PSYCHOLOGICAL PROFILE OF INMATE SAMPLE AT THE VEGA ALTA PENAL INSTITUTION FOR WOMEN

ARTICLE

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THE MODEL PROJECT AT THE VEGA ALTA PENAL INSTITUTION, A COLLABORATIVE effort in training and clinical research, was designed and implemented with the United States District Court, the University of Puerto Rico and the private sector.[1] It was funded by a grant from the *Carlos Morales Feliciano vs. Sila María Calderón* Fund[2] and assisted by the FILIUS Institute (hereinafter Institute), an organization established to provide education, training, research and technical assistance to Puerto Rico's correctional system. One

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1 The project was under the jurisdiction of federal judge Juan Pérez Giménez, United States District Court for the District of Puerto Rico, and directed by Dr. Nicolás Linares, Director of FILIUS Institute, Institute of Correction and Rehabilitation; Prof. Olga Elena Resumil, of the University of Puerto Rico School of Law; Dr. Carmen Rodríguez Delgado, University of Puerto Rico Medical Sciences Campus; Dr. Nelson Miranda Sánchez, University of Puerto Rico, and Dr. Carol M. Romey, private practice.

2 *Morales Feliciano v. Calderón Serra*, 300 F. Supp. 2d 321 (D.P.R. 2004).

of the specific objectives of the Institute is the conceptualization and design of an interdisciplinary and comprehensive service and treatment model to be implemented at the Vega Alta Penal Institution.

I. PROJECT DESIGN AND PROCEDURES

The research design and methodology was reviewed by the Institutional Review Board at the University of Puerto Rico, Medical Sciences Campus. All procedures were designed in compliance with the Department of Correction's policies and procedures, judicial stipulations in the *Morales Feliciano* case and professional standards and ethics in forensic psychology. The following presentation corresponds to the Psychological Profile of the Inmate Sample Study.

The Psychological Profile of the Inmate Sample Study (hereinafter Study) was designed primarily to describe the specific characteristics of the sentenced population and identify service and program needs based on an individualized psychological assessment process. There were various reasons for the selection of the women inmates as the sample for this investigation. The prison population in Vega Alta is relatively stable. The female inmate's role as mothers and their relationships with their children and custodial caretakers places them in a vulnerable and difficult situation during their confinement and isolation from their dependents. A major aspect of their adjustment difficulties is linked to their concerns and worries about their children and their welfare. Clinical experiences affirm the very complex, profound and overwhelming psychological needs of the female inmate population.

The process of assessing individual needs of the inmate population had additional goals and benefits: aid the host institution in the acquisition and implementation of updated assessment tools and procedures; upgrade existing assessment practices with the introduction of training and technological resources; and integration of these new approaches and resources into on-going institutional practices.

With state-of-the-art assessment theories, procedures and practices, the Vega Alta prison's staff and the study's staff were able to design a model intervention program founded on a solid and scientifically based level of knowledge of human behavior and criminal behavior patterns.

The Psychological Profile of the Inmate Sample Study was carried out in the Vega Alta prison in coordination with on-going institutional programs and operations. The study's staff received full cooperation from the Department of Corrections and the Correctional Health Program, and full compliance with existing rules and procedures that form part of the consent decrees in the *Morales Feliciano* litigation. The study's staff was provided with adequate office space and facilities for the assessment process. The assessment process was conducted on weekends (Saturdays and Sundays) when office space was available and minimal interference with normal institutional routines and activities would be caused.

In line with the stated goal of the Psychological Profile of the Inmate Sample Study of integrating the assessment process into institutional operations, the

project's staff participated in extensive and comprehensive training sessions designed to upgrade assessment procedures and practices. This staff included clinical psychologists licensed in Puerto Rico that have a contract with the Department of Corrections or Correctional Health Program. All staff psychologists demonstrated adequate competencies in clinical interviewing, psychological assessment, clinical conceptualization and report writing.

A full battery of psychological tests, materials, protocols, computer programs and reference resources were budgeted and acquired. All assessment materials and technological resources were left on-site. A resource library was established to aid the project and institutional staff for continued assessment and service/program planning needs.

II. Selection of Inmate Sample

It was not possible to select a random sample of subjects given the institution's record keeping practices. The inmate census had yet to be prepared for data entry into a computer program. It was not possible to define the universal population at the Vega Alta facility, from which a random sample could have been derived. Given these limitations, the project chose to use the volunteer method of subject selection. The final sample of inmates is not representative of the general inmate population.

For security reasons, only those women housed in the general population were invited to participate. No subjects housed in the maximum-security unit or in the intermediate care units with acute medical and psychiatric conditions were included.

The project was presented to the female inmates housed in the general population. After this meeting, volunteers who fulfilled the selection criteria of placement, within the ages of twenty one to fifty years old and sentenced from one to ten years, signed up. This group, from the general population, constitutes the largest sector of the inmate population and to whom the long-term institutional service offerings are directed. Furthermore, with a relatively short prison term, this sector of the inmate population will be returning to the community. Therefore, priority was given to their mental health status and treatment needs.

It should be noted that the response to general participation by the inmate population was very positive. As the inmates became familiarized with the study, volunteers were added to the list of potential subjects. The study was not able to assess all of those who volunteered. Subjects were selected in the order they enlisted.

