# FINAL REPORT

## Evaluation of DS-311-72A

## Penna. — Bureau of Corrections Psychiatric Facility

## EXECUTIVE SUMMARY

I. Objectives

The original goal of the project was to provide short term, intensive, inpatient psychiatric care for approximately 25 residents of Bureau of Corrections facilities. The care is provided at Norristown State Hospital with staff provided jointly by the hospital and the Bureau of Corrections. Patients selected for treatment are to remain at Norristown for a maximum of one year and then, hopefully be reintegrated into the prison or another suitable setting. If no improvement is observed by the end of this time, then regular commitment procedures are to be initiated.

The project was designed to alleviate the lack of facilities and personnel for treating the mentally ill within the correctional system. At any given time there are approximately 25-40 residents of Bureau of Corrections facilities who are acutely ill and in need of prompt psychiatric treatment. The evaluator has observed through visits to the Graterford facility and discussion with the treatment staff there that there is, indeed, no facility to properly treat these particular residents. The only alternative has been a court order for commitment which often takes so long that the resident's mental status deteriorates to the point that he is not amenable to treatment. Therefore, the Norristown unit functions as a facility where acutely mentally ill inmates may be transferred rapidly for prompt psychiatric treatment.

II. Activities

As of March 1, 1974, the unit has treated 30 patients for an average length of 3½ months, with a range of from 1-7 months. Twelve of these have been discharged. Nine inmates have been referred to the unit and rejected by the screening team as not appropriate candidates for treatment at Norristown.

Treatment consists of the following:

(1) Psychotropic Medication (24 patients)

(2) Psychological Evaluation (all patients)

(3) Group Psychotherapy (all patients)

(4) Individual Psychotherapy (26 patients)

(5) Occupational Therapy (20 patients)

(6) Hospital Employment (20 patients)

(7) Vocational and Academic Evaluation and Counseling (10 patients)

(8) Academic School (9 patients)

(9) Recreation Therapy (all patients)

III. Results

Of the twelve patients who have completed the program, nine patients were returned to prison, one was returned to a community treatment center, one was released on parole, and one was committed to Farview State Hospital.

A significant improvement in behavior as measured by the Physical and Mental Status Notes was observed in a sample of 17 patients.

IV. Recommendations

(1) The designation of an individual to solve the following communications problems that currently exist between unit, prisons,

courts, parole boards:

a. Inappropriate referrals from prisons and inadequate information accompanying referrals.

b. Failure of unit staff to provide clear treatment plans to prisons when inmates are returned at referral or release and failure of prisons to follow treatment plans when they are provided.

c. Confusion over patients' legal rights.

d. Slowness in release of patients after parole has been approved.

2. Employment of additional psychiatric aides so that patients may be escorted to all available therapeutic activities.

3. Selection of future corrections officers to be made by the Norristown professional staff.

FINAL REPORT

Evaluation of DS-311-72A

Bureau of Corrections Psychiatric Facility

I. Statement of Problem, Goals, Objectives

The original goal of the project was to provide short term, intensive, inpatient psychiatric care for approximately 25 residents of Bureau of Corrections facilities. The care is provided at Norristown State Hospital with staff provided jointly by the hospital and the Bureau of Corrections. Patients selected for treatment are to remain at Norristown for a maximum of one year and then, hopefully, be reintegrated into the prison or another suitable setting. If no improvement is observed by the end of this time, then regular commitment procedures are to be initiated.

The project was designed to alleviate the lack of facilities and personnel for treating the mentally ill within the correctional system. At any given time there are approximately 25-40 residents of Bureau of Corrections facilities who are acutely ill and in need of prompt psychiatric treatment. The evaluator has observed through visits to the Graterford facility and discussion with the treatment staff there that there is, indeed, no facility to properly treat these particular residents. The only alternative has been a court order for commitment which often takes so long that the resident's mental status deteriorates to a point that he is not amenable to treatment. Therefore, the Norristown Unit functions as a facility where acutely mentally ill inmates may be transferred rapidly for prompt psychiatric treatment.

## II. Project Activities

As of March 1, 1974, the Unit had treated 30 patients for an average length of 3½ months, with a range of from 1-7 months. Twelve of these have been discharged. Nine inmates have been referred to the Unit and rejected by the screening team as not appropriate candidates for treatment at Norristown.

See Table 1 for a description of the type of patients accepted for treatment.

The patient population contains significantly more black than white inmates, and this tends to accurately represent the racial distribution of the prison population as measured in our random sample of prisoners at Graterford. The employment status of the patient group is primarily unskilled laborer. During the formative years, most patients were raised in unstable, broken homes. Most patients have never been married or are divorced or separated. Almost all come from urban areas and have poor or marginal incomes. None is in the "above average" income bracket.

In terms of criminal record statistics, more than half the patients have been convicted of crimes against property, i.e. burglary, larceny, etc. The patient group has a low rate of drug and sex related crimes. The greatest number of prisoners have been referred by the Huntington facility, followed by Graterford, with a few from each of the remaining institutions.

The most frequent reason given for referring an inmate is psychotic-like behavior: hallucinations, confusion, bizarre actions.

Other frequently occurring reasons for referral are:

(1) Depression and/or suicidal thoughts, attempts or gestures.

(2) Delusions and paranoid ideas.

(3) Isolating oneself from the rest of the population. Asking to be "locked up."

(4) An unclear category "strange actions." This reason is often indicated by referring prisons and is very unclear to the screening team at Norristown, which has requested that the person referring an inmate clearly define the unusual behaviors that occur.

(5) "Homosexual panic" - a real or imagined fear of homosexual assault in prison. Often the inmate asks to be locked up because of this, so the two behaviors of isolation and homosexual panic frequently occur together.

It is interesting to note that, whereas seven of the patients were assaultive while in prison, this is listed as a reason for referral in only one case. Perhaps assaultive behavior is not seen by prison personnel as indicative of mental illness, whereas suicidal, withdrawn, and unusual behavior is. Ten patients exhibites suicidal behavior in prison.

More than half the patients had received previous psychiatric treatment, most on an inpatient basis. Almost half had relatives with a history of mental illness, with alcoholism of the father being the most common form. Almost half the patients had drug and/or alcohol problems.

Most patients were diagnosed as schizophrenic by the Norristown screening team, meaning that they suffer from the most prevalent form of psychosis.

The patient intelligence level (Beta) is slightly below average and their average grade level as measured by the Wide Range Achievement Test is 8.84 for reading, 6.73 for spelling, and 5.51 for arithmetic.

## Description of Treatment

Treatment is provided jointly by psychiatrists, psychologists, social workers, nurses, recreation specialist, occupational therapist, aides, and corrections officers. The exact number of each type of personnel changes from time to time as specialists from various departments devote a certain proportion of their time to the Unit. The entire Forensic Psychiatric Unit (FPU) of which the correctional unit is a part, employs two full-time psychiatrists, two consulting psychiatrists (one for correctional unit only), one full time and one half time psychologist, one half-time social worker, two half-time social workers (correctional unit only), two social work students (correctional unit only) three nurses during day and one at night, one vocational counselor, three occupational therapists and two recreation therapists. The unit itself has 14 psychiatric aides and 6 corrections officers; these are round the clock employees who work on shifts so the number on the unit at any given time is 1/3 of the above.

Treatment consists of the following:

(1) Psychotropic Medication. These are used in the traditionally prescribed manner; their use does not differ with offender patients from routine psychiatric usage. The usage of medication is indicated if the patient is either psychotic or depressed. Major tranquilizers such as prolixin, thorazine, mellaril, and stelazine are used for

psychotic patients. Anti-depressants such as elavil are used for depression. Specific dosages and combinations are tailored to the individual patient, and the medication is frequently reviewed and changed as the patient's behavior indicates.

(2) Psychological evaluations consisting of the Beta (intelligence test), MMPI (personality test), Sentence Completion, and other tests indicated by the patients problems are administered to every patient shortly after his admission. (Note that psychologicals and group psychotherapy are omitted in the following charts (2 & 3) because all patients receive these treatments).

(3) Group Psychotherapy: All patients are assigned to at least one group at admission. Some groups are mandatory, others voluntary; patients are assigned according to their varying treatment needs. There are currently eleven groups including five special groups for drug, alcohol, sex offender, and anti-social personality problems. Groups are led by psychologists, psychiatrists and social workers; there is currently one patient-led drug therapy group.

(4) Individual Psychotherapy: Most patients (26 of 30) have been assigned to an individual therapist to deal with problems on a one to one basis.

(5) Occupational Therapy: 20 patients have participated in occupational therapy, engaging in crafts and art work.

(6) Hospital Employment: A patient is assigned a job (usually janitorial) in the building as soon as he is mentally able. When he has attained further privileges (see below), he may be assigned to work elsewhere in the hospital: kitchen, cafeteria, workshop, warehouse, etc. Twenty patients have participated in the hospital

work program; they are paid 50¢ per day, generally less than they would receive in prison.

