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U. S. DEPARTMENT OF JUSTICE
LAW ENFORCEMENT ASSISTANCE ADMINISTRATION

DISCRETIONARY GRANT
PROGRESS REPORT

GRANTEE	LEAA GRANT NO.	DATE OF REPORT	REPORT NO.
N. H. Governor's Commission on Crime and Delinquency, 80 So. Main St., Concord, NH	#73-ED-01-0028	May 31, 1974	

IMPLEMENTING SUBGRANTEE
Division of Mental Health
105 Pleasant Street
Concord, New Hampshire

TYPE OF REPORT
☐ REGULAR QUARTERLY ☐ SPECIAL REQUEST
☒ FINAL REPORT

SHORT TITLE OF PROJECT: Mental Health Approaches to Problem Offenders

GRANT AMOUNT: $214,048.00

REPORT IS SUBMITTED FOR THE PERIOD 11/1/73 THROUGH 10/31/74

SIGNATURE OF PROJECT DIRECTOR: William J. Byrne

TYPED NAME & TITLE OF PROJECT DIRECTOR: William J. Byrne, Director

COMMENCE REPORT HERE *(Add continuation pages as required.)*

See Attached

7001

RECEIVED BY GRANTEE STATE PLANNING AGENCY *(Official)* | DATE

LEAA FORM 4587/1(REV. 1-73) REPLACES LEAA-OLEP-159, WHICH IS OBSOLETE. DOJ—1973—05

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Summary

The first "grant year" of the project which ran seventeen months, from June 1, 1972 through October 31, 1973, was one of evolution. As with most new programs, the grant was written in general terms to address a specific problem, in this case, that of the disturbed inmate. The goals and objectives of the grant were stated variously as providing "psychiatric, psychological, social and biological treatment" to inmates who were criminally insane or severely disruptive to the correctional process in the prison, State Hospital, and ten county houses of correction. It was also indicated that the mental health team would "... work with correctional and other mental health and social agencies, legislative personnel to develop intermediate and long range plans for dealing with this population of inmates, for study, control, prevention of criminal and devient behavior, research on causes, epidemiologic studies, treatment, education of correctional officers, police judiciary and legislative systems". A longer range goal was to determine the necessity for a facility to house this population and make recommendations as to its location, staff and programs.

As the program evolved there was need for further definition of the project goals. With the consent of the Advisory Group, emphasis was placed on the prison and to a lesser degree, the hospital, with very little service being available to the ten county houses of correction.

The research aspect of the project was after some time settled upon the use of trained interviewers to collect data on inmates using among other things, a structured scorable psychiatric interview. Emphasis was placed on prediction of disturbed and disruptive behavior rather than the effect of prison on measures of psychiatric stability.

In the spring of 1973, after the program had been operating for about nine months, a staff person, Loren Roth, M.D., from the National Institute of Mental Health, Center for Studies of Suicide Prevention, came up from Washington or three occasions and did an informal evaluation of the program and offered some suggestions as to how our operation could be improved. A few weeks later, and independently from the above, the Governor's Commission on Crime and Delinquency requested technical assistance from Law Enforcement Assistance Administration and in response, Mr. James Maybury and Kenneth Babcock, M.D., spent two days with the project.

The subsequent reports from these two evaluations both in their verbal and written forms had several similarities. Both commented on their understanding of why certain changes in direction from the original grant had been made. Both were interested, though from different points of view, in mental health diagnostic screening of all inmates, not just a certain population of inmates. Further, both the L.E.A.A. and N.I.M.H. representatives stated in their reports that they did not feel the building of a separate, special facility for these troublesome inmates would solve the problems.

During the grant year, every effort was made to evaluate each new inmate arriving at the prison as well as all inmates suggested by the administration or who otherwise came to our attention. The members of the team also provided 24 hour service for crisis intervention and daily were available for short term therapy sessions at the request of inmates themselves, other treatment programs, or the custodial force. The psychiatrists on the program sent psychiatric reports to the Parole Department and the Work Release Board upon request. During the course of the year, the project had direct contact with no less than 470 inmates. The team carried an average of 65 to 75 inmates per month in individual therapy. Extensive research and planning went into the development of group therapy sessions and the project demonstrated the feasibility of this type of treatment.

One of the more critical areas in establishing a complete treatment for inmates was the physical exams. Because of the increase in the prison population, and the limited time of the prison physician, the physical examinations backlogged. Early in the grant year, the project secured permission from the Advisory Council to try to fill this gap. Over 200 inmates had received physical exams through the program and follow-up treatment when indicated. We also developed the capability of testing for organic brain damage.