A total of fifty-nine women signed up to participate in the study. Table 1 summarizes the participation of the women that form the study sample.

Table 1. Summary of Inmate Sample Participation

Inmate Classification	Number	Percent of Sample

Inmates that completed assessment process	32	54.2%
Inmates that did not complete assessment process	1	1.7%
Inmates that initially agreed to participate and later refused	9	15.2%
Inmates that initially were available to participate but then were released or transferred	11	18.5%
Inmates not able to be assessed for medical reasons	2	3.5%
Inmates previously assessed in another institution	1	1.7%
Unable to locate inmate in institution	1	1.7%
Inmate available but limited staff resources did not permit assessment	2	3.5%
Total Number of Inmates in sample	59	100%

The age distribution of the inmate sample is outlined in Table 2 and illustrates the wide range of ages within twenty-one to fifty years.

Table 2. Age Distribution of Inmate Sample

Age group	**No. of participants**	**Percent of Sample**
21-25 years	6	19 %
26-30 years	8	25 %
31-35 years	6	19 %
36-40 years	3	9 %
41-45 years	7	21 %
46-50 years	2	6%

A. Informed Consent

The institutional community (Department of Corrections' officials, Correctional Health Program staff and sentenced inmates) was informed of the purpose and scope of the study in Vega Alta and encouraged them to become active participants in the project. All assessed inmates signed the appropriate consent form.

The process of assessing the needs of the sentenced inmate population was designed to be compatible with institutional policies and procedures and integrated into existing record keeping practices, service offerings and program planning. The implications of an integrated assessment approach were seen in the need to establish two levels of confidentiality in the handling of data collected.

All data obtained from inmates that related directly to their person and for which the Department of Corrections had a direct responsibility to provide assistance and services were noted and appropriate staff were informed. The existing institutional norms of confidentiality applied to these assessment data. On the other hand, all data collected wherein the identification of the inmate and source of information was deemed prejudicial to that person's standing in the institution (be it staff or sentenced inmate) were coded and reported in statistical summary format. At no time was the identity of the source of the confidential information revealed.

B. Psychological Assessment Components

The Psychological Profile of the Inmate Sample included the following components:

A. In-depth interviews of sentenced inmates that included the following thematic areas:
    1. Socio-demographic profile
    2. Developmental history
    3. Health and Mental health history
    4. Drug/Alcohol use history
    5. Criminal justice history
    6. Violence history
    7. Trauma history
    8. Educational placement
    9. Neuropsychological history

B. Psychological assessment of sample cases included the administration of the following test battery:
    1. Wechsler Intelligence Scale-III (WAIS-III)
    2. Bender Visual Motor Gestalt Test
    3. Projective Drawings
    4. Rorschach Psychodiagnostic Plates
    5. Minnesota Multiphasic Personality Inventory-2 (MMPI-2)
    6. Millon Clinical Multiaxial Inventory-III (MCMI-III)
    7. Personality Assessment Inventory (PAI)
    8. Validity Index Profile (VIP)
    9. Thematic Apperception Test (TAT)
    10. Incomplete Sentence Blanks (Rotter)
    11. Woodcock-Muñoz Cognitive and Achievement Battery
    12. Beck Depression Scale (BDI)
    13. Beck Suicide Potential Scale (BSI)
    14. Trauma Symptom Inventory (TSI)

C. Clinical observation

D. Review of medical file

Each clinical psychologist (evaluator) completed one client assessment in a two-day period (twenty hours on Saturdays and Sundays). Subsequently, additional time was designated in the assessment process for supervision, test correction, data analysis, case discussion with project staff, case conceptualization, formulation of treatment recommendations and report preparation. Project staff completed thirty-two psychological assessments during the period of January through March 2003.

During seven consecutive weekends, five clinical psychologists administered the comprehensive test battery to five women from the list of volunteers. After concluding the phase of direct contact with the client, each psychologist corrected the tests, entered data into computer programs, analyzed the data, presented the case to the staff, prepared the written report and completed the evaluation of the assessment instruments.

The test materials were shared amongst staff for a maximization of use throughout the process. As cases came to closure, the project's staff moved from the private office area to the conference room (Occupational Therapy room) where tests were corrected, cases discussed, supervision provided and computer programs were used.

The close proximity of the private offices and the conference area assured timely supervision, enhanced collaborative efforts amongst staff, facilitated security measures for correctional officers and limited the intrusion of the project's workings on the regular functioning of the medical unit.

The model was designed to train, supervise and provide high quality assessment as well as maximize the utilization of resources. The model achieved the goal of creating a learning environment that was challenging, enriching and professionally stimulating.

The project developed, in collaboration with Ms. Hilda Acevedo, Director of the Psychology Department of the Correctional Psychiatric Hospital, a report format for the recording of assessment data for use in the Correctional Psychiatric Hospital as well as in the study. It organizes, in a comprehensive manner, test scores and observations to record relevant data and facilitate monitoring the treatment and progress, and for comparative analysis of sequential assessments. The format was designed to facilitate the entry of clinical scores and findings into a data bank for research and policy planning purposes.

