D. C. DEPARTMENT OF CORRECTIONS
DELBERT C. JACKSON, DIRECTOR

FINAL REPORT
PSYCHIATRIC TREATMENT UNIT
(71 - DF - 802)

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INTRODUCTION

The purpose of the Psychiatric Treatment Unit as stated in the grant application was to offer more complete mental health services to the disturbed inmate. It was believed that such a service would reduce the tensions present in an incarcerated population, and assist the inmate in his adjustment to society upon release.

Furthermore, the grant application stated that the project aim was to modify behavior through psychotherapy and to study and evaluate the effectiveness of the therapeutic technique employed by the Unit. On page seven of the grant proposal, it is stated:

> "....there will be an opportunity to find new ways of reaching an inmate population characterized by impulsive, violent, aggressive, hostile, emotionally immature and inadequate behavior. Experience, has shown, for example, that impulsive behavior can be modified through group therapy on an out-patient basis and one of the objectives of the mental health program will be to treat patients in a correctional setting, wherein controlled and innovative therapeutic techniques can be developed and applied. Careful, long-term study and evaluation will provide important data regarding the efficiency of such new methods and ultimately their becoming significant techniques in the armanentarium of the therapist."

The project was designed to provide psychiatric treatment on both an in-patient and out-patient basis. The operation of the Unit was to be carried out by a psychiatric organization under contract to the Department. Treatment modalities and the internal organization of the unit was to be determined by the contractor.

The project was approved for funding June 22, 1971. On December 18, 1972 the contract between the Department and the consultant, Psychiatric Institute of Lorton, was signed. The first stages of implementation began in January, 1973 when the first staff member, a registered nurse, was hired. Following this, the Chief Psychiatrist position was filled along with other supportive staff positions: nursing assistants and group leaders - therapists.

The delay in implementation resulted from difficulties in deciding on a qualified contractor to deliver the psychiatric services, a lengthy negotiating period with the contractor, and problems in constructing or renovating facility for in-patient care. The most difficult of the above was the latter. The proposal stated that the Department would provide facilities and space for office staff and treatment services, and a residential dormatory for in-patient psychiatric care. Matching funds of $16,000 along with $2,000 federal funds were allocated to accomplish the construction and renovation needs. It was

found that $18,000 was not adequate to construct a separate facility for residential treatment. At the same time, there was some concern in the Department that a highly secure facility (the in-patient component) within a medium secure area would present a management problem. This and other questions concerning the appropriateness of providing psychiatric care in a correctional institution had to be resolved before any capital improvements began.

The final arrangement for an in-patient component was to convert six rooms and one 6-bed ward in the complex hospital to rooms similar to those in the John Howard Pavilion at St. Elizabeths Hospital. The out-patient unit and staff offices were housed in a partitioned trailer located approximately ten yards from the hospital.

Following the completion of the in-patient and out-patient components, and the hiring of staff, the unit became fully operational in October, 1973. At this time, patient referral and diagnosis was underway, individual and group psychotherapy was being conducted, and medication dispensed as prescribed by the Unit's Chief Psychiatrist.

The project expended its funds on April 30, 1974 and thus terminated operation. Requests to continue the program were made by the Project Director, a Clinical Social Worker with PSC; by the Chief Administrator of the Central Facility,

and by the Superintendent's Office to Program Development and Coordination. Efforts were made by the Office of Planning and Program Analysis and by the Grants Coordinator to find additional grant monies or appropriated funds with which to continue the operation of the unit. These efforts were not successful and the Project terminated its services.

The project was credited by those staff members requesting its continuation with reducing tensions at the Central Facility by providing immediate and continuous, seven (7) days a week, psychiatric care for the disturbed inmate.

In addition to the support of the staff, the inmate body also had a high regard for the program. A petition signed by approximately 500 inmates requesting the units continuation indicates inmates interest in program. (See attachment A).

DESCRIPTION OF OPERATIONS

The unit was fully operational for seven months, during which time approximately 85 inmates received psychiatric services. Monthly reports reflect that a range of 5 to 11 inmates a month received in-patient care. The remaining inmates were receiving treatment as out-patients. Both in-patients and out-patients received full diagnostic procedures and treatment services, i.e. individual psychotherapy, group psychotherapy, and drug therapy. There was a tendency for the in-patients to receive more individual therapy than the out-patients, who primarily participated in the groups. Out-patient groups of 10 to 12 members each were conducted four times a day, five days a week. Because of the number of in-patients, it was only necessary to have one group a day, five days a week. The in-patient group was conducted in the hospital day room. Group psychotherapy was the predominate treatment modality, with individual psychotherapy and drug therapy playing supportive roles or used for crisis intervention.