(7) Vocational and/or academic evaluations and counseling, (10 patients), performed by the psychology department when requested by the unit treatment staff.

(8) Academic and Business Schools: Nine patients have attended the academic school held on hospital grounds. Two have attended business school and four have attended the vocational school which provides training in carpentry, janitorial services, electronics, auto repair, and plumbing.

(9) All patients attend regularly scheduled recreational therapy consisting of gym and movies.

(10) A Music Therapy program was initiated in March.

In addition to the preceding activities there are various unit meetings and conferences.

Each patient is first seen at an initial screening session attended by the unit's psychiatric consultant, psychologist, and social workers. The screening team decides whether the inmate is a good candidate for treatment at Norristown. If he is accepted a diagnosis and treatment recommendations are made and he is immediately admitted. This same screening team will again see each patient at a regularly scheduled (about every two months) court conference, where decisions are made concerning his plans

Nile

C. Fossett

June 11, 1974

Mr. Gerald M. Croan
Evaluation Planner
Evaluation and Monitoring Unit
Governor's Justice Commission
P. O. Box 1167
Harrisburg, PA 17120

Dear Mr. Croan:

In reply to your letter dated May 29, 1974, regarding the Final Evaluation Report on Bureau of Correction's Psychiatric Facility at Norristown, (DS-311-72A) by Mortimer B. Lipton, as Project Director, I would like to state the following:

1. The report is considered factually accurate for those represented.

2. I am in full concurrence with the recommendations provided by that report and proud to state that we have been in the process of recruiting a "coordinator" for the last month and a half. It is anticipated that this position will be occupied by the last part of June.

As Project Director, I have sent a copy of Dr. Lipton's report to the significant staff members participating in the project during the previous year. The staff members have generally responded with disappointment but satisfaction. Some specific issues brought about by their review are:

1. That the report fails to identify the diagnosis rendered by the correctional institution staff.

2. That Corrections has a "bad guy" image in the report.

3. That we were concerned with the belief that the Bureau of Correction is dumping on the unit. The specific concern is that the document does not present logical reasons for that claim, and that we are in total disagreement with that conclusion.

4. That the section regarding officers was too general. That two officers appeared to be unsatisfactory staff members for a treatment facility should have been specific and to the point. It so happens that since the report was written, the staff at Norristown has specifically requested that, rather than replacing one of the two officers identified, both officers stay in the unit due to the tremendous personal investment of time in establishing a rapport with the resident whose parent died.

5. That the evaluation failed to bring to the surface the fact that the Bureau of Correction provides a screening process and that individuals are screened and referred to the Farview State Hospital as an alternative to the Norristown Psychiatric Unit.

6. That there is an obvious bias in the report toward the mental health services. It is, consequently, recommended that in the next evaluation period, the Bureau of Correction work closely with a member of Dr. Lipton's staff in drawing up the evaluation reports. It is the desire of the Project Director that we maintain the coordination that has been established in the unit by hiring one of Dr. Lipton's staff, Mrs. Penny Cooke, as a part of next year's evaluation component.

An important ingredient left out of the evaluation was the fact that the project was implemented in a very sound fashion. We gradually increased the population of the unit as we increased the staff complement associated with the project. I am, as Project Director, completely satisfied with the progress that has been made during the first year, and with the fact that treatment is delivered and ongoing in the Bureau of Correction's Psychiatric Facility at Norristown.

Sincerely yours,

J. Harvey Bell
Chief of Treatment Section
Project Director

JHB:jm

cc: S. Werner
E. DeRamus
J. T. Snavely
C. Morn
T. Berard
C. Fossett
Dr. M. Lipton, Norristown
Dr. J. Canals, Norristown

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

NORRISTOWN STATE HOSPITAL
Norristown, Pennsylvania 19401

MICHAEL D. McGUIRE, M.D.
DIRECTOR

TELEPHONE
AREA CODE 215, BROADWAY 5-9700

June 6, 1974

Ms. Christine Fossett
Evaluation and Monitoring Unit
Governor's Justice Commission
Dept. of Justice
Commonwealth of Pa.

Dear Ms. Fossett:

We would like to be sure that you received a copy of the final report re: DS-311-72A. We would welcome an opportunity to discuss the report with you.

Sincerely,

M. B. Lipton, Ph.D.
Director, Program Research Unit

MBL:jg

MAJOR EVALUATIONS UNDERWAY OR COMPLETED IN YOUR SPA

Project or Program being Evaluated:

Grant Title: NARRISTOWN (PA)
DS-311-72A Bureau of Corrections Psychiatric Facility
(include grant number)

Grantee: Dept. of Justice

Brief Description: Facility designed to provide short-term
(both project and evaluation effort)
intensive in-patient treatment.

Scheduled date of final Evaluation Report: 5/8/74

Person to contact concerning the Evaluation:

Christine A. Fossett, Chief, Evaluation & Monitoring Unit
(name)
Governor's Justice Commission, Department of Justice
(address)
Box 1167, Harrisburg, PA., 17120

717-787-1422
(telephone)

If completed, is Evaluation Report on file with NCJRS? ____yes x no

---

Please mail completed form to:

Keith Miles
Office of Evaluation
LEAA-NILECJ
Department of Justice
Washington, D.C. 20530

F/w/Reports

September 1, 1974

FOLLOW-UP EVALUATION REPORT - DS-311-72A
Bureau of Corrections Psychiatric Facility

The Bureau of Corrections Psychaitric Unit, located at Norristown State Hospital, continues to function smoothly, and the level of treatment remains the same as previously reported. Communications problems among staff and between the unit and the correctional institutions still exist, but are continually improving through the efforts of a newly hired unit coordinator.

The following figures reflect total numbers of residents served by the Unit as of 9/1/74. The figures are meant only to report statistical information and not to reflect treatment effectiveness as the data is insufficient at this time. Future follow-up evaluations will focus on treatment effectiveness.

| | | |
|---|---|---|
| 1. | Residents screened by Bureau of Corrections Central Office (this figure represents number of different individuals screened, no individual is repeated, although some may have been screened more than once). | 65 |
| 2. | Rejected by Central Office | 6 |
| 3. | Screened at Norristown | 59 |
| 4. | Rejected at Norristown (this figure includes one resident who was later admitted and one whose records of screening cannot be located at present). | 11 |
| 5. | Treated at Norristown | 48 |
| 6. | Discharged by Norristown | 32 |
| 7. | Discharged longer than 3 months. (for purposes of follow-up data below). | 18 |

The following figures represent the status of residents who have been discharged from Norristown for 3 months or more.

| | | |
|---|---|---|
| 1. | Returned to Norristown (both have since been discharged again) | 2 |
| 2. | Farview State Hospital | 2 |
| 3. | Still incarcerated in Bureau of Corrections Institutions, | 6 |
| 4. | CTC | 1 |
| 5. | Parole | 3 |
| 6. | Maximum Sentence Expired | 1 |
| 7. | Parole violator (These individuals are as yet unconvicted parole violators) | 3 |

for eventual release. Also, weekly ward meetings are held with all staff and patients attending. At these meetings, each patient is able to request additional privileges, express complaints, etc. A team meeting follows, in which the staff considers and acts upon the patients' requests, at the same time reviewing each patient's case, adjusting medication, etc.

A therapeutically oriented privilege system was initiated in December. Privileges are used as a reward for good behavior and removed when rules are broken or the patient's mental status deteriorates. A hierarchy of privileges has been developed and a patient climbs the ladder of privileges as his behavior improves and stabilizes. The patient or a staff member may initiate a request for a change in privileges and a final decision is reached at the weekly team meeting.

Criteria for privileges are as follows:

(1) The patient must have been presented at a staff conference.

(2) He must follow ward rules routinely.

(3) He must not be overtly psychotic.

(4) For privileges without staff escort the patient must have no detainers and be judged not an escape risk.

Privileges are as follows:

(1) Staff escort.

(2) Patient escort

(3) No escort

Small steps are made within these categories regarding amount of time and/or places the patient may go. For example: the first step

is with staff escort of 1 hour twice a week. This may then be increased to 1½ hours 3 times a week, and so on. The no escort level is begun with the limitation of attending only job or school, and at the final level, the patient may go unescorted on hospital grounds only, to patient snack shop, laundry, library, recreation building, job and school, as long as he returns by 3:30 p.m.

III. Evaluation Activities

The evaluation effort attempts to cover a wide scope of approaches. The statistical approach is used in the evaluation of the procedure used in selecting patients, in the evaluation of actual treatment services provided, and in the measurement of outcome and follow-up of patients treated on the unit. A more descriptive, problem-solving approach is used to complement the statistical approach by means of interviewing and practical problem solving attempts.