III. Characteristics of Clinical Psychology Staff

A total of eighteen clinical psychologists licensed in Puerto Rico and drawn from the public and private sectors participated in the psychological assessment

of the inmate sample.[3] Each clinical psychologist assessed from one to three inmates.

A. Training of Clinical Psychology Staff

Training of Clinical Psychology Staff took place in three stages. A five day intensive training in psychological assessment was provided to all clinical psychologists that have a contract with the Correctional Health Program. The training sessions took place at the Correctional Psychiatric Hospital on October 30 and 31, 2000; November 1, 2000; December 1, 2000; and January 16, 2001.

The training seminar on psychological assessment within correctional settings was coordinated by Esther Rodríguez, Ph.D. Dr. Carol M. Romey was the training resource. The seminar offered 27.5 hours of training in assessment.

The objectives of the training seminar were:

(1) Update knowledge and skills in comprehensive psychological assessment;
(2) Develop clinical skills in integrating multiple levels of personality assessment in a case formulation;
(3) Develop clinical skills in integrating assessment data into treatment planning; and
(4) Develop skills in the integration of assessment data into evaluating effectiveness of treatment interventions.

The topics covered in the training program were:

(1) Benefits and costs of psychological assessment in treatment planning;
(2) Clinical model of comprehensive psychological assessment;
(3) Ethical and professional issues in clinical assessment in correctional settings;
(4) Integrating assessment findings into clinical reports for treatment planning;
(5) Principles of Rorschach administration, coding and interpretation; and
(6) Case discussions of assessment findings, diagnostic issues, and special concern in clinical assessment within correctional settings.

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3 These were: Hilda Acevedo, Psychiatric Correctional Hospital (PCH); José Casiano, Bayamón prison facility; José Delgado, Guayama prison facility; Wendy Fernández, Río Piedras prison facility; Ivonne Ferrer, Río Piedras prison facility; Virginia Gründler, PCH; Alejandro Lebrón, Sabana Hoyos prison facility; Mayela Llaurador, PCH; Ángel Mercado, Río Piedras prison facility; Migdalia Pérez, Río Piedras prison facility; María Rivera, Sabana Hoyos prison facility; Aida Rodríguez, Ponce prison facility; Esther Rodríguez, Guayama prison facility; Luís Javier Rodríguez, PCH; Carol Romey, FILIUS and private practice; Ana María Ruano, Bayamón prison facility; Alexandra Ruíz, PHC; Ernesto Santini, private practice.

The final phase of training was on site and utilized live supervision, consultation and peer supervision during the assessment process at the host institution.

IV. ASSESSMENT FINDINGS

A. Summary of diagnostic classifications of Inmate Sample

Of the thirty-two women in the inmate sample, all but one person was diagnosed with a serious mental health disorder.[4] Table 3 outlines the diagnosed conditions that are substantiated in the assessment process for the inmate sample. A complete listing of the diagnosis for each inmate is provided in Appendix A.

Table 3. Frequency of Diagnostic Categories in Inmate Sample[5]

Diagnostic Category	Frequency	Total Number and Percent of Sample
SUBSTANCE ABUSE/DEPENDENCE		26 81%
Polysubstance	11	
Opioids (Heroin)	5	
Alcohol	4	
Cocaine	3	
NOS	2	
Cannabis (Marihuana)	1	
MOOD DISORDERS		18 56%
Major Depression	13	
Dysthymic Disorder	3	
Bipolar	2	
ANXIETY DISORDERS		9 28%
Posttraumatic Stress Disorder	7	
Generalized Anxiety Disorder	2	
ADJUSTMENT DISORDERS		6 19%
With Anxiety	3	
Mixed with Anxiety and Depressed Mood	2	
Unspecified	1	
PERSONALITY DISORDERS		12 38%
Borderline	5	
Antisocial	4	
Dependent	1	
Histrionic	1	
Avoidant	1	

4 It should be noted one of the women's diagnostic information was not available.

5 Table figures represent multiple diagnostic categories for the inmate sample.

INTELLECTUAL DEFICITS		18	56%
Borderline Intellectual Functioning	13		
Mild Mental Retardation	5		

The diagnostic process documents the multiple layers of trauma and dysfunction and the very complex nature of the inmate sample's psychological profile. Many of the subjects were not receiving mental health services and these underlying mental health conditions were undiagnosed and unknown to institutional staff.

It is highly significant that eighty-one percent of the sample reported a history of substance abuse and/or dependence along with additional diagnostic conditions. Furthermore, fifty-six percent of the sample was diagnosed with a Mood Disorder, predominantly Major Depression. Anxiety Disorders were found in twenty-eight percent of the sample and Adjustment Disorders in nineteen percent of the sample.

Personality Disorders were diagnosed in thirty-eight percent of the sample and were often found in combination with other diagnosed conditions. It is highly significant that fifty-six percent of the sample qualify, on the basis of WAIS-III scores, for placement in the Mild Mental Retardation and Borderline Intellectual Functioning range (I.Q. 70-84).

