INTENSIVE EVALUATION OF THE DOVER ODYSSEY HOUSE, INC.

THE DOVER PROJECT

GRANT #: 75E1034 J07

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For The

New Hampshire

Governor's Commission on Crime and Delinquency

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INTRODUCTION

Introduction

The New Hampshire Governor's Commission on Crime and Delinquency contracted with this analyst in early December of 1976 to carry out an evaluation of the Dover Odyssey House program currently being funded by that Commission under Part E funds. The contract called for a period of at least 40 working days to be spent in pursuit of this evaluation and a final report to be filed with the GCCD no later than March 15. 1977. The evaluation which was to be undertaken was described as an intensive evaluation and was to involve an intensive examination of all aspects of the Dover Program funded by the Crime Commission. That program was originally funded in December of 1975 and was first put on-ground in March, 1976. Its current funding cycle will expire in March, 1977. Accordingly, it is anticipated that this evaluation will be completed in time to mesh with the end of the funding cycle of the Dover House program so as to provide some basis for evaluation as regards further funding for that program by CGGD.

In the attempt to complete this evaluation, over 400 man-hours were invested in the project. Of these at least 20 working days (160 man-hours) were spent on site in either Dover itself or in the Hampton Odyssey facility. During the approximately 48 days in which this evaluation was being accomplished, interviews were conducted with well over 50 people. The number of people belies the diversity of interviews that were conducted. Interviews ranged from the entire staff associated with both the Hampton and Dover facilities to include Miss Jackie Adams, the special education teacher, Mr. Dave Sandberg, who is State Director of Odyssey House, Mr. Bernie Letvin, who is the recent Director of Hampton Odyssey House, and other critical administrative staff people to include Mr. Calvin Legg, who for some nine months was Director of the Dover program until his departure from that program in January of 1977. A full range of interviews were conducted with the referral agencies which normally provide clientele for the Dover Program. These included the major probation officers, not only in Dover and Hampton but in other cities as well, who have in the past sent clientele to the Dover program. Interviews with individuals such as Miss Marilyn Vicairo, a resource worker for the Somersworth School District, Martha Barrows, a youth service worker for the Dover Police Department, Mr. Greg Butterfield, formerly head of Youth Services Division for the City of Dover and now head of the Special Guidance Team at the Dover High School, were also held. Also included were such critical individuals as Miss Donna Boulin who is the chief school psychologist for the entire Dover School System and an individual who is in a critical position to refer individuals from the school system to the Dover Program. Interviews were conducted as well with the superintendent of schools in Dover.

Equally important in terms of the interviews conducted were those which went beyond the staff members of Dover House, Odyssey House, and which went beyond the individuals which staff the referral agencies which normally supply Odyssey House with its clientele. In this regard, one must mention interviews with Dr. Rowen Hochsteadler, chief psychiatrist for Hampton and the Dover programs as well as Dr. Steve Seeman, chief psychologist and testing officer for the Dover and Hampton House. Certainly a source of great advice and insight into how the program worked

was gained by in-depth interviews with all participants in the Dover Program, which is to say all of the patients involved in this program, both resident and out-patient were contacted and interviewed in depth in order to solicit their views as to how the program operated. In short, this analyst is extremely confident that with regard to discussing the question of the Dover Odyssey House and its operation with individuals who are in a position to know how the program actually functions, that not a single important individual has been left uninterviewed during the course of some 400 man-hours which constitute the duration of this project. For further reference, a complete list of those individuals interviewed is attached herein. (See Appendix A).

After spending some 20 days on-site this analyst began to understand and know the town of Dover rather well. It is a mill town of approximately 25,000 with a long and interesting history. Its law enforcement officials attempt, in my view, to be among the best in the state as is its probation department, which is both extensive, varied, and as best as I could determine, highly professional and very dedicated to the kinds of jobs that they were doing. The service which the Dover program extends goes beyond a service provided only to the people of the town of Dover. In point of fact, it serves virtually every community in the state, at least judging from the referrals that are received by it, and the towns from which individuals finally placed come. From an impact point of view, however, its potentially greatest impact is likely to be made in the Dover-Somersworth-Rochester area, at least in terms of the type of program it is designed to be and in terms of the potentially largest source of referrals to the program.

The Dover Program was welcomed with enthusiastic support by the town fathers and important political figures of the town of Dover. Even a cursory examination of the grant application will reveal a battery of letters that were supplied by important people in the Dover community welcoming and urging the Crime Commission to support the Dover Program. Needless to say, this is somewhat unusual especially as regards the fact that Odyssey House has in the past been primarily a drug rehabilitation program something which the Dover program is not but which, nonetheless, must surely have had to overcome the stigma of drug associated youth in order to gain community support. In any case, at least in the beginning of the program, it is clear that the town of Dover has extended itself in every possible way in order to attempt to make the Dover House program a working success.

As regards the place of the Dover Program in the overall State of New Hampshire Criminal Justice Plan, one is referred to the booklet entitled, Comprehensive Criminal Justice Plan Annual Action Programs for Fiscal Year 1977. The Dover Program most clearly fits into the overall philosophy of the Governor's Commission on Crime and Delinquency in dealing with juvenile offenders. Specifically, the Dover Program falls under Section D entitled, Juvenile Diversion: Program No. 77-2-D-2, subtitled "Community Based Intervention: Diversion and Treatment Programs for Juveniles". As stated in the philosophy of the State Plan, the Dover Program is designed to fit into the following philosophical orientation as stated by the Governor's Commission on Crime and Delinquency:

"Many communities in New Hampshire lack the necessary programs which are directed towards serving youth who might be appropriately diverted from the criminal justice system. In many cases, youth exhibiting disruptive behavior and in need of professional assistance are processed through the system due to a lack of community-based alternatives and services for juveniles. Structured coordination of youth services within communities is also lacking. Wherever youth services exist, huge gaps are readily apparent. Once existing services in a community are identified, uniform statistical record keeping to assess their effectiveness and identification of needs must be accomplished. At present, there is no separate system of services for the person in need of supervision (PINS). By July 1977, a PINS may not be placed at the New Hampshire Youth Development Center. In many areas emergency housing is desperately needed for PINS and delinquent offenders. New Hampshire Statutes also state that a PINS may also be placed in a shelter care facility which is physically unrestrictive. There is an increased need for shelter care facilities within local communities which would provide much more than temporary crisis housing. This program area is designed to assist communities to provide the above-needed services and alternatives to incarceration so that youth may be served outside the criminal justice system."

The overall program area is divided into three subsections, (1) community-based diversion treatment services, (2) community-based alternatives to incarceration and (3) structured coordination of youth services. With specific reference to the Dover program, the program area under which it falls is program area #1, that is, community-based diversion and treatment services. Philosophically, therefore, an attempt has been made to integrate the Dover Program into the overall philosophical orientation of the 1977 Criminal Justice Plan for the State of New Hampshire as well as its comprehensive Criminal Justice Plan Annual Actions Programs booklet.

THE METHODOLOGY OF EVALUATION

The Methodology of Evaluation

The approach which this evaluation takes has essentially two elements to it. The first step is to undertake what might be called summative evaluation and the second step is to undertake impact evaluation. Perhaps a short analogy could best be used to explain the distinction between the two types of evaluative approaches. Consider, for example, that a light bulb is lit by electricity flowing over wires that is being produced by a small generator. The generator itself has a myriad number of working parts and one can get a fair idea as to whether or not the generator is working by simply listening to the hum of those parts. Of course, the object of the generator is to generate electricity so that it may travel along the wires and finally light the lightbulb. Now, it is, of course, quite possible that the generator may be doing everything consistent with its own operation and yet there may still be something hindering the production of sufficient electricity to light the lightbulb. Drawing upon this analogy, one might look at summative evaluation in a structural sense. It is that type of evaluation which would tend to focus upon the generator involved in our little dynamic. The object of the evaluation would be to examine the generator in terms of its wide-ranging structural aspects and operations in order to determine whether or not the generator itself is performing all of its assigned tasks.

By stretching the analogy and applying it to the program under assessment, the object of summative evaluation is to examine the structural aspects of the grant and the operation of those structural aspects as it regards the program currently being funded. Accordingly, the evaluation tends to focus upon such factors as administrative operation, staffing levels, manning levels, time studies, administrative bookkeeping, financial arrangements, auditing and all of those other operational aspects which are intimately connected with the structural component of the program itself. Such an evaluation must of necessity describe each structural component and attempt to assess its operation in terms of its contribution to the overall program and in order to discern whether or not the operations of the program are consistent with the directives and expectations of the grant and any other further letters of understanding that may have been evolved between the program directors, as an example, and Governor's Commission on Crime and Delinquency personnel. Of necessity, this type of evaluation, that is summative evaluation, must rely very heavily upon non-empirical "soft" data in most instances. It relies particularly heavily upon in-depth interviews, observations and the technique of cross-checking in order to arrive at findings. This is not to suggest that there are no empirical aspects to the summative elements in the evaluation design. It is rather to suggest that the measurement of the operational aspect of the structural elements in the program often, (although by no means always) are given to measurement by means that are other than totally empirical. This has been the case with the Dover Program and insofar as this analyst has been able to tell, this evaluation will very clearly reflect these types of data, at least as it addresses this aspect of the evaluation.

The second element of which this evaluation is comprised is termed impact evaluation. Drawing once again upon our analogy, it will be recalled that the object of the generator was, after all was said and done, to generate enough electric current to light the lightbulb. By extension the impact of any given program may well be compared to that lightbulb. The ultimate question which we would ask in our analogy is whether or not the lightbulb is lit. Accordingly, the ultimate question that we would ask with regard to any program undergoing a rather intensive evaluation is whether or not the structural operations of the program are having an impact upon the clientele for whom the program was obstensibly designed. Thus, the object of an impact evaluation is very simply to measure the impact of the operational aspects of the structural element upon the clientele, in this instance upon a clientele in both a residential and out-patient setting. To be succinct, is the program achieving its goals in terms of modifying the behavior of the clientele that are participating? Again, it is not difficult to imagine a situation in which all structural elements are operating correctly (or nearly correctly) but one in which the actual results of the program are negligible or judged to be cost ineffective. Thus, the focus on impact evaluation is clearly upon the impact - the results and outcomes which the organizational structure of the program is having upon the participant clientele. Very simply, if the results are not as predicted in the grant proposal, then the program is considered to be a failure; whereas if such results are as predicted, then the program is considered to be a success.

Of necessity, impact evaluation lends itself far more readily to the utilization of empirical data. The critical question, however, in this type of evaluation and, indeed, any other impact evaluation, is the availability of empirical data. Indeed, the extent to which empirical methodologies can be employed depends very heavily upon the availability of data. This evaluation is indeed no different from any other evaluation insofar as other types of data are concerned which this analyst would like to have had at his disposal but were not available or were simply too expensive to obtain. Nonetheless, it might be suggested that the impact evaluative aspect of this evaluation makes optimum use of the existing empirical data. Levels of sophistication will differ; that is to be expected and once again one cannot always do the kinds of tests that one would like to do in the amount of time available and given the kinds of data available. The availability of data notwithstanding, the orientation of the second aspect of the evaluation remains the same, namely, an attempt to answer the question of how the program is affecting its clientele in measurable terms. When direct answers have been able to be provided, they have been provided. When not, impressionistic evidence has been marshalled.

With regard to the impact aspect of this evaluation, every effort has been made to utilize an intervention strategy. Intervention strategy as a research design is conceptually very simple: it is a simple "before and after" approach. One delineates a certain measure of effectiveness prior to the application of the program; one then witnesses the application of the program upon the clientele and then notes the state of the clientele after it has been exposed to the program. One hopefully is

able to construct the designs in more highly empirical terms so as to be able to get a hard measure of "success" or "failure". Clearly such an approach requires the development and adoption of indicators of impact effectiveness. In this regard, some reliance has been placed upon the earlier evaluation study which was done by Mr. Joseph D. Ryan for the American Correctional Association for the Governor's Commission on Crime and Delinquency in May of 1976. Additionally, the letter of understanding between Governor's Commission on Crime and Delinquency and Odyssey House program personnel of June 14, 1976, in which specific details of measurable staff indicators of effectiveness were worked out will serve as a point of departure for this evaluation. However, it should be clear that there have been additional measures of impact evaluation developed and utilized in this study.

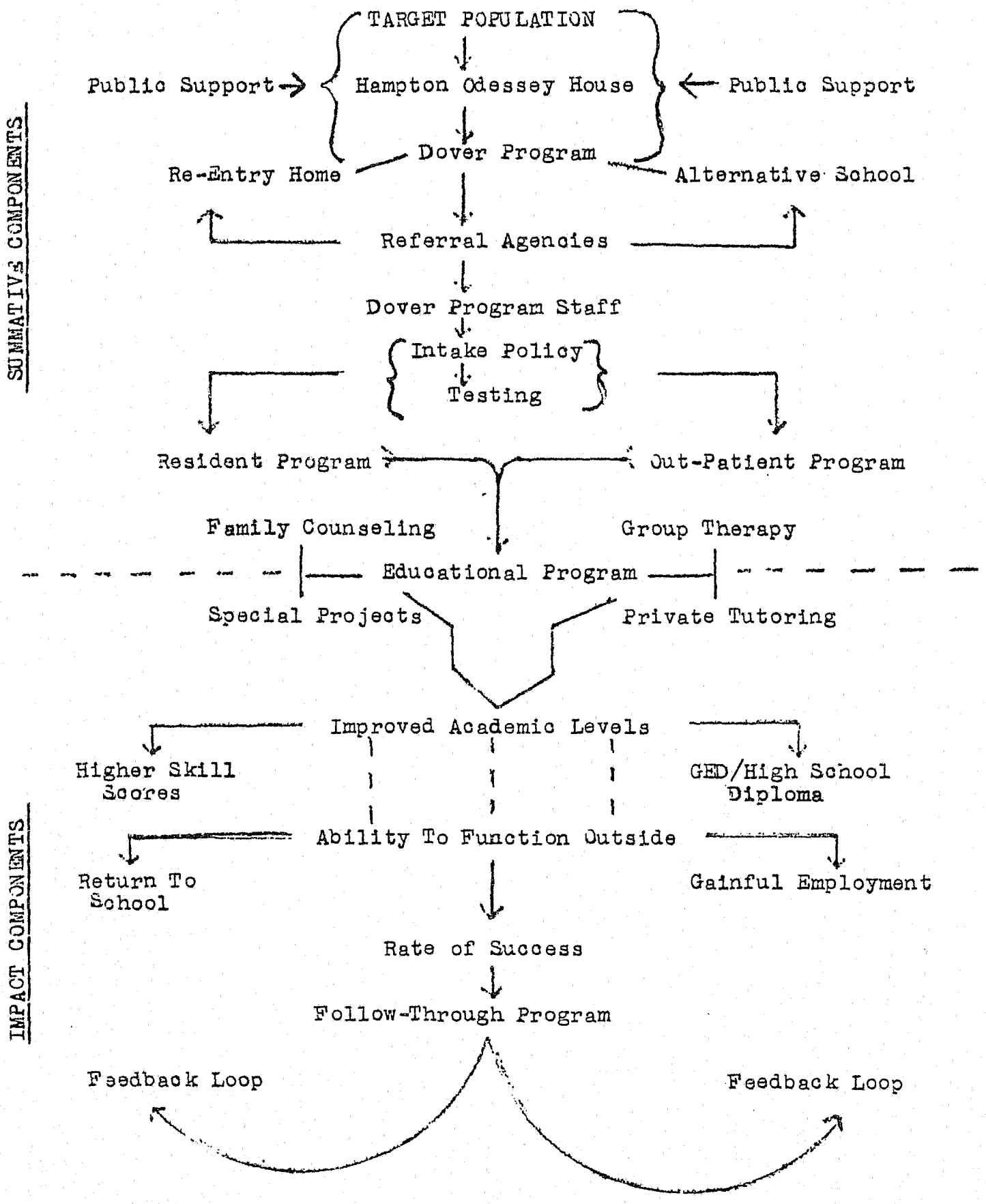
In the final analysis, an evaluation is only as good as its recommendations. It would do very little good if it were totally negative. Accordingly, after spending many, many hours in collecting data, interviewing individuals and evaluating and interpreting data, and finally placing that data into a formatt which can be understood by interested persons, it is the view of this analyst that it is incumbent that serious recommendations be made where appropriate. Once again, it is important that a negative tone be avoided. The object of an evaluation is not to find fault with a program. The object of an evaluation is to determine whether or not the program is operating in the manner specified by the funding proposal. And, if not, an attempt must be made to discern why not. Further, an attempt must be made to suggest what kinds of changes might be adopted in order to bring the program back into line with its original program objectives. Here, this evaluation has made every attempt to offer appropriate recommendations which seem in most instances workable.

Evaluations are, again, largely positive instruments. They are positive instruments from the policy makers perspective. A good intensive evaluation can aid the policy maker not only as it addresses a particular program under scrutiny, but far more so insofar as the lessons learned from the particular programs examined might be applied to other programs either already existing in the same program area or, indeed, those which have not yet been put into effect but which are planned. In this regard, this evaluation and analyst have once again made every effort to extrapolate where appropriate those kinds of lessons that might be put to good use by the policy maker in other different but at least similarly related programs. Such extrapolations are of necessity somewhat more tenuous than the recommendations which address specific wrongs or areas of the evaluated program itself. Nonetheless, they do potentially at least serve as a valuable source of information to avoid similar mistakes in the future, but more importantly to increase the probabilities of similar program success should the need arise.

THE EVALUATIVE MODEL

Figure 1

The Evaluation Model



The Evaluative Model

No evaluation is ever conducted in a vacuum. This is to say that there must be some orientation, some model for organizing the thrust of the evaluative process. Accordingly, it is appropriate that as a mechanism for ordering both the thought process and the data to the evaluation itself, some form of research strategy or data evaluation strategy must be developed. In this regard, Figure 1 below presents a model of the Dover Program as it should operate. An examination of Figure 1, the evaluative model, will indicate clearly the way in which the program is supposed to function while at the same time it identifies for the evaluator the major components of the program as they appear relative to their place in the overall program schematic. This will allow one to move beyond the mere identification of the methodologies and modalities of the program to an understanding of the actual operation of each mechanism as it is contributing to or not contributing to the thrust of the overall program.

The model details the process of program operation. Very briefly, the target population is defined as that group of individuals that the program is seeking to reach; the operant question is, of course, whether or not the group that is actually being reached by the program is in fact equivalent to the group that the program set out to reach in the first place. As can be recalled Hampton House and the Dover Program are very closely linked. By this it means that the Dover resident program was originally intended to extract its clientele totally from the Hampton Odyssey House for a reason which the methodology makes clear; i.e., Dover not being equipped to deal with behavioral problems nor having the capability to modify behavioral problems had to assume that those phased into their program would be clients whose behavior problems had already been solved. Accordingly, the operational link between the Hampton Odyssey House and the Dover Program is methodologically very close. Obviously, Hampton House and the Dover Program operate within an ambience of public support and it is very clear that public support can come to play a crucial role in the ability of the program to succeed. Thus, one identifies the extent of public support as a major variable in the successful operation of the program.

Focusing upon the Dover Program itself, it is clear that there are essentially two major elements to the overall program: the re-entry home and the alternative educational center. Each must be evaluated on its own and then must be evaluated again insofar as there is a reciprocal relationship between the two in terms of the impact that each may be having upon the clientele. Once again, following the model, it is noted that the referral agencies play a critical role in the program because they constitute the point of contact from which the clientele emerge. The clientele move from the referral agencies into the Dover Program, both into the re-entry home as residents and into the alternative educational center as out-patients. Accordingly, their role becomes very critical to the successful functioning of the program.

When one speaks of referral agencies, it is important to understand the role of two additional elements in the program, namely, the roles played by testing and in-take policy. It is a fair question to inquire as to what intake policy is extant. Is it successfully screening, and what are the impacts that it is having upon the program? The same is true of testing. The grant makes much of the ability of Hampton House to bring to bear highly sophisticated psychological, psychiatric, and educational testing devices upon the clientele. Is this testing being carried out? Is it being administered and utilized in a manner prescribed by the grant? These two elements come to represent legitimate points of evaluative focus.

Looking once again at the Dover Program proper, once an individual has entered the program he may move into either the resident program or the out-patient program. In any event, whether resident or out-patient, he must be exposed to at least four modalities which are aimed at improving his own self-esteem, self-worth, altering his behavior and changing his education achievement levels. Accordingly, one primarily examines the educational program insofar as the Dover House is rested upon a methodology of education as a major innovative tool. Nonetheless, the educational program cannot stand alone as the grant itself specifies and examination must also be brought to bear upon the role of special projects in the overall treatment plan as well as group therapy and family counselling. Assuming that the individual is exposed to all of these modalities, it still remains an important question as to the extent to which these modalities are being employed correctly or, indeed, whether they are being employed at all. Most certainly an assessment must be made as to their impact upon the patient population.

If the Dover Program is operating correctly, then there really should be two measurable indicators of program success - one, the improved academic skill levels as measured by standard measurement tools such as the California Achievement Test and, two, the increased ability of the patient to function outside of the controlled environment provided by the Dover House. Accordingly, these two indicators become primary elements of focus for the evaluation. The question is raised immediately, how does one measure each of these goals? With regard to improved academic levels, measurement here must be seen in terms of hard empirical data, i.e., the higher reading, spelling and math scores that are achieved by the patient by the testing mechanism. A second measure of improved academic levels are the number of patients who do in fact achieve the GED, which is the equivalent to a high school degree. Both of these measurements lend themselves to hard data treatment. With regard to the ability of the patient to function outside of the structured Dover Program, there are two indicators of success: one, the number of individuals who return to a public school system at a level commensurate with their age group having thus been brought up to that age group because of the educational program, and second, the number who obtain jobs in the community. Taken together then, these indicators can be utilized in an empirical manner to determine the "success rate" of the program.

Certainly critical to the operation of the program is a follow-up program which serves not only to gather data which can be utilized to assess program success but also serves to operate as a major feedback mechanism so that the system is capable of short-term correction, which is to say when confronted with its own results, the system can then take from these results some clues as to what kinds of operational and design changes ought to be made in the program itself.

From the perspective of the earlier distinction made in the introduction to this evaluation, namely from the perspective of what constitues summative evaluation and what constitutes the elements of impact evaluation, a thorough examination of Figure 1 will indicate that those elements which appear above the dotted line constitute the elements comprising summative evaluation while those elements appearing below the dotted line constitute the elements comprising aspects of impact evaluation. To be sure, while the earlier analogy of generator and lightbulb is a valid one in devising a schematic to organize the data and indeed even to interpret it, the fact of the matter remains that the evaluative model developed and presented here is really designed to organize the data in such a way as to present the reader with an overall view of the Dover Program and, thus, the distinctions between summative and impact evaluation are essentially more logical than they are empirical distinctions. While one ought to be able to judge the relative impact of any given component in the program, the fact of the matter is that the focus on the evaluation still remains holistic, which is to say focusing upon the overall operation of the program itself.

PROGRAM DESCRIPTION

Program Description

Perhaps one way to proceed in conducting an evaluation of this type is to establish in a descriptive manner just what the goals of the program are. Additionally, it is worth expounding upon the goals of the program in some detail in order to provide a comprehensive portrait of just what was originally intended by the grant. Having once established, therefore, what the program intended both in terms of goals as well as mechanisms for the achievement of these goals, it is then possible to evolve a model which describes in modular terms the main thrust of the program and to examine each of the components of that module individually. This will be the approach utilized here. Accordingly, what follows is a relatively brief description of the program as outlined in the grant application and associated documents filed by Odyssey House, Inc. of New Hampshire with the Governor's Commission on Crime and Delinquency. It is this description which will form the basis for a point-by-point evaluation throughout in this study.

As specified in the grant application finally approved by the Governor's Commission on Crime and Delinquency on December 12, 1975, the Dover Program has as its goal the achievement of three program objectives: (1) to establish a 15-bed community-based residential treatment center for the 14-17 year old juvenile delinquents, both male and female who require far more treatment that can be provided in short-term group homes; (2) to establish an alternative educational center, a therapeutic school which would serve for adolescents who demonstrated that they could not succeed within the conventional structure of the existing public school system; and (3) to develop an innovative delinquency prevention project aimed at therapeutic and special education intervention into the delinquency process at the first sign of emerging delinquency. These three stated objectives sum up the goals of the Dover Program. Taken by themselves, however, they remain somewhat vague in providing guidelines for evaluation. Accordingly, some further elaboration of each of these goals is necessary in order to begin to isolate those elements of the program which lend themselves to evaluation.

Turning our attention for the moment to the Dover treatment center, it will be noted that this facility, hereafter referred to as a re-entry home, would provide a maximum 15-bed unit for both male and female patients. However, the clientele which would be allowed to utilize this facility would be between the ages of 14 and 17. Under no conditions would 18-year olds, defined as participating adults, be allowed in the program. The resident population at the Dover re-entry home would be comprised largely of patients who had already completed intensive behavioral modification treatment at Odyssey's Hampton Center and who are ready to begin the re-entry process. These patients, the majority of whom originate within the Rockingham, Stratford, Hillsborough County area, would typically reflect prior histories of alcohol and drug abuse and what the grant identifies as emerging criminality. By way of example, emerging criminality is defined in the grant as auto theft. Additional

identification characteristics for this clientele would include severe trauma experienced in the home environment to include physical abuse, incest, extreme emotional neglect, and, perhaps, a history of failing at less structured rehabilitative and educational programs such as group homes, out-patient programs, Youth Development Center, as well as public school systems.

With regard to the Dover alternative educational center, namely, the Dover school program, the grant suggests that the primary clientele to be served in this facility would be the senior Odyssey House adolescent population described in the above paragraph. In short, those individuals, again between the ages of 14-17, who had already completed the Odyssey Hampton center's intensive behavior modification program and who were ready for re-entry into society and who were prepared to utilize the Dover educational program as a basis for bringing up to level their educational achievements. As originally envisioned, up to 25 Dover area junior and senior high school students, both male and female, between the ages of 12-17, were to participate in this program which makes extensive use of auto-tutor and machine-learning devices. Once again, characteristics of this group would include those youth which manifest pre-delinquent syndromes such as minor alcohol and drug abuse, petty theft, low academic achievement and general disruption in the school and in the home. From a methodological perspective, the grant indicates that historically such youngsters are eventually suspended, expelled, or drop out from the public school system and run away from home. There is the feeling, therefore, that the provision of an alternative educational environment through the Dover Program school could be of some help in rescuing this population from developing further pathology.

With regard to the third objective stated in the grant, Odyssey House of New Hampshire through the Dover Program intends to use both the Dover re-entry house and the alternative educational center as the basis for conducting an "innovative prevention project", which would involve up to 25 pre-delinquents extracted largely from the Dover junior and senior high schools. Senior Odyssey residents are to serve as the key link in this program, at least initially, insofar as they can serve as a bridge between the pre-delinquent youngsters on one side and the Dover guidance officers and Odyssey House staff on the other. The presupposition underlying this objective is the proposition that time and time again senior adolescents are able to effectively motivate a diseffected age peer in a way that older staff are unable to do because of what is called a "major experiential gap". The prevention project, which is the thrust of goal three would seek to provide an alternative educational therapeutic environment for those young people in the public school system, particularly at the junior high school level who are just beginning to exhibit delinquency problems. The Dover alternative school program would be used in lieu of suspension or expulsion from the public school system or, indeed, even in some cases, as an alternative to referral to the Youth Development Center. The basic outline of the program is rooted, therefore, in prevention as opposed to waiting for the individual to commit offenses which are serious enough to warrant incarceration or further intervention. In this sense, in its preventive aspect, the third

goal can be seen to be different from goals one and two, although it is very clear that the achievement of goal three represents an extension of the existing programs as stated in goals one and two. Indeed, goal three really functions as the methodology that can be utilized in the Dover school to deal with out-patients.

As part of the prevention project outlined in goal three, several services are to be provided in support of goal achievement. The first of these is a complete psychological and educational evaluation which would be done by the Dover public school system and the Odyssey staff prior to referral to the Odyssey educational center. Once again, one must keep in mind here that we are talking fundamentally about out-patient referrals. Secondly, goal three is to be supported by the formulation of an individualized curriculum by a learning machines specialist for each referral to be followed by full-time placement at the Odyssey educational center if warranted for a period of up to three months. This procedure would serve to achieve the following two sub-objectives: (a) namely, the positive engagement in the academic process largely through the utilization of learning machines as well as modification of the individual to encourage positive behavior; (b) once this program has begun an evaluation at the end of the three-month period would be followed by a referral back to the public school system if basic objectives had been met and if both the Dover public school and the Odyssey staff considered the public school a viable placement option. Finally, once back into the public school mainstream, a six-month follow-up of each patient who has successfully completed three months at the educational center would take place and his referral back to the public school on a more or less permanent basis would ensue. This follow-up would include continued discussion with the family and family counselling where needed.

In attempting to describe goal three, the construction of a juvenile delinquency prevention program, it is somewhat difficult conceptually to separate it from the statements directed at the achievement of goals one and two. Fundamentally, it strikes this analyst that the achievement of goal three is largely an attempt to take the Dover program of educational modification and upgrading and to extend it to the community on an out-patient basis. Thus, what the Dover alternative educational system attempts to do with its resident patients, all of which according to the grant would have gone through Hampton House in order to assure that successful behavioral modification would have occurred, is to apply that same process to pre-delinquent youths on an out-patient basis. In short, the attempt to achieve objective three represents a logical if somewhat unclear further application of the methodologies designed to achieve objectives one and two.

The attainment of program objectives rests necessarily upon two further elements, and they are the methodologies and modalities employed in the pursuit of the program objectives. By methodology one means the premises, principles, and assumptions upon which program modalities and program expectations are based. By modalities, one means the actual on-ground operating instrumentalities that the program utilizes to achieve

its goals. Accordingly, one can gain insights as to what the program is actually attempting to achieve and how it is attempting to achieve them by exploring the methodologies and modalities which underlie its program objectives. To this end, an exploration of methodologies and modalities associated with the Dover Program seems appropriate.

As indicated previously, the proposed Dover Program was seen to be the natural outgrowth of Odyssey, Inc.'s work with troubled youngsters at its Hampton treatment center over the past two years. It will be noted that the Hampton Program had between 1970 and 1975, undergone a metamorphosis in its orientation in terms of treatment. During that period fewer and fewer adult offenders classified as drug abusers were being admitted and more and more largely delinquent youth under the age of 17 whose problems were essentially non-drug associated began to occur. In response to this shift in clientele, Odyssey shifted its program at the Hampton House from an 18-month intensive modification experience aimed at modifying behavior to a three-month program somewhat less intensive but coupled with the option of extending the contract of the client for another three months. It has been learned from Odyssey personnel through actual day-to-day experience that seriously disturbed youth which Odyssey House typically treats require an intensive motivational and treatment experience before they can be expected to successfully participate in any type of reintegration process. Such a reintegration process would include, of course, any educational or vocational training that is targeted at getting the individual to assume greater responsibility for himself as well as developing positive relationships at all community levels. In point of fact, therefore, it was assumed that the function of Hampton House would be to bring about this intensive motivational and treatment experience in order to modify the behavioral pattern of its clients prior to sending their clients into the Dover House program. The first rehabilitative phases, by which is meant the intensive motivational and treatment experience, were to be carried out at Odyssey's highly structured Hampton center. This center would also serve as a diagnostic medical, psychiatric, educational, and psychological evaluation unit, for all residents admitted to Odyssey House of Hampton and Dover.

In terms of methodology, it has been the experience of the Odyssey program that most of the youngsters that interact with the Odyssey program are in serious trouble largely because of highly disruptive home environments. Accordingly, one witnesses severe emotional neglect, physical abuse, and even incest to be the rule rather than the exception. It is suggested from a methodological point of view that to return an individual patient who has completed a motivational and treatment phase of the Odyssey program at the Hampton Center to such a threatening, non-supportive, and, indeed, potentially destructive environment would simply be to risk undoing whatever good had been done by the motivation and modification of behavior program at Hampton House. Additionally, the lesson has been gained from experience that young people who have been subject to this type of upheaval and severe disruption can succeed only through a gradual reintegration process with the development of an ever-widening circle of positive relationships at its center. Of course, the critical word in the methodology here is "gradual". Accordingly, it would not make much sense from

the perspective of the methodology of this grant to simply modify the behavior of an individual through an intensive program at Hampton House and then to reintegrate him back into a destructive and disruptive family environment or to merely cut him loose into the city or community with the hope that he will swim, rather than sink.

As a consequence of this methodological underpinning the concept for Dover House begins to evolve very clearly. In a brief synopsis the Dover House then can really be seen as a stepping stone between the rigid confines of the Hampton center where the resident is expected to learn and is subjected to positive behavioral modification as well as to fundamental concepts which will help the individual make his own way in the community at large. The highly structured environment of the Hampton Center is designed to prepare the individual to launch himself into society in a more gradual manner. A kind of halfway linkage between the Hampton House and the society at large is what the Dover House truly becomes, so that the Dover House provides a safe environment which is supervised by strong caring role models who are charged with the positive responsibility of guiding the adolescent patient toward greater achievement, greater self-worth and greater educational achievement to an age level appropriate to the individual patient. There is also the attempt to guide the individual toward appropriate independence which, contrary to popular opinion, is based upon the premise that disaffected and alienated youth are highly dependent persons. Clearly, such an instrumentality as the Dover House would require as a prerequisite for admission to the program some evidence that the individual patient has been reflecting generally positive behavior and has made some kind of personal commitment to pursuing either educational or vocational goals.

Due to the maturation process that the patients have undergone at the Hampton facility, the Dover House is designed to be necessarily less rigid and strict in nature. The atmosphere at the Dover House is far more personal that at the Hampton House and is one in which most of the young people are assumed to be ready for by the time they are admitted to Dover. Of course, it must be clear that such an assumption is predicated on the prior assumption that the modification program at Hampton is sufficient to bring about the kinds of changes in order to make an individual ready for a stepping stone environment. There is some question in this analyst's mind which will be explored at a later point as to whether this is really the case in light of the fact that Hampton itself has reduced the modification program from an 18-month program to a more modest three-month program. I think it a fair question to raise as to whether or not three months at the Hampton facility is indeed sufficient time as to bring about the kinds of behavioral modification that the methodology of the grant requires for admission to the Dover center. In any event, the experience of the Odyssey program has been that prior to six months of therapy most seriously troubled young people simply cannot tolerate environments that are too close or personal out of fear of exposure. Again, one can see from a methodological perspective the necessity here to assure that the Hampton modification program is taking root <u>prior</u> to sending a patient into the Dover re-entry home.

The modalities as opposed to the methodologies of the Dover House are interesting for an examination of the modalities allow the analyst an opportunity to discover those instrumentalities which quite literally give affect to the program. In short, they define for the analyst those mechanisms, those structures, those instrumentalities through which the program hopes to achieve its goals. With regard to the Dover program, the following modalities appear important: first, to reinforce a growing sense of belonging to a healthy family unit which is indeed the point of the Dover House, the Dover House will have a live-in graduate of the Odyssey Program who can serve as a "big brother" figure and who can bring to bear his own experiential training to the problem of adolescent youth. In the lexicon of the Odyssey Program, these individuals would be called Level Fours and are defined later in this evaluation. Additionally, the plan was devised to utilize live-in senior citizens who could serve as surrogate grandparents. It was the belief of the individuals who designed the Dover Program that a "secure, orderly home base is the most essential prerequisite" for the transition of young people from their highly turbulent former existences to a stage where they are able to assume greater and greater responsibility for self-development, employment, higher education or placement in an outside permanent secure home environment, by which, of course, is meant foster homes. In short, Dover resident programs, especially the re-entry house, was designed in concept to represent a modality which could function as a home for these young people which would be highly stable, which would be loving, caring, compassionate, and above all, exemplary. It would be the home that these adolescent patients never had. Clearly, the major emphasis would be placed on the continued learning of healthy family concepts, values, constructive relationships, and achievement orientations, that are all essential to becoming a part of a surrogate family unit by assuming a contributing role. In this regard, then, Dover specifies for its patients that they have certain roles and expectations to fulfill within the larger community, and this constitutes a major instrumentality or modality of the program.