The only major limitation of the evaluation is a problem common to any program that tries to measure outcome. That is, we must have a reasonable amount of time after a patient's discharge, before we can assess the effects the treatment has had upon hom. Moreover, we must have enough patients who have been discharged for at least three months before we can draw any meaningful follow-up conclusions. Since the project has been in operation for less than a year, there have been only eight patients who have been discharged for 3 months or more. Therefore at this point, no follow-up conclusions can be drawn and no recommendations can be made from the little follow-up data we now have.

The major evaluation activities have been:

(1) Intensive search of the records of all patients and of inmates referred but rejected by the Norristown facility.

(2) Collection of demographic data and test scores from these records.

(3) A record search of a random sample of prisoners to collect the same information for purposes of comparison with the patient population.

(4) Collection of the same information on a "prison psychiatric sample" for purposes of comparison. This sample is defined as all prisoners currently on anti-psychotic medication at the Graterford institution.

(5) Statistical coding and analysis of the above information for comparison of groups and evaluation of the selection procedure.

(6) Constant monitoring of all admissions, discharges, staffings, screenings, treatment, diagnosis changes, medication changes, and privilege changes and routine recording of all of these.

(7) Communications with correctional facilities, parole officers, etc. regarding condition of patients after their release from Norristown.

(8) Communications with Graterford personnel and with the project director when explanation or clarification was required.

(9) Visits to Graterford to collect information from the facility, and talk with the treatment staff about their needs.

(10) Occasional attendance at unit screenings, staffings, ward and team meetings to get a feel for routines, procedures, and

problems and to become acquainted with the treatment staff.

(11) Interviewing aides, officers, and treatment staff about problems. (See Table 9)

(12) Interviewing all patients. (See Table 7)

(13) Conducting a survey of directors of treatment of all correctional institutions to determine their feelings about the Norristown Unit. (See Table 8)

IV. Results of Project

The project has treated thirty inmates, twelve of whom have been released and re-integrated into a prison setting or other suitable setting as outlined in the anticipated results section of the grant application.

See Table 5 for Outcome and 3 Month Follow-up information on discharged patients.

In summary, 9 patients were returned to prison, 1 was released on parole, 1 was returned to a community treatment center, and one was committed to Farview State Hospital. Of the eight patients on whom follow-up data is available, none remains in prison; 2 have been committed to Farview, 3 are on parole, 1 has served his full sentence, and 2 have been returned to Norristown.

No meaningful conclusions regarding eventual outcome can be drawn from the few patients who have been discharged for three months or more, but a glance at the patterns of movement sheds light on some of the difficulties encountered in communications between the correctional insitutions and the Norristown facility. The fact that not one patient of the six who were returned to prison has remained there for three months or more deserves attention.

Three of the six either served their full sentence or were released on parole. The other three are currently in mental institutions, one at Farview and the other two at Norristown.

The case that was committed to Farview was sent there from Rockview after the Norristown Unit had released him and recommended that he return to prison as he was not in need of or amenable to psychiatric treatment. One of the cases returned to Norristown is of the same nature as the above. He was released after treatment at Norristown with the recommendation that he had benefitted as much as he possibly could from treatment. Medication was prescribed to be administered in prison. The patient was returned to Norristown by Rockview, where he apparently was not routinely given his medicine. The Norristown screening team unanimously agreed at this time that the patient did not need further treatment, that, in fact, he appeared to be in a better mental condition than when he was released, and that hospitalization might even be to his detriment. But, Rockview refused to take the patient, so a compromise was worked out whereby the patient would remain at Norristown for one week until the Bureau of Correction could find a suitable place for him; at this writing he has been at Norristown for almost 4 weeks. In addition, this evaluator had requested information from Rockview about this patient's status and medication three months after release; the request remained unanswered when the patient was returned to Norristown. This situation and others like it point out the need for better communications between the Norristown Unit and the correctional institutions, especially

as to the nature and status of an inmate who may require hospitalization. The evaluator pointed out to both parties the necessity for solving these problems between themselves and for considering this particular patient's welfare as a separate issue. The fact that none of the institutions have kept a patient once he is returned by Norristown indicates that they may indeed be using the facility as a "dumping ground" for problem cases, contrary to the terms of the grant.

Results in terms of treatment rendered may be observed on tables 2, 3, and 4 under Project Activities, although at this point, we can also make some comparison of treatment rendered at Norristown and at the correctional institutions. A few of the patients had received group therapy in prison; other than that the sole treatment was medication. Nineteen of the thirty patients were treated with psychiatric medication in prison; twenty-four received medication at Norristown. An inspection of the types of drugs administered indicates that the Norristown facility has usually administered primarily a single anti-psychotic drug except in the cases of depression when an anti-depressant is used in addition. The prisons tend to use multiple combinations of drugs combining one or two types of anti-psychotic medication with an anti-depressant.

The attempt to measure outcome of the treatment provided on the unit has focused on medication changes, privilege changes, diagnosis changes, and measurement of personality changes as reflected by the Physical and Mental Status Notes.

Assuming that a decrease in daily dosage of medication is contingent upon improvement of mental condition, analyses were made of initial, stabilized, and final medication for each patient. It was found that five patients' dosages remained the same, ten increased, and nine decreased.

The granting of privileges and increases in privileges may also be considered as a measure of improvement. Eleven of thirty patients have been granted the first level of privileges. Of these, three have been granted further increases.

Diagnosis changes may be measured only for those 12 patients who have been discharged (See Table 3), as the initial diagnosis is made at screening and the final diagnosis at the court conference immediately preceding discharge. Of these twelve, five diagnoses remained the same. This is to be expected when one carefully examines the diagnostic categories to which the five belong. One of the five had a diagnosis of "no mental illness"; the other four were diagnosed as personality disorders, a classification for which little or no improvement is expected. The other seven had changes in diagnosis which indicate definite improvement; all had been diagnosed as schizophrenic upon admission and were diagnosed as schizophrenia in remission on medication upon release.

The Physical and Mental Status Notes were available for only 17 patients (see evaluation problems section). The forms were filled out close to admission and 2-6 months later for each patient. The following items were rated on a one to three scale: physical health, orientation, memory, abstract thinking, judgment, cooperation, somatic preoccupation, incoherence, irrelevance, verbally over-productive, verbally underproductive, obsessive compulsive, emotional

instability, inappropriate affect, flatness of affect, depression, manipulative behavior, motoric overactivity, motoric underactivity, withdrawal, paranoia, fears, excessive anger, anxiety, delusions, hallucinations, emotional agitation, eating problem, sleeping problem, incontinence, lack of insight. As measured by the PMS, overall improvement of the 17 patients was statistically significant at the $p < .01$ level.

The major statistical aspect in the evaluation has focused on analysis of the selection procedure; that is, who is selected for the project (the accepted and treated patients) and do these individuals differ from normal prison inmates (a random sample of 30 inmates at Graterford), from those inmates referred to the unit and rejected, or from mentally disturbed inmates who are treated in prison and never referred to the unit (consisting of all inmates at Graterford currently on anti-psychotic medication).

For a statistical description of the patient population, see Table 1. Few differences were noted between the four groups, so it is unnecessary to report all information for the three non-patient groups. The few differences noted are as follows: The random prison sample had a significantly greater number of murderers; obviously murderers have longer sentences to serve. Also, both random prison sample and prison psychiatric sample have significantly longer ($p < .05$) minimum and maximum sentences. In addition, there is a definite trend for those referred as psychiatric problems to be younger. These differences indicate that the prisons tend to refer and Norristown tends to accept those inmates who have shorter sentences, thus making them eligible for parole or pre-release

sooner, as well as those who are younger and therefore most likely more amenable to treatment.

One other difference is observed in the MMPI, a widely used personality test (See Table 6). Scale number 8 (schizophrenia) is higher (approaches significance) for patients than for the random prison sample. This scale is the one most likely to reflect psychosis or severe mental illness.

Comparison of Results with Other Programs

To our knowledge, there are no programs with a similar approach in the treatment of mentally ill offenders. The only other hospital program that treats only prisoners already serving sentences, does so only under court order.(1) We can, however, compare our results with those of programs using different approaches (for example, those treating any type of mentally ill offender, pre-trial, in prison etc.). In terms of treatment provided, all of these programs have indicated that "most or all" patients are treated with only drugs and recreational therapy.(1) In contrast, all Norristown patients receive group psychotherapy, psychological testing and recreational therapy. Most receive drug therapy and individual psychotherapy. Scheidmandel(1) concludes that offender patients "receive relatively little therapy directed wither toward mental health or correctional needs." Norristown appears to provide the necessary therapies directed toward mental health as well as those for correctional needs, related to "the capacity to avoid criminal action at discharge." The correctional needs are met by the educational and vocational counseling and training provided at the hospital.