The groups were free interaction groups employing the techniques of W. R. Bion, an English psychiatrist, who believes behavior can be best observed and changed by focusing on the dynamics of group interaction rather than by focusing on the individual and his past. Participation in groups was voluntary; failure to attend group therapy was not met with any disciplinary action. It is important to note that 84% of the participants in group therapy remained with their

group until the program terminated.

Approximately 90% of the hospitalized patients received some form of medication, although there was a trend to reduce medication as the patient began participation in psychotherapy, either group or individual. Approximately 63% of the out-pateints received medication at some point while in the program. This figure should not be construed to mean that 63% of the out-patients were on continuous drug therapy.

Procedures existed to admit a patient to the in-patient component on the weekend with diagnostic procedures to follow the next Monday. This was done in emergency or crisis situations where the inmate imposed a threat to himself or others.

Evaluation

The method of evaluation as prescribed in the grant application was to compare the treated group with a "normal" group within the institution and following their release.

Within the institution the treated group would be compared with the normal group in terms of participation in inmate activities, training programs, incidence of disciplinary infractions, and incidence/recurrence of behaviors diagnosed as dysfunctional. Following their release, the two groups were to be compared on degrees of reinvolvement in the Criminal Justice System.

The use this proposed evaluation makes of the control group is not valid; it would not be fair in this instance to compare these controls with the experimentals. The unit did not purport to "cure" the patient-inmate of all his psychological ills thus making him comparable with the inmate diagnosed as not disturbed. The unit's goals were more realistic in that it was incremental change in the disturbed inmate's overt behavior that was desired.

Therefore this evaluation will not employ a comparative analysis, but will narratively state the unit's performance in accomplishing its objectives.

The objectives are of two types: (1) those that are concerned with system improvements; and, (2) those that are concerned with treatment effectiveness. The latter will be difficult in that indicators for the measurement of be-

havioral change are not firmly established or agreed upon.

> "All too frequently, behavioral outcome measures are not directly available. How, for example, do you observe, record, and quantify a decrease in neurotic behavior? The measurement problems are staggering. In many such cases the evaluator turns to expert judgements. Experts can rate the patient on a scale from "very much improved? to "very much worse."[1]

> "Perhaps the gravest impediment to the use of social indicators for evaluation is that it expects so much. A program must be pervasive enough to reach a significant part of the relevant population and effective enough to bring about change sufficient to shift people from one category to another. A little bit of change is not enough; people have to move from "hospitalized" to "not hospitalized," from "below grade level" to "on grade level," from "unemployed" to "employed." This is asking for program success of giant magnitude. Programs generally reach relatively small numbers of participants and make small improvements. Even the poverty program, considered to be a massive undetaking at the time, was able to mobilize

[1] Weiss, C.H. Evaluation Research, Englewood Cliffs, N.J.: Prentice Hall, 1972, p.59

resources that were scanty in comparison with the size of the problems. It is little wonder that indicators resist dramatic change."[2]

Because of the difficulty in determining reliable measures for behavior change, treatment effectiveness was based on observed change in the inmate's overt behavior by the therapists and the unit's Project Director. To reduce the bias, it is recommended, for future programs of this type, that experts in the field who are not involved with the project conduct entrance and exit interviews which can be used as a basis for estimating behavioral change. It should be kept in mind that even though some degree of bias may exist in this approach, it is most likely not sufficient to invalidate the observation. Judgements are commonly used as indicators of outcome in the area of behavioral change. Also it is common for participants' opinions about the program to be used as an outcome measure. This report, in responding to treatment effectiveness, will employ both professional judgement and participant opinion for evaluative indicators.

Program Objectives

The objectives of the unit as set forth on Page 6 of the grant proposal to LEAA were:

[2]Ibid. P. 40

1. To develop more systematic methods of identifying and evaluating the emotionally disturbed offender committed to the Correctional Complex.

2. To provide needed psychiatric services so as to improve modes of functioning and enable inmates to be capable of benefiting from the total treatment and training program.

3. To strengthen psychiatric and psychological services through the establishment of a central facility for the diagnosis and treatment of the disturbed inmate.