Another major modality which is employed in support of the methodology of the Dover Program is the Odyssey alternative education center located in downtown Dover. As this program integrates into the resident re-entry house, it is designed to help each resident achieve educational learning levels appropriate to his age and peer group. Accordingly, each resident is expected to be provided with a specialized curriculum designed by a learning machines specialist and special education teacher which will allow the patient to overcome whatever educational handicaps he may possess. Odyssey's thesis in this regard is that educational deprivation may be a root cause of adolescent acting out and, therefore, proper curriculum design is essential to these youngsters becoming healthy, well-adjusted youth. The experience of these youth has already indicated that the public school system is not a viable option for most of them due to many years of prior negative reinforcement and to their typically being at least two years behind their peers in educational achievement. It is worth pointing out here that the proposition which methodologically underlies the operation of the Odyssey alternative educational center is fundamentally that educational deprivation is the root cause of adolescent behavioral difficulties. This is far different from the proposition most

often expressed that educational difficulties are a reflection of behavioral problems. Accordingly, this assumption is somewhat unique, rather controversial and, as will be addressed later on in the impact phase of the evaluation, it leaves considerable room for doubt as to its accuracy. Nonetheless, it is merely stated here to indicate one additional modality that is employed in the support of the program operation of the Dover alternative educational program.

The educational center is intended to make extensive use of ten auto-tutors under the supervision of a special education teacher and learning machine specialist. The auto-tutor or teaching machine concept has been borrowed from the Odyssey House Utah program in which auto-tutors were used on a trial basis during the 1974-1975 school year period and which some evidence of rather substantial success is available. In utilizing the auto-tutor, Odyssey's experience is that it is possible in approximately 60 hours of operation on the machine to raise the level of an individual's learning ability one full school year. The use of the auto-tutor, of course, is supplemented with an additional 60 hours of participation in "special projects" so that it's a fair equation to note that approximately 120 hours (60 hours in an auto-tutor mode and 60 hours in a special project mode) are relatively equivalent to one full school year's teaching experience and learning equivalent in the normal public school process. Individuals participating in the alternative educational program at Dover are expected as a minimal objective to obtain either a GED, which is a high school equivalency diploma, or to re-enter the public school system at a grade level appropriate to their age with the final goal being the achievement of a high school diploma through the regular public school system. Emphasis was also placed on educational and cultural enrichment made possible by the extensive educational material which was to supplement the learning machine program.

Still another modality in support of the objectives of the Dover Program is the utilization of vocational training services to be provided for resident students and out-patients who are interested in acquiring blue-collar occupations or skills and who seek this kind of experience either for personal enjoyment or for training toward eventual employment. Training facilities are being made available through the Dover High School industrial arts department and through Pease Air Force Base, which has opened up its manual arts department for apprenticeships. By and large, this modality has not been a major one used in support of the goals of the program. Additional modalities included in the original grant include the evolution of a community restoration project to be carried out by students for the purpose of self-enhancement and learning via actual experience but this has been dropped in accordance with a letter of agreement between the Governor's Commission on Crime and Delinquency and the Dover Program staff. Very simply, the project proved to be too ambitious. Another modality in support of the Dover Program is an agricultural project to be carried out at the Dover re-entry house which includes the utilization of 90 acres of land. Crops will be grown to provide food for the Dover House residents and perhaps even to sell for market. Residents are also encouraged to acquire a caring for animals in the 4-H tradition and at the present time there are two dogs and one horse in residence at the

Dover farm. Proceeds acquired from selling crops (if any) will go to weekly allowances and purchasing needed supplies for the Dover House and educational center. Again, the evidence here is that the agricultural project really falls under the special project element of the program and it has not been heavily used.

The final modality which is used in support of the methodologies underlying the entire Dover program in all three of its elements is group therapy. Group therapy is seen as a major therapeutic tool which is to be used with both senior Odyssey residents and with Dover out-patients. The fundamental mode of therapy is group therapy although there is also a considerable amount of individual therapy anticipated. All groups are to be conducted by "highly trained Odyssey staff" with senior adolescents serving as unit leaders or communication bridges in those groups held for the Dover out-patients. Odyssey House uses group therapy to explore basic problem areas, to discuss concepts and values, and, indeed, as a force upon each individual in order to encourage him to conduct his life in an honest, open, and socially accepted manner. It is the group process which, it is argued, makes Odyssey House's educational center somewhat unique as it has been their experience that troubled youngsters do not succeed educationally without a closely related group therapy process. In short, there is an effort to make the group therapy process an integral part of the educational process within the Dover Program. Minimum group therapy objectives for Dover out-patients are honest participation in the group process and a willingness to begin to assume some responsibility for the self by reflecting positive behavior. Now, those Odyssey patients which are already engaged in the group process after a six-month period at the Hampton Center and which present no behavioral problems will utilize group therapy to work on more advanced problem areas concerning their relationships with others. Prior to graduation from Odyssey House, each senior resident must demonstrate that he or she is sensitive to the needs of other people and has sufficient inner strength to move ahead in life without being completely dependent upon Odyssey House. Graduation is also contingent upon a resident being successfully enrolled in either on-going educational or vocational training or appropriate employment and having a healthy environment in which to live. It should be clear that in many instances Odyssey House patients, whether at the Hampton facility or at the Dover facility, continue to remain in the program for longer and longer periods simply because of the lack of viable options available to them as described above. In short, it is very difficult to find an individual who has a healthy environment in which to return. As a result, often times individuals remain within the program for periods far longer than might normally be expected.

Taken together, then, the foregoing represents an attempt to describe the operations of the Dover Odyssey Program as outlined in the project grant. Additional elements which have been included in this description have been drawn from letters of understanding between the Governor's Commission on Crime and Delinquency personnel and Odyssey House staff. The object of this brief program description is to provide a general narrative baseline which identifies the major methodological and modality components of the Dover Program in order to provide a focus upon which the analyst can level his gaze so as to undertake a detailed and intensive evaluation.

In a word, this narrative can serve as a general baseline for the evaluation. The question now becomes as to whether or not an evaluation of the programs actual operation dovetails with the types of modalities and methodologies of operation that were outlined in the grant. To the extent that such a convergence of expectations and practices does occur, then the program can be seen as a success. To the extent there is a divergence of expectations and practices, then program changes, recommendations, and criticisms are indicated. Thus, utilizing this description as a point of departure we now proceed with a further and more detailed evaluation of each of the components in the program.

DOVER HOUSE: BACKGROUND

Dover House: Background

The Dover Program is really a spinoff from the Hampton Odyssey House and is a full participant in the Odyssey House national program concept and philosophy. As regards the program in New Hampshire, Odyssey House Hampton was originally begun as a program for adult drug abusers. It utilized an 18-month program of intensive behavior modification. The underlying philosophy affirmed only after an individual had undergone behavioral modification could he reasonably be expected to succeed at other societal pursuits such as educational achievement, job retraining, and reintegration into society at large. Hampton House was, therefore, in operation long before the Dover Program.

Between 1971 and 1974 it became clear to the staff at Hampton House that the clientele that they were dealing with were becoming younger and younger all the time. Early in 1974 the court system began referring juvenile offenders to the Hampton Program. So that by 1974, all adult patients in the program at Hampton had left and had been replaced by patients under 17 years old. What this circumstance did was to force a reconceptualization of what Hampton House was all about in order to come to grips with the particular kinds of problems that the new type patients aged 17 and under presented for the program itself. For a while, Hampton House continued to utilize its 18-month program of intensive behavior modification in an effort to apply the treatment model that had originally been used to deal with adult patients. Experience demonstrated that this particular approach simply did not work well. The problem appeared to be that an 18-month program simply did not work with regard to 17-year old and younger patients because it was too long a period in that the patients themselves could not perceive any "light at the end of the tunnel". In short, it required too extensive a commitment from the juvenile patient in order to result in a secure and stable client population over time. As a result of this experience, many of the 17-year old juvenile patients left the program, some voluntarily, while others simply ran away.

These circumstances required that the personnel at Hampton House take a good look at the 18-month program (which, after all, had been adopted as a result of the former adult program) and to determine whether or not it was necessary to change this program in terms of its application for expressly juvenile patients. In March, 1976, Hampton House changed its approach for dealing with juvenile offenders. Whereas, prior to March 1976, the program had been one of 18-months duration in the Hampton facility, itself aimed at intensive behavioral modification, the program was now reduced to three months. At the end of a three month period a patient would either commit for an additional three months in an effort to ensure that the behavioral problems with which he had to deal were solved, or he could then exit the program and move directly into a job or back into society or into a foster placement or into the Dover House. The Dover Program is the aspect with which this study is most concerned.

Like the Hampton Program, the Dover Program was conceptualized as a place to which graduates of Hampton could go after they had completed the Hampton program. This very clearly reflects the Odyssey philosophy that an individual is not likely to be able to succeed at educational achievement until he had first come to grips with whatever behavioral difficulties he may have had. The philosophy supports the proposition that behavioral and emotional problems will likely affect one's performance in other areas. Accordingly, the Dover facility (and more about this will be said later) was viewed essentially as a "stepping stone" between the Hampton Program and reintegration into the community. The patients that were to be admitted to the Dover Program were conceived of as patients who had by and large overcome whatever behavioral difficulties they were facing and were able to address other concerns, i.e., essentially educational achievement in bringing themselves up to educational standards which would allow their integration not only into the community but back into the school system itself. It is worth stressing here once again, that the underlying thesis was that referrals to the Dover Program would all have had their behavioral deficiencies "cured" at least in the main prior to their entrance to the Dover facility. The Dover Program was never conceived of as a replacement for Hampton House, nor was it conceived of as a program which could in and of itself cure behavioral difficulties. Rather, it was designed far more as an adjunct to the kinds of therapies that the Hampton House itself was offering. In a word, the Dover Program was to be a transitional step between the behavioral modification taking place at Hampton and the acquisition of the kinds of primarily educational skills which would be required for the individual patient to reintegrate himself into the social process.

The Odyssey House, Inc. of New Hampshire, which had operated an in-resident treatment center dealing with drug abuse in Hampton since 1971, decided to establish a community-based treatment center which they named a re-entry house as well as an alternative educational center in the city of Dover. The attempt to establish the Dover Center was seen as a natural outgrowth of Odyssey House's work in Hampton dealing with troubled youth and drug addicts. The Dover site was selected primarily because of its unusually strong and traditional support of youth projects, such support being viewed as an essential prerequisite if the efforts which were to be attempted on the behalf of troubled youth were to have any real chance of success.

In September of 1975 the Odyssey House staff first met with Mayor Sylvester of the City of Dover in an effort to discuss the creation of the Dover Program. The Mayor first consulted with the Youth Services Coordinator in Dover, Mr. Greg Butterfield, who assured the Mayor that Odyssey's proposed services would not duplicate any existing or planned services in the Dover area. Further assurances were given that the Odyssey Program would substantially strengthen the town's overall ability to come to grips with its problem youth. Once these understandings had been concluded, both Mayor Sylvester and Mr. Butterfield, as well as other town personnel, lent their support to aiding Odyssey House in getting its program off the ground. In early October, Odyssey House was able to secure the use

of a farmhouse situated on 90 acres of land which had been donated at the cost of $1.00 a year by Cpt. Joseph McCarthy of the Dover Police Department. Between October and November, staff and patients from the Hampton Odyssey House as well as prospective Dover patients traveled to Dover every day in an effort to carry out renovations which were needed on the facility in order that it would receive approval by fire and building inspectors so that the facilities could be physically occupied. Indeed, $4,000.00 in donated goods and services were obtained by the staff of Odyssey House from local merchants in order to make the facility livable. It was at this time that the staff of Odyssey House Dover applied for a grant to the Governor's Commission on Crime and Delinquency under LEAA funds in an effort to achieve financial support for the Dover Program. That grant was approved on December 12, 1975, by the overall Commission. Now, although the grant was first approved on December 12, 1975, the first monies were not spent until March 17, 1976, a delay of three months. The reason for this delay is understandable in that the resident house itself was still undergoing renovations and still had some difficulty in meeting New Hampshire safety and fire codes. A letter is on file requesting that a change in the starting date from March 1 to April 1,. 1976, be granted. The Commission did so grant the request and the Dover House began receiving funds on April 1, 1976.

Although the Dover facility was finally placed into operation on April 1, 1976, it must be noted that the resident facility addressed here was designed for use by patients who were going to be in residence at the Dover School. The Dover Alternative Education Center, although part of Dover Program per se, really represents a distinct part of the program which the Governor's Commission on Crime and Delinquency is funding. The alternative educational center was originally operated at the Dover resident house itself. Some discussions with Mayor Sylvester followed in an attempt to gain use of either the City Hall auditorium or one room in the Dover Junior High School as a site for the school. Both these sites proved to be inadequate for the needs of the Dover Alternative Education Center and, as a result, in September of this year, the Dover Alternative Education Center rented and retained, under a one-year lease, a suite of offices in a building located at 100 Locust Avenue in the City of Dover. It must be clear in this regard that the Dover program is actually comprised of two sets of physical facilities, one comprising the housing and feeding facilities for resident students which is located in the town of Dover on Longhill Road, and the second facility housing the Alternative Education Center, which is also located in the town of Dover on Locust Street and is physically separate although operationally combined within the Dover program. As a point of reference, it should be noted that the Dover Program began its formal operation, at least as far as funding from the Governor's Commission on Crime and Delinquency is concerned, on April 1, 1976, and its current funding is scheduled to run until March 30, 1977. It is these parameters which set the terms of this evaluation.

THE HAMPTON-DOVER LINKAGE

The Hampton-Dover Linkage

It must be clear that the Dover facility was not originally intended to operate in the same manner as the Hampton facility. It will be recalled that the Hampton facility's first and primary task was, through a three-month program, to attempt to modify the behavior of its patients so that they would be prepared to reintegrate into the community at large, either through the Dover School Program or through some other mechanism such as foster home placement, placement back into school, or obtaining employment. The point is that the Dover facility cannot and, indeed, was never intended to operate like the Hampton facility. To do so would obviously render it superfluous in that it would duplicate Hampton's functions. Thus, Hampton still maintains its intensive behavioral modification orientation utilizing a basic three-month program with the option of an extension to six months. By and large, the original 18-month program design has been abandoned. The point at issue is that the Dover House was never conceptualized as an adjunct to Hampton House but rather the Dover House was to function as an adjunct to the alternative educational Dover school program.

Accordingly, the primary thrust of the Dover program in concept was to be educational and not behavioral modification. The patients involved in the Dover program are presumed to have already overcome their behavioral difficulties and to reflect extant difficulties that are centered primarily upon educational learning abilities. The educational thrust is the central element in the Dover program. The residence at Dover is a place where the patients whose problems are primarily educational may stay while their educational problems are being dealt with. To be sure through the efforts of group therapy and other adjunctive mechanisms some efforts are made to come to grips with what are presumed to be minor behavioral problems. In short, the basic difference between Hampton and Dover is that the stress at Hampton is upon behavioral modification while the stress at Dover is upon educational achievement and improvement. Indeed, it is presupposed that students at Dover, whether in the resident or the out-patient program, will not reflect severe behavioral problems but are presumed to have problems which are primarily educational in nature. This is central to comprehending the Dover program for it must be clearly recognized that the Dover program does not have the resources to deal with patients manifesting primarily behavioral problems.

In order to truly grasp what the Dover Program is attempting to do, one must first understand clearly the connection that was posited to exist between the Hampton and Dover facilities in terms of the role that would be played by the Hampton facility in referring and screening clientele for the Dover Program. To quote directly from the grant:

> "We have learned from actual day-to-day experience that seriously disturbed youth that Odyssey House typically treats require an intensive motivational and treatment experience before they can successfully participate in a reintegration process which includes educational training, assuming greater responsibility for the self and developing positive relationships at all community levels."

Accordingly, as a basic point of departure it must be understood that the Dover resident program was expected to receive its referrals from the Hampton Program. There were very good and adequate reasons for this expectation. Primarily, there is a clear recognition that the Dover facility is educational in orientation. Its task is to take patients who are not suffering from major behavioral difficulties and whose problems have been defined as primarily educational and, through the use of auto-tutors, to raise their levels of educational skills and achievement. There is then an open admission that the Dover Program cannot deal with patients who have major behavioral problems. As originally envisioned in the grant, one fuction of the Hampton House was to ensure that the patients who were referred to Dover would be considered "stable" insofar as their major behavioral difficulties would have been modified in the Hampton phase of the program where they would undergo an "intensive motivational and treatment experience".

When the Hampton program first began to operate in relation to the Dover Program and an exclusively juvenile population, it utilized the model of motivation modification which had been developed with adult drug users. As a result, the initial approach of Hampton House to the juvenile program was to require an 18-month program based on the adult model within which severe behavioral modification could take place in a very rigid and an intensive atmosphere. As has been mentioned earlier, the 18-month program proved not to be overly successful. In response to this lack of success, the Hampton Program reduced the amount of time from 18 months to three months with the option of a client being able to extend his stay for an additional three months with a maximum anticipated stay of six months. This analyst could find virtually no staff member who was willing to maintain that the Hampton program would be able to accomplish behavioral modification in the juvenile population in three months what the 18-month program was able to accomplish when it dealt with an adult population. Given this finding it seems a reasonable conclusion that the individuals exiting Hampton House and entering the Dover Program could not be assured of being as behaviorally stable as one would expect judging from the methodology of the grant proposal.

There is some evidence in support of this contention. As of the time of this writing fully 30% of the ten residents at the Dover resident facility were in a process of being removed from the program because they were judged to be "inappropriate" for the program. This suggests again that the Hampton facility in its use of a three-month program of behavioral modification is simply not in a position to guarantee the behavioral stability of the clients that are sent to the Dover House. This point is important because it is admitted by all concerned with the Program that Dover does not have the capability of dealing with patients who have behavioral problems. The thrust of the Dover Program is essentially educational, and before educational progress can be expected to take place, behavioral modification must have already taken place to an extent that the behavioral problems of the patient do not interfere with the educational process. Once again the available data suggest that in at least 30% of the cases this is simply inoperative.

Even more troublesome as one looks to the future of the Dover Program is the expectation that the recruitment of patients both for the out-patient and the resident program will rest more and more upon referral agencies within the community. Indeed, this is already the case as Table 1 suggests. This means that prospective clients in the resident program at Dover will not have gone through the Hampton House experience. Given the fact that the Hampton House experience has not been overly successful in providing clientele with highly stable behavioral patterns there is some additional risk that as the pattern of recruitment changes away from the Hampton program through community referral agencies, the probability that "inappropriate" clients will be admitted to the resident program most certainly will increase. In short, there is no good reason to believe that the future will not bring a type of clientele into the resident program which will not have behavioral problems. Accordingly, it becomes critically important that the testing and screening mechanisms utilized in this program be tightened, and, as we shall see, the looseness of such mechanisms currently represents a major difficulty.

The major thrust of this analysis to this point is simply that the "before treatment" model which was presented in the grant application and which underlies the connection between Hampton and Dover facilities, and, indeed, upon which many of the operational elements of the Dover Program are predicated, is seen to be operating in only a partial manner. Furthermore, there is a serious question as to whether or not that model can successfully operate in the future when the points of referral to the Dover program change away from the relatively rigid Hampton House facility to a more loosely structured community-based referral system. In any event, it is reasonable to expect that clients referred to the Dover program in the future will almost certainly not have undergone that "intensive motivational experience" which is fundamental to the methodology of the present program. Furthermore, as long as the majority or indeed all of the individuals referred to the Dover resident program were coming from Hampton House there was at least the expectation that in most instances the motivational problems of these individuals would have been reduced to an extent where education remained the primary obstacle to be overcome; the fact of the matter is that we can no longer be sure that even the Hampton facility is working properly. The mere fact that three out of ten residents could be still judged "inappropriate" suggests either one or two possibilities: that the Hampton Program for addressing and dealing with motivational problems prior to sending a client into the Dover Program is something less than a total success, or that the screening process through which potential clients must pass prior to their admission to the Dover Program is breaking down. Of course, a third possibility is that a combination of both factors is at work and indeed it is this analyst's suspicion after examining the screening process that this probability is most likely.

When this problem was discussed with the Dover staff, there was fundamental agreement that the Hampton modification program was simply not working to the extent that had been anticipated and that the fears which have been expressed here in this evaluation were shared by both the special education teacher and indeed by the newly appointed Acting

Table 1

Profile of Referral Sources For Students Sent To Dover Program

Referral Agency	# Accepted Referrals	% Of Total
Probation	12	46.3%
Hampton/Odessey Sources	5	19.2%
Other	3	11.5%
Welfare	2	7.9%
Schools	2	7.9%
Voluntary Admission	2	7.9%
	26	100.7%

** Data valid as of January 15, 1977

Director. The fact of the matter is that Odyssey's staff is aware of this problem and one of the reasons why a new Acting Director was appointed was essentially to come to grips with the problems. At the present time, however, while the Director admits that "something will have to be designed at Dover" to deal with the problem of inappropriate clients being admitted to the Dover Program, the fact of the matter is that at the time of this writing, no design to correct the problem is in place and as best I could discover, there is really no design in the planning stages as to how the problem may be solved. Fundamentally, however, there is little doubt that the Hampton-Dover connection is critical to the successful operation of the program and there is even less doubt that the nature of that connection as specified in the methodology section of the grant proposal simply is not operating in the manner that was expected. As long as these conditions obtain, the problem of inappropriate referrals can only be expected to worsen.

PROGRAM BUDGET

Program Budget

The Dover House Odyssey Program has an annual budget of $97,739.00 of which $35,000.00 is provided by LEAA. Of a total budget of $36,842.00 which come from sources, channeled through the New Hampshire Governor's Commission on Crime and Delinquency, $33,158.00 represents federal monies, $1,842.00 represents non-federal Crime Commission monies and $1,842.00 represents match funds for the sub-grantee. With regard to expenditures, $19,700.00 is spent on salaries, of which $10,500.00 is spent for the Director and $9,230.00 is spent for the full-time teacher, Miss Jackie Adams. Not included in the salary figures is an 18% calculation for fringe benefits amounting to $3,191.00. Total personal services, therefore, as regards funding by the Crime Commission amount to $23,246.00. Under "consultant services", $1,600.00 has been allotted for the hiring of a consultant to aid in establishing the auto-tutor program. These monies have gone to Miss Corrine Milles and have been spent as indicated later in this evaluation. Travel and subsistence allowances of $1,805.00 have been granted, of which $1824.00 has been spent, thus resulting in a deficit of about $19.00, which, of course, comes out of the sub-grantee funds. With regard to funds provided for capital equipment, $3,842.00 was provided in this category and a total of $4,000.00 has been spent thus far. Four auto-tutors at $500.00 apiece comprise an expenditure of $2,000.00; a cost of $1,500.00 for the initial set of tapes totaling $3,500.00, plus the spending of an additional $500.00 for new tapes to be utilized in conjunction with the Craig Reader comprise an expenditure of $4,000.00. Thus, the program has spent slightly more than the amount provided and again the difference has come out of the matching funds provided by the sub-grantee.

With regard to other expenditures, a total cost of $6,349.00 has been allowed in the "all other" category. This category of expenditures include $105.00 for hygienic supplies, $359.00 for office supplies, $290.00 for maintenance supplies, $700.00 for educational supplies, $650.00 for telephone, $1,100 for utilities, $-0- for insurance, $87.00 for postage, and $640.00 for miscellaneous. This comprises a total of $3,936.00, leaving an unexpeded balance in the "all other" category of $2,413.00. It is worth clearing up at this point something which seems to be a miscomprehension on the part of Governor's Commission on Crime and Delinquency personnel with regard to funds that may have been sent to the Odyssy National Institute. When this analyst first addressed the project, he was briefed to the effect that 15% of total grant monies awarded were sent as overhead to Odyssey National Institute. As best as this analyst can determine this is not the case. What is sent to the National Odyssey Institute is 15% of the $1,600.00 listed under consultant services. Thus, it is simply incorrect that 15% of the total grant is funneled to the National Odyssey Program. In point of fact, this is not the case.

In analyzing the budget of the program, this analyst could find no major discrepancies dealing with Governor's Commission on Crime and Delinquency funds. To the best that he was able to determine, all procedures

are being complied with. The bookkeeping is very adequate and utilizes a color code system for keeping separate the different money sources utilized by the program. Everything seems in order, records were easily available, and were made open to my examination without any difficulty.

On aspect did present some initial difficulty and that is with the grant adjustment. It will be recalled that in the original grant proposal monies were budgeted to hire a full-time fiscal officer, Mr. Frank Sanders, and to hire the special education teacher for only two days a week. As a result of the grant adjustment, fully approved by the Governor's Commission on Crime and Delinquency, Mr. Sanders was removed and allocated monies were switched to support Miss Adams' salary. In addition, a grant adjustment was made which allowed the reallocation of money out of certain other categories into the support of the salary category for the full-time teacher. The amount of money transferred amounted to $295.00 and was taken from the travel category, office supply category, and hygienic category to comprise the salary adjustment for paying the full-time teacher. For authorization of the salary adjustment, one is referred to minutes of the meeting held on June 14, 1976, between the Governor's Commission on Crime and Delinquency personnel and the Dover staff. Attached in Table 2 is the item budget as it appears in the grant proposal itself with matching figures. Also attached as Table 3 is the total budget for the Dover Program as provided by Odyssey staff encompassing not only Governor's Commission on Crime and Delinquency funds but other funds as well. They are listed in terms of category expenditure and identification of other funding sources is evident.

Table 2

DOVER ODESSEY HOUSE PROGRAM BUDGET
(GCCD FUNDED MONIES ONLY)

ITEM	TOTAL COST	FEDERAL LEAA CASH	NON-FEDERAL CASH CRIME COMMISSION	NON-FEDERAL CASH SUB-GRANTEE	TOTAL NON-FEDERAL CASH
1.a. Salaries	19,700.	17,730.	985.	985.	1,970.
b. Fringe Benefits	3,546.	3,191.	177.	178.	355.
c. Total Personnel Services (1a & 1b)	23,246.	20,921.	1,162.	1,163.	2,325.
2. Consultant Services	1,600.	1,440.	80.	80.	160.
3. Travel & Subsistence	1,805.	1,625.	90.	90.	180.
4. Capital Equipment	3,842.	3,458.	192.	192.	384.
5. Construction & Renovation					
6. Rental (space)					
7. All Other	6,349.	5,714.	318.	317.	635.
TOTAL	36,842.	33,158.	1,842.	1,842.	3,684.

Table 3

BUDGET

Total Dover Project (includes Dover house & educational center)

I.	**Personnel**		
	A. Full time		
	1. Admin/Counselor	$9,750	
	2. Counselor	8,500	
	*3. Special Ed. Teacher	8,500	
	*4. Night time supv. (2)	14,000	
	Fringe @ 18%	7,335	$48,085
	B. Part time		
	*1. Arts & Crafts Teacher (20 hrs/wk)	4,000	
	*2. Secretary (20 hrs/wk)	3,500	
	*3. Adams & LeRoux (PA's)	600	8,100
II.	**Consultants**		
	A. Learning Machines Specialist (1 day/mo x 12 mo)		1,600
III.	**Equipment**		
	A. Autotutors	7,100	
	*B. Automobile (used)	2,500	
	*C. Typewriters (2)	600	10,200
IV.	**Supplies**		
	A. Food ($2.45 day x 15 x 365)	13,414	
	B. Office	1,500	
	C. Hygenic	1,000	
	*D. Maintenance	1,000	
	*E. Building	1,000	17,914
V.	**Travel**		2,000
VI.	**Other**		
	A. Urine Screening ($3.00 sample x 15 x 52 wks)	2,340	
	*B. Utilities	2,000	
	*C. Telephone	2,500	
	*D. Insurance	1,000	
	*E. Postage	500	
	*F. Misc. (auto repairs, medical bills)	1,500	9,840
	Total Cost		$97,739

*These line items reflect budget increases over and above the Odyssey House budget for 45 residents originally figured for the Hampton unit only (see attachment E 7aa). Total increase= $49,250. of this total. Manpower is expected to fund $34,050

PHYSICAL FACILITIES

Physical Facilities

In describing the physical facilities of the Dover Project, one must keep in mind that one is talking about two separate sets of facilities: first, the Dover resident house and second, the Dover alternative educational program facility in which the actual educational training is accomplished. With regard to the Dover resident house, this facility is located approximately 4.5 miles from the central business district of Dover, on Long Hill Road. This facility is fairly isolated and sits on approximately 95 acres of woodland. This house has been recently renovated by the residents themselves under the direction of the Odyssey House staff and some $4,000.00 in donated goods and services were obtained by the Dover/Hampton staffs from local businessmen in the community. As one looks at the house, it is relatively small and its furnishings sparse. Nonetheless, after some renovation it did meet the local health and fire codes. There are bathroom facilities on the first and third floors, and there is a living room, a kitchen-dining room located on the first floor. There are also three small bedrooms for boys and an 11 x 7 classroom located on the second floor. At one time in the early stages of the program, this house was used to maintain female residents as well. As female residents have transferred out of the program, the facility presently houses an all male population.

Taken in general, the house, being as it was obtained for only one dollar a year lease from Captain Joseph McCarthy of the Dover Police Department, can be said to be "adequate". This analyst in spending many hours in the house talking to students received the impression that it tended to be cramped, somewhat unkept and clearly in need of space. The staff is giving considerable thought and, indeed, effort to the creation of a recreation room to be added to the back of the existing structure. By and large, however, the structure is safe. It has adequate fire escapes, electrical and heating facilities, and given the background from which many of the clients resident in the facility come, it is likely that the facility as it presently stands is adequate for what it seeks to do, i.e., to provide a place where patients can live in relative comfort and yet at the same time be under the close supervision of the Dover staff.

If one had to utilize a single word to describe the facility, one would use the term adequate. By no means is it luxurious and by no means does it provide all the amenities of what we would call a middle-class home or even of those amenities which we have tended to associate with more heavily financed governmental projects. At the same time, it must be pointed out that not a penny in federal or state dollars has been spent on the Dover house and that the facility has been entirely self-generated by the Hampton and Dover programs. And in this regard, it does provide the kind of adequate facility which the Dover residents program needs to operate.

With regard to the physical facilities in which the Dover alternative educational school is located, it is recalled that at the time at

which the grant was proposed, it was suggested that the school itself would possibly be located either in the City Hall Auditorium or in a single room to be provided by the Dover Junior High School. Both of these alternatives were in fact made available to the Dover staff but were rejected on the grounds that such facilities would be inadequate in terms of necessary space and, indeed, the times in which these facilities could be utilized. As a result, the present Dover school is located in a rented building at 100 Locust Street in the center of Dover. The building is comprised of a suite of rooms which has a kitchen, an adequate bathroom, classroom facilities, and a small living room. Although the facility is physically small, it is adequate under the present patient case load. The classroom can be closed off so that it can be used either for group teaching or for group therapy sessions and the auto-tutors can be utilized at the same time in a second room. Presently, the existing facility in Dover costs the project $200.00 a month, but that includes the rent of the building as well as all utilities. Although the facility in which the Dover School is located is adequate under the present patient load, the projected patient load within a year of twenty-five out-patients as well as twelve residents would make the space inadequate for projected teaching needs. Relying heavily upon these projections, plans are under way to transfer the Dover school facility to a new site when the present lease runs out on September 15, 1977. While this analyst was on site, a real estate agent who handles the facility in which the school is located was showing it to other interested clients, which leaves me to suggest that the Dover personnel are quite serious about moving this facility. At the present time, to the best of my knowledge, there is no specific facility chosen which could serve as a replacement, although very clearly one gets the impression that the search for a new facility is already under way. Figures 2, 3, 4, 5, 6, 7, and 8, give a pictorial view of the physical plant of both the Dover resident house and the school facility.

