

The Referral Decision Scale

A Validation Study^{*,†}

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We examined the validity of the Referral Decision Scale (RDS), a test designed to screen for mental disorder in jail inmates, in a sample of 790 men admitted to an urban pretrial jail. Our results indicated that, in general, the RDS had excellent reliability and acceptable validity as a screening measure for serious mental disorder in jail settings, despite making a large number of false positive errors relative to both contemporaneous and subsequent assessments of mental disorder. Although the RDS is well suited for use in research, more information is needed before the test is used for clinical purposes. We discuss some potential problems with the use of the RDS in correctional systems.

Changes in civil commitment laws, the increased number of homeless people, and insufficient community mental health services have all had an impact on the prevalence of mentally ill individuals in pretrial jail facilities (see Barnes & Toews, 1983; Kiesler, 1980; Roesch & Golding, 1985; Steadman, McCarty, & Morrissey, 1989, for further discussion). In a review of a large number of studies examining the prevalence of mental disorder among jail detainees, Teplin (1991) reported

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rates ranging from about 5% to 12% for severe mental disorder and from 16% to about 67% for any mental illness. The substantial variation in prevalence rates is due to differences in sampling and diagnostic methods used in the studies. Nevertheless, there is little doubt that a substantial and perhaps increasing number of jail detainees experience serious mental health problems.

Inmates with mental disorder or mentally disordered offenders (MDOs), are a group of key concern to corrections administrators for two primary reasons. First, jails have a (limited) legal responsibility to provide health care, including mental health care, to inmates (e.g., Cohen & Dvoskin, 1992; Mayer, 1989; New York City Board of Correction, 1983). Failure to provide these services leaves facilities liable to civil actions. Second, MDOs require more time, energy, and resources to manage than do other offenders. For example, MDOs are more likely to breach institutional regulations and require segregation and seclusion time, and they are perceived by security and medical staff as being more difficult and stressful to deal with (Adams, 1986; Kropp, Cox, Roesch, & Eaves, 1989; Hart & Hemphill, 1989; Toch & Adams, 1986; Uhlig, 1976).

Appropriate treatment and/or management of MDOs is entirely dependent upon rapid and accurate assessment procedures (see Ogloff & Roesch, 1992; Steadman et al., 1989). Unfortunately, it is difficult, if not impossible, to conduct thorough mental health assessments of jail inmates. Jails, especially those in urban settings, are characterized by a high number of admissions, most of whom stay for only a brief period of time. Furthermore, collateral information concerning medical and psychosocial history is often incomplete or even totally absent. Thus, because most facilities lack the resources and information needed to be thorough, they can, at best, conduct only brief, cursory assessments ("screens") of mental disorder.

With one exception, there have been no studies of measures designed specifically to screen for mental disorder in a pretrial jail. In a study published in this journal several years ago, Teplin and Swartz (1989) presented data on such an instrument, called the Referral Decision Scale (RDS), which was developed as part of a larger study of the prevalence and treatment of mentally disordered jail detainees (e.g., Teplin, 1990). The RDS was designed to identify those individuals likely to have a serious mental illness that is potentially treatable who could then be referred for further evaluation and possible treatment. It comprises 18 questions taken from a structured diagnostic interview, the Diagnostic Interview Schedule, Version III (DIS; Robins, Helzer, Croughan, & Ratcliff, 1981). The 18 questions, which are subsequently collapsed into 15 items, were selected for their ability to predict DIS lifetime diagnoses of three major mental disorders: schizophrenia, bipolar disorder (mania), and major depressive disorder. Most of the questions inquire whether respondents have experienced specific symptoms (e.g., loss of appetite, flight of ideas, persecutory thoughts) at some point in their life; one question concerns previous hospitalizations for mental disorder. Symptoms are considered present only if they were unrelated to physical illness and substance use. One noteworthy feature of the test is that because the DIS was designed to be administered by lay interviewers, the RDS was intended for use by correctional officers rather than by mental health professionals.

