written request, an authorized call to a privileged correspondent shall be arranged to preclude recording or listening.

H. Inmate Property. Shall be in accordance with Administrative Directive 6.10, Inmate Property, and as follows:

1. A television shall be allowed as long as the inmate remains free of any Class A and/or B misconducts which shall result in loss of T.V. for 30 days. In cells that are doubled, both inmates must remain misconduct free.
2. A radio with headset may be allowed.
3. Commissary shall be the same as for the General Population.

I. Inmate Accounts. The Unit Administrator shall monitor the inmate's account activity.

J. Classification. Classification shall be in accordance with Administrative Directive 9.2, Inmate Classification.

K. Work Assignments. Work assignments shall be limited to cleaning and food service jobs within the Unit.

L. Program Assignments. Program opportunities shall be provided in-cell/unit or separate from the general population in a secure area. The Unit Administrator shall submit a program plan to the Deputy Commissioner of Operations for approval.

M. Recreation. Recreation shall be authorized to include one (1) hour per day, five (5) days a week in a

controlled area.

N. Showers. Three (3) showers with a 15 minute limit shall be allowed weekly.

O. Food Service. Regular meals shall be provided but must be provided within the cell or unit.

P. Visits. Two (2) non-contact visits per week shall normally be allowed. No extended family visits shall be allowed. Legal visits will be allowed as needed and approved by the Unit Administrator (or designee).

Q. Sentence Credits. Statutory Good Time credits shall not be authorized. Outstanding Meritorious Good Time award shall not be granted.

R. Good Time Restoration. Restoration of forfeited good time shall not be permitted in accordance with Administrative Directive 9.5, Code of Penal Discipline.

14. Change in Security Risk Group Safety Threat Member Designation. The Director of Security shall review any inmate's designation as a Security Risk Group Safety Threat Member as new information requires, or at least every six (6) months, to determine whether the inmate should remain in this status. Any recommended change in the inmate's status shall be forwarded to the Director of Security and submitted to the Commissioner for action utilizing Form, CN 61402. The Director of Security shall notify the Offender Classification Administrator, the appropriate Unit Administrator and the inmate of any changes in the inmate's designated status.

An inmate may request reconsideration, in writing to the Commissioner, whenever circumstances have changed enough to merit review.

15. Security Risk Group Renunciation. An inmate identified as a member of a Security Risk Group but who is not a Threat member, may submit a letter to the Unit Administrator to request removal from such designation. The Unit Administrator (or designee) shall interview the inmate to determine the validity of the request and have the inmate sign the Security Risk Group Renunciation form, CN 61404. When the Unit Administrator, in consultation with the Director of Security, reasonably determines the inmate has discontinued unauthorized associations and activities, the Unit Administrator may approve a change in designation and forward a written copy of the decision, along with any related information to the Director of Security. The designation shall be removed by the Security Division on the RT46 and RT50 screens upon approval from the Director of

Security. The inmate's Security Risk Group file shall be kept in an inactive file in the Security Division for future reference.

16. Re-Designation. An inmate re-designated as a Security Risk Group Member in accordance with this Directive, after having been allowed to renounce membership, shall not be allowed to renounce again without authorization of the Commissioner. The Director of Security shall reactivate the file which shall be maintained on the RT46 and RT50 screens.

17. Movement. The Offender Classification Administrator shall notify the Director of Security and the receiving Unit Administrator prior to the movement of any known Security Risk Group Safety Threat Member.

18. Discharge of a Security Risk Group Safety Threat Member. The Unit Administrator (or designee) of the discharging facility, shall notify the Director of Security when a Security Risk Group Safety Threat Member is scheduled for discharge to the community. The Director of Security shall notify the appropriate local law enforcement and State Police, providing a profile of the released inmate.

19. Exceptions. Any exception to the procedures in this Administrative Directive shall require prior written approval from the Commissioner.

inmate photograph

CN 61401
4-10-92

Inmate Security Risk Group Membership

Connecticut Department of Correction

Inmate name	Inmate number
Alias(es)	Date of birth
Security risk group affiliation	
Facility	

MEMBERSHIP DETERMINATION
(check all applicable items and attach all supporting documentation)

- ☐ Self admission
- ☐ Identified security risk group tattoo
- ☐ Possession of security risk group paraphernalia (e.g., clothing, colors, literature)
- ☐ Information from outside law enforcement agency
- ☐ Information from internal investigation
- ☐ Information from confidential informant
- ☐ Inmate correspondence or outside contacts
- ☐ Security risk group picture
- ☐ Other

Based on the attached information, I have determined the above-named inmate to be a member of a security risk group.

Unit Administrator signature Date

CN 61402
4-10-92

Inmate Security Risk Group
Safety Threat Determination, Page 1
Connecticut Department of Correction

Inmate name	Inmate number
Alias(es)	Date of birth
Security risk group affiliation	
Facility	

SECTION 1: SAFETY THREAT ACTIVITIES
(attach all supporting documentation)

Current group involvement/activities:

Past involvement:

Specific status, behaviors or actions that demonstrate that the inmate is a threat to departmental safety and security:

SECTION 2: INMATE WITNESS REQUEST

Name

Nature of testimony

Name

Nature of testimony

Name

Nature of testimony

Inmate declined to present witnesses ☐ Yes ☐ No

Advocate choice: (1) ☐ Declined advocate

(2)

(3)

Reviewer signature Date

CN 61402
4-10-92

Inmate Security Risk Group
Safety Threat Determination, Page 2
Connecticut Department of Correction

SECTION 3: HEARING SUMMARY

Inmate name | Inmate number

Date | Time ☐ a.m. ☐ p.m.

Hearing Officer

☐ Advocate not requested

☐ Advocate requested ☐ Advocate not requested, but assigned

Advocate name | Title

Witness testimony:

Assessment of current group involvement/activities:

Assessment of past group involvement/activities:

Assessment of potential continued/future group involvement:

Conclusions/recommendations:

Hearing Officer signature | Date

SECTION 4: UNIT ADMINISTRATOR REVIEW

Conclusions/recommendations:

Unit Administrator signature | Date

CN 6.402
4-10-92

Inmate Security Risk Group Safety Threat Determination, Page 3

Connecticut Department of Correction

SECTION 5: DIRECTOR OF SECURITY REVIEW

Inmate name	Inmate number

Conclusions/recommendations:

Director of Security signature	Date

SECTION 6: COMMISSIONER DESIGNATION

__ Designated as a security risk group safety threat member

__ Not designated as a security risk group safety threat member

Comments:

Commissioner signature	Date

Notice: A request for reconsideration may be made by the inmate directly to the Commissioner.

Distribution: Director of Security (original and all attachments)
Deputy Commissioner for Institutional Services (form only)
Unit Administrator (form only)
Director of Classification (form only)
Inmate (form only)
Inmate master file (form only)

CN 61403
4-10-92

Security Risk Group Safety
Threat Member Hearing Notification

Connecticut Department of Correction

Inmate name	Inmate number
Hearing date	Hearing time ☐ a.m. ☐ p.m.
Hearing location	

Hearing purpose: Pursuant to Administrative Directive 6.14, Security Risk Groups, the hearing will address whether the inmate should or should not be designated as a Security Risk Group Safety Threat Member.

Summary of reasons:

Inmate signature

Unit administrator signature Date

Delivering staff signature Time ☐ a.m. ☐ p.m. Date

Security Risk Group Renunciation

Connecticut Department of Correction

CN 61404
12-7-93

I, _____

(print inmate name)

renounce my affiliation with the

_____

(print name of security risk group)

This is my first positive step toward reintegration into the general inmate population.

I realize that my status is directly controlled by the recommendations of the unit administrator to the director of security.

In making this renunciation, I am obligated to remain unaffiliated with the

_____

(print name of security risk group)

or any other security risk group.

If I am observed participating or associating with members of any security risk group or potential security risk group, I understand that I will immediately revert to my former security risk group member status for the remainder of my incarceration.