Another service which we provided to the existing medical department at the prison was the development and implementation of a new medical records system.

The same psychiatric services and crisis intervention were also provided to the maximum security unit at the State Hospital and were continued in full force until the advent of the new Forensic Unit.

The project directly assisted in the training of 25 prison guards, 98 hospital aides, and approximately 250 police officers. The basic skills which we tried to impart were in the field of recognizing and handling mental disturbance.

The research component of the program ran into some initial difficulties but did find the area of need and generated essential data

upon which to build. With its continuation, we are developing a reliable predictive tool that will be of great assistance in the determination of treatment approaches.

Perhaps the greatest achievement of the program was its ability to survive and demonstrate the need and the advantage of a mental health team in the prison setting.

FINAL REPORT

The first "grant year" of the project which ran seventeen months, from June 1, 1972 through October 31, 1973, was one of evolution. As with most new programs, the grant was written in general terms to address a specific problem, in this case, that of the disturbed inmate. The goals and objectives of the grant were stated variously as providing "psychiatric, psychological, social and biological treatment" to inmates who were criminally insane or severely disruptive to the correctional process in the Prison, State Hospital, and ten county houses of correction. It was also indicated that the mental health team would "... work with correctional and other mental health and social agencies, legislative personnel to develop intermediate and long range plans for dealing with this population of inmates, for study, control, prevention of criminal and devient behavior, research on causes, epidemiologic studies, treatment, education of correctional officers, police judiciary and legislative systems". A longer range goal was to determine the necessity for a facility to house this population and make recommendations as to its location, staff, and programs.

As the program evolved and staff were hired, several things became evident. There was little need for the staff positions of recreational and occupational therapists and there was a great need for a business manager or administrative assistant.

There was need for further definition of the project goals. With the consent of the Advisory Group, emphasis was placed on the prison and to a lesser degree, the hospital, with very little service being available to the ten county houses of correction. This decision was made in view of the difficulty of hiring full-time professional staff to fill slots which had no guarantee of existence beyond one year.

In view of the sociologically oriented research called for in the grant, it was decided to trade one of the three psychologist positions for a sociologist. The research aspect of the project was after some time settled upon the use of trained interviewers to collect data on inmates using among other things, a structured scorable psychiatric interview. However, the goal of this data collection was not clearly defined until near the end of the grant year, when the emphasis was placed on prediction of disturbed and disruptive behavior rather than the effect of prison on measures of psychiatric stability. At one point, in the project, there was an effort to compare the cost time effectiveness of screening of all new inmates, as done by social workers, psychiatrists and trained interviewers. Although only informally evaluated, the trained interviewer concept won out.

One of the difficulties in operating a short term grant was that of recruiting and maintaining staff on board once hired. This problem manifested itself differently at different levels. There was great difficulty in hiring a full-time psychiatrist although the program director position was able to be filled by Dr. Payson, who, through a nine month contract, was able to be loaned to us by Dartmouth. One of the three psychologists was hired. Three different people filled the chief clinical social worker slot although none ever worked full time. There was less difficulty in hiring and maintaining people at intermediate levels such as psychiatric social workers and psychiatric nurses.

Competent secretarial support was also difficult to recruit mostly because of the temporary nature of the job and the less than competitive pay and fringe benefit package offered by the state. In the 17 month grant-year there were seven different secretaries who at various times filled these three

positions, and three administrative assistants in the project coordinator slot.

The listing below compares the proposed list of personnel with the best typification of how the project was actually staffed.

PROPOSED	ACTUAL
(all full time)	(full time unless indicated)
Psychiatrist	Psychiatrist
Psychiatrist	Consultant Psychiatrist - 2 days per week
Psychologist	Psychologist
Psychologist	Consultant Sociologist - 2 days per week
Psychologist	
Chief Clinical Social Worker	Chief Clinical Social Worker - 4 days per week
Psychiatric Social Worker	Coordinator of Treatment Activities
Psychiatric Social Worker	Senior Psychiatric Social Worker
Psychiatric Social Worker	Psychiatric Social Worker - 4 days per week
Psychiatric Nurse	Psychiatric Nurse
Psychiatric Nurse	Psychiatric Nurse
Psychiatric Nurse	Psychiatric Nurse
Occupational Therapist	Administrative Assistant (Project Coordinator)
Recreational Therapist	
Medical Stenographer	Medical Stenographer
Clerk Stenographer	Clerk Stenographer
Clerk Stenographer	Clerk Stenographer - 3 days per week
	3 Interviewers - 3 days a week each
	2 Medical Internists (average 1 day a week between the two)

It must be kept in mind that the above enumeration of actual positions represents only a rough mode of project staffing. For example, throughout most of the project there was a full-time psychiatrist; i.e., Dr. Henry Payson from July, 1972 through March 15, 1973 and Dr. Liam Daly for a six week period during the summer of 1973, but during the rest of the grant year there was only consultant coverage.