Teplin and Swartz (1989) found that the RDS accurately predicted DIS major mental disorders in two different samples: one of jail admissions and one of sentenced inmates. In both samples, however, the RDS was not administered as a separate test; rather, it was "scored" from existing DIS protocols. It is not surprising that a subset of items from a scale predicts total scores on that scale with reasonable accuracy, especially when the items are selected for their predictive efficiency. Before the RDS is adopted for use by corrections systems, it is important to demonstrate that the RDS has acceptable interrater reliability and that it can predict *independent* assessments of mental disorder (e.g., Teplin & Swartz, 1989, p. 15). The present study is apparently the first to address this issue, using data collected as part of a larger study of MDOs in jail (Corrado, Roesch, Hart, & Cox, 1993; Roesch, in press; Roesch, Corrado, Hart, & Cox, 1993).

METHOD

Participants

Participants were adult males randomly selected from English-speaking admissions to the Vancouver Pretrial Service Centre—a facility for pretrial defendants whose catchment area includes a large, metropolitan area—for the 12-month period between August 1, 1989, and July 31, 1990. We selected consecutive admissions for the first 5 months, and every third admission for the last 7 months. Sampling was done without replacement, so that readmissions were ineligible for inclusion. The sample represented approximately 50% of men admitted to the jail during the study period. After being selected, potential participants were approached by the researchers (typically within 8 hours of admission), advised of the nature and purpose of the research, and asked to consent to a brief interview. Participation was voluntary and unpaid. All procedures were approved by the appropriate university and institutional ethics review boards and were in accordance with the ethical principles of the Canadian and American Psychological Associations.

A total of 881 men were approached to participate in the study; 20 were excluded because they were completely unable to speak English. Of the remaining 861 men, 78 (9.1%) refused to participate; 54 (6.3%) were released on bail or recognizance before they could be interviewed; 28 (3.3%) were unable to be interviewed because of medical problems (most frequently severe opiate withdrawal); and researchers were denied access to 17 (2.0%) because of their extreme security risk. For those men unwilling or unable to complete assessment interviews, researchers attempted to complete standardized rating scales (described below) on the basis of their health care files (which may contain nursing and/or psychological assessments) and institutional progress logs (which contain security staff's observations of the behavior of participants on the living unit). Enough information was available to complete rating scales for 106 of 177 men (59.9%) who were not interviewed: 59 of 78 refusals (75.6%); 6 of 54 released on bail or

recognizance (11.1%); 26 of 28 with medical problems (92.9%); and 15 of 17 security risks (88.2%).

To sum, we collected interview-based assessment data on 684 men and file-based data on a further 106 men, yielding a final sample size of 790; information was unavailable for the remaining 71 men initially selected for inclusion in the sample.

PROCEDURE

Overview

We used a two-stage assessment procedure. In the first stage, referred to below as the screening stage, a simple random sample of participants was assessed for the presence of symptoms of mental disorder. As noted above, most participants completed a semistructured interview designed to elicit information concerning current and lifetime psychosocial functioning. The first section of the interview gathered basic demographic data, including employment status and living conditions; the second section covered past mental health contacts, substance use history, and recent utilization of physical health care resources; and the third section consisted of a mental status exam and questions concerning the participant's self-perceived need and desire for mental health treatment. The RDS was embedded in the third section of the interview. The screening interviews took, on average, 20 to 30 minutes to complete. Those individuals who were not interviewed underwent a thorough file review. On the basis of interviews and/or file reviews, all participants were then rated on a number of standardized rating scales of psychiatric symptomatology, including the Brief Psychiatric Rating Scale (BPRS; Overall & Gorham, 1962) and the Diagnostic Profile (DP; Hart & Hemphill, 1989). Cutoff scores on the RDS, BRPS, and DP (described below) were used to classify participants as *cases* (i.e., probable MDOs) or *noncases* (i.e., not MDOs). The assessments were conducted by four Ph.D.-level graduate students in clinical psychology, all of whom had undergone formal training in the use of the rating scales; interrater reliability was assessed in a subsample of 50 participants using the interviewer-observer method. (All possible pairs of raters were represented in the reliability subsample.)