Inmate signature	Date
Inmate number	
Witness signature	Date

Distribution: Director of Security
Unit Administrator
Inmate file
Inmate SRG file

INDIANA DEPARTMENT OF CORRECTIONS
WOMEN CLASSIFICATION STUDY

Prepared by

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William Elms

September 22, 1993

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EXECUTIVE SUMMARY

In 1990, the Indiana Department of Corrections (IDOC) implemented an objective prison classification system which has greatly enhanced its overall prison operations. Nevertheless, IDOC is concerned that the current system is over-classifying the female inmate population which is known to pose lower security risk. IDOC also recognizes the importance of identifying the needs and problems unique to female inmates before the Department can devise changes to fulfill those needs.

In August 1992, NCCD received a grant from the National Institute of Corrections (NIC) to evaluate the effect of the current IDOC classification system on female inmates, especially on the issue of potential over-classification. It is also the purpose of this study to assess the specific difficulties that female inmates experience during their incarceration.

SUMMARY OF FINDINGS

Women Survey Data

- This study affirms the general perception that women inmates commit fewer infractions compared to their male counterparts.
- Though female inmates pose less threat to management regarding institutional misconduct, they present several unique levels of need that have to be addressed by the Department.
- Most women inmates who are mothers do not receive visits from their children mostly because of transportation problems and guardians' refusal to bring them.
- The vast majority of female inmates are uneducated and unskilled.
- Over half of the female inmates have been victims of physical abuse and a quarter of them victims of sexual abuse.
- Female inmates tend to have a greater demand for medical and psychiatric services.

Classification and Disciplinary Data

- Misconduct among both male and female inmates is best predicted by age, institutional disciplinary history, drug involvement, probation or parole violations, and scored security level.

- The classification system presently in use tends to over-classify women inmates. It is indicated by females' consistent lower rates of misconduct across all security levels when compared to males'.

- The IDOC classification system has an override rate which doubles the generally accepted rate of 20 percent.

- The basis for overrides is poorly documented, so it is difficult to determine if IDOC is using overrides improperly.

RECOMMENDATIONS

1. To prevent over-classification of women inmates, IDOC should adjust Section III of the female classification instrument: the scale for recommending either a reduction, no change, or an increase in security level should be expanded as indicated in Table 9.

2. The OIS Classification Data Base need to be modified so that the precise reasons for overrides are documented. Although preliminary steps have been taken by IDOC to eradicate this problem, this modification needs to be implemented as soon as possible.

3. Once the basis for the Department's excessive use of overrides is assessed, steps should be taken by the IDOC to determine whether overrides are being used in an appropriate manner.

4. A needs assessment form is required to document properly the unique needs of both male and female inmates (Appendix IV).

5. The siting of any new female prisons should be done to increase visits between inmates and their children.

INTRODUCTION

In 1990, the Indiana Department of Corrections (IDOC) successfully developed and implemented an objective prison classification system to guide the transfer and housing of inmates. That system was developed with the direct assistance of the National Institute of Corrections (NIC) which provided funds to help design, pilot test and implement the objective classification criteria.

The entire system was put in effect by February, 1991 and has had a very positive effect on overall prison operations. Inmates are now being assessed and housed according to standardized criteria. The Department is also able to describe its inmate population security needs which is helping them to better plan future correctional resources.

Despite these successes, the IDOC is concerned that its growing female inmate population may be inappropriately classified by the newly implemented objective system. Since the current system was pilot tested on a predominantly male inmate population, the tested criteria may not properly apply to the female inmate population. And, since females in general represent a lower security risk there may be some danger that the current system is over-classifying them. Finally, there is the remote concern that by not having a separate female classification system, the Department may be unnecessarily exposed to potential litigation.

The issue of possibly over-classifying female offenders takes on greater significance given that the female population has been

growing far faster than the male population and that the IDOC soon needs to decide which type of facilities the future female inmate population will require.

Because of these outstanding concerns, the IDOC seeks to develop a classification system which caters to the specific attributes and needs of female inmates. In August 1992, the National Council on Crime and Delinquency received a grant from the NIC to design and evaluate such a system in collaboration with the IDOC. After almost a year of research efforts, this report is prepared to demonstrate the effectiveness of the existing classification instrument in predicting institutional misconduct among female inmates and to assess the prevalence of over-classifying female inmates in the IDOC. In addition, findings from a female inmate survey are presented to describe the major concerns and needs among female inmates at IDOC.

DATA

There were two types of data used in this study. First were two extract files from the automated record system (OIS) maintained by the IDOC. The first file contained classification data of the stock prison population on one particular day and the second file held all disciplinary incidents that occurred between June 1, 1992 and April 30, 1993.[1] The two files were merged and cases with

[1] The IDOC only began automating its disciplinary data by June 1, 1992 which explains why this time frame was used.

missing classification data were dropped. The procedure resulted in a total of 13,164 inmates, 741 of which were women.

In order to look more closely at the problems and needs specific to female inmates and to assist IDOC in long-term planning for its future female inmate population, a survey study was conducted which collected information on demographics, abuse history, children, and prison visitation of female inmates. The questionnaire was administered to a random sample of 401 female inmates. All responses were voluntary.

COMPARISON OF MALE AND FEMALE INMATES (CLASSIFICATION DATA)

The distributions of male and female inmates in racial and age groups are similar (Table 1). For both genders, whites constitute over half of the inmate population and blacks about 40 percent. The majority of inmates are over 30 years of age; 56.7 percent for males and 61.7 percent for females.

The two sexes differ mainly in their levels of threat as reflected in variables regarding severity of current crimes and conviction history. There are 20 percent more female inmates than male who are currently convicted of minor crimes and about the same difference in the absence of violence in current crimes. There is a higher level of deaths involved in females' current crimes (21 percent as opposed to the males' 14 percent). This is probably a result of women's self-defense mentality especially in domestic violence cases. Women inmates are also less likely to have prior convictions, and if they do the convictions are for minor crimes.

TABLE 1

CLASSIFICATION DATA BY SEX

ATTRIBUTE	MALES	FEMALES	ATTRIBUTE	MALES	FEMALES
	N=12,423	N=741			
Race			Job Level		
White	57.7	56.3	Highly Skilled	3.0	0.8
Black	39.9	42.7	Skilled	6.2	2.4
Other	2.4	1.0	Semi-Skilled	18.0	2.0
			Unskilled	72.8	94.7
Separation?	45.0	7.0			
			Academic Level		
Security Level			Post Secondary	9.1	1.8
Minimum	9.1	13.5	High School/GED	41.5	37.5
Low Medium	43.4	55.3	6 Grade Plus	25.5	33.2
High Medium	21.2	13.6	Literacy Not Met	15.6	21.1
Maximum	26.3	17.5	Literacy Waived	8.3	6.5
Custody Level			Current Severity		
High	7.2	1.1	Low	12.9	35.6
Low	77.5	80.2	Low Moderate	16.9	8.8
Maximum	0.4	0.0	Moderate	36.6	26.9
Out	15.0	18.8	High	33.7	28.7
Medical Level			Violence		
No Conditions	73.3	58.7	None	37.4	58.6
AIDS	0.3	0.5	Deadly Weapon	35.5	11.2
Gross Mental	1.0	0.3	Serious Injury	13.4	9.3
Chronic Condition	5.3	7.7	Death	13.7	20.9
Stabilized	15.2	12.4			
Psychiatric	4.8	18.6			
Pregnancy	0.0	1.8			
Other	0.1	0.0			

TABLE 1
(CONTINUED)

CLASSIFICATION DATA BY SEX

ATTRIBUTE	MALES	FEMALES
Prior Conviction		
None	12.4	28.3
Low	33.1	49.9
Low-Moderate	30.1	15.0
Moderate	19.3	5.5
High	5.0	1.2
Prior Violence		
None	56.1	76.6
Deadly Weapon	38.6	18.9
Serious Injury	3.8	3.6
Death	1.5	0.8
Time Remaining		
LT 730 Days	20.9	33.1
731 - 1,460	19.8	22.4
1,461 - 2,190	13.0	9.6
2,191 - 2,555	4.0	2.7
2,555 + /Life	8.2	5.9
3,286 + /Death	34.2	26.3
Prob/Parole Viol		
No Record	78.1	83.8
Prob/Parole	18.1	13.4
CAB	3.8	2.8
Security Score		
Minimum	23.4	45.1
Low Medium	36.3	27.5
High Medium	22.2	10.5
Maximum	18.2	16.9