It is somewhat surprising that in spite of the staff turnover and occasional unfilled positions, the project was able to maintain enough continuity to go through a steady process of evolution and program development.

In the spring of 1973, after the program had been operating for about nine months, a staff person, Loren Roth, M.D., from the National Institute of Mental Health, Center for Studies of Suicide Prevention, came up from Washington on three occasions and did an informal evaluation of the program and offered some suggestions as to how our operation could be improved. A few weeks later, and independently from the above, the Governor's Commission on Crime and Delinquency requested technical assistance from Law Enforcement Assistance Administration and in response, Mr. James Maybury and Kenneth Babcock, M.D., spent two days with the project.

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Clinical Service at the State Prison

During the initial stages of the grant every effort was made to have each new inmate evaluated by one of the team's psychiatrists. The social workers culled the records and supplied detailed personal histories which, combined with the psychiatrists interview, produced a rather accurate evaluation.

With the loss of a full-time psychiatrist, however, the system began to break down, and we fell behind. At this point we initiated the position of "Director of Treatment Activities" which placed the responsbility of screening and intervention decision upon a para-professional on the team. In this fashion we were able to supply twenty-four hour a day emergency coverage to the prison despite the fact that the psychiatrists were on a consultant basis and at an appreciable distance from the prison.

This new system was greatly augmented by the "Planning Team Approach" at the prison. This was a battery of four teams comprised of members of the various departments and services. We were fortunate in having a representative on each team. This gave us, in conjunction with others, the opportunity to screen and evaluate each new inmate and to select treatment modalities. These evaluations were coordinated by the Director of Treatment and the psychiatrist was advised whenever necessary.

The psychiatrists saw three to four new inmates per week; the majority of those presented minor problems and were treated with chemotherapy. This entailed normal medical follow-up on the part of the psychiatrists. The minority, perhaps three or four new inmates per month, were taken on by the psychiatrists in their caseload of psychotherapy.

In several instances, there was indication of organic brain damage and the consultant neurologist was immediately advised. Where there was suspicion without

obvious indication, the inmate was tested as is further described in the section of Neuropsychological Testing.

Normal Prison Referrals

1. Disturbing Inmates - On the average of at least once a day, there was some situation involving one or more inmates that was directly referred to the Disturbed Offender Project by the Deputy Warden for evaluation and/or solution. These referrals came through the Associate Warden to the Coordinator of Treatment Activities and depending on the nature of the problem, and availability of program personnel, the inmate was either seen by the Coordinator of Treatment Activities himself, further referred to the social worker who had the inmate's case, or screened by the Coordinator of Treatment Activities to determine the advisability of contacting one of the consultants.

2. Self-referrals - Three to four inmates each day asked to see some member of the program's team. These were screened by the Coordinator of Treatment Activities in the same manner as the administration requests.

3. Weekly, the Coordinator of Treatment Activities was provided with a list of men who were to be considered for "Work Release". This list was checked against the active caseload of the program and the personnel involved with a given inmate prepared a report for the "Work Release Committee".

4. Monthly, the Coordinator of Treatment Activities was provided with a list of men who were to appear before either the Parole Board of the Board of Trustees for Pardon. The Offender Project was expected to provide reports for all their clients; but, in addition, this list often indicated that the Boards required a complete evaluation for certain inmates. The Coordinator of Treatment Activities assigned these reports to the proper personnel on the team.

Crisis Intervention

The program provided the prison with 24 hour coverage for serious problems. With the onset of a serious problem, the Coordinator of Treatment Activities was notified and he interviewed the inmate and made the determination as to wehther or not to call in one of the consultants.

Ongoing Therapy

Most all clinical project staff were engaged with inmates at the prison. During the course of the year the project had direct contact with no less than 470 inmates. As the project progressed, and reporting became more sophisticated, categories in which statistics were placed, changed. Thus, statistics collected at the beginning of the project were difficult to combine and legitimately compare with current statistics.

The team carried an average of 65 to 75 inmates per month in individual therapy with an average number of therapy hours well over 250 per month.

A further service that we provided was the beginnings of some Family Therapy wherein we dealt not only with the particular inmate but also had joint sessions with the members of his family. We have engaged in this type of help with eight different inmates to date.

Physical Examinations

One of the more critical areas in establishing a complete treatment for inmates was the physical exams. Because of the increase in the prison population, and the limited time of the prison physician, the physical examinations backlogged.