These assessment findings of a prevalence of serious mental health disorders (above ninety percent in the female inmate sample) are alarming when one considers that epidemiology studies of the prevalence of mental health disorders in Puerto Rico estimate an overall prevalence of eight point three percent of the adult general population suffer from severe mental illness.[6] Regarding the diagnosis of drug abuse in the adult population, estimates are that one point two percent of the Puerto Rico adult population fulfills clinical criteria for substance abuse and three percent of the adult population fulfills clinical criteria for a diagnosis of drug dependence.[7]

B. Classification of inmate psychological profile and treatment needs

The clinical conceptualization of each assessment was classified into six treatment categories based on the principal or initial focus of the intervention. With multiple levels of diagnostic concerns, it is necessary to focus on the entry level or the level of dysfunction that should be addressed prior to accessing the more traumatic, deeper or secondary levels. The six treatment categories are:

CATEGORY I

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6 Enrique Rivera Mas, *Análisis de la Salud de Puerto Rico, Salud Mental*, 69 REV. COL. ABOG. __ (2008).

7 *Id.*

In a controlled environment, the inmate does not evidence a need for mental health treatment. The inmate is stable and adjusted to prison life. In the community, the person may need follow-up services to reduce the risk of recidivism. The person demonstrates adequate intellectual, educational and occupational resources. There is no history of drug or alcohol use.

CATEGORY II

The principal diagnosis is drug and/or alcohol abuse or dependence. The addictions may be complicated with health conditions that require medical care and supervision (HIV+, AIDS, Hepatitis, etc.)

CATEGORY III

The principal diagnosis is a trauma originated disorder such as post-traumatic stress disorder (PTSD) and/or victimization (for example: domestic violence, rape, abuse). The psychological impact of the traumatic experiences is seriously impacting the ability of the person to cope with prison life and afterwards.

CATEGORY IV

The principal diagnosis is a personality disorder (Antisocial, Borderline, etc.). The person's level of adjustment in prison and in the community is seriously impacted by these personality disorder dynamics.

CATEGORY V

The person evidences serious cognitive and/or sensory limitations (Mild and Moderate Mental Retardation, brain dysfunction). The focus of treatment should be in vocational rehabilitation and independent living skills.

CATEGORY VI

The person is experiencing a serious mental disorder (for example, major depression with suicide ideation, psychotic break, violent behavior) that requires immediate and intensive care.

Table 4 outlines the number of inmates that were assigned to each treatment category.

Table 4. Classification of Inmate Psychological Profile by Clinical Conceptualization and Treatment needs[8]

Clinical Conceptualization	Treatment Needs	Percent of Sample

8 A note should be made that inmates may qualify for more than one category of treatment needs. Mental health staff would assess treatment priorities and as one diagnostic need was addressed and treated a second level of treatment, if it surfaced, would also be attended. Data is not available for one inmate.

Category I In a controlled environment, the inmate does not evidence a need for mental health treatment. The inmate is stable and adjusted to prison life. In the community, the person may need follow-up services to reduce the risk of recidivism. The person demonstrates adequate intellectual, educational and occupational resources. There is no history of drug or alcohol use.	There are no immediate treatment needs to be addressed by mental health professionals.	3% (1 of 32 inmates)
Category II The principal diagnosis is drug and/or alcohol abuse or dependence. The addictions may be complicated with health conditions that require medical care and supervision (HIV+, AIDS, Hepatitis, etc.)	The person needs mental health treatment for addictive processes, maladaptive cognitive thinking patterns and behaviors that increase the risk of recidivism. Mental health treatment needs to be coordinated with health care for related conditions.	35% (11 of 32 inmates)
Category III The principal diagnosis is a trauma originated disorder such as PTSD and/or victimization (domestic violence, rape, incest, child abuse). The psychological impact of the traumatic experiences is seriously impacting the ability of the person to cope with prison life and afterwards.	The person needs mental health treatment that focuses on trauma and psychological coping mechanisms to deal with chronic and active reliving of past traumas. Treatment may be intensive and short term and/or long term and supportive depending on the time frame for the abuse, intensity and psychological areas impacted.	32% (10 of 32 inmates)
Category IV The principal diagnosis is a personality disorder (Antisocial, Borderline, etc.). The person's level of adjustment in prison and in the community is seriously impacted by these personality disorder dynamics.	The person needs mental health treatment in a very structured setting directed towards restructuring of personality organization and learning of more adaptive behavioral and attitudinal responses. Treatment may be long term.	25% (8 of 32 inmates)
Category V The person evidences serious cognitive and/or sensory limitations (Mild and Moderate mental Retardation, Brain dysfunction). The focus of treatment should be on vocational rehabilitation and independent living skills.	The person's limited intellectual abilities seriously limit their ability to benefit from traditional psychotherapy. Treatment focus should be on vocational and daily living skills.	3% (1 of 32 inmates)
Category VI	Mental health treatment is	0%

The person is experiencing a serious level of major depression with suicide ideation or psychotic processes that requires immediate and intensive care.	crisis oriented and should be intense and focused on suicide prevention and protection of self and others. Upon reduction of suicide risk, mental health treatment should focus on major depressive symptoms, stressors and the origins of these symptoms.	(None of 32 inmates)