ATTRIBUTE	MALES	FEMALES
Age		
30 plus	56.7	61.7
22-29	34.3	31.9
21 below	9.1	6.5
Drug Involvement		
None/Never	18.7	21.8
Past	64.3	72.4
Current	17.1	5.9
Escape History		
None	80.5	79.8
Past Minor	7.4	5.9
Recent Minor	4.3	11.1
Past Serious	5.6	2.4
Recent Serious	2.3	0.8
Misconduct - Severity		
None	43.3	61.5
Low Moderate	7.0	5.2
Moderate	24.1	17.3
High	15.6	8.7
Greatest	10.0	7.3
Misconduct - Freq.		
None	43.4	61.9
1-3	36.1	28.2
4-7	12.8	7.3
8 +	7.7	2.6

Their use of violence in prior offenses, 23.3 percent, is much lower than males' 43.9 percent.

Due to the above factors, it is only logical that most females are classified for low security and custody supervision and their institutional conduct is superior to the males'. Inmate behavior will be discussed in greater detail in a later section.

Female inmates have more needs in terms of medical services, education and job training than their male counterparts. Almost 20 percent of female inmates enter the prison system requiring psychiatric counselling and related service; one-fifth of them have not attained a functional level of literacy and 95 percent have no job skills at all. If IDOC intends to prepare their female inmates for the demands of life after release, it should give additional attention to meeting these needs.

SURVEY RESULTS OF FEMALE INMATES

A common issue that arises among female inmates is their need to maintain relationships with their children and it is expected of the corrections system to accommodate such needs. The IDOC female survey addresses this issue by measuring the scope of the problem and by assessing the inmates' attitude toward visitation arrangements.

The survey sample of 401 female inmates is representative of the total female inmate population as shown by the almost identical distributions in racial and age groups between the sample and the population (Table 2-1).

TABLE 2-1

CHARACTERISTICS OF WOMEN INMATES

	N	%
Inmate Characteristics		
Race		
White	401	57.0
Black	292	41.6
Hispanic	8	1.1
Indian	2	0.3
Age		
17-20	22	3.1
21-30	282	40.2
31-40	256	36.5
41-50	101	14.4
> 50	41	5.8
Age (Mean)	34 yr. 1 mo.	
Marital Status		
Single	323	46.0
Married	134	19.1
Divorced	173	24.6
Separated	28	4.0
Widowed	44	6.3
Number of Children		
0	133	18.9
1	149	21.2
2	186	26.5
3	123	17.5
4	65	9.3
5 or more	46	6.6
Age of Children (N=1,401)		
Under 6	315	22.5
6 to 12	434	31.0
13 to 18	276	19.7
19 to 25	224	16.0
Over 25	152	10.8
Inmates With Children Under Age 18		
Yes	482	68.6
No	221	31.4

TABLE 2-2

CHARACTERISTICS OF WOMEN INMATES

	N	%
History Of Abuse As Victim And/Or Perpetrator		
Victim Of Sexual Abuse (Incest) As A Juvenile		
Yes	157	22.5
No	542	77.5
Victim Of Sexual Abuse (Rape) As A Juvenile		
Yes	162	23.2
No	536	76.8
Victim Of Sexual Abuse As An Adult		
Yes	157	22.6
No	539	77.4
Victim Of Physical Abuse		
Yes	370	52.9
No	330	47.1
Sexual Abuse As Perpetrator		
Yes	20	2.9
No	679	97.1
Physical Abuse As Perpetrator		
Yes	81	11.6
No	618	88.4
Pregnant Within 6 Months Of Admission To Prison		
Yes	85	12.1
No	616	87.9
Had Abortion Within 6 Months Of Admission To Prison		
Yes	12	1.7
No	689	98.3

TABLE 2-3

CHARACTERISTICS OF WOMEN INMATES

	N	%
Information On The Children Of Inmates (N = 1,401)		
Gender		
Male	717	51.4
Female	678	48.6
Number Of Visits To Prison Per Month		
None	732	52.2
Not More Than Once	429	30.6
Two To Four Times	204	14.6
More Than Four Times	36	2.6
Who Are Children Residing With (Relationship To Mother)		
Mother	301	22.1
Husband/Child's Father	228	16.7
Foster Care/Ward Of State/Group Home	123	9.0
Father	56	4.1
Sister	79	5.8
Older Children	23	1.7
Other Relatives	105	7.7
Child's Relatives	32	2.3
Friend	30	2.2
Adopted	28	2.1
Of Age	360	26.4
Custody Rights		
Mother	410	29.9
Father	104	7.6
Joint	65	4.7
Relatives/Friend	127	9.3
Foster Care/Ward Of State	47	3.4
Adopted	34	2.5
No	180	13.1
Yes	57	4.2
Of Age	347	25.3

TABLE 2-4

CHARACTERISTICS OF WOMEN INMATES

	N	%
Information On Inmate Visitation		
Number Of Primary Visitors		
0	157	22.3
1 to 2	186	26.5
3 to 4	184	26.2
5 or more	176	25.0
Who Visit The Inmates*		
Children	496	25.7
Parents	363	18.8
Siblings	331	17.2
Husband/Boyfriends	135	7.0
Friends	342	17.7
Other Relatives	216	11.2
Minister	44	2.3
Number Of People Inmates Would Like To Have Visited But Are Unable To		
Nobody	241	34.3
1	183	26.0
2	104	14.8
3	81	11.5
4 or more	94	13.4
People Inmates Wish To See**		
Children	394	39.0
Parents	196	19.4
Siblings	156	15.4
Husband/Boyfriends	43	4.3
Other Relatives	125	12.4
Friends	96	9.5

TABLE 2-5

CHARACTERISTICS OF WOMEN INMATES

Reasons The Desired Visitors Are Unable To Come**		
Transportation Problems/Distance	514	50.9
Guardians Of Children Refuse To Bring Them	101	10.0
Health Problems	89	8.8
Incarcerated/Parole/Probation	84	8.3
Feel Uncomfortable In Prison	51	5.0
Administrative (Not On List, Court Order No Visit)	42	4.2
Bad Relationship/Estranged	36	3.6
Too Busy	36	3.6
Don't Know	57	5.6

* Figures in this item are based on multiple responses given by inmates. Total responses = 1,927.

** The inmates were asked whom they wish to see in prison (no more than four people). The figures in these items are based on the total of 1,010 responses collected.

Forty-six percent of female inmates are single and 19.1 percent are presently married. More than 80 percent of them have at least one child and 68.6 percent have children under the age of 18. A little over half of all inmates' children are under 13 and 22.5 percent are in their tender years of one to six. Not counting those children who are of age, the most common living arrangements for these "motherless" children are either to stay with the inmates' mother (22.1 percent) or with the child's father (Table 2-3). Nine percent of these children are under the care of the state being placed in foster care, group homes and the like. Close to 40 percent of the female inmates still have sole or joint custody rights over their children and are expected to resume their maternal duties once they exit the prison system.

Even though inmates' children compose the highest portion of visitors (25.7 percent) to female inmates, it is clear that a good number of the women yearn to see their children who for various reasons do not visit (Table 2-4). The two major reasons which the inmates perceive as preventing visitation from their children and other desired visitors are transportation problems/distance and refusal from children's guardians (Table 2-5).

One portion of the questionnaire inquires about inmates' abuse history and as expected, the data collected paints a sorry picture of these inmates. Fifty-three percent of the female inmates have been victims of physical abuse, around 23 percent victims of incest and rape as a juvenile, and 22 percent victims of sexual abuse as an adult. These traumatic experiences may explain partly why

female inmates are more likely to seek psychiatric assistance than male inmates.