In the second stage, a stratified random sample of 108 cases and 84 noncases subsequently completed the DIS, Version III-A (Robins & Helzer, 1985). The DIS yields current and lifetime diagnoses of a number of mental disorders according to the criteria contained in the *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edition (DSM-III; American Psychiatric Association, 1980). We used screening data from the first stage to oversample cases in the second stage. This was an important feature of our design that allowed us to accurately determine the prevalence of low-base-rate disorders using a relatively small sample. The DIS was administered, on average, about one week after the initial screenings, by graduate students who had undergone extensive training and who were blind to participants' RDS results.

Details of the RDS, BPRS, DP, and DIS assessments are presented below.

RDS

We administered the RDS using the usual DIS probe flow chart and scored it according to the procedures recommended by Teplin and Swartz (1989): the five items comprising each scale (see Table 1) were summed to yield a total score, and total scores that met or exceeded the recommended cutoff for each scale were considered diagnostic of mental disorder. The cutoffs for the RDS scales were as follows: Schizophrenia, 2 or greater, Bipolar–Mania, 3 or greater; and Depression, 2 or greater. Participants whose score on any of the RDS scales exceeded these cutoffs were designated cases; all other participants were designated non-cases. (It is important to emphasize here that although the interviewers who administered the RDS were graduate students in clinical psychology, they followed the highly structured DIS procedures precisely and did not use clinical judgment to ignore DIS probe or decision-making rules.)

BPRS and DP

The BPRS is a rating scale designed to assess the severity of specific psychopathological symptoms. We used a 19-item version of the scale, with each item rated on a 7-point scale according to its severity at the time of assessment and over the preceding past month (1 = *not present*, 7 = *extremely severe*). Below, we analyze BPRS total scores (the sum of the individual items), which are a highly reliable index of global symptomatology (Overall & Gorham, 1962; Lukoff, Liberman, & Nuechterlein, 1986). The BPRS has been validated extensively in clinical populations (Lukoff et al., 1986) and also has been used in studies of mentally disordered offenders (e.g., Hart & Hemphill, 1989; Neighbors, 1987). Participants with a BPRS total score of 34 or greater were considered cases, following the recommendations of Hart and Hemphill (1989).

The DP is a rating scale designed to assess the severity of major psychopathological syndromes (i.e., symptom clusters) in jail settings. It has good test–retest and interrater reliabilities, as well as good concurrent validity with respect to the BPRS and predictive validity with respect to institutional behavior (Hart & Hemphill, 1989). We used a 7-item version of the DP, with each item rated on a 4-point scale (0 = *absent*, 3 = *severe*). As recommended by the authors, we collapsed the DP items to yield scores for three syndromes: *Psychosis*, defined as the presence of delusions, hallucinations, illogical speech, and bizarre behavior;

Table 1. Summary of Items in the RDS Scales

Schizophrenia	Bipolar	Major depression
1. Feels watched	1. Racing thoughts	1. Disturbed appetite
2. Feels followed	2. Grandiose delusions	2. Hypo/hyperactive
3. Feels poisoned	3. Reduced sleep	3. Hyposexual
4. Thought insertion	4. Hyperactive/hypersexual	4. Feelings of guilt
5. Others know thoughts	5. Prior hospitalization	5. Prior hospitalization

Note. For details, see Teplin and Swartz (1989, pp. 16–17).

Acting-out, defined as hostility, violence, manipulativeness, and noncompliance; and *Distressed*, defined as acute anxiety, depression, suicidality, and social withdrawal. Participants meeting the criteria for one or more DP syndromes were considered cases.