Figure 2

Dover Residence House

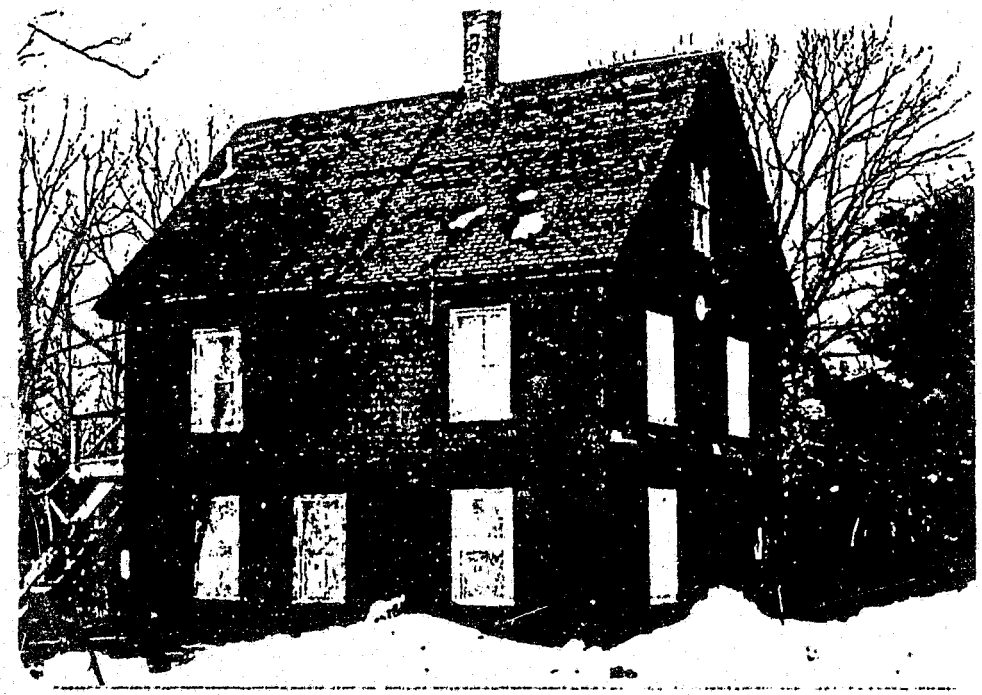
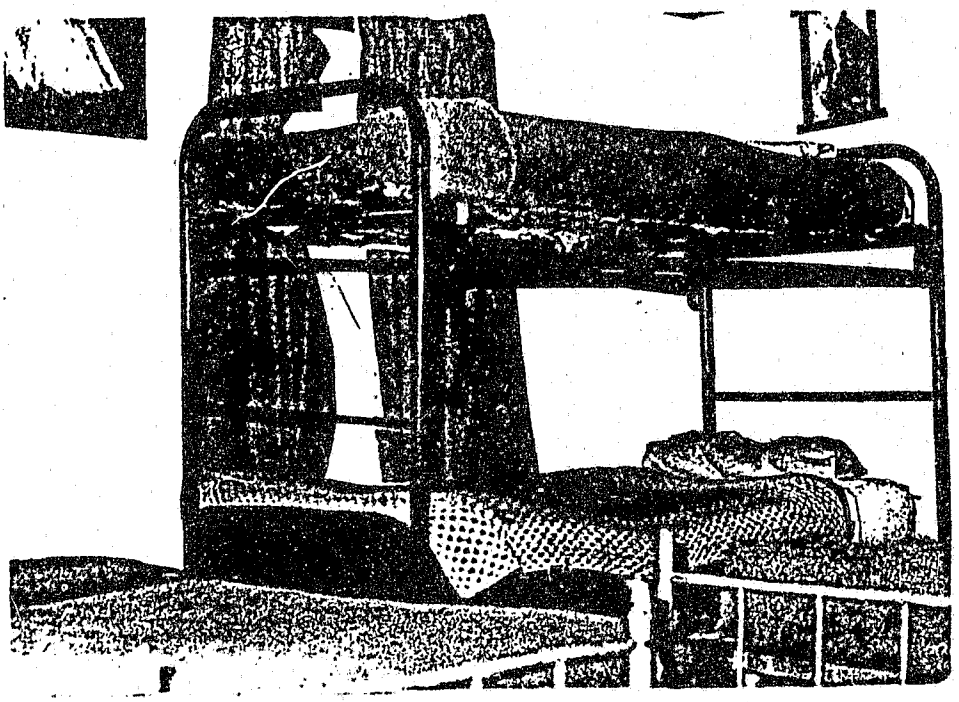


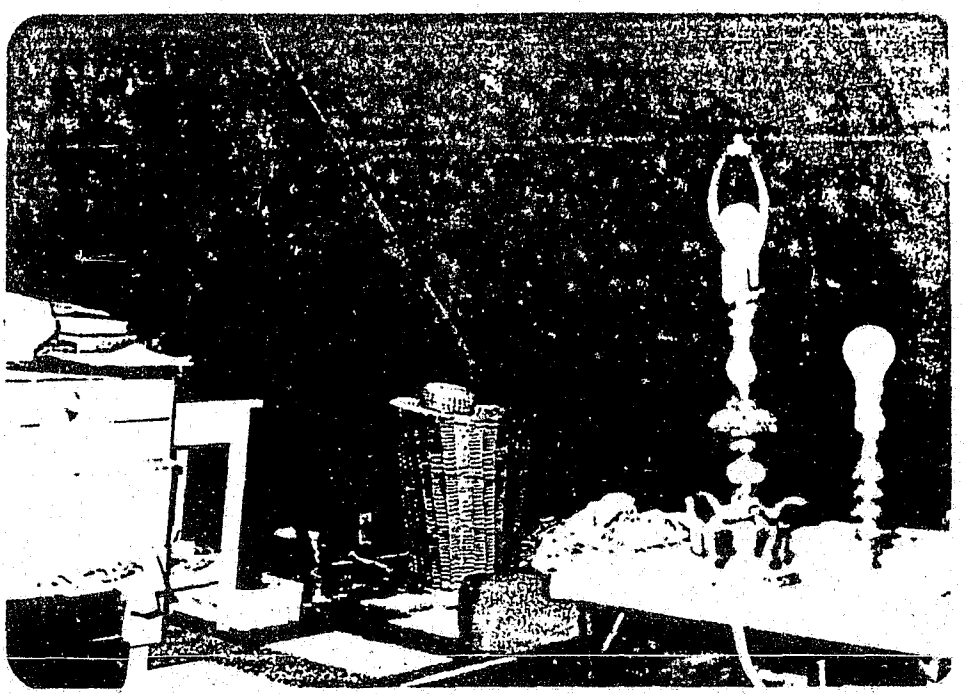
Figure 3

Dover Residence House

(Sleeping Quarters)



Third Floor Quarters

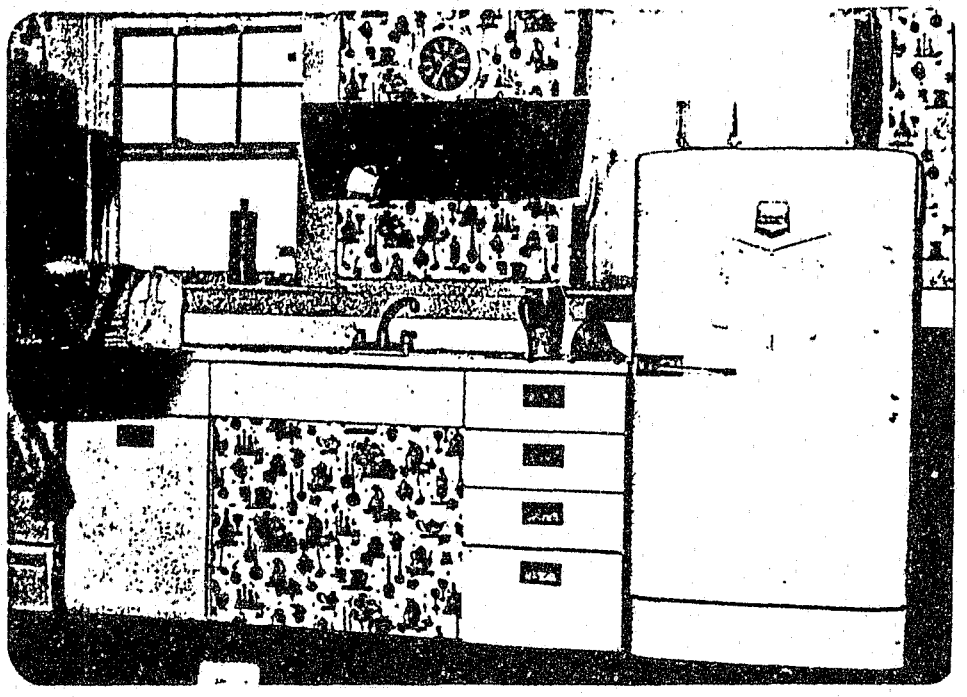


Second Floor Quarters

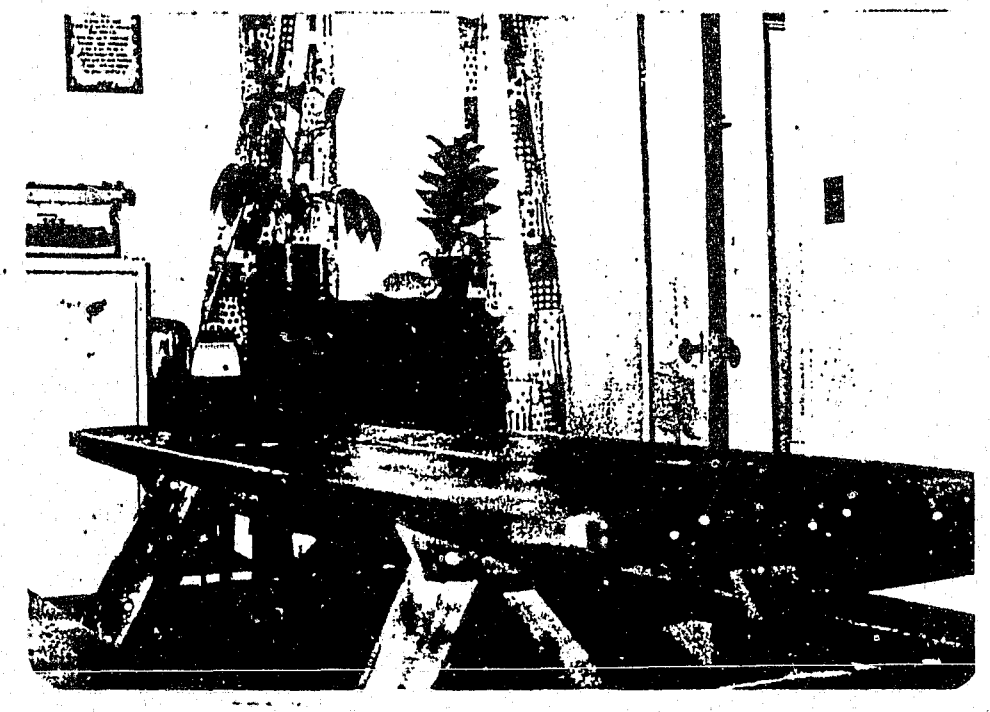
Figure 4

Dover Residence House

(Cooking-Dining Facilities)



Main Kitchen



Common Dining Hall

Figure 5

Dover Residence House

(Counselihg Room)

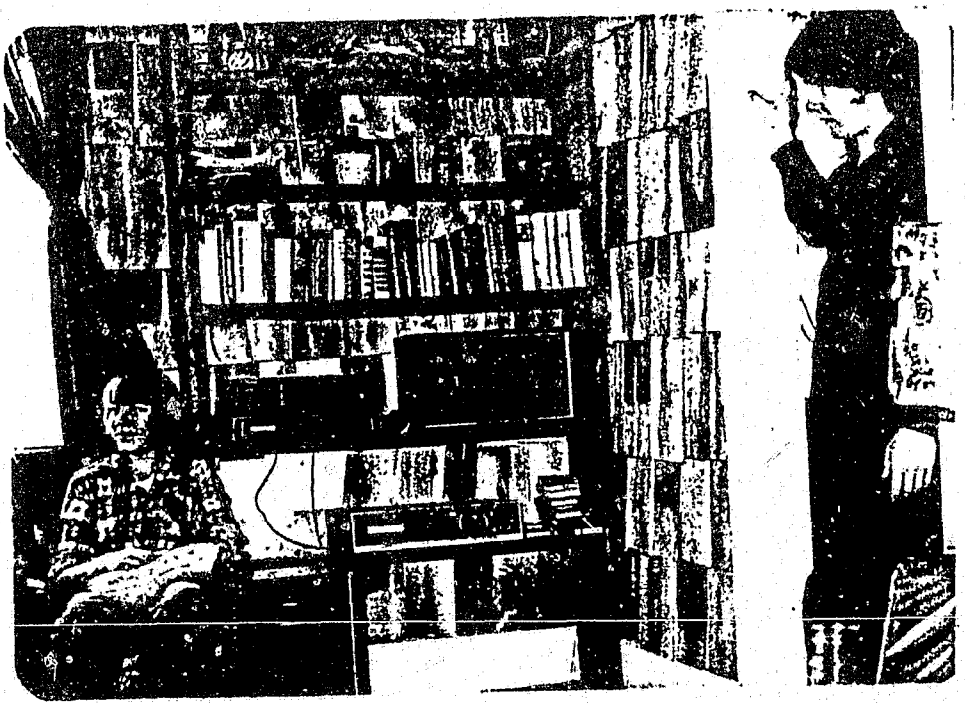


Figure 6

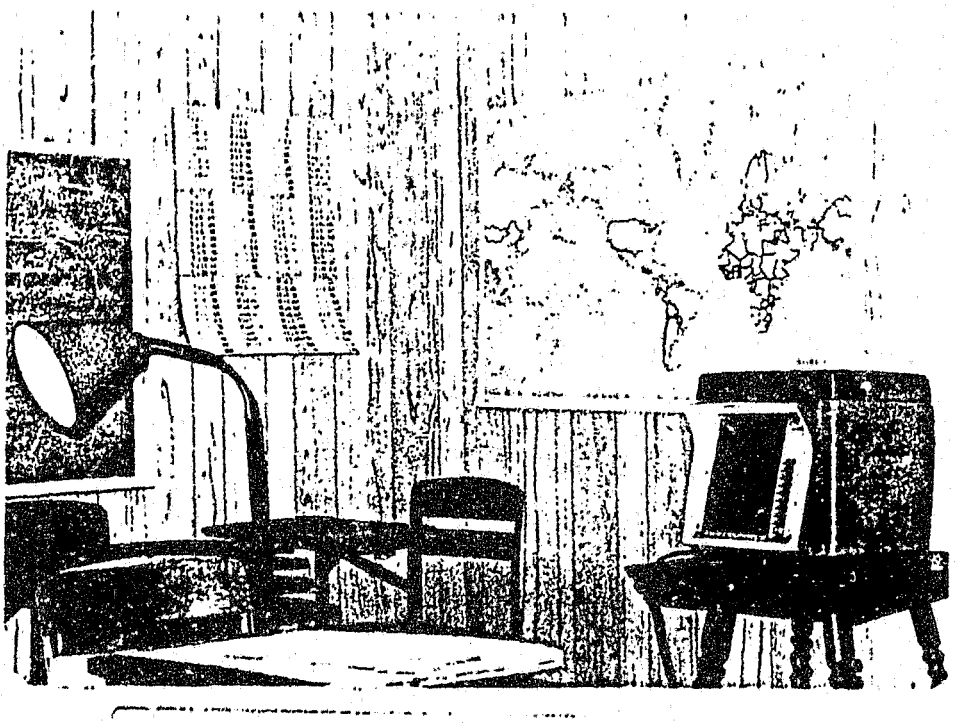
Dover Odessey School

Main Classroom Building

Administrative Office

Figure 7

Dover Odessey School

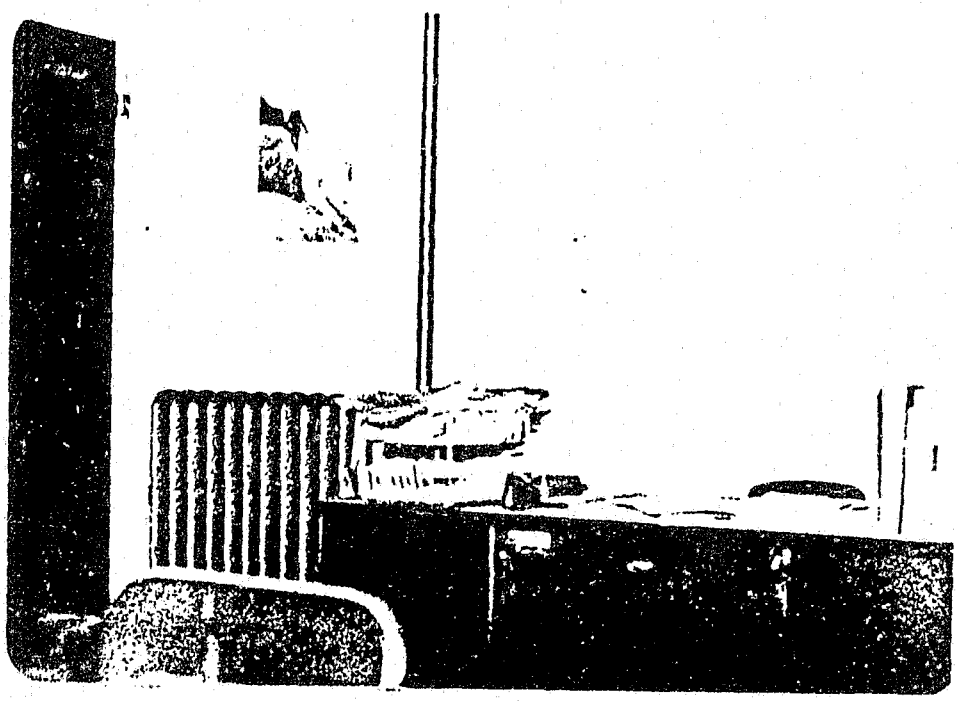


Main Classroom

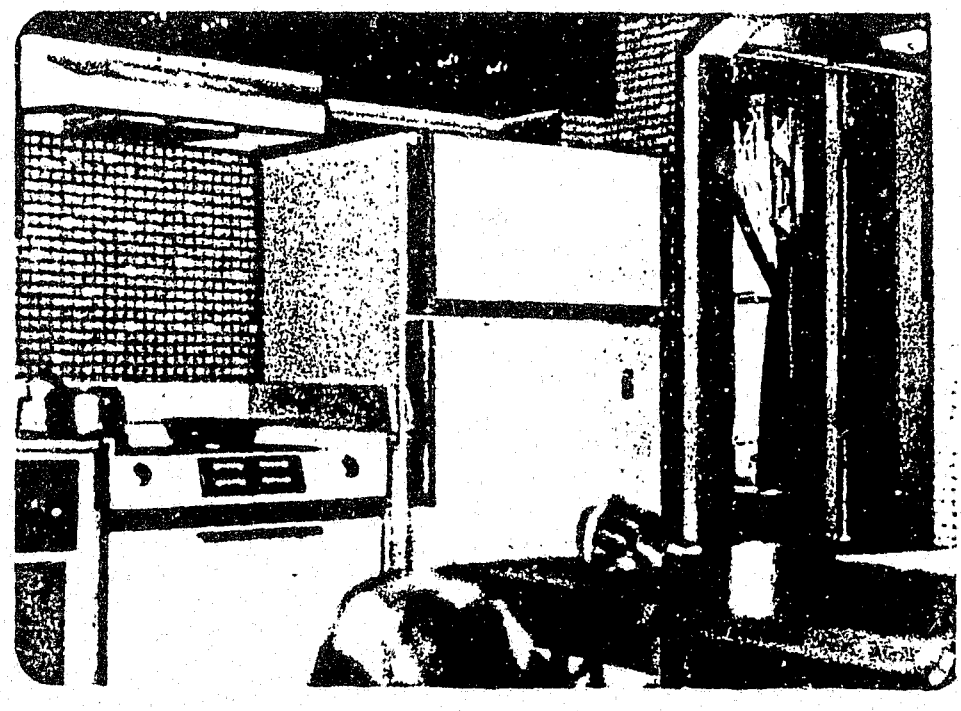
Autotutor Classroom

Figure 8

Dover Odessey School



Counseling Office



Kitchen Facilities

PUBLIC SUPPORT

Public Support

No program of the type such as the Dover Program can ever hope to get off the ground much less succeed without a substantial amount of public and political support. It might be mentioned that when one addresses public support, such support need not be overt and indeed may need not even be positive. Often it is sufficient that the support for a program merely be neutral in the sense that there are no powerful sources of interest or power within the community that are willing to martial their resources in opposition to the program. In this regard, the Dover Program must be noted for its ability to have gathered public support in the initial phases of its operation. Undoubtedly, having the Dover program associated with Odyssey House, Inc., most certainly raised the stigma of drug-associated juvenile offenders in the community. This kind of image is almost certain to produce difficulty. The facts of the matter are that in the case of the Dover program, however, these difficulties did not arise. As one can see from an examination of the original grant proposal, the letters of recommendation which poured in from community notables were in themselves notable, not only in numbers but for their tone.

At the present time, the Dover program seeks to maintain its support in the community by three mechanisms. The first mechanism is the Dover liaison committee, a larger mechanism exists in which a 15-man oversite committee is responsible for issues of public support. This committee deals with both the Dover and the Hampton programs. Finally the public relation functions provided on a day-to-day basis by the staff of the Dover Program itself constitute a third mechanism. Most particularly as it is related to the Dover Program, the Dover liaison committee is potentially the most important.

The Dover liaison committee itself is comprised of three members: Mr. Leon Yeaton, a former member of the Governor's Council and a local community notable; Chief Charles Reynolds, Chief of the Dover Police Department and a strong supporter of the program; and Captain Joseph McCarthy, Commander of the Patrol Division of the Dover Police Department and a man instrumental in the formation of the Dover Program from the beginning. It was Captain McCarthy who leased for the taken fee of a dollar a year the housing facility which serves as the official re-entry house residence for Dover patients. Taken in the whole, therefore, the Dover Program has helped to ensure its support in the community by selecting for its most direct liaison committee, three well-known, relatively influential community notables.

By the same token, however, it must be pointed out that the Dover liaison committee is a relatively new creation having only made appointments to the committee since December, 1976. As a result, very little has been done in the way of overt solicitation of public support by this committee and, indeed, as best as this analyst could discern, there are no hard plans drawn at this stage to involve the Dover liaison committee in any further action. This is not to say that such plans will not be forthcoming at a later date; it is simply to say that at the time of this

writing no such plans were extant. However, it is of note that the members of the committee are in strategic positions in government, law enforcement and private industry and are potentially able to act as sounding boards for any major difficulties which may confront the Dover program. One notes in all frankness that such individuals are in a position to help. Accordingly, there is little doubt in this analyst's mind that the Dover liaison committee potentially, and as soon as it starts operating in actuality, can become an effective instrument in maintaining public support that the Dover program will require.

The evidence of public support is largely of the neutral type. In talking with businessmen at random throughout the town of Dover, one does not uncover a staggering awareness of the positive aspects of the Odyssey program. Rather what one obtains from talking with the "man on the street", and it is admittedly a random accidental sample upon which this analyst is relying, is a feeling that the Dover program is trying to do some good, but that there is simply a lack of awareness on the part of the average citizen as to how they are going about it. On the other hand, when one begins to talk with the professionals in the field who work with the Dover program and who are the chief referral sources for the Dover program, one finds that the awareness of what the Dover Program does in general terms increases substantially. However, while an awareness of the generalities of the program increase substantially, the fact of the matter is that there still is some confusion as to exactly what the program does. In talking with probation officers, community youth services director, guidance counsellors, school case workers, and with members of the Dover school establishment, one discerns that they have in their minds a picture of what the Dover program is supposed to do that is not quite accurate. In this sense, this would suggest that there is some need for clarifying to these critical referral sources just what the nature of the service that Dover is providing consists of.

In all frankness, when one talks to the professionals associated with the program, one finds that they have generally "balanced" views of the program. They are not at this point prepared to give it what might be called high praise but neither could I find (except for one instance) anyone prepared to mount a really severe critique of the way the program operates. In the instance where the one individual did make a severe critique of the program, it was clear that he did not really understand what the nature of the Dover Program was. So, taken in general, the analysis of the public support component in the evaluation schematic suggests that (1) public support for the program is generally in evidence, (2) it is being fostered by the appointment of committee notables to appropriate boards which can help maintain that public support, and (3) there is on the part of the average citizen of Dover a somewhat unclear idea as to exactly what the specifics of the program are. Nonetheless, support at a more generic level is evident, and (4) when one speaks to those professionals who interact with the program in their own professional capacities, one finds a generally balanced view as to what is happening in the program and some moderate confusion as to exactly what the techniques and goals of the program are. On the whole, therefore, I think it is safe to conclude that the public support variable in the evaluation component

is functioning pretty much the way it is described in the grant. Certainly, much of this is the result of the fact that the Dover Program has had no major public failures yet. The key word here, of course, is public. They have not had, for example, an instance where an individual who was a member of the Dover Program become involved in such severe trouble as to outrage the local community. As long as this condition can be avoided, one suspects that public support will remain relatively intact.

In passing, it ought well to be noted that this analyst could only uncover once instance in which a community notable was asked for his support for the Dover Program in the form of a letter of recommendation in support of the original grant application. The individual refused to write in support of the program and my conversations with him tend to indicate that has not changed his negative views of the Dover Program. Some of his failure to support the program seems to be rooted in misinformation as to what the Dover Program is supposed to be doing as well as in a perception that his position and his official capacities are somewhat competitive with those of the Dover Program. In any case, of all the community notables that this analyst interviewed, of all the professionals and para-professionals, as well as a random selection of average citizens on the streets of Dover, this was the only instance of negative public support that this analyst could uncover. I conclude, therefore, from the existing data that the Dover Program has been able to maintain an adequate level of public support since the operation of the grant period.

STAFF OPERATION AND STABILITY

Staff Operation And Stability

As originally designed, the Dover Program was to have six full-time staff members. These included, an Administrative Director of the Dover resident and educational center. His responsibilities would include coordination of major components of the Dover project, chief liaison to the town of Dover and Senior Group Leader. He would be directly responsible to the State Director of Odyssey House of New Hampshire. His funding would come from funds provided by the Governor's Commission on Crime and Delinquency. A second full-time staff person was a special education teacher whose funding was also to come from the Governor's Commission on Crime and Delinquency. The teacher's responsibilities were to include instruction in core subject areas, the supervision of learning machine programs in conjunction with a learning machines specialist, coordination of volunteer tutors and to assist the staff psychologist in testing and evaluation of students. The teacher would be directly reportable to the Director of Odyssey House of the Dover project.

A third full-time person was to be a counsellor for treatment and educational units. Responsiblities in this area were to include serving as counsellor to the senior Odyssey House resident students and Dover outpatients attending the educational center, assistant group leader, and on-site supervisor of the residential community restoration and agricultural project. He would be directly responsible to the Administrative Director. In addition, a live-in, night-time supervisor for adolescent residents living at the Dover house was provided for, whose responsibilities would include supervision and maintenance of the Odyssey House program structure in the late evening and night-time hours. Moreover, there were to be two additional live-in nighttime supervisors for the adolescent residents living within the Dover treatment center in an effort to ensure that there would be adult role models present at all times and to oversee or at least supervise the patients there during night-time hours. It was originally anticipated that this position would be filled by senior citizens in an effort to have them serve as model grandfather and grandmother figures. In addition to thse six full-time personnel, six other part-time personnel were to participate in the program. These roles will be addressed later.

As one examines the staff profile of the Dover Program in terms of its staff stability, one encounters several findings which raise substantive difficulties. For example, as of January 15, three staff people critical to the continued and successful operation of the Dover program have left their positions. Certainly, the most important of these is Mr. Calvin Legg, the Director, whose task was to administer the entire program. He has left, and indeed, at the time of much of this research he was already on administrative leave. Mr. Legg will be returning to school at the University of New Hampshire in a program of pre-law. At the same time, Mr. Floyd Jozitis, the live-in, nighttime supervisor and group therapy counsellor at Dover, has left the Dover Program and has been transferred to Hampton House. Thirdly, Miss Denise Trahan, who was serving in the

post of community liaison officer and who was being paid out of Manpower funds has left the program as a result of personal health problems. Thus, as of January 15, it is fair to conclude that three of the program's critical fixed staff people are no longer active in the program. In addition, the two live-in night supervisors originally provided for in the grant have also left as of June 15. The reasons for their departure are significant insofar as they were an experiment in the use of non-paid supervisors. The experiment proved to be a failure. Live-in counsellors proved to be a horrendous mistake. They failed to provide the strong role models expected and apparently showed little interest in the students and, indeed, had no real training. Their posts were assumed by Level Four's (a category of worker to be explained later), and they will be serving in an overnight capacity at the Dover house.

As things stand, future staff organization for the Dover facility remains rather unclear. At present, Mr. Sandberg was able to suggest that Mr. Bernard Letvin, currently working at the Hampton facility, will be the nominal director of the Dover program but will not be continuously on site. Instead, an acting director, Mr. Bruce Dupuis, also presently employed at the Hampton House, will take on the full tasks of administering the Dover program. The evident problem here is that Mr. Dupuis is not expected to remain in his position after July 1, 1977. Indeed, it is not envisioned that he will act as a true director at all. Rather, he will be placed in the Director's post for approximately a six-month period in order to solve some "particular problems" which seem to be hampering the smooth operation of the Dover program. Among these problems certainly is the difficulty the program has been having in securing appropriate referrals from the community at large. There is also the problem of inadequate funding for a proposed second teacher yet to be brought into the program. In short, Mr. Dupuis will be expected to wear at least three hats - that of Acting Director, that of acting as Chief Community Liaison Officer, and that of overseeing the chief counselling job at the Dover resident center. This analyst clearly has some severe doubts as to the extent to which this balancing act can be performed by a single individual and still be effective. These doubts are compounded by the fact that Mr. Dupuis does not have any formal management or executive training that could be brought to bear on the task but rather is an in-house upward mobile of the Odyssey program itself.

Taken as a whole, therefore, it must be noted that since the program has begun there has been a total turnover of five individual positions, three of which can be designated as being very critical to the successful operation of the program. Such a situation is hardly encouraging. Additionally, the planned replacement for the individuals who are leaving the program or being transferred by a single individual does not auger well for the future as far as management capabilities are concerned. In short, the entire higher staff management of the Dover Program seems to be marked by a tendency to plug people in an almost a crisis fashion. To be sure, there is some necessity to move people around in an effort to come to grips with the problem of applying scarce resources, especially so in terms of funding for personnel. Nonetheless, it strikes this analyst that the instability associated with this program at the staff

level may well have already become chronic with little in the way of reforms to stop it. At this stage, the problem of staff instability must be seen as a major difficulty effecting program operation.

In an effort to handle the problems of management and critically needed personnel in the Dover Odyssey Program, some discussion has taken place about attempting to bring a second teacher into the program who would be qualified to teach the retarded. At the present time, funding for this position is unsecured with an anticipated funding line running to the Manpower Program. Mr. Sandberg could not assure this analyst that such funding would be available so the possibility remains that the program may be forced to continue along with the one special teacher that it presently has.

Addressing the problem of support for the staff, Odyssey has drafted and begun to utilize what are known in the Odyssey lexicon as Level Fours. "Level Four" is a designation that was once utilized to describe adult graduates of the Hampton or the National Odyssey program. These individuals were former patients who had successfully completed the behavioral modification program and had spent six months in service to the Odyssey House program in a kind of "pay back" situation. After these six months had expired, some of these individuals were selected to be eventually hired by Odyssey House at the National level and are sent to selected sites to gain experience and additional training. As regards Dover, two Level Fours have been sent, Mr. Warren Brunay and Mr. Mark Gipson, who are currently on site. Mr. Brunay has been here about one month; Mr. Gibson about two months, and both will depart when a three-month period expires. These individuals are expected and indeed do take over much of the group therapy sessions and do serve the role of live-in nighttime supervisors now that the position has been removed through the transfer of Mr. Jozitas. They bring to the program not so much professional expertise as they bring a kind of experiential learning obtained from their own life experiences within the Odyssey program. Accordingly, they are, potentially at least, an asset to the program. But, from the perspective of a staff stability situation, the fact that Level Fours will rotate out of their positions every three months really means that they can constitute an element of further instability within the staff.

Viewed from this perspective, it would appear that staff instability represents a major difficulty confronting the Odyssey program. While its effects can be partially offset by the tendency of single individuals to wear several staff hats, by a tendency to insert people in a crisis fashion, and by a tendency to utilize Level Fours in crisis roles, the fact of the matter is that the Dover program has been forced to abandon some staff positions such as the live-in nighttime supervisors because they have been unworkable and to get rid of others because funding has run out. It has lost still others because of a desire of staff members to pursue personal career goals. Such a set of circumstances means that with the exception of the full-time teacher with special educational qualifications, in this case Miss Jackie Adams, the staff of the Dover Program is marked by a singular lack of professional qualifications. This is not to suggest that they are not making an effort to fulfill their task well; but rather it is only to suggest that this analysis finds it diffi-

cult to avoid the conclusion that they are tremendously overextended and their overextension cannot help but affect in a negative manner the way in which the program will operate.

The Dover Program not only has its own full-time staff complement but has available to it a part-time staff element through Hampton House. In this regard, there are six part-time staff positions that serve as adjuncts to the Dover facility. These include Mr. David N. Sandberg, who is State Director of Odyssey House, Inc. in New Hampshire, and is in overall charge of Odyssey House projects in New Hampshire. He provides weekly on-site inspection of both the Hampton and Dover units. Funding for his position does not come out of Governor's Commission on Crime and Delinquency monies. There is Dr. Rowen Hochstedler, a psychiatrist for Odyssey House who provides psychiatric evaluation and treatment as well as educational planning to the Dover staff as needed. Again, no funding for this position is drawn from Governor's Commission on Crime and Delinquency monies. Dr. Frank Gvozdenovic is the M.D. internist for Odyssey House and provides medical services to the Dover facility, again as needed. As with the other staff positions, no funding from Governor's Commission on Crime and Delinquency monies is utilized in this position. A fourth part-time position is that of Dr. Steve Seeman who is the psychologist for Odyssey House, Inc., and who provides psychological testing services for both residents and out-patients as requested by the Dover facility. Once again, funding is through Hampton House sources and not Governor's Commission on Crime and Delinquency. A fifth position is occupied by a registered nurse to provide medical services for the residents and out-patients as needed by Dover and again no funds are drawn from the Governor's Commission on Crime and Delinquency.

There is a difficulty with this position insofar as this nurse has been replaced twice and that the position is among the most unstable of all part-time or full-time staff positions. Indeed, the new nurse did not begin her duties until January 15, so that, as of that date, Dover House will have been without a nurse for about one and one-half months. A final part-time position is provided by Mr. Frank Sanders, who is the bookkeeper for Odyssey House Dover project. It is worth noting here that the day-to-day bookkeeping was done by Mr. Calvin Legg, the former Director, and Miss Jackie Adams, the full-time teacher. They oversee such daily occurrences as bill paying, outgoing checks, weekly cash positions, etc. A more substantial accounting is provided by the public accounting firm of Adams and LaRue, which is located in Portsmouth, New Hampshire. It is of some importance in terms of the requirements of the grant to note that Mr. Sanders had originally been hired under Governor's Commission on Crime and Delinquency funds as a part-time fiscal officer and according to the terms of the letter of understanding of June 14, 1976 between Governor's Commission on Crime and Delinquency and Dover House, this position was to be eliminated from GCCD funding in order to allow the transfer of such funds to support the full-time special education teacher position.

With some minor exceptions that will be noted later on in this report, this analyst can locate no difficulty in the manner in which part-time staff are made available to the Dover project when asked. By and large, with some obvious exceptions address later, they are available and

very much appear to perform the functions for which the positions they occupy are intended and funded by either Hampton House proper or other sources other than Governor's Commission on Crime and Delinquency, which have been obtained by Hampton House. These individuals and their relative expertise are on loan to Dover House and are made use of by the Dover facility whenever the latter deem it appropriate. In the view of this analyst with the exception of the instability of the nurse program (which I do not see as a major problem), the utilization of part-time staff members by the Dover facility is generally adequate at this time. The exceptions are of some import in the context of other operational aspects of the Dover Program and will be noted when these aspects are addressed.

In attempting to anlayze the operation of the Dover program staff the term over-extension comes readily to mind. Yet, this term does not really convey the depth and extent of confusion and unclear lines of communication, authority, and function, which strike this analyst as being characteristic of the entire staff operation of the Dover Program. This analyst was witness to a rather curious case study in poor management that I think is reflective of the kinds of difficulties that generally tends to affect the Dover program. It is worth recounting the events of this situation here to serve as an example of crisis management.

On January 13, 1977, this analyst visited the Dover House for a period of about nine hours for the purpose of conducting interviews and obtaining data from various staff personnel. At that time a problem developed in which the fuel oil supply at the resident house had run out and the road to the house had not been plowed. The fact of the matter was that in an attempt to come to grips with these problems, there was no one in charge of insuring that oil was to be kept flowing to the house. Indeed, there was no one in charge to make sure that the road was plowed, although it was very obvious that in any given snowstorm the location of the house would require heavy plowing. As a result of this, the teacher, Miss Jackie Adams, had to virtually exhaust herself on the phone calling various local and private agencies extolling, cajoling, and literally pleading with them for some help in order to get the oil supply replenished. As far as I could determine, the problem was solved by (1) not plowing the road and (2) contracting with an oil company to leave 100 gallons in two 50-gallon drums at the base of the hill which were then to be trucked up to the house by the residents themselves in a kind of oil-bucket brigade. Efforts were unsuccessful in getting the city to plow the road out.

The point of recounting this case is not so much to make the point that the case is typical, although it certainly is analogously so, but rather the point is that it reflects in microcosm what strikes this analyst after twenty days of being on-site with these people to be characteristic of the organization in macrocosm. As best as I can determine, problems tend to arise without any lead time. There does not appear to be a mechanism in the staff organization for anticipating even the normal routine day-to-day problems that one can expect to arise. Such problems as routine as getting the oil tank filled in the middle of winter should have some institutionalized base for addressing them. As

far as I am able to discern, no such system for anticipating operational problems exists. As a result, management in the Dover facility tends to be characterized largely by what has been called "crisis management". Thus, there is a tendency, because of a failure to anticipate, to confront problems as they arise and to have to deal with them on short notice. This compounds the problem of limited staff resources by stretching those resources to an almost impossible degree and, indeed, this analyst has seen these resources stretched to the point where they snap. Once resources become stretched so thin, the ability to function is certainly called into question. To be sure, one of the problems which is at the root of these difficulties is that there are confused lines of functional authority. At the present time, the program is going through a transition. It is losing its Community Liaison Officer, the Director is leaving, a new Acting Director is coming in while the former Director will remain at Hampton House. In short, the staff situation is one of total confusion. This analyst has very little hope that this situation will correct itself simply because the incoming staff members will have to wear several hats once again. The characteristic quality of staff operation in which resources tend to be stretched thin and is compounded and confused by unclear lines of functional authority leading to situations in which there is an inability to anticipate leading to a further difficulty in establishing lead times will be in evidence. These are the types of characteristics which one finds in analyzing and observing the staff operations of the Dover program and at best, they can be defined as "crisis management". To be sure, there is great need for staff reform, for staff management in this program, if resources are to be as effectively employed as possible. The argument that by allowing staff-lines to remain unclear allows the program to increase its flexibility by being able to move individuals into probelm areas as they occur strikes me as a spurious one. The fact of the matter is that there is a point in which too much flexibility simply becomes confusion and indeed this point is fast approaching in the Dover program. The need for staff reorganization and good staff management beginning at the top is very evident.