Early in the grant year, the project secured permission from the Advisory Council to try to fill this gap. Some of the difficulties have been overcome and by October 1, 1973, over 200 inmates had received physical exams and follow-up treatment when indicated.

The Prison Medical Department

Along with the medical histories and physical examinations, the Offender Project supplied other services to the prison infirmary in an attempt to upgrade its whole physical care structure.

One psychiatric nurse on the project has helped in giving care to inmates who offered particular problems or during some of the occasions when there has been an unusually heavy load at the infirmary due to demands made by the project's existence. These and other opportunities have given the nurses a chance to plan ways in which the system could be improved. An additional opportunity was that two of the nurses did a complete inventory of infirmary medications including arranging for the disposal of outdated drugs.

As a result of these endeavors, the project nurses, in cooperation with the prison nurse, are planning and revising the present system of carrying out orders of medication and treatment. A doctor's order book has been prepared and is now in use in conjunction with the revised medical records system introduced by one of the project psychiatrists.

The records system is the problem-oriented medical record which is similar to the concept of management by objectives. Medical and psychiatric problems are numbered and a treatment plan for each problem is outlined and carried through with consultation or referral as appropriate. As problems are resolved, they need no longer be considered in the routine reviews of the problems list. Thus far, the new prison medical record system has just finished its first pilot stage and the forms have gone into their second revision.

In addition, the psychiatric nurses have reviewed medical records, both at the State Prison and at the State Hospital, providing data for use by the sociologist on the project. They have also initiated and conducted a quantitative survey

of incoming mail and visitors at the prison, as well as participating in Inmate Summary preparation and inmate interviews.

Neuropsychological Testing

One of the questions frequently asked concerning violent and disturbed offenders relates to whether there is some organic basis for their behavior. After careful consideration, a battery of nine psychological tests known as the Halstead-Reitan battery was selected for use on the Offender Project. A mental health nurse was trained to administer this group of tests which examines many areas of functioning and is comprised specifically to assess brain dysfunction. The complete battery takes between four and six hours.

Although there was some delay in receiving the complete package of testing equipment, 85 inmates were tested in the first year (6/1/72 to 5/1/73); of these 85 inmates, 53 inmates were given the complete battery.

Of the 53 inmates tested with the complete battery, seven were diagnosed as having cortical dysfunction. In most cases it was a relatively minor factor in regard to their overall personality functioning. In all but two of the cases, the inmates medical history provided adequate explanation for the problem such as diagnosed head trauma or epilepsy.

Of the 85 inmates tested, a random sample of inmates who had not been specifically referred to the project was included to determine a baseline level of incidence of diagnosable cortical dysfunction within the population. Based on data collected to date, it has been determined that only a small percentage (6%) suffer from such dysfunction.

In addition to information related to cortical dysfunction, areas of strengths and weaknesses in the educational and vocational training was incorporated into other prison services for rehabilitative and educative processes.

A neurological is available on a consultant basis to render diagnosis and treatment in this regard.

Some of the tests in the Halstead-Reitan battery have a usefulness beyond just diagnosis of brain damage. For example, the Wechsler Adult Intelligence Scale (WAIS), which yields both verbal and performance I.Q.'s, has obvious usefulness to this program as well as to vocational rehabilitation and the educational programs at the Prison.

Other tests have been added which are useful to this and other programs. One is the Wide Range Achievement Test (WRAT) which determines the person's educational grade level in reading, spelling, and arithmetic. This provided the project team information as to which point functional school learning stopped and is obviously useful to the prison educational programs.

Group Therapy

The first group treatment program for disturbed prisoners began on June 7, 1973 to test the feasibility of group treatment in the prison. Initially, there was some feeling expressed by administration that grouping problem inmates together might lead to explosive behavior. Thus, the actual beginning of the group had been preceded by several months of groundwork with the prison administration.

The design consisted of three groups selected from a list of problem inmates compiled by the Warden. The groups were matched using demographic data and PSS scores. The first group was to receive group treatment. The second group to receive group treatment plus focused attention from representatives of prison administration to determine whether cooperative planning between the disciplines of mental health and corrections would have any effect beyond that of group treatment alone. The third group being a control group receiving no