(1) Scheidmandel et al. (see bibliography)

V. Project Problems and Recommendations

Referrals and Screening Criteria

As has been mentioned before, the inmate's first contact with the Norristown staff is at the initial screening conference where the decision is reached as to whether he should remain at Norristown for treatment. The interview is conducted by the psychiatric consultant, the chief forensic psychologist, and the head social worker for the Forensic Psychiatric Unit, as well as any other unit staff members who choose to be present. The inmate is first given a brief personality test; his entire history is then discussed by the staff. After this, the inmate himself is interviewed by the entire team. The entire process usually lasts from 1-2 hours, occasionally longer or shorter, depending on the nature of the case and the difficulty of diagnosis. The team then reaches one of the following conclusions:

(1) Accept the inmate for treatment.

(2) Recommend that the individual be committed to a state mental hospital under Section 411.

(3) Refer the resident back to the prison with an individually prescribed treatment plan which can be carried out by the psychological and psychiatric staff of that facility.

The correctional facilities have complained that when a patient is returned to prison the information provided by Norristown staff has not included an adequate or detailed history of the treatment at the Norristown facility or recommendations for further treatment in prison. This occurs both when inmates are rejected at screening and when they are released from Norristown after treatment. In addition,

there are cases where Norristown has recommended treatment and the correctional facilities have failed to carry it out, especially in regard to administering medication. Clearly, a system must be worked out whereby treatment plans are recommended by Norristown and followed through by the correctional facilities. In short, Norristown staff feels that prisons are not following their recommendations; prisons complain that treatment plans are not suggested; again, better communications between facilities is needed. This is one place where the STEP form could be extremely useful, both in indicating the treatment a patient has received and in recommending further treatment.

The second problem with screening and selection relates to the appropriateness of referrals made to the Unit by the prisons. Originally; "Criteria for Referrals to Norristown State Hospital" (Jan. 1973) specified the procedure by which an inmate is to be referred. First, a psychologist from the correctional institution must extensively test the resident and diagnose his behavior as pathological and in need of psychiatric help. Second, an institutional psychiatrist must diagnose the resident's behavior as severely psychotic, or unmanageable and untreatable in prison to the extent that he cannot function in the prison population.

The records of all the above interviews are to be sent to Norristown with the inmate; very often this has not been the case, and the screening staff is left with very little information about the patient and why he is referred. The screening team has requested that all records contain <u>specific</u> examples of the type of maladjusted behavior that required a referral, rather than such vague terms as "strange behavior" or lengthy psychiatric jargon.

A second memo (Jan '74) more clearly informed the prisons of what type of referrals are appropriate to the Norristown facility.

(1) The patient's mental status must be one of the following:

a. Actively psychotic

b. Depressed and/or suicidal

c. In a panic anxiety state

d. Assaultive

(2) The patient should be (legally and time-wise) eligible for a pre-release program, as most patients treated at Norristown will be placed on pre-release or parole rather than returning to prison.

In spite of these memos, correctional facilities have continued to refer some inmates who clearly do not fit the criteria, specifically drug addicts and alcoholics who have no other mental problems. In fact, in their responses to questionnaire (see Table 8), some prisons criticized the project for its non-acceptance of non-psychotics, drug addicts, and overtly aggressive escape risks and indicated that there are too many rejections.

The second criterion in the January 1974 memo is rightfully confusing to the prisons; the original grant specified that patients would be "reintegrated into the prison or other suitable program." Over the course of the year, emphasis has shifted from improving mental status for reintegration into the prison population to preparation for pre-release or parole. Further clarification is needed on which approach the unit plans to pursue.

Communications Problems

Perhaps the most important problem that the evaluator has observed is one that has been pointed out by both patients and staff. That is the tremendous time lapse between the recommendation for parole or pre-release and the actual release of the patient.

In one case, parole was recommended in November and the patient was not released until March. The staff strongly feels that such a time lapse, with the patient remaining within the psychiatric population after his own mental status is improved can, and in several cases has, led to further mental deterioration, rendering the program's treatment useless.

The greatest time lapse appears to occur not between the time the Norristown staff recommends parole and the parole board grants it, but after the parole has been approved. It must be determined where, in the course of paper work, this delay is occurring. Corrections officers and patients have indicated that the delay is longer than it would be if the patient were in prison.

Another communications problem occurs at admission; in several cases patient's legal status (eg. length of sentence, detainers) has been unclear. This makes it impossible for the staff to plan a meaningful treatment program. In one case, the staff had recommended pre-release and prepared the patient for this only to find that his legal status as indicated in the records they had been given at admission was incorrect; he had a detainer and would have to return to prison. It must be made mandatory that before a patient can be accepted, his legal status be made absolutely clear to the staff.

Perhaps one individual should be appointed to solve all of these communications problems, that is to provide ongoing liaison between the Bureau of Corrections, courts, parole officers, and correctional facilities. The liaison's purpose would be to correct the following communications deficiencies:

(1) Inappropriate referrals from prisons and inadequate information accompanying referral.

(2) Failure of unit staff to provide clear treatment plans to prisons when inmates are returned at referral or release and failure of prisons to follow treatment plans when they are provided.

(3) Confusion over patient's legal status.

(4) Slowness in granting of parole after it is approved by parole board.

Personnel Problems

There are many therapeutic activities for patients to engage in within the hospital but very few on the ward itself. Most patients who have improved somewhat feel that the unit is more boring than prison. Yet, those patients without unescorted privileges cannot take advantage of the hospital activities without a staff escort. A unit such as this with security problems needs more than the usual amount of psychiatric aides, so that there are enough to maintain security and provide treatment on the unit as well as escort patients to the various activities. Quite often, there are not enough aides to do both, so the patients are not taken to gym, movies, etc. even at their regularly scheduled times. There are currently only 14 aides employed by the unit (in three shifts). Twenty-four were requested originally, and the Unit Director feels that this is the absolute minimum the unit needs; the hiring of additional psychiatric aides to bring the total to 30 is strongly recommended. That would be 10 for each shift, or approximately 1 aide for each 2-3 patients.

The second personnel problem relates to the hiring of guards (correctional officers). It has been the opinion of the majority of the treatment staff that the officers have been non-therapeutic. They tend to view the patients only as inmates and not as mentally ill and their behavior towards the patients reflects this. In some cases, training has improved their attitudes, but in others there has been no change. Although the grant clearly states in the anticipated results section that decisions regarding the function of the unit will be made by the line of authority extending from the hospital superintendent, the unit director has been informed by correctional authorities that he may not remove those officers whose behavior he sees as counter-therapeutic. Clearly there is a need for guards for security purposes, but it is recommended that in the future the professional staff of the Norristown unit select the officers on the basis of a screening device related to their attitudes toward mental illness.

## VI. Problems of Evaluation and Recommendations for Further Research

Because of the aforementioned difficulties with staffing, etc., and the individual nature of the therapeutic programs, the unit staff has had difficulty in completing the BCL, PMS, and STEP forms. Also there has been a lack of response from several of the correctional facilities when follow-up data was requested on patients who had been returned to them. Other than these two aspects, cooperation from the unit, correctional facilities, and the Bureau of Corrections has been good.

Further evaluation efforts should focus intensively on follow-up data on all patients who have been released from the program and on continued monitoring of treatment and activities on the unit.

Hopefully, monitoring of treatment activities will be simplified by the eventual usage of the revised STEP form by the unit staff, (see Table 10).

TABLE 1

Description of Patients Accepted for Correctional Unit

| Factor | N=30 | $\bar{X}$ or Frequency |
|---|---|---|
| **A. Demographic Information** | | |
| 1. Age | | 18.92 |
| 2. Race | | |
| a. Black | | 21 |
| b. White | | 9 |
| 3. Employment History | | |
| a. None | | 2 |
| b. Unskilled Labor | | 21 |
| c. Skilled Labor | | 6 |
| d. Student | | 1 |
| 4. Family History | | |
| a. Number of Siblings | | 4.60 |
| b. (1) Parents together during formative years | | 5 |
| (2) Parents Separated | | 10 |
| c. (1) Stable Environment | | 2 |
| (2) Unstable | | 8 |
| 5. Marital History | | |
| a. Never Married | | 19 |
| b. Married or Common-Law | | 4 |
| c. Separated, Divorced, etc. | | 6 |
| 6. Socio-Economic Level | | |
| a. Income | | |
| (1) Poor | | 10 |
| (2) Marginal | | 4 |
| (3) Average | | 5 |