Perhaps there is no clearer example of the failure of the Dover administration to routinize those normal tasks which we would associate with a program like Dover than the difficulty which is faced periodically in terms of food supplies for the Dover resident facility. In at least one instance that this analyst was able to uncover, the administration broke down in its ability to secure the necessary funding from the food stamp sources, which comprise the source of money to buy food for the resident patients. During this breakdown of administrative capability, the resident facility had run out of food and, indeed, the individuals in the program would have gone without food for almost a week had it not been through the efforts of some of the individuals within the program who were able to obtain food through donations. In any event, it is very clear that the administrative difficulties in obtaining food are an almost monthly occurrence insofar as there always seems to be a time lag between ensuring that the funds for food purchase are in the pipeline, finally obtaining them, and expending them for food.

I do not wish to imply by focusing upon the above administrative failure that the individuals within the resident facility are not getting

enough to eat. Indeed, my coversations with all the resident patients indicated very clearly that the amount of food that they were getting is in fact adequate and that the type of food is varied and sufficient. In proof of this statement attached in Appendix B are copies of menus, running from January 24 through January 31 and February 1 through February 7. An examination of these menus clearly shows that the diet is both sufficient and balanced enough. Indeed, in my visits to the Dover House, I was fortunate enough to partake of one of their meals and indeed found it to be adequate.

As regards the regulation of the food supply and its distribution, patients in the resident facility do their own cooking on a rotating basis. This, of course, will affect the quality of the meal eventually prepared but not significantly. Further, individuals must eat at regulated times and there was some disgruntlement about this but nothing severe. Individuals have no kitchen privileges. One eats at the specified time or one does not eat. Individuals are allowed, howver, to have their own private food supplies such as packages from home or anything they may have purchased out of their own funds. To date, there has been no problem with regard to confrontations arising over private vs. community food supplies and, in general, the mechanisms which are extant for the control of food once it is in the house are both adequate and necessary. The fact of the matter is that unless some controls are established, it would be impossible to predict the duration of food supply in terms of rates of consumption. More importantly, forcing individuals to eat at specified times is part of the overall philosophy which tries to implant some control, regulation, and regularity in the lives of these individuals who all too frequently come from homes in which there were no regulations. As a result, forcing the individual to eat at specified times or pay the penalty of not being there, namely missing a meal, should not only be seen from the physical perspective of food supply, but also from the therapeutic perspective of reinforcing acceptable behavior.

In a summary, it appears that except for the problem of food supply in terms of the administrative difficulty of continually having to grapple with getting funds into the pipeline, there do not appear to be any serious difficulties in feeding the individuals in the program. The diet is adequate and certainly well-balanced, controls on the food supply appear adequate and, indeed, these controls seem to be serving an effective therapeutic function.

STAFF TRAINING

Staff Training

In attempting to evaluate the staff training aspect of the grant, it must be noted that there is no way really to determine whether or not the staff training as outlined in the grant iself is actually taking place. The reason for this is that no records regarding training session are actually kept. But the grant calls for basically five modules for training: the weekly conference call, on-site supervision training provided by Odyssey Institute, weekly staff meetings, case conferences presented by Odyssey medical staff, and participation in regional and national health conferences and organization. If one totals the number of hours which the grant indicates and which Dover staff confirm in interviews, that they do in fact participate in, one ends up with a total of 890 hours spent on training per year. If one divides by a normal eight-hour work day, this means that roughly 120 days of any given work year are being spent in staff training. In the absence of records, it is difficult to make any assessments with regard to whether or not this training is in fact going on or whether or not how effective it is. This analyst merely notes that some things, such as case conferences, weekly staff meetings and weekly conference calls, which are listed as training devices are really little more than mechanisms for organizing the day-to-day business of the Dover Program. In any event, the notion that 120 man days are being spent in training strikes this analyst as suspiciously high, and indeed if this were the case (and I have my doubts that it is), this analyst would recommend very clearly that the amount of staff training be lowered considerably.

What is probably happening is that staff have simply inflated the hours devoted to staff training because they have included in staff training those things which are normal administrative housekeeping mechanisms such as weekly staff meetings. Whatever the case, no records or minutes exist of these training sessions so that it is impossible to assess the staff training programs at all. From this perspective then, one must really accept the staff as one finds it.

RESIDENT COUNSELOR

Resident Counselor

It will be recalled that the original grant proposal for the Dover Program required the presence of two live-in counselors to be responsible for overseeing the behavior of the patients at the Dover Resident House during the evening hours. The object of that provision was to provide the patient with strong, positive role models that they might emulate. Some thought was given to training these individuals so that they might be able to intervene in whatever crises may have arisen in the behavior of the patients at the resident house during the evening. The fact of the matter is that all associated with the Dover Program agree that the live-in counselor idea has been a failure.

As it operated at the Dover resident house, the live-in counselors were comprised of two single male teachers who work in the local school system and who live on the top floor of the resident house. Their behavior has constituted an unmitigated failure. They have provided weak role models and, indeed, there is very great evidence that they simply did not care very much about their tasks and agreed to serve in the program merely as a way of obtaining free room and board. On the other hand, it must be pointed out that the Dover Program did not provide any real training for these individuals so that to some extent the responsibility for failure must be shared. It is most clear that that section of the grant which requires that the individuals that were going to live in the Dover House be senior citizens who would serve as surrogate grandparents cannot be plausibly implemented. Neither the physical facilities nor the extant environmental factors are conducive to the use of surrogate grandparents in this program. As a result of the initial failure, the role of live-in counselors has been assumed by the two Level Fours now in the program, Mr. Mark Gipson and Warren Bruney. They have by and large done the job well. However, as has already been pointed out in another place in this evaluation, they are here only for a limited amount of time working as Level Fours and can soon be expected to leave the Dover Program. The point which must be made here is that the section of the grant calling for live-in counselors has been a definite failure in the judgment not only of this analyst but of everyone associated with the Dover Program.

THE SCREENING PROCESS

The Screening Process

When trying to understand the screening, testing and intake policies which are utilized at Dover House, it must first be understood that Dover accepts two different types of individuals into two distinct aspects of the same program. In the first instance, it accepts resident students who are housed at the re-entry home on Long Hill Road and, secondly, it accepts and treats out-patient students who do not stay at the resident house, but return to their homes in the community at the end of the teaching day. Accordingly, one would have expected that two distinct modes of screening individuals for admission into the program would have been developed. In theory, this is the case, but in point of fact, the modalities of screening, testing, and intake tend to overlap substantially. The risk here, of course, is that inappropriate referrals will be accepted into the Dover Program and thus lay the groundwork for treatment.

The importance of the screening process, that is the process by which the Dover staff decides who will be accepted into the program and who will not, is crucial to the level of success of the program. Drawing upon the grant application once again, it is noted that the purpose of the Dover Program is to provide alternative educational training for those individuals who do not have severe behavioral problems. Additionally it is to provide this type of training for individuals in its resident phase who may at one time have had behavioral problems but through their experience at the Hampton House have had these behavioral problems modified to the point where their primary difficulties are indentified as educational. From this perspective, then it becomes critically important that the screening process function in such a way as to insure that the individuals finally accepted into the program are appropriate for the services for which Dover is able to offer. From another perspective if the screening process does not function adequately, what will happen more and more is that students will be accepted into the program who are inappropriate for the service that the Dover Program offers. If this were to occur on a large sclae, then clearly the program will fail. The evidence uncovered by this analyst suggests that the screening process has not been as effective as it could be and indeed represents one of the major areas in which change is necessary within the Dover Program.

Addressing first the screening process which is used for resident students, a good point of departure is to examine the grant application and to extract from that application what exactly Odyssey promised to do in regard to screening resident patients. In this regard, the following intake policy was established:

> "All Odyssey residents living at the Dover House will have first entered Odyssey House's intake unit. Intake is proceeded by a formal interview conducted by Odyssey staff in conjunction with the referring agency. Upon intake, a complete social, medical, psychiatric and psychological history is compiled by a professional staff, which is used as a base for the treatment plan.

> A medical treatment folder is maintained for each resident including those adolescents who are referred to the Dover House."

In general, all aspects of this intake policy as they address the complete social, medical, psychiatric, and psychological history for those referrals which come from Hapton House are being observed. But this is not the crucial point. The crucial element of the screening process appears in the first sentence of the grant procedure statement and that statement requires that "all Odyssey residents living at the Dover House will have first entered Odyssey House, Hampton Center, which is the central intake unit." It will be recalled that the grant application insists that individuals who are finally accepted into the Dover Program have undergone an intensive motivational and modification experience so that the personnel at the Dover Center can be assured that the problems with which they must deal are primarily educational in nature. Accordingly, it was planned that all resident students (in the terms of the grant) would have first undergone the treatment procedure at Hampton in order to insure that their behavior was modified at a point appropriate for application to the Dover Program. The fact of the matter is that in the early stages of the program, this was the case. At the time of this writing (January 27, 1977), however, of the seven resident students, five of those did not go through the Hampton House procedure first. Here we have an incidence in which at least 70% of the patients were not exposed to the procedures promised in the grant in terms of intake and screening. More importantly for the impact upon the Dover Program itself, the risk is exceedingly high that those patients who have not gone through the Hampton Program but have been accepted directly into the Dover Program will be inappropriate unless the screening procedures are exceedingly tight. Otherwise, as will be suggested later on, the risk exists that these direct referral students will be increasingly inappropriate for the Dover Program. Indeed, the evidence that we have suggests that of the ten resident students, which we could track, at least three have been deemed inappropriate for that particular program and at some point in the future will be phased out of the program.

As regards the out-patient screening procedure for admission into the Dover Program, once again the grant promises to establish a policy in this area. That policy appears below:

> "For Dover out-patients Odyssey and Dover public school staffs will first discuss the appropriateness of the referral. Once the referral is made to the education center, the Dover youth will be tested by both the learning machines specialist and Odyssey psychologist. This data will be used as the basis for formulating an educational and therapeutic plan for the youth."

This, then, is the basis for the intake and screening policy for out-patients. Upon closer examination it is revealed that the process of screening individuals in both the resident program and the out-patient program leaves something to be desired.

The process actually utilized by the Dover facility is interesting insofar as it demonstrates the weakness of the screening process to insure that inappropriate referrals do not slip through the net and end up in a program for which they are unfit. Examining the screening process, one can identify approximately five major steps leading to a decision to admit or not to admit the student into the Dover Program. The first and most obvious step is referral by an outside agency. Here the definition of outside agency becomes important for six of the ten original patients who were referred to the resident program were referred by Hampton House. Four were not. The prognosis for the future is as the program expands (if it does), that more and more students will be referred directly to the resident program without first passing through the Hampton experience. A re-examination of Table 1 presented earlier clearly demonstrates this to be the case. In any case, referral by an outside agency is the first step. Once referral has been made, an interview with the referral agency and with the subject is conducted by the community liaison officer in charge of inductions. During this interview, an attempt is made to determine whether or not the individual is appropriate for the program. Once again the definition of "appropriate", which is used at this stage, is rather broad. Drawing upon the promises made by the grant, the fundamental guiding consideration must be, if the program is to stay consistent with its own proposal, is that the individual being considered for admission have essentially educational problems and not behavioral problems, or at least, that he not have severe "acting out" problems. Hopefully, this can be ascertained in the entrance interview. Examining the rate at which referrals are terminated, that is to say not accepted by the program after the interview is conducted, in almost a year in which the program has been in operation, only six individuals have been rejected at the interview stages as being inappropriate for the Dover Program. Unfortunately, no records are kept as to the total number of interviews which may have taken place. It is worth pointing out in this connection, however, that the community liaison officer suggests that a substantial number of contacts are made at the initiation of referral agencies over the phone, in which requests are made regarding the placement of an individual in the Dover Program. She indicates that often in the initial stages of referral over the phone, it is able to be determined that an individual is ill-suited for the Dover Program. At any event, no hard data exists on this phase of the screening program.

The third phase of the screening program is engaged if the staff determines that the individual is potentially appropriate for the Dover project. If this determination is made, the individual is then referred back to the original referral source whose task it is to locate funding for the patient to attend the Dover Program. If it is impossible to find funding to support the individual at Dover House, the individual is simply not allowed in the program. Thus, a critical requirement becomes the availability of money. If money can be found to support the individual then he moves on to the next step in the screening process.

Step four is a rather intriguing procedure for it involves a battery of tests designed to determine once and for all whether or not the individual is truly appropriate for the Dover program. The first

series of tests which are given are administered by the special education teacher and center about the California Achievement Test and/or a Wide-Ranging Achievement Test. The object of these tests is to determine the level of grade achievement on the part of the patient in the three areas of reading, math, and language skills. Once these tests have been administered and the results examined, the individual goes through the second step in the testing process in which a request for his entire record of schools and other activity is made by the Dover facility and an examination of these records is conducted. What is appropriate here is that the focus is upon determining the individual's I.Q. level. In many instances, such records contain I.Q. tests, in others they do not. In the latter cases, I.Q. tests are to be administered by the staff psychologist, Dr. Steve Seeman, located at the Hampton House. It is worth noting here with regard to the testing administered by Dr. Seeman that official Odyssey policy is that every individual entering the program (whether he is entering Dover or Hampton House) must undergo a battery of psychological testing at one time or another. The fact of the matter is that often times the battery of tests which is defined as a standard batter and which includes an intelligence test, the Wisconsin R, intensive kinds of judgments, and more intensive kinds of tests such as the MMPI personality test, which is an objective test, and the Projective Personality Test which is a projective test, are in point of fact often not administered. The reason for this is, Dr. Seeman pointed out, that there is a tendency to rely upon existing tests in the patient's file and, therefore, there is often no great need to retest. In any event, to get an idea of the extent to which I.Q. testing and standard psychological testing is done in the screening process, one notes the following data which indicate that since August, 1976, only 10% of the individuals tests by Dr. Seeman have been from the Dover Program. The reason that is given is that many patients have already been tested and records are in the files. Additionally, (as we shall support later on) there is often a schedule problem with Dr. Seeman's time. I think it a fair conclusion, therefore, to say that by no stretch of the imagination is every individual coming into this program given a fully battery of tests and that there is a growing propensity to rely upon tests which are already in the individual's file. The difficulty here, of course, is that such tests may have been administered inaccurately, differentially and, indeed, they are often somewhat out of date. Accordingly, one suspects that there is a clear need here to insure that at least psychological testing is accomplished for every individual as quickly as possible upon his entering the program.

Upon completing the California Achievement Test and the battery of psychological tests, the potential patient is then referred to Dr. Rowen Hochsteadler who is the staff psychologist for the Hampton facility, and who works on a consultant basis for the Dover Program. Hochsteadler then conducts a series of in-depth interviews with the individual in order to arrive at a diagnosis expressed in psychological terms. The object here, of course, is to as specifically as possible delineate what the nature of the patient's problems are so as to eliminate the most obvious types which would be inappropriate for the Dover Program. The Dover Program would be expected to rely heavily upon Dr. Hochsteadler's findings in this regard in deciding whether to accept a given individual or not.

Finally, the last step in the process is the decision to admit or not to admit the individual to the program. Once admitted, the individual is brought into the mainstream of the program and if rejected, of course, he is sent back to the original referral agency. The time lag required to accomplish this procedure is between 10 - 30 days with the grestest time lag occurring in psychological and psychiatric testing. During those 10 to 30 days while the individual is undergoing testing, just what happens to the patient is unclear. There seems to be no definitive policy regarding this point. In some instances he is allowed to remain at the resident facility while testing is being undertaken, while in other instances he is not. With regard to out-patients, sometimes they are brought right into the program and begin immediately the teaching program while testing is still going on, and in other cases not. Clearly, there is no definitive policy here and certainly one ought to be developed.

The point of examining the screening process in the kind of detail with which it is addressed here is this: on paper the program appears to be an exceedingly thorough one for separating appropriate referrals from the inappropriate ones. In point of fact, this is not really the case. Consider for example the following problem which this analyst regards as a major one. There is no formal decision-making prcoess for making the final decision as to whether or not an individual should be accepted or not accepted. In the final analysis one suspects that the Director of the Program, Mr. Calvin Legg, would bear the final decision, but in point of fact the decisions are made in a rather informal and haphazard manner. There is no formal schedule for meeting together, for bringing in Dr. Hochsteadler, Dr. Seeman, Denise Trahan, the referral agency, the Director of the program, or the special education teacher, and arriving at a consultative decision as to the appropriateness of a given individual for the Program. More often than not, the decision process is one in which unless the individual applying is obviously and manifestly inappropriate for the program, virtually all applicants are accepted. In this regard, one notes here that only six cases have been rejected as inappropriate. The fact of the matter is that individuals are virtually automatically admitted to the Program. Very clearly, when one examines the base of inappropriate referrals in the resident program alone, which is at least 30%, no data are extant on the number of the inappropriate referrals in the out-patient program, although this analyst suspects that it may very well be much higher. It is very clear that the initial screening process must be made as tight as possible in terms of the arriving at a decision to admit or reject. As things now stand, that screening process, at least as it regards the ultimate decision-making structure, is far too loose for the program and its operation. It must be tightened throughout the whole process.

As indicated, there is some question as to whether or not the original Dover design has broken down. It will be recalled that the original program's design required that the individuals at the residence facility be first sent through the Hampton House in order to assure that their behavioral problems were by and large dealt with. There were provisions to be made for external direct referrals, but this was to be done only when the screening of psychological testing was adequate to

determine that the individual had in fact rid himself of his behavioral problems. If one examines the number of students who were present at the resident facility as of January 22, 1977, it becomes clear that there has been a real shift away from the concept of sending individuals to Hampton prior to sending them to Dover, so that very clearly a majority of those students resident in the Dover facility now are direct referrals without having gone through Hampton. In this regard, of the seven individuals currently in residence at Dover facility, no less than five are direct referrals who have not had any experience in the Hampton House. This would tend to indicate that earlier conclusions were correct; namely, that the referral process has shifted to such an extent that the types of individuals who are coming into the Dover Program are coming directly from referral sources often without adequate psychological and psychiatric testing, thereby increasing the probabilities that referrals to the Dover facility will be inappropriate, in the clinical sense of the word.

TESTING

Testing

Very clearly, the screening process leading to a decision to admit a patient to the Dover Program should be very closely linked to the testing processes that the individual must undergo. And, indeed, on paper both in the grant and in terms of the incoming screening process that has already been outlined, one could legitimately conclude that the testing processes are tight and adequate. In point of fact, this turns out not to be the case. Consider, for example, that not every patient referral goes through every step in the screening process. There is a tendency to skip either parts of the screening process or indeed, in some cases, all of the screening process. It must be mentioned here with clarity that Mr. Bruce Dupuis is being placed in the role of Acting Director at the order of Mr. David Sandberg precisely to put in place and to institute the screening procedure in a far more consistent and far more rapid manner than has been the case to date. In short, there is a clear recognition on the part of the staff of the program that the screening process as it addresses the testing phase has not been applied either rapidly or consistently.

To examine each phase individually provides one with an idea of exactly where the failings in the testing and screening processes are occurring. For example, the problem of administering the California Achievement Test and having it scored and then designing a learning prescription for a patient's use, used to take upwards of two weeks. The reason for this delay is that the prescribed learning program and results of the tests had to be sent to the Odyssey Center in Utah where a final decision as to the way the tests themselves were scored and the prescription was made. One positive point in this procedure as it now operates is that Miss Adams has taken it upon herself to administer the tests in Dover, to correct the tests, and to design the prescription so as to get the individual immediately involved in the program. Copies of the tests and attendant scores are sent to Utah so as to eliminate a two to three week time lag. When the results are returned from Utah, if there are any changes to be made, they are made on the spot. To date, this aspect of the testing procedure has worked rather well. Unfortunately, the same cannot be said for the other elements involved.

As was noted a goodly percentage of the students who come into the program even at the resident level simply do not go through all of the screening and testing steps. For example, of the present ten students in the resident program, four, or 40% have skipped either all or part of the above screening and testing procedure. Indeed, the element most likely to be omitted is the psychological testing done by Dr. Seeman. To be sure, some of this is excusable insofar as existing tests may already be on file in the individual's record. On the other hand, when one begins to encounter 40% of the patients not being tested psychologically during the screening process, the door very clearly is open for more and more inappropriate referrals to be accepted simply because the tests on file may have been differentially administered, may in fact be different tests, or may have been administered so long ago as to be virtually irrelevant to

an admission decision at the present time. The reason for this lack of testing is, of course, that the staff psychologist position has been among one of the most unstable of the staff positions in that three psychologists have been hired in three years. Another reason is that the scheduling of Dr. Seeman's time is very tight. He is hired for only ten hours a week to work with both the Dover and the Hampton facilities. He must do family counselling also so that major scheduling problems do occur and the result is that a large number of patients in the Dover Program simply are not being psychologically tested. This situation may cure itself somewhat as Dr. Seeman will shortly be establishing his own practice and may be available for more time than he has been in the past; this might mitigate the scheduling problems somewhat.

It is critically important to note that out of the ten patients at the Dover facility, six went through the entire battery of psychological and psychiatric testing. The six who did go through the entire battery were precisely those students who had been long-term Hapton residents and who had been there long enough to be tested regardless of any scheduling problem so that what we have here really is not an indication that these six people were thoroughly tested while entering the Dover Program, but rather, they had been thoroughly tested while at the Hampton Program for a long period of time. In short, what we are witnessing here is a mere transfer of files. The crucial point is that the four individuals who were not tested were precisely the same four individuals who did not come directly from the Hampton Program but rather came from outside referrals. The difficulty is clear in that the process of psychological and psychiatric testing is breaking down precisely with regard to the newer arrivals who have come from outside referral sources. Projecting these trends towards the future the Dover Program is far more likely to get more of these types of outside referrals than referrals from the Hampton House. Accordingly, we have a situation where the testing procedure is breaking down at the most crucial point in the referral process, that is, as it deals with clients who are coming from outside the Hampton track. This represents a major problem and, in this analyst's view, can only represent a problem which will get worse in the future. That it must be corrected is simply beyond doubt.

With regard to out-patient referrals, under present operating conditions at the Dover facility, out-patients do not as a rule receive any psychological testing in-house. Rather a heavy reliance is placed upon the records which the individual brings with him. The California Achievement Test is, of course, still administered as a method of designing the specific prescription for the patient but from the psychological perspective, tests simply are not given. The decision on out-patient admission is made by and large in a rather haphazard manner as earlier comments indicate. At least in this regard, Miss Adams seems to have a preponderant influence and justly so considering the grant requires that the patient admitted to the program have primarily educational problems. Taken in the whole, however, there is with regard to the out-patient problem no real mechanism to screen and test for behavioral problems on site simply because of the lack of psychological testings, which is not done for out-patients. As

a result, the reliance upon the advice of referral agencies is exceedingly heavy and in the view of this analyst entirely too heavy. The point is that there is a clear need to establish a requirement that all patients regardless of resident or out-patient status go through a complete and rapid battery of not only academic tests, but psychological testing as well. As already suggested, the psychological testing aspect of the program is breaking down at crucial junctions in the screening process. This can only increase the probability in both the resident and out-patient programs that inappropriate referrals will be made especially as the base of referrals shifts as expected in the future away from the Hampton facility toward the more community-based referral agencies.

With regard to psychiatric testing, as opposed to psychological and educational testing, the situation is only moderately better. In the case of Hampton referrals, as indicated before, all six have undergone complete psychiatric interviews. With regard to the four individuals in the resident program, once again it is noted that some of them have not undergone psychiatric interviews. The out-patients as far as this analyst can discover are not being exposed to much in the way of psychiatric interviewing. The point is this, that with regard to the screening procedure, psychiatric testing is a critical element because it is here that one can discover the extent to which there are major psychiatric problems, and behavior problems, as opposed to primarily educational problems. Interviews with Dr. Hochsteadler, the chief psychiatrist, reveal that a certain amount of pre-screening is done and if a patient is referred to him, he will conduct an examination. About 25% of the inductees are seen at the request of the Dover staff, which leaves 75% which are not. The object of psychiatric screening is of course to provide a diagnosis as to what is wrong with the individual. About a week is required for a psychiatric "work-up", to do an evaluation, and produce an in-depth interview which leads to a kind of diagnosis as to what is wrong. One notes that Dr. Hochsteadler, as regards the Dover Program, is a passive resource, that is, he does not initiate requests for psychiatric examinations but rather reacts to those requests made by the Dover staff. Since the Dover staff calls Dr. Hochsteadler in for a diagnosis when they feel a problem is evident, the probability exists very clearly that the Dover staff lacks the expertise to determine when a problem exists. In these instances, once again, the probability increases that inappropriate referrals will get through. Indeed, in talking with Dr. Hochsteadler about the Dover Program, some interesting facts emerged regarding the psychiatric aspects of the screening process. His view is that Dover is over-ambitious in that it feels that it can deal with all kinds of problems, and is especially ambitious in terms of its perceived ability to deal with behavioral problems. In short, there is the feeling on the part of the Chief Psychiatrist that the educational function of the school may be somewhat retarded by the presence of severe behavioral difficulties and even to some extent cases demonstrating borderline mental retardation. This view tends to confirm what the main thrust of this analysis has been in this section, namely, that more inappropriate referrals are being accepted into the program than one has a right to ordinarily expect. There is absolutely no doubt in his mind that there are a number of inappropriate referrals to the Dover Program.

During my interviews with Dr. Hochsteadler dealing with whether or not the Dover Program was working, Dr. Hochsteadler suggested that there was limited progress being made, but he did not feel that the program was likely to constitute a major breakthrough, at least, as a model for other programs. He indicated that the program is still groping for an appropriate mode of operation and that more effort and staff is needed in the area of "true" special educational programs. On the other hand, some valuable information is being gained and, indeed, also, some valuable experience. Here we have a professional indicating that he is not entirely certain that the program is dealing with the kinds of problems that it should be, which once again raises the question of inappropriate referrals.

In an effort to determine types of individuals who Dr. Hochsteadler has examined and who then went on to the Dover Program so as to generate a kind of acceptance profile leading to an understanding of the range of problems that the Dover referral may represent, Dr. Rowen Hochsteadler was asked to delineate a general profile of the type of patients he sees and the kinds of problems they have. This would allow this analyst to make some rough judgment as to whether or not the types of individuals entering the program were in fact appropriate. In this regard, Dr. Hochsteadler drawing upon his own experience in the Dover and Hampton Programs, described at least four types of problems: (1) those who had a combination of emotional and behavior problems; (2) those with problems primarily educational (but he did indicate that in all probability behavioral problems tend to be very strongly linked to educational problems so that separation of the two, becomes very difficult); (3) there are those whom he had found to be borderline retarded although this analyst could not find anyone whose I.Q. was under 80 in the Dover Program, (an I.Q. of under 80 is the functional definition of borderline retardation) but he did note that there were some organic problems evident; (The possibility of improvements for individuals with organic problems are, of course, limited.) also there is the additional problem that individuals with borderline retardation simply cannot be dealt with by the Dover Program for no other reason than the present special education teacher is not qualified to teach them; (4) and finally, there is the individual who has a combination of all the above. What is to be learned from this profile is that with the exception of those students with primarily educational problems, by and large those who fall into the other categories would be inappropriate for referral to the Dover Program. Nonetheless, drawing upon my conversation with Dr. Hochsteadler, apparently there are individuals in that program whose problems are not primarily educational but, indeed, fall into one or the other three categories of problems. Clearly, such patient types are inappropriate for the Dover Program.

A major conclusion which follows from this examination of the screening program is that <u>although some psychiatric testing is being done, and although some psychological testing is beong done, the decision mechanism through which the results of these tests are funneled within the Dover staff organization are so unstructured and so informal as to make it increasingly possible that individuals will slip through the screening and testing net and be admitted into the program even though they are inappropriate for it.</u> As it stands now, Dr. Seeman does not make any recommendations as to acceptance or non-acceptance; neither does Dr. Hochsteadler. What they do is examine

the individual and arrive at a professional diagnosis from a psychological and psychiatric point of view. The evidence is then turned over to the Dover staff who then make the final decision with regard to acceptance or not. Very clearly the possibility exists that the Dover staff is making decisions on grounds that are less than professional because of their own lack of training. Some tightening of the decision process to admit or not to admit is required. Only when this process is tightened can one really expect the intake policy, the screening policy, and the testing policy to be brought effectively to bear on the decision process. As things stand now, they are brought to bear only tangentally and the probability for error in terms of referrals increases.

In an effort to come to grips with the decision process as it presently operates insofar as it is incapable of bringing to bear psychological and psychiatric test results, the following suggestion is made: it is strongly recommended that every individual who comes into the Dover Program, whether though Hampton House, whether though outside referrals, whether as a resident or as an out-patient, be given a complete battery of educational tests. Secondly, it is recommended that he be given a standard battery of psychological tests and it is recommended that he be given an in-depth psychiatric test as well. Once these results are made available, a mechanism should be created in which the psychologist, the psychiatrist, the special education teacher, the community liaison officer and the Director, formerly sit down in a consultative mode and for a period of time, decide through consultation, whether or not an individual is appropriate to enter the Dover Program or not. In short, reliance upon tests that have been given prior to the individual's application for the Dover program should be not only minimized but hopefully abandoned altogether. More importantly, such a procedure will insure that all individuals entering the program would be rapidly tested, consistently tested and more importantly, that the results of these tests would be brought to bear on the decison making--process in a qualified and highly professional manner. This would help close the loopholes in terms of the possibility of inappropriate referrals being admitted into the program. This analyst cannot help but feel that unless the screening and testing process is made more consistently and rapidly applicable and that the results of these tests are brought to bear in a more formally structured decision making process of admission, the risks will increase that the Dover Program will continue to accept more and more individuals who are truly inappropriate for the service which they offer under the provisions of the existing grant.

In discussions with the Department of Welfare staff which handles referrals in the Dover area, it became rather clear that the purposes for which the Dover Program are utilized by welfare personnel are distinctly not those which the Dover Program itself envisioned as providing. There is very little doubt about the fact and, indeed welfare workers openly admit this, that they use the Dover facility far more as a placement facility than as an educational one. Their second priority, when it exists, is the educational program in Dover. By and large what they are most interested in is finding some place to place their individuals in order to reduce their own case loads. In all fairness, it does not necessarily mean that welfare personnel are unfairly utilizing the Dover Program.

What it does mean, however, is that there is a chronic shortage of placement facilities in the Dover-Rockingham area. All of the group homes are filled, there are few crisis beds, the foster homes are all filled, as are the orphanages. As a result whenever welfare has an individual whom they must place, normally because he has been referred by the court, since welfare are often the only source of money, they will tend to place him wherever they can. Dover seems to be receptive to accepting many of their clients. Thus, they utilize the Dover facility not because of its educational thrust but largely simply because it is there as a placement facility.

The importance of this practice is that it most greatly increases the probability that inappropriate individuals will be referred to the Dover Program. This places upon the staff in charge of the Dover Program the added responsibility that the screening and testing program not only be rapid but that it be exceedingly thorough so that they are in a position to accept those referrals who are appropriate in terms of what Dover can do for them and can reject others. In point of fact, at least as it addresses those individuals sent by the Welfare Department to the Dover Program, it is very clear that the screening and testing process is breaking down and that more and more inappropriate referrals are being made and accepted.

An interesting case study in this regard involves one individual who was sent by the Department of Welfare to the Dover facility and who was so inappropriate as to quite literally be beyond belief. Here is an individual who has a terrible family background and whose personal life is a series of continuous horrors. He comes from a broken family with an alcoholic mother. His mother does not want him and has told him so on several occasions so that the individual has developed deep-seated emotional problems. When he was tested by the Vocational Rehabilitation people, he tested out as being retarded. His problems are almost totally emotional and behavioral and are described in the words of the clinician as "deep-seated and severe". To be sure, there is an educational aspect to these problems but only as a reflection of deep-seated, severe emotional problems. This particular individual most clearly would not in any reasonable sense be a proper referral to the Dover Program. Yet, in fact, he was referred to the Dover Program in November and he was accepted!! Indeed, the caseworker who sent this individual was markedly surprised that Dover accepted him and under questioning she indicated that had Dover staff asked her if she thought this individual was appropriate for the Dover Program or whether she thought he could have survived in it, the welfare worker indicated she would have said no. On the other hand, she quite frankly indicated that she was not about to refuse the opportunity to place an individual within a facility in order to reduce her case load. Focusing upon this particular case study indicates very clearly that the screening and testing program as it is presently employed is simply not adequate enough to screen out those individuals who should not be in the program. As a kind of postscript, the individual was accepted in November and is still in the program, but has given the staff so much difficulty that he has been shifted out of the Dover Program to the Hampton Program. There

is really serious doubt as to whether or not he would survive. There is absolutely no question on the part of any one at this point that this individual was inappropriate for the Dover Program and that he should not have been accepted in the first place. The point is, however, that he was accepted.

Lest it be suggested that this type of process of accepting inappropriate referrals was going on in November and that it has been changed, it is important to note that a recent referral who was accepted on February 1 comes from essentially the same type of disturbed family background, in which his problems in the words of his own caseworker, "tend to be emotional and behavioral and only moderately educational", has also been accepted at the Dover Program, which undoubtedly will constitute an inapprorpriate environment for the individual. In any case, interviews with his caseworker once again note that the individual really should not be in the Dover Program, that the Dover Program itself is not designed to treat his kind of problem, but once again, it is a facility in which he can be placed and with the critical shortage of placement availabilities, Welfare is simply going to refer anyone they can.

Equally enlightening in studying the second case is the manner in which the decision to admit the individual was made. In this particular case, the Welfare caseworker contacted Dover first by telephone, and gave them a brief outline of the individual. The individual was brought to where he had an interview with the Director and with Jackie Adams. Most of the interviewing was done, of course, with the Director and the decision to accept the individual was made on the spot. What is interesting is that the acceptance was made without any proper psychological and psychiatric testing. Furthermore, there are no available records concerning the individual that were present at the time in which the decision to accept was made. Further, the individual caseworker stated very clearly when asked as to whether this individual would be appropriate for Dover that she did not think he would work and indeed, "No one asked me if he would work out or not". She admitted that she would have been quite willing to tell the Dover staff that he would not be an appropriate referral if she had been asked. The point to be made, however, is that in the interview process neither proper psychiatric testing nor psychological testing was utilized, nor, indeed, were there even old tests utilized to help in the acceptance decision. It was simply a decision made on the spot by the Acting Director of the program who, I think can be relatively agreed, simply is not qualified from any clinical perspective to make these kinds of judgments. Nonetheless, this is reflective of earlier observations that the decision process at the Dover facility in terms of acceptance is highly diffused, highly unlocalized so that again no one really bears the responsibility for the full decision process. Furthermore, this case study once again indicates that the tendency for the screening and testing net at Dover to allow inappropriate individuals to slip through remains very much a characteristic of the Dover intake program.

In conclusion, it would seem that in addressing the question of testing and screening at least as it can be discerned from this analyst's

examination of several referrals from several different kinds of agencies that the Dover Program is not exercising the type of control over the testing/screening process that allows them to place themselves in a position to make accurate clinical decisions as to whether or not an individual is appropriate for their program or not. Either that, or they are simply trying to keep the program afloat by accepting any individual who is referred. Perhaps what is really happening is a combination of the two factors. In any event, whatever the reasons, it is clearly the case that more and more inappropriate referrals are being made to the Dover Program and as a result, the failure rate can generally be expected to increase. There is very little doubt that something must be done in this area if the Dover Program is going to continue to try to make a success of itself.