DIS

As noted above, the DIS is a structured diagnostic interview that was designed for use by lay interviewers in epidemiological research. We administered the DIS using the standard procedures; completed interviews were double-edited, keypunched, and verified, and scored by computer to ensure accuracy.¹ There is a large literature attesting to the reliability and validity of the DIS in community samples (see Robins & Regier, 1991), and it also has been used in several major studies of MDOs in prisons and jails (e.g., Correctional Service of Canada, 1990; Daniel, Robins, Reid, & Wilfley, 1988; Neighbors, 1987; Teplin, 1990).

Data Analyses

In our initial data analyses, we determined how many participants were able to complete the RDS, as well as the prevalence of cases according to each scale. We then compared these figures to the results obtained using the BPRS and DP. Next, we calculated the interrater reliability of the RDS. Finally, we looked at the RDS's concurrent validity (relative to the BPRS and DP) and predictive validity (relative to DIS major disorders).

RESULTS

Prevalence of Cases According to the RDS

Of the 684 men who were interviewed, 616 (90.1%) completed the RDS. The remaining 9.9% were unable to answer some or all questions owing to limited fluency in English, thought disorder, or intellectual deficit. None of the individual RDS questions was particularly problematic to administer, although extensive probing was required for items tapping paranoid delusions on the Schizophrenia scale (as many participants, especially drug dealers and gang members, had realistic concerns about being followed by the police or being harmed by others) and those tapping vegetative symptoms on the Depression and Bipolar–Mania scales (as many participants had experienced cocaine and opiate withdrawal in the past). No participant who agreed to be interviewed refused to answer the RDS questions. Taken together, these findings suggest that the RDS is suitable for the vast

¹ It is important to emphasize here that although the interviewers who administered the RDS were graduate students in clinical psychology, they followed the highly structured DIS procedures precisely and did not use clinical judgment to ignore DIS probe or decision-making rules.

Table 2. Psychometric Properties of the RDS Scales

	Schizophrenia	Bipolar	Major depression
Prevalence of Items (%)			
1	4.7	21.9	37.5
2	4.6	9.3	28.9
3	3.6	20.9	9.4
4	2.3	28.7	42.0
5	1.8	18.9	18.9
Scale scores			
Mean	0.17	1.00	1.37
SD	0.62	1.15	1.28
Alpha	0.72	0.51	0.54
Prevalence (%)	4.6	12.7	39.3

Note. $N = 615$. RDS, Referral Decision Scale (Teplin & Swartz, 1989); *SD*, standard deviation; alpha, internal consistency (Cronbach's alpha); Prevalence, percent of participants scoring above the cutoff for that scale.

majority of interviewable jail admissions. (Of course, the RDS could not be completed for admissions who were unwilling or unable to be interviewed.)

Table 2 presents the prevalence of items for each scale, as well as the mean, standard deviation, internal consistency, and prevalence of cases for each scale. Internal consistency was acceptable for all the scales, given their brevity. Note that 39.3% of participants scored above the cutoff on Depression, compared to only 12.7% on Bipolar–Mania and 4.6% on Schizophrenia. Overall, 40.7% of participants were designated cases by the RDS and would be referred for subsequent evaluation if the test results were used for decision-making purposes.² In some respects, this rate seems excessive, even for a screening test; the prevalence of serious mental disorder in correctional facilities is typically estimated to be between 10% and 25% (e.g., Hodgins & Cote, 1990; Steadman, Holohean, & Dvoskin, 1991; Teplin, 1990). It may be that the cutoff score for Depression is too liberal: When we increased it from ≥ 2 to ≥ 3 , the prevalence of cases on the scale decreased to 20.2%, and the prevalence of overall RDS cases decreased to a more reasonable 28.1%.³ (Below, we look at the concurrent and predictive validity of the RDS using these cutoffs.)