treatment, at least in group form. The groups were to last two months, and inmates who agreed to participate made an agreement to stay with the group until its end unless they first discussed their leaving the group and gain group's permission to leave. The group sessions were to be videotaped with the understanding that the videotapes might be available to the administration in an effort to learn about inmate problems and reactions. Evaluation was to be done on an impression basis, both clinical and administrative, as well as on the basis of changes in the inmates profiles as measured by the psychiatric status schedule. The groups were to include, in addition to active members, a "stabilizer" for each group, that is an inmate who in the eyes of the prison administration, had made a good adjustment to the prison routine and was emotionally well put together. This person was included in an effort to negate the group explosiveness that was foreseen as a possibility. Of a potential group of seven active treatment clients plus one stabilizer for each of the two active groups, five men in each of the proposed groups chose to take part in the program. There were five active inmates in the group designated as the group receiving both treatment and administrative attention and four active inmates plus one stabilizer in the group receiving group treatment only. One of the latter attended only two weeks before being transferred to a medical unit at the State Hospital, leaving only three active participants in that group. Otherwise the groups remained stable throughout the two month trial period.

From the beginning, it was obvious that the groups, despite the matching criteria used, were in no way comparable, the first group being composed of older, more controlled, more action-oriented members and the second group being comprised basically of younger, more impulsive, less stabilized members. The first group latched onto the idea of using the videotapes to get messages to the administration and at the same time were extremely distrustful of the video-

taping process, feeling that it might jeopardize their chances for parole and turning off the machine rather frequently as they were free to do. Only toward the end of the sessions did they begin to look at their own feelings and achieve a more therapeutically oriented focus. The second group, in contrast, agreed readily to videotaping and very seldom turned off the machine and did not emphasize the tapes as a vehicle toward communication with the administration. Initially, the second group had a very difficult time attaining any focus or any successful interaction pattern, two of the group members having moderately severe problems with interpersonal relationships and communication. Once the communication patterns were focused on as a treatment problem, however, the focus developed very quickly onto individual problems of communication and adjustment. The initial communication problem concerned not only individual interpersonal relationship difficulties and concentration difficulties of two members, but were complicated by a leadership struggle between the "stabilizer" and the member who left the group for medical reasons. It should also be noted that the stabilizer who had experience with a transactional analysis based program in the federal system, pressed for using this approach to treatment which the group agreed to, and despite the staff co-therapists relative inexperience at that time with this treatment modality, it was adopted.

The plan for regular meetings between administration and the therapy team representatives to focus on the problems presented by the first group did not materialize due to scheduling problems and was held only sporadically. Therefore, it was not possible to carry out this part of the evaluative procedure.

PSS re-testing at the end of the two month period proved to be inconclusive. We did, however, gain several impressions on a clinical basis from the assembly of the individaul reports on the group members as follows: We felt that exper-

ience of the two groups showed the feasibility of treating disturbed inmates in a group without major difficulties arising from this process in their everyday lives of the prison routine. It was our impression, further, that the group process had been instrumental in enhancing the progress group members had made when compared to progress that might have been expected in individual treatment in that the groups had made it possible for more confrontation and increased support to take place than would have been possible in individual interactions.

At the end of the two month period, the first group agreed to disband until possible further group involvement in the fall, while the second group wished to continue and the impressions reported above were enhanced in this process.

On October 1, the two groups were combined with the addition of new members to a total of ten, without videotaping and with a pre-arranged focus on individual adjustment patterns and a transactional analysis model of treatment. Although all the former group members agreed to join in a new combined group, three of them as well as a fourth man that joined the second group shortly before that group ended, decided to leave the new group within a couple of weeks of its inception. Our initial impression of the new combined larger group, with its explicit transactional analysis model, is that it is even more successful than the original groups. Attendance is high, involvement seems genuine and enthusiastic and, again, there have been no incidences of behavioral difficulties generated by the group process, either in the group itself or outside it. Participants are learning transactional analysis (T.A.) theory and reading Harris "I'm O.K. - You're O.K.", and report applying their new found knowledge outside the group on an informal basis in their everyday interactions. We do not feel that enough time has passed with this group to make any meaningful

judgments about longer term behavioral change, although the co-therapists are optimistic that this might be demonstrated.

We are planning to begin other group treatment efforts including a pre-release group and a group for non-verbal, less active, potentially disturbed inmates, both with a preventive focus. It is our impression that these groups might do better with a combination of disturbed, potentially disturbed and non-disturbed members than with a homogeneous group of disturbed inmates, and this is the general proposed design for these groups.

In conclusion, from our experience with groups to date, group therapy appears to be an effective treatment mode in a prison setting. It also does not appear to exacerbate acting-out problems as originally feared. Finally, we also have the impression that a co-therapy team composed of male and female staff is a distinct advantage to group treatment in this setting.

New Hampshire Hospital Forensic Unit

The Forensic Unit consists of three wards (P-1, P-1 Annex, and 5 and 8) all located in the Northside of the Main Building. P-1 is a 21 bed, medium security ward which must be crossed through to get to P-1 Annex. P-1 Annex is a 13 bed ward, classified as maximum security.