THE REFERRAL PROCESS

CONTINUED

1 OF 3

The Referral Process

In attempting to understand how the referral process works in the Dover Program, one must first be aware of the fact that the referral program is in theory intimately connected with the functions of the Dover school itself. By this I mean that the Dover school primarily was designed as an educational alternative facility in which two elements of the program would operate: an out-patient program and a resident program. Regardless of whether one focuses upon the resident or the out-patient aspect of the program, the basic thrust of the Dover grant is to provide an alternative educational setting. This implies that the types of individuals with which it will deal are those individuals whose problems are minimally behavioral and primarily educational. Furthermore, the referral process, or out-reach process, specifically has to be designed to attract patients into the program at a very early stage in whatever problem cycle they have begun to run. Otherwise, if the program waits until the end of the problem cycle, or even until it is well established, the types of individuals who will be coming into the program will tend to have more and more behavioral problems and less and less educational problems. Taken then in a nutshell the object of the program is to attract patients at an early stage in the problem cycle and whose problems are primarily educationally based.

If the thrust of the program is to be maintained in operation it should be immediately clear that the overwhelming majority of the referrals to the program should be from the school system. This is not to suggest that some patients will not come from Welfare, Probation and the courts. However, if the major task of the program is to deal with educational problems, then clearly the mechanism which is in the best position to identify when an individual has an education problem and to refer him early before he gets into severe behavioral trouble are clearly the schools. Thus, I think it fair to assume that a measure of the success of the referral policy must be the extent to which the patients referred to the in and out-patient program of the Dover school have come from the school system. Indeed, I think it fair to argue that unless one can demonstrate very clearly that the schools are referring large numbers of individuals to Dover, then something is quite wrong with the program in which case it may be inferred that the program is attracting more and more inappropriate types of patients from referral sources, which in themselves are not the most strategically located to define primarily educational problems at an early stage of problem development.

Given this initial orientation, as one examines the rates of intake from various sources through which patients are referred to the Dover Program, it becomes quite clear that the referral program is simply not operating in the way it should operate. An examination of Table 1 makes this clear. For example, of the 25 students in both the resident and out-patient programs that have been processed through the Dover School since its inception, only three have been referred by school agencies or school-connected agencies. Of these, two came from the Somersworth School District and once came from the Dover School District. Although the grant indicates that there have been plans afoot to open up a liaison with the

Table 1

Profile of Referral Sources For Students Sent To Dover Program

Referral Agency	# Accepted Referrals	% Of Total
Probation	12	46.3%
Hampton/Odessey Sources	5	19.2%
Other	3	11.5%
Welfare	2	7.9%
Schools	2	7.9%
Voluntary Admission	2	7.9%
	26	100.7%

** Data valid as of January 15, 1977

Portsmouth School District, as of this writing, no such liaison has been developed. As a result, the primary source of potential school referrals must remain the Dover and Somersworth school districts. As a rough indicator of success of these types of referrals, one looks at the three who have been referred and finds that one individual was barely accepted into the program and then simply left. This can can be reasonably regarded as a patient failure. Another patient was in the program for several weeks and he is even now in the process of being referred out as being inappropriate. The remaining individual who was referred by the Dover School system is a severe dyslexic as well as having a whole range of other behavioral and personality problems. Nonetheless, he appears to at least have been able to survive the program to this date. The point which must be made here is that in terms of the total numbers of referrals, only a tiny handful, indeed, only three of the total number of referrals, have come from the school department. This indicates very clearly that there has been a failure somewhere along the line on the part of the referral program to extract from the more appropriate referral agencies, in this case the Dover and Somersworth School systems, sufficient numbers of patients into the Dover education program.

If it is a fair assumption that the program is not attracting patients from the most appropriate school systems, it is a fair question to ask why this is the case. The answers to this are necessarily complex but clear enough to indicate that the Dover school system, in terms of its referral policy and referral function, may be a major contributing factor. What, then, are the reasons why the school systems have not seen fit to refer substantial numbers of individuals to the Dover Program? Certainly, in my interviews with several school personnel, in both systems as well as with guidance counselors and school workers, one fact emerged rather clearly and that is that the school personnel at all levels are rather unclear as to just what the Dover Program is designed to do. Indeed, this lack of clarity concerning the Dover Program extends not only to the school systems as referral agencies but to other potential referral agencies as well such as Welfare and Probation. I was able to discern that the Dover staff has not clearly educated its potential referral agencies as to just what the kinds of services it has to offer. Indeed, this may be largely a logical consequence of the factor that they may not have in their own minds clearly defined their target population. In any event, the individuals with whom I talked offered strong indications that although they supported the Dover Program in general, they were unclear as to what it did. Thus, some felt that it was merely a holding facility, others felt that it was a good outlet for individuals who had behavioral problems, while still others, among them people in very important positions in the Dover School system, felt that the program was really designed to teach the emotionally handicapped. The fact of the matter is that none of these perspectives are entirely correct; certainly, none represent a clear idea of what the Dover Program is supposed to be about.

It is difficult to assess as to whose fault the lack of clarity as to Program services is in terms of not being able to explain what the Dover Program is supposed to do. However, it is fair to suggest that in the

final analysis the Dover staff has the responsibility of communicating with potential referral agencies just what kinds of services it is prepared to offer. In my conversations with Miss Trahan, who is the community liaison officer, she did inform me that the Dover staff have had local radio advertisements, that there were weekly press releases, that they have met with local clubs at least once a year and, in short, that there was in operation some sort of public relations effort matched with a public relations committee. I have no doubt that such an effort and committee does in fact exist and does function. What is questionable as a result of my conversations with representatives of the target populations of these public relations efforts is that the public relations efforts must in some way be refined so that they are able to communicate to potential referral sources just what it is that the Dover Program is trying to do. In the present state of affairs potential referral agencies are confused, especially the school sources, as to the services provided through the Dover Program. This confusion most certainly represents one of the reasons for the small number of referrals to the Dover Program.

Certainly among the major difficulties which affect the referral rates from the schools to the Dover Program is the problem of finances. Under present circumstances, every student referred to the Dover Program is charged $100.00 a month tuition and a $25.00 initial testing fee. The question is immediately raised by all referral agencies, and most particularly by school referral agencies, as to who is going to pay for this "tuition". It is an open secret that as a general condition throughout the entire country school budgets are increasingly under local public pressure. More and more school officials are forced to make hard and difficult choices as to where to spend their resources. More and more the political support for bond issues and other sources of school funding is dropping off. As a result, there is little doubt that the cost of sustaining an individual in a program becomes a very major consideration when it comes to referral. In general, probation, the courts, or welfare normally can find the money without too much difficulty. Not so with local school department. School department budgets are rather curious animals insofar as allocations are normally made on a line item basis so that flexibility is severely reduced. This is not to suggest that there is no money available to sustain patients in the Dover Program, but it is to suggest that expenditures of such money must be weighed very carefully against other alternatives that are available in treating a given patient. In short, expenditures must be watched very closely. Public officials must assume responsibility for such expenditures and, as a result, there is a tendency to retain monies in more tried and true program areas rather than to risk them on new areas such as the Dover Program, especially when the goals and methods of that program have never been clearly communicated to the potential referral sources.

Another factor relavent to costs and the flow of financial support to patients in the Dover Program is a legal one. In my conversations with the Dover superintendent of schools, Mr. Bernard Rider, it was made very clear that he has been advised that there is a substantive legal question as to whether or not public school monies can be spent in support of any program, such as Dover House, which has not yet received final certification from the Department of Education of the State of New Hampshire. It is his view

and the view of his advisors that local tax monies cannot be spent on such a facility until it is officially certified. As a result, the present policy of the Dover school system emanating from the Office of the Superintendent is that until the Dover Program is officially certified by the State of New Hampshire, the town of Dover school department is not authorized to spend any money on this program. And, indeed, until such certification is forthcoming, Mr. Rider has expressed his very clear view that no further referrals to this program will be made. This analysis has pointed out that one referral has been made to the program from the Dover system but this was prior to the legal issue having been raised. Thus, from the legal and financial perspective, one can begin to see clearly that at least in the Dover school system there is not much support and not going to be much support for referring individuals to the Dover Program until it is certified by the State of New Hampshire. In short, the availability of funds and the willingness to spend those funds on the Dover Program remains a fundamental reason for low referral rates from the school system.

As an adjunct to the financial conditions affecting referral rates from the school system, one must also note another factor which negatively affects the referral rate to the Dover Program and this is the existence of alternative programs, which, at least, appear to do what Dover does and, indeed may perform some of the services that the Dover Program does and yet are readily available, are free of charge, or have been in existence longer insofar as they have established lines of communication with the school system. As a result, there is always a tendency to utilize either the lowest cost unit or, if one must spend money, to utilize that treatment facility with which one is most familiar. In both instances, the Dover Program is in a disadvantageous position. With regard to the towns of Dover and Somersworth, one can note several programs which dovetail very neatly with the Dover Program and which have the additional advantage of being either free or more solidly established. The first is the adult basic education program which has a juvenile sub-program with it. It is a free service, a highly popular one, and a program which is used very extensively by the Somersworth and Dover school systems. There is also the Youth Discovery Program which has been receiving a considerable amount of attention and publicity and is about to get under way in the spring. This program operates under the Guidance Department of the school system and attempts to specify and tailor academic programs to an experiential program in the community. This, too, is free and seems to offer the additional advantage of placing the individual into the community in a business environment. Thirdly, both Somersworth and Dover have applied for a group home program, paradoxically from LEAA funding sources. This again, would seem to provide a free service which seems to be in competition with the Dover Program. The Stratford Guidance and Mental Health Center which, in a very strict sense, is not really competitive with the Dover Program but yet is used as a highly professional organization with which the existing school power structures feel very secure. Taken as a whole, it is fair to conclude that one of the factors contributing to the lack of school referrals to the Dover Program must certainly be the existence of other programs which are either more established and, therefore, with which school personnel feel more comfortable, or which are perceived as functioning in a way similar to the kinds of services provided by the Dover Program. In

an age of tight money, in an age where financial responsibility has become the watch word, it is understandable that the potential school referral agencies will tend to move in the direction of free programs or toward programs that are more established and with which they have a working history.

To be sure, the factors mentioned to this point are having an important impact upon the referral rate. But certainly among the most important factors which affect the rate of referrals from the school systems to the Dover Program is something which could lossely be termed "professional jealousy". The fact of the matter is that both Somersworth and Dover maintain substantial guidance and testing departments within their school systems. Indeed, these are very integral parts of the school system and support its underlying philosophy which is to "mainstream a problem child", that is keep him within the school system and to keep him functioning rather than to seek for alternative sources of help. This is not to suggest that alternative sources are not sought. It is, rather, to say that both school systems have made very substantial investments in terms of time, public support and money into the construction and operation of their own professional guidance teams. As a result, it is only to be expected that these professional teams will perceive themselves to be in competition with the Dover Program. By this is meant simply that the individual who is having problems in school is supposed to be handled quite properly by the indigenous school-trained experts in this area. So that if one talks about referral outside of the school system by these very experts who are supposed to handle the problem within it, there is a perspective in which this case is likely to be viewed as a failure from a professional point of view. Thus, if it were to develop that the Somersworth or Dover system was to suddenly open the flood gates and begin to pump large numbers of students into the Dover Program, this in effect would be an admission that the existing guidance and diversion facilities within the school structure itself have in fact failed.

It has been this analyst's experience that no one is quite prepared to fall on his own sword in defense of social policy. In this sense, then, it is simply unrealistic to expect that students are going to be referred directly out of the school system by those very professionals whose job it is to deal with them within the school system. Indeed, in a very real sense, the fear is that too many referrals out of the system might be perceived as professional failure by public officials which could, in the long run, lead to a decline in public support for guidance programs. As a result, there is a very strong tendency to reinforce the mainstreaming philosophy and to make the case that the schools have appropriate and professional staff for dealing with most kinds of problems. Indeed, in my discussions with the head psychologist of the Dover School system, it was made quite clear that the Dover system has not really run into any cases that they could not handle "by some sort of special arrangement within the Dover system itself". This is not to suggest that they will not refer individuals out; it is only to suggest that before such individuals are likely to be referred out of the system, the professionals within the system are going to make every effort to handle that problem in-house. Accordingly, they are not likely to see referral as a potential help to

their own careers but rather as a potential hindrance. In such circumstances it is only naive to expect that professional jealousy will decline. Indeed, there is no reason to expect that staff within the Dover school system are going to open up the gates and recommend large numbers of students to the Dover Program in the foreseeable future.

Two other factors seem to come together at a point within the Dover school system to retard what is the potentially largest source of referrals to the Dover Program. This is the view of both the chief psychologist of the Dover School system and the Superintendent of Schools. It must be clear that as head of the guidance team of the Dover School District, the chief psychologist is in a strategic position to block any flow of students out of the Dover system into alternative programs such as the Dover Program. This is not to suggest that she is doing such things deliberately. It is only to suggest that she does occupy a strategic position as indeed does the superintendent. In point of fact, it must be said in all candor that both the superintendent and the chief psychologist have severe doubts about the professional quality of the staff at the Dover alternative school and have severe doubts about what they are trying to do and whether or not the programs can work. After several conversations in an effort by this analyst to try to resolve their doubts it must be pointed out that there is a deep suspicion of the Dover program coupled with a question of professional competence in their minds, and until such questions are resolved, it does not appear that the Dover School system in the persons of the superintendent or the chief psychologist are likely to move in the direction of increasing referral flow to the Dover Program. Expressed in terms of their strategic positions, there is no doubt that this view will continue to represent a major difficulty which must be overcome if the Dover alternative school program truly wishes to increase its flow of referrals from the Dover-Somersworth school systems.

Still another factor has to do with the fact, that the Dover Program is a relatively new one. Although the program itself has been under way for almost a year, it has not been in its present location for more than six months so that, despite its own public relations effort, there is some lack of clarity as to exactly what it does. Indeed, the staff itself is still "shaking down" in terms of their own roles and staff organization. Taken in the main what this suggests is that any new program always has some problems of adjustment in its early stages. The Dover program seems to be having quite its share in this regard and it is affecting its ability to extract referrals. There is no doubt that the hesitance to refer people to the Dover program (out of the school system anyway) is in some measure due to the newness of the program itself. A certain period of adjustment is required and should be expected. But, again taken in conjunction with the other factors mentioned here, I would rank this particular element as a relatively minor consideration in light of the other factors which are impacting upon referral rates. In conjunction with the fact that the program is relatively new is the fact that it has no demonstrable success rate. Now, it is not to be implied here that the program may not be a success. Not at all. I merely wish to note that it has few successes that it can point to as a means of demonstrating to the Dover school system that its program works. One of the reasons why it has few successes that

it can point to relative to the school system is the fact that the school system has referred only a small number of students to it to begin with. A kind of circular and vicious cycle is developing in which the Dover Program cannot point to successes relative to the school system unless the school system sends it more referrals and the school system is not going to send it more referrals until it can point to more successes. Taken in conjunction with the fact that the program is new and that it has been unable to demonstrate specific successes, one can readily comprehend why the referral rate from school sources has not been as high as originally anticipated.

To recapitulate those factors which are responsible for the lack of a substantial number of referrals from the school system to the Dover Program: (1) there is a lack of clarity among referral agencies which goes even beyond the school agencies themselves as to what the Dover Program is actually trying to do; (2) there is a financial problem in terms of the general economic conditions of the school budgets which has severely restricted funds and, from the perspective of the Dover Superintendent, there is a legal problem attached to the expenditures of tax monies at a facility which is not certified by the Department of Education of the State of New Hampshire; (3) there is the problem of the existence of alternative programs which are free and which have been used by the school system for a longer time and in which they have more confidence; (4) a fourth factor relative to the rate of referrals from the school system is the fact that both the chief psychologist and the Dover Superintendent who are clearly in strategic positions to reduce or increase the flow of referrals to the Dover Program, have serious doubts about the professionalism of the program itself and of the staff who administer the program. And, indeed, until these doubts are resolved, it does not appear likely that the flow of referrals will increase; (5) a fifth variable is the fact that it is a new program and that a normal amount of adjustment must be expected and although in the Dover case it does seem that this period is taking a little longer than might be expected; (6) finally, this set of circumstances is compounded by the fact that as yet, there is no demonstrable success rate or even a number of success stories which could be utilized as mechanisms to demonstrate to the school system that their referral process is working. To some extent, some of these problems are public relations problems and imply strongly that the public relation functions of the community liaison officer have not been as strong as they could have been. In other instances, however, it is very clear that these problems are rooted in circumstances which are very clearly beyond the control of the Dover Program, at least in a generic sense. Accordingly, these conditions do not auger well for their potential solution as time continues to pass.

In assessing the potential impact of the failure of the Dover Program to establish a referral mechanism which can assure it of a substantial flow of appropriate patients with whom the program is capable of dealing, it must be clear that some ramifications of this failure also impact upon the nature of the Dover Program itself. In the first instance, this analyst's conversations with referral agencies, both school referral agencies and others, such as Welfare, Probation and court systems, indicate that by the time an individual is referred to the Dover Program, he has pretty well "run out his string". Now, what this means is that by the time he is sent to the Dover Program by the referral agency, it is

because nothing else has worked. Such a referral policy may very well serve a functional purpose for the referral agency in that it allows it to clear another case. But it does very little to aid the Dover Program because it virtually insures that the types of individuals who will be sent to the Dover Program are highly inappropriate for the kinds of service that the Dover Program can offer. Again, it is worth reiterating that the Dover Program is designed primarily to deal with educational problems and only secondarily with moderate or limited behavioral problems. As referral is presently operating, it virtually guarantees that the type of individuals who will be sent to the program will be those who have failed in almost all other programs and, indeed, whose problems are not primarily educational but largely behavioral. Such a situation is paradoxical but nonetheless all too evident.

The problem of money certainly represents a major stumbling block to an adequate referral program and often leads to a condition which is not only paradoxical but peculiarly vicious. Consider for example, one case as related to me by a referral case officer. From time to time, the Probation Department does run into an individual who could qualify for the Dover Program, that is, he has a demonstrable motivation to learn, his problems are primarily educational, and his behavioral problems have been largely solved or are only minor. In short, he has been intercepted at a very early stage of the trouble cycle. The problem immediately arises as to who is going to pay for this individual's tuition in the Dover Program. Probation often finds it necessary as a means of acquiring financing to take an individual who may not really have been involved in anything serious, who may have true motivation for the program, and present him as a "person in need of supervision" (PINS). Then the court can order the county or city welfare to pick up the cost of the individual's tuition. Again, the Dover Program cannot be blamed for such a situation, but nonetheless, the fact of the matter is that the probation, welfare and courts are far more likely to be able to come up with the money to support referrals to the Dover Program than are other referral agencies to include the schools. As a result, it seems only logical that because they have the money that their share of referrals to the program will be among the highest and, indeed, if one looks at the existing data in this regard (Table 1), one finds that the overwhelming majority of patients sent to the Dover Program, indeed, all but three have been referred by either the courts, probation or welfare. The problem with this condition is that such individuals are far more likely to be less appropriate for the kinds of services that the Dover Program provides than would be the case had they been referred at an earlier stage directly from the school system. A paradox of curious funding patterns that impacts directly upon the ability of the Dover Program to accomplish its goals is evident.

Taken in the large, the upshot of the failure of the referral policy of the Dover Program to successfully obtain large numbers of patients directly from the school system at a point early in their developmental problem cycle actually raises the question as to whether or not the Dover Program can continue to function in the manner in which it was intended to function within the grant proposal for any length of time.

There is a high degree of danger here that since the schools will not or cannot send appropriate referrals and since other referral agencies which do have the wherewithall to support their referrals are likely to produce only inappropriate referrals, there is a clear and I think present danger that as the program continues to develop, it will receive more and more of its referrals from non-school agencies. This, of course, directly calls into question the central proposition of the grant, that is, its ability to deal primarily with educational problems instead of motivational problems, and, in addition, raises the question of how appropriate such referrals are in the first place. This suspicion is rooted in the earlier observation that the screening process was not a fine sieve as much as it was a steel plate full of large gaping holes through which inappropriate individuals were often allowed to slip. Taken as a whole, the Dover system risks becoming a mere dumping ground for patients that probation, the courts, and welfare, must deal with and who simply send them to Dover as a means of clearing one additional case regardless of how appropriate the referral may be. To be sure, some responsibility must be placed upon Dover's staff to insure that referrals are appropriate. But the fact of the matter is if the program wishes to survive in the face of the refusal of the schools to send adequate numbers of referrals, it will be faced with the dilemma of a single alternative: that is, it will have to accept those referrals that are sent or reject them and close the doors. This analyst does not feel that the second alternative is likely to be chosen.

It can readily be seen, therefore, from what has been said here, that the referral function as performed by the community liaison officer under the direction of the Dover staff has been something less than a resounding success. It has meant, in effect, for all of the reasons listed above that the Dover and Somersworth school systems have not been convinced to send adequate numbers of students to the Dover Program and, as a result, the Dover Program has had to depend, for its referrals, more and more upon other agencies such as the courts, probation and welfare. This is compounded by the fact that from a financial perspective these alternative agencies are often able to be in the best position to financially support their referrals. This clearly represents dangers for the Dover Program in terms of its ability to continue to function in accordance with the original concepts outlined in the grant proposal. And, indeed, if it does not continue to operate within these original outlines, then obviously some serious questions are raised as to whether or not the Dover Program is doing its job. In the final analysis there is a very clear need to totally reform the referral mechanism as it now operates in the Dover Program and to undertake a detailed study by the staff (perhaps with outside help) in order to evolve a mechanism which will be successful at attracting the type of clientele that the Dover Center is most properly prepared to deal with.

PROGRAM CERTIFICATION

Program Certification

At the time in which the grant was originally approved on the 12th of December, 1975, it was noted that Odyssey House, New Hampshire, as regards its Dover program was currently under evaluation by the New Hampshire Department of Education for approval as a special education program. This analyst, in his attempts to evaluate this program, notes that as of this writing this approval has still not been forthcoming. The question immediately is raised as to why the New Hampshire Department of Education has not approved this program, and, indeed, what benefits would accrue to the program if such approval were forthcoming. In conversations with Mr. Robert Kennedy, head of certification for the New Hampshire Department of Education, the following history of attempts to certify the Dover Program as a special education facility emerged.

The Dover program originally had submitted its application for certification last year. At that time, a team was sent in to evaluate the program and it was discerned that several physical problems presented themselves. Not the least of these was that the facility did not meet existing fire codes as well as other minor physical problems. These have since been corrected, but the nub of the matter did not involve the physical facilities of the program but involved the qualifications of the teacher herself. The fact of the matter is that the present teacher, Miss Jackie Adams, is not certified to teach the emotionally handicapped which some of the patients partially qualify as being. In short, the State of New Hampshire certified Miss Adams to teach in special education but not for educating the handicapped.

The application remained pending until the Dover Program moved from the Dover Residence House into its present location at 100 Locust Street. Then, a new request was reinitiated this fall and then it too was withdrawn. My understanding as a result of conversations with the Dover staff is that as of the present writing, they have not formally re-applied for approval from the New Hampshire State Department of Education. The problem at base is, again, the fact that Miss Adams is not certified and it would be exceedingly difficult for her to become qualified to receive this certification status under present conditions. As a result, some thought is being given by the staff in terms of hiring a second teacher (would already be certified in this area) if one can be made available through Manpower. This would then mean that the Dover school could get its certification from the State of New Hampshire utilizing the credentials of the new teacher. The difficulty that presents itself here is that the staff is by no means certain that it can get funding from Manpower or any other source to provide a full-time teacher to deal with the education of the handicapped. Thus, at the present time, there is no movement in the direction of certification of the Dover program because Miss Adams is uncertified; no efforts are being made for her to become certified; and the staff is uncertain as to whether it can acquire funds for a new teacher; it is unsure as to whether such a new teacher could be found at a funding

level which would meet the requirements of the State of New Hampshire; and finally, because the application procedure has not been re-initiated. In short, the form simply has not been completed and filed. Providing all other requirements are met the State of New Hampshire requires a minimum of approximately six weeks to grant this certification.

It is interesting to point out that if the Dover Program was able to get certified by the State of New Hampshire, several benefits would accrue to the program almost immediately. The first would be that the educational credits which the patients in the program now achieve thorugh the use of the auto-tutor would be more easily acceptable to all schools throughout the state. Under present conditions acceptability of credits is a major problem and one which forces the Dover Program to make individual arrangements with various schools in order to get the credits earned by each patient accepted by the various school departments. This procedure is highly cumbersome and highly subject to disruption. Much of the difficulty may be mitigated if the program were certified by the state. Indeed, as pointed out in another context, one of the major stumbling blocks to the admission of referrals from the Dover school system as voiced by Miss Donna Boulin, the Dover school psychologist, and the School Superintendent, Mr. Rider, would be removed if the program were able to be certified. From this perspective, therefore, certification takes on an additional importance.

Still another advantage which would accrue to the Dover Program if certification were to be forthcoming would be that a wide range of voational rehabilitation services and even some additional state funding would become potentially available to the program. Given the level of funding under which it now operates, given the staff stability which could be somewhat cleared up by additional funds, additional sources of funding then come to assume some importance to the success of the program. Such additional funding is at least marginally contingent upon receiving certification from the State of New Hampshire. Finally, certification would allow student teachers who were attempting to be certified in the area of educating the handicapped to work within the Dover Program. This would serve the purpose of giving the student teacher an opportunity to gain on-ground experience while at the same time it would make available to the Dover Progarm a wide ranging array of teaching resources that would be virtually free of charge. Taken together, therefore, it would seem that the approval of the Dover program by the New Hampshire Department of Education ought well to be regarded as a major item on the staff's agenda. In point of fact, it has not been a major item and the result has been that after a year of being in operation, the Dover Program still remains uncertified by the State of New Hampshire to perform the kinds of services that it does. Indeed, all available indications suggest that it will continue to remain uncertified unless some funding is found for an additional teacher. Given such circumstances, one cannot wonder whether or not the problem of staff stability or instability as noted in another place has not rebounded to the detriment of the program insofar as that no

one on the staff has either taken the initiative or remained on top of the certification program. The result is that a whole host of potential resources that could be brought to bear on the problems with which Odyssey House deals have gone unused.

In addressing the question of certification, it must be clear that the argument presented by a Dover school system official as to the major reason why they do not refer individual patients from the schools to the Dover Program is precisely that the program remains uncertified by the State of New Hampshire and that, in the opinion of the Superintendent of Schools, Mr. Ryder, to spend tax dollars on this program in this manner would be illegal. They imply very strongly that if the program were certified they would indeed send what they regard as appropriate referrals. This analyst cannot help but suggest that perhaps this may in fact be a kind of "smokescreen" behind which they are hiding and that the reasons for their not referring patients go much deeper. Be that as it may, a critical question still remains.

The critical question is this: what is the relationship between a program such as Dover which offers to provide a service which will raise the skill levels of its patients and the local school programs? In a word, if an individual is able to demonstrate through the Dover Program that his skill levels have been increased from, let us say, from the eighth to tenth grade level, will the school accept those credits and allow the individual to return at the tenth grade level? Where is the policy decision making mechanism located? What is state policy here? What is local policy? These questions become critical for there is absolutely no point in sustaining a program such as Dover if the attempt to increase educational skill levels which are registered by the methodologies of the program are not going to be accepted by the school system. In a word, we talk about reintegrating individuals back into the school system at a level equal to their age group and yet if the school system is not willing to accept the program which raised the individual's skill levels, then clearly there is absolutely no point to running the program. Therefore, the policy regarding the relationship between the alternative educational programs and the local school boards is critical.

In this regard this analyst's interviews with personnel of the Special Counseling Section of the New Hampshire Department of Education revealed the following information: the State of New Hampshire does not presently have any specific policy regarding whether or not local school boards may accept credits earned in either a tutorial or alternative school setting. The decision whether or not to accept such credits is purely and totally a local decision. The only time that state authorities are likely to get involved is by invitation and then only when a local school has some doubt about the ability of an alternative facility to produce adequate training. Then, it will ask the state to investigate and issue an opinion as to whether or not it feels the program is adequate. However, this type of assistance is rarely called upon so that in practice the decision to accept credits

from an alternative school or teaching facility is purely and simply a local concern. As regards the Dover Program, this finding is crucial because it completely wipes away the excuses provided by Dover school system personnel as to why they will not refer students to the Dover Program, namely, that it is not certified by the State of New Hampshire Department of Education. In point of fact, it is totally within the power of the local school committee in the Town of Dover or indeed in any other town in the State of New Hampshire to make a decision to accept the credits earned in an alternative educational setting such as the Dover school program. In point of fact whether formally or not the Dover system has taken the position that it will not accept such credits until the program is certified and even then it is unclear whether an agreement can be worked out.

The importance of the foregoing discussion is clear. There is no point in attempting to raise the skill levels of individuals through alternative programs such as the Dover Program or any other alternative facility unless there is in force an agreement between the alternative school and the existing school system that the system will accept the credits the student earns in the alternative setting. Furthermore, there has to be an agreement that if the individual raises his skill level let us say two grade levels that he will be allowed to reintegrate at the higher skill level. Otherwise, the individual will be forced to remain in the alternative setting until he either turns 16 or obtains his GED or returns to the same grade level which he left in which case the program would have absolutely no point. At the present time, no such prior agreement exists between the Dover school system and the Dover alternative program facility and, as a result, one must seriously question the whole purpose of the Dover Program in the absence of such an agreement. Moreover, while certification may well clear at least a technical stumbling block to convincing the Dover school system that the grades received through the Dover alternative program should be accepted, certainly far more has to be done in this area before one can expect that the Dover Program will be in a position to justify even attempting to raise the level of its patients since, under present conditions, they are not going to be allowed back into the Dover school system.

In similar future situations it is recommended that any alternative school system which seeks to raise skill levels and to reintegrate individuals into the mainstream of the school system obtain as a prior condition of grant an agreement between the alternative facility and the school system delineating clearly that individuals who do raise their skill levels in an alternative setting will be allowed back in at the new demonstrated level. At the present time no such agreement is in force between the Dover facility and other school systems and the question of acceptance remains a matter of individual negotiations with individual schools, a condition which clearly is less than satisfactory.

FILE SYSTEMS

File Systems

As a result of an evaluation design constructed for the Governor's Commission on Crime and Delinquency by the American Correctional Association under an LEAA contract on May of 1976, recommendations were made as a result of that evaluation that certain forms be kept by the staff of the Dover Program. At a meeting between GCCD and Odyssey House staff on June 14, 1976, a letter of agreement was drafted in which the Director of the Dover facility agreed to be responsible for maintaining all required data on resident patients and that a minimum data sheet on out-patients would also be maintained. However, as one examines the Dover staff's maintenance of the required records format some difficulties appear.

The forms in question are the following: Form 1 is known as the Odyssey Evaluation Form which is filled out for each youth and kept in his file upon entering the program. Form 2 which is also called the Odyssey Evaluation Form is also completed on each youth and kept in his file and addresses largely the educational history and achievement of the individual client. Form 3 also known as the Odyssey Evaluation Form lists and maintains a record of the number of contacts made between the Dover staff and families of all resident students for an entire year; it is kept by month. Form 4 entitled, Evaluation for Odyssey, is a termination form which is again kept on all students as they exit the program. It is worth noting that these four forms, copies of which appear attached as Figures 9, 10, 11 and 12, were designed by an outside consultant and Odyssey House and Dover staff agreed in a letter of agreement to maintain these forms on file and keep them up to date.

The difficulty in maintaining a file system such as the one described above is that the burden for maintaining such files in a current status fell essentially upon one person. This person was Miss Denise Trahan who served as the primary induction officer for the Dover program and who also served in dual capacity as Community Liaison. In short, her job was to communicate with external agencies and to track all individuals, both day and resident patients, entering the program. The forms designed by the prior evaluation were to be used precisely to accomplish that tracking procedure. In point of fact, Miss Trahan has had a history of long illness as a result of which has forced her to be absent from her job for a substantial period. As of January 15, she had been absent virtually for the entire month of December due to her recurring illness. Correlarily, the filing system relative to the four forms previously mentioned as it exists in practice within the Dover Program leaves much to be desired. For example, Form 1 which is principally to be filled out on every student entering the program in point of fact has not been filled out in all cases. The staff at Dover indicates that the data which are required by this form do in fact exist and a check of the existing files by this analyst reveals this to be the case. However the data has not been transposed into the required format as of this writing and to the best of my knowledge no substantial effort has been made to do so.

With regard to the remaining three forms, these were also kept by Miss Trahan and, again, there is some unevenness in terms of the manner in which they were maintained. Form 2 for example which details the patient's educational data tends to be relatively complete in all the files. The reason for this is, of course, that it largely requires educational history and educational testing scores and, as a prerequisite to entering the program, each patient in the program must be tested educationally. Accordingly, Form 2 has been generally kept up to date. Form 3 which deals with the number of contacts by all residents with their families made during every month are again maintained by Miss Trahan. This analyst discovered in a check of the existing files that such forms are missing for at least three persons. In addition, a family contact program has not really been placed in force since the program's inception although efforts in that direction were promised in the letter of understanding of June 14, 1976. In point of fact, Form 3 which lists all the contacts made with all resident families during the month has not been adequately maintained with some forms missing. Since Miss Trahan's illness in December there has been a period of over four weeks in which records have not been maintained. In short, there is a major staff difficulty insofar as the illness of a single staff officer and the resultant slack left by this officer has not been taken up by additional staff members. Again, this condition can accurately be perceived as largely a function of staff over-extension.

Form 4 which is a termination form that indicates what date upon which the individual was terminated from the program, and where he has gone from there, is relatively up to date. The reason for this is probably because only three individuals have left the program since its inception and even here I was able to uncover only two of the three forms. With regard to the third form, it is unclear as to where it may physically be located and Miss Trahan also doesn't know where it is! Taken together, therefore, the filing system as it addresses the requirement to maintain the four forms specified by the original consultant evaluation and agreed to between Odyssey House staff and GCCD personnel in the letter of June 14, 1976, has by and large not been complied with. Perhaps, more accurately, some sections have been complied with totally, other sections partially and some sections not at all. It is my recommendation that these conditions be corrected as rapidly as possible, probably by requiring all records to be checked periodically by the director of the program.

In addition to the four record forms already addressed that were required by the letter of understanding between GCCD and Dover House and which were recommended by the previous consultant, the Dover program also maintains on file four additional forms which contain potentially valuable data to the program personnel in addressing the kinds of problems that individual patients may reflect. These forms include Odyssey House's own induction form which is completed upon the induction of every individual in the program and is filed in his treatment folder.

Figure 9

ODYSSEY
EVALUATION FORM

FORM 1.

(To be completed for each youth, and kept in his file upon entry)

DATE OF APPLICATION:_____

NAME:_____ DATE OF BIRTH:_____RACE:_____

SEX:_____COMPONENT:- HOUSE:_____ SCHOOL:_____BOTH:____

REFERRING AGENCY:_____ REASON:_____

_____

_____

RESIDENCE: (prior to initial enrollment at Odyssey)

A. At time of application youth living: (check One)

both maternal parents_____ mother only_____father only_____

mother & stepfather_____father & stepmother_____other relative__

independently_____public or private agency_____

B. (For Odyssey Dover House Residents only)
At time of referral youth was living at: (check one)

ODYSSEY HAMPTON_____ Other_____(explain where)_____

Child's state of residence prior to Odyssey referral (cehck one)

New Hampshire_____Other_____(mention city & state)

FAMILY INFORMATION:

PARENTS ADDRESS:_____

Family annual income previous year:_____

If parents employed state where and occupation:_____

_____

SIBLINGS:

Number of Siblings:_____

Youth's Rank in Family_____

Number of Siblings with Juvenile Court Referrals_____

FORM 1 (continued)

SCHOOL INFORMATION:

Was youth enrolled in school at time of referral?_____
(yes or no)

Grade in which enrolled_____last grade completed_____

Semester of last attendance_____

Expected grade level_____actual grade level_____

If not enrolled, state reason_____
(expelled, drop-out, etc.)

COURT HISTORY:

Child's status with Court at time of enrollment_____

_____
(opened, closed, no history, adjudicated, on probation, etc.)

List childs court history

Charge 1_____ Date:_____Disposition_____

Charge 2_____ Date:_____Disposition_____

Charge 3_____ Date:_____Disposition_____

Figure 10

ODYSSEY
EVALUATION FORM

FORM 2.