For the purposes of comparison, completed BPRS results were available for 676 of 684 interviewed participants (98.8%); completed DP results were available for all 684 interviewed participants, as well as 104 noninterviewed participants. It appears that the rating scales were somewhat easier or more flexible to administer than was the RDS, although the former may require considerable expertise. Focusing only on the 616 participants who completed the RDS, the prevalence of cases was 12.1% on the BPRS and 11.6% on the DP. These figures are significantly

² If we also referred for evaluation those people who were unwilling or unable to complete the RDS, the rate jumps to 46.6%—almost half of all admissions.

³ Or 35.2%, if we include those who did not complete the RDS.

lower than those obtained using the RDS, $t(615) = 13.82$ and 13.77 , respectively, both $p < .001$.

Interrater Reliability

In the subsample of 50 participants who were jointly interviewed, RDS data were obtained for 43 of 50 participants. As would be expected for a structured interview, agreement between raters for the presence versus absence of cases on one or more RDS scales was very high, even after correcting for chance ($\kappa = .95$). Nearly identical results ($\kappa = .76$) were obtained when we changed the cutoff on Depression to ≥ 3 .

Interrater agreement (κ) on the individual scales was also high: for Schizophrenia, 1.00; for Bipolar–Mania, 1.00; and for Depression, .91. However, in the subsample of 43 participants, only one scored above the cutoff on Schizophrenia and Bipolar–Mania; thus, the κ s for these scales may not be robust. There was no such problem on Depression, where 18 participants scored above the cutoff. The interrater reliability of total (i.e., dimensional) scores on the three scales was also high, with intraclass correlation coefficients of .92 for Schizophrenia, .93 for Bipolar–Mania, and .89 for Depression.

We should point out that the interviewer–observer method used in our study tends to overestimate agreement relative to other methods, such as independent reinterview. Regardless, the interrater reliability of the RDS appears to be excellent.

Concurrent Validity

As noted above, the RDS yielded a higher prevalence of cases than did the BPRS and DP. Chance-corrected agreement (κ) among the three measures was as follows: RDS and BPRS, .21; RDS and DP, .16; and BPRS and DP, .92. Clearly, the BPRS and DP agreed with each other much more than with the RDS. The Bayesian statistics most helpful for evaluating the predictive efficiency of the RDS as a screening test are positive predictive power (PPP) and negative predictive power (NPP). In the present case, PPP was the probability of cases on the BPRS or DP, given cases on the RDS; NPP was the probability of no cases on the BPRS or DP, given no cases on the RDS. For the BPRS, PPP was .23 and NPP was .95; for the DP, PPP was .20 and NPP was .94. These results indicate that the RDS consistently overpredicted cases relative to the other measures, but made few false negative errors.

Although this is the pattern of results that one might expect if the RDS is used to screen for mental disorder, the large number of false positive errors limits the test's utility—although preferable to false negatives in a screening test, false positives also come at a cost. We therefore investigated the impact of increasing the Depression cutoff to ≥ 3 . The overall chance-corrected agreement with the BPRS and DP improved slightly, to $\kappa = .30$ and $.19$, respectively, with little change in PPP or NPP.

Table 3. Predictive Validity of the RDS and Its Scales With Respect to DIS/DSM-III Lifetime Diagnoses of Major Mental Disorders

RDS Predictor/ DIS criterion	PPP	NPP	Kappa
Schizophrenia	.33 (.63)	.97 (.99)	.32
Bipolar	.13 (1.0)	.97 (.99)	.13
Major depression	.15 (.73)	.99 (1.0)	.17
Any major disorder	.32 (.79)	.96 (.99)	.32

Note. $N = 182$. RDS, Referral Decision Scale (Teplin & Swartz, 1989); DIS, Diagnostic Interview Schedule, Version III-A (Robins & Helzer, 1985); PPP, positive predictive power; NPP, negative predictive power. Corresponding figures from Teplin and Swartz (1989) are shown in parentheses.

