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Rehabilitation of Delinquents: The Tale of an Experience

The subtle changes of the early 1960s in the practice of institutional psychiatry were suddenly accelerated by the desire for freedom that swept the world later in that decade. The growing interest in the therapeutic community approach, the shift from custodial care to community placement, and the new respect for patients' rights substantially altered the life and the fate of mental patients in civil institutions. However, only in the last few years have public opinion and legislation focused on two other groups of institutionalized persons: the "mentally retarded" and the "criminally insane." In the wake of the Willowbrook scandal and the von Wolfersdord case [*1*], official policy backed by legislation resulted in the placement in civil institutions of persons with a history of criminal conduct. More often than not the court decisions first affected individuals, then groups of individuals. This paper studies what happened when a group of 19 mentally retarded individuals were transferred to a newly created unit in a civil institution as the result of a New York State Court of Appeals ruling in 1973.[3] We recorded the events following the transfer, the staff-patient interactions, the difficulties encountered, and their resolution. We also monitored the patients' patterns of behavior to evaluate the therapeutic efficacy of the new treatment approach to which they were exposed.

Method

Behavior patterns were ascertained from interviews with subjects and staff and from a researcher's observations concerning the overall atmosphere of each unit, the staff morale, the patients' involvement in activities, and behavior changes that might have been missed during the interviews.

The interviews provided information on the subjects' degrees of social disability. We utilized the Social Breakdown Syndrome Inventory [*2*] that lists function level deficits (in terms of work, recreation, and supervision) and troublesome behavior (help with personal needs, incontinence, restriction of movement, failure to initiate conversation, noisiness, threats, assaults, and self-harm).

The men were interviewed prior to their transfer to ascertain their behavior profile. All 19 subjects were interviewed a week after their transfer. The escape of two patients precluded their being interviewed at the three-month follow-up. At the time of the six-month follow-up a third patient, sent to the Mid-Hudson Psychiatric Center, was unavailable.

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[3] Section 29.13 of the Mental Hygiene Law, allowing administrative transfers of patients who committed antisocial acts while residing in a civil institution (state hospital or school) to a correctional facility, was declared unconstitutional by the New York Court of Appeals in 1973.

The Subjects

The 19 male patients were in the 18 to 46-years age range (mean age, 28). Twelve were black, one was Puerto Rican, and six were white. All but one came from a low social class. The IQ range was 14 to 84, with a median of 61. The diagnosis recorded for all the men was mental retardation; one had a secondary diagnosis of schizophrenia, another of schizoid personality. Six had a history of epileptic seizures.

The total number of years spent in state schools and in Beacon State Institution (B.S.I.) ranged from 8 to 39, with a median of 17. Entry into the state school system had occurred in the first decade of life for 13 subjects and before age 15 for the remainder. Fourteen had spent more than half of their lives in institutions. Their placement at B.S.I. had been justified on the grounds of physical assaults (13 cases, including one homicide), sexual assaults (9 cases), or arson (4 cases); secondary reasons were chronic running away, repeated threats, vandalism, or theft.

During their stay at B.S.I., eight patients had achieved a fairly peaceful modus vivendi: overall, they were passive, compliant, and only occasionally allowed themselves to be provoked into a fight or an argument. One was considered by the guards as a trusty: he helped in handing out work assignments, in quelling incipient fights, and by assisting the staff in emergencies. Four patients were considered extremely disruptive and dangerous: not only did they foment agitation among the other inmates, but they also engaged in frequent fights. On occasion they had viciously attacked some of the guards. The remaining seven patients presented some problems because of their passive resistance to orders, their antisocial behavior (chronic stealing or occasional arson), or unpredictable, but not frequent, aggressive behavior. Two patients in this group were markedly obese, severely retarded men whose bizarre, sometimes threatening motions and senseless loud utterings were frightening.

Although housed in two different wards in the correctional institution, all patients had had contact with each other and some had formed homosexual relationships. The group was homogeneous in terms of chronic institutionalization, social class, and the severity of the past antisocial behavior. They were, however, heterogeneous as to intellectual level and institutional adjustment.