Another issue that is unique among female inmates concerns pregnancies and what they entail, i.e., abortions, child births and child custody. Twelve percent of the sample report they have been pregnant at a certain time in the last six months and 1.7 percent say they have had an abortion during the same period of time.

The survey information reiterates some of the pressing problems which face the management of female prisons. IDOC has to enhance its current visitation program to encourage the meeting of inmates and their children. It may mean making prisons more accessible to the public or it may require the Department to loosen its visitation restrictions in order to provide for longer and more frequent visits between inmates and their children. It is obvious that a prison is not the most natural place for maternal bonding and female inmates, because of their circumstances, may actually find communication with their children impossible. It would be useful for the Department to introduce innovative parenting workshops to help female inmates optimize the little time they have to spend with their children during visitation.

The vast majority of female inmates are not well-equipped to sustain a normal productive life outside the prison walls due to their lack of education and job skills (more so than male inmates). Therefore, the Department should seek to expand and improve its current educational and work programs available at prison facilities.

DISCIPLINARY CONDUCT

This section will focus on the distribution of disciplinary misconduct across different security levels and the extent to which the classification instrument predicts misconduct. If, indeed, the instrument is measuring inmates' risk in misconduct, then some type of association should exist between scoring items and disciplinary rates. Statistically, the classification items are the independent variables, or predictors, and disciplinary incidents the dependent variable. Readers should bear in mind that institutional disciplinary incidents are rare occurrences in general, and so, any relationship between the independent and the dependent variables may not be obvious.

Table 3 displays the types and the frequency of disciplinary incidents of male and female inmates. Comparing the two gender groups confirms that female inmates are less likely to break rules than male inmates. While female inmates make up 5.6 percent of the sample, they are responsible for only 3.2 percent of total infractions. And the infraction rate (number of incidents per inmate) of men almost doubles that of women; 1.63 for men compared to 0.91 for women.

Total disciplinary incidents include both minor and major infractions, and since the IDOC does not consider minor infractions significant or deserved of special attention, all statistical analyses from this point forward refer to major infractions only. Major infractions compose 51.9 percent of all infractions in IDOC,

TABLE 3

TYPES OF DISCIPLINARY INCIDENTS BY SEX

	MALE		FEMALE		TOTAL	
	N	%	N	%	N	%
Sample Total	12,423	94.4	741	5.6	13,164	100.0
Total Disciplinary Incidents	20,268	96.8	672	3.2	20,940	100.0
Number of Incidents per Inmate	1.63		.91		1.59	
Total Major Disciplinary Incidents (% of all incidents)	12,417	(61.3)	391	(58.2)	12,808	(61.2)
Types of Major Incidents						
Fighting or Battery	962	97.7	23	2.3	985	7.7
Threats	495	96.7	17	3.3	512	4.0
Possession of Weapons, Explosives, or Chemicals	94	100.0	0	—	94	0.7
Sex Violations	171	86.4	27	13.6	198	1.6
Attempt Class A Offense	14	77.8	4	22.2	18	0.1
Destroying Property	245	98.4	4	1.6	249	1.9
Theft	192	96.0	8	4.0	200	1.6
Drug Possession	548	98.9	6	1.1	554	4.3
Trafficking	34	94.4	2	5.6	36	0.3
Possession or Making Intoxicants	144	98.6	2	1.4	146	1.1
Violation of Any Law	88	97.8	2	2.2	90	0.7
Habitual Conduct Rule Violator	397	91.7	36	8.3	433	3.4
Engaging in Group Demonstration	98	100.0	0	—	98	0.8
Encourage Others to Riot	8	100.0	0	—	8	0.1
Resisting or Fleeing	233	99.6	1	0.4	234	1.8
Disorderly Conduct/Insolence	3,192	96.3	124	3.7	3,316	25.9
Refuse to Obey Order	4,302	98.3	73	1.7	4,375	34.2
Unauthorized Possession of Money or Property	672	94.3	41	5.8	713	5.6
Being in Unauthorized Area	528	92.2	21	3.8	549	4.3

Note 1: All percents for "males" and "females" are row percents and those for "total" are column percents.

Note 2: Table reflects disciplinary incidents recorded from 6-1-92 to 4-30-93.

and female inmates have a slightly lower percentage of major infractions (44.6 percent).

Major infractions which occur most frequently are refusal to obey order (40.4 percent) followed by fighting or battery which happens far less often (9.1 percent). Major infractions committed by females tend to be non-violent such as refusal to obey order and unauthorized possession of money, whereas male inmates are more likely to engage in fights and assaults.

Cross-tabulations were run to assess the association between classification factors and misconduct. If the likelihood of misconduct varies proportionally with the levels of an item, it suggests an association between the two variables. For example, the older an inmate is the fewer his incidents of misconduct. The presence or lack of association with misconduct among the factors is shown on Table 4 and the level of variation for those factors which demonstrate an association are shown on Table 5. Note that the initial classification scoresheet contains only the security items and therefore the number of cases involved in the analysis of custody items is smaller than total inmate population.

Two findings stand out from Table 3: first, custody items are much better predictors of disciplinary misconduct than security items and second, factors which correlate with misbehavior for males are the same for females. Probation/parole violation level is the only factor among security items which shows an association with misconduct. 80.4 percent of female inmates (68.3 percent for males) with no prior probation or parole violations have clean

TABLE 4

FACTORS ASSOCIATED WITH MAJOR DISCIPLINARY MISCONDUCT BY SEX

	DEGREE OF ASSOCIATION	
	MALES	FEMALES
Security Items		
Current Severity Level	None	None
Current Violence Level	None	None
Prior Conviction Level	None	None
Prior Violence Level	None	None
Remaining Time Level	None	None
Probation/Parole Violation Level	+	+
Total Security Score	None	None
Security Score Level	None	None
Custody Items		
Current Age Level	+	+
Drug Involvement Level	+	+
Escape History Level	None	None
Serious Conduct History Level	+	+
Frequency of Conduct History Level	+	+
Total Custody Score	+	+
Custody Score Level	+	+
Final Security Level	+	+

Note: Degree of association refers to the ability of an item score to predict misconduct behavior.

TABLE 5

CLASSIFICATION FACTORS ASSOCIATED WITH MISCONDUCT BY SEX

CLASSIFICATION FACTORS	PERCENT WITH NO DISCIPLINARY INCIDENTS	
	MALE	FEMALE
	(N=12,423)	(N=741)
Total Rate	61.9	75.2
Security Level Items		
Probation/Parole Violation Level		
No Record	64.9	76.1
Probation or Parole Violations	53.7	72.7
CAB Convictions	37.8	57.1
Custody Level Items		
Current Age Level	(N=9,625)	(N=496)
Age 30 or Greater	70.0	82.7
Age 22-29	48.5	58.9
Age 21 or Lower	33.2	43.8
Drug Involvement Level		
Never	68.2	82.4
Past	59.4	71.0
Current	49.3	55.2
Serious Conduct History Level		
None	85.4	87.9
Low Moderate	72.7	65.4
Moderate	43.2	54.7
High	31.0	32.6
Greatest	20.0	38.9
Frequency of Conduct History Level		
None	85.4	87.6
1-3	50.8	56.4
4-7	25.4	30.6
8 or More	9.0	7.7
Custody Score Level		
Decrease	84.9	90.7
No Change	57.3	68.6
Increase	20.5	36.9
Scored Security Level	(N=12,423)	(N=741)
Minimum	77.5	81.6
Low Medium	55.6	64.9
High Medium	57.4	75.2
Maximum	53.4	67.2

disciplinary records, and 66.7 percent (42.4 percent for males) of those with CAB convictions are so. The variation in misconduct among female inmates is lesser in degree mainly due to the fact that they commit fewer infractions in general. This observation will hold true in regard to other factors indicated on Table 5.

Five custody items which are used for reclassification are associated with institutional misconduct. All of them, except for drug involvement, are much stronger predictors of misconduct than the security item mentioned above. Young inmates 21 years of age or younger are more prone to commit infractions than inmates 30 or older (37.3 percent male and 46.9 percent female compared to 73.1 percent male and 86.6 percent female with no violation records). Custody score level, a factor to determine whether an inmate should be moved up or down on the security scale according to his or her total custody score, is strongly correlated with misconduct. Inmates who were recommended a decrease in security level are mostly infraction free (86.8 percent male and 92.4 female), a much smaller group of those given a higher security level are so (24.3 percent male and 40.0 percent female).

There should be no surprise that the two factors which measure misconduct history are strongly correlated with frequency of infractions. To a degree, both the independent and the dependent variables measure the same thing. Despite that, the link between prior misconduct and future risk should not be understated in classification. An inmate's disruptive behavior does not normally improve over a short period of time and the threat he/she imposes

on the system should not be taken lightly. In fact, it may well serve the purpose of classification to include in the initial classification scoresheet previous misconduct committed by new admissions while serving prior sentences.

The correlation between scored security level and misconduct is not linear (i.e., not directly proportional), but the relatively higher misconduct-free percentages (80.2 percent male and 86.5 percent female) in the minimum category and the somewhat lower percentages in other categories suggest that inmates placed at minimum security facilities are less prone to disciplinary problems.

Overall, women inmates behave much better than male inmates across all scored security levels. Assuming the disciplinary rates of male inmates reflect the tolerance threshold of IDOC toward misconduct in its prison system, then it is obvious that most female inmates are overclassified and placed in a security level higher than necessary. This leads to the next section which discusses what measures can be taken during the classification process to bring women inmates more in line with male inmates.

ADJUSTING SCORED SECURITY LEVEL (SECTION II)

Section II of the IDOC classification instrument is the only section that deals with security assignments based on procedures and can be used during both initial intake and reclassification, so it should be the most logical place for adjustments to be made. However, as mentioned in the previous section (see Table 4),

security items (i.e., items on Section II) do not correlate with disciplinary rates with the exception of Parole/Probation Violation, thus, it is difficult to make statistically-sound adjustments assuming IDOC's main concern in classification is disciplinary rates.

There is a lack of variation or pattern in misconduct rates among security scores to warrant a change in the security scale, and this is true for both initial and reclassification cases. Looking at initial cases only, the female no-misconduct rates start at 85.2 percent at minimum, slide to 81.8 percent at low medium but shoot back up to 94.4 at high medium (Table 6). The lack of variation is even more visible when all cases are considered where the rates hover around the upper seventies (Table 7).

Since the no-misconduct rates of female inmates at intake are so much lower than the males' (average of 84.9 percent compared to 73.9 percent) and there is no variation by security level scores, one suggestion is to place all newly-admitted women inmates in either minimum or low-medium security for a 12-month period of time, excluding those to whom Departmental restrictions apply, and allow the reclassification process to weed out those who have shown habitual or major behavioral problems such as sexual offenses. In other words, there would be only two possible security levels for women at intake.

This suggestion actually sounds more outrageous than it really is for three reasons. First, the classification instrument in its present form already classifies 208 of the 245 female inmates at

TABLE 6

MISCONDUCT RATES BY TOTAL SECURITY SCORES (SECTION II) INITIAL CASES ONLY

	MALE		FEMALE	
	CELL TOTAL	% NO MISCONDUCT	CELL TOTAL	% NO MISCONDUCT
2	13	100.0	5	100.0
3	111	82.0	40	90.0
4	66	83.3	12	83.3
5	184	81.5	26	84.6
6	102	72.6	7	57.1
7	203	79.3	22	86.4
8	177	78.0	16	75.0
9	180	73.9	14	92.9
(minimum)	(1,036)	(78.7)	(142)	(85.2)
10	197	79.7	12	83.3
11	160	75.6	14	71.4
12	137	66.4	4	100.0
13	115	67.0	10	70.0
14	130	68.5	7	85.7
15	72	56.9	6	83.3
16	112	61.6	7	85.7
17	90	70.0	6	100.0
(low medium)	(1,013)	(69.9)	(66)	(81.8)
18	121	65.3	5	100.0
19	109	73.4	5	100.0
20	93	66.7	4	75.0
21	80	75.0	3	100.0
22	79	65.8	1	100.0
(high medium)	(482)	(69.1)	(18)	(94.4)
23	74	75.7	13	84.6
24	83	90.4	4	100.0
25	30	76.7	0	—
26	38	71.0	0	—
27	17	70.6	1	100.0
28	12	50.0	1	0.0
29	4	100.0	0	—
30	6	100.0	0	—
31	2	100.0	0	—
32	1	100.0	0	—
(maximum)	(267)	(79.4)	(19)	(84.2)
Total:	2,798	73.9	245	84.9

TABLE 7

MISCONDUCT RATES BY TOTAL SECURITY SCORES (SECTION II) ALL CASES

	MALE		FEMALE	
	CELL TOTAL	% NO MISCONDUCT	CELL TOTAL	% NO MISCONDUCT
2	27	81.5	10	100.0
3	214	74.8	71	84.5
4	135	77.0	22	77.3
5	401	69.8	61	77.0
6	296	67.2	27	74.1
7	587	67.5	65	75.4
8	561	62.6	31	74.2
9	685	61.3	47	80.8
(minimum)	(2,906)	(66.5)	(334)	(79.0)
10	672	61.2	31	77.4
11	700	61.4	52	65.4
12	677	57.5	14	64.3
13	555	59.1	24	79.2
14	564	59.6	16	81.2
15	436	57.1	23	82.6
16	469	55.9	21	85.7
17	432	58.6	23	82.6
(low medium)	(4,505)	(59.0)	(204)	(76.0)
18	495	63.2	22	81.8
19	605	67.4	21	80.9
20	500	62.2	14	85.7
21	588	66.2	17	70.6
22	567	66.8	4	75.0
(high medium)	(2,755)	(65.3)	(78)	(79.5)
23	607	81.2	73	87.7
24	596	81.2	27	85.2
25	285	74.7	3	100.0
26	315	72.1	11	100.0
27	179	72.6	4	75.0
28	119	65.5	3	33.3
29	46	56.5	1	100.0
30	42	73.8	1	100.0
31	31	38.7	1	0.0
32	23	73.9	1	0.0
33	6	33.3	0	—
34	5	40.0	0	—
35	3	66.7	0	—
(maximum)	(2,257)	(76.1)	(125)	(85.6)
Total:	12,423	65.3	741	79.4

initial intake to either minimum and low medium, which is 85 percent of the intake population.

Second, while prison staff may worry that certain newly-admitted inmates with propensity toward major violations will become under-classified, the reality is that the initial instrument is not designed to predict what type of misconduct an inmate is likely to commit. Therefore violations which have proven to be a great concern in the lower security level facilities such as sex violations are to be dealt with in the reclassification procedure, after a period of observation.

Third, sex violations and habitual conduct violations which are relatively prevalent among female inmates occur mostly among reclassification cases (Table 8). Of the 63 incidents which took place within the 11-month period, only ten were instigated by initial cases, and nine out of the ten by minimum and low medium cases.

NCCD consulted IDOC on this option of eliminating high medium and maximum security levels at intake and the response was that due to Departmental criteria and other administrative restrictions this suggestion would be impractical. Currently, female intake cases who are assigned to high medium and maximum are mostly driven by Departmental criteria, therefore, changing the instrument as suggested by NCCD is not likely to bring any marked difference in the outcome.

TABLE 8

SEXUAL AND HABITUAL VIOLATIONS AMONG FEMALE INMATES BY SCORED SECURITY LEVELS

SECURITY LEVELS	ALL CASES N=741		INITIAL CLASS N=24		RECLASS N=496	
	SEXUAL	HABITUAL	SEXUAL	HABITUAL	SEXUAL	HABITUAL
Minimum	7	4	1	2	6	2
Low Medium	17	24	3	3	14	21
High Medium	1	6	0	0	1	6
Maximum	2	2	1	0	1	2
Total:	27	36	5	5	22	31

ADJUSTING SCORED SECURITY LEVEL (SECTION III)

Section III of the classification instrument requires a twelve month period of incarceration to be served before it is used. The score derived from this section is not written in the final classification designation and is merely used as a recommendation for overrides. Despite these limitations this section does affect the majority of inmates being classified, and the impact incurred by changing this section should not be overlooked. Above all, the scored security level recommended by this section correlates with disciplinary rates and this association supports an adjustment of the scale based on quantitative evidence.