TABLE 1 (continued)

| Factor | N=30 | $\bar{X}$ or Frequency |
|---|---|---|
| 6. Socio-Economic Level (continued) | | |
| b. Location | | |
| (1) Urban | | 11 |
| (2) Rural | | 2 |
| 7. Education (years) | | 9.51 |
| 8. Religion | | |
| a. Protestant | | 14 |
| b. Catholic | | 6 |
| c. Muslim | | 3 |
| d. Baptist | | 5 |
| e. 7th Day Adventist | | 1 |
| f. Jehovah's Witness | | 1 |
| **B. Criminal Information** | | |
| 1. Present Charges (N > 30 because charges may be multiple combinations) | | |
| a. Burglary, Larceny, etc. (crimes against property) | | 19 |
| b. Assault, etc. (crimes against people) | | 7 |
| c. Rape, sodomy, etc. (sex crimes) | | 2 |
| d. Drug sale and/or possession | | 2 |
| e. Murder | | 4 |
| 2. Minimum & Maximum Sentence (years) (life= 14-40 years) | | 2.79-7.66 |
| 3. Time served in prison for present sentence before transfer to NSH (months) | | 27.30 |
| 4. Number of prior convictions (not including juvenile) | | 2.02 |
| 5. Age at first conviction (including juvenile) | | 18.92 |
| **C. Psychiatric Information** | | |
| 1. Prison Referring | | |
| a. Graterford | | 7 |
| b. Huntington | | 14 |

TABLE 1 (continued)

| Factor | N=30 | $\bar{X}$ or Frequency |
|---|---|---|
| 1. Prison Referring (continued) | | |
| c. Rockview | | 2 |
| d. Dallas | | 1 |
| e. Camp Hill | | 3 |
| f. Pittsburgh | | 2 |
| g. Greensburg | | 1 |
| 2. Two primary reasons for referral | | |
| a. Psychotic, bizarre, confused, hallucinating | | 12 |
| b. Assaultive, hostile | | 1 |
| c. Depressed, suicidal | | 9 |
| d. Homosexual panic | | 5 |
| e. "Strange" actions | | 5 |
| f. Refuses Medication | | 1 |
| g. Isolate, asks to be locked up | | 4 |
| h. Paranoid, delusional | | 9 |
| 3. Previous psychiatric treatment | | |
| a. Inpatient | | 13 |
| b. Outpatient | | 4 |
| 4. Relatives with history of mental illness | | |
| a. Mother | | 1 |
| b. Father - alcoholic | | 8 |
| c. Sibling | | 1 |
| d. More than 1 above | | 3 |
| 5. Behavior in prison | | |
| a. Suicidal | | 10 |
| b. Assaultive | | 7 |

TABLE 1 (continued)

| Factor | N=30 | $\bar{X}$ or Frequency |
|---|---|---|
| 6. Drug History | | |
| a. Drug dependence, injections (heroin, methedrine) | | 10 |
| b. Occasional use - no dependence | | 3 |
| 7. Alcohol History | | |
| a. Heavy Use | | 7 |
| b. Alcoholic | | 5 |
| 8. Primary diagnosis by NSH screening team | | |
| a. No mental illness | | 1 |
| b. Personality disorders | | 7 |
| c. Neurosis | | 1 |
| d. Schizophrenia | | 19 |
| e. Mental retardation | | 1 |
| 9. Test Scores | | |
| a. MMPI (see profile, Table 6, and Text) | | |
| b. Beta (IQ) | | 93.25 |
| c. WRAT (grade level) | | |
| (1) Reading | | 8.84 |
| (2) Spelling | | 6.73 |
| (3) Arithmetic | | 5.51 |

TABLE 2

ACTIVE PATIENTS AS OF 3/1/74 - SUMMARY OF HOSPITALIZATION
(Listed from oldest admission to most recent)

| | Initial Medication | Stabilized Medication | Treatment | Privileges |
|---|---|---|---|---|
| 1. | Mellaril 600 mg | Mellaril 200 mg | Individual Therapy<br>Hospital Employment<br>Vocational Counseling<br>Vocational Training<br>Educational Evaluation<br>Occupational Therapy | 1. December - Full<br>2. Furlough recommended but denied by court |
| 2. | None | None | Individual Therapy<br>Occupational Therapy<br>Academic School<br>Vocational Evaluation<br>Hospital Employment | 1. December - Full<br>2. Furlough recommended |
| 3. | Stelazine 15 mg | Stelazine 10 mg | Occupational Therapy<br>Social Services<br>Individual Therapy<br>Academic School<br>Vocational Training<br>Hospital Employment | 1. December - Full<br>2. Furlough - approved by court<br>3. Parole recommended |
| 4. | None | None | Individual Therapy<br>Occupational Therapy<br>Hospital employment | 1. December - staff escort<br>2. February - time increased |
| 5. | Elavil 150 mg<br>Stelazine 20 mg | Same | Occupational Therapy<br>Individual Therapy<br>Academic School<br>Hospital Employment | 1. February - staff |
| 6. | Mellaril 100 mg | Mellaril 400 mg | Occupational Therapy<br>Hospital Employment<br>Individual Therapy<br>Academic School | 1. December - unescorted time limit<br>2. December - parole recommended<br>3. January - parole approved<br>4. February - unescorted full privileges |

TABLE 2 (cont)

ACTIVE PATIENTS AS OF 3/1/74 (continued)

| | Initial Medication | Stabilized Medication | Treatment | Privileges |
|---|---|---|---|---|
| 7. | Stelazine 10 mg | None | Individual Therapy<br>Hospital Employment | 1. December - patient escort<br>2. February - Staff escort |
| 8. | Mellaril 600 mg | Same | Occupational Therapy<br>Hospital Employment<br>Vocational Evaluation<br>Individual Therapy | None |
| 9. | Thorazine 900 mg | Thorazine 600 mg | Individual Therapy<br>Educational Evaluation<br>Hospital Employment | 1. Unescorted to work only |
| 10. | Mellaril | Mellaril<br>?escaped | Occupational Therapy<br>Educational Evaluation<br>Business School<br>Individual Therapy | 1. December - patient escort<br>2. Full |
| 11. | Mellaril 300 mg | same | Occupational Therapy<br>Individual Therapy<br>Educational Evaluation<br>Hospital Employment<br>Academic School | 1. February - patient escort |
| 12. | Stelazine 20 mg<br>Thorazine 400 mg | Stelazine 20 mg<br>Thorazine 200 mg | Individual Therapy<br>Occupational Therapy<br>Hospital Employment | None |
| 13. | Haldol 15 mg | Same | Occupational Therapy<br>Hospital Employment<br>Individual Therapy<br>Educational Evaluation<br>Academic School | None |
| 14. | None | None | Occupational Therapy<br>Hospital Employment<br>Individual Therapy | None |

TABLE 2 (cont)

ACTIVE PATIENTS AS OF 3/1/74 (continued)

| | Initial Medication | Stabilized Medication | Treatment | Privileges |
|---|---|---|---|---|
| 15. | Mellaril 50 mg | None | Hospital Employment<br>Individual Therapy | None |
| 16. | Stelazine 20 mg | Same | Educational Evaluation<br>Occupational Therapy<br>Individual Therapy | None |
| 17. | Mellaril 100 mg | Mellaril 600 mg | Individual Therapy | None |
| 18. | Elavil 75 mg | Elavil 150 mg<br>Mellaril 150 mg | Individual Therapy | None |

TABLE 3

Patients Discharged as of 3/1/74 - Summary of Hospitalization

| | Length of Hospitalization | Diagnosis | Medication | Treatment Received | Privileges (NA=privilege system not in effect) |
|---|---|---|---|---|---|
| A. | Adm:5/10/73<br>Dis:9/16/73 | Initial:<br>Paranoid Schizophrenia<br>Discharge:<br>Paranoid Schizophrenia, in partial remission on medication | Initial:<br>Thorazine, 200 mg<br>Stabilized:<br>Thorazine, 1000 mg<br>Prolixin, 1½ cc every 2 weeks<br>Discharge:<br>Prolixin, 1½ cc every 2 weeks | Hospital Employment | NA |
| B. | Adm:5/24/73<br>Dis:9/25/73 | Initial:<br>1-Personality Disorder<br>2-Sexual Deviation<br>3-Organic Brain Syndrome<br>Discharge: Same | Initial: None<br>Stabilized:<br>Mellaril, 300 mg<br>Discharge:<br>Mellaril, 300 mg | Social Services<br>Individual Therapy<br>Occupational Therapy | NA |
| C. | Adm:5/24/73<br>Dis:8/3/73 | Initial:<br>Paranoid Schizophrenia<br>Discharge:<br>Paranoid Schizophrenia in partial remission on medication | Initial:<br>Prolixin, 3/4 cc every 2 weeks<br>Stabilized:<br>Prolixin, 1½ cc every 2 weeks<br>Discharge:<br>Prolixin, 1½ cc every 2 weeks | | NA |
| D. | Adm:6/7/73<br>Dis:8/2/73 | Initial:<br>Paranoid Schizophrenia<br>Discharge:<br>Paranoid Schizophrenia in partial remission on medication | Initial:<br>Mellaril, 200 mg<br>Stabilized:<br>Mellaril, 200 mg<br>Discharge:<br>Mellaril, 200 mg | | NA |
| E. | Adm:6/7/73<br>Dis:8/2/73 | Initial:<br>Paranoid Schizophrenia<br>Discharge:<br>Paranoid Schizophrenia in partial remission on medication | Initial:<br>Prolixin, ½ cc every 2 weeks<br>Stabilized:<br>Prolixin, 1½ cc every 2 weeks<br>Discharge: Prolixin 1½cc every 2 weeks | Individual Therapy<br>Occupational Therapy | NA |