The Change in Environments

The differences between the two environments were marked and many. For the sake of brevity, they are summarized in Table 1. In the correctional institution, guards saw their duties as "watching over men doing time." The civilian institution unit's official

TABLE 1—*A brief summary of the differences between the correctional and the civil facilities.*

Service	Correctional Facility	Civil Facility
Administration	New York State Dept. of Correction	New York State Dept. of Mental Hygiene, Mental Retardation Division
Head of unit	administrator	psychiatric nurse
Building	jail	cottage
Personnel	male guards	male and female therapists
Population	"inmates"	"residents"
Privileges	restricted; not individualized; visits and phone calls strictly limited; access to yard once a day for 1 h; no passes	individualized; daily visiting hours; access to phone under supervision; passes
Clothes	prison garb	civilian clothes
Therapeutic program	minimal	intensive

statement of policy was "the primary purpose of the Unit is to protect and nurture the dignity, health, and development of each resident." Program objectives, implemented by a multidisciplinary team, concentrated on teaching self-care skills, controlling and eliminating disruptive behavior, and promoting socialization. As few rules as possible existed. The doors in the new unit were locked, and the subjects were not allowed to leave the building unaccompanied. Although this was an unalterable way of life in the correctional institution, the new unit's staff considered those measures temporary and exceptions based on patients' trustworthiness were possible. In fact, during the study, two patients were granted ground privileges.

Only three of the men were on continuous neuroleptic medication in the correctional facility where neuroleptics were prescribed on an ad-hoc basis in case of agitation. Upon arrival in the new unit, all the subjects were evaluated as to the need for medication. All but four were placed on tranquilizers (thioridazine, chlorpromazine, fluphenazine, and others). Medication was routinely reviewed and adjusted by the consulting psychiatrist when needed.

Staff-Patient Interaction at Hillcrest

Prior to the Patients' Arrival

As they were hired, staff members became involved in the building preparation: whatever their job level, they moved furniture, washed windows, and did other tasks. This was useful in establishing a feeling of camaraderie and esprit de corps. Joviality and enthusiasm prevailed but an undercurrent of anxiety was occasionally expressed as well, mostly as "sick jokes." Newspaper and radio announcements of the patient's transfers had been followed by a community uproar. Rumors were rampant as to the dangerousness of the patients, and local politicians were having a field day launching petitions protesting the arrival of "murderers, rapists, and arsonists." Attempts by the Department of Mental Hygiene representatives to reassure the community were received with skepticism. While the unit's chief was familiar with the patients' histories, he chose not to share his information with his staff on the grounds that they might become prejudiced towards the patients instead of making their own judgments.

The Arrival and the Honeymoon

The transfers were staggered over two months. The first wave (10 men) arrived in May. They had been selected because of their fairly good adjustment at B.S.I. The nine others, judged to be more troublesome, arrived in June.

As the first wave arrived and settled, the staff's anxiety lessened: they were obviously reassured and enthusiastically started their therapeutic program. Patients and staff participated in housekeeping tasks as well as games and "community meetings." Visits by the Hudson River Psychiatric Center (H.R.P.C.) Director (Dr. Herman B. Snow) and one by the New York State Mental Hygiene Commissioner (then Dr. Alan D. Miller) boosted morale. There were, however, difficulties in hiring staff and getting consultations from physicians or psychiatrists. This lasted until early June when anxiety regarding the arrival of the second wave began to build. The staff seemed to realize that they had been dealing with the best and, since community controversy was still raging, they were expecting the "really dangerous" patients.

Tension Mounts

As the second group of residents settled, the seemingly ample staff/patient ratio (1/2)

became suddenly insufficient (1/4). It was apparent that most of the new arrivals were indeed disruptive and needed attention and surveillance. It is interesting to note that B.S.I. had a smaller staff/patient ratio (3/10); however, staff energies had been solely devoted to maintaining order and discipline. Attempting a more therapeutic program and allowing more physical freedom proved onerous in terms of staff needs. Very soon there were incidents (fights, assaults, destruction), some quite serious. During July, two staff members who had been assaulted and one who became frightened quit, making the relative staff shortage more acute. At the peak of the tension (July 10th), one patient made a successful escape. This patient was a chronic runaway, and it is not clear whether his escape would have occurred regardless or whether it was a response to the prevailing tense and chaotic atmosphere. Somehow the staff regained control of the situation, and by August the scene had calmed.

This tenuous peace was dramatically broken on August 25th when one of the residents, considered a model patient, cut another's throat. The victim survived, but the overall consequences, as we shall see, were serious.

The dynamics of the attack are not clear. Apparently on the preceding day, the assailant A. had been mercilessly pestered by the victim R. R. was one of the most retarded in the group, and his frequent pestering of people for cigarettes had previously resulted in fights. A., who usually took everything in stride, became annoyed and hit him with a soda-pop bottle, inflicting a scalp wound necessitating seven stitches. The staff kept them apart for the rest of the day. A. received an injection of chlorpromazine intramuscularly and slept in a private room that night. The next day there were no incidents between the two, and the staff relaxed. A. was reassigned to the dormitory. During the night, while R. was asleep, A. cut his throat with a razor blade A. apparently had stolen a few days earlier. A staff member making rounds found R. in a pool of blood and saw A. returning to bed with bloodstained pajamas. A. was placed on medication and isolated while R. received 17 stitches. The next day A. was making incoherent statements about God and the devil and "taking R.'s voice box out."