4. To provide the necessary treatment climate and resources for the care and psychotherapy of inmates referred by the Reception-Diagnostic Center.

5. To study the effectiveness of an internal residential treatment center and to determine the performance, administrative and service requriements for future expansion.

The following reports on the unit's performance in achieving the proposed objectives.

Objective 1. - Development of more systematic methods of identifying and evaluating the emotionally disturbed.

The P.T.U. established various methods of identifing and referring patients to the unit. Prior to the establishing of the unit, the psychological diagnostic and treatment system

was as follows:

> Inmates arriving at the complex received an orientation program at which they were administered tests. The test measured intellectual abilities, educational level, and personality type. Also, a personal recources survey was conducted.
>
> Those inmates whose test scores indicated a disturbed personality were identified as needing psychological treatment. Their test material, the results of an interview with a Classification and Parole Officer, and their institutional file were sent onto Psychological Services for further study. If the inmate was literate, he was administered the MMPI and CPI which indicates personality and character traits. These tests along with the interviews were used to determine who was in need of psychological services, and the type of treatment to be given.

The P.T.U. augmented this system by adding a psychiatric component to further diagnose and treat the more severely mentally ill on a regular basis, and to provide immediate

in-patient psychiatric care for the acute psychotic. Prior to the unit's existence if an inmate had a psychotic episode on Friday evening after the Psychological Service Center had closed he would not receive any treatment until Monday. If hospital beds were available, he might be placed in the hospital over the weekend. But even then there were problems. Since the hospital's primary function was to provide beds and medical treatment for the physically ill, it was not equipped to serve psychiatric patients. Nor were the normal patients too eager to share accommodations with a diagnosed schizophrenic. Only if the hospital could free an entire room would the mentally ill person be admitted to the hospital. This lack of facilities resulted in placing the acutely disturbed in either a control cell or an individual cell in Maximum Security. The P.T.U. remedied this problem by converting five rooms and one six (6) bed ward into secured and stripped units.

Further improvement of the identification and diagnostic system was the expansion of the referral process. Correctional Officers, Classification and Parole Officers, Program Administrators, and in certain cases, inmates were utilized in detecting bizarre or withdrawn behavior. They then referred the inmate

to the Chief Medical Officer who physically examined the inmate to detect any health problem which might be affecting his behavior. The inmate's medical history and examination results are then forwarded to the Chief Psychiatrist of the P.T.U. He in turn diagnoses the inmate's behavior and recommends treatment. Self-referrals are also diagnosed if the Chief Psychiatrist deems it necessary.

This referral system assists in early detection of diversified disturbed behavior by accepting referrals for psychiatric evaluation from a full range of people having daily contacts with the inmates. A referral does not mean a committment but only a closer look at the inmate's behavior. It may be decided that the referral was ill-founded, and that no further involvement with the unit is necessary, in which case the inmate is evaluated and then returned to the general population. However, potential crisis situations frequently are identified in the initial stages.

Objective 2. Providing needed psychiatric services so as to improve modes of functioning and enable inmates more capable of benefiting from training programs.

Records were not kept on the patients participation in training programs. However, even if they had been, they

would not necessarily indicate the degree to which patient is more capable, since it is possible to be more capable and yet perform at a level below capability.

To respond to this objective, the elements which indicate increased capability must be identified. I spoke with the Project Director and the Group Leaders concerning their judgement of change in inmates' behavior, and whether this change enabled inmates more capable in benefiting from other programs. The unit staff stated that they observed many changes, but the ones which were observed in the majority were the following:

1. Increased responsibility for self
2. Increased ability to recognize one's own symtoms
3. Increased self-esteem
4. Descreased incidence of bizarre behavior

It was determined that inmates progresssed in these areas by applying the following criteria:

1. Responsibility for self: The ciriteria for determining increased responsibility for self was less incidence of "scapegoating" e.g., holding other people, institutions and society responsible for this behavior or failure. When less attempts are made to "blame" others for his situation, the inmate is beginning to charge himself with the responsibility of his behavior and his failures and success.

2. Ability to recognize symptoms: It was observed that as the inmate progressed through therapy, he became increasingly aware of the connection between his emotional conflicts and his symptoms. In understanding this relationship, the symptoms are less frightning and can become less intense. The inmate can be come more comfortable with his symptoms which before seemed totally outside of himself, while still controlling him. This awareness is often the first step toward deminishing the symptoms.