These treatment categories should be considered as initial placements and when each case is individually analyzed, treatment priorities may change over time and new factors affecting the person's daily life and adjustments may need to be taken into consideration. At the time of the study, there was only one subject who was not in need of mental health treatment. The study found no person in need of crisis intervention or who presented a high risk for suicide in the study sample.[9]

An important clinical criterion was incorporated in assigning treatment categories. Some diagnostic categories are more resistant to treatment efforts. In some instances the presence of persons with any of these diagnosed disorders may sabotage program efforts. It is for this reason that the personality disorders were classified together in a treatment program. This was done to assure a comprehensive approach to the treatment of personality disorders in the prison population, as well as to segregate this population from the other treatment programs. It is recognized that many of the persons with a diagnosed personality disorders may have compounded clinical symptoms such as depression and stress reactions; however, it is argued that the presence of a fully diagnosed personality disorder should be a central focus in the selection of the overall approach to treating additional disorders.

V. SUMMARY OF EVALUATION BY CLINICAL PSYCHOLOGISTS OF THE CLINICAL CONTRIBUTIONS OF PSYCHOLOGICAL TESTS TO THE ASSESSMENT PROCESS

The project incorporated into the assessment process an evaluation of the psychological tests and procedures customarily used in Puerto Rico in clinical assessment. Clinical practice exhorts the selection of tests that are culturally sensitive and appropriate for the age and intellectual level of the subjects. The study administered all of the clinical tests that are available for Hispanic subjects. When available and appropriate, normative data was used for the interpre-

9 The inmate sample was drawn from voluntary recruits and excluded those persons residing in intensive care units.

tation of the results. The study proposed to assess the relative clinical contributions of these tests on the female inmate population in Puerto Rico.

Each clinical psychologist rated the psychological instruments administered from the perspective of the examiner and in terms of the relevance for the specific person evaluated. The relative contribution of each test to the formulation of clinical opinion was rated in the areas of:

(1) Contribution to diagnosis
(2) Contribution to treatment plan
(3) Contribution to the formulation of recommendations
(4) Contribution to the need for specialized referrals
(5) Contributions to validity measures

The project's staff found that the following tests made the greatest contribution to the diagnostic process, in order of priority:

(1) Rorschach Test[10]
(2) Wechsler Intelligence Scale for Adults, III (WAIS-III)[11]
(3) Bender Gestalt Test[12]
(4) Millon Clinical Multiaxial Inventory, third edition (MCMI-III)[13]
(5) Minnesota Multiphasic Personality Inventory-II (MMPI-2)[14]
(6) Personality Assessment Inventory (PAI)[15]
(7) Trauma Symptom Inventory (TSI)[16]

The project's staff found that the following tests made the greatest contribution to treatment planning, in order of priority:

(1) Rorschach

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10 The Rorschach Inkblot test is a measure of the internal structure, maturity and personality dynamics and processes. It is comprised of 10 inkblots that are coded, analyzed and compared with a normative age sample.

11 The Wechsler Intelligence Scales is an individually administered test of cognitive functioning that covers the domains of verbal comprehension, perceptual organization, working memory and processing speed.

12 The Bender Gestalt Test is a screening measure of visual motor coordination and perceptual mediation.

13 The Millon Clinical Multiaxial Inventory is a self reporting measure of attitudes, behaviors and psycho-social-health concerns.

14 The Minnesota Multiphasic Personality Inventory is a self reporting measure of attitudes, behaviors and psycho-social-health concerns.

15 The Personality Assessment Inventory is a self reporting measure of attitudes, behaviors and psycho-social-health concerns.

16 The Trauma Symptom Inventory is a self reporting measure of attitudes, behaviors and psycho-social-health concerns associated with trauma.

(2) MCMI-III
(3) TSI
(4) WAIS-III
(5) Incomplete Sentence Blanks[17]

The project's staff rated the following tests as having contributed greatest to the formulation of clinical recommendations:

(1) Rorschach
(2) WAIS-III
(3) MMPI-2
(4) MCMI-III
(5) Thematic Apperception Test (TAT)[18]
(6) PAI
(7) Incomplete Sentence Blanks

The project's staff rated the following tests as having contributed greatest to the identification of the need for specialized referrals:

(1) Rorschach
(2) MCMI-III
(3) MMPI-2

The project's staff rated the following tests as having contributed greatest to measuring validity:

(1) Test of Memory Malingering (TOMM)[19]
(2) Validity Index Profile (VIP)[20]
(3) MMPI-2

In summary, the clinical psychologists recommended, on the basis of these findings, that the essential clinical battery for the comprehensive psychological assessment of the female inmate population in Puerto Rico should include the following tests:

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17 The Incomplete Sentence Test is a self reporting measure of attitudes, behaviors and psycho-social-health concerns.

18 The Thematic Apperception Test is a series of pictures and the subject is asked to make a story drawing from inner concerns, experiences and personal perspectives.

19 The Test of Memory Malingering is an independent measure of validity and reliability associated with immediate recall and short term memory.

20 The Validity Index Profile is an independent measure of validity and reliability in the cognitive domain of visual logic and reasoning.

(1) Rorschach
(2) WAIS-III
(3) Bender Gestalt
(4) MCMI-III
(5) TSI
(6) MMPI-2
(7) TOMM
(8) VIP

The following tests were recommended as supplementary instruments to be used as alternative measures should the subject not be able to perform one of the first-order instruments.