In the beginning of our project, an attempt was made to segregate sentenced inmates transferred from the prison from patients sent by the courts for pre-trial evaluation.

P-1 then became the evaluation ward and P-1 Annex the ward where the project could attempt to provide in-patient psychiatric treatment to prison inmates. However, our efforts were blocked by several factors. First, the distinction between P-1 and P-1 Annex was made cloudy by the necessity to use the P-1 Annex to care for patients who exhibited unruly or disturbed behavior on P-1. Also, pre-trial

patients were placed on P-1 Annex when the courts sent more patients than P-1 could handle.

A second problem arose from the fact that the maximum security area was without a full-time psychiatrist and was seriously understaffed in all areas.

Because of these limitations, every effort was made to treat psychiatric problems at the prison rather than by transfer to the State Hospital. The presence of the project at the prison made it possible to cut the number of transfers to the State Hospital by two-thirds. For example, between July 1, 1971 and June 30, 1972 there were 63 transfers from the prison to the maximum security ward of the hospital. From July 1, 1972 to June 30, 1973 there were 19 transfers from the prison to the hospital.

Along with this decrease in prison transfers, an attempt has been made to institute programs for the inmates on P-1 Annex including group therapy, individual therapy, ward meetings, occupational therapy, regular library service, increased number of recreational alternatives, and other improvements both physical and psychological. In spite of these efforts, the situation was far from ideal.

As part of the overall process of improving New Hampshire Hospital, the Forensic Unit was created in September, 1973. The new unit, with Dr. Ruick S. Rolland as director, has meant considerable change for prison transfers. Dr. Rolland has assumed medical responsibility for prison patients. Walker Brown, a senior psychiatric social worker with our project, is assigned to provide ongoing clinical treatment of prison transfers and under Dr. Rolland's general supervision. Mr. Brown also provides liaison between the mental health team and the forensic unit.

With the establishment of the Forensic Unit, the function of P-1 Annex

has been changed to meet the need for a period of close observation of newly admitted patients. In addition, the Annex provides a place for the more severely disturbed or disruptive patients to be placed until they regain control of their behavior. As a result of this change, the majority of prison patients are now on P-1.

In spite of many improvements resulting from the establishment of the Forensic Unit, the situation for prison transfers is far from ideal. As prison inmates, they are required to be kept on the locked ward. This means that they must remain in a confined, overcrowded area which offers far less choice of activities than prison. This policy also prevents them from participating in vocational, educational and other programs which are an integral part of any psychiatric treatment program.

Our experience has been that patients who remain too long in this closed setting often begin to regress markedly. They have, in effect, reached maximum benefit of the locked ward. Since they cannot be transferred to less secure wards or allowed to participate in off-ward activities, the only solution is to return them to the prison even though their psychiatric illness remains and they could benefit from further psychiatric treatment.

Training and Education

During the spring and summer of 1972, a 120-hour correctional officers training program was being conducted at the State Prison. This course was attended by 25 prison guards and was run by the Prison Training Officer. This training program was well underway before the inception of the Offender Project, but near the program's end, three of the two-hour sessions were taught by the Offender Project staff. In addition, four meetings were held during the summer

of 1973 to aid the Prison Training Officer set up the 1973-74 training program. In line with this, eight training films were purchased by the grant for the beginnings of a training library.

Hospital Aides

Between November, 1972 and October, 1973 seven groups or classes of aides attended the New Hampshire Hospital Attendant Training Program. The classes ranged in size from 11 to 17, and the total number going through the program at that time was 98. A minimum of one hour of each of these seven classes was taught by a member of the Offender staff.

State and Local Police

The New Hampshire Police Officers Training School graduated six classes of 40 to 45 men each between July of 1972, and April of 1973. For each of these six schools, the two-hour session on handling mentally disturbed people was conducted by a Project team member. Thus, over 250 police officers were taught some basics in how to recognize mental disturbance, how to deal with these people, and what to do with them once they are under custody. Additional information was given on suicide and suicide prevention and handling people in times of disaster.

Medical Interns

A nucleus of six medical interns at Dartmouth Medical School participated in a two-fold program aimed at informing and demonstrating the need for physicians and the challenge of working in the corrections system; the secondary goal was to provide closer ties between the State Hospital, the State Prison and Dartmouth Medical School in order to obtain better medical and mental health services in the future. The program consisted of 11 two and one-half hour sessions and two field trips.

Staff members have also been involved in various other short-term educational and training activities bridging the gap between mental health and corrections. Some of the activities have been as guest lecturers, panel discussants, resource people, and so forth.

Research and Evaluation for 1972-73

The original intent of the study of inmates was to design and utilize an economically feasible method of systematic psychiatric data collection. This would (a) enable identification of disturbed or mentally ill inmates who might benefit from mental health services, (b) predict from new goups of inmates which inmates would be likely to develop psychiatric symptoms (including abnormal behavior) which would be disruptive to prison routine.

The task was ambitious particularly because (1) it was not proposed or planned in the original project, (2) supporting funds had to be obtained with approval of L.E.A.A. and Governor and Council from unused money in the original grant, (3) resistance was encountered in the personnel office when we requested the creation of appropriate job descriptions for interviewers and other research personnel. One consequence of this resistance was that all personnel had to be hired on a consultant basis at a maximum of three days per week. Another consequence was that the consultant category of funds, on at least two occasions, was exhausted and appropriate reallocation of such funds was delayed (in order to obtain approval of Governor and Council) for extended periods during which the interviewers and other research personnel could not be paid, (4) the usual income protections and performance controls for State employees could not be applied to individuals in the consultant category, (5) research staff had to be recruited and continually replaced "at the last minute" from a very limited pool of available individuals because of the high rate of resignation of consultants who could not financially afford the extensive delay of payment for their services.

The sociologist, Dr. Joan Smith, agreed in July of 1972 to work on the program on a three day per week basis on the condition that at least part of the time paid for would be spent on the project in her office in Hanover, New Hampshire, organizing, supervising, computer data input and analyzing data. It was also understood that she be given professional discretion to assign and supervise the program without interference from the program director. Tacit in this understanding was the assumption that the quality of her own professional performance was to be judged by the results submitted in her final reports. Apparently she had the mistaken impression that all of the research data was to become her private property. Shortly after her start with the program, she had to contend with an unpredictably heavy teaching schedule imposed upon her at Dartmouth College. Hence, she was not able to personally supervise the interviewers data collection and computer input. Dr. Payson, the program director, began to examine some of the data of the program in January of 1973 for the purpose of planning a revision of the psychiatric interview questions. This revision was necessary because the interviewers and Dr. Smith had reported low frequency of responses to many of the questions in the schedule that was originally designed for psychiatric outpatients. Dr. Payson wanted to identify the questions which had high and low frequency of response in order to know where the emphasis of new questions appropriate for prisoners should be focused.

Dr. Smith's interim report in January, 1973 revealed that (1) the data stored in the computer memory bank had not been checked for inaccuracies, and that (2) she did not understand the limited validity of the Spitzer scores (the instrument was designed for use with psychiatric outpatients and not incarcerated inmates and had not yet been checked against direct clinical observations).

Therefore, no validation of the symptom or distress scores was available. Dr. Smith's analysis and interpretations of the scores in her January summary was, therefore, based on erroneous assumptions. Dr. Payson had planned a collaboration with Dr. Smith to establish a validation of the symptom scores. However, the low frequency in inmate responses indicated that the questions were not appropriate for the inmate population. (3) Dr. Smith had not applied statistical tests to the data. One can see by examining Graph A on Page E 11 in her March 1 report that the frequency of the scale scores on all signs and symptoms was (1) or less (0). It was not until Dr. Paul Breer, another sociologist, was introduced in consultation that Dr. Smith did apply statistical tests for significance to the material. This was reported in her September report of 1973. The latter report revealed that the data showed only minimal differences in the population Dr. Smith had studied.

After March, 1973 several reviews of the research data were made. Inaccuracies in computer input were found and also an error in the original method of selecting the "random sample" was discovered. The random sample was found to be an arbitrary selected group of individuals that was not representative of the inmate population.

Just as attempts were initiated to correct the above errors, the prison lockup of March, 1973 occurred. This lockup (which was from the standpoint of the research team a lockout) immediately terminated incomes of the interviewers and forced them to seek employment elsewhere. This prevented chances of reviewing and correcting the data file as well as interviewing a more representative sample of the inmate population; it also prevented the validation of Spitzer scores by direct clinical observation. The reintroduction of research activity was not fully resumed until June, 1973.

in predicting in those inmates who are newly arrived at the prison who will ultimately become psychiatrically impaired and (because of psychiatric illness) disruptive to prison routine. Dr. Smith's administration of the research and the evaluative parts of the Disturbed Offender Program, although inconclusive, are still useful for initial data on 57 new inmates which can be examined for predictive variables.

One of the original intents of the epidemiological survey was to determine the incidence of various psychiatric problems of the prison inmate population. This has still not been achieved. This is primarily because validation of the Spitzer scores by comparison of actual clinical observation was not and probably will not be done because of attenuation of research test personnel after March 1973.