(To be completed on each youth and kept in his file)

EDUCATIONAL DATA

CLIENT: _____ DATE OF BIRTH: _____ SEX: ___ RACE: _____

REFERRING AGENCY: _____

REASON FOR REFERRAL: _____

_____

_____

LAST GRADE COMPLETED: _____ LAST SEMESTER OF: _____

ENROLLMENT: _____

PSYCHOLOGICAL CLASSIFICATION: _____

		C.A.T.	W.R.A.T.
PRE-TEST -	MATH	_____	_____
	READING	_____	_____
	ENGLISH	_____	_____

DATE OF ENROLLMENT: _____

		C.A.T.	W.R.A.T.
POST TEST-	MATH	_____	_____
	READING	_____	_____
	ENGLISH	_____	_____

DATE OF POST TEST: _____

STUDENT COMPLETED COURSE WORK YES _____ NO _____

IF NO, REASON FOR TERMINATION: _____

_____

_____

STATUS AT TIME OF SIX MONTH FOLLOW-UP:

IN SCHOOL: _____ DROP-OUT _____

DATE RETURNED TO PUBLIC SCHOOL: _____

ODYSSEY
EVALUATION FORM Figure 11

FORM 3

Contacts made with all residents families during month.

Jan.	Feb.	Mar.	Apr.	May	June
July	Aug.	Sept.	Oct.	Nov.	Dec.

Contacts made with referring agency for all residents.

Jan.	Feb.	Mar.	Apr.	May	June
July	Aug.	Sept.	Oct.	Nov.	Dec.

Contacts made with significant other for all residents.

Jan.	Feb.	Mar.	Apr.	May	June
July	Aug.	Sept.	Oct.	Nov.	Dec.

Total number of Individual Counselling Sessions with residents.

Jan.	Feb.	Mar.	Apr.	May	June
July	Aug.	Sept.	Oct.	Nov.	Dec.

Total number of Group Counselling Sessions with residents.

Jan.	Feb.	Mar.	Apr.	May	June
July	Aug.	Sept.	Oct.	Nov.	Dec.

Figure 12

EVALUATION DESIGN
ODYSSEY

FORM 4

(To be completed upon termination of all enrolled youth)

TERMINATION DATA

NAME:_____ DATE OF ENROLLMENT_____

COMPONENT: HOUSE _____ SCHOOL_____ BOTH_____

REFERRING AGENCY_____

DATE OF TERMINATION_____

REASON FOR TERMINATION:

a) RETURNED HOME_____ (RESIDENTIAL ONLY)

b) MOVED TO:_____

c) ARRESTED _____ RAN AWAY _____ OTHER_____

_____

d) COMPLETED SCHOOL COURSE/RETURNED TO PUBLIC SCHOOL_____

e) UNCOOPERATIVE_____ f) TRUANT_____ g. OTHER_____

_____

_____

NOTES ON ADJUSTMENT WHILE IN PROGRAM:_____

_____

_____

_____

_____

_____

_____

_____

_____

Figure 13

TREATMENT FOLDERS

A. LEGAL

1. induction form
2. general information sheet
3. release and consent forms / adolescent forms
4. full description sheet
5. drug use questionaie
6. photo concent form

* NOTE *
forms # 2 and # 4 are combined

B. MEDICAL INFORMATION @
1. special forms for female residents
2. regular mediacl info. sheets

C. PSYCHIATRIC EVALUATION @
1. Rowan's resident evaluation
2. Rowan's family evaluation
3. Rowan's family therapy sessions

D. PSYCHOLOGICAL TESTINGS

E. EDUCATION

1. all educationial reports

F. SELF-EVALUATIONS

1. welcome contract
2. unit leader / progress notes
   a) put into sequence with the evaluation

G. GROUP-IN

1. signed contracts & goals
2. typed reports from group leaders
3. residents autobiography
4. 'my sexual experiences'
5. 'what sex means to me'
6. list of worst things that happened to me
7. list of best things that happened to me.

H. MARATHON-REPORTS

1. all notes and reports from group leaders
2. new goals, if any, set by the resident / marathon report from the residents in the 'group'

I. GROUP - OUT REPORTS

1. all notes and reports from group leaders
2. direction and plans for the resident

J. SPECIAL REPORTS

1. reports on visits home
2. reports on phone calls home
3. priviate therapy reports
4. any special reports the 'group leader' wants

K. AWARENESSES

It is completed by any individual who happens to induct the patient into the program. Up to the present time it has been maintained largely by Miss Denise Trahan, although this is expected to change as Mr. Dupuis takes over the job which Miss Trahan has left. The data on these forms appears to be relatively complete and I would suspect it is this data on the in-house Odyssey induction form which was to be transferred onto Form 1 as recommended by the evaluation originally done on the project and agreed to in the letter of understanding between Odyssey House and the GCCD staff members. A second form which Odyssey House and the Dover House use internally is a release and consent form and once again this was being maintained by Miss Trahan. As best as I could determine, this data was kept rather haphazardly insofar as only three students have left the program and I was able to find only two original forms. The whereabouts of the third form is at this time unknown. Again, I suspect that it is the data kept on this release and consent form that will eventually be transposed to form 4.

A third format is the Unit Leader Report Form which was originally devised by Hampton House for use with its own clients. Prior to three months ago, Dover did not utilize this form. However, it has gone over to employing this form for individual students. It is filed weekly and placed in the individual's treatment folder. It is completed by the unit leader or by the group therapy leader. Once again, the data here appeared to be fairly complete as far back as they go which is only about three months. Finally, there is a quarterly report which is filed for each individual and is again placed in each folder. This is a relatively complete form which attempts to detail all kinds of characteristics of the individual and, at the same time, provide through a section on the evaluation of the individual the short-term treatment plan as well as long-term treatment plan. Again, I found that the quarterly reports on an individual basis were by and large complete.

Examined in perspective, therefore, I think that this analysis of the filing and records maintenance system as it presently exists in the Dover Odyssey Program is one which could certainly stand some improvement. More specifically, the forms recommended by the letter of understanding of June 14, 1976, have by and large not been maintained. On the other hand, it must be clear that most of the data that these four forms would require with the exception of Form 3 which addresses the number of contacts made with all resident families during the month, such data is already being kept for the most part on internal Dover Program forms and needs only to be transposed. In most instances that transposition has not occurred at all. Thus, it is difficult to escape the impression that the records keeping system at Dover, at least as it addresses the eight forms mentioned previously, is in some need of improvement.

The location of the records does not seem to present a major difficulty. In point of fact, the record jackets are split. Forms 1, 2, 3, and 4 as previously mentioned are kept at the Dover House for the residents while the same forms are kept at the school for the out-patients. The reason for this is very simply that the school records must be easily available in the classroom facility in order to allow the special education teacher maximum access. The records are locked, the keys are restricted only to the Director, Miss Trahan, Miss Adams and the Level-Fours. Adequate security for these records appears

to be in force. The physical location of the filing system is such as to maximumly facilitate its use. The files which are relevant to the resident patients at the Dover House are kept under lock and key there, while those which are relevant to the school out-patient clientele are kept at the Dover School. While there might be some benefit in centralizing the physical location of these files, my own feeling is that they are much better left in separate locations. The reason for this is that Miss Adams has almost a daily need for such files and, accordingly, it would be rather inconvenient for her to have to travel to the Dover residence some four miles away to obtain the necessary files on a daily basis. I would suggest that such files be centrally located only if one individual on full-time staff was tasked with their maintenance and security, a condition which is not likely to occur in the future given the level of staff instability and over-extension. Under such conditions, therefore, the present arrangement whereby the files are left in two locations presents an inconvenience only for the evaluator who is forced to make two trips in bringing them together. It does not appear to represent any major functional difficulty for the staff which is involved in the day-to-day operation of the Dover Program.

With regard to the type of purely clinical records which are kept for both resident and out-patients in the Dover Program, an examination of these records reveals them to be relatively complete and mostly up to date. It must be clear that two separate sets of clinical records are maintained for each patient, whether out-patient or resident. The first type is called a legal folder. The legal folder contains within it all information relevant to legal status and legal record of the individual in the program. It includes such things as induction forms, general information sheet which lists with it the subject's interview sheet upon arrest, his personal profile, his physical description, clothing, personal affects that the individual brought with him, a property release form, arrest record, all release and consent forms and any information drawn from parents, probation or other sources that are relevant primarily to the legal aspect and legal status of the individual. In addition, the same legal folder includes a drug use questionnaire as well as photo-consent form. An examination of several legal folders led this analyst to conclude that the information within them was relatively complete and gave the staff member working with a patient an excellent opportunity to review the legal background and record of the patient under study.

A second type of clinical file is called the treatment folder. Now the treatment folder is purportedly a complete record of all types of treatment which the individual has undergone either within the Dover program itself and, in many instances, from any previous program from which he may have come. In short, much of the information within the treatment folder has been forwarded by the referral agency when the individual arrives in the Dover Program. The information contained within the treatment folder includes medical information, psychiatric evaluation to include those tests that may have been done prior to the

individual's arrival. Additionally, any testing that is likely to have been done by Doctor Rowen Hochstedler as the resident psychiatrist in terms of a patient's resident evaluation, family evaluation and family therapy sessions will also be included. Also included are psychological tests and their results, prior records, or those administered by Miss Adams or Dr. Seeman. All educational reports are also included as are self-evaluations filled out by the individuals; group-in records, including signed contracts and goals, typed reports from group leaders, residents' autobiographies, history of his sexual experiences, list the worst things that happen to him, the best things that happen to him and additional questions are all contained in the treatment folder. Further, there are marathon reports which do note all reports and notes from all group leaders, and new goals set by the resident and marathon reports from residents in the group. There are also what are called group-out reports which are all notes and reports from group leaders in terms of direction and plans for the resident. Special reports are also included such as visits homes, phone calls home, private therapy reports if any, as well as private tutor reports and any special reports a group leader wants to include. Finally, there is a section on awareness in which individual records are kept indicating the extent to which the individual has become increasingly aware of the kinds of problems with which he must confront. Figure 13 lists the data contained in each type of folder.

It is worth noting that a thorough examination of these forms, namely the legal and treatment folders, revealed a record keeping system that is adequate, generally thorough and must be of great use to the professionals and para-professionals involved in the treatment phase of the Dover Program. However, one point of interest is worth making in this regard and that is that at times the legal and treatment folders are not physically separate. Indeed, the most common occurrence is to keep the treatment and the legal folders together in one overall file. I am assured by the members of the Odyssey staff that, upon departing the program or upon being transferred to Odyssey House, legal records are removed and either transferred with the individual to the Hampton House or other appropriate agency that has a right to these records; or if the individual departs the program, such records are destroyed. With regard to the latter option, it is worth noting that there is in force no written policy of destruction of these legal records. On the other hand, it is also worth noting that the Dover Program has not yet had a single individual who has exited the program directly and, therefore there has been no need to this point to destroy legal records.

PRIVACY AND ACCESS POLICY

Privacy and Access Policy

As a result of the meetings between GCCD and the Dover Program staff which occurred on June 14, 1976, Mr. David Sandberg assured GCCD staff at the time that privacy and security policies would be adopted regarding the destruction and retention of files concerning the juvenile population resident at Dover. There was some concern expressed by GCCD at the time that juvenile records according to the law must be destroyed after a juvenile reaches the age of 18. This analyst was unable to discover any policy of file destruction in force. As things now stand, the fact of the matter is that the Dover Program has only three individuals reach the age of 18 since the program began and these individuals were transferred to the Hampton facility and, therefore, did not in a strict technical sense exit the program. As a result, their files were not destroyed but were also transferred to the Hampton facilities on the grounds that treatment was still continuing.

As noted, the Dover facility maintains two sets of files; a legal folder which contains all the individual's court records, police records, probation and other records relative to legal questions; and a medical record which contains purely clinical material. At the time of this writing, no policy is in force to destroy legal records of juveniles upon program exit. At the same time, it must be made clear that the problem of destruction has not yet arisen directly for the very simple fact that the Dover program has had no individuals turn 18 and exit the program. It is my understanding that the qualification that records be destroyed upon a juvenile coming to the age of majority applies only if the individual exits the program. Accordingly, when an individual turns 18 and moves from Dover to Hampton House, the transfer of his files to that facility does not represent a violation of state statutes. However, a formal legal opinion may be required on this issue. On the other hand, it is clear that there is an obvious need for a written policy regarding destruction and the safe-guarding of records, none of which exists to this date. It has been recommended by this analyst to the Dover staff that such a policy guaranteeing the destruction of files for juveniles who turn 18 and exit the program be devised and adopted as soon as possible.

Addressing the problem of access to these same files, it is clear from this analyst's researches that there is no written policy in effect which addresses the question of just who shall have access to patient files. At the same time, however, there is an informal and unwritten policy regarding access to client files. In this regard only the immediate staff of the Dover facility, Hampton House and the Level Fours associated with the Dover facility have access to the files. From time to time requests are made from external agencies for information contained in these files, in which case a release form is provided in order to obtain the consent of the parents. No in-house form is utilized. Normally, what occurs is that the originating agency will send a request form to the Dover staff which will then utilize that form to obtain the

necessary permission for access. The completed form is then kept on file. As best as I can discover, there is no wide-spread dissemination of files beyond what one would regard as normal and appropriate to authorities such as Probation, courts, psychiatrist, psychologist, etc. On the other hand, it is once again clear that although an informal policy restricting access to the files and guarding their transfer of file information out-of-hosue is in force, there is every need to formalize this policy in an effort to ensure that staff members who may come into the program at a later date will not make mistakes and allow information to be extracted from the files which should otherwise be kept confidential.

INTEGRATED CONSULTANT SERVICES

Integrated Consultant Services

As part of the funding provided by GCCD under the Dover Program monies were made available for the hiring and use of a consultant in the field of education. This consultant was Miss Corrine Myles who works for the National Odyssey Center and who lives and works in Utah. Under the provisions of the grant, this Learning Machines Specialist/ Consultant would carry out the following tasks: (1) testing and curriculum planning for Odyssey senior adolescent and Dover out-patients; (2) installation of 10 auto-tutors and attendant learning tapes; (3) training and on-going supervision of on-site special education teacher; (4) on-going evaluation of senior adolescent and Dover out-patient students. Under the provisions of the grant, Odyssey House, Inc., of New Hampshire contracted for the services of Miss Corrine Myles as a learning machines specialist with the Odyssey Institute. The services to be provided were budgeted at 12 days per year or 96 total hours for a total fee of $1,600. A formal contract between New Hampshire and the Odyssey Institute and the Governor's Commission on Crime and Delinquency was indeed drawn up and Miss Myles began to participate in the program.

An examination of the types of services provided by this consultant raises some questions in the mind of this analyst as to whether or not the expected services were being truly provided at the level which GCCD was led to believe that they would be provided from an examination of the grant narrative. For example, according to the grant, Miss Myles was to provide "testing and curriculum planning for Odyssey senior adolescents and Dover out-patients." With regard to testing and curriculum planning, there have been several changes which have occurred in the Dover Program that I think significantly reflect on the anticipated role of the hired consultant. Thus, when the program first got underway, Miss Adams, the teacher in residence, used to adminster the California Achievement Test to all students in the out-patient and resident program. Once these tests had been administered, the unscored tests were then sent back to Utah to Miss Myles' office. There the scores were calculated and a curriculum for use on the auto-tutor was developed. In the lexicon of Odyssey House this curriculum is called a "prescription." The prescription involves the elevation of scores in reading, math and language and the development and utilization of prescribed tapes for use on the auto-tutor that would be targeted at the individual's learning level. The lag time in this procedure to obtain the tapes and the design curriculum was normally 2-3 weeks. There is a specific series of tapes for every grade level and this series of tapes is utilized as a major teaching device. The problem which arises here specifically with regard to how these tapes were designed and the role of Miss Myles is the following: under present conditions, the Dover program no longer sends the California Achievement Test scores to Miss Myles to be scored. Rather, the test is administered and scored right in Dover. Additionally, the program is also designed on site. This, of course, is facilitated by the fact that a complete set of tapes covering all subjects at all grade levels is already in the possession of Dover House. Thus, it is

merely a problem of matching the California Achievement Test scores to grade levels in the subjects of reading, math, and language and utilizing the appropriate tapes for each grade level. The point remains, however, that Miss Myles no longer scores the California tests and no longer designs a particular curriculum program; both tasks are now done on site. This, of course, reduces the lag time between the scores and actually getting the student on the auto-tutor but it does raise the interesting question as to whether or not Miss Myles is being paid for some services that are in fact being provided by the Dover staff itself.

With regard to the second function that the consultant was to perform, the installation of 10 auto-tutors and attendant learning tapes, Miss Myles did oversee the establishment of the auto-tutors but, indeed, instead of there being 10 such machines on site, there are only four and as of January 20, 1977, two of those are in need of repair. One again has some questions with regard to just how much expertise is required to install the auto-tutors on site. Nonetheless, this consultant feels that Miss Myles has adequately provided this service.

Addressing the third service to be provided, the grant requires that the consultant provide for "training and on-going supervision for the on-site special education teacher." The fact of the matter is that Miss Myles did fly in from Utah for about a week in September, 1976, and indeed some of that week was spent in consultation and training of the on-site special education teacher. However, this appears to be the full extent of the training and supervision that the on-site special education teacher has received from the consultant. It is true that Miss Myles does make a monthly "supervision telephone" call and during these calls she addresses whatever aspects of the monthly report which is filed by Miss Adams back to Utah headquarters seem relevant. The question that arises in the mind of this analyst is whether or not a monthly supervision call addressing a monthly report really constitutes "on-going supervision" of the on-site special education teacher? While, of course, this is subject to some question, in the view of this analyst, the language of the grant may have well led GCCD personnel to expect something more from Miss Myles as far as training is concerned.

Finally, with regard to the fourth service that the consultant was to provide, namely "on-going evaluation of senior adolescent and Dover out-patient students," the fact of the matter is that there is not much in the way of continuous direct supervision. As things presently operate, the educational folder of the student insofar as it reflects his progress on the auto-tutor is xeroxed every month and sent to Miss Myles in Utah. There, some monthly notes are made on the folder and some suggestions are made from time to time and the folder returned to Dover House. Again, while this may technically qualify in terms of the service being provided as far as the grant is concerned, one suspects that the language of the grant application is

somewhat misleading in terms of what one would expect from the consultant.

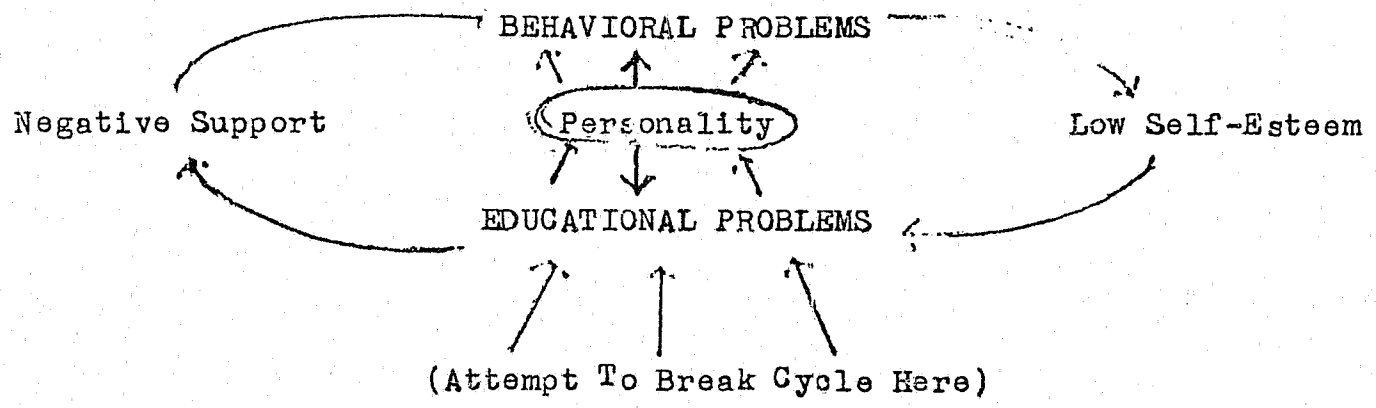
I think that the thrust of the examination conducted here with regard to the functions performed by the consultant is simply this: the grant application would lead one to believe that there is a continuing, on-going effort on the part of the Dover educational staff to train themselves and up-grade their qualifications in order to keep current with developments in the field. In point of fact, to the extent that this is correct, it cannot be attributed to the kinds of performance and help that is being brought to bear by the consultant. Once again, there is the suspicion that the grant language was misleading in terms of what actual impact the consultant would have upon the educational staff. This in no sense represents a reflection on the abilities or efforts or sincerity of the educational staff in the Dover Progarm. It merely is to suggest that not much in the way of on-going overt training is in fact occurring. On the other hand, the fact that the Dover Program has been able to adjust to what I regard as the lack of supervision from an exterior consultant, especially with regards to reducing completely the 2-3 weeks lag time that used to be associated with the administering and scoring of the California Achievement Test and the design of the curriculum, suggests very strongly that this program may be very easily transferred to other programs and other areas provided it is found in the final analysis to have some worth.

In short, there appears to be no real need for the Dover Program to utilize the services of the Utah-based organization, at least as far as the administering of the achievement tests, the scoring of those tests and the designing of the curriculum program and the administration of that curriculum program with the auto-tutor is concerned. This alone may make it possible for this program to be utilized in the context of other programs which may be funded by GCCD or other State agencies.

THE ALTERNATIVE EDUCATION PROGRAM

Figure 14

Reciprocal Impact Model Conceptualizing The Role of Education and Behavior in Personality Development In Dover Program



The Alternative Education Program

When one attempts to understand how the educational component of the Dover Grant Program operates, one must be fully aware of the underlying methodologies and modalities which support the actual teaching mechanisms which the Dover alternative school utilizes. In this regard an examination of the grant is important in terms of understanding the methodology underlying the existing teaching mechanisms. One notes that "Odyssey's thesis is that educational deprivation may be a root cause of adolescent acting out and, therefore proper curriculum design is essential to these youngsters becoming healthy." The point that is at issue here is, what is the role of educational problems in the overall problem spectrum of any given patient? It is clear that the Dover program is predicated on the following proposition that failure at educational achievement is essentially a major contributing cause to whatever behavioral pathology an individual client may manifest in his life.

In consultations with several education experts to include Dr. Hochsteadler and Dr. Seeman of the Hampton Center there surfaced some very substantive disagreement as to whether or not the operational propositions of the Dover educational program are rooted in fact. It would appear that, at best, the notion that behavioral problems are a function of educational failure is certainly problematical and certainly a case for which great argument has yet to be made. There does not appear to be any overwhelming evidence from the Dover Program or indeed even from the methodology available to special education teachers that this proposition is true. As both the psychologist and psychiatrist at Hampton see it, a far more likely occurrence is to be a problem in which educational difficulties are a <u>reflection</u> of deeper-seated emotional and behavioral problems and not the reverse.

As a result of this assumption as to the primacy of educational failure as a causal link in the behavioral problems of a given patient, it is clear that the Dover Program has adopted a specific model of educational behavioral linkage, and that model appears below in Figure 14. Primarily, the model is a reciprocal one. It can be seen, for example, that the following terms of the model are operative: behavior leading to low self-esteem in which low self-esteem is reinforced by educational failure which then reinforces behavioral problems which then re-interact with low self-esteem in a kind of vicious and closed circle. It is noted again that the assumption of the Dover Program is that the primary factor in this circle, this reciprocal model, is educational. The Dover Program has chosen to attempt to sever the circle at the educational point. The difficulty, of course, is that one simply does not know in any certain sense the true relationship between behavior and education. The bulk of the evidence that was able to be uncovered by this analyst in discussions with professionals in the field <u>is that educational problems do not as a rule lie at the root cause of behavioral and emotional problems; rather the reverse is the case</u>.

The implications of this finding for the Dover Program are not terribly staggering in terms of operation but they do remain as a major difficulty in terms of conceptualization. One could easily draw the inference from the adoption of this model that if there are any difficulties which are being encountered in the design of Dover's educational programs, they could be traceable fundamentally to the adoption of a conceptual model which is empirically non-verifiable. In any case, this analysis is content to note the lack of supporting evidence for the proposition upon which the educational program is based and to await a further examination of the data in terms of the impact of the program as a basis for further judgments as to its success or failure. Indeed, it would not be the first time in which a program operated successfully in terms of impact even though its concepts lacked some precision.

How does the actual educational program work? It is an interesting program and somewhat unique. The first stage of the program involves testing by the special education teacher of the proposed client. He is given the California Achievement Test in which his skill levels in language, reading, and math are assessed. Any given individual on a standard schedule should have certain skill scores given the level of achievement from an educational perspective. Once it has been determined what the individual's skill levels are, they are related to his actual grade level in school. Now, it may well turn out, for example, that the individual is actually in the 10th grade but has a language proficiency level at the 6th grade level and a math proficiency at the 8th grade level and a reading proficiency level of a 4th grade level. Once this has been determined, the special education teacher is now in a position to design what is called a "prescription." A prescription really amounts to the selection of an appropriate teaching program designed for each of the skill areas to be directed at the client so as to allow him to raise each of his skill levels to the level at which his age suggests he ought to be. As presently operating in the Dover Program, the prescription is comprised of a series of learning tapes which have been provided by the Odyssey Center in Utah. One need not be overly concerned about whether or not these tapes are successful teaching mechanisms. The evidence available not only to Odyssey and its own tests but to other educational facilities suggests that the method of auto-tutor learning can be a very effective one. Accordingly, this analysis has absolutely no difficulty with the utilization of tests, auto-tutors and prescriptions that are designed by the National Odyssey Organization for use at the Dover level. I think one can assume that this is a valid teaching method for students who are behind their normal achievement level.

The prescription consists of a series of learning tapes that are to be used for the student in order to bring him up to the grade level in the skill areas at which he should be functioning. The auto-tutor works generally in the following manner. A question appears on the individual readout screen and the student selects one of

several possible answers. If he chooses the correct answer, the auto-tutor will then select the next and more complicated question. However, if the student selects a wrong answer, the machine will then select a less difficult question still targeted at the same concept and program the student into a series of less complicated questions until he is able to acquire the correct response. Indeed, except for the use of a visual readout device, this type of educational learning technique has been utilized by the military for years. It has essentially two basic virtues. One, it allows the student to proceed at his own speed and, two, it puts the student in a non-threatening environment. Both are very important as far as the concept of the Dover school is concerned because it will be recalled that the hypothesis which supports the program is that difficulty in behavioral problems is a result of failure in the academic realm. Accordingly, allowing the student to proceed at his own pace and to allow him to learn in a non-threatening environment clearly suggests that the auto-tutor is being used not so much for educational reasons but for therapeutic reasons. In point of fact, it is a teaching device that ensures that the student will not fail; it ensures that his educational experiences will be positive. And, indeed, if it is true that students in the program have had severe educational failures, and if it is true that their behavioral problems are largely a reflection of these educational failures, then clearly the opportunity to provide an individual with an educational experience that is positive and reinforcing is a very important gain. From this perspective, therefore, the teaching methods are clearly consistent with the methodology and models upon which the educational program itself has been based.

The school itself and the teaching function is carried out by a certified special education teacher, Miss Jackie Adams, who is on-site five days a week for a full 8-hour working day. She is assisted in her duties by a Level Four aide, Mr. Mark Bruney. However, in my observations of the actual teaching program, it is clear that the preponderance of the teaching load is carried by the full-time teacher and not by the Level Four teaching aide. The facilities within which the teacher works consist of four auto-tutors and one Craig reader, although since January two auto-tutors have been out of service. There are, of course, other appropriate learning devices such as books, maps, desks, papers, pencils and improved program workbooks which are used in conjunction with the auto-tutor. In addition to this there is the capability of private tutoring on a one-to-one basis which Miss Adams does or outside personnel may do on a volunteer basis when it is deemed that the individual has to go beyond the private tutor or needs some particular support beyond the auto-tutor by going to a private resource person.

The teaching day is a rather full and very highly structured one. There are two sessions in which resident and out-patient students are mixed. The first session begins at 9:00 in the morning and goes to 12:00 noon; the second begins at 1:00 and goes to 3:45. Each student must spend at least two hours on the auto-tutor or the Mott

language series in which he preps for reading. The third hour is spent in either reading, private study, extra work or private tutoring. There is some work in the workbook which might also be addressed in that extra hour. Also, there might be a group discussion or a reading of newspapers. A group discussion in this context is always directed to some subject which is related to the teaching day so that it should not be confused with the conduct of group or individual therapy that takes place outside of the teaching situation. Accordingly, at least half of the student's day is taken up with educational and highly structured material. The other half of the student's day is filled up with what are called a "special projects operation" headed by one of the Level Fours. The point to remember, however, is that the student's day is quite full and he is under supervision at all times. From an educational perspective, two hours on the auto-tutor accompanied by one hour on the workbook or private tutoring or discussion or reading of newspapers is probably about the maximum amount of time that children with evident kinds of learning problems can stand. Indeed, anyone who has spent any amount of time on an auto-tutor or has been exposed to the military method of teaching in this manner understands that two hours of continuous barragement of questions requiring thinking and response is enough to make even an individual with normal and adequate intellectual powers tired. So, there is again little doubt in this analyst's mind that a typical teaching day meets the requirements set forth in the grant and, meets as well those requirements which are implied by the theory and methodology which underlie the educational program.

It was noted earlier that each student receives a prescription designed specifically for him in order to raise his level of academic skills to the level at which he ought to be performing congruent with his age group. The question may be raised as to how progress among the students is measured. The Odyssey Dover program has adopted the National Odyssey formula in which it has been demonstrated that 120 hours of exposure to the classroom facility at the Dover Program is equivalent to one full academic year exposure in a normal school environment. Of that 120 hours, one must be clear that 60 hours are spent in special projects, which is to say outside of the classroom, and the other 60 hours are spent in a structured classroom environment mostly on the auto-tutor but again including private tutoring and workbook use. From a functional perspective it can be said that 60 hours of intensive educational experience is equated with one full year of normal educational experience. As a general rule of thumb, it takes about three months for an individual on the auto-tutor to accomplish the 60 hours. Once this has been accomplished, the individual is then retested with the same California Achievement Test and his scores compared with previous levels. In this manner, the Dover Program is able to measure the actual academic skill level rise, fall-off or rate of change for each of the individual students in a manner that is highly empirical and probably acceptably valid. The ultimate goal, of course, is of seeking to raise student educational skill levels either to give the individual an opportunity to pass the GED or high school equivalency test, or if the individual is not at the age where he may take the high school equivalency test, to bring him up to an academic

skill level equivalent to his age peer group and to re-integrate him into the mainstream of the public educational system.

One of the observations which might be made as to whether or not this program is adequate is the extent to which the tapes themselves are really programmed to increase one's performance on the California Achievement Test and in passing the GED test. The special education teacher was quite frank in saying that the auto-tutor prescriptions are targeted at both the California Achievement Test and the GED test. One sees no great difficulty here except to suggest that there is a methodological difficulty which may arise insofar as passage of the GED itself or raising one's skill level on the CAT may in and of themselves be insufficient indicators of how the individual may truly react in the world at large. In short, because an individual's skill levels are raised on the CAT, does this mean he can keep up once he is back at the school? Or because an individual has a GED equivalency test, does that mean he has truly learned to spell? Frankly, this remains an open question for which there is no definitive answer. As such, it cannot be seen as a major difficulty with this program for, in the end, impact evaluation must assess the success or failure of this program precisely on the grounds of the ability of the student to function. Nonetheless, in the interest of completeness, the issue is raised here.

In addition to what we might call the educational component proper, there is also a vocational training component. The grant indicates that the Dover Program will provide vocational training services for resident and out-patient students interested in acquiring blue-collar job skills or who seek this kind of experience for personal enjoyment. The training facilities that are available are those at the Dover High School Industrial Arts Department and Pease Air Force Base which has opened up its Manual Arts Department for Odyssey apprenticeships. The fact of the matter is that this vocational program has not gotten off the ground very successfully. There has only been one referral to the vocational program largely because there is a lack of interest on the part of potential referrals and, frankly, because such referrals were not truly appropriate. The one individual who was referred to the vocational program remained only a short time and then withdrew. By and large the vocational educational component of the overall Dover educational program is generally not operative at the present time.

THE INNOVATIVE DELINQUENCY PREVENTION PROGRAM

The Innovative Delinquency Prevention Program

As the Dover Program was originally envisioned in the grant application, several project objectives were sought. Besides those already addressed, an additional objective is stated below:

> "To develop an innovative delinquency prevention project aimed at therapeutic and special education intervention at the first sign of delinquency."

In an effort to determine just what was "innovative" about this particular aspect of the Dover Program, this analyst conducted in-depth interviews with several members of the Dover staff to include the individual most directly involved with the educational element, Miss Jackie Adams. In these interviews it emerged that basically the program at Dover offered nothing truly innovative or different. More to the point, the program represented really a conglomeration of other programs which were already underway or being attempted in other places. To the extent that there was an innovative aspect, it was a minimal one insofar as it represented an attempt to join therapy with the educational process. When one talks about joining therapy with the educational process, one must be clear about the kinds of terms that are being utilized. With regard to the educational aspect, "education" within the Dover project means the use of auto-tutors and pre-programmed tapes. The point is simply that the patient is allowed to utilize the auto-tutor as a means of increasing his own math, reading, language and communicative skills. The value of the auto-tutor is that the individual cannot fail. If he selects a right answer, then the tutor automatically programs him into the next set of questions. If, on the other hand, he selects a wrong answer, then the program recycles the questions so as to come at the concept from another direction. At no point is there an indication that the individual utilizing the auto-tutor has failed. As a result, the individual patient is allowed to progress at his own rate; that is to say, learn the concepts being taught and improve his own skills at a rate that is singularly applicable to the talents which he may possess.

With regards to the second term used in the statement of project objectives, that is "therapy," it must be noted that therapy as defined within the Dover program really means group therapy coupled with individual therapy sessions. These are to be combined within the environment of a stable community peer group. Thus, therapy is an attempt to build confidence in the individual which can be reinforced by the success gained by the utilization of the therapeutic auto-tutor. The point remains, however, that there is nothing truly innovative about the use of the auto-tutor per se except that they are placed at the core of the Dover special educational program rather than as an adjunct to another program. Accordingly, it is really unclear as to where the thrust of the program lies; namely, does it lie primarily in education or does it lie primarily in therapy? The answer probably rests somewhere in between. I think it clear to say, however, that it is difficult

to locate an aspect of this program which is truly innovative. Indeed, it must be noted that even the educational aspect which appears to be the main thrust of the Dover Program is centered about the auto-tutor not so much for educational reasons as for therapeutic reasons. Translated into layman's language, this means that the individual uses the auto-tutor so as to be placed within an educational environment different from that of a normal school system insofar as it is (1) non-threatening and (2) one in which the student cannot fail but is allowed to proceed at his own work level no matter how long this may take. In a nutshell then, it is fair to suggest that in terms of this project objective, the attempt to develop an innovative delinquency prevention project aimed at therapeutic special educational intervention simply is not being achieved. There is nothing that is highly innovative about the Dover therapeutic/educational program that this analyst could discern.

Referring to the same project object, it is important to note that the program envisioned bringing to bear the "Innovative Delinquency Prevention Project" through the use of "therapeutic special education intervention" at "the first sign of delinquency." In short, the assumption was that the project objective could work if individuals were referred to the program when they first became involved in minor trouble. In correlary, the supposition is that the kinds of difficulties that they would have would be largely educational and that it was the failure to succeed at educational tasks that were provoking delinquent behavior. While more has already been said about this in another place in this evaluation, it is worth mentioning here that what appears to have happened in the Dover Program, especially as regards the types of individuals that have been referred to it and have been accepted into the program, is that the types of individuals who finally do come to Dover do not come "at the first sign of delinquency." Rather, they are referred here after they have had long and established records of delinquency, frequent encounters with the police, with the probation, and with the courts. It is only after other agencies, especially as with regards to schools, have really given up on the individual that he is sent to Dover. To quote one member of the Dover Special Education and Guidance Committee, "When an individual is sent to the Dover Program it is because he has already run the full gamut of programs which we have available and we have been unable to do him any good. In short, it is a last resort." Taken from this perspective then, the element which requires the application of the Dover Program "at the first sign of delinquency" simply is not being achieved, at least as far as can be discerned from the profile of the types of students who are being sent to Dover House, when they are being sent to Dover and from an analysis of the kinds of backgrounds they have. This view is supported by frequent conversations and interviews with members of referral agencies.