(1) PAI
(2) Incomplete Sentence Blanks
(3) Beck Suicide Index[21]
(4) Beck Depression Index
(5) Draw-a-Figure[22]

The clinical contributions of the assessment instruments were highly significant and provided valuable clinical data that would otherwise have not been available to institutional staff for treatment and programming purposes. It was highly significant that the data obtained from these instruments was of great personal value to the women subjects and provided vital feedback and understanding as to their life circumstances and options open to them for rehabilitation and improving the quality of their lives. All subjects were very appreciative of the feedback received at the conclusion of the assessment process.

VI. SUMMARY

The project revealed the following picture of the psychological profile of the mental status and psychological needs of the inmate sample:

(1) Eighty-one percent of the inmate sample was diagnosed with Substance Abuse or Substance Dependency
(2) Fifty-six percent of the sample suffer from serious Mood Disorders
(3) Twenty-eight percent of the sample suffer from Anxiety Disorders
(4) Nineteen percent of the sample suffer from Adjustment Disorders
(5) Thirty-eight percent of the sample suffer from Personality Disorders

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21 The Beck Suicide and Depression Indexes are self-reporting measures of the frequency and intensity of symptoms associated with depression and suicide ideation.

22 The Draw-a-Person test is a measure of self-imaging and motor coordination.

(6) Fifty six percent of the inmate sample suffers from serious and limiting intellectual deficiencies (Mild Mental Retardation or Borderline Intellectual Functioning)
(7) Many of the inmates from the sample suffer multiple mental disorders, most of long term duration originating in early childhood trauma, abuse and neglect
(8) Ninety-seven percent of the inmate sample was in need of treatment for their diagnosed conditions
(9) Without the benefits of treatment, the women are at risk for continued victimization and marginalization that increases risks for continued criminal behavior upon release
(10) The women confined in the Vega Alta facility have multiple and serious psychological problems that impact their ability to adapt to prison life, negatively affect their ability to be responsible parents to their children, and seriously limit their ability to participate in social goals and obtain independent and productive life styles
(11) The inmate sample was very cooperative with assessment procedures, open to personal awareness of their circumstances and willing to invest personally in their rehabilitation
(12) The study's objective of creating a learning environment wherein professional staff update clinical skills, enrich case presentations and conceptualizations, and explore treatment options based on sound clinical criteria was achieved
(13) The experiences of the staff provide sound clinical criteria for the recommendation of the essential assessment battery to be used for the female inmate population in Puerto Rico. The essential assessment battery should include the following instruments and procedures:

Test Instruments:

1. Rorschach
2. WAIS-III
3. Bender Gestalt
4. MCMI-III
5. TSI
6. MMPI-2
7. TOMM
8. VIP

Procedures:

1. Informed consent
2. Comprehensive clinical interviews
3. Administration of psychological tests
4. Clinical observation
5. Review of records and documents
6. Analysis of assessment data
7. Preparation of written report on findings

The assessment findings for the Vega Alta Project portray a most devastating and profound picture of the psychological needs of the women we have judicially processed and confined in the prison system. The level of psychological despair, trauma and personality disorganization impacts not only the women but their families and social networks. The effort to address the psychological needs of the imprisoned women will have a significant impact on their ability to raise their children, obtain a productive lifestyle and maintain a stable and goal directed adult life style.

VII. RECOMMENDATIONS

Based on the study findings, the following recommendations were presented:

(1) The treatment needs for the inmate population should be a priority within the correctional setting. Diagnosed conditions are often a reflection of predisposing conditions and vulnerabilities that have a direct linkage to initiating into and continuing in criminal behaviors.
(2) Comprehensive psychological assessment of the target population provides treatment program planners with relevant and accurate data upon which to design and implement programs.

Baseline data of participants at the pre-program stage provides essential outcome assessment data to measure levels of functioning, changes in diagnosed conditions and achievement of therapeutic goals.
Data obtained from clinical assessment provides an invaluable resource to guide psychological services towards scientifically grounded methods, procedures and sound clinical practice.
(3) Academic centers that prepare clinical psychologists for work in correctional settings must revise curriculum and upgrade the teaching of clinical skills and competencies in light of the assessment tools that are shown to contribute most to the diagnostic process, formulation of treatment plans and provide outcome measures of treatment progress.
(4) The model designed for the teaching of the comprehensive assessment model was successful in developing a coordinated assessment effort within the correctional setting.

The model was able to train, supervise and provide high quality assessments as well as maximize the utilization of resources. The model achieved the goal of creating a learning environment that was challenging, enriching and professionally stimulating for both the examiner and subject.

Lastly, it is highly significant that these clinical findings are found in the sample of women who volunteered to participate and who were confined in the general population of inmates. These findings are what would be expected, perhaps, in a clinical sample of women in outpatient treatment, drug rehabilitation

programs and intensive inpatient mental health care programs or in programs that focus on women in maximum security units. To find that over ninety percent of the women in the general prison population have serious mental disorders and are in need of intensive treatment raises questions. Without adequate treatment guided by a scientifically validated diagnosis, how will these women be able to achieve the goals of rehabilitation and help themselves and their children once they return to the community?