One can only speculate as to whether the incident could have been prevented. The staff might not have appreciated the gravity of the soda-pop bottle incident and did not question why there was such a change in behavior in a previously "good" patient. It is possible that A. (one of the few residents not receiving tranquilizers on a regular basis) was becoming delusional or that he felt threatened by R. Some staff members reported that besides pestering A. for cigarettes, R. had threatened to tell A.'s mother something, possibly about his homosexual activities, that obviously he did not want her to know. In any case, not much attention was paid to A. and his problems. A. may have been one of those patients who have not learned how to communicate incipient distress and attract staff attention and support. Such patients are likely to reach the breaking point and explode in a dramatic fashion, taking everyone by surprise [3]. His distress may have been caused by the too sudden—for him—removal of strict external controls and his perception of the staff's high expectations. There were also indications that the staff had not fully integrated the need for safety and security in their daily work. They saw themselves primarily as therapists and, hence, were lax concerning patient supervision. The razor-blade incident is a case in point: not only was it allowed to be stolen from the barber's tray, but efforts to retrieve it were halfhearted and quickly abandoned.

The Consequences

The incident had a tremendous impact on staff and patients alike. Anxiety, fear, and guilt were translated into forceful demands that A. be swiftly dealt with (sent to jail) and threats such as "I'll get him before he gets me." This mood was exacerbated by the fact that A. was not immediately transferred. Patients engaged in more fights, and

the staff felt that they were losing control. At the same time, their personal fear of being attacked prevented them from effectively dealing with confrontations: one patient escaped and apparently the staff let him go rather than physically restrain him. This particular patient managed to hitchhike to Buffalo. The administrative decision to release him to his mother's custody was perceived by staff and patients as a reward and demoralized them further. More attempted escapes occurred as well as more incidents. One patient made a suicidal gesture. This mini-epidemic of disruptive behavior is fairly similar to incidents described by Stürup [*4*] and Redl [*5*].

The unit's chief initiated a staff reevaluation through group discussions in which the staff explored what they perceived as role inconsistencies. The need for strictly observed safety measures, for thoroughly dealing with each incident, and for not glossing over observed infractions was stressed; the therapeutic results which remained the primary goal of the unit could not be obtained without structure and discipline. The unit was reorganized so that the upper floor housed the five most disruptive patients and was heavily staffed. The first floor had less staff and continued with the better patients. Assuming a more directive role, the unit's chief established new, more restrictive rules. For example, a behavior chart listing rewards selected by the staff for specified good behavior had been used in the upstairs ward. The most coveted ones (home visits or ground privileges) were not granted when they had been earned because the patients could not be trusted to return to the unit. The chart was then modified to include only realistic rewards.

As the judicial proceedings regarding the homicidal attack went at their usual slow tempo (it took an entire month for the order of transfer to arrive), the staff and the patients mellowed toward A. Statements of sympathy and regrets of having been too harsh with him were expressed. However, the fact that action had been taken was generally therapeutic for the unit.

The Aftermath

When we visited the unit in December, the atmosphere had changed considerably. No longer was there chaos or haphazard activities. While staff vigilance remained high, no serious incident had marred the peace. The patients upstairs, although still quite disturbed, now seemed to be making as much progress as the downstairs patients in their less structured milieu. One of the two most retarded, obese patients had improved dramatically: he took care of his personal needs, looked neat and clean, initiated conversation, and engaged in useful work. The staff, gratified by his progress, experienced a sense of accomplishment. In general, the staff seemed to have achieved a more realistic appraisal of the goals attainable for each patient and had accepted the fact that their efforts would have to be sustained before dramatic changes would occur.

The Behavior Changes

During this time, what happened to the patients in terms of overall changes in behavior patterns? Our measure of disability was the Social Breakdown Syndrome (SBS) inventory. A patient's social disability is determined by the presence or absence of certain behaviors during the week of observation. The final score for each patient is obtained by adding the function level to the troublesome score. Those not socially disabled have a score of four or five, people who are disabled have a score of three or less. The lower the score, the more severe the disability. In analyzing the data, we have, at times, separated the first-wave from the second-wave arrivals since they had been selected on the basis of a better adjustment level in the correctional institution and had entered the unit earlier.