In summary, circumstances within the prison, the inmates population and the Disturbed Offender Project itself militated against the original hopes of the research team. Adequate staffing of the team was a continuous problem only partly overcome by paying consultants rather than devising new job descriptions for permanent State employees. The subject under investigation was also vague and undefined; the question was long debated as to whom was in fact a "disturbed offender". There were those who saw them as "disruptive or disturbing"; others followed the medical definition. The Spitzer test itself was found to have grave shortcomings during the second stage of the investigation. It was significantly revised to meet the specific needs of the program. Methodology after it was found to be inadequate was changed. Since September of 1973, the administration and achievement of the research effort, particularly in the area of development of prediction testing instruments, has markedly improved.

On March 15, 1973 Dr. Payson ceased being the program director and Dr. Wells assumed this position. Dr. Payson attempted to continue work with Dr. Smith to reorganize the research methodology but in May, she informed Dr. Wells of her decision not to allow Dr. Payson or Dr. Wells to have access to the data. She insisted that the director of the program and Dr. Payson be given only reports of her data analysis not the data itself, which she felt was her property and under her exclusive control. The problem was resolved in June, 1973 when, on Dr. Wells insistence, she allowed reaccess to the data that was stored at the Dartmouth computer under her user number. The months of July and August 1973 were spent by the interviewers correcting the errors in the individual inmate folders and reintroducing the data into the computer memory bank. Corrections of this data were almost complete by September, 1973.

Dr. Breer agreed to take over the research efforts of the program in September, 1973 and has been able to use the corrected Spitzer scores for the new inmates for comparison with scores obtained from these inmates on retesting. In the meantime, Dr. Payson during the months of July and August, completely rewrote the Spitzer Psychiatric Status Schedule to include questions which would be appropriate and eliminate other questions which were inappropriate for incarcerated inmates. The new "prison" Spitzer Schedule is now being utilized in retesting of the inmates who were initially tested with the old schedule at the time they entered prison. The 57 inmates who were interviewed "new" and who have subsequently become disturbed or disruptive to prison routine will be compared with subsequent evaluations including those afforded by the "prison" Spitzer. It is anticipated that the variables in the original Spitzer data will be useful in correlating with those individuals who later become disturbed and disruptive to the prison process. Such data in turn will ultimately be helpful

The study, therefore, to date, has still not produced the total desired results. There is still much to be gained, much to be developed; but the program has produced a direction, a goal and a great deal of raw data. It has also produced a great deal of optimism and under the very capable direction of Dr. Paul Breer, we anticipate that the second year will accomplish many of the original aims.

Conclusion

The project primarily has suffered because it, as a program for treatment of mentally disabled offenders, was not ever fully accepted and supported by the State mostly because of unwillingness to make long range commitment of funds to support such a program after Federal seed money terminated. A proper conclusion to this limited report should be affirmation of the real value of the first year of the project. It is limited because it merely summarizes the project's work throughout the initial grant and describes accomplishments that are of an abstract nature beyond simple statistical reporting.

Much of the first year was consumed in trying to win grudging acceptance of the program and in determining who our clients actually were, how they were to be recognized, and what treatment course should be taken. We were well into the middle of the grant year before we could even begin to consider what should be reported, by what method and to what extent. Time-consuming administrative tasks (dealing with delays in salary payments, delays in delivery of equipment, space shortage, political interference, delay and obstruction in State Personnel hiring and job classification, etc.) and crises in the prison (e.g., the March 1973 lock-out) had catastrophic effects on the program's operation. Because of the process of evaluation and growth, the method and content of statistics changed several times and, therefore, has limited the picture of the total worth of our effort.

There were too many negative elements, intangible circumstances and outside influences to ever know what the project on its own could have accomplished.

One might say, how did the prison atmosphere compare before and after the inception of the program? There is no answer to this question because the prison changed. The Warden, the deputies, the inmates, the times, were different; only the building was the same. Even the public attitude and the courts have changed perceptively during the course of the first year of the grant.

Perhaps the project's real contribution in 1973 has been in its own survival as an initial team approach to the treatment of mental illness within the New Hampshire Prison and the development of interview methods that will increase the team's future ability to predict, anticipate and prevent psychopathology that may disrupt corrective forms of rehabilitation. Hopefully, this survival will continue long enough to help the State to begin to recognize sufficient value of services to justify eventual support by New Hampshire citizens. Once a commitment to such a program is made, permanent professional staff can be obtained and long range treatment and rehabilitation efforts can be planned and carried out.

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