EDUCATIONAL SUPPORT MECHANISMS

Educational Support Mechanisms

The preceeding description of the operation of the educational program at the Dover Center remains incomplete. Although the major thrust of the Dover Program is educational and although the major methodologies and models upon which the program is built suggests that the primary difficulties leading to behavioral problems are educational and not emotional, the fact of the matter is that the Dover staff is too experienced and seasoned to conclude that education in and of itself is capable of solving all of the difficulties that their clients may present. Nonetheless, although the major thrust remains educational it is supported by at least three other instrumentalities which are placed in direct support of the educational function. These are the special project element of the educational program, the group therapy element, and the family counseling element. Thus, the total educational program of the Dover Program is really comprised of the educational program as outlined above and three adjunctive mechanisms just mentioned. It appears appropriate to examine each of these three elements in order to see how they integrate into the overall educational plan and also to assess the manner and completeness with which each aspect is operating in support of the major program thrust.

The interesting thing about the special projects element of the overall educational program is that it doesn't appear anywhere in the grant proposal. Rather it appears to have been that kind of element which evolved in response to the needs of the program as the program itself developed. In this regard, it might be suggested that the special project element is really a kind of adaptation from the Hampton experience. It will be recalled that the Hampton experience is one in which the client is placed in a highly rigid and controlled environment as a means of modifying behavior. The Dover Program, on the other hand, must of necessity operate within a looser environment. Yet, the behavioral aspect of the client must yet be addressed. Accordingly, what the Dover Program seems to have done is to evolve the special projects element as a means of adopting the Hampton approach while at the same time modifying it and tailoring it to the needs of the Dover program.

In general, special projects occupy about 50% of the time of the average client in the Dover educational program, the other 50% being spent entirely in a "pure" educational environment involving auto-tutors, private tutors, workbook work and reading. The special projects are overseen by a Level-Four operative. (At the time of this writing this is Mr. Mark Gipson, a Level-Four graduate of Odyssey of New York). The purpose of the special projects program is to expose the clients to a relatively wide variety of activities as to provide them a kind of balance to the academic atmosphere in which they must learn while, at the same time, hoping to instill in them the kinds of characteristics that tend to be associated with socially acceptable behavior. Thus, it strikes this analyst that the point of the special projects program

is through group activity to teach responsibility, trust and honesty, and other characteristics normally associated with individuals who are law-abiding and community desirable.

The kinds of projects or activities which the special projects officer is likely to oversee include such things as farming on the 90-acre site on which the resident facility is located, taking care of the animals located at the facility (at the present time that includes a full-grown horse and several dogs and cats), overseeing dirt bike riding and other recreational activities to include a relatively well-organized sports program such as ice skating and hockey. Also there is choir singing and indeed the special projects are often organized as a means of contributing to the physical upkeep of the program's physical facilities. Thus, for example, the particular group that I examined was attempting to put together a recreational room in the empty storage center at the back of the main facility. They have taken part in snow shoveling campaigns and in one instance they were actually organized as a means of transporting oil to their facility because the main road was not plowed.

Not very much can really go wrong with the special projects program given its original intentions. Its intention is not to be a copy of the strict, rigid, totally controlled environment that one finds at the Hampton program. Rather it is an attempt to modify the Hampton approach and to make it less rigid but controlled, strict but understanding, and free without being too lenient. The object, of course, is by example and group activity to teach habits to the individuals that are supportive of the educational training that they are also receiving in the program and indeed to instill in them by example and operation those kinds of habits which we tend to see as community acceptable. The one facet of the program that could perhaps be improved is the attempt to design some kind of long-term schedule for special projects. As best as I could determine, there is no long-term schedule or long-term plan for special projects. On the other hand, this view which really aims at administrative tidiness must be balanced by the fact that, in the end, the program must operate with limited resources and must take advantage of the kinds of activities that are available at a particular time so that this is one instance where I feel that administrative tidiness can be sacrificed to flexibility.

What must be clear, however, regardless of how this element of the program operates is that special projects is merely an adjunct to the educational program proper and that it is not designed to either take the place of the educational program or, indeed, even to carry on into another environment the lessons of the classroom. It is instead a supportive mechanism aimed at dealing with perhaps another facet of the problem cycle which really defines every client in the program so that once again the educational thrust of the program is central. Special projects is supportive and adjunctive to it and in this sense falls in very much the same kind of area of policy impact as group therapy and family counseling. They are all important

but they cannot be substitutes for or indeed interfere with the primary educational thrust of the program. In general, in my discussions with the patients at the resident facility, it became evident that the patients were not very happy with special projects. Most expressed the view that the projects were not only not recreational, but, indeed, often appeared to have no point at all to them. Furthermore, they expressed the view that such special projects seem to be things that were designed merely to "keep us busy" during the day. They certainly did not find the currently existing scope of the projects such as taking care of the horse, cleaning out stalls, building furniture, raking the yard and other "arts and crafts" to be of any serious compelling interest. And there seems to be no truly recreational value perceived by the residents of the Dover House in participating in special projects.

Most agree that if it were entirely up to them, they would reduce the amount of time spent on special projects so that they would have more time to themselves to "do other things." Now, some special projects, largely ad hoc ones like skiing, skating trips, are well liked and certainly had an enthusiastic and indeed positive impact among the individuals involved. The patients at the residence expressed a clear desire for what might be called more sports-oriented activities and, at present, it must be noted in all candor that there are not much in the way of sports-oriented activities. There is a deflated football on the premises, no bats, balls or gloves. The area that they were preparing for a recreational room collapsed physically under the pressure of a recent snowfall (see attached photograph in Figure 2) so that in effect there certainly are not any sports or recreational activities in the special projects arena which are compelling the students to participate.

There is no doubt in this analyst's mind that much more could be done in the area of special projects to help reinforce the individuals' attachment to the program and hopefully serve as an adjunct in support of his educational achievement. On the other hand, this view must be balanced with the more clinical need to keep individuals busy when they are not in the classroom. Now, this is necessary certainly as a means of teaching them to get along with others, certainly as a means to ensure that they do things that they don't always like as a means of conditioning, and also to try to get them to work in small teams in an effort to ensure that they develop mechanisms for working things out with others. Additionally, it is clear that if too much leisure time is allowed individuals in the resident facility, given their backgrounds of behavioral problems, the probability of interpersonal difficulties will increase. Given this probability, a balance must be struck between the time in which individuals are engaged in activities which are seen as useful and that time which they are allowed to spend on their own.

In point of fact, it is very difficult to pinpoint the impact of the special project program upon the individuals since it is clear that it often requires, under the guise of recreation, those things which other people would normally associate with work. Now this linkage has a good therapeutic basis, namely to get the individuals to accept responsibility, do things they need not like, and interact with one another without engendering conflict. On the other hand, there is equally no doubt in this analyst's mind that a wider spectrum of activities of a recreational nature should be provided. Some suggestions are a basketball hoop, baseballs, gloves, bats, perhaps a volleyball net, and one individual even suggested the creation of a Dover House softball team and, indeed, this has been used in a Louisiana Odyssey program and has met with some success. In the final analysis, the term recreation is to be taken literally: a recreation of the individual. From the time of the ancients it has been recognized that recreational activities are exceedingly functional in bringing about a balance in the individual. This should apply more so to individuals who are having behavioral, emotional and educational difficulties. Therefore, it is clear that special projects is certainly not doing all it can do and in most instances is not really doing even as much as it could do with the existing resources. More needs to be done in this area.

As the Dover Program perceives the role of group therapy and as outlined in the original grant application, it is clear that group therapy is seen as central to the achievement of educational goals. In this regard, the Dover philosophy regarding the relationship between group therapy and education is as follows: group therapy is a major therapeutic tool which is to be used with both Odyssey residents and out-patients in a major therapeutic role. All groups will be conducted by highly trained Odyssey staff with senior adolescents serving as unit leaders or communications bridges in the groups for the Dover out-patients. Odyssey House uses group therapy to explore basic problems areas, discuss concepts and values and as a force upon each individual to conduct his regular life honestly. The point of connection with the educational program is very important and in the philosophy of Odyssey House the proposition is taken as central that the group process in linkage with the educational process is one of those things which makes the Dover educational program unique for it is Odyssey's experience that "troubled youngsters do not succeed educationally without closely related group processes." Accordingly, it seems fair to conclude that group therapy is seen as a major adjunct to the achievement of educational goals within the Dover program.

How then is group therapy conducted, what types of group therapy are used? Who is involved? How frequently is it utilized? What impact is it having upon the program? With regard to its actual operation, group therapy sessions are held at least once a week. In the initial program there used to be two sessions held a week--one session for the resident students and one for the out-patients. However, as the number of resident and out-patients declined, the group

has become small enough so that it can meet once a week. Under the present operating circumstances we are talking about the meeting of a group therapy session once a week and involving about eight patients on the average. The session is presided over by one of the members of the Dover staff. In the past, Mr. Floyd Jozitis was really the chief therapy counselor, but he has left the Dover Program and gone back to Hampton so that at least in the past month and a half the group therapy program has been actually handled by whoever was available, Miss Adams, Calvin Legg, or Bruce Dupuis. Under the present circumstances it is by and large being conducted by Mr. Dupuis and the two Level-Fours, Mr. Mark Gibson and Warren Bruney.

The purposes of group therapy sessions are by and large rudimentary. The object of the session is pretty much to deal with problems which occur in-house. As regards the residents, since they all share the same facility, it is inevitable that difficulties will arise insofar as individuals living together engender conflict or do not carry out the kinds of assignments that they are expected to. The group process is utilized in order to bring these problems to the surface and to try to come to some kind of modus vivendi in order to solve them. Additionally, some effort is made to try to get the individual patients to "ventilate" the problems that may be bothering them at a deeper level. This, of course, is somewhat easier to accomplish with the resident population than it is with the out-patient population but, nonetheless, the goal for the session remains the same. In specific terms I think it fair to suggest that the goal of group therapy is far less intense than one would find at the Hampton program. It is really an attempt to reinforce certain kinds of behavior and, indeed, to remove and smooth out some of the day-to-day difficulties that patients in the program may be finding in order that such problems will not begin to interfere with their educational achievement. So, from this point of view, it seems that Mr. Bernard Letvin in his comments with regard to group therapy is quite correct, namely, that group therapy at the Dover Center is truly not analytic insofar as it is aimed at getting patients to come to grips with problems that are bothering them but rather it plays a more supportive role. In this sense it is designed to be a supportive therapy mechanism which serves to reinforce in the minds of patients that the course of action that they are presently undergoing is a legitimate one and worthy of role model support.

In addition to the actual group therapy which occurs approximately once a week, there are what are known as encounter sessions and confrontation sessions which may occur daily. An encounter session is a session in which individuals get to address problems in which they have a personal stake. Thus, for example, it may very well be that two individuals may have an argument over some procedure in the house or over the failure of one to perform a task. In short, some individuals has a personal stake in the issue under consideration. The object of

the encounter session which also takes place within the overall group session allows the individual a formalized mechanism for "ventilating" his feelings towards another patient. Again, it is held within the group session format and supervised by a staff or Level-Four individual. The object of the "game" here is for the individual to try to work out problems between themselves but in a group format. The actual procedure for initiating an encounter session is rather interesting in that each individual involved in the encounter actually sits down and fills out what is called an encounter slip in which they place the problem on paper, detail their various charges and then everyone in the group is exposed to the information. Once this has been accomplished and the listening process and the group process utilized, the group and everyone involved aim at evolving a solution to the problem so that the encounter session really serves as a further adjunct to the group therapy session. It does this by providing a structured, non-violent, formalized controlled mechanism through which individuals who feel that they have been wronged by another individual can bring the issue to the forefront and have that issue dealt with publicly rather than brooding and letting it interfere with their studies.

A second adjunctive mechanism to group therapy is what is called the confrontation session which also takes place within the overall framework of a group encounter. The confrontation session is different from the encounter session in that at least one individual does not truly have a personal stake in the problem being raised. An example might be that an individual might observe another individual stealing or may observe another not watering the horse or carrying on his duties. But in this observation, the individual who observed is not in fact affected by being personally hurt. Nonetheless, the individual who observed it may feel that what this other individual has done is against the rules and has to be dealt with. Again, what he does is fill out a confrontation slip and once again a group meeting is held in which the individual is confronted with his failing. Again, a group process takes place and a penalty is assigned. But it must be clear here that confrontation sessions are not "RAP sessions." Rather they are really therapeutic teaching tools. They attempt not so much to assign the penalty, which is almost always a token or nominal penalty, as much as they attempt to try to teach the individual that there are rules that must be followed and that there are expectations which are leveled upon him and that he must be prepared to live up to. The confrontation session and the encounter are far more therapeutic teaching tools which aim at reinforcement of "good behavior" and the undermining of "unacceptable behavior."

As has been mentioned, the encounter session and the confrontation sessions take place within a group session. While it is true that some of these sessions occur within the weekly group therapy session, as a rule however, encounter sessions and confrontation sessions can occur at what is known as the general community meeting which is held every night in which the entire community of the resident facility mixed with out-patients gets together to address events or problems that may

arise. Thus, encounter and confrontation sessions are held almost every night or whenever the need arises. What is important here is to understand that there is a separate mechanism for dealing with the encounter and confrontation session which is in place and which can be activated at virtually a moments notice.

By and large, the types of problems with which group therapy deals at the Dover Program tend to be rather basic ones. They include such things as manipulating, dealing with issues in which the individual is able to get at other individuals in order to get them to do their share of the work; there is the problem of lying and the problem of verbal argument. It is a curious and indeed interesting fact to note that there have been no instances of physical violence in the Dover Program where one would have thought there would have been given the clientele. Finally, there is the problem of guilt feelings and here it must be noted that many of the individuals in the program come from home environments that are highly traumatic. Paradoxically there seems to be a propensity on the part of young people to assume that the difficulty at home is not objectively caused but that they somehow are responsible for home conditions and, as such, they tend to feel a tremendous amount of guilt. One of the functions of group therapy is therefore to try to get them to release some of this guilt. At base, however regardless of the types of problems which the group therapy session deals with, the object is to try to smooth over, remove, or in any way, get around those kinds of difficulties which may ultimately be interfering with the educational progress of the student. It cannot be stressed strongly enough that the Dover Program is fundamentally an educational one and that all its adjunctive mechanisms must, in the end, tie in with education.

One of the objectives of group therapy is to allow individuals within the program to overcome the kinds of basic problems that we have mentioned in order that they can go on to deal with more advanced personal difficulties that may be troubling them. In my conversations with Mr. Jozitis, chief group therapy counselor, it became clear that the number of individuals who have moved to a more advanced stage of group therapy despite the frequency of treatment is somewhat less than 50% of those who have engaged in group therapy. There are some good reasons for this. One of them is that the program is still new so that its clientele have not been involved in it long enough to be able to make a transition to the higher stages. Additionally, group therapy in which an individual can overcome minor problems and be prepared to move into deeper and advanced problems is a process that takes from three to six months and in which intensive counseling is needed. The fact is that there have not been that many individuals who have been in the program for more than three months so that at this point it is difficult to assess the success of this particular aspect of the group therapy process. Thus, the ability of individuals to move from the more basic problems into the stage where they can address more advanced problem areas concerning the self in relationship to others remains generally undetermined. At the present time, however, group therapy

does seem to be coming to grips with the basic program needs which face the individuals within the Dover Program.

As part of the group therapy process a kind of additional adjunct mechanism has been formed, and this is a kind of intensive "one-on-one" conference. The fact is that not all individuals relate very well in a group setting and it often takes some getting used to before a patient is prepared to explore the kinds of difficulties, failings and fears he has in front of a group. In order to bring individuals to this point, the program utilizes "one-on-one" intensive counseling. All this really amounts to is having one of the staff members (perhaps Mr. Legg or Mr. Jozitis or Miss Adams) meet in a closed session with an individual in an effort to get him to explain his fears. It must be clear that this is an adjunct to group therapy and that it does not exist structurally alone. Rather, the individual who might be undergoing "one-on-one" sessions may be at the same time engaged in the layer group process. Ultimately, the objective is to encourage the individual to become more and more relaxed within the group process and that whenever he encounters a problem that he cannot solve in the group process or does not want to discuss in a group setting, to move him into the more intensive form of discussion. By and large, this process from what I can gather has been adequately successful.

Although the grant notes that group therapy is a major therapeutic tool to be conducted by "the highly trained Odyssey staff," the fact of the matter is that the staff that does conduct group therapy sessions is not highly trained, at least not in a formal sense. Most of the individuals involved in it are such people as Calvin Legg, Bruce Dupuis, Floyd Jozitis, and Bernie Letvin and are all graduates of the Odyssey program themselves. Thus, they bring to the group therapy process a substantive and indeed experiential facet but one that is not necessarily likely to be defined as "highly qualified" in any formal educational sense. To be sure, there is the presence of Dr. Hochsteadler and Dr. Steve Seeman, professional psychiatrist and psychologist respectively, who can be brought in on the therapy sessions, but in point of fact the group therapy sessions are pretty well conducted by the existing staff. They do get involved, however, from time to time and, although very rarely, in intensive one-to-one sessions whenever the need arises. In terms of defining that need, there is a case conference which is held at least bi-weekly in which the entire Dover staff as well as the Hampton staff meet together with Drs. Hochsteadler and Seeman. At that time particular problems relating to either group therapy or individual counseling that cannot be handled by the existing group staff are raised and attempts made to delineate therapies that might be effective. Thus, an effort is made in the group therapy aspect of the program to interface available resources from the Hampton facility with those of Dover though not as in as direct a manner as one finds in the Hampton facility.

Two additional questions remain to be addressed. The first is the extent to which group therapy is an appropriate tool for dealing with the kinds of difficulties that the patients in the Dover Program

are likely to have. In my discussions with several of the social workers and referral sources outside the Dover Program the thought was expressed again and again that perhaps group therapy was utilized far too much and that in many instances it was inappropriate. The question was raised with the Dover staff as to whether or not group therapy may not be an appropriate tool in some instances. And, indeed, all concerned were willing to admit that group therapy simply does not work for everyone and that some of the patients in the Dover Program are so bad in terms of the kinds of problems they face that group therapy is not really going to help them to any major degree. Now, of course, this raises the additional question of whether or not the screening procedure addressed earlier is functioning in a manner which is adequately filtering out those kinds of individuals who should not be referred to the program in the first place. In any case, it seems clear that for at least some number of patients in the Dover Program the group therapy approach is somewhat inappropriate and the reason is that the patients bring to the program deep-seated problems which simply cannot be addressed by the existing technique of the methodologies of the Dover Program itself. In short, they need more intense and need a different type of help than the Dover facility can provide. And, as indicated before, this suggests once again that the screening process is not being as thorough as it could be.

Conversations with Mr. Bernard Letvin of the Hampton House tend to reinforce the notion that group therapy at Dover may be in some instances inappropriate in dealing with the kinds of problems that are evident there. He makes the point that some of the individuals at the Dover facility have such exceedingly low educational levels that they frankly have great difficulty in comprehending their environment much less coming to grips with it. Accordingly, in the Hampton facility and in the context with which we are normally used to thinking of group therapy, group therapy is normally thought of as being largely analytic, i.e., an effort to inform the individual of what might be bothering him so that he may come to some kind of internal understanding of what is happening or what has happened to himself. This concept represents a rather common use of the term group therapy. At the Dover facility, Mr. Letvin points out, this is really not the primary use of group therapy. Rather it is actually therapeutic and supportive instead of analytic. In short, an effort is being made through the group process to lend support and to try to convey to the individual that what he is doing is worthwhile, is worth doing, and that in this sense the effort here is to reinforce what the Dover Program has defined as positive behavior. The shift in concept from group therapy as analytic to group therapy as supportive is apparent, although I suspect in truth both such roles are performed in all such settings, suggests once again that there is the possibility that there are some inappropriate referrals being made to the Dover Program.

A final question which arises is the degree of success that the Dover Program may be having with the use of group therapy as it relates

to supporting the primary educational function. It is easy enough to chronicle the average number of individual counseling sessions which are provided to each resident on a monthly basis as well as to provide the average number of group counseling sessions provided each resident on a monthly basis. Indeed as regards the Dover Program, those numbers are 3.4 for the number of individual counseling sessions for each resident on a monthly basis and 11.7 number of group counseling sessions provided each resident on a monthly basis. These data will be addressed in more detail later. However, these data, although they do tend to suggest that if nothing else some number of meetings is being held are in and of themselves really not indicative of anything except the fact that a group therapy program is in operation. The question of success must be rooted in a deeper analysis.

In analyzing the elements of group therapy success with the Chief Counselor and other members who have been involved in the program, all are agreed that it was very difficult to evolve any kind of empirical measure of success and that, indeed, outside of extreme psychiatric testing which is beyond the resources of both this analyst and indeed of the Dover Program itself one must in the end rely largely upon extensive as opposed to intensive measures. In this regard, this analyst was able to agree with the chief therapy counselor that we would define success as consisting of those individuals who after being exposed to the group therapy process were able to achieve a "major positive output from it" insofar as they "were able to realize problems and deal with them." Utilizing this definition of success some very rough numerical indicators of the success rate of the group therapy program were evolved. These were provided by Mr. Jozitis and it must be clear that they are only rough indicators. However, it may clearly be argued that they are better than simply noting the number of sessions held. The data suggest the following indications of success and failure. With regard to failures, one out of every five resident students can be regarded as a failure in the group therapy program in terms of the definition of success outlined above. However, with regard to out-patients the rate of failure approaches 55%, at least more than half. By turning the figures around it is clear that the success rate is an adequate 80% in one instance and a somewhat inadequate 45% in the other. The reasons for the differing success rates are not that difficult to understand. Simply put the residents are in a "group situation" all the time. Even after the formal therapy sessions they continue to live together, to play together, and to go to school together. The out-patients, on the other hand, no matter how much time they spend in organized activity either in the formalized education program or through the special projects program ultimately must return to the environment from which they came every night. Accordingly, their exposure to peer models, peer pressure and group sessions is, in effect, functionately at least 50% less than the exposure rate of the residents. As a result, the out-patient failure rate is categorically slightly more than 2 and 1/2 times higher than that experienced for the

residents. Given the essential difficulty in dealing with the human personality, the rate of failure on the part of the residents is in the view of this analyst generally acceptable; however, for the outpatients it might be categorically deemed unacceptable. On the other hand, one must understand that the rates of failure are not objective and that they relate to the conditions under which the program must operate. One cannot be sure that we can expect higher rates of success from the group therapy technique for out-patients as long as they remain, by definition, out-patients, i.e., as long as they must return to their family environments day in and day out. It may be only common sense that it is unlikely that the group therapy process would be highly successful in their cases.

In conclusion, it would seem that the group therapy process is operating largely in support of the educational centerpiece of the Dover Program but further, more exact measurement may indicate otherwise. There is, however, one major difficulty associated with the group therapy process. For nine months of the program's operation it had a chief therapist in the person of Mr. Floyd Jozitis who conducted therapy sessions and who was currently appraised of virtually every case with which he had to deal. He is, as has been noted earlier, departing the program and there is, to the best of my knowledge, no effort going to be made to replace him with another full-time individual whose job would be to attend to group therapy. At the present time, group therapy is being done on a rather haphazard and casual basis insofar as Calvin Legg filled in for a while; but he will soon be leaving the program so that Mr. Bruce Dupuis, who is already wearing three other administrative hats is expected to carry the role in group therapy. Also, one of the Level-Fours, Mr. Mark Gibson, has been conducting group therapy sessions in the interim. The following observation is warranted: the group therapy process does represent an integral adjunct to the educational success of the Dover program. Accordingly, it is an important element in the program and, thus, must be treated as such. I do not think it sufficient to have Mr. Dupuis who is wearing several other hats also take on the additional task of group counselor. Nor do I think it necessarily sufficient that Level-Fours are in positions to do this kind of counseling. As a recommendation, it is more logical to require the utilization of a full-time, stable staff member such as Mr. Jozitis as represented in the original program whose task it would be to administer primarily the group therapeutic aspect of the program. It is my feeling that under present conditions the conduct of group therapy in terms of its administration is somewhat haphazard and indeed this situation should be corrected immediately and important priority given to the possibility of hiring a man such as Mr. Jozitis to perform the task that he used to perform as a full-time therapy counselor under the original grant.

A third element which interacts and supports the educational program at Dover is family counseling. According to the meeting between Odyssey staff and GCCD personnel on June 14, 1976, it was agreed that Calvin Legg,

then Project Director for the Dover Program, would be responsible for establishing, implementing, and coordinating a family-counseling component for the Dover Program. It was also agreed at that time that there would be a policy established and procedures would be set down in formal fashion which would outline clearly the objectives and mechanisms of family counseling. Mr. Legg at that meeting indicated that such a policy could be formulated and could be placed in writing within a week. This analyst in conversations with Mr. Legg and other Dover staff notes that there is as yet no formal family counseling policy in place. Rather, what is operational is the old policy which really amounted to a non-policy. What is occurring at the present time is that Odyssey continues in its unwritten, informal policy of trying to maintain contact with the parents of residents and of out-patients while they are at the Dover facility. They do this via visits, telephone calls, letters, etc.

Although it has been requested by GCCD at the above-mentioned meeting that a formal policy be established, no such formal policy is in place. GCCD requested, in addition at that time, that Odyssey House log all phone calls, visits, and parent meetings in an effort to evaluate its consistency and success. And, indeed, as of July 1, 1976, this process has occurred and records regarding the number of family contacts that have occurred for each individual have been kept. Such records seem to be complete and readily available.

In general, the policy of family counseling as it presently operates really makes an effort to begin formal family counseling sessions when the Dover Odyssey House staff thinks it necessary. Clearly this raises the question of who decides when its application is necessary? While it is clear that the professional staff of Dr. Hochsteadler and Dr. Seeman of the Hampton House ought to be directly involved in this process of deciding when family counseling is appropriate, the fact of the matter is that their input is rather minimal. Indeed, Dr. Seeman in his year in the program has only undertaken family counseling with one resident student of the Dover House. So, the question of who decides remains an important one. As things now stand, the decision to seek family counseling is largely made by the Dover staff with only minimal input from what one might call the more professional elements available in the Hampton facility.

Yet, in trying to analyze the impact of family counseling on the Dover Odyssey education program or, in this instance, the lack of family counseling, one must be clear about one thing. That is that the establishment of a family counseling modality in most instances simply makes little sense for the Dover Program. The fact of the matter is that most of the patients in the Dover Program, whether residents or out-patients, tend to come from families or home environments that are either fragmented or terribly traumatic in that they involve either one or both parents being alcoholics, child abusers, or having sexual problems. As a rule, then, family counseling is simply

not really an appropriate tool for building the individual's integration into the educational program. Indeed the proposition seems to be strongly held by the staff at Dover that in most instances family counseling simply will not help reduce family problems and, certainly, there is the feeling that to ask Dover to do this is simply to ask too much. In practice, Dover aims at a more modest goal of trying to make the parent available for at least one visit. The fact of the matter is that they have not been terribly successful even in this goal except perhaps to arrange a visit where the individual parent understands that his child will be admitted to the program. As for additional visits, the success rate is extremely low. The reason is again that the family situations are such that they do not regard counseling as important nor do they see it as necessary for their own health. It is an interesting insight which emerged in discussions with the Odyssey staff as regards family counseling that by and large as it is addressed to the majority of individuals within the resident aspect of the Dover Program, the Dover staff does not really expect to be able to re-integrate individuals going through the program back into their own homes. Rather, the search is for foster homes or an anticipated long stay within the Dover resident House or, indeed, if the individual passes his GED exam and is over the age of 16 to set him out on his own. As a result of this orientation compounded with the very real pragmatic problems of the degree to which family counseling is appropriate and the difficulty involved in getting family cooperation, the fact of the matter is that the amount of contact with family regarding Dover students is relatively small.

Furthermore, the amount, extent, and effectiveness of family contact--and that is really what we are talking about--will vary proportionately with the lack of pathology on the part of the family and the extent to which they care about the individual. So that, paradoxically, in one or two cases involving out-patients, there is a very stable home environment in which parents are very concerned about the individual who appears to be manifesting educational problems. In these instances family contact rates and counseling are very high. But it must be pointed out that in almost all other instances the extent of family contact is very low and effectiveness even lower. I would add that these conditions in terms of the effectiveness of the family counseling aspect of the educational program are by and large beyond the control of the Dover staff.

Nonetheless, the family counseling component must be seen for what it is and, in this regard, it is difficult to utilize the sheer number of contacts with the individual as a measure of success. The fact of the matter is the requirements to simply keep a log of the number of contacts and phone calls which was agreed to by GCCD and the Dover staff strikes this analyst as not being a very appropriate indicator of success. What should have been required along with the log is the development for each contact of a small synopsis which could be written out and thereby help the analyst. Nonetheless, the point really becomes moot because the family counseling component

in the Dover Program is not that well developed to be contributing fundamentally to the extent to which the program achieves its educational goals. Nonetheless, the agreement was entered into by the GCCD and the Dover staff to develop a family counseling component and to put it in operation as soon as possible. As of the time of this writing, that task has not been accomplished. No family counseling component in terms of a formal policy exists or has been put in place. And in this sense, at least a technical violation of the letter of agreement dated June 14, 1976, can be seen to be in evidence. Yet, this analyst cannot help but point out that the impact of the failure to carry out this particular aspect does not strike him as being a substantial failure of the Dover Program.

The fourth adjunctive mechanism which operates in support of the overall educational program as offered at the Dover Odyssey House is the tutorial program. As presently constructed, one tutor is available for students who need this type of help. The utilization of the auto-tutors presents a moderate difficulty in that an individual must have at least a fourth grade reading skill level in order to utilize the teaching machine. In at least one instance this is not the case so the problem arises as to how to get the individual student who does not have the necessary required reading skill to function on the machine and raise them to that level so that he can be placed in the mainstream of the class. In order to raise the individual's skill to the fourth grade level, the Dover Program has engaged the services of Miss Ruth Farrell. Miss Farrell is a volunteer worker who is qualified in her field and is not a representative of any agency. Indeed, she answered an ad for a free-tutor placed by the Dover Program and as an older woman she seems to be very dedicated to her job. She spends about two hours a week as a volunteer on a one-to-one basis with the single individual who needs special attention to raise his learning skills to an appropriate level. Moreover she also is available to take part in the group teaching process which she does from time to time.

In addition to Miss Farrell, the Dover program looks forward to bringing on board two additional personnel. They are Miss Cathy White and Miss Marie Haughton, both seniors at the University of New Hampshire in the special education program. They will work as unpaid interns two days a week and will take part in the group teaching process and aid in helping individual students raise their skill levels and operate the machines. This type of help comes at no cost to the Dover Program but more importantly it tends to be the type of help that is highly committed to a program, truly interested in the student's welfare and attracts the kinds of individuals who are likely to give fully of themselves more than perhaps would be the case of paid workers.

It is difficult to assess the impact of the tutorial program upon the Dover Program except to note that its mere existence provides help for those students who are below normal learning levels. Through the

group teaching process, it provides help for those students who are moving along at a rate where they are prepared to take on more subjects in a kind of quasi-lecture environment. Thus, its mere existence and the fact that it is operational indicates that the Dover Program is attempting to make full use of a range of available resources and, at the same time, to ensure that its program offers these resources and makes them available to the student at crucial points in the teaching program. In a general sense, it is unclear as to the true impact but it seems obvious that were the tutoring program not there the problem of what to do with those students who are particularly slow and need special attention would either go unresolved or, indeed, would be overlooked. As far as this analyst can determine, the tutor program as it operates is an effective adjunct to the overall educational program.

To this point this analysis has attempted to examine those aspects of the Dover Program which can be placed fairly logically within that part of the evaluative model which I have called summative evaluation. This is to suggest that the focus to this point has been upon those mechanisms, modalities and instrumentalities that are largely internal to the program itself. Thus, we have focused upon the role of public support, the role and connection between the Hampton Odyssey House and the Dover program itself, the role and operation of the re-entry home, the alternative school, the impact and policies associated with referral agencies, some aspects of the Dover Program staff, the nature and problems of intake policy as well as testing and an examination of the resident and out-patient program. All of these examinations have been to one further point, and that is to examine in some detail the basic thrust of the Dover Program, i.e., the education aspect of the program.

With regard to the educational program, we have analyzed the program as it is supposed to operate, as it does operate, and have gone further to indicate that the educational program per se moves beyond the attempt to raise individual skills and that it brings to bear upon the educational process at least four adjunctive mechanisms which are designed to support the education function. These include the role of special projects, group therapy, family counseling, and the private tutorial program.

The examination of the program to this point has been summative. In the terms of the earlier analogy, the focus has been upon the generator. We have been able to locate and examine the moving parts of the mechanisms and to delineate how those parts operate and to detail to some extent the difficulties and successes of each of the respective moving parts. It is now time to move to that aspect of the evaluation which we have termed impact evaluation. The point to be examined is this: How effective has the program been? If one defines effectiveness in terms of extensive empirical indicators of success or failure expressed as impacts upon the program's clientele,

one can ask, has the program worked? What have the individuals who have been involved in the program received from it? Given the empirical data available to us, what types of assessments can be made addressing the success or failure of the Dover Odyssey Program?

PROGRAM IMPACT

Program Impact

To this point we have concentrated our analysis upon the structural aspects of the Dover alternative educational school program and we have found that there have been some serious difficulties with the program's organization and with the way in which it operates. In terms of the earlier stated analogy we have examined the generator and not its connection with the light bulb so what we have focused upon is the working parts of the generator in an effort to indicate whether or not the generator itself may be producing current. Having made some observations about the way in which the program itself actually functions and having detailed some of its strengths and weaknesses, it is now time to move to an examination of the impact of the program itself.

When one talks in terms of impact ultimately what is attempted is to try to determine and in a measurable and empirical manner the extent to which the program is affecting the clientele participating in it. In this regard, one examines as a baseline the goals that the program set out to achieve and then inquires as to whether or not these goals have been achieved through the mechanisms that have been designed and utilized in the treatment program. In a sense, what is being addressed is a kind of intervention strategy model. By intervention strategy one attempts to arrange the data in such a manner that the conditions operant in the clientele prior to exposure to the treatment can be examined and then measured in some quantitative manner. The clientele is then exposed to the treatment process and finally the condition of the clientele is remeasured in order to determine the impact of the program itself. Thus, what this aspect of the evaluation will attempt to do is to examine in terms of an intervention strategy the impact that the Dover Program's operation has had or has not had upon this clientele. From an examination of the available data, statements with regard to the success or failure of the program can be evolved. And once the statements of success or failure for both the summative and impact evaluatative components have been combined, then the analyst is in a position to develop some recommendations that can be made to bring the program back into line in hopes of achieving its original goals.