The Baseline

The median SBS score for the entire group was three; only six people achieved a score of four, that is, not socially disabled. Such persons had a good function level and did not exhibit troublesome behavior.

The troublesome behaviors observed in the socially disabled patients consisted of noisiness (four cases), threats (two cases), assault (one case), incontinence (one case), failure to initiate conversation (five cases), and physical restriction (three cases).

The Impact of the Transfer

During the week following the transfer, we observed the following changes in behavior: overall, seven patients became less disabled, seven remained unchanged, and three became more disabled.

Some types of behavior showed changes. Failure to initiate conversation completely disappeared as a result of the persistent efforts of the staff to have patients "come out of their shells."

Five patients received "some help" with their personal needs. The "help" consisted of verbal encouragements by the staff to improve appearance and table manners. This may reflect the fact that the Hillcrest staff was more sensitive to certain lacks in social graces ignored at B.S.I. It may also reflect the emergence of a true stress response in the form of mild helplessness on the patients' part. Although we cannot be sure, our impression was that this was more of a staff than a patient response. The improvement reported corresponded with the pervasive euphoria and optimism in the unit at that time.

Outcome Three Months After the Transfer

Three months after the transfer the median score for the group had returned to the baseline value of three. Regression was limited to second-wave patients. While the first-wave patients had continued to gain (median score, 4.5), the second-wave patients had regressed to a two, and all of its seven remaining members were socially disabled.

One must remember, however, that the first wave, having arrived earlier, was interviewed one month earlier than the second wave. The second wave had not only lost two of its better-functioning patients but was also interviewed while the unit was chaotic, that is, a week after the throat-slashing incident reported earlier. It is possible that had we reinterviewed the first wave at that time, we would have found signs of regression among its members too. In other words, the deterioration was more likely to have been a general phenomenon related to the violent behavior of A. and the consequences described in the previous section.

Outcome at Six Months

In December, the first and second waves were interviewed again. A. had been transferred, leaving 16 patients in the unit. The median score for the total group was 4.50, with 4.30 for the first wave and 3.50 for the second wave. Nine of the patients had improved when compared to their baseline level, five had the same score, and three had deteriorated.

If one graphs the individual patient's course during the study period, it is obvious that no clear pattern emerges; among those who improved, some improved early, some improved late, some regressed below their baseline at some time to improve again, some improved dramatically and then lost some of their gain. Similar jigsaw lines can be observed for those who regressed or returned to their baseline level. This confirms the

well-known instability of chronic patients' clinical courses. Improvement is not a continuous upward trend; neither is regression a steady downward slide.

We reviewed the data to ascertain whether we could identify outcome predictors. We examined the following possibilities: personal characteristics such as age, IQ level (at last ascertainment), race, percentage of life spent in institutions, and history of convulsive disorders; assignment to first or second wave; level of disability on baseline; patterns of behavior on baseline; and patterns of behavior one week after transfer.

In terms of personal characteristics, race and history of convulsive seizures were not related to outcome. There was a trend for the improved patients to be somewhat older (median age 31) and somewhat brighter (median IQ 61), and to have spent more of their lives in institutions (62% of lifetime) than those who deteriorated (median age 23, median IQ 45, median lifetime in institution 52%). The group who did not change had intermediate values.

None of the findings reached statistical significance, but the trend is consistent with findings reported by Steadman [6] on the Baxstrom patients: those hospitalized for longer periods were less likely to exhibit assaultive or disruptive behavior. A possible explanation is that older people who have been institutionalized for long periods have internalized some of the rules governing the institution so that when confronted with their liberalization, they adapt in a more cautious and less turbulent manner than those who have no internalized controls.

Patient's affiliation with the first or second wave shows that none of the first wave patients deteriorated. The second wave split about equally among improved (four cases) and deteriorated (three cases). None of them remained at their baseline level. Again, the findings only approach statistical significance, and the trend is toward a better outcome for first-wave patients. The level of disability on baseline was not related to outcome, nor were particular patterns of behavior.

Behavior ascertainment one week after the transfer was not a good predictor of outcome either: people who showed improvement then were as likely to be either improved, unchanged, or worse at six months as people who had not changed or had regressed. The only pattern of troublesome behavior that showed some relationship to outcome was "some help with personal needs." The five patients exhibiting this behavior were improved six months later. Although the meaning of this finding is moot, it is significant at the $P < 0.05$ level (Fisher's exact test). It may mean that patients who were perceived by the staff as being in need of advice for their dressing or eating habits were able to build successfully on this way of relating. Thus only one of the possible predictors at which we looked was significantly related to outcome.

We also tried to find whether there was any pattern in the extinction over time of troublesome symptoms existing at baseline (Table 2). The first behavior to disappear en masse was failure to communicate; it appeared in two patients. One, after "blossoming" socially, returned to his withdrawn, uncommunicative pattern. (This could be a "mourning" reaction, as it occurred after the transfer of A., the assaultive patient with whom our subject was very friendly.) The other had regressed overall.

TABLE 2—*Number of times a symptom was reported.*

Symptom	Baseline	Follow-Up		
		1	2	3
Restriction	2	0	2	2
Aggressive behavior	7	6	8	4
Failure to initiate conversation	5	0	0	2
Incontinence	1	1	1	1

Physical restriction, which was against the unit's policy and had not been used in the first two months, was instituted as a means of control. It was implemented only when the unit's chief and the consulting psychiatrist agreed on the necessity of this measure, which consisted of the patient being placed in a room (door unlocked) for no longer than 2 h at a time. This was done in the framework of the unit's new policy that insisted on rules being observed and on violent behavior being viewed as unacceptable. Insisting that rules be obeyed or that certain activities be attended has been proven rewarding in other settings [*7,8*]. Aggressive behavior (we are grouping noisiness, threats, and assault) was the most stubborn behavior. Six months later its prevalence had declined only slightly from 38 to 25%. Incidentally, the decline took place during the last three months and coincided with the use of physical restriction.

In conclusion, the transfer itself was followed by an immediate and transient alteration of previously established behavior, at least in some of the patients. In terms of long-term change there was more improvement than failure: nine of the patients improved. It would be tempting to count the two escaped patients as improved, since escaped patients have been reported to do as well as, if not better than, the normally released patients [*9*]. In these two particular cases, one, after being jailed for assault, was sent home to his family, and the other was apparently conforming to the demands of a noncorrectional psychiatric facility. Conservatively they could be judged unchanged or better.

The improvement noted in the subjects' social adjustments does not mean that they are ready to return to the community. Only one resident has reached this level: he started working as a porter in a supermarket and traveled to and from work by himself at the time of our last follow-up. We heard since that the staff was helping him prepare his first income tax return; his placement on family care is presently being arranged. Two others are going to be transferred to a developmental center near their relatives. For the six others whom we found to be improved, intensive therapeutic efforts are still needed before similar placements can be considered.

We saw the unit reach near chaos as the staff seemed unable to control violent behavior and resume a more organized and eventually therapeutic atmosphere after acknowledging that stern controls were necessary to allow therapeutic functions and attitudes to bear fruit.

Possibly, some measures could have been taken at the onset of the unit that would have prevented some incidents or given the staff a clearer picture of what its role ought to be. More openness about the patients' histories may have given the staff a more realistic idea of what their approach should be. The staff members saw themselves as therapists only and were unwilling to accept the need for strictness and surveillance until it became obviously imperative. They failed to recognize that by promoting socialization, useful activities, and initiative, they were making demands or showing expectations which were disproportionate with the abilities the patients perceived themselves to have. The relative lack of structure and the systematic nonpunitive approach were also disquieting for patients used to a much more authoritarian environment [*10*]. Not all the patients reacted that way, but enough of them showed evidence of regression at one time or another to make the explanation reasonable.

Another important factor in the unit's difficult adaptation was the fact that it was not fully staffed when all the patients had arrived. How onerous the demands would be in terms of staffing needs had not been accurately predicted. It is likely that the unit's operation would have been much smoother if there had been enough staff to insure one-to-one coverage around the clock for the patients who defined themselves as problems. The staff's relative inexperience with this kind of patient made the need for full staffing even more crucial.

The treatment of mental retardates with serious behavior disorders is one of the most frustrating tasks facing today's "caregivers." This paper shows evidence that progress

can be achieved in a therapeutically oriented setting, even with a relatively inexperienced staff. It also showed that predicting which patients would benefit from such a setting was not, in this instance, feasible, and that therapists have to be prepared to cope with transitory regressions and erratic progress courses. A reconciliation of the role of the ever-vigilant guard and the role of the permissive therapist should be emphasized in the training of staff destined to treat violent patients.

Summary

Nineteen mentally retarded men with a history of violent behavior were transferred to a civilian institution as a result of a court decision. The problems encountered in the day-to-day management of the unit specially created for their care as well as the behavior changes observed in the group are described and their implications discussed.

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