

Offenders with Mental Illness in Colorado

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TABLE OF CONTENTS

<i>Introduction</i>	<i>1</i>
Historical Antecedents	1
Comorbidity of Substance Abuse	3
Challenges to the Criminal Justice System	3
Adjustment to Prison Life	4
Challenges to Reentry	5
Attempted Solutions	6
OMIs in Colorado	7
<i>Method</i>	<i>8</i>
Participants	8
Materials	8
Procedure	9
<i>Prevalence Analyses</i>	<i>10</i>
<i>Profile Analyses</i>	<i>12</i>
<i>Prison Adjustment</i>	<i>17</i>
<i>Release Analyses</i>	<i>19</i>
<i>Recidivism Analyses</i>	<i>20</i>
<i>Discussion</i>	<i>21</i>
<i>References</i>	<i>24</i>

EXECUTIVE SUMMARY

This report examines the incidence of, and issues related to, offenders with mental illness (OMIs) in the Colorado Department of Corrections (CDOC). Nationwide, 24% of U.S. inmates in state facilities have been found to be mentally ill (James & Glaze, 2006), a number that is fast on the rise.

OMIs present unique challenges to the criminal justice system, specifically regarding screening and identification of mentally ill persons and surrounding limited mental health resources. While in prison, OMIs' psychological health, behavior, and coping abilities are greatly affected by their medication compliance and the prison environment, which in turn affect security and control. Pursuant to their release, OMIs face monumental re-entry challenges, such as scarce transitional placements or aftercare plans, lack of employment, homelessness, co-occurring substance abuse problems, and difficulties obtaining psychotropic medications.

The present study included CDOC inmates and parolees to examine OMI prevalence rates, to determine the characteristics of OMIs, and to describe their adjustment, release, and recidivism information. Offenders were grouped into 3 categories according to their mental health status: (1) *qualifying* who met CDOC criteria for a serious and pervasive mental illness, (2) *non-qualifying* who had mental health issues but did not meet the stringent criteria for a qualifying disorder, and (3) *none* who had no mental illness diagnosis or needs.

Prevalence Rates

- **Colorado's prevalence rate for OMIs matches national averages.** 16% of the inmate population met the criteria for a qualifying disorder and 9% had a non-qualifying diagnosis or mental health issue.
- **Limited resources may be impacting mental health staff's ability to evaluate OMIs.** The rate of non-qualifying OMIs among prison intakes in-

creased 3% due to the use of a temporary code from FY01 to FY05. During this same time, qualifying OMIs decreased 2%.

- **OMIs within the prison population are growing at a faster rate than is found for prison intakes.** OMIs with qualifying and non-qualifying disorders increased from 20% in FY01 to 25% in FY05.

Profile Analysis

- **OMIs are predominantly female.** Female offenders are twice as likely as males to be classified as a non-qualifying OMI and three times as likely to be classified as a qualifying OMI.
- **State facilities are the most common placement for OMIs.** 26% of offenders in state prisons were OMIs as compared to 17% in private facilities, 15% in community corrections, and 20% on parole.
- **Qualifying OMIs are the most likely to be convicted of a violent crime.** 49% of OMIs with a qualifying disorder were convicted of a violent crime as compared to 42% of OMIs with a non-qualifying disorder and 43% with no diagnosis.
- **Mental illness corresponds to greater needs across a host of areas, which means coordination across services is essential.** Although vocational and substance abuse are the highest needs areas for all offenders, OMIs had much greater medical and self-destruction concerns than non-OMIs, two domains that are likely to affect monetary and staffing resources.

Prison Adjustment

- **The majority of OMIs are managed within the prison environment without a placement in CDOC's mental health prison or without a crisis intervention.** 4% of the entire prison population was involved in a crisis event and 1% was placed in Colorado's mental health prison during FY05.

- **OMIs commit a disproportionately high rate of disciplinary infractions although their violations were no more serious than the ones committed by non-mentally ill inmates.** Qualifying and non-qualifying OMIs accounted for 25% of the population but committed 34% of the disciplinary violations.

Release

- **OMIs have a greater likelihood to release into the community from high security facilities than from minimum security.** Offenders were more than twice as likely to release from administrative segregation or close custody if they were mentally ill than those who were not.
- **Community placements are less often available to OMIs.** 28% of OMIs were placed in community corrections during their incarceration as compared to 36% of non-mentally ill inmates.
- **OMIs were more likely to discharge their sentence while in prison than receive discretionary parole.** 24% OMIs with a qualifying disorder discharged their sentence compared to 19% with a non-qualifying disorder and 18% with no disorder. Discretionary parole was granted to 16% of qualifying OMIs and 14% of non-qualifying OMIs as opposed to 21% of non-mentally ill offenders.

Recidivism

- **Mentally ill inmates had higher-than-average recidivism rates, but those with a non-qualifying disorder had the highest rates.** At 3 years post-release, return rates to CDOC were 49% for qualifying OMIs, 58% for non-qualifying OMIs returned, and 47% for non-mentally ill inmates.

INTRODUCTION

The criminalization of persons suffering from mental illness is a critical component contributing to the escalating prison population in the United States. Largely a result of the deinstitutionalization period of the 1960s, many persons with serious mental illness, who at one time would have been treated in mental hospitals, are being displaced into correctional facilities. According to the Bureau of Justice Statistics (James & Glaze, 2006), prevalence estimates suggest approximately 24% of U.S. inmates incarcerated in state facilities are mentally ill—a number that is continually growing. Furthermore, it is possible this estimate might minimize reality, as research suggests many offenders with mental illness (OMIs) go undetected during entrance screening (Birmingham, Gray, Mason, & Grubin, 2000). Data illustrating that approximately 2.6% of persons in the populace are mentally ill (Beck & Marushak, 2001) makes it evident that this subclass of individuals is disproportionately represented in the criminal justice system. Of particular concern are research findings that indicate persons with mental illness are no more likely to commit serious crimes than non-mentally ill individuals (Teplin, 1984), calling into question why they are so highly represented amongst incarcerated populations.

While the burgeoning mentally ill offender population demonstrates a need for increased mental healthcare, the correctional system is devoid of the large amount of monetary resources necessary to meet this demand (Human Rights Watch, 2003). Shortages in correctional system budgets necessitate that finances are concentrated on security and control, leaving limited funding available for mental health treatment. There is much political controversy surrounding the question of whether more money should be allocated for rehabilitative measures, and if this would reduce recidivism and eventually save the correctional system money.

It has been suggested that limited treatment resources, both in correctional facilities and in the community, have contributed to longer sentences and

increased reincarceration rates for OMIs. A statistical analysis by James and Glaze (2006) showed that OMIs serve prolonged sentences, averaging approximately 4 months longer than their nonmentally ill counterparts. Accounting for this are OMIs' limited abilities to cope with the prison environment as opposed to nonmentally ill offenders (Human Rights Watch, 2003). Hence they have more trouble conforming to prison rules and controlling their behavior and accordingly garner more conduct infractions and time in solitary confinement. Taken together with limited transitional aftercare placements and inadequate discharge planning (Osher, Steadman, & Barr, 2003), OMIs often serve the full duration of their sentence in prison and do not have intermediate assistance before assimilating into the community.

Inadequate transitory aftercare leaves OMIs with limited services to aid in their reentry into society. Many OMIs are released without a discharge plan or connections to social services and consequently have difficulty accessing treatment, finding housing, and maintaining employment (Petersilia, 2003). Thus many offenders become homeless and recidivate by committing survival-related crimes (e.g., petty theft). Additionally, expression of mental illness symptoms (e.g., loitering, public disturbances) frequently leads to rearrest, collectively leading OMIs to continually cycle through the criminal justice system (Lurigio & Lewis, 1987; as cited in Lurigio & Swartz, 2000). Repercussions from the lack of community mental healthcare centers can be traced back to deinstitutionalization and persist in the present.

Historical Antecedents

The transition of OMIs from mental hospitals to prisons was largely precipitated by the period of time subsequent to World War II known as deinstitutionalization, an era marked by changes in state mental healthcare systems. Changes were catalyzed by numerous media sources publicizing negative depictions of state mental hospitals (e.g., abuse, neglect, unsanitary living conditions) and were intended to make treatment of patients more humane. During this time

new psychotropic medications were developed. It was thought that the new medications, when accompanied with increased community mental healthcare placements, would facilitate a more humanitarian way of treating people with severe mental illness and eliminate the need for lengthy and costly inpatient hospital stays (Thomas, 1998).

Correspondingly, policy makers began initiating reforms and advocating mental health legislation that resulted in the dramatic decrease of mental health inpatients from 560,000 to 77,000 from 1955 to 1994. Consequently many state mental hospitals were closed (U.S. Department of Health and Human Services, 1994).

Reforms accompanied deinstitutionalization with the implementation of the Community Mental Health Centers Act of 1963. This act was an attempt by the National Institute of Mental Health to create a community-based outpatient system so patients could be closer to their families and live more normal lives. Other mental health law reforms made it more difficult to involuntarily commit individuals to mental health institutions without proper judicial procedures and legal representation (Torrey, 1997). Some of these laws, enforced by the American Civil Liberties Union, prevented the institutionalization of, and subsequently the treatment of, mentally ill individuals, until mental deterioration became extreme or a crisis ensued. (Torrey).

Mental health law reforms seemed to be a positive change as they limited the number of people being unjustly institutionalized; however these laws ended up being over-compensatory in nature. These reforms have taken institutionalization to the opposite end of the spectrum. Now many people who are not necessarily classified as dangerous, but in serious need of mental health services, are not placed in hospitals where they can receive help.

The mental health law reforms would have been less detrimental had the community treatment centers that were envisioned during the deinstitutionalization movement been established. Unfortunately, the upsurge of persons with mental illness back into the community coincided with financial strains imposed

on society from the Vietnam War and economic crisis of the 1970s. As a result community-based substitutes could not be funded and the amount of aftercare and support available for newly released patients was greatly limited. Currently, there continues to be little money available for community-based mental health services leaving persons with mental illness limited resources and support to aid in successful functioning in society.

Limited community care resources are problematic largely because individuals with mental illness who do not have access to treatment and social services often have poor medication compliance and experience survival difficulties that can elicit criminal activity. Studies (Lurigio & Lewis, 1987; Lewis et al., 1994; as cited in Lurigio & Swartz, 2000) have shown that 42% of crimes committed by the mentally ill are related to symptomatic expression and 30% are related to survival. This finding is not unexpected when considering that persons with mental illness report high rates of homelessness, unemployment, and substance use prior to incarceration (Ditton, 1999; James and Glaze, 2006).

Decreased numbers of mental health placement beds make hospitalization an impractical alternative for people with mental illness when they commit crimes (Teplin, 1983). Thus, police officers who deal with mentally ill persons who are disruptive or engage in criminal activity have limited courses of action. In addition, stringent legal criteria for involuntary commitment, complicated admission procedures, and long emergency waiting room periods often make incarceration seem like the most efficient alternative. Abram and Teplin (1991) observed police officers for a 14-month period and found they were most likely to arrest mentally ill persons in two types of circumstances: when a mentally ill person's behavior exceeded the public's limited tolerance for deviance (e.g., behavioral disruptions that disturbed the peace) or when the officer at the scene felt there was a strong likelihood that disruptions would continually necessitate law enforcement if the offender was not arrested.

Substance abuse and addiction are often contributory to the survival complications OMIs face as well as their criminal behavior. Abram and Teplin (1991) studied jail detainees and found 72% of offenders suffering from mental disorders also had a co-occurring substance abuse disorder, indicating dually-diagnosed offenders are the majority rather than the minority. A more recent survey (James & Glaze, 2006) revealed that 76% of jail and 74% of state inmates showed substance dependence.

Summarized research findings show dually-diagnosed persons have higher rates of rehospitalization, experience more psychotic symptoms, and are more likely to be noncompliant with treatment regimens in comparison to persons with mental illness who do not abuse substances (Osher & Drake, 1996). Other research more specifically indicates that the co-occurrence of mental illness and a substance abuse disorder is a major precursor to violent offending (Swanson, Borum, Swartz, & Monahan, 1996), elevated rates of homelessness, and increased chances of violating parole (Hartwell, 2004). In light of these findings it can therefore be ascertained that substance abuse has been a substantial contributor to escalating reincarceration rates of persons with mental illness.

Challenges to the Criminal Justice System

Expanding incarceration rates of persons with mental illness pose many challenges for the criminal justice system and, in turn, confinement in correctional facilities can exacerbate pre-existing mental health conditions. Meeting the rehabilitative needs of this special subgroup is complicated, costly, and often comes secondary to maintaining security and control in the prisons. Despite complexities in providing treatment for OMIs, it is necessary that these challenges be addressed as it is more costly for correctional budgets when OMIs are continually reincarcerated. Criminal justice system challenges are largely related to screening difficulties and limited resources.

Screening challenges. The purpose of mental

health screening upon intake is to determine which offenders need psychological treatment and placement in specialized living accommodations. OMIs have differing treatment, medication, and social support needs than nonmentally ill offenders to enable them to cope with prison life and, therefore, need to be identified as such.

One of the most prominent assessment challenges correctional systems face is detection of mental illness. Teplin (1990) studied jail detainees and identified several factors that impact identification of mental disorders in offender populations. Perhaps the strongest contributing factor was having a charted history of mental illness. When offenders had a recorded treatment history, 91.7% of them were accurately detected as mentally ill, whereas when OMIs treatment histories were unknown to correctional personnel, only 32.5% were detected. The types of mental illness exhibited also influenced the discovery of mental illness. Teplin found a 7.1% detection rate for depression in comparison with a 45% detection rate for schizophrenia. This is of particular concern considering depressed individuals are at a high risk for suicide—a problem shown to be much higher in forensic populations than the general population (Liebling, 1993; as cited in Jeglic, Vanderhoff, & Donovan, 2005). One possible explanation for this is that mental disorders comprised of overtly displayed symptoms (e.g., hallucinations) are easier to recognize than disorders with less conspicuous symptoms. Another possible reason for lower detection rates of depression could be attributed to the possibility that these individuals cause less problems for prison staff, as symptoms including isolation and withdrawal do little to create disruption. These findings suggest that improved screening instruments and procedures are needed in order to ensure accurate identification of mental illness.

In addition to disorders that easily go undetected, identified psychological disorders may not be categorized as such. Definitions of mental illness vary between correction agencies. The most common definition of serious mental illness encompasses Axis I disorders, specifically psychotic and mood disorders,

and frequently does not include Axis II disorders (e.g., personality disorders; Lurigio & Swartz, 2000). When serious mental illness is limited in scope to only these definitions, other disorders (e.g., Post Traumatic Stress disorder, Obsessive-Compulsive disorder, Borderline Personality disorder) needing clinical attention may be neglected. Overlooking some of these disorders could create dangerous situations for inmates in the general prison population, correctional staff, and the individual OMI, in that certain mental illness symptoms can include aggressive, self-harming, or suicidal behaviors.

Limited resources and treatment programs. Even when screening procedures identify OMIs, correctional budgetary constraints leave minimal funding available for mental health treatment and rehabilitative measures (Rice & Harris, 1997). Constricted resources for mental health care results in limited staff and restricted program variability (Dvoskin & Spiers, 2004). Seemingly, research suggests that the amount of time clinical personnel are available to assist OMIs is inversely correlated with the education and training of the clinical staff (Human Rights Watch, 2003). Consequently, prison psychiatrists and clinical psychologists have extremely large caseloads, which drastically limit the effectiveness of treatment per individual. Decreases in educated and experienced mental health workers are largely a result of the low salaries offered and the high stressors produced in prison environments (Human Rights Watch). Limited staffing also restricts the amount of available treatment groups and the number of offenders who can participate. Hence not all prisoners in need of treatment are placed into mental health groups.

In addition to limitations on group enrollment, another treatment-related issue is that most therapy groups do not address co-morbid mental and substance abuse disorders. Many treatment groups focus on these areas individually and often do not accept offenders with dual-diagnoses. This limits the treatment efficacy of OMIs, as serious mental illnesses frequently co-occur with substance abuse in prison populations (Chandler, Peters, Field, & Juliano-Bult, 2004) and the two interchangeably affect each other

negatively. Accordingly, it would be most logical to address these issues simultaneously.

Resource shortages not only affect staffing and treatment group availability, but also drive housing decisions about where to place inmates with mental illness. There are limited numbers of beds in mental health prisons and mental health care units as they are very costly for the correctional system; therefore not every OMI can be placed in these specialized accommodations (Human Rights Watch, 2003). Inevitably, large quantities of OMIs must be placed in the general prison population where they might not get as much individual treatment and support. Sometimes OMIs are placed in or voluntarily choose to be housed in segregated living accommodations as a protective measure. The verdict remains undetermined as to whether or not segregating OMIs from the general population is a beneficial practice. It is suggested that while OMIs may be better protected in specialized living accommodations, they might not always have access to the same programs, privileges, and services offered when integrated with the general population (Wormith, Tellier, & Gendreau, 1988).

Adjustment to Prison Life

Screening difficulties and limited resources are best conceptualized as problems inherent within the criminal justice system that can be improved by making changes to the criminal justice system. Differentially are problems caused by OMIs' reactions to incarceration and difficulties adjusting to this new lifestyle. OMI behavioral responses to environmental stimuli are largely influenced by mental illness symptoms and accordingly cannot be controlled by correction officials. While in prison, OMIs' psychological health, behavior, and coping abilities are greatly affected by their medication compliance and the prison environment. Security and control in correctional settings is contingent on how OMIs are affected by these two variables.

Psychotropic medications relieve many of the manifestations of mental illness that precipitate behavioral infractions; therefore, disruptive behaviors are

most likely to occur when OMIs are not taking their medication. Many mentally ill inmates refuse to take medication, and when this occurs, prison staff cannot force consumption without a court order (Jacoby & Kozie-Peak, 1997). Noncompliance occurs because OMIs want to avoid the unpleasant side effects induced by their prescriptions and also due to the immediate reinforcement from selling or bargaining for desired amenities such as cigarettes or food.

Detrimental effects of medication noncompliance are further agitated by environmental variables. The prison environment is comprised of many adverse conditions that negatively affect all prisoners. Environmental adversities include overcrowding, excessive noise and uncomfortable temperatures (Human Rights Watch, 2003). Additionally, lack of autonomy, uncomfortable physical limitation, and humiliation evoke fear and stress (Dvoskin & Spiers, 2004). The abrasive atmosphere in correctional facilities, compounded by mental illness, can easily trigger OMI behavioral infractions (e.g., yelling, aggression) which lead to punitive consequences.

Further evidence of prison adjustment issues was found in a 2006 study (James & Glaze) where 58% of OMIs were charged with rule violations in comparison to only 43% of nonmentally ill offenders. Additionally, OMIs' behavioral disturbances can sometimes agitate other inmates and result in aggression towards the individual causing the annoyance. Correspondingly, it appears as though OMIs are twice as likely to get injured as a result of fighting behaviors, than their nonmentally ill counterparts. As shown by Bureau of Justice Statistics (James & Glaze, 2006) 20% of OMIs have been injured in a fight during incarceration as opposed to only 10% of offenders who are not mentally ill.

Limited behavioral control makes OMIs appear mentally weak and vulnerable, which greatly increases chances of them becoming victimized by other inmates for abuse and manipulation. OMIs are often targets of predacious inmates in part because of their limited mental functioning and also because their allegations may be taken less seriously by prison staff.

Challenges to Reentry

Challenges persist for OMIs upon release from incarceration when they must attempt to reintegrate back into society. As a result of their illnesses, OMIs require more aid in this process than nonmentally ill offenders, but discouragingly often receive very little assistance (Petersilia, 2003). Often there is no intermediate phase (e.g., parole, halfway house accommodations) between prison and the community to aid in these offenders' adjustment to a new lifestyle.

Dually-diagnosed OMIs, representing the majority of OMIs, have increased chances of being denied acceptance into treatment programs. Similar to correctional facilities, a large majority of treatment programs in the community focus on specific disorders and do not address co-morbid issues (Messina, Burdon, Hagopian, & Prendergast, 2004). Mental health programs often decline treating persons with substance abuse problems in apprehension that addicts may try to bring drugs into the program or will be disruptive. Substance abuse programs will often not accept clients with severe mental illness because they are not adequately equipped to deal with individuals with these disorders (Hartwell, 2004). Discharge planning is one of the least frequently provided services for OMIs (Osher, Steadman, & Barr, 2003) who are often released with little or no mental health aftercare planning (Lamb, Weinberger, & Gross, 1999). Discharge planning aids offenders in establishing and maintaining links to various social services (e.g., employment and housing assistance) and treatment resources (e.g., support groups, medication monitoring, substance abuse treatment).

Many challenges result for OMIs due to insufficient aftercare planning. One primary challenge is difficulty finding and maintaining employment. Studies show that all offenders have reduced chances of being hired for a job as a result of having a criminal record (Petersilia, 2003). If offenders are able to find employment, they commonly earn considerably lower wages and receive fewer benefits (Petersilia). OMIs' employment obstacles are exacerbated beyond those faced by offenders who are not mentally ill. Ditton

(1999) showed approximately 38% of OMIs in state and federal prisons were unemployed in the month before they were arrested. From these findings it can be inferred that psychiatric symptoms sometimes limit the types of jobs OMIs are able to perform and could also precipitate termination.

Lack of employment is a major determinant of homelessness in mentally ill populations. Statistical analyses reflect that approximately 20% of OMIs were homeless at some point during the year before they were arrested (Ditton, 1999). Other possible antecedents of homelessness include substance abuse, weak social support systems, and limited access to medication.

Compliance with psychotropic medication regimens is often substantial in an OMI's adjustment when re-entering society. Federal court rulings in *Wakefield v. Thompson* (1999) ordered that the state must provide a newly released OMI with enough medication to last them until they are able to consult a doctor and obtain a new supply of medication. The objective behind this ruling was to ascertain that OMIs would not be left without the medications upon which their daily functioning was contingent upon. Nevertheless, problems still exist due to OMIs inability to pay the high costs of prescription medications predicated by their difficulties maintaining employment (Weisman, Lamberti, & Price, 2004). Accordingly, many OMIs use alcohol or drugs as a way to self-medicate symptoms of mental illness as they are less costly and easier to obtain.

Even when prescriptions can be attained, problems still arise. Side effects of medication and mental illness symptoms can cause cognitive impairments that hinder OMIs' abilities to adhere to parole requirements and attend appointments (Lurigio, 2001). This often results in technical violations and can eventually lead to rearrest.

Attempted Solutions

While funding is scarce, it is argued that improving discharge planning, aftercare services, and treatment programs will actually lower costs by de-

creasing reincarceration rates of OMIs. Several states have made different attempts to decrease correctional costs by diverting mentally ill offenders from prison to community treatment. Other states have focused on reducing recidivism through the improvement of aftercare and integration of criminal and psychological services.

Diversion programs have been established with the main objective to redirect mentally ill persons who commit crimes from prison to treatment facilities. This is done through specialized court systems developed specifically for criminals with mental illness. Mental health courts vary from state to state in some ways, but all still share a number of common attributes (Goldkamp & Irons-Guynn, 2000). First, they only accept participants with demonstrable mental illness. Second, they all highly prioritize public safety when they are making arrangements for mentally ill inmates in the community. Finally, mental health courts sentence offenders to certain prescribed amounts of treatment instead of incarcerating them, and therefore shift the focus from punishment to treatment and rehabilitation.

Integration of mental health and criminal justice systems is the alternative to diversion programs when attempting to keep mentally ill persons out of correctional institutions. One way integration of these two systems has been achieved is through the cross-training of police and correctional officers in mental health topics (Steadman, Morrissey, Deane, & Borum, 1999). It is thought that making criminal justice staff more sensitive to mental health issues will lead to improvement in the understanding and treatment of offenders with mental illness in the correctional system.

Another example of integration of systems is assertive community treatment (ACT) which provides long term services in order to help OMIs function successfully in society. Specialized treatment teams work to prevent crises in the community, develop individualized care plans for each OMI, and connect clients to needed resources. ACT programs involve many different services including mental health, substance abuse treatment, medical care, case management, em-

ployment assistance, housing assistance, and education.

Despite recently attempted solutions, the number of persons with mental illness being incarcerated in the criminal justice system has been escalating for the past 40 years (Thomas, 1998). Previous research discussed in this paper suggests that incarceration of persons with mental illness negatively impacts the criminal justice system and can adversely affect the individual offender. While some solutions to lower incarceration rates of OMIs have been attempted, further research must be conducted and new solutions explored in order to decrease the financial burden placed on correctional facilities and improve the lives of OMIs. It seems particularly important that attention be focused on aftercare services that aid in reentry to society. Improvements in aftercare could help lower the number of mentally ill who become homeless and recidivate and in turn lower costs for the correctional system.

OMIs in Colorado

As is the case across much of the nation, Colorado has struggled with its flourishing OMI population and the challenges they pose among the incarcerated. Although the Colorado Department of Corrections (CDOC) has had a screening and assessment process in place for decades, scant resources limit the quantity and type of services for identified OMIs.

In 1995, a 250-bed specialized mental health facility, San Carlos Correctional Facility (SCCF), was opened on the state hospital grounds. This facility was intended to treat offenders whose psychiatric symptom acuteness was so serious that they could not be safely managed within the general population. Although the purpose of the facility is primarily to stabilize offenders, programs and classes offered at SCCF include basic education, substance abuse treatment, work skills, mental health education, symptom and medication management, and institutional coping skills.

Even though Colorado has a dedicated mental health facility, CDOC endorses a model whereby

OMIs are integrated into the general population. However, maintaining this population in a desegregated environment is difficult. A recent study showed that not only were OMIs placed in administrative segregation – long term solitary confinement – more often than their non-mentally ill counterparts, they represented the OMIs with the most serious psychiatric problems (O’Keefe, 2005). The rate of OMI placements in administrative segregation was also found to increase with corresponding budget reductions. These obstacles extend beyond the prison walls; resources are so constrained that most OMIs are unable to access transitional community services, resulting in their cycling in and out of prison.

The ever-present challenge of reducing rising rates of mentally ill persons in the criminal justice system suggests the necessity to learn more about this subgroup of offenders. The present study is an exploratory one, designed to examine characteristics of OMIs in the Colorado correctional system. Prevalence, release and recidivism data is investigated to understand the rates of OMIs entering, releasing, and returning to prison. This study profiles mentally ill offenders across demographic, criminal history, psychological, and needs areas as well as some prison adjustment factors to determine how OMIs differ from the general prison population, particularly in relation to findings in the literature.

METHOD

Participants

The present study has five sections with different sampling procedures for each, although participants in all were offenders under the jurisdiction of CDOC. Sampling varied as function of the type of information being explored and accordingly is explained in greater detail in subsequent sections. In all sections, offenders were grouped into three categories (qualifying, non-qualifying, and none) according to their mental health diagnosis as determined during the prison intake process or later by a mental health clinician.

All offenders are assigned a rating of 1 to 5 to denote severity of psychological needs, and qualifier codes are used to differentiate among offenders who have a rating of 3 or higher. There are four qualifier codes: 'C' for chronic disorders, 'O' for organic disorders, 'N' for non-qualifying diagnoses, and 'T' for temporary or rule-out disorders.

Offenders classified as 'qualifying' met the CDOC definition of OMI, which requires a C or O qualifier in addition to a psychological code of 3, 4, or 5. Individuals in the qualifying group had a diagnosis consistent with certain Diagnostic and Statistical Manual of Mental Disorders-text revision (DSM-IV-TR; 2000) Axis I and Axis II disorders, specifically those which encompass the most disruptive ones within a prison environment. These include bipolar disorder, major depressive disorder, depressive disorder not otherwise specified, dysthymia, paranoid/ delusional disorders, schizophrenic disorders, schizophreniform disorder, schizoaffective disorder, psychotic disorder not otherwise specified, induced psychotic disorder, brief reactive psychosis, dissociative identity disorder, post-traumatic stress disorder and cluster A personality disorders (schizoid, schizotypal, and paranoid).

Offenders in the 'non-qualifying' group had a psychological code in the 3 to 5 range, but differentially were assigned a N, T, or no qualifier. Accord-

ingly, offenders in the non-qualifying group presented with significant mental health needs, although their diagnoses may not meet CDOC's stringent definition for OMI or they may have needed a diagnostic interview to rule-out a qualifying disorder.

Offenders placed into the category labeled 'none' were those with no diagnosis and only minimal mental health needs. These offenders had psychological codes of 1 or 2.

Materials

Several different assessments are administered to offenders at intake or during their sentence in CDOC facilities. The assessments used in this study are described below.

The Level of Supervision Inventory-Revised (LSI-R; Andrews & Bonta, 1995) is a 54-item assessment conducted in a semi-structured interview format. It measures offender recidivism risk and can be utilized to determine the amount of supervision necessary for offenders in the community. The LSI-R is administered to all prison intakes as part of the diagnostic assessment and, using norms set for Colorado parolees, scores between 0 and 12 are representative of offenders designated as low risk, 13 to 25 of medium risk, and 26 to 54 of high risk.

The Millon Clinical Multiaxial Inventory-III (MCMI-III; Millon, Davis, & Millon, 1997) is a 175-item assessment which uses a true/false response format to obtain information about clinical syndromes and personality pathology. Base rate scores above 75 indicate the presence of a personality trait or clinical syndrome, and scores above 85 indicate the presence of a personality disorder and the prominence of a clinical syndrome. The MCMI-III contains one 3-item validity scale and three modifying indices that measure disclosure, desirability, and debasement to determine if test scores are interpretable. The MCMI-III was administered to all offenders upon intake between 1996 and 2004; although it has since been replaced by the Coolidge Correctional Inventory (2004), more cases had data from the MCMI-III than the newer measure.

Substance abuse treatment levels are obtained from the standardized offender assessment (SOA), which is conducted by counselors with offenders who are screened on the diagnostic needs level as having substance abuse problems. The substance abuse counselor bases the treatment level on scores from the LSI-R and other assessments. SOA levels range from 1 to 7, with corresponding treatment modalities ranging from no treatment needs to very severe needs that require further assessment for psychopathy. Higher scores indicate greater needs for more intensive treatment.

The Brief Psychiatric Rating Scale (BPRS; Overall & Gorham, 1962) is a 24-item semi-structured interview that ranks psychiatric symptoms (e.g., anxiety, depression, suicidality, unusual thought content) on a 7-point scale (i.e., 1 indicates not present, 7 denotes extremely severe). The first 14 items are scored based from patient self-reports and the last 10 items are obtained from interviewer observations (Thomas, Donnell, & Young, 2004). Burger, Calsyn, Morse, Klinkenberg, and Trusty (1997) found that select combinations of items load onto five different pathological factors: thinking disorders, withdrawal, anxiety-depression, hostility-suspicion, and activity scale.

Procedure

Offender data for this study was downloaded from the CDOC database. This database tracks offender information throughout the duration of their sentence.

Demographic data, criminal history, and offender needs information are gathered at intake. Needs levels are assessed through a variety of different methods including interviews, pencil and paper tests, and file reviews. Screening for mental health needs, including the administration of psychological assessments, is conducted at intake. Subsequent interviews and test administrations (e.g., diagnostic interview, BPRS) are conducted as needed or minimally every 6 months for individuals identified with serious mental health needs.

Other data pertaining to offenders' incarceration

period is tracked in the CDOC database. Disciplinary violations, classification data, movements between facilities, crisis interventions, and re-incarceration are some of the data used in this study.

PREVALENCE ANALYSES

Sampling

Offenders admitted to CDOC during fiscal years 2001 to 2005 were included in the prevalence analyses. Fiscal years (FY) begin on July 1st and end on June 30th. Cases with missing psychological needs data were excluded from the analyses.

The incarceration status type was obtained for all prison admissions and coded into three types: court commitments, technical commitments, and other admissions. Court commitments included new commitments, parole returns with new felony convictions, court ordered returns with new convictions, probation returns with new convictions, and offenders who failed in the youthful offender system. Technical returns included court ordered discharges as well as parole, probation, and appeal bond violators who were not charged with new convictions. Other admissions included dual and state hospital commitments and interstate compact agreements.

Results and Conclusions

The prevalence of the three groups among prison admissions is presented in Table 1 by fiscal year. When looking at percentages, only the non-qualifying group showed a small but steady increase across the 5-year span. In contrast, offenders in the qualifying group showed a small decline in prevalence. Figure 1 illustrates that individuals with a T qualifier were primarily responsible for the recent growth within the non-qualifying group, representing those needing to be seen by a mental health clinician to assign a diagnosis.

Prevalence rates for OMIs were examined further by comparing trends across status types (see Table 2). The increase within the non-qualifying group shown in Table 1 was found to exist among both new commitments and technical returns. The qualifying

group, conversely, declined 4% from FY01 to FY05 among new commitments. OMI prevalence rates among other admissions fluctuated between fiscal years with no clear trend, likely a result of the low number of admissions in these categories.

Although the prevalence of OMIs among prison intakes demonstrated only minimal changes, the total number of OMIs, particularly those in the non-qualifying group, increased significantly due to the introduction of the T qualifier. Additionally, a snapshot of the prison population at the end of each fiscal year revealed a rising rate of incarcerated OMIs, even though the rate among intakes grew only slightly (see Figure 2).

Table 1. OMI Prevalence Rates of CDOC Intakes

	Qualifying		Non-qualifying		None	
	n	%	n	%	n	%
FY01	1,034	15%	617	9%	5,308	76%
FY02	1,071	14%	716	9%	5,948	77%
FY03	1,030	13%	809	11%	5,889	76%
FY04	1,017	13%	982	12%	6,064	75%
FY05	1,184	13%	1,130	12%	6,987	75%

Figure 1. Qualifier Codes for Non-Qualifying Group

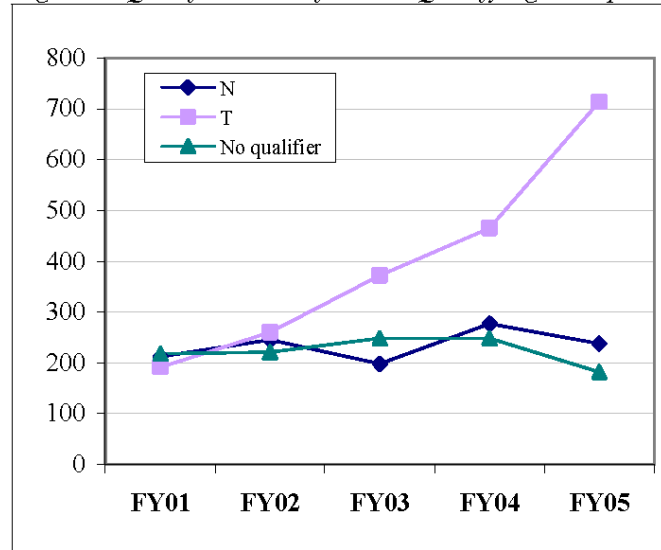
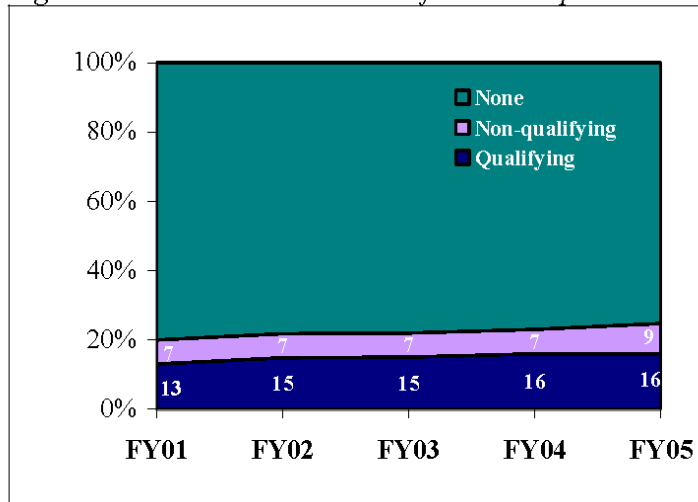


Table 2. OMI Prevalence Rates by Admission Status Type

	FY01 N = 6,959	FY02 N = 7,735	FY03 N = 7,728	FY04 N = 8,063	FY05 N = 9,301
New Commitments					
Qualifying	15%	13%	13%	12%	11%
Non-qualifying	9%	10%	11%	12%	12%
None	76%	77%	76%	76%	77%
Technical Returns					
Qualifying	16%	16%	15%	15%	17%
Non-qualifying	8%	7%	10%	12%	13%
None	76%	77%	75%	73%	70%
Other Admissions					
Qualifying	9%	17%	19%	13%	17%
Non-qualifying	0%	17%	33%	33%	17%
None	91%	66%	48%	54%	66%

Figure 2. OMI Prevalence Rates of Prison Population



PROFILE ANALYSES

Sampling

Participant data for the CDOC offender population ($N = 26,442$) at the end of FY05, excluding jail backlog and parolees out of state, were used to profile OMIs. Some cases could not be grouped ($n = 281$) due to missing psychological data. Of the available data, the qualifying group was comprised of 3,844 offenders (15%), the non-qualifying group included 1,996 offenders (8%), and the none group consisted of 20,321 offenders (77%).

Results and Conclusions

The distribution of OMI groups was analyzed across state facilities, private facilities, community corrections, and parole (see Figure 3). State facilities had the highest concentration of both qualifying and non-qualifying OMIs while community-based inmates

had the lowest rates.

Demographic characteristics are presented by group in Table 3. Differences across all three groups existed for gender and ethnicity variables. The female population presented with greater mental health needs than the males. Examination of ethnicity yielded a greater rate of Caucasians among both OMI groups and, subsequently, fewer African Americans and Hispanics. The average age for offenders varied slightly by group with the qualifying group showing the oldest average age. Amount of education completed and degree attainment did not appear to differ substantially between the three groups.

Criminal history data is presented in Table 4. Participants' most serious offense was grouped into four categories according to the type of crime committed: violent, property, drug, and other (e.g., contributing to the delinquency of a minor, being an accessory to a crime).

Table 3. Demographic Data by OMI Group

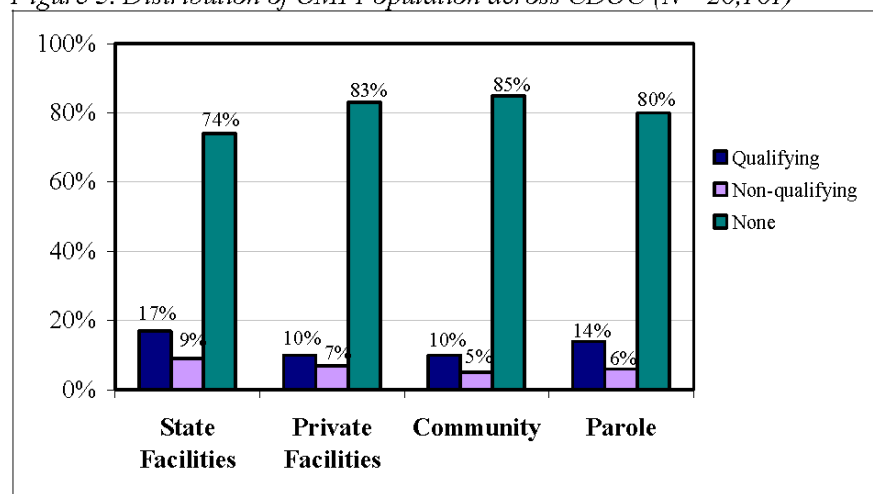
	Qualifying ($n = 3,844$)	Non-qualifying ($n = 1,996$)	None ($n = 20,321$)	Total ($N = 26,161$)
Gender				
Male	76%	85%	92%	89%
Female	24%	15%	8%	11%
Ethnicity				
Caucasian	60%	60%	44%	47%
African American	16%	14%	21%	20%
Hispanic	21%	23%	32%	30%
Other	3%	3%	3%	3%
Highest grade completed				
0-8	11%	11%	10%	10%
9-11	61%	62%	62%	62%
12	16%	16%	17%	17%
Post secondary	12%	11%	11%	11%
Degree				
GED	50%	50%	53%	53%
HS diploma	22%	21%	22%	22%
None	28%	29%	25%	25%
Mean Age (<i>SD</i>)	36.4 (9.9)	34.3 (9.8)	35.1 (10.3)	35.2 (10.2)

Number of prior incarcerations did not appear to differ between groups. The qualifying group had higher rates of violent crimes and lower rates of drug crimes than non-qualifying and none groups. The non-

qualifying group showed higher rates of other crimes and were more likely to commit class 4 through 6 felonies as opposed to class 1 through 3.

Findings indicated that the non-qualifying group on

Figure 3. Distribution of OMI Population across CDOC (N =26,161)



average received shorter maximum sentences than the qualifying and none groups, which coincides with this group having less serious offenses as indicated by their felony class. Average sentence length data did not include offenders serving life sentences; an analysis of life sentences showed a higher rate of these sentences for the qualifying group than the other two groups, which is likely a function of this group committing a higher percentage of violent offenses. In addition to being connected to longer prison sentences, mental illness was associated with

increased recidivism risk, as illustrated by higher LSI-R scores for offenders in the qualifying and non-qualifying groups than those with no diagnosis.

An examination of eight needs categories is presented in Figure 4. Offenders scoring a 3 through 5 on these 5-point scales were considered to have needs for that area. The amount of missing cases varied by needs area, ranging from medical needs with 93 missing cases to self-destruction needs with 1,357 missing cases.

Table 4. Criminal History Data by OMI Group

	Qualifying (n = 3,844)	Non-qualifying (n = 1,996)	None (n = 20,321)	Total (N = 26,161)
Prior incarcerations				
None	72%	73%	73%	73%
One	20%	19%	19%	19%
Two or more	8%	8%	8%	8%
Crime type				
Violent	49%	42%	43%	44%
Property	21%	22%	22%	21%
Drug	18%	21%	23%	22%
Other	12%	15%	12%	13%
Felony class *				
1	3%	2%	3%	3%
2	6%	5%	6%	6%
3	25%	21%	29%	28%
4	44%	46%	41%	42%
5	19%	20%	17%	17%
6	3%	6%	4%	4%
Mean max. sentence (SD)	9.4 (18.7)	8.0 (17.6)	9.2 (17.4)	9.2 (17.6)
% serving life sentence	8%	6%	6%	6%
Mean LSI-R score (SD)	32.7 (7.9)	32.1 (7.7)	28.6 (7.7)	29.5 (7.9)

* Felony class data excludes 202 offenders with missing data and 6 offenders with misdemeanors.

Vocational and substance abuse were the two areas where offenders in all groups showed the greatest needs. Needs were greater across all categories for both OMI groups than the none group. Differences were more dramatic in self-destruction and medical than in other areas (e.g., academic, vocational), two domains that are likely to affect monetary and staffing resources necessary to care for OMIs and also could impact prison safety.

Substance abuse levels, as measured by the SOA, were explored to see if mental illness influences treatment modality (see Figure 5). Findings indicated that OMIs in both groups were shown to need more intensive substance abuse services than those with no mental health needs, particularly in levels 5 through 7 which would generate a prison therapeutic community referral. While correctional populations in general evidence high substance abuse needs, SOA data suggests that offenders with mental health needs have enhanced substance abuse issues and require treatment that can address both their substance abuse and mental health issues.

The initial psychological screening conducted at intake involves an offender's psychological history in combination with

Figure 4. Offender Needs by OMI Group

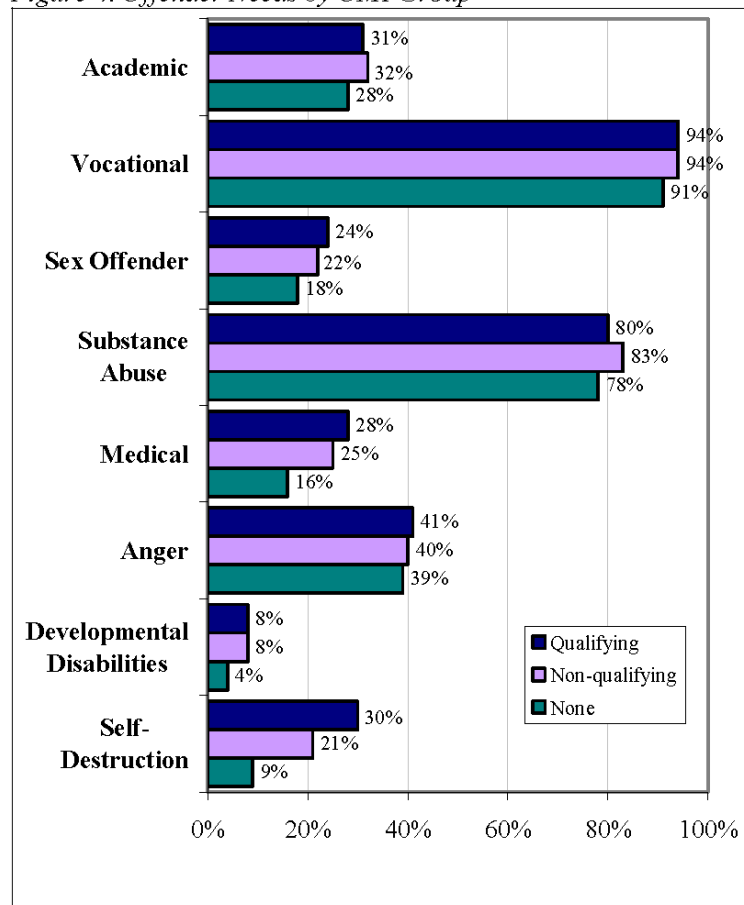


Figure 5. Substance Abuse Treatment Needs (N = 16,254)

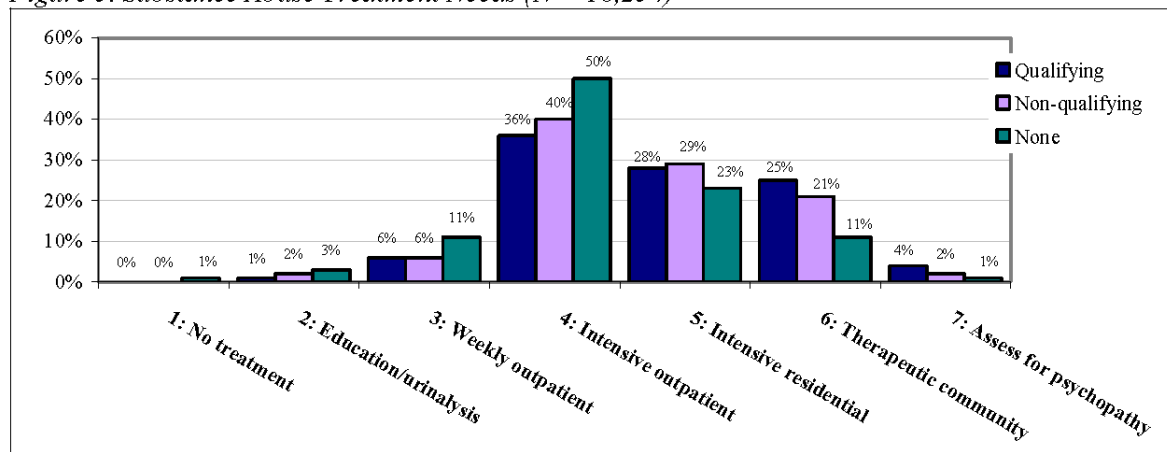


Table 5. Psychological Intake Data by OMI Group

	Qualifying (<i>n</i> = 3,844)	Non-qualifying (<i>n</i> = 1,996)	None (<i>n</i> = 20,321)	Total (<i>N</i> = 26,161)
Prior psychiatric hospitalizations	24%	18%	5%	9%
Prior outpatient mental health tx.	47%	42%	27%	31%
History of psychotropic medication	34%	23%	4%	10%

interview data, medical examination information, and scores on psychological measures (e.g., MCMI-III). All of these items are used together to determine the psychological code assigned to offenders at intake. Examples of other items that factor into offenders' psychological ranking include their appearance and whether they have a raised index of self-injury risk.

As previously described, psychological literature suggests that mental health treatment history data (i.e., past hospitalizations, psychotropic medications, outpatient treatment) is largely influential in the detection and diagnosis of mental illness in correctional populations (Teplin, 1990). Treatment history data for the current study reflected that offenders in the qualifying group reported significant mental health treatment histories in comparison with offenders in the other two groups (see Table 5).