It should be noted right from the beginning that the basis for this impact evaluation rests in the report delivered to the Governor's Commission on Crime and Delinquency by the American Correctional Association in May of 1976. At that time, GCCD contracted with a Mr. Joseph D. Ryan to help them evolve an evaluative component for the Dover alternative educational program. In that report, several objectives, data requirements, and indicators of effectiveness were evolved, and these form part of the present impact evaluation. It must be clear, however, that the attempt here is to go beyond the parameters that were originally set by the Ryan study in attempting to evaluate impact and, furthermore, it must be clear that some of the requirements that were set down as methods of evaluating the impact of the program cannot

be utilized here for the very simple reason that the data which would be required to utilize them is not in existence. To be sure, the lack of data is oftentimes the result of poor collection techniques, but with regard to those aspects of the Ryan program which cannot be addressed due to lack of data, it must be pointed out that this lack of data has nothing to do with the ability of Dover personnel to collect it. Rather it has to do with the fact that the Ryan study was essentially projective in many of its aspects. By projective is meant that it attempted to establish a long-term time projection on individual client behavior and as a result would require in some instances data over a period of at least two years. Obviously, the Dover Progarm has only been in operation slightly under one year so that the extant data either is insufficient or indeed lacking entirely. In any event, some of the Ryan study is incorporated where pertinent; other parts are not incorporated whether data have been unavailable or indeed not pertinent and, in general, the attempt at evaluation as presented here utilizes the Ryan study as a baseline and attempts to go beyond it by evolving its own mechanisms and reaching its own conclusions.

PATIENT PERCEPTIONS

Patient Perceptions

One way to discover how a program is operating is of course to talk to those individuals who are directly involved in it. In this regard, this analyst undertook to interview every individual past and present in the Dover Program that he could find. This analyst was able to interview all of the members of the Dover resident program. Their views are rather enlightening.

In my conversations with them it emerged that almost to a man all said that failure at school was a major problem in their lives but some admitted, however, that it was just one problem in a whole range of home problems. However, the stress that they placed upon the impact of educational failure suggests very clearly that the original premise of the Dover Program namely that behavioral problems are affected by educational failure, is not entirely inaccurate. Of course, the question still remains as to the strength of the impact, but there is no doubt at all that the utilization of auto-tutors as a therapeutic as opposed to an educational devise is well intended and well-targeted. Here, the use of the auto-tutor gives the individual a chance to succeed in an academic environment often for the first time in his life and to do so in an environment that is non-threatening and one in which they can move at their own pace. All of the patients agreed on the value of the auto-tutor; that they liked learning by auto-tutor far more than they liked learning with teachers. Indeed, an examination of their success rates later in this evaluation indicates that they have done much better under the auto-tutor than they would have in a normal school program.

Most of the resident students do seem to have some general goal-directed activity in that they felt that if they could get their GED or their diploma that "things would change" for them. Indeed, the socialization of the Dover Program in stressing the GED and the high school diploma seems to have taken root rather well, perhaps even too well, in that those who do finally achieve their GED tended to show somewhat of a disappointment that it did not open more doors for them than they expected it would. Nonetheless, there is some evidence that the individuals are getting supportive stimuli from the Dover Program.

To be sure, most were still unclear about the future and most did not really know in specific terms where they were going but again all said that they thought that the program was good and that it ought to be continued because they could help themselves. Indeed, a high percentage said that the program could help their friends as well. Only one individual said that if he was given the opportunity to walk out the door that he would. All others said that they would try to stay and stick out the program.

In general, the views that were voiced about the Dover Program by the patients in the program are views which tended to strongly support the program. Most particularly, they speak highly of the educational aspect of the program. They speak highly of the auto-tutor as a mechanism for teaching and they speak very highly of the staff involved. Furthermore, they all feel that from an educational perspective they are learning far more than they ever did; they like the environment in which they are learning and, as will be shown later on, the evidence of learning as measured by the California Achievement Test scores in a "before and after" intervention strategy shows that their enthusiasm is well supported. They are learning and they are raising their skill level scores. To be sure, this is a major positive accomplishment and that the individuals perceive it as such and are willing to recommend it to their friends suggests that at least from the educational perspective the perceptions of the Dover Program by those closest to it is a very positive one.

THE EDUCATIONAL IMPACT

The Educational Impact

The "bottom line" of any program evaluation is whether or not the program is working. In terms of the Dover Program, that can mean several things since several goals were set up for it. Certainly, if the Dover Program is going to be judged in any meaningful sense, then focus must initially be placed upon its educational component. As regards the objectives of the program, one of the main objectives addressing the educational element of the program was "to increase the academic functioning of all enrolled students in and not in residence at the Dover Odyssey Program by one full academic year within a period of not more than three calandar enrolled months." This specified objective is to be measured in terms of indicators of effectiveness, namely the California Achievement Test skill level scores for three areas of academic skills: reading, math, and English language skills. By examining the data on the part of the clientele before they entered the program and while they were enrolled in the program for a three month period, we ought to be able to determine whether or not the objective of raising the academic skill levels is in fact being achieved or not. Utilizing this as a point of departure, attention can now be turned to this question.

If one examines the data portrayed in Table 4, it is clear that some raising of academic skill levels scores is occurring. In Table 4 the first column represents the entry grade level score as measured by the California Achievement Test for academic skills in the areas of reading, math and English. Column 2 represents those same scores as measured by the same testing instrument in the same three areas after the individual has been exposed to the program for three months. Column 3 represents the net change in those scores in each of the three skill areas. It will be noted that in all cases but one, the skill levels actually increased or stayed the same. This would suggest at least in general terms that the educational levels of academic skills in the three areas to which individuals have been exposed are by and large being raised as a result of exposure to the program.

However, if one attempts to treat the data in a somewhat more sophisticated manner so as to be able to test whether or not individuals are beginning at the same point in their educational struggle for upward mobility, one can arrange the data in the way that it has been arranged in Table 5. Now Table 5 projects the mean rates of skill improvements for the three subject areas as measured by the California Achievement Test score. An examination of the data indicates that in all three skill areas, reading, math and English, the rates of different achievement expressed in terms of scores evident at the beginning of the program are very small. So that on the average, it is fair to say that almost all students entering the program are beginning with approximately 6th grade academic average skill. Furthermore, an analysis of additional data suggests that on the average they tend

Table 4

Raw Skill Level Scores At Entry and After A Three Month Exposure To Educational Program At Dover

Student	Grade Level Entry Scores Reading	Math	English	After 3 Month in Program Reading	Math	English	Grade Level Change Reading	Math	English
A	6.8	5.0	5.1	8.0	7.1	6.5	1.2	2.1	1.4
B	2.8	4.4	3.8	2.8	5.2	5.3	0.0	1.2	1.5
C	10.5	9.8	12.1	12.0	12.0	12.0	1.5	2.2	0.0
D	6.2	5.8	8.2	7.1	7.5	8.2	.9	1.7	0.0
E	8.1	7.2	5.0	5.6	8.4	10.6	- 2.5	1.2	5.6
F	4.8	4.6	4.6	6.1	5.2	5.6	1.3	.6	1.0
G	5.2	5.7	5.6	7.2	---	---	2.0	---	---
H	5.3	6.5	3.9	7.3	9.0	6.0	2.0	2.5	2.1
I	4.4	7.3	5.3	5.6	9.9	7.6	1.2	2.6	2.3
J	13.1	11.8	12.5	12.0	12.0	12.0	0.0	.2	0.0
K	10.8	7.7	8.2	12.0	12.0	12.0	1.2	4.3	3.8
L	7.9	9.4	7.5	12.0	12.0	12.0	4.1	2.6	4.5
M	10.9	9.7	8.9	12.0	12.0	12.0	1.1	2.3	3.1
N	5.6	7.1	4.3	Under 3 Months Exposure			---	---	---
O	1.5	2.3	.9	Under 3 Months Exposure			---	----	---
P	5.1	5.4	4.4	Under 3 Months Exposure			---	---	---
Q	5.9	6.9	6.4	Under 3 Months Exposure			---	---	---
R	4.4	6.3	4.4	Split Program			---	---	---

Table 5

Mean Rates Of Skill Improvement For Three Subject Areas As Measured By Raw CAT Scores

	Measured By CAT Scores Achievement Year	
Subject Area	Mean CAT Entry Scores	Mean Gain
Reading	6.7	1.4
Math	6.8	1.9
English/Language	6.1	2.1

** Data indicate that on the average, students are beginning with approximately sixth grade academic skill levels in all three areas. Further, improvement is most rapid in the area of language skills

to be approximately two years behind their peer group. Focusing once again upon the data in Table 5 specifically on the column entitled "mean gain," here the data indicates that the average gain in terms of school years for those students exposed to the program in the area of reading skills is 1.4 years, in the area of math skills is 1.9 years and in the area of English and language skills is 2.1 years. Clearly if one argues that the point at which most students begin is realtively constant than Table 5 suggests a very important finding and that is not only are individuals exposed to the program raising their California Achievement Test scroes in all three areas, but the area of most rapid success appears to be occurring in the area of English and language skills. It is difficult to overestimate the importance of the ability of individuals to function in a society who do not have adequately developed language skills. Indeed, this finding goes far beyond the implication for employment or successful integration into school systems; rather it reaches deeper into psychological areas as well. As any psychologist will attest one of the most potent weapons that a patient potentially has in coming to grips with or defending himself from the probing eyes of the psychologist is silence. Not because he wishes to remain silent, although that is sometimes the case, but more often because he cannot express himself adequately. Thus, the findings demonstrated in Table 5 that English language skills are being raised more rapidly than other skill areas suggests that the Dover Program is having a highly positive impact in an area that is very crucial to future student success. While this finding is important, it ought not to be allowed to obscure the fact that progress as measured in terms of mean years of improvement is occurring in all three areas at significant rates, certainly rates that are considered to be acceptable.

Utilizing the intervention strategy approach, Table 6 delineates the data for comparison of "before and after" grade achievement levels for students exposed to the Dover educational program. It again utilizes as a baseline the educational scores achieved in reading, math and English language skills but combines the scores in order to develop an indicator of total grade achievement levels. Column 1 in Table 6 on the far left delineates the total grade achievement levels which the individual student reflected upon entering the Dover Program. Column 2 notes the grade achievement levels which he has attained after exposure to the program. Column 3 lists the net change that has occurred and Column 4 lists the number of instructional days that the individual has spent in the program. It will be noted in regard to the term "instructional days" that the Dover school program, in adopting its guidelines from the Utah Odyssey program, argued in its application grant with considerable support from additional data drawn from experience in the Utah House that 60 instructional days was approximately equal to one school year of achievement. Given that proposition, an examination of the data indicates very clearly that in terms of total grade levels of achievement that are a function of

combined performance in the three skill areas of reading, math and English language, that the students in the program are in fact raising their average levels of grade achievement relative to the number of instructional days exposed to the program. Thus, it is important to note that the average gain of students exposed to the program is 2.03 school grades. More importantly, individuals exposed to the program were able to raise their grade levels after 55 days exposure to the program. What is interesting in terms of this particular finding is not that the individuals are raising their grade achievement levels, although that clearly is a most significant factor in indicating the success of the program, but they are doing so clearly within the time rate projected by the Dover school program, namely 55 days. In fact, the rate of learning is actually faster than that which was anticipated under the original Dover-Utah Odyssey Program. Taken together, the data in Table 6 indicates beyond any significant doubt that from the perspective of educational achievement the Dover Program is functionally raising the achievement levels of almost all its participants at a rate which is clearly acceptable and which must be considered a success. Some idea as to how successful the Dover Program has been with regard to its educational impact component can be gained from an examination of similar results in other states. For example, in Georgia the learning rates for students utilizing the auto-tutor method in the Georgia Earned Release Program has approximated one full grade per one hundred hours of exposure to the machine. By contrast, normal school systems regard a rise of one full grade per 180 hours as "normal." Expressed in similar terms, the Dover Program is raising the student's skill level approximately 1.34 grade years per hundred hours of exposure. Clearly, then, it seems safe to conclude that the program is within acceptable parameters in terms of the impact of its educational component.

In examining the evidence to this point, the data have been combined for day-students and resident students on the grounds that total program impact must be examined in terms of its accumulative clientele. On the other hand, there does appear to be some value in examining the individual instructional level gains for resident students as opposed to day-students in an effort to determine whether or not one aspect of the program is being more successful than another. In this regard, the data as presented in Table 7 presents a comparative "before and after" achievement level profile for resident and day students exposed to the Dover program as an indicator of respective learning rates.

An examination of the data displayed in Table 7 indicates very clearly that both groups are learning at a rate that is acceptable and can be determined successful. If one examines the mean achievement level measured in terms of total school grade levels which are in turn a function of cumulative scores on the CAT in reading, math and language skills, it becomes clear that there is no significant difference between the amount of school grades achieved or gained between the resident and the day students. Indeed, the achievement level for residents is 2.3

Table 6

Comparative "Before and After" Grade Achievement Levels For Students Exposed To Dover Educational Program

C.A.T. Grade Achievement Level Upon Entering Program	C.A.T. Achievement Level After Exposure	Plus Net Change	Instructional Days
8.3	12 GED	3.7	46
9.8	12 GED	2.2	--
5.6	7.5	1.9	45
3.7	6.0	2.3	75
10.0	12 GED	2.0	--
*10.0	9.0	0.0	26
5.0	6.0	1.0	--
4.8	---	---	--
6.7	7.6	.9	38
6.8	8.2	1.6	35
3.9	6.0	2.1	66
5.5	9.0	3.5	88
5.6	6.0	.4	79
5.1	7.5	2.4	79
3.0	tutor	---	39
5.1	tutor	---	37
5.1	7.5	2.4	67
8.9	12 GED	3.1	51
1.6	tutor	---	37
8.8	---	---	10
*12.5	GED	0.0	32
kindergarder level	tutor	---	--
5.0	---	---	39
6.4	---	---	4
5.4	---	---	34
5.7	---	---	39

* Indicates student tested at that level although his actual grade placement within the school system may have been lower

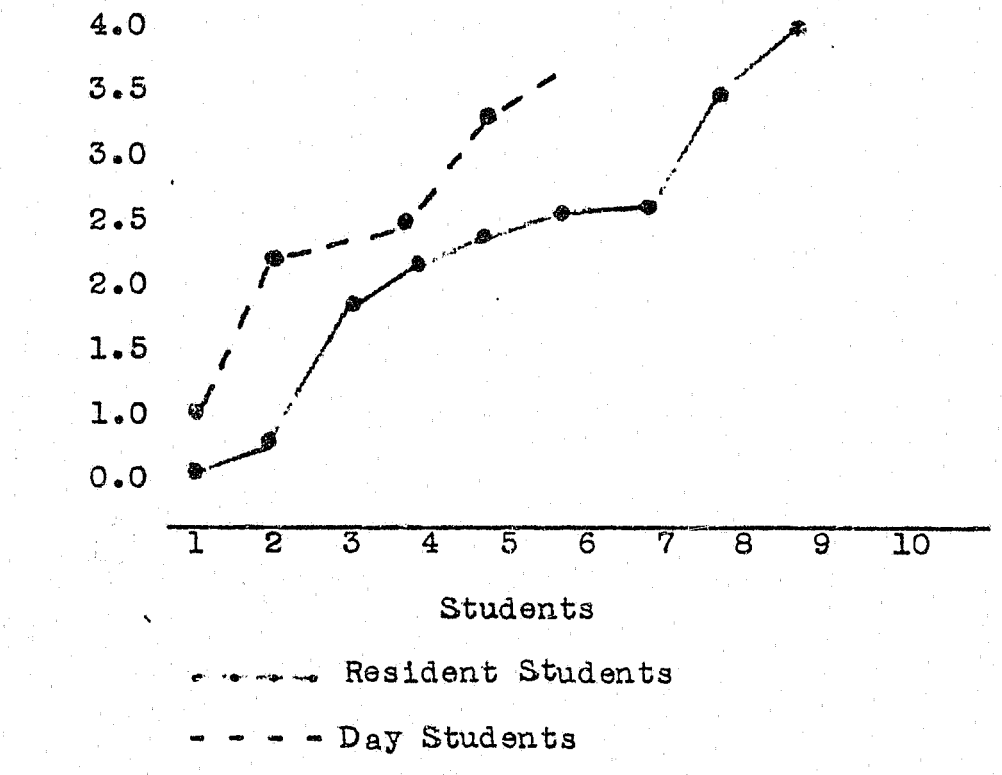
** Data are valid for period beginning in January, 1976 through December 31, 1977

Mean Gain: 2.03 grades
Mean Time Spent In Instructional Days: 55

Table 7

Comparative "Before and After" Grade Achievement Levels For Resident and Day Students Exposed To Dover Program As An Indicator Of Learning Rates

Achievement Level Resident Students	Instructional Days	Achievement Level Day Students	Instructional Days
3.7	46	2.3	75
2.2	--	2.4	67
1.9	45	3.1	51
0.0	26	1.0	32
2.1	66	---	--
3.5	88	---	--
.4	79	---	--
2.4	79	---	--
2.4	67	---	--
Mean Achievement Level: 2.3	Mean Instructional Days: 67	Mean Achievement Level: 2.2	Mean Instruct: Days: 54



school grades while the mean achievement for day students is 2.2 school grades. The difference between them is simply insignificant given the number of cases from which it is calculated. Accordingly, it is fair to say that in terms of educational achievement levels both groups of students, resident and day students, are obtaining approximately the same level of academic success. And this indeed is an important finding given the fact that day students tend to be exposed to all kinds of additional stresses and strains from which resident students are isolated, if for no other reason than the resident students are living in a relatively controlled environment.

What is equally important, however, is to attempt to determine the rate of learning. One way of determining the rate of learning is to calculate the mean number of instructional days to which resident students have been exposed and compare that to the mean number of instructional days to which day students have been exposed. The data in Table 7 indicate that with regard to the resident students an average of 67 instructional days have been required to raise their achievement level 2.3 grades; with regard to day students the average number of instructional days required is 54 to raise the mean achievement level to 2.2 grades. Expressed in terms of an average as a method of projecting the rate of learning, it seems safe to suggest that the data indicate very strongly that the number of days required to achieve almost the same grade level gain for day students is somewhat less than that required for resident students. If this difference is calculated as a rate of learning, it appears that the same level of grade achievement has been attained by the day students at a rate some 19% faster than that by the resident students. To be sure, this is a rather curious finding for the implications of the program. Although the resident facility is a major support of the educational facility, the data indicate that the individuals in the day program are in fact learning at a faster rate than resident students. What might be responsible for this? One of the things that might be responsible for it is that the day students are entering the program with either less behavioral problems or are starting at a higher grade level. An investigation of the data reveals that neither of these factors are affecting their scores. In point of fact, this analyst can offer no reasonable explanation as to why the day students are learning at a rate faster than the resident students. Perhaps it is simply that the impact of the auto-tutors upon the individual is highly differential in any case and that what the data are witnessing here is a relatively idiosyncratic situation in which day students are doing better precisely because they are not in a residential environment. If it were possible to prove this proposition its implications upon the program might well be staggering. However, the data simply do not allow themselves of further extrapolation to definitively address this particular point. The question must remain unanswered.

As a result of the above findings, it seems clear that the educational levels as measured by either raw entry test scores in the three areas of reading, math and English or as measured by a cumulative index indicating the total grade level to which an individual has improved, the data are overwhelmingly clear that from the perspective of raising the academic skill levels of the students in the Dover Program there is absolutely no doubt that the program is doing exactly that. Furthermore, the most rapid area of improvement is taking place in the area of English language skills and that has significant implications in terms of the individual's ability to integrate into a society which is becoming increasingly "oral." An equally important finding rests in the fact that the day students are learning at a rate some 19% faster than the resident students. In any case whether one focuses upon resident students or day students, the mean levels of achievement, 2.3 years and 2.2 years respectively, suggest that the extent to which the learning experience has taken hold is relatively constant in both groups. In a word, as one addresses the rates of academic skills, the data are as clear as they can be in suggesting that the academic skill levels of individuals exposed to the Dover educational process are being raised at a rate which can be deemed acceptable and are certainly within the projected parameters of the Utah/Dover Odyssey model as outlined in the grant.

In the view of this analyst, therefore, the data indicate that the program objective which aimed at increasing the academic functioning of all enrolled students in both the day and resident programs at the Dover Odyssey school by one full academic year within a period of not more than three calendar enrolled months is being achieved. The data really allow themselves of no other interpretation.

An examination of the original evaluative model outlined at the beginning of this study clearly shows that the Dover Program never intended for the educational element of the program to operate in isolation. To be sure, the attempt to raise educational skill levels represented the major thrust of the Dover Program but it was recognized that the educational program in and of itself could not function in a vacuum. What was required was that there be a set of adjunctive mechanisms which would aid the individual in obtaining increased educational skill levels by providing him with the kinds of external support mechanisms to the educational program that would engender confidence, provide a willingness to work, and establish a capacity for concentration. Thus, the original plan of operation for the Dover program, although remaining a serious education program at its center, relied heavily upon other mechanisms which were to be adjunctive and highly supportive of the educational program. The argument has been made that if there was a breakdown in the adjunctive mechanisms in the program, then this breakdown would significantly affect educational achievement levels. In correlary, higher educational

achievement levels would tend to imply that the adjunctive mechanisms were operating as well. In an effort to try to move beyond the implications of the inferential linkages which appear in the original program concept, it seems important to factor out each of the individual supportive mechanisms of the educational program and to examine each one in some detail in order to arrive at some judgment as to whether or not these adjunctive mechanisms are in fact performing the kinds of supportive roles expected of them.

In examining the original plan of the Dover Program one finds that there are five areas which can be considered as adjunctive in terms of their ability to support the educational program. They are the areas of group counseling, the number of "significant other" contacts, individual counseling, contacts with referral agencies, and family contacts. It is to be noted that all of these areas are included in the Ryan study but, in and of themselves, do not appear to be indicators of anything. In short, it appears that Mr. Ryan is simply asking the question as to whether or not the data for these particular adjunctive areas are being kept. As the earlier analysis shows, in general the data are being kept. But that is not the right question. The question to be asked is, to what extent does each adjunctive act as a function in and of itself successfully to impact in a positive manner upon the educational program? This is what this part of the examination is all about; to examine each of these adjunctive areas in order to determine whether or not they are having a meaningful impact upon the major educational thrust which rests at the center of the Dover therapeutic and remedial program.

GROUP THERAPY IMPACT

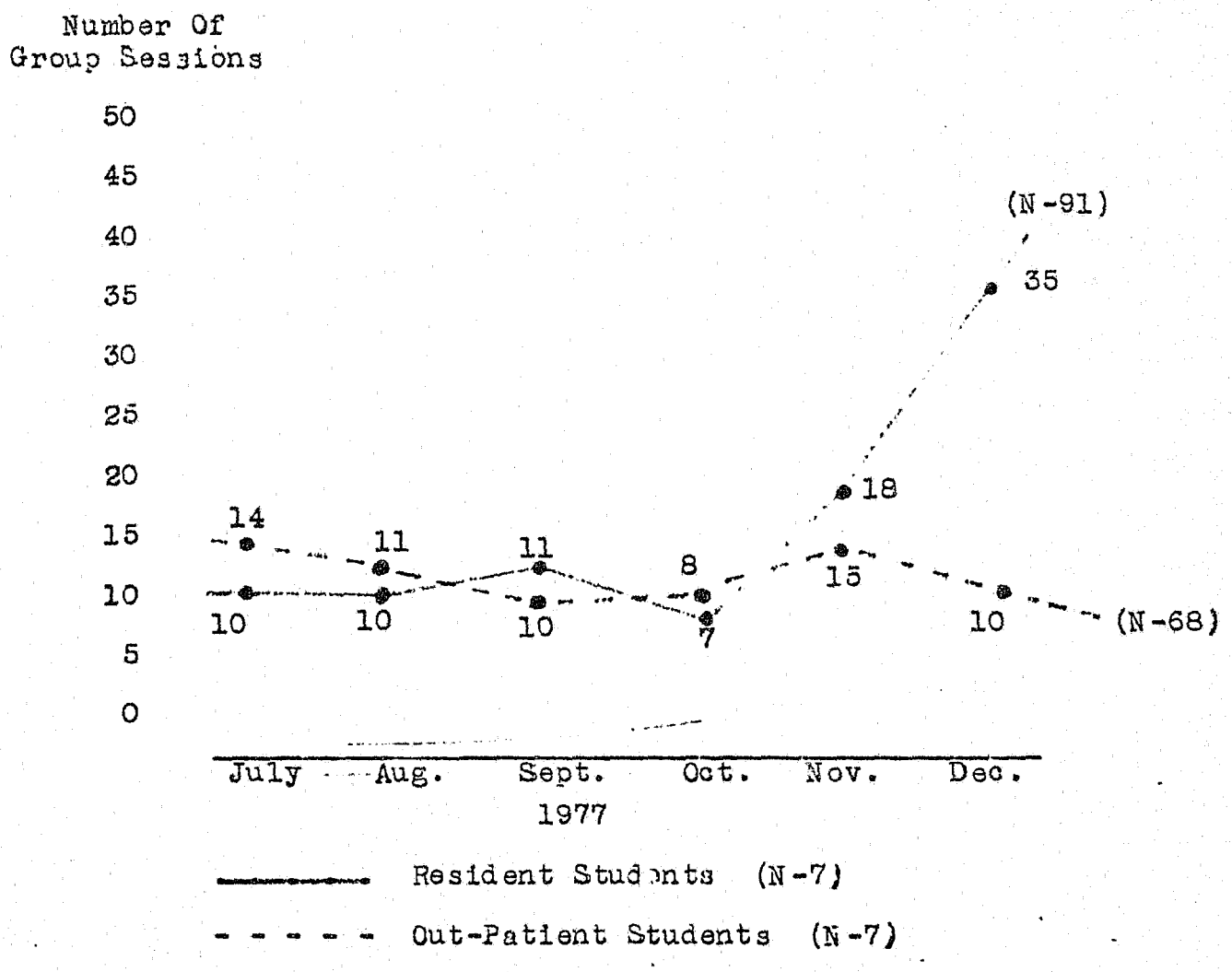
Group Therapy Impact

The first of the adjunctive devices to be examined is group counseling. As originally outlined in the Dover plan, group counseling was to be used as a mechanism for coming to grips with whatever behavioral problems the individual might have while also attempting to get the individual to develop a substitute for "acting out." The underlying proposition was that successful group counseling could aid the individual in coming to grips with his "whole man outlook" so as to minimize the possibility that behavioral and emotional problems, whether moderate or severe, would interfere with educational achievement. Moreover, group counseling sessions can be used in a highly therapeutic environment in that they give the individual support for educational success. In any case, success in a group counseling area would seem to be critical to the ability of the student to succeed at his educational tasks. Figure 15 plots the real number of group counseling sessions that have been held for both resident and out-patient students in the Dover Progarm. An examination of the number of actual contacts, sessions which have been held, as indicated in the table suggests that resident students have undergone an average of 12.8 contacts per month while outpatients have undergone a rate of 9.7 group sessions per month. However, an examination of the data, especially at the right end of the scale, raises the possibility that the data are highly skewed.

What this suggests is that it raises the question that the data themselves may be being pulled off center by a small number of cases which are actually receiving most of the attention while many of the other students may be receiving only minimal attention. In a word, the data indicate that the number of resident and out-patient group counseling sessions may be highly differential. In an effort to try to control for this, the data are plotted so as to appear in Figure 16. Figure 16 plots the number of counseling sessions received by each student over a six month period. It is immediately obvious upon inspection that students A,B,C,D and E have been the recipients of a disproportionate amount of the group counseling sessions; whereas other students from F through N have received only a minimal amount. Indeed, if one calculates the mean number of group counseling sessions for both day and resident students as indicated by the dotted line on the graph, it totals at 11.7 group counseling sessions per month per student. As a rule one would tend to suggest that this is a considerably high level of sessions indicating roughly about three a week. However, closer examination of the data is required. If one again looks at the plot of the curve of the data in Figure 16, it becomes clear that at least 64.2% of the students in the program at Dover are receiving a number of group counseling sessions which are considerably below the mean. Fully 64.2% of the students are not receiving their "fair share" of group counseling sessions and accordingly, one might well conclude from this that to the extent that group counseling is an adjunctive support

Figure 15

Real Number of Group Counseling Sessions
For Residents and Out-Patient Students
In Dover Program

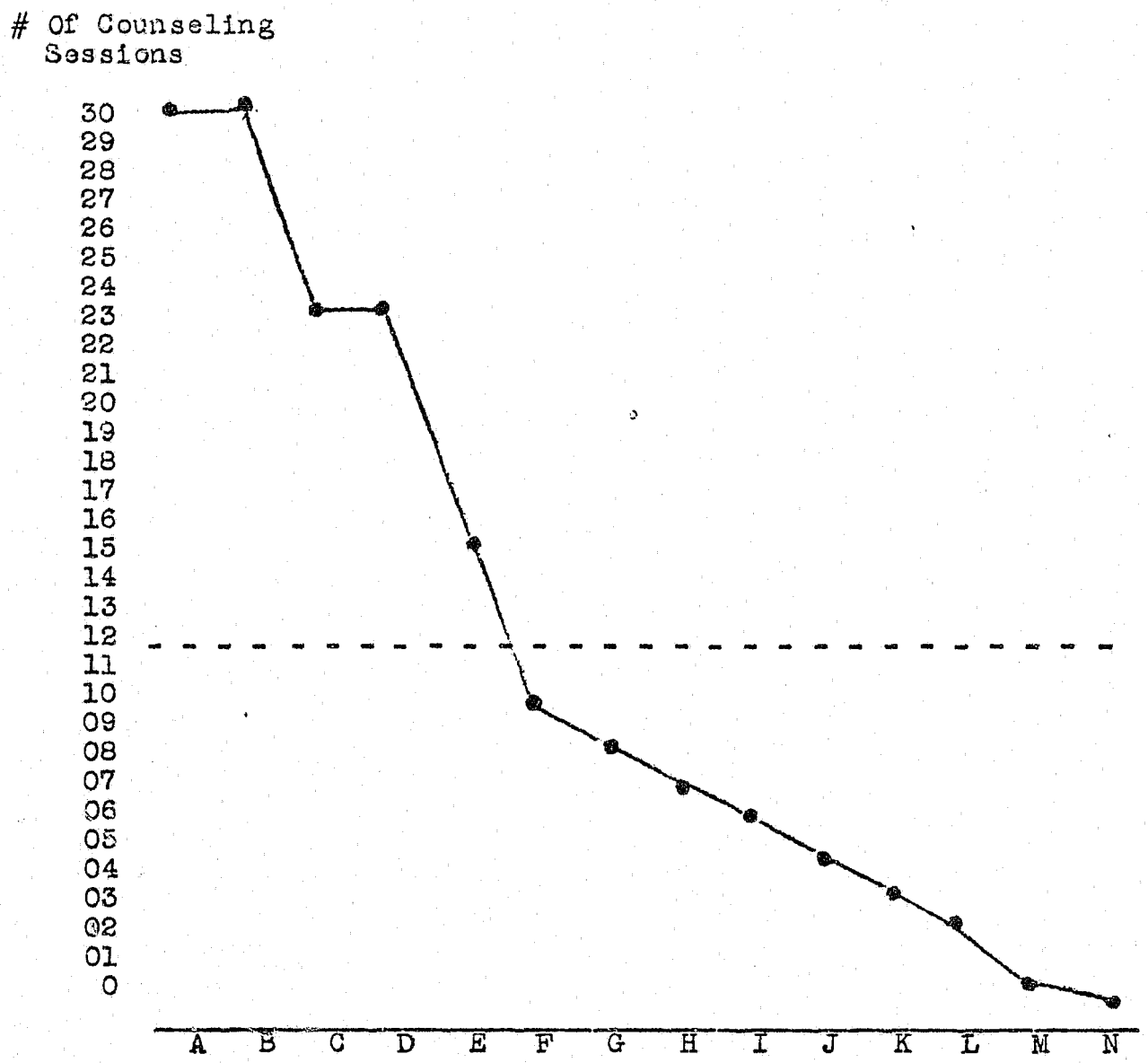


Mean # Of Group Sessions:

Residents: 12.8
Out-Patients: 9.7

Figure 16

Polygram Distribution of Number of Group Counseling Sessions Held With Resident and Day Students In The Dover Program



N - 164

Mean - 11.7

% Below Mean: 64.2%

Average Deviation: 8.7

of the educational program, then clearly the number of students who are not receiving their fair share of group counseling sessions are also not receiving the kind of support that would be necessary to succeed at the educational program.

In an attempt to assess the data in an even more accurate manner, this analyst met for several hours with three trained psychologists in an effort to determine what number of group therapy sessions would be "minimally sufficient" given the types of students with the types of background problems that the Dover program deals with. Granting the premise that the patients are not suffering from severe behavioral problems, all of the psychologists interviewed were able to come to an agreement after some three and one half hours of debate that the present once a week schedule which is programmed in the grant for group therapy is simply an inadequate number of group therapy sessions in order to secure even moderate or, indeed, any success. Further, depending upon the type of individual, group therapy may well be required daily. However, if the Dover Program is given the benefit of the doubt and it is granted that their screening process is operating adequately enough to remove the most severe behavioral problems and, therefore, remove those who do not need group therapy sessions daily, it seems evident that the number of sessions per week that would be required to be "minimally sufficient" in the eyes of professional psychologists would be at least three sessions per week.

Given that baseline of three sessions per week as a minimally accepted rate of group counseling, the data expressed in Figure 16 begin to take on ominous proportions. If one notes the mean number of group counseling sessions which in fact have been held, namely 11.7 such sessions per month per student, one might take some comfort in the fact that that would be almost approaching the recommended mean of 12. However, once again the data are misleading. An examination of the curve shows that five cases are pulling off the entire curve; i.e., skewing it in a negative direction. The fact remains that 64.2% of the students are receiving a number of sessions which are below the mean. In terms of our previous discussion, this means that 64.2% of the students are receiving or being exposed to a number of group therapy sessions which are considerably below the number regarded as minimally sufficient in order for group therapy to have any positive therapeutic impact upon the individual involved. What this suggests is that group counseling as presently being undertaken and utilized at the Dover Program cannot be viewed as a success in terms of its ability to act as a supportive adjunctive mechanism of the educational process. Certainly, the data do not allow themselves of any other interpretation.

With regard to group counseling, there is a further aspect which should be addressed in terms of its ability to be supportive to the educational program and that is that under current conditions at Dover,

group therapy is being run almost entirely by para-professionals. Indeed, the term para-professional, which certainly would have applied to Mr. Floyd Jozitis who was at that time the chief group therapist and who has since left, cannot truly be applied to the Level-Fours who are currently in charge of group therapy. Indeed, the Level-Fours themselves are still involved in the therapeutic aspect of the overall Odyssey Program so that, in effect, what you have is more stable students leading less stable students. However, no highly professional talent is being brought to bear upon the group counseling process. In the views of professional psychologists, the use of para-professionals without the direct and overt supervision of a trained expert runs some very great risks in terms of impact. The fact of the matter is that group therapy can actually have severe negative effects if it is not done properly. As it applies to Dover, the almost exclusive of para-professionals with only minimum on-ground supervision most certainly increases the risk that group therapy will have negative impacts.

Taken together, therefore, with the fact that the number of group counseling sessions is insufficient for most of the program participants to be effective in terms of achieving group counseling goals, and coupled with the fact that the use of para-professionals has exceeded all tolerable bounds, it seems fair to conclude that the group counseling aspect of the Dover Program plan cannot feasibly be expected to be viewed as a success insofar as it is a supportive adjunctive mechanism for those clients who participate in the educational program. And from this perspective, group counseling as an element in the overall program design certainly cannot be deemed as a success.

IMPACT OF INDIVIDUAL COUNSELING

CONTINUED

2 OF 3

Impact of Individual Counseling

A second major adjunctive mechanism in support of the educational element of the Dover Program is the number of individual counseling sessions. If group counseling sessions attempt to address the individual's problems in a group setting, individual counseling sessions become even more important insofar as they are designed to get at problems that the patient himself feels he cannot express in a group setting. Accordingly, they are mechanisms which support the group counseling process and which are very important in that they given an individual who may not be prepared to discuss his problems in a group setting a functional alternative. In any event, the object of individual counseling as it appears in the original Dover Program plan, is to provide the kind of therapeutic and peer support necessary to serve as an adjunct mechanism to the educational program itself. From this perspective, therefore, Figure 17 plots the actual number of individual counseling sessions which resident and out-patients in the Dover Program have undergone per month for a period of six months. An examination of the data in Figure 17 is alarming. Focusing upