Letters from readers are welcome. They will be published at the editor's discretion as space permits and will be subject to editing. They should not exceed 500 words with no more than three authors and five references and should include the writer's telephone and fax numbers and e-mail address. Letters related to material published in *Psychiatric Services*, which will be sent to the authors for possible reply, should be sent to John A. Talbott, M.D., Editor, *Psychiatric Services*, American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, MS#4 1906, Arlington, Virginia 22209-3901; fax, 703-907-1095; e-mail, psjournal@psych.org. Letters reporting the results of research should be submitted online for peer review (http://appi.manuscriptcentral.com).

Axis V Revisited

To the Editor: The Global Assessment of Functioning (GAF) represents the launch, but not the landing, of the assessment of psychiatric functioning. It debuted in 1980 as axis V in *DSM-III* (1) to measure an individual's functional capacity. In a brief report in the July issue of *Psychiatric Services,* Hay and colleagues (2) noted that "concern has been raised about the fact that [the GAF] combines psychological and social functioning measures on a single axis. In contrast, the SOFAS [Social and Occupational Functioning Assessment Scale] focuses on the individual's level of social and occupational functioning while excluding severity of symptoms."

The GAF does indeed collapse two major factors—symptoms and functioning—into a single axis. However, the SOFAS also merges two major areas of functioning—social functioning and occupational functioning—into a single axis. Like axis V, the single-score SOFAS does not allow the rater to specify which factor is being measured. Because the GAF and the SOFAS are either too global (GAF) or too narrow (SOFAS), they are limited in research and clinical settings.

In contrast, the Kennedy Axis V (K Axis) (3,4) breaks symptoms and functioning into their major clinical categories: psychological impairment, social skills, violence, and activities of daily living or occupational skills. It also features three subscales: substance abuse, medical impairment, and ancillary impairment. Because it captures the universe of symptoms and functioning in its seven categories, one can measure each category, rather than losing the information to a single global score. The K Axis can also generate a total score, roughly equivalent to the GAF.

Because the K Axis allows for the measurement of symptoms and functioning in each of the major clinical areas, inefficient and expensive alternatives, such as using a number of different instruments to measure these areas separately, are not necessary. The K Axis also categorizes clinical information in such a way that it can flow directly into the treatment plan (5). Follow-up ratings of the K Axis are easily used to measure progress in specific areas of functioning and symptoms.

More studies are needed to address the assessment of functioning and its relationship to symptoms, treatment decisions, disease management guidelines, and outcome measurement. The GAF represents an important maiden voyage for axis V. However, it may now be time to embrace other deliberative approaches, such as the Kennedy Axis V.

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Recognition and Treatment of Alcohol Use Disorders in U.S. Jails

To the Editor: Evidence for the high prevalence of substance use disorders in correctional settings is increasing (1–3). One report estimated that 80 percent of the 1.7 million adult Americans who are in correctional facilities have a history of involvement with drugs or alcohol (1). Alcohol intoxication is temporally related to several crimes, ranging from driving while intoxicated to assault and homicide, and it has been estimated that 40 percent of inmates in local jails and state prisons had consumed alcohol at the time of their offense (2,3).

Jails may provide unique opportunities for the assessment and treatment of alcohol use disorders. Recently arrested alcohol-dependent individuals may be intoxicated or in acute withdrawal. Newly incarcerated individuals may have various levels of problematic drinking. Alcohol screening instruments, such as the Alcohol Use Disorders Identification Test, can be useful in evaluating the severity of heavy drinking and in selecting appropriate interventions (4). Brief interventions can be effective in reducing alcohol consumption among nondependent heavy drinkers, particularly if coupled with a description of adverse consequences of drinking (4). The method consists of providing individual feedback on the negative effects of drinking, followed by advice to stop or reduce drinking.

Inmates whose incarceration is clearly related to drinking may be more receptive to feedback on cause-and-effect implications of their alcoholism.

The management of inmates with established alcohol use disorders generally consists of detoxification followed by relapse prevention. Health care workers in jails need to recognize signs of intoxication and understand the course of various withdrawal syndromes and clinical factors that influence the course and severity of withdrawal.

Rehabilitation in jail settings presents unique problems. Rapid turnover and large numbers of antisocial participants may make it difficult to conduct group sessions. Alcoholics Anonymous (AA) slogans such as "Staying sober one day at a time" may need to be reinterpreted or cognitively rehearsed for future use. On the other hand, incarceration may have a protective effect on cravings and compulsions to use substances because of the limited availability of alcohol and drugs. In the jail setting, individuals may more readily recognize their lack of control over substance use, because they are experiencing a lack of control in the most basic activities of daily living.

Although incarceration may provide a period of "forced abstinence," alcoholics may experience considerable difficulties in sustaining abstinence once they are released into the community. Inmates preparing for discharge may benefit from "relapse prevention packages" that include cognitive, behavioral, or pharmacological strategies. Cognitive-behavioral therapy focuses on the identification of factors that promote drinking and the development of skills for dealing with high-risk scenarios. Cognitive-behavioral therapy can be augmented by the use of pharmacological therapies. For example, the opioid antagonist naltrexone may be useful in alcohol-dependent individuals in conjunction with probation or early release programs. Mobilization of community resources before inmates are discharged is essential.

The need to identify and treat substance use disorders in correctional settings has been recognized by the Center for Substance Abuse and Treatment (CSAT). Five of the CSAT Treatment Improvement Protocol monographs (numbers 7, 12, 17, 21, and 30) provide guidelines for screening for and treating these disorders in correctional settings (5).

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