3. Increased self-esteem: Although many of the patients take on roles of bravado and importance, this is in most instances a defense for their deeper feelings of inadequacy. Therefore, therapeutic techniques are used to penetrate the defense of false grandeur and to begin the real work of strenghtening the weak ego. The therapists were also to judge the degree to which the ego had been strengthened as seen by the inmate's ability to cope with criticism, and by his resistance to manipulation. Inmates who were observed at the program's termination were regarded as better able to deal with criticism without responding defensively, and better able to identify attempts of others to manipulate him.

4. Reduced incidence of bizarre behavior: Bizarre behavior, which is very often the "acting out" of strong emotions, was defined as highly inappropriate behavior or behavior disproportionate in intensity to the apparent stimulus. The PI staff observed that bizarre behavior was much more prevalent at the onset of the unit's operation then towards the end.

Incremental progress in the above four categories would contribute to a person's capability to perform in other institutional programs.

Objective 3. Strengthening psychiatric and psychological services through the establishment of a central facility for the diagnoses and treatment of the disturbed inmate.

The intention of the grant was to construct a separate, secure facility to be used as the in-patient unit. However, this facility was never constructed. There are several reasons for this: First, the $16,000 local share money and $2,000 federal share money allocated for construction was not sufficient to build the type of facility needed. Plans were then drawn up to convert one of the dormitories near the hospital into an in-patient unit, but insufficient funds precluded even this being accomplished. What did result was the conversion of 5 hospital rooms and one six bed ward into secured stripped rooms similar to those at the John Howard Pavilion. Because there was not enough room in the hospital for both in-patients and out-patients, a trailer was located approximately ten yards from the hospital

to be used for out-patients and staff offices. The trailer was partitioned into three offices, an area to dispense medication and a central room for conducting group therapy.

Although the method set forth in the objective, "through establishing a central facility" was not followed, the end, "to strengthen psychiatric and psychological services," was accomplished. The services offered through the unit reduced the burden on Psychological Services by taking responsibility for the acutely and severely mentally ill.

The main weakness in the Complex's mental health services was in providing immediate and daily care for the acute mentally disturbed. With the operation of the P.T.U., an inmate undergoing an acute psychotic break would be placed in the hospital for observation, be diagnosed and then be administered treatment with the option to continue treatment as an out-patient after the attack had subsided. The unit strengthened the psychological services available for the emotionally and mentally disturbed by offering an alternative to PSC, and by providing psychiatric services on a daily basis, 24 hours a day. Psychotherapy was offered five days a week, and inmates experiencing a crisis could be admitted for hospital care at any time.

Objective 4. Provide necessary treatment climate and resources for the care and psychotherapy of referred inmates.

Climate: This objective overlaps with objective three,

in that it involves establishing a central and separate facility for psychiatric care. The objective was functionally met by the conversion of hospital rooms for the physically ill to rooms suitable for psychiatric cases; and the use of the partitioned trailer for out-patient treatment.

Resources:

Resources, i.e., personnel, drugs, general supplies and materials were adequately supplied:

Personnel.

The staff, paid from the federal funds, were provided by the Psychiatric Institute of Lorton. Four of the staff members had received their training in Group Therapy Dynamics from the Psychiatric Institute Foundation. The staff consisted of:

NAME	POSITION	DATE	SALARY
George Krizak, M.D.	Psychiatrist	4/73 - 4/74	$36,000
Eleanor Heath	Registered Nurse	1/73 - 4/74	12,600
Marilyn Cataliotti	Secretary	7/73 - 1/74	8,500
Joan Hilliard	L.P.N.	8/73 - 4/74	8,500

Name	Position	Dates	Salary
Roosevelt Rayford	Group Leader	10/73 - 4/74	$12,580
Tommy Smith	Nursing Asst.	11/73 - 4/74	7,780
Dennis Gasper	L.P.N.	10/73 - 12/73	8,500
Ruth Ward	Registered Nurse	10/73 - 4/74	8,500

The above were full time staff located at the P.T.U. at Lorton. The following are Psychiatric Institute staff who lent adminiatrative support from the central Psychiatric Institute Office:

Allen	@ $35/hour
J.R. Stalick	@ $35/hour
Allen Weissberg	@ $35/hour

From the local share, the Department provided the following support:

Name	Position	Time	Cost
Howard Calkins	Project Director Clinical Social Worker, GS-12	50%	$10,009
	Correctional Officer, GS-7	50%	4,984
	Correctional Officer, GS-7	50%	4,984
	Correctional Officer, GS-9	50%	6,083
	Med. Tech. Asst. GS-7	50%	4,984
Pat Bledsoe	Project Monitor GS-11	10%	1,467
		Total Cost	$32,511
		10% Overhead	3,251
		Total Local Person.	$35,762

Drugs.