Predictive Validity

Detailed analyses concerning the current and lifetime prevalence of DIS/DSM-III diagnoses in the current sample are presented and discussed elsewhere (Corrado et al., 1993). In brief, virtually every interviewee (93.6%) met the criteria for some disorder, with lifetime prevalence rates for individual disorders ranging as high as 77.6% (for alcohol abuse and dependence). To simplify the diagnostic data, we divided participants into two groups: those with a lifetime diagnosis of any major mental disorder (organic brain syndrome, schizophrenia, bipolar affective disorder, or major depressive disorder; prevalence = 15.6%) versus those with no mental disorder or a minor mental disorder only (e.g., dysthymic, anxiety, psychosexual, substance use, or antisocial personality disorders; prevalence = 84.4%).⁴ Because we used a stratified random sample for this part of the study, we weighted the raw DIS data prior to conducting the analyses described below.⁵

We eliminated from the analyses 10 participants who completed the DIS due to missing or incomplete RDS data, leaving a subsample of 182 participants. Next, we used caseness on each RDS scale to predict the corresponding DIS/DSM-III diagnosis, and RDS caseness to predict any major DIS/DSM-III diagnosis. Table 3 presents the predictive validity (PPP, NPP, and kappa) of the RDS in these participants. As was the case in the previous section, the RDS consistently over-predicted mental disorder relative to the DIS (by a factor of about 4), but made very few false negative errors. Increasing the cutoff on the Depression scale to ≥ 3 improved that scale's predictive efficiency (PPP = .19, NPP = .98, kappa = .22),

⁴ We follow the convention established by Teplin (1990) and others in calling the latter "minor" disorders. One could argue that correctional facilities are designed to house and manage people with, say, substance use or antisocial personality disorders. Also, although disorders such as simple phobias (e.g., small animal phobias) or dysthymia may be problematic in community residents, they are of little concern in an institutional context.

⁵ The statistical weighting procedures employed have a minimal impact on subsequent estimates of the predictive efficiency of the RDS.

without reducing the efficiency of overall RDS caseness (PPP = .35, NPP = .92, kappa = .31).

To allow a comparison between our findings and those of Teplin and Swartz (1989), Table 3 also presents the PPP and NPP values they reported (pp. 12–13). It is clear that although the NPP values for the RDS were similar in both studies, our PPP values were considerably lower.

The predictive efficiency of the RDS was very similar to that of the BPRS (PPP = .33, NPP = .89, kappa = .23) and the DP (PPP = .38, NPP = .88, kappa = .26). This finding is somewhat surprising, given that the BPRS and DP assess only *current* symptomatology, whereas the RDS assesses both past and present symptoms.

DISCUSSION

Our results indicated that, in general, the RDS had acceptable reliability and validity as a screening measure for serious mental disorder in jail settings. The RDS made a large number of false positive errors relative to both contemporaneous and subsequent assessments of mental disorder, but this problem was partially overcome by increasing the cutoff on the Depression scale from ≥ 2 to ≥ 3 . The predictive validity of the RDS in our study, where the RDS and DIS were administered independently, was considerably lower than that reported by Teplin and Swartz (1989). To the extent that the conditions under which we administered the RDS more closely approximated clinical reality than did those of Teplin and Swartz, our findings better reflect the RDS's "true" validity.

Our findings indicate that the RDS has sufficient reliability and validity to be used as a research instrument. In this context, the RDS could be used by non-clinical personnel to estimate the rates of major mental disorder among various types of offender groups, changes in prevalence rates over time, and so forth, in a rapid and cost-effective manner. Note that the RDS will be less useful when researchers are interested in estimating absolute, rather than relative, rates of serious mental disorders, because of the test's prediction errors. Also, the RDS will be less useful if researchers want to study a broader spectrum of symptoms and disorders, or current rather than lifetime mental disorders. Researchers interested in studying these latter issues and who have access to clinically trained personnel may prefer to use other tests, such as the BPRS or the Structured Clinical Interview for DSM-III-R (SCID; Spitzer, Williams, Gibbon, & First, 1992; Williams et al., 1992).