TABLE 3 - Patients Discharged as of 3/1/74 - Summary of Hospitalization (continued)

| | Length of Hospitalization | Diagnosis | Medication | Treatment Received | Privileges (NA=privilege system not in effect) |
|---|---|---|---|---|---|
| F. | Adm:6/27/73<br>Dis:1/22/74 | Initial:<br>Schizophrenia<br>Discharge:<br>Schizophrenia in remission | Initial:<br>Thorazine, 200 mg<br>Stabilized:<br>Thorazine 400 mg<br>Prolixin, 2 cc every 2 weeks<br>Discharge<br>Prolixin, 1½ cc every 2 weeks | Individual Therapy<br>Hospital Employment | None |
| G. | Adm:7/12/73<br>Dis:10/17/73 | Initial:<br>None<br>Discharge:<br>None | Initial: None<br>Stabilized: None<br>Discharge: None | Individual Therapy<br>Occupational Therapy<br>Rehab. Evaluation | NA |
| H. | Adm:7/26/73<br>Dis:10/9/73 | Initial:<br>Deferred<br>Discharge:<br>Dyssocial personality with schizoid seizures | Initial: None<br>Stabilized:<br>None<br>Discharge:<br>None | Occupational Therapy<br>Individual Therapy<br>Academic School | NA |
| I. | Adm:8/9/73<br>Dis:1/25/74 | Initial: None<br>Discharge:<br>Dyssocial Reaction | Initial: None<br>Stabilized:<br>Mellaril, 600 mg<br>Discharge:<br>Mellaril, 600 mg | Individual Therapy<br>Occupational Therapy<br>Academic School<br>Hospital Employment | NA |
| J. | Adm:8/16/73<br>Dis:11/23/73 | Initial:<br>Paranoid Schizophrenia<br>Discharge:<br>Paranoid Schizophrenia in partial remission on medication | Initial:<br>Haldol, 5 mg<br>Stabilized:<br>Haldol, 10 mg<br>Discharge:<br>Haldol, 10 mg | Group Therapy<br>Individual Therapy<br>Occupational Therapy<br>Psychological Tests<br>Hospital Employment | NA |
| K. | Adm:10/4/73<br>Dis:2/5/74 | Initial: Schizophrenia<br>Discharge: Passive Dependent personality with anti-social features | Initial:<br>Sinequan, 50 mg<br>Stabilized:<br>Sinequan, 25 mg<br>Discharge: None | Individual Therapy<br>Hospital Employment<br>Occupational Therapy<br>Business School<br>Academic School | December-Patient Escor Furlough, Recommended |
| L. | Adm:1/21/74<br>Dis:2/25/74 | Initial: Deferred<br>Discharge: Without Psychiatric Illness | Initial: None<br>Stabilized: None<br>Discharge: None | | NA |

Note: All patients received Psychological Evaluations, Group Psychotherapy and Recreational Therapy

TABLE 4

TREATMENT INITIATED EACH MONTH AND TOTAL AS OF 3-1-74

| | Court Conference | Psych. Tests | Group Therapy | Indiv. Therapy | Occup. Therapy | Hospital Employ. | Social Services | Educat.& Vocat. Counsel. | Vocat. Train. | Educat. Eval. | Academic School | Business School |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| May | 0 | 2 | 4 | 1 | 0 | 2 | 0 | 2 | 0 | 0 | 0 | 0 |
| June | 2 | 4 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| July | 5 | 4 | 3 | 2 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| Aug. | 3 | 6 | 7 | 5 | 10 | 0 | 2 | 1 | 0 | 0 | 1 | 0 |
| Sept. | 5 | 3 | 6 | 6 | 1 | 0 | 0 | 0 | 2 | 0 | 5 | 0 |
| Oct. | 4 | 5 | 30 | 2 | 4 | 11 | 0 | 1 | 2 | 0 | 0 | 0 |
| Nov. | 6 | 1 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 |
| Dec. | 5 | 2 | 11 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | 1 | 2 |
| Jan. | 5 | 5 | 0 | 0 | 4 | 9 | 0 | 0 | 0 | 2 | 0 | 0 |
| Feb. | 7 | 3 | 10 | 8 | 4 | 0 | 0 | 1 | 0 | 1 | 2 | 0 |
| Total | 42 | 35 | 77 | 26 | 23 | 22 | 3 | 5 | 4 | 6 | 9 | 2 |

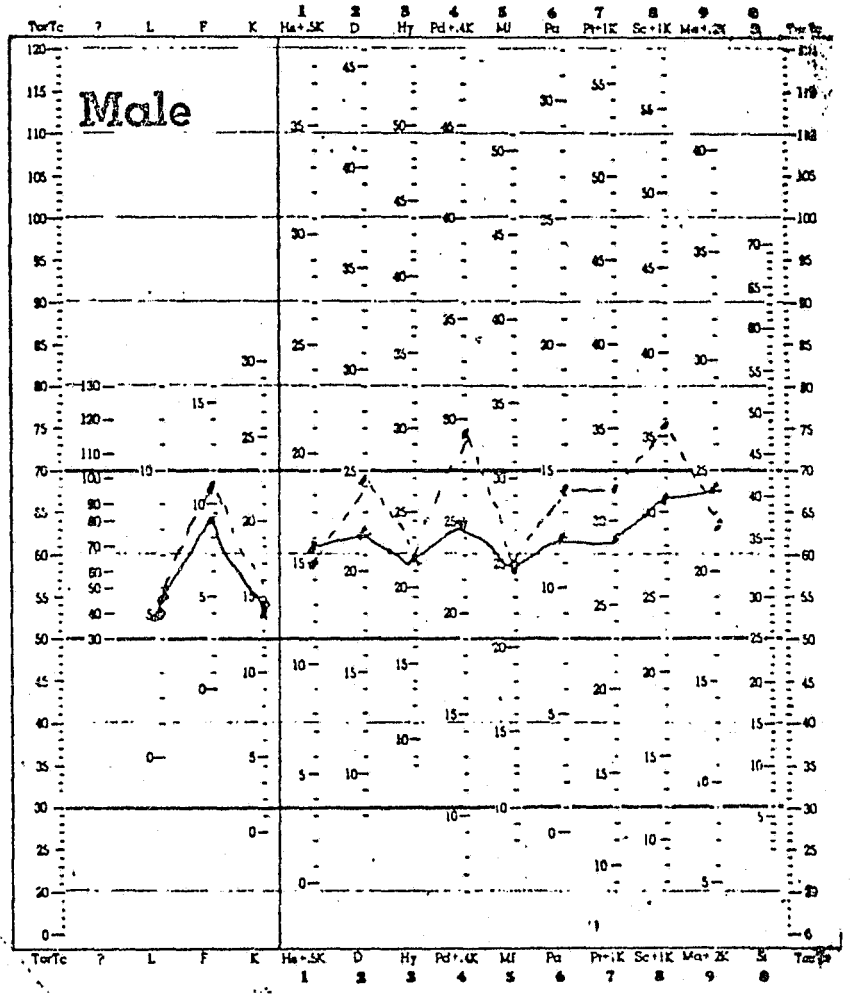
TABLE 5

Outcome and 3 Month Follow-Up of Discharged Patients

| Prison Referring | Returned To | 3 Months After |
|---|---|---|
| 1. Rockview | Farview State Hospital | Farview State Hospital |
| 2. Huntington | Graterford | Parole |
| 3. Rockview | Rockview | Farview State Hospital |
| 4. Huntington | Parole | Parole |
| 5. Greensburg | Greensburg | Parole and vocational Rehab. Center |
| 6. Huntington | Huntington | Return to Norristown |
| 7. Huntington | Huntington | Maximum sentence expired |
| 8. Huntington | Huntington<br>Ret. to Norristown<br>Ret. to Rockview | Return to Norristown |
| 9. Pittsburgh | Pittsburgh | Not Available |
| 10. Camp Hill | Camp Hill | Not Available |
| 11. Graterford | Graterford | Not Available |
| 12. Scranton Community Treatment Center | Scranton Community Treatment Center | Not Available |

TABLE 6

MMPI Scores - Comparison of Patients and Random Prison Sample




Prison

Hospital

TABLE 7

Patient Questionnaire

| | Norristown | Prison |
|---|---|---|
| 1. Do you prefer to be at Norristown or in prison? | 7 | 6 |
| 2. Do you feel the Unit has helped you? | Yes - 11 | No - 1 |
| 3. What is good about the Unit? | More freedom - 7<br>Less tension - 7<br>Medication - 1<br>Someone to talk to - 1<br>More individual attention - 1 | |
| 4. What is bad about the Unit? | Boredom - 1<br>Less freedom - 2<br>Parole takes longer than from prison - 2 | |
| 5. How would you change the Unit? | More activities - 4 | |

TABLE 8

Summary of Prison Directors of Treatment Responses

Responding: Graterford, Huntington, Pittsburgh, Greensburg, Rockview, Camp Hill

| | Yes | No | Can't Tell Yet |
|---|---|---|---|
| 1. Has the Unit fulfilled its function in treating inmates who cannot, for psychiatric reasons, adjust to the prison population? | 1 | 3 | 2 |

2. If not, why?

Sample of comments:

Non-acceptance of overtly aggressive and escape risks, those not close to parole or pre-release, non-psychotic drug problems, juveniles.