The number of offenders with a prior successful not guilty by reason of insanity (NGRI) or related pleas was less than 1% for all groups of offenders and therefore is not shown in Table 5; however, this information is also factored into an offender's psychological code. Taken together, all of the psychological treatment data reflect the high levels of treatment needs that seriously mentally ill offenders have and reflects the increased costs of care for these offenders in comparison to offenders with minimal or no mental health needs.

For analytic purposes, DSM-IV-TR Axis I clinical diagnoses assigned by clinicians to offenders in the profile sample were grouped into ten categories (see Table 6). Drug use/dependence were the most common

diagnoses followed by severe mood disorders (e.g., major depression, bipolar disorder), and anxiety disorders. Even though major depression/depressive disorders are among the most prominent, it is possible that estimates of these disorders could be relatively conservative as they are less frequently detected due to lack of overt symptoms (Teplin, 1990).

MCMI-III data provided details about offender psychopathology. MCMI-III test scores were available for 14,984 offenders. Of this initial total, 2,469 were eliminated for several reasons: scoring a 2 or greater on the validity scale, scoring extremely high or low on the disclosure scale, having over 11 items missing, providing inaccurate demographic information, or being under 18 years of age.

The percentages of offenders with clinically significant MCMI-III scales (i.e., base rate scores above 85 indicating the presence of a disorder) were examined. MCMI-III results were divided into clinical scales and personality scales and illustrated accordingly in Table 7. As expected, the qualifying group had the highest incidence of both personality pathol-

Table 6. Prevalence of Axis I Disorders (*N* = 8,299)

Axis I Clinical Diagnosis	Frequency	Percent
Drug Use/Dependence	2,472	30%
Major Depression/Depressive Disorders	1,393	17%
Bipolar Disorders	817	10%
Anxiety Disorders/PTSD/Phobias	759	9%
Alcohol Use/Dependence	575	7%
Schizophrenia/Psychotic Disorders	514	6%
Dysthymic Disorders	495	6%
Disorders Usually Diagnosed in Childhood	291	3%
Sexual and Gender Identity Disorders	88	1%
Other Disorders	895	11%

Note. The sample size reflects diagnoses rather than offenders.

ogy and clinical disorders followed by the non-qualifying group. On average, the qualifying group was elevated on three scales, the non-qualifying group on two, and the none group on one.

When examining the entire sample, passive-aggressive, avoidant, and antisocial personality disorders appeared to be the three most prominent *personality patterns*. Depressive, avoidant, and passive-aggressive personality disorders were the most common ones specific to OMIs. Offenders with no clinical diagnosis showed passive-aggressive, narcissistic, and antisocial as their most prominent personality disorders.

Anxiety, alcohol dependence and drug dependence were the most commonly elevated *clinical syndromes* evidenced in the entire sample overall and

also when looking at each mental health group individually.

BPRS data was available for 7,131 offenders. This assessment is typically administered only to offenders classified as OMIs, although at times other individuals may be assessed as well. Average offender scores for the five BPRS scales were examined: thinking disorder scale ($M = 4.8$, $SD = 1.7$), withdrawal scale ($M = 5.0$, $SD = 1.6$), anxiety-depression scale ($M = 8.0$, $SD = 3.2$), hostility-suspicion scale ($M = 4.1$, $SD = 1.8$), and activity scale ($M = 3.9$, $SD = 1.3$). Total scores ranged from 24 to 84 ($M = 32.8$, $SD = 7.5$), which were low in general given that the range of possible scores is from 24 to 168 and that the prison population is believed to house the most serious mentally ill individuals.

Table 7. MCMI-III Scores by OMI Group

	Qualifying ($n = 2,083$)	Non-qualifying ($n = 949$)	None ($n = 9,483$)	Total ($N = 12,515$)
MCMI-III Personality Patterns (% of group with Base Rate Scores > 85)				
1- Schizoid	12%	9%	4%	6%
2a- Avoidant	22%	17%	9%	12%
2b- Depressive	25%	15%	7%	10%
3- Dependent	12%	7%	4%	5%
4- Histrionic	4%	4%	5%	5%
5- Narcissistic	8%	10%	11%	10%
6a- Antisocial	13%	14%	10%	11%
6b- Aggressive	13%	14%	8%	9%
7- Compulsive	1%	0%	1%	1%
8a- Passive-aggressive	21%	18%	12%	14%
8b- Self-defeating	10%	5%	2%	3%
s- Schizotypal	7%	4%	1%	2%
c- Borderline	8%	4%	2%	3%
p- Paranoid	7%	4%	2%	3%
MCMI-III Clinical Syndromes (% of group with Base Rate Scores > 85)				
a- Anxiety	37%	29%	17%	21%
h- Somatoform	3%	2%	0%	1%
n- Bi-polar: manic disorder	4%	2%	1%	2%
d- Dysthymic disorder	10%	6%	2%	3%
b- Alcohol dependence	15%	14%	10%	11%
t- Drug dependence	20%	15%	10%	12%
r- Post traumatic stress	10%	5%	2%	3%
ss- Thought disorder	4%	2%	1%	1%
cc- Major depression	10%	5%	1%	3%
pp- Delusional disorder	5%	3%	1%	2%

PRISON ADJUSTMENT

Sampling

Three measures of how OMIs adjust to incarceration, and in turn the prison environment, were selected from the existing dataset: admissions to San Carlos Correctional Facility (SCCF), mental health crises, and disciplinary violations. Offenders are placed at SCCF when they present with extremely serious mental health needs and as result are unable to function within the general prison population. The latter two variables can be thought of as behavioral reactions to the correctional environment and accordingly provide some indication as to an offender's adjustment to this type of lifestyle.

Sampling for SCCF admissions only took into account individuals placed during FY05, and did not include anyone who was at the facility on July 1. Sampling for mental health crises and disciplinary violations was based on the numbers of events that occurred rather than the number of offenders.

Results and Conclusions

During FY05, 173 offenders were placed in SCCF, representing 1% of the incarcerated population. The number of incoming offenders ranged between 11 and 21 per month (see Figure 6). The highest number of placements occurred during the months of March, July, and November.

There were 1,195 recorded mental health crisis incidents in CDOC facilities during FY05, for which 686 offenders were involved. Crisis

incidents included any event that required crisis intervention by mental health staff, regardless of their mental health group, and were subsequently recorded in the CDOC database. When examining the total number of incidents per offender, approximately 65% of offenders were involved in a single crisis event, 31% in 2 to 4 events, and 4% were involved in 5 or more crisis incidents.

As expected, offenders in the qualifying group had the highest rate of mental health crises (65%); however considerable frequencies also occurred in the non-qualifying (23%) and none groups (12%).

The resulting actions during mental health crises are shown in Table 8. In general it was found that

Figure 6. Number of Movements to San Carlos Correctional Facility per Month (FY05)

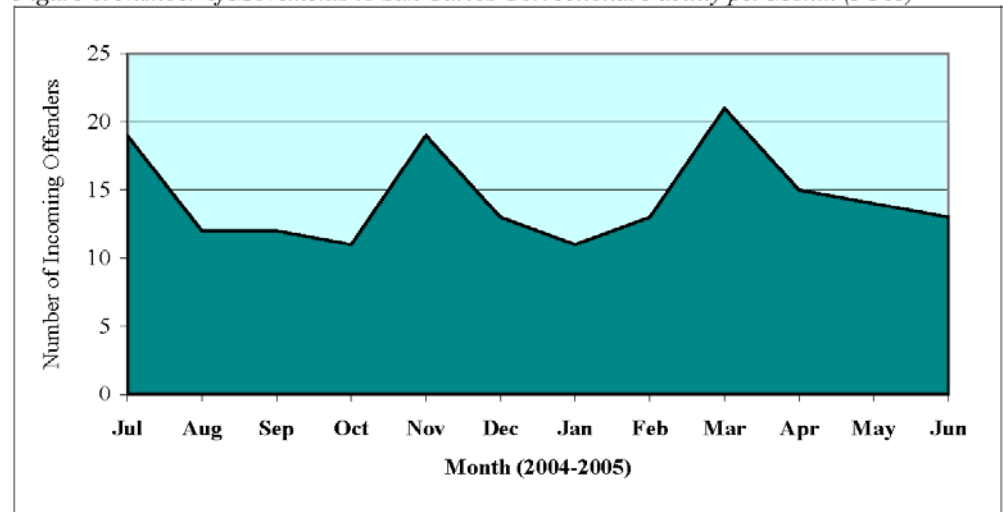


Table 8. Resulting Actions during Mental Health Crises

	Frequency	Percent
Counseling	576	48%
Observation Cell	396	33%
Admit to CDOC Infirmary	123	10%
Ambulatory Restraints	66	6%
4-Point Restraints	20	2%
Admit to Hospital	12	1%
Emergency Admit to SCCF	1	0%
Deceased	1	0%
Total	1,195	100%

most crises were resolved with counseling and the return of offenders to their cells. The next most common course of action, mainly for self-harm and suicide attempts, involved the placement of offenders in strip cells. Ambulatory and 4-point restraints were the least frequent responses to these situations. Infrequently did the outcomes result in admission to a general hospital or SCCF or death.

Figure 7 shows the breakdown of crisis incidents per CDOC facility. The highest number of incidents occurred at DWCF, CTCF, DRDC, SCF, and FCF. It is possible several of these facilities had elevated rates of recorded mental health incidences as these are where infirmaries are located.

Disciplinary violations were found to occur at a much more frequent rate than mental health crises as illustrated by 23,852 disciplinary violations during FY05. Qualifying and non-qualifying OMIs were responsible for approximately 34% of these events (see Table 9), a disproportionately high rate as only 25% of the inmate population was identified as qualifying or non-qualifying OMIs. However, severity of disciplinary violations (as indicated by class type) did not vary as a function of mental health group.

Disobeying a lawful order (class 2B) was the most frequent violation, regardless of group. For the OMI groups, advocating facility disruption (2A), unauthorized possession (2A), and verbal abuse (2B) were the next most common violations. On the other hand, unauthorized possession (2A), possession or use of dangerous drugs (2A), and tattooing (2A) were the most common violations for the non-OMI group.

Figure 7. Crisis Incidents by CDOC Facility

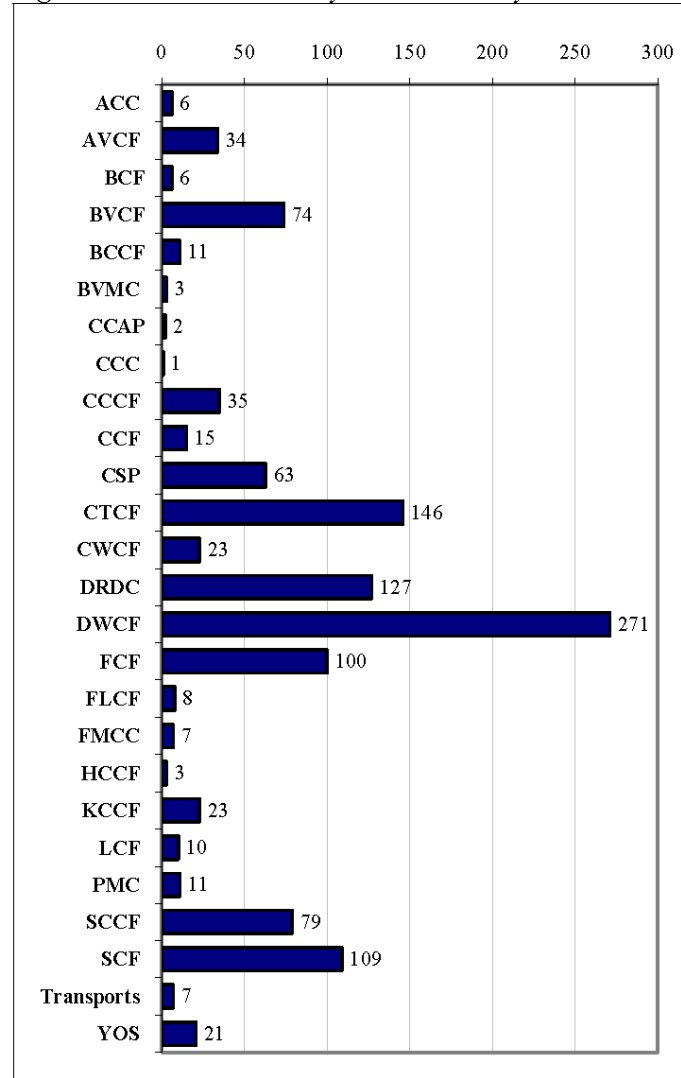


Table 9. Prevalence of Disciplinary Class Types by OMI Group

Class Type	Qualifying (n = 5,141)	Non-qualifying (n = 2,938)	None (n = 15,773)	Total (N = 23,852)
1	12%	13%	11%	11%
2A	51%	51%	51%	51%
2B	35%	34%	35%	35%
3	2%	2%	3%	3%

RELEASE ANALYSES

Sampling

Participant data for offenders releasing from prison during FY05 was downloaded from the CDOC database to examine how groups varied for release variables. Of the initial sample ($N = 8,251$), 11 cases could not be categorized due to missing mental health data.

To examine the status of offenders releasing from prison, participants were grouped into five categories: discharges, mandatory parole, mandatory reparole, discretionary parole, and other. Discharges include sentence discharges, Martin/Cooper discharges, discharge to charges, and discharge to detainer. The 'other' category included probation, court ordered discharges, appeal bonds, inactivated cases, and deceased offenders.

Results and Conclusions

Release findings (see Table 10) yielded that offenders in the qualifying and non-qualifying groups

were more likely to release from high custody levels, such as administrative segregation and close custody, and less likely to release from minimum security facilities than offenders with no diagnosis. Percentages of offenders releasing from medium and minimum restrictive custody levels appeared to be similar.

Offenders with significant mental health needs were also less likely to receive discretionary parole and go to community corrections upon release than offenders with no diagnoses. Contrary to literature that suggests OMIs serve significantly longer sentences than their non-mentally ill counterparts (Ditton, 1999), average time served did not appear to be influenced by mental health status, which may be skewed due to mandatory release to parole.

Table 10. Release Data for OMI Groups

	Qualifying (<i>n</i> = 1,294)	Non-qualifying (<i>n</i> = 589)	None (<i>n</i> = 6,357)	Total (<i>N</i> = 8,240)
Custody level at release				
Admin. segregation	7%	7%	3%	4%
Close	16%	17%	8%	10%
Medium	21%	23%	20%	20%
Minimum restrictive	24%	26%	26%	26%
Minimum	28%	22%	39%	36%
Unclassified	4%	5%	4%	4%
Release Type				
Discharges	24%	19%	18%	19%
Mandatory parole	39%	43%	42%	42%
Mandatory reparole	18%	21%	14%	15%
Discretionary parole	16%	14%	21%	19%
Other	3%	3%	5%	5%
Community placement	28%	28%	36%	34%
Mean time served (<i>SD</i>)	3.0 (3.2)	2.6 (2.7)	2.9 (3.2)	2.9 (3.1)

RECIDIVISM ANALYSES

Sampling

Offender data for adult offenders releasing from prison between FY01 and FY05 was used to examine recidivism rates. Recidivism is defined as returning to CDOC for new criminal charges or technical violations of parole or probation requirements. Three- and five-year rates were only calculated for offenders who had an at-risk period of 3 or 5 years (e.g., 5- year rates could not be calculated for offenders releasing from prison during FY04 as they were only out of prison less than 2 years).

Results and Conclusions

Recidivism findings (see Table 11) showed that offenders with mental health needs (qualifying and non-qualifying) were more likely to return to prison than offenders with no diagnoses for 1-, 3-, and 5-year periods. Offenders in the non-qualifying group showed the highest recidivism rates. This finding is surprising given that the non-qualifying group had the least serious offenses and the shortest sentence lengths; however, it is congruent with the prevalence analyses that showed increased rates of non-qualifying OMIs among new commitments and technical returns.

Table 11. Recidivism Rates by OMI Group

	FY01 (n = 6,122)	FY02 (n = 6,549)	FY03 (n = 6,972)	FY04 (n = 7,500)	FY05 (n = 8,243)	Average
1 Year						
Qualifying	37%	32%	29%	35%	37%	34%
Non-qualifying	36%	33%	38%	42%	40%	38%
None	29%	29%	28%	30%	32%	30%
3 Year						
Qualifying	51%	47%	48%	---	---	49%
Non-qualifying	60%	57%	57%	---	---	58%
None	47%	46%	48%	---	---	47%
5 Year						
Qualifying	57%	---	---	---	---	
Non-qualifying	65%	---	---	---	---	
None	52%	---	---	---	---	

DISCUSSION

The incidence of mental illness among Colorado's prison population models nationwide trends. In fact, study findings closely mirror national estimates that show 16% of inmates manifest serious and pervasive mental illness (Ditton, 1999) and 24% of state prisoners had a recent history of a mental health problem (James & Glaze, 2006). As of June 30, 2005, 16% of CDOC offenders were identified with a serious and pervasive psychiatric disorder. An additional 9% were classified as having mental health needs, although their diagnoses may be considered less serious within a prison environment than those meeting criteria for a qualifying diagnosis. Altogether, 25% of Colorado inmates were found to have mental health needs.

Screening and Identification

The literature speaks to challenges in the detection of mental illness among inmates. Colorado has in place a well-established screening process which classifies offenders using various means including treatment history, psychological assessments and diagnostic interviews. This system is dynamic, allowing for status changes to be made anytime during an offender's incarceration as deemed appropriate by a mental health clinician.

The finding that Colorado's detection rate is the same as national averages suggests that CDOC is not impeded by screening problems. However, an increase in offenders carrying the 'T' qualifier, a temporary code, may indicate resource limitations surrounding screening and assessment. Although there was a steady increase of T qualifiers over the entire 5-year period studied, that rate accelerated sharply beginning in FY03 when serious budget reductions struck.

Interestingly, the standardized psychological assessments (i.e., MCMI-III, BPRS) did not seem to provide data consistent with other measures of mental illness. Specifically, MCMI-III scores detected lower rates of major depression, dysthymic, and bipolar disorders than did clinicians. On the other hand, much

higher rates of anxiety were found by MCMI-III than clinicians. While these disparities bring into question the validity of the MCMI-III, they also suggest that mental health staff are less concerned with anxiety disorders and are identifying mood-disordered individuals who might otherwise go unnoticed.

The extremely low BPRS scores also appeared incongruent with other data (e.g., diagnoses, disciplinary violations, crisis incidents). On this scale, clinicians rate offenders' symptoms across 24 domains where a score of 24 indicates patients with no symptoms present. Therefore, scores for seriously mentally ill inmates that were barely elevated above the lowest possible score suggests that the BPRS should be evaluated to determine whether its psychometric properties are faulty or whether it is being improperly administered.

Re-entry Issues

Although there was only a modest increase (1%) in the rate of OMIs among prison *intakes*, the sheer number grew 39% over a 5-year span as a result of prison growth and expanding use of temporary mental health codes. OMI prevalence rates within the prison *population* rose 5% over the same period. This phenomenon – the number of incarcerated OMIs increasing at a faster rate than among prison intakes – might be attributable to the high number of OMIs serving life sentences. However, it must further be considered that mental health staff are identifying inmates with mental illness who were not detected during the screening process.

An important finding from this study was that technical returns (i.e., violators) are increasingly responsible for many of the OMI prison intakes as opposed to new commitments. This supports the literature that indicates mentally ill offenders are cycling in and out of the prison system. Indeed, recidivism rates showed that OMIs were more likely to return to prison, even at 5 years post-release. Surprisingly, mentally ill inmates with a non-qualifying diagnosis had the highest recidivism rates, even though there was nothing in their profile to suggest they were

higher risk. Notably, individuals in the non-qualifying group were a mixed group, consisting of offenders diagnosed with less serious Axis I disorders (e.g., phobias, somatization), diagnosed with Axis II disorders which are generally considered untreatable, or needing a diagnostic interview where a qualifying disorder is possible (i.e., T qualifier). The present research did not explore how these subgroups within the non-qualifying group differed from each other.

While this study did not specifically study re-entry issues, several of the findings indicated that OMIs face greater barriers than non-OMIs, which is consistent with the literature. First of all, OMIs were more likely to release from administrative segregation or close custody than were their counterparts. This means that OMIs who already have difficulties assimilating into society are releasing from settings where they are more isolated than the average inmate. Secondly, they were less likely to have a transitional community corrections placement following their release from prison. Community corrections programs often assist with re-entry planning and assist in areas of housing, income, and treatment. Finally, it was found that OMIs, compared to the general population, were less likely to be granted discretionary parole and more likely to discharge their sentence. While it makes inherent sense that they would not be granted parole given that they were housed at higher custody levels, those who discharge their sentence receive no post-release services.

The Person Behind the Mental Illness

Among the incarcerated, mental illness was more common among females than males. There was also a higher incidence of mental illness among Caucasians than other races. However, age and education were not discriminating factors.

OMIs who had a qualifying disorder were more likely to be incarcerated on a violent crime and, consequently, were more likely to serve a life sentence. On the other hand, OMIs with a non-qualifying disorder appeared to have less serious offenses than other inmates and served slightly shorter sentences.

All in all, mental illness corresponded to greater needs across a host of areas – academic, vocational, sex offender, substance abuse, medical, anger, developmental disabilities, and self-destruction. These elevated needs translate into greater risk factors, as confirmed by elevated LSI-R scores. This means that many of the same individuals need services from a variety of treatment or program areas, and coordination of those services is essential.

Within a 1-year timeframe, 686 inmates were involved in crisis incidents. While it is impossible to make judgments about what is an acceptable rate, 4% of the prison population is far lower than the rate of OMIs, which suggests that most of them are being managed without crisis intervention. Additionally, when a crisis ensues, mental health staff were found to use a system of graduated responses such that low level responses were the most frequently used.

Unfortunately, the disproportionately high rate of disciplinary violations suggests that OMIs have a harder time adapting to their environment than non-OMIs. While their infractions were no more serious than others', their accumulation of infractions resulted in higher custody placements. Research conducted elsewhere (O'Keefe, 2005) has shown that OMIs are over-represented in administrative segregation, a costly and highly restrictive environment.

Future Directions

This study provides only a cursory review of incarcerated OMIs in Colorado. Future research should more closely examine the non-qualifying group to understand why they return at a higher rate and whether it is possible to identify a high risk subgroup within that population that should be targeted for services. Of particular interest are inmates with a T qualifier, a temporary code, who may truly be part of the qualifying group pending a mental health evaluation. On the other hand, it may be that offenders with an Axis II disorder (i.e., personality disorder) may be resistant to therapeutic intervention and are responsible for the higher recidivism rate.

Two significant areas not examined by this study, but would benefit from research, include: (1) re-entry challenges specific to OMIs in Colorado using a qualitative research design and (2) how mentally ill persons influence the correctional system, specifically in terms of the costs and resources necessary to house and treat these individuals, their effect on treatment programs, and their impact on the overall security of correctional facilities. Future research could provide some insight into these areas.

REFERENCES

- Abram, K. M., & Teplin, L. A. (1991). Co-occurring disorders among mentally ill jail detainees. *American Psychologist*, 46, 1036-1045.
- American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed. tr.). Washington, DC: Author.
- Andrews, D. A., & Bonta J. L. (1995). *LSI-R: The Level of Service Inventory – Revised*. Toronto: Multi-Health Systems.
- Beck, A. J., & Marushak, L.M. (June, 2001). Mental health treatment in state prisons, 2000. *Bureau of Justice Statistics*, NCJ Publication No. 188215.
- Birmingham, L., Gray, J., Mason, D., & Grubin, D. (2000). Mental illness at reception into prison. *Criminal Behavior and Mental Health*, 10, 78-87.
- Burger, G. K., Calsyn, R. J., Morse, G. A., Klinkenberg, W. D., Trusty, M. L. (1997). Factor structure of the expanded brief psychiatric rating scale. *Journal of Clinical Psychology*, 53, 451-454.
- Chandler, R. K., Peters, R. H., Field, G., & Juliano-Bult, D. (2004). Challenges in implementing evidence-based treatment practices for co-occurring disorders in the criminal justice system. *Behavioral Science and the Law*, 22, 431-448.
- Coolidge, F. L., (2004). *Coolidge Correctional Inventory*. Colorado Springs, CO: Author.
- Ditton, P. M. (1999, July). *Mental health and treatment of inmates and probationers*. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.
- Dvoskin, J. A., & Spiers, E. M. (2004). On the role of correctional officers in prison mental health. *Psychiatric Quarterly*, 75, 41-59.
- Goldkamp, J. S., & Irons-Guynn, C. (April, 2000). Emerging judicial strategies for the mentally ill in the criminal caseload: Mental health courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage. *Bureau of Justice Assistance*, [Monograph] (NCJ 182504).
- Hartwell, S. W. (2004). Comparison of offenders with mental illness only and offenders with dual diagnoses. *Psychiatric Services*, 55, 145-150.
- Human Rights Watch. (2003). *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*. New York: Human Rights Watch.
- Jacoby, J. E., & Kozie-Peak, B. (1997). The benefits of social support for mentally ill offenders: Prison-to-community transitions. *Behavioral Sciences and the Law*, 15, 483-501.
- James, D. J., & Glaze, L. E. (2006, September). *Mental health problems of prison and jail inmates*. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.
- Lamb, R. H., Weinberger, L. E., & Gross, B. H. (1999). Community treatment of severely mentally ill offenders under the jurisdiction of the criminal justice system: A review. *Psychiatric Services*, 50, 907-913.
- Lurigio, A. J., & Swartz, J. A. (2000). Changing the contours of the criminal justice system to meet the needs of persons with serious mental illness. *Policies, Process and Decisions of the Criminal Justice System*, 3, 45-100.
- Lurigio, A. J. (2001). Effective services for parolees with mental illness. *Crime and Delinquency*, 47, 446-461.
- Messina, N., Burdon, W., Hagopian, G. & Prendergast, M. (2004). One year return to custody rates among co-disordered offenders. *Behavioral Sciences and the Law*, 22, 503-518.
- Millon, T., Davis, R.D., & Millon, C. (1997). *Manual for the Millon Clinical Multiaxial Inventory-III (MCMI-III)* (2nd ed.). Minneapolis: National Computer Systems.
- O'Keefe, M. L. (2005). *Analysis of Colorado's Administrative Segregation*. Technical report. Colorado Springs, CO: Department of Corrections.
- Osher, F. C., & Drake, R. E. (1996). Revising a history of unmet needs: Approaches to care for persons with co-occurring addictive and mental

- disorders. *American Journal of Orthopsychiatry*, 66, 4-11.
- Osher, F., Steadman H. J., & Barr, H (2003). A best practice approach to community reentry from jails for inmates with co-occurring disorders: The APIC model. *Crime and Delinquency*, 49, 79-96.
- Overall, J. E., & Gorham, D. R. (1962). The brief psychiatric rating scale. *Psychological Reports*, 10, 799-812.
- Petersilia, J. (2003). When prisoners come home: Parole and prisoner reentry. New York: Oxford University Press.
- Rice, M. E., & Harris, G. T. (1997). The treatment of mentally disordered offenders. *Psychology, Public Policy, and Law*, 3, 126-183.
- Steadman, H. J., Morrissey, J. P., Deane, M. W., & Borum, R. (1999). Police response to emotionally disturbed persons: Analyzing new models of police interactions with the mental health system. U.S. Department of Justice: Unpublished report.
- Swanson, J. R., Borum, R., Swartz, M., & Monahan, J. (1996). Psychotic symptoms and disorders and the risk of violent behavior in the community. *Criminal Behavior and Mental Health*, 6, 317-332.
- Teplin, L. A. (1983). The criminalization of the mentally ill: Speculation in search of data. *Psychological Bulletin*, 94, 54-67.
- Teplin, L. A. (1984). Criminalizing mental disorder: The comparative arrest rate of the mentally ill. *American Psychologist*, 39, 794-803.
- Teplin, L. A. (1990). Detecting disorder: The treatment of mental illness among jail detainees. *Journal of Consulting and Clinical Psychology*, 2, 233-236.
- Thomas, A. (1998). Ronald Reagan and the commitment of the mentally ill: Capital interest groups, and the eclipse of social policy. *Electronic Journal of Sociology*. Retrieved July 11, 2006, from <http://www.sociology.org/content/vol003.004/thomas.html>.
- Thomas, A., Donnell, A. J., & Young, T. R. (2004). Factor structure and differential validity of the expanded brief psychiatric rating scale. *Assessment*, 11, 177-187.
- Torrey, E. F. (1997). *Out of the shadows: Confronting America's mental illness crisis*. New York: John Wiley & Sons.
- U.S. Department of Health and Human Services, Center for Mental Health Services, Survey and Analysis. (1994). *Resident patients in state and county mental hospitals*. Rockville, Maryland.
- Wakefield v. Thompson, 177 F. 3d. 1160. (9th Cir. 1999).
- Weisman R.L., Lamberti J. S., Price, N. Integrating criminal justice, community mental healthcare, and support services for adults with severe mental disorders. *Psychiatric Quarterly*, 75, 71-85.
- Wormith, J. S., Tellier, M. C., Gendreau, P. (1988). Characteristics of protective custody offenders in a provincial correctional centre. *Canadian Journal of Criminology*, 30, 39-58.

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