Many patients who were on medication prior to their involvement in the unit, were able to have their dosage reduced following their entering the unit's program. It is believed that supportive daily psychotherapy relieved some of the psychological stress and therefore reduced the patient's need for mood altering or tranquilizing drugs.

All inmates placed on medication received psychotherapy, either in individual or group session. This allowed for the continuous observation of the patient while he was on drugs to judge the dosage, the drug effect, and whether additional treatment was needed.

Out-patient medication was dispensed from the trailer three times a day by a Registered Nurse who observed the taking of the drugs. In-patients were administered drugs three to four times within a 24 hour period, depending on need, by a Licensed Practical Nurse stationed at the hospital.

Supplies and Materials.

Supplies and materials were requisitioned from the Department as needed.

Objective 5. Study the effectiveness of an internal residential treatment center and to determine the performance, administrative and service requirements for future expansion.

This report is intended to satisfy the fifth objective.

SUMMARY

The mentally disturbed offender within a correctional institution presents many problems, none of which are easily resolved. The Psychiatric Treatment Unit was designed to relieve many of these problems by providing immediate and continuous psychiatric care on both an in-patient and out-patient basis.

Although the unit experienced some difficulties which is to be expected of a pilot project, on the whole the complete range of psychiatric services provided by the unit appeared to benefit the mental health of the participants and subsequently may have assisted in reducing tension in the general population.

The objectives of the unit were accomplished in part. Those objectives concerned with system improvements, i.e., improving diagnostic procedures, strengthening psychiatric services, improving treatment climate were clearly satisfied. Treatment effectiveness was more difficult to determine. Indicators for measuring behavior change are not firmly established. Therefore treatment effectiveness was determined through professional judgement. The Project Director and the Unit's therapists agreed that there was observable change in the areas of: (1) increased responsibility for self; (2) increased ability to recognize one's symptoms; (3) increased self-esteem; and, (4) decreased incidence of bizarre behavior.

The Unit terminated its services on April 30, 1974 when the project's funds were expended.

Efforts to continue the project were made by the Chief Administrator of the Central Facility, the Project Director and the Superintendent of Program Coordination and Development. Approximately 500 inmates signed a petition stating their interest and requesting that the program be continued. However, because of the unavailability of funds, the project was not continued.

ATTACHMENT A

March 20, 197[illegible]

MEMORANDUM TO: Mr. Delbert C. Jackson
Director

THRU: Mr. Charles M. Rodgers
Associate Director

THRU: Mr. Marion D. Strickland
Acting Superintendent

FROM: Resident Population
Correctional Complex

We, the Residents of Lorton are concerned about the continuation of a meaningful psychiatric program which has been operated by the Psychiatric Institute, for the D.C., Dept. of Corrections on a contract basis thru a grant from L.E.A.A.. April 30, 1974 is the termination date of this program.

In as much as this program has provided the residents with another positive channel to rehabilitation which has allowed us to gain some self insight and self awareness. We feel that therapy sessions operated in the trailer has allowed us to be more open to deal with our problems with more truthfullness and sinceruty all on a voluntary basis, as opposed to the administrative therapy operated by P.S.C. We feel that we are treated or looked upon as adults, who have capabilities and potentialities which we are becoming more aware of the longer we are involved in therapy.

We are concerned about the inmates now enrolled in the P.I. therapy sessions who have benefitied greatly. On April 30, 1974, what will happen........Where do we go for continued group sessions?........

This should be the concern of the Administration and the community at large, therefore, we are appealing to you, for a extension with expansion of this program with modifications..... better facilities to meet the needs and demands of residents needing this type of service.

Respectfully submitted,

Resident Population,

NAME	NUMBER	WANT THERAPY? Yes	No
[illegible]	153-350	yes	
Edward Jackson	88250	yes	yes
Thomas Brooks	155-459	yes	yes
Rufus E.X. Adams	143595	yes	yes
[illegible]	153-[illegible]	[illegible]	
Jerry Matthews	153185	yes	
Joseph W Palmer	143913	yes	yes
[illegible]	153-[illegible]	yes	
[illegible]	170-367		
[illegible]			

END