Referring back to Scored Security Level, the last item on Table 5, the misconduct rate at the minimum category is distinctively lower than those in the higher categories and we assume that moving a certain number of low-risk female inmates one level down the security scale will not inflate disciplinary incidents to an unacceptable degree. With this assumption in mind, we adjusted the rule which determines the final security level and made it more difficult to increase an inmate's security level (see Table 9).[2] We eventually placed 56.0 percent of all women inmates in the minimum category, 22.9 percent in low medium, 15.2 percent in high medium, and 5.8 percent in maximum (Table 10). At this level of placement, the infraction rates of women are still

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[2] This manipulation can only be applied to inmates with reclassification data because the initial classification data do not contain any custody items, which are used to derive the final security level. The first part of Table 11 shows the effect of score adjustment on the reclassification cases only.

TABLE 9

ADJUSTMENTS ON CLASSIFICATION SCORESHEET IN DETERMINING FINAL SECURITY LEVEL

SECURITY LEVEL	REDUCTION IN SECURITY LEVEL		NO CHANGE IN SECURITY LEVEL		INCREASE IN SECURITY LEVEL	
	ORIGINAL	AMENDED	ORIGINAL	AMENDED	ORIGINAL	AMENDED
Minimum	N/A		0-12	0-18	13+	19+
Low Medium	0-6	0-10	7-15	11-21	16+	22+
High Medium	0-6	0-10	7-15	11-21	16+	22+
Maximum	0-6	0-10	7-31	11+	N/A	

TABLE 10

DISTRIBUTIONS IN SECURITY LEVELS

SECURITY LEVEL	PRE-ADJUSTMENT		POST-ADJUSTMENT	
	N	%	N	%
Minimum	369	49.8	415	56.0
Low Medium	185	25.0	170	22.9
High Medium	129	17.4	113	15.2
Maximum	58	7.8	43	5.8
Total	741	100.0	741	100.0

comparable to those of men; 82.4 percent of no infraction in the minimum category among women inmates compared to 80.2 percent among males (see Table 11).

The initial recommendation for Section II and the adjustments suggested for Section III were experimented on the classification data and the procedure placed 56 percent of female inmates in the minimum security level, 27.9 percent in low medium, 12.8 percent in high medium, and 3.2 percent in maximum (Table 12). The recommended system will place approximately ten percent more female inmates in either the minimum or the low medium levels compared to the current system.

OVERRIDES

The scored security level derived from the classification instrument will become the actual designation unless overridden by classification personnel. Overrides discussed here refer to the discrepancy between the staff-recommended security level and the scored security level found in Section II in the case of initial classification. As for reclassification cases, the scored security level has accounted for increase or reduction in security as suggested by Item 33. Recommendation for overrides is usually justified by policy mandates, potential management problems, and other compelling reasons. Though downward overrides are possible, they are generally rare.

IDOC has an unusually high percentage of overrides as shown in Table 13. Generally, overrides exceeding 20 percent signify flaws

TABLE 11

MISCONDUCT RATES FOR ADJUSTED FINAL SECURITY DESIGNATIONS BY SEX

	PERCENT WITH NO DISCIPLINARY MISCONDUCT	
	MALES	FEMALES
Adjusted Final Security Level (For Cases With Reclassification Data)	(N=9,625)	(N=496)
Minimum	80.8	81.0
Low Medium	56.9	60.6
High Medium	58.3	84.2
Maximum	52.9	66.7
Adjusted Final Security Level (For All Cases)	(N=12,423)	(N=741)
Minimum	80.2	82.4
Low Medium	60.1	68.8
High Medium	59.9	85.8
Maximum	57.3	74.4

TABLE 12

FEMALE DISTRIBUTION IN SECURITY LEVELS PRE AND POST RECOMMENDED ADJUSTMENTS

	CURRENT CLASSIFICATION		AFTER ADJUSTMENTS	
SECURITY LEVEL	N	%	N	%
Minimum	369	49.8	415	56.0
Low Medium	185	25.0	207	27.9
High Medium	129	17.4	95	12.8
Maximum	58	7.8	24	3.2
Total:	741	100.0	741	100.0

TABLE 13

FREQUENCIES OF OVERRIDES

	MALE	FEMALE	TOTAL
	%	%	%
	All Cases		
	(N=12,423)	(N=741)	(N=13,164)
Override Up	37.1	50.6	37.8
Override Down	3.2	1.2	3.1
Total Overrides	40.3	51.8	40.9
	Cases With Initial Classification Only		
	(N=2,798)	(N=245)	(N=3,043)
Override Up	23.0	41.2	24.5
Override Down	0.0	0.0	0.0
Total Overrides	23.0	41.2	24.5
	Cases With Reclassification		
	(N=9,625)	(N=496)	(N=10,121)
Override Up	41.1	55.2	41.8
Override Down	4.2	1.8	4.1
Total Overrides	45.3	57.0	45.9

in the instrument itself or in its administration. When all cases are considered, IDOC has a total of 40 percent of overrides, 37.8 of which are upward. Female inmates have an even higher rate of 51.8 percent, 50.6 percent of which are upward overrides. Overrides tend to be more prevalent for reclassification than initial cases; 57 percent in reclassification compared to 41.2 percent in initial classification for women and 45.3 percent compared to 23.0 for men. Also, most overrides are upward movements from minimum to low medium and high medium to maximum (see Table 14).

IDOC captures the basis for overrides in four main categories, namely, score, criteria, time restriction, and management. If a recommendation is based on the final security score and the outcome from Item 33, then SCORE will be checked. For all practical purposes SCORE is irrelevant in explaining overrides since adhering to classification scores for inmate placement is not considered an override in the first place. CRITERIA refer to Departmental policies and restrictions (other than time restriction) which prevent a scored level placement. When the remaining time of incarceration of an inmate exceeds the limits of his scored security level, the necessity to reassign him to a different level is termed TIME RESTRICTION. The last category MANAGEMENT includes a number of considerations such as mental and psychiatric needs, maladaptive behavior in jail, escape threats, detainer and sex offender restrictions.

TABLE 14

COMPARISON OF
RECOMMENDED SECURITY LEVELS AND SCORED SECURITY LEVELS
(ALL CASES)

	RECOMMENDED LEVEL		SCORED LEVEL	
FEMALE	N	%	N	%
Minimum	99	13.4	369	49.8
Low Medium	419	56.5	185	25.0
High Medium	95	12.8	129	17.4
Maximum	128	17.3	58	7.8
Total:	741	100.0	741	100.0

	RECOMMENDED LEVEL		SCORED LEVEL	
MALE	N	%	N	%
Minimum	1,272	10.2	3,450	27.8
Low Medium	5,209	41.9	4,068	32.7
High Medium	2,772	22.3	3,299	26.6
Maximum	3,170	25.5	1,606	12.9
Total:	12,423	100.0	12,423	100.0

The following analysis will concentrate on upward overrides because they compose the bulk of all overrides and also because of the litigation risk that unjustified upward overrides may incur. Also note that when one or more reasons were given to support a recommendation, CRITERIA will take precedence because of its mandatory nature, then MANAGEMENT because of its degree of prevalence and then TIME RESTRICTION. SCORE is rejected unless it is the only reason stated.

What accounts for IDOC's extensive use of overrides? Unfortunately, the information provided by the classification data does not yield a clear answer. The major problem is the frequent use of the SCORE category as justification for upward overrides. As mentioned before, SCORE is basically a non-reason and should be ignored. Table 15 displays the distributions in the reason categories by scored security levels and gender. Initial classification cases have the "cleanest" distribution as the SCORE cells are very small. For male inmates, over 90 percent of upward overrides are explained by reasons other than scores, and for female inmates it is an impressive 100 percent. Problems seem to arise during the reclassification process, as shown by the high percentages in the SCORE cells. The male percentages in this category are 49.3, 38.7 and 62.5 for minimum, low medium, and high medium respectively, whereas female inmates have an average of 44.5 percent. These overrides will remain an enigma until their recommendations are accounted for.