We caution readers that several aspects of our research need replication and extension before the RDS is used by corrections systems for routine screening of admissions. First, no one has systematically investigated the coverage of psychiatric symptomatology provided by the RDS. Recall that the RDS was designed to predict DIS/DSM-III diagnoses of only three "treatable" disorders. The use of DSM-III diagnoses as a criterion for mental disorder is both good and bad. On one hand, it ensures that mental disorder is explicitly defined and associated with

significant impairment in psychosocial functioning. On the other hand, several other DSM-III disorders that are also treatable and associated with psychosocial impairment (e.g., panic disorder, organic psychoses), and many others that cause impairment are also manageable in jail (e.g., personality disorders, mental retardation, dementia). In this respect, the coverage of the RDS appears rather limited. Furthermore, many symptoms and syndromes are valid targets of treatment or management, even if they do not meet the formal DIS/DSM-III criteria for disorders. A good example is suicidality. Inmates who are acutely suicidal require immediate management to reduce the likelihood of self-harmful behavior. Yet, suicidality is not a mental disorder *per se*. Research is needed to determine whether the treatment and management of mental health problems in jails is best conceptualized in terms of symptoms or disorders (and which symptoms or disorders).

Second, although we are confident that our results concerning the RDS will generalize well to other large, urban jails that house adult male offenders, it also remains to be seen whether the RDS is useful with young, rural, female, and/or sentenced offenders. This is a concern because if the selection ratio of the RDS or the base rates of DIS/DSM-III disorders fluctuates considerably across settings, then the validity of the RDS will also change. In correctional research, it is quite common that a scale derived in one group fails to generalize to another (e.g., Nuffield, 1989).

Third, at present there are no data concerning the use of the RDS by correctional officers (COs). There are good reasons to believe that the RDS, although reliable and valid when administered by highly trained and experienced research assistants, will be less useful when used by COs. COs may lack the clinical skills necessary to engage inmates in the assessment process. In our study, many inmates entered the jail in a state of considerable psychological distress, and interviewers spent a significant part of their contact time calming and building rapport with participants. Failure to engage inmates might lead to a "nay-saying" response bias on the RDS and an unacceptably high false negative error rate. Thorough training in interviewing and/or counseling skills is a possible solution, but could be very costly to implement. Another issue is that even COs with good interviewing skills may suffer from role conflicts when asked to screen for mental disorder. In the course of training COs to identify and manage MDOs, we have heard many COs voice discomfort at switching between their usual "security-oriented" role and a "service-delivery" role. This concern may be realistic. For example, once they have established a type of caring relationship with an offender, some COs find it more difficult to enforce rules and regulations or to contemplate the use of physical force against that offender. This may place the officers at some jeopardy in the event of a major security incident, such as a fight or riot. Also, "caring" about inmates—or at least, inmates perceived as dangerous and unpredictable—may be contrary to the subcultural norms of COs. COs who violate these norms may be rejected by their peers, a situation that can also lead to security problems. Once again, training is a possible solution, as is the creation of specialized positions for COs who deal with MDOs; but both of these are expensive options. Finally, even if COs can be trained in interviewing skills

and can avoid role conflicts, some inmates may refuse to cooperate with them because such cooperation may be perceived as a violation of subcultural norms by other inmates (especially in sentenced facilities). Put another way, COs may not be accepted as screeners by some inmates. Possible solutions to this problem include the creation of specialized CO positions, the use of principles from environmental psychology to encourage cooperation (e.g., private interviewing rooms, COs wearing street clothes rather than uniforms), or administration of the RDS by staff who are not COs, such as health care staff (nurses, social workers, etc.).⁶

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⁶ Note that these last two issues are not specific to the RDS; they might apply when any test is used by COs to screen for mental disorder.

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