VIII. APPENDIX

Appendix A. Inmate Sample by Diagnosis Suggested by Assessment Process[1]

Case	Diagnosis Suggested	Wechsler I.Q. Scores[2]
1	Axis I: 296.3 Major Depression, Recurrent Axis II: 317 Mild Mental Retardation Antisocial Personality features Axis III: Intoxication with Clorox at age 17,R/O brain dysfunction	Verbal I.Q 62-72 Performance I.Q. 58-72 Full I.Q.[3] 59-67
2	Axis I: : 296.3 Major Depression, Recurrent 309.81 Posttraumatic Stress Disorder Axis II: V62.89 Borderline Intellectual Functioning Borderline Personality features Axis III: None	Verbal I.Q. 65-75 Performance I.Q.90-101 Full I.Q. 76-83
Case	**Diagnosis Suggested**	**Wechsler I.Q. Scores**
3	Axis I: 300.02 Generalized Anxiety Disorder Axis II: V62.89 Borderline Intellectual Functioning Antisocial Personality features Axis III: None	Verbal I.Q. 76-86 Performance I.Q. 75-89 Full I.Q. 75-83
4	Axis I: 304.80 Polysubstance dependence 304.00 Opioids Dependence Axis II: 301.7 Antisocial Personality Axis III: HIV+	Verbal I.Q. 80-89 Performance I.Q. 83-96 Full I.Q. 81-89
5	Axis I: 300.4 Dysthymic Disorder 309.28 Adjustment Disorder, with Mixed Anxiety and Depressed Mood	Verbal I.Q. 81-90 Performance I.Q.91-105 Full I.Q. 86-94

1 The diagnosis follows the Diagnostic and Statistical Manual for Mental Disorders, American Psychiatric Association, DSM-IV-TR.

2 The DSM-IV-TR classifies the I.Q. ranges as follows:
Very Superior: above 130
Superior: 121-129
High Average: 110-119
Average: 90-109
Low Average: 80-89
Borderline: 70-79
Mild Mental Retardation: 50-55 to approximately 70 (DSM-IV-TR code is 317)
Moderate Mental Retardation: 35-34 to 50-55 (DSM-IV-TR code is 318.0)
Severe Mental Retardation: 20-25 to 35-40 (DSM-IV-TR code 9s 318.1)
Profound Mental Retardation: IQ below 20 or 25 (DSM-IV-TR code is 319)
Borderline Intellectual Functioning places in the I.Q. range of 71-84 (DSM-IV-TR code is V62.89))

3 The Full Scale I.Q. is used to classify intellectual functioning.

	305.00 Alcohol Abuse 305.60 Cocaine Abuse Axis II: Paranoid Personality features Axis III: Hypertension	
6	Axis I: 309.81 Posttraumatic Stress Disorder 305.90 Substance Abuse, NOS Axis II: V62.89 Borderline Intellectual Functioning Axis III: Speech impairment	Verbal I.Q. 62-72 Performance I.Q. 71-91 Full I.Q. 70-79
7	Axis I: : 296.32 Major Depression, Recurrent, Moderate 305.90 Substance Abuse, NOS Axis II: V62.89 Borderline Intellectual Functioning 301.50 Histrionic Personality Disorder Obsessive Compulsive and Paranoid Features Axis III: None	Verbal I.Q. 74-82 Performance I.Q. 84-95 Full I.Q. 76-84
Case	**Diagnosis Suggested**	**Wechsler I.Q. Scores**
8	Axis I: 300.4 Dysthymic Disorder, late Onset 304.00 Opioid Dependency, by history Axis II: Avoidant Personality features Axis III: None	Verbal I.Q. 74-84 Performance I.Q 86-99 Full I.Q. 80-88
9	Axis I: : 296.3 Major Depression, Recurrent, Moderate 303.90 Alcohol Dependence Axis II: 317 Mild Mental Retardation Axis III: None	Verbal I.Q. 62-72 Performance I.Q 68-81 Full I.Q. 63-71
10	Axis I: : 296.3 Major Depression, Recurrent, Severe with Psychotic features 304.80 Polysubstance Dependence Axis II: V62.89 Borderline Intellectual Functioning Dependent Personality features Axis III: None	Verbal I.Q. 75-85 Performance I.Q 75-89 Full I.Q. 74-83
11	Axis I: : 296.3 Major Depression, Recurrent 304.80 Polysubstance Dependence Axis II: V62.89 Borderline Intellectual Functioning Axis III: None	Verbal I.Q. 68-78 Performance I.Q. 72-85 Full I.Q. 68-77
12	Axis I: 303.90 Alcohol Dependence 304.80 Polysubstance Dependence 309.24 Adjustment Disorder with Anxiety Axis II: V62.89 Borderline Intellectual Functioning Antisocial Personality Traits	Verbal I.Q. 63-73 Performance I.Q. 84-97 Full I.Q. 72-79

	Axis III: None	
13	Axis I: 304.80 Polysubstance Dependence Axis II: V62.89 Borderline Intellectual Functioning Axis III: Hepatitis A & B	Verbal I.Q. 76-86 Performance I.Q. 84-91 Full I.Q. 80-88
Case	**Diagnosis Suggested**	**Wechsler I.Q. Scores**
14	Data not available	
15	Axis I: 304.80 Polysubstance Dependence Axis II: 301.83 Borderline Personality Disorder Axis III: None	Verbal I.Q. 74-84 Performance I.Q. 84-97 Full I.Q. 78-86
16	Axis I: 309.9 Adjustment Disorder, Unspecified Axis II: V71.09 No diagnosis Axis III: None	Verbal I.Q. 92-102 Performance I.Q 90-104 Full I.Q. 93-101
17	Axis I: 309.81 Posttraumatic Stress Disorder 304.80 Polysubstance Dependence Axis II: V62.89 Borderline Intellectual Functioning Borderline Personality Disorder Axis III: HIV+	Verbal I.Q. 77-86 Performance I.Q 77-91 Full I.Q. 76-84
18	Axis I: 304.00 Opioid Dependence Axis II: V62.89 Borderline Intellectual Functioning Axis III: None	Verbal I.Q. 70-80 Performance I.Q. 79-93 Full I.Q. 73-82
19	Axis I: 309.81 Posttraumatic Stress Disorder 296.3 Major Depression, Recurrent 304.00 Opioid Dependence 304.20 Cocaine Dependence Axis II: V62.89 Borderline Intellectual Functioning Axis III: None	Verbal I.Q. 63-73 Performance I.Q.88-101 Full I.Q. 78-82
20	Axis I: 300.02 Generalized Anxiety Disorder Axis II: V62.89 Borderline Intellectual Functioning Avoidant Personality traits Axis III: None	Verbal I.Q. 67-77 Performance I.Q. 74-88 Full I.Q. 70-79
Case	**Diagnosis Suggested**	**Wechsler I.Q. Scores**
21	Axis I: 309.81 Posttraumatic Stress Disorder 296.3 Major Depression, Recurrent Axis II: 301.7 Antisocial Personality Disorder Axis III: Cocaine dependence at birth	Verbal I.Q. 68-78 Performance I.Q.93-107 Full I.Q. 80-88
22	Axis I: 296.33 Major Depression, Recurrent, Severe with Psychotic	Verbal I.Q. 80-89 Performance I.Q.91-105

	Features Axis II: V62.89 Borderline Intellectual Functioning Axis III: None	Full I.Q. 85-93
23	Axis I: Bipolar (by history) 296.3 Major Depression, Recurrent, Moderate 304.80 Polysubstance Dependence Axis II: Antisocial Personality traits Axis III: None	Verbal I.Q. 86-96 Performance I.Q. 84-97 Full I.Q. 86-94
24	Axis I: 309.24 Adjustment Disorder with Anxiety 305.20 Cannabis Abuse Axis II: Antisocial Personality traits Axis III: None	Verbal I.Q. 74-84 PerformanceI.Q100-113 Full I.Q. 86-94
25	Axis I: 304.00 Opioid Dependence Axis II:301.83 Borderline Personality Disorder Axis III: None	Verbal I.Q. 81-91 Performance I.Q. 75-89 Full I.Q. 79-87
26	Axis I: 309.81 Posttraumatic Stress Disorder 296.31 Major Depression, Recurrent, Mild 304.80 Polysubstance Dependence Axis II: 317 Mild Mental Retardation Axis III: None	Verbal I.Q. 62-72 Performance I.Q. 67-80 Full I.Q. 63-71
Case	**Diagnosis Suggested**	**Wechsler I.Q. Scores**
27	Axis I: 304.80 Polysubstance Dependence Axis II: V62.89 Borderline Intellectual Functioning Axis III: HIV+	Verbal I.Q. 78-87 Performance I.Q. 71-84 Full I.Q. 73-82
28	Axis I: : 296.33 Major Depression, Recurrent, Severe with Psychotic features 309.28 Adjustment Disorder with Mixed Anxiety and Depressed Mood Axis II: 301.82 Avoidant Personality Disorder V62.89 Borderline Intellectual Functioning Axis III: None	Verbal I.Q. 72-82 Performance I.Q. 81-95 Full I.Q. 75-83
29	Axis I: 305.00 Alcohol Abuse 300.4 Dysthymic Disorder Axis II: Antisocial and Borderline Personality traits Axis III: None	Verbal I.Q. 81-90 Performance I.Q.97-111 Full I.Q. 84-95
30	Axis I: 292. Bipolar Disorder Axis II 301.6 Dependent Personality Disorder Axis III: None	Verbal I.Q. 73-83 PerformanceI.Q. 92-106 Full I.Q. 82-90

31	Axis I: 309.81 Posttraumatic Stress Disorder 296.3 Major Depression, Recurrent 304.20 Cocaine Dependence Axis II: 317 Mild Mental Retardation Axis III: Epilepsy	Verbal I.Q. 59-69 Performance I.Q. 60-74 Full I.Q. 58-66
32	Axis I: 305.90 Polysubstance Dependence NOS 309.24 Adjustment Disorder with Anxiety Axis II: 317 Mild Mental Retardation 301.7 Antisocial Personality Disorder Axis III: None	Verbal I.Q. 61-71 Performance I.Q. 64-78 Full I.Q. 61-69