TABLE 15

BASIS FOR UPWARD OVERRIDES

SCORED SECURITY	N		REASONS							
			SCORE		CRITERIA		TIME RESTRICTION		MANAGEMENT	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
			%		%		%		%	
All Cases										
Minimum	2,209	270	37.1	10.0	46.8	79.6	0.9	1.8	15.2	8.5
Low Medium	1,114	33	37.8	69.7	9.1	18.2	17.3	3.0	35.8	9.1
High Medium	1,282	72	60.0	100.0	3.4	0.0	11.2	0.0	25.5	0.0
Cases With Initial Classification Only										
Minimum	562	100	1.2	0.0	87.4	95.0	0.2	0.0	11.4	3.0
Low Medium	31	1	6.4	0.0	51.6	100.0	16.1	0.0	25.8	0.0
High Medium	52	0	0.0	—	32.7	—	63.5	—	3.8	—
Cases With Reclassification										
Minimum	1,647	170	49.3	15.9	33.0	69.4	1.2	2.9	16.5	11.8
Low Medium	1,083	32	38.7	71.9	7.8	15.6	17.4	3.1	36.1	9.4
High Medium	1,230	72	62.5	100.0	2.1	0.0	8.9	0.0	26.4	0.0

e: Row percentages added up to 100 percent.

SCORE aside, CRITERIA is the most prevalent reason for recommendation, then followed by management concern. The majority of upward overrides for the initial cases are supported by some type of Departmental criteria (an average of 81.3 percent for males and 96.0 percent for females), so are reclassification cases but to a lesser degree (an average of 16.5 percent for males and 44.9 for percent females). Female inmates who score minimum are most likely to be moved up the security level because of criteria restrictions, 95 percent for initial cases and 69.4 percent for reclassification.

While TIME RESTRICTION is relatively infrequent, it is a compelling reason to move high-medium male inmates up to maximum security facilities (63.5 percent). Management problems concern mostly the reclassification cases; around ten percent for women inmates in minimum and low medium and an average of 24.9 percent for men. Most potential management problems are not detected until inmates have resided in an institution for a period of time which explains the above pattern.

CONCLUSIONS

This report affirms the general perception that women inmates commit fewer infractions compared to their male counterparts. Nevertheless, they present several unique levels of needs that have to be addressed by the Department.

The foremost issue is the difficulty women inmates experience in maintaining relationships with their children. The majority of female inmates have young children over whom they hold legal

custody, and such children are often unable to see their mothers because of distance and transportation problems. Inmates frequently complain that they do not get to see their children. The Department must revise its visitation rules to encourage more frequent and longer meetings between inmates and their children, and in planning for future prisons for female inmates, give more consideration to location and accessibility.

Another concern specific to female inmates is their higher demand on medical and psychiatric services, which includes gynecological and obstetric care and family-planning counselling. Lastly, the majority of female inmates are uneducated and unskilled, the Department must determine its role in preparing these women for independent living through education and job training.

The classification and disciplinary data provided by IDOC show that misconduct among both male and female inmates is best predicted by age, institutional disciplinary history, drug involvement, probation or parole violations, and final security level. The custody items on Section III are much better predictors than the security items on Section II.

The classification instrument presently in use tends to over-classify women inmates. Most can be placed at a lower security level without jeopardizing safety in the facilities. Based on statistical results, NCCD would recommend placing all female inmates in minimum and low medium facilities at initial intake, however, recognizing the valid concern IDOC has on this issue, NCCD

agrees that Section II of the classification instrument should be left as is.

The designation scales of Item 33 in Section III of the classification instrument was adjusted for females, and note that this measure does not increase their disciplinary rate in the minimum security category to an unacceptable degree. The IDOC should revise its classification process as NCCD has done here to bring women inmates more in line with the male inmates.

A major concern with the IDOC classification system is the excessive use of overrides which doubles the generally accepted rate of 20 percent. And because the justification for overrides is poorly documented, NCCD cannot determine whether overrides have been improperly used. The amount of information available suggests that Departmental criteria are responsible for most upward overrides during initial classification for both males and females, and management restrictions account for a quarter of upward overrides at reclassification for male inmates. There are more overrides applied to female inmates than male and the primary reason is also Departmental criteria.

The issue of overrides has to be resolved before the current instrument can be meaningfully revised. The purpose of an objective classification system is to minimize subjective biases and arbitrary decisions-making during the classification process, and IDOC's frequent use of overrides, regardless of reasons, will defeat this very purpose.

RECOMMENDATIONS

1. To prevent over-classification of women inmates, IDOC should adjust Section III of the female classification instrument: the scale for recommending either a reduction, no change, or an increase in security level should be expanded as indicated in Table 9.

2. The OIS Classification Data Base need to be modified so that the precise reasons for overrides are documented. Although preliminary steps have been taken by IDOC to eradicate this problem, this modification needs to be implemented as soon as possible.

3. Once the basis for the Department's excessive use of overrides is assessed, steps should be taken by the IDOC to determine whether overrides are being used in an appropriate manner.

4. A needs assessment form is required to document properly the unique needs of both male and female inmates (Appendix III).

5. The siting of any new female prisons should be done to increase visits between inmates and their children.

SECTION I
Demographic Data

State Form 7263 (Revised)
DEPARTMENT OF CORRECTION

(1) FACILITY	(2) I.D. #
(3) NAME. (Last. First. Initial)	(4) D.O.B.

CURRENT CLASSIFICATION DESIGNATION (5) (6) (7) (8) (9)

(10) SENTENCE RESTRICTION
1= Misdemeanor 2= Partially Suspended 3= Single Felony 4= Consurrent 5= Consecutive — (10)

(11) ADDITIONAL CONSIDERATION
0= None 1= Dental/Medical 2= Psychiatric 3= Sex Offender 4= Jail Disciplinary 5= Escape 6= Detainer — (11)

(12) MONITORING CASE ☐ Yes ☐ No

(13) SEPARATEE(S)

(14) JUDICIAL RECOMMENDATION ☐ Yes ☐ No

(15) SECURITY | (16) FACILITY | (17) PROGRAM

SECTION II
Security Level

(18) SEVERITY OF CURRENT COMMITMENT PERIOD — (18)
2= Low 4= Low Moderate 6= Moderate 8= High

(19) VIOLENCE IN CURRENT COMMITMENT PERIOD — (19)
0= None 1= Deadly Weapon/or Bodily Injury 3=Serious Bodily Injury 5=Death

(20) PRIOR CONVICTION(S) — (20)
0= NONE 1= Low 2= Low Moderate 3= Moderate 4= High

(21) VIOLENCE IN PRIOR CONVICTION(S) — (21)
0= None 1= Deadly Weapon/or Bodily Injury 3=Serious Bodily Injury 5=Death

(22) SUBTOTAL: Items (18)+(19)+(20)+(21) — (22)

(23) REMAINING TIME OF INCARCERATION — (23)
0= 1-730. 2=731-1460. 4=1461-2190. 6=2191-2555. 8=2556-3285. 10=3286 or more

(24) DOC CONFINEMENT RECORD / PROBATION OR PAROLE VIOLATIONS — (24)
0= No Record 2= Probation or Parole Violations 5=CAB Convictions

(25) TOTAL OF SECTION II — (25)

(26) SCORED SECURITY LEVEL — (26)
0-9= 1; 10-17= 2; 18-22= 3; 23-37= 4

SECTION III
Custody Level

(27) CURRENT AGE — (27)
0= 30 YEARS AND ABOVE 3= 22-29 YEARS 5= 21 YEARS OR UNDER

(28) INVOLVEMENT WITH DRUGS AND / OR ALCOHOL — (28)
0= Never 3= Past 5= Current

(29) HISTORY OF ESCAPE — (29)
0= None 1= Past Minor 3= Recent Minor 5= Past Serious 7= Recent Serious

(30) TYPE OF MOST SERIOUS CONDUCT REPORT — (30)
0= None 2= Low Moderate 4= Moderate 6= High 8= Greatest

(31) FREQUENCY OF CONDUCT REPORT — (31)
0= None 2= 1-3 4= 4-7 6= 8 or more

(32) TOTAL OF SECTION III — (32)

(33) SCORED CUSTODY LEVEL — (33)

SCORED SECURITY LEVEL	REDUCTION IN SECURITY LEVEL	NO CHANGE IN SECURITY LEVEL	INCREASE IN SECURITY LEVEL
1	N / A	0-12	13 AND ABOVE
2	0-6	7-15	16 AND ABOVE
3	0-6	7-15	16 AND ABOVE
4	0-6	7-31	N / A

SECTION IV
Recommendations

(34) PROJECTED LOWEST SECURITY LEVEL (Taken from Item (22)) — (34)

RECOMMENDED WORK-RELEASE / RCA CATEGORY | (36) P.A.D. | (37) E.P.R.D. | (38) CREDIT CLASS

BASIS FOR RECOMMENDED CLASSIFICATION DESIGNATION
☐ Score ☑ Criteria ☐ Time Restriction ☐ Management

RECOMMENDED CLASSIFICATION DESIGNATION (40) (41) (42) (43) (44)

COMMENTS / MANAGEMENT BASIS

(46) PREPARED BY

SECTION V
Class. Action

SIS FOR NEW CLASSIFICATION DESIGNATION
☐ Score ☐ Criteria ☐ Time Restriction ☐ Management

NEW CLASSIFICATION DESIGNATION (48) (49) (50) (51) (52)

WORK-RELEASE CATEGORY | (54) P.A.D. | (55) LAST REVIEW DATE | (56) NEXT REVIEW DATE

COMMENTS / MANAGEMENT BASIS

APPROVED BY: | (59) OFFENDER: | (60) DATE REVIEWED

APPENDIX II

INDIANA FEMALE CLASSIFICATION -- SUPPLEMENTAL CODESHEET

1. Inmate's Name_____ 2. Number_____ 3. Race_____

4. Sex_____ 5. Facility_____ 6. DOB_____ 7. Marital Status_____

	AGE	SEX M/F	# OF VISITS PER MONTH	RESIDING WITH (RELATIONSHIP TO MOTHER)	CITY/STATE	CUSTODY RIGHTS TERM?	CHILD'S FATHER	FATHER'S LOCATION CITY/STATE
1.								
2.								
3.								
4.								
5.								

Y/N

8. Was Inmate Pregnant Within 6 Months Of Admission To Prison? _____
9. Did Inmate Experience Abortion Within 6 Months Of Admission To Prison? _____
10. History Of Sex Abuse As A Juvenile? _____
11. If Yes To #10, Was Abuse Incest? _____
12. If Yes To #10, Was Abuse Rape? _____
13. History Of Sex Abuse As An Adult? _____
14. Since Incarcerated, Who Have Been Your Primary Visitors? (List Name and Relationship)
15. History Of Physical Abuse?

a. _____ d. _____

b. _____ e. _____

c. _____ f. _____

16. Is There Anyone You Would Like To Have Visit You But Have Been Unable To Do So?

	Name	Relationship	Reason For No Visit
a.			
b.			
c.			

INDIANA DEPARTMENT OF CORRECTION

E334 Indiana Government Center South
302 W. Washington St.
Indianapolis, IN 46204
(317) 232-5715

TO: Thuc Van Phan, Senior System Analyst
OIS Project Manager

FROM: Randall Short, Analyst
Classification Division

DATE: May 11, 1993

RE: Offender Information System (OIS) Modifications

As a follow up to our conversation on April 28, 1993, we are requesting the following modifications to the classification screens in the Offender Information System.

1. Allow the use of a numeric code 1-8 instead of "X" in the "basis for new designation" - criteria field.

2. Modification of the "basis for new designation to allow only one option score, criteria, time restriction or management to be entered.

We are also requesting the development of two (2) additional classification reports.

1. An on-demand report which would provide raw and percentile data of the number of offenders in each criteria category. Raw and percentage totals of offenders at each facility and raw and percentage totals for each security level for the entire department.

2. A cycle report (daily) which would select and list offenders of a specified criteria category at a specific facility.

We are requesting a approximate completion date on these modifications. If you have additional questions please contact this office.

cc: Mr. Norman G. Owens, Director
Classification Division
Mr. Robert Hughes, Director
Information Management Services
Mr. James Wynn, Supervisor of Offender Placement
Classification Division
File

INDIANA DEPARTMENT OF CORRECTION

E334 Indiana Government Center South
302 W. Washington St.
Indianapolis, IN 46204
(317) 232-5715

ATTACHMENTS:

The following is a listing of criteria categories.

1. Active warrants, detainers or pending charges extending beyond the offenders Earliest Possible Release Date. Includes Parole Violators who have not appeared before the Parole Board.

2. Escape - significant escape history in past four (4) years, or current commitment for escape. Includes documented Absconding from probation or parole.

3. Violent Offenses - as defined in current criteria.

4. Sex Offenses - as defined in current criteria.

5. Disciplinary Transfer - history of disciplinary transfers during the previous two (2) years.

6. Conduct Adjustment Board Actions - Class A conduct reports guilty findings in the past twelve (12) months, and Class B conduct report guilty finding in the past six (6) months.

7. Medical Status Codes.

8. Multiple Life Sentences.

9. Class A Felonies

APPENDIX IV

[illegible] DEPARTMENT OF CORRECTION
NEEDS ASSESSMENT FORM

NAME _____ DOC NUMBER _____

DATE _____ COMPLETED BY _____

FACILITY _____ DOB _____

____ 1. SUBSTANCE ABUSE:
- 0 = No alcohol consumption or limited use in social situations. No illicit drug use.
- 1 = Use of alcohol predominant in most social and private situations. Experimentation and/or recreational use of illegal drugs or abuse of prescription drugs.
- 2 = Heavy use of alcohol/illegal substances and/or criminal behavior involving substance abuse.

____ 2. EDUCATION:
- 0 = Has attained GED or High School diploma.
- 1 = Literacy skills at sixth grade level or higher, but has not attained High School Diploma or GED.
- 2 = Illiterate or literacy skills below the sixth grade level.

____ 3. VOCATION:
- 0 = Maintained employment with marketable skills.
- 1 = May have some work skills.
- 2 = Unstable or no employment with no marketable skills.

____ 4. EMOTIONAL STABILITY:
- 0 = Maintains emotional stability with appropriate life skills.
- 1 = Experiencing minor emotional difficulties due to inadequate life skills.
- 2 = Poor emotional stability requiring psychological/psychiatric evaluation and treatment.

____ 5. VIOLENT BEHAVIOR:
- 0 = No history of physical violence
- 1 = Involvement in act(s) which resulted in bodily injury to others.
- 2 = Involvement in act(s) which have caused serious bodily injury/death to others or a lengthy history of acting out physically.

____ 6. PHYSICAL ABUSE:
- 0 = No history of being physically abused.
- 1 = The victim of an isolated incident of physical abuse which may or may not present an emotional conflict.
- 2 = The victim of physical abuse occurring on multiple occasions.

____ 7. SEXUAL BEHAVIOR:
- 0 = No history of inappropriate/illegal sexual behavior.
- 1 = Non-predatory sexual behavior such as prostitution or promiscuous activity that may be dangerous to health.
- 2 = Involvement in predatory sexual behavior by use of force, weapons or threats. Also includes all sexual offenses with minors.

____ 8. PARENTING:
- 0 = No indication of parenting needs.
- 1 = Any reported evidence of parenting skill needs.
- 2 = Any documented record of inadequate parenting skills including but not limited to criminal convictions for neglect or abuse.

____ 9. SEXUAL ABUSE:
- 0 = No history of being sexually abused.
- 2 = The victim of sexual abuse as an adult or child.