Too many rejections.

No discharge summary with recommendations for treatment on return to prison.

No outline of treatment for rejected.

TABLE 9

Summary of Norristown Treatment Staff Responses to Questionnaire

Responding: 4 professionals, 6 aides, 6 guards

| | Yes | No |
|---|---|---|
| 1. Is the unit providing a more therapeutic atomsphere than prison? | 16 | 0 |
| 2. Is relationship between correctional authorities and Unit staff satisfactory | Yes 10 | No 6 -(Fair or worse) |
| 3. Are prisons making appropriate referral and following Norristown recommendations | Yes 16 | No 0 |
| 4. Current Problems | Personnel shortage<br>Personnel training | |
| 5. Recommendations | Hire more psychiatric aides and other treatment personnel. | |

Table 10

DATE OF COMPLETION: _____ (1:18–23)

TREATMENT UNIT # : _____ (25–26)

STEP SCORE SHEET Page 1

ADDRESSOGRAPH IMPRINT:

## STATEMENT OF ADJUSTMENT PROBLEMS

Specify in order of priority the patient's adjustment problems (not in terms of diagnosis).

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

## TREATMENT OF ADJUSTMENT PROBLEMS

List all proposed treatments for specified adjustment problems.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

## MEDICAL-SURGICAL PROBLEM CHECKLIST

Specify in order of priority the patient's medical-surgical problems.

1. _____
2. _____
3. _____
4. _____
5. _____

## MEDICAL-SURGICAL TREATMENT PLAN

List all proposed treatments including medication for specified medical-surgical problems.

1. _____
2. _____
3. _____
4. _____
5. _____

# STATUS AND EXPECTATION RATING SCALE

Page 2

For each of the items below, enter one rating for the patient's PRESENT STATUS, and one rating for the condition which can reasonably be EXPECTED following the proposed treatment. Use the rating scale explained below.

## RATING SCALE

1 GOOD ADJUSTMENT, OR NO APPARENT PROBLEM

2 FAIR ADJUSTMENT, OR VERY MINOR PROBLEM

3 BORDERLINE ADJUSTMENT, OR PROBLEM OF MODEST PROPORTIONS

---**

4 RELATIVELY SEVERE PROBLEM

5 SEVERE PROBLEM

6 EXTREMELY SEVERE PROBLEM

7 PROBLEM OF DEVASTATING PROPORTIONS

---

9 NO RATING POSSIBLE

** Ratings of 1–3 indicate behavior which is acceptable within the community. Ratings of 4–7 indicate problems of sufficient severity to warrant continued treatment.

FOR OFFICE USE ONLY:

| | |
|---|---|
| 1 – 2 | FORM # 77 |
| 3 – 5 | INSTITUTION # |
| 6 – 11 | CASE # |
| 12 – 17 | PATIENT NAME |
| 18 – 23 | DATE |
| 24 | CARD # |

| | | STAT | EXPECT |
|---|---|---|---|
| TOILET SKILLS | 27 | [ ] | [ ] |
| DRESSING, GROOMING | | [ ] | [ ] |
| BATHING, CLEANLINESS HABITS | | [ ] | [ ] |
| SELF-FEEDING | | [ ] | [ ] |
| POOR APPETITE | 35 | [ ] | [ ] |
| OVEREATING | | [ ] | [ ] |
| ORIENTATION | | [ ] | [ ] |
| MEMORY | | [ ] | [ ] |
| ATTENTION SPAN | | [ ] | [ ] |
| JUDGEMENT | 45 | [ ] | [ ] |
| INSIGHT | | [ ] | [ ] |
| ABSTRACT THINKING | | [ ] | [ ] |
| ALCOHOL ADDICTION | | [ ] | [ ] |
| NARCOTIC ADDICTION | | [ ] | [ ] |
| AMPHETAMINE ADDICTION | 55 | [ ] | [ ] |
| HALLUCINOGEN ADDICTION | | [ ] | [ ] |
| BARBITURATE ADDICTION | | [ ] | [ ] |
| WORK PERFORMANCE | | [ ] | [ ] |
| SCHOOL PERFORMANCE | | [ ] | [ ] |
| HOBBIES,READING,TV,ETC. | 65 | [ ] | [ ] |
| GROUP RECREATION | | [ ] | [ ] |
| ORGANIZATION PARTICIPATION | | [ ] | [ ] |
| SEXUAL ADJUSTMENT | | [ ] | [ ] |
| FAMILY RELATIONSHIPS | | [ ] | [ ] |
| PEER RELATIONSHIPS | 75 | [ ] | [ ] |
| RELATIONSHIP TO AUTHORITY | | [ ] | [ ] |
| INSOMNIA | | [ ] | [ ] |
| DISTURBED SLEEP | 2:25 | [ ] | [ ] |
| SEIZURES | | [ ] | [ ] |
| SOMATIC PREOCCUPATION | | [ ] | [ ] |
| CONVERSION SYMPTOMS | | [ ] | [ ] |
| MOTORIC OVERACTIVITY | | [ ] | [ ] |
| MOTORIC UNDERACTIVITY | 35 | [ ] | [ ] |
| EMOTIONAL AGITATION | | [ ] | [ ] |
| EMOTIONAL INSTABILITY | | [ ] | [ ] |
| ANXIETY OR TENSION | | [ ] | [ ] |

| | | STAT | EXPECT |
|---|---|---|---|
| DENUDATIVE | 43 | [ ] | [ ] |
| MANIA | | [ ] | [ ] |
| HALLUCINATIONS | | [ ] | [ ] |
| DELUSIONS | | [ ] | [ ] |
| FEARS, PHOBIAS | | [ ] | [ ] |
| PARANOID, SUSPICIOUS | | [ ] | [ ] |
| BIZARRE IDEAS OR MANNERS | 55 | [ ] | [ ] |
| DEPRESSION | | [ ] | [ ] |
| DEPENDENCY, PASSIVITY | | [ ] | [ ] |
| OBSESSIVE THOUGHT | | [ ] | [ ] |
| COMPULSIVE ACTS | | [ ] | [ ] |
| SOCIOPATHIC BEHAVIOR | 65 | [ ] | [ ] |
| MANIPULATIVE BEHAVIOR | | [ ] | [ ] |
| OVER ASSERTIVENESS | | [ ] | [ ] |
| INCOHERENCE | | [ ] | [ ] |
| IRRELEVANCE | | [ ] | [ ] |
| VERBALLY OVERPRODUCTIVE | | [ ] | [ ] |
| VERBALLY UNDERPRODUCTIVE | | [ ] | [ ] |
| SPEECH DEFECTS | | [ ] | [ ] |
| FEAR OF COMMUNICATION | 3:25 | [ ] | [ ] |
| AFFECTIVE WITHDRAWAL | | [ ] | [ ] |
| INAPPROPRIATE AFFECT | | [ ] | [ ] |
| SOCIAL WITHDRAWAL | | [ ] | [ ] |
| FEAR OF CRITICISM OR FAILURE | | [ ] | [ ] |
| SELF-CONCEPT,INTELLECTUAL | 35 | [ ] | [ ] |
| SELF-CONCEPT,PHYSICAL | | [ ] | [ ] |
| SELF-CONCEPT, SEXUAL | | [ ] | [ ] |
| EXCESSIVE ANGER | | [ ] | [ ] |
| VERBAL HOSTILITY | | [ ] | [ ] |
| DESTRUCTIVE TO PROPERTY | 45 | [ ] | [ ] |
| ASSAULTIVE OR HOMICIDAL | | [ ] | [ ] |
| SUICIDAL THOUGHT OR BEHAVIOR | | [ ] | [ ] |
| ELOPEMENT | | [ ] | [ ] |
| FIRE-SETTING | | [ ] | [ ] |
| STEALING | 55 | [ ] | [ ] |
| RESISTIVE TO DISCHARGE | | [ ] | [ ] |

Addressograph
Imprint:



## GURRENT AND/OR RECOMMENDED REFERRALS & SERVICES

(Check all applicable)

3:59 [ ] ACADEMIC EDUCATION
[ ] ADL–COOKING,GROOMING,CLOTHING CARE
[ ] AFTERCARE SERVICES

[ ] ATHLETIC ACTIVITIES
[ ] BEHAVIOR MODIFICATION THERAPY
[ ] BOWEL & BLADDER TRAINING

65 [ ] BUILDING MAINTENANCE SCHOOL
[ ] BUSINESS EDUCATION
[ ] COMMUNITY EMPLOYMENT

[ ] COMMUNITY RE–ENTRY
[ ] DAY TREATMENT CENTER
70 [ ] DETOXIFICATION

[ ] DIAGNOSTIC STAFF EVALUATION
[ ] DISPOSITION STAFF
[ ] EDUCATIONAL EVALUATION

[ ] ELECTROSHOCK THERAPY
75 [ ] EYEGLASSES
[ ] FAMILY SERVICES

[ ] FINANCIAL AID
[ ] FOLLOW–UP
[ ] HEALTH TEACHING

[ ] HEARING AID
4:25 [ ] HOMEMAKER'S SERVICES
[ ] HOSPITAL EMPLOYMENT

[ ] INDIVIDUAL CASEWORK
[ ] MUSIC THERAPY
[ ] NEWSROOM

30 [ ] NIGHT TREATMENT CENTER
[ ] OCCUPATIONAL THERAPY
[ ] OFF GROUNDS ACTIVITY

[ ] OT PREVOCATIONAL EVAL.& TRAINING
[ ] PASTORAL COUNSELING
35 [ ] PHYSICAL RESTORATION

[ ] PRIVATE PHYSICIAN
[ ] PROSTHETIC APPLIANCE
[ ] PSYCHOICONOGRAPHY

[ ] PSYCHOLOGICAL EVALUATION
40 [ ] PSYCHOSOCIAL HISTORY
[ ] PSYCHOTHERAPY, FAMILY

[ ] PSYCHOTHERAPY, GROUP
[ ] PSYCHOTHERAPY, INDIVIDUAL
[ ] PSYCHOTROPIC DRUG THERAPY

45 [ ] REMOTIVATION TRAINING
[ ] RESOCIALIZATION ACTIVITIES,GROUP
[ ] RESOCIALIZATION ACTIVITIES,INDIVIDUAL

[ ] SHELTERED WORKSHOP
[ ] SPECIAL ACTIVITIES PROGRAM
50 [ ] VISITING NURSES

[ ] VOCATIONAL COUNSELING
[ ] VOCATIONAL EDUCATION
[ ] VOCATIONAL EVALUATION

[ ] VOCATIONAL TRAINING
55 [ ] VOLUNTEER SERVICES
[ ] VOLUNTEER SERVICES,FOLLOW–UP

[ ] WORK ACTIVITY CENTER
[ ] NONE
[ ] OTHER, (specify)

_____
_____
_____
_____
_____

## RESOURCES NECESSARY TO TREATMENT PLAN BUT PRESENTLY UNAVAILABLE

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

## PATIENT'S AGE:

4:60 [1] UNDER 18
[2] 18 – 40
[3] 41 – 65
[4] OVER 65

## PATIENT'S SEX:

4:61 [1] MALE
[2] FEMALE

## ESTIMATED DATE OF SEPARATION:

(Check one)

4:62 [ ] WITHIN 1 MONTH
[ ] WITHIN 3 MONTHS
[3] WITHIN 6 MONTHS
[ ] WITHIN 9 MONTHS
[5] WITHIN 1 YEAR
[ ] WITHIN 2 YEARS
[7] WITHIN 3 YEARS
[ ] LATER THAN 3 YEARS
[9] SEPARATION NOT LIKELY

## GENERAL MEDICAL-SURGICAL RATING

Enter one STATUS and one EXPECTATION rating for each item using the 1 – 7 RATING SCALE.

| | | STAT | EXPECT | |
|---|---|---|---|---|
| GENERAL PHYSICAL HEALTH | 4:63 | [ ] | [ ] | 64 |
| VISION | | [ ] | [ ] | |
| AUDITION | 67 | [ ] | [ ] | |
| AMBULATION | | [ ] | [ ] | |
| COORDINATION | 71 | [ ] | [ ] | 72 |

## CURRENT AND EXPECTED ADJUSTMENT LEVEL

For each of the three adjustment scales below, check in the first column the level at which the patient is currently functioning and check in the second column the level likely to be achieved by the patient following the proposed treatment. Enter only one check per column in each scale.

| SCALE | ADJUSTMENT LEVEL Current | | Expected | |
|---|---|---|---|---|
| **Basic Self-Care (Eating, Dressing, Toilet Skills etc.)** | | | | |
| 1. Totally Dependent | 1. [ ] | 4:73 | 4:74 [ ] | 1. |
| 2. Highly Dependent | 2. [ ] | | [ ] | 2. |
| 3. Moderately Dependent | 3. [ ] | | [ ] | 3. |
| 4. Minimally Dependent | 4. [ ] | | [ ] | 4. |
| 5. Completely Adequate | 5. [ ] | | [ ] | 5. |
| **Living Situation (Degree of Residential Supervision Required)** | | | | |
| 1. Totally Dependent | 1. [ ] | 4:75 | 4:76 [ ] | 1. |
| 2. Highly Dependent | 2. [ ] | | [ ] | 2. |
| 3. Moderately Dependent | 3. [ ] | | [ ] | 3. |
| 4. Minimally Dependent | 4. [ ] | | [ ] | 4. |
| 5. Totally Independent | 5. [ ] | | [ ] | 5. |
| **Work Capability** | | | | |
| 1. No Work Capability | 1. [ ] | 4:77 | 4:78 [ ] | 1. |
| 2. Minimal Work Capability Within Residence | 2. [ ] | | [ ] | 2. |
| 3. Minimal Work Capability Outside Residence | 3. [ ] | | [ ] | 3. |
| 4. Capable of Holding Part Time Job Outside Residence | 4. [ ] | | [ ] | 4. |
| 5. Capable of Holding Full Time Job Outside Residence | 5. [ ] | | [ ] | 5. |

## RESIDENTIAL EXPECTATION

Specify one or more likely residential locations for patient if treatment goals are met.

| | | | |
|---|---|---|---|
| 5:25 | [ ] APARTMENTS FOR AGED | [ ] | JUVENILE RESIDENTIAL TREATMT.FACILITY |
| | [ ] BOARDING HOME | [ ] | LIVE-IN POSITION |
| | [ ] CHRONIC DISEASE INSTITUTION | 40 [ ] | MENTAL HOSPITAL, PRIVATE |
| | [ ] CONTROLLED COTTAGE OR RESIDENTIAL CARE | [ ] | MENTAL HOSPITAL, PUBLIC |
| | [ ] CORRECTIONAL INSTITUTION | [ ] | NURSING HOME |
| 30 | [ ] FOSTER HOME | [ ] | REHABILITATION & REMEDIAL CENTER |
| | [ ] GROUP HOME | [ ] | RESTORATION CENTER |
| | [ ] HALFWAY HOUSE | 45 [ ] | ROOM OR HOTEL RESIDENCE |
| | [ ] HOME, OWN | [ ] | SCHOOL DORMITORY |
| | [ ] HOME, PARENTS | [ ] | SHARE APARTMENT OR HOME WITH ANOTHER |
| 35 | [ ] HOME, OTHER RELATIVE | [ ] | T B HOSPITAL |
| | [ ] INSTITUTION FOR RETARDED | [ ] | YMCA TYPE RESIDENCE |
| | [ ] INTERMEDIATE CARE FACILITY | [ ] | OTHER, specify_____ |

### OCCASION OF PRESENT RATING

(Check One) 5:51

[1] NEW CASE CONFERENCE
[2] OTHER TEAM OR CASE REVIEW
[3] DISCHARGE

### PRIMARY DISORDER

(Check One) 5:52

[1] FUNCTIONAL
[2] ORGANIC

Additional Comment:

| Dept: | Comment: |
|---|---|
| | |
| | |
| | |
| | |
| | |

RATERS' SIGNATURES: _____

DEPT. CODE & STAFF CODE: / / /—/ / / / (53-58)

/ / /—/ / / / (59-64)

DATE: _____

(65-70)

SEND COMPLETED SCORE SHEET TO DATA PROCESSING
AFTER PROCESSING, SCORE SHEETS WILL BE RETURNED TO UNIT CLERK FOR FILING IN PATIENT'S CHART

OMH 10/73

Bibliography

1. Scheidmandel, Patricia and Kanno, Charles. The Mentally Ill Offender, A Survey of Treatment Programs. The Joint Information Service of the American Psychiatric Association and the National Association for Mental Health. Washington, D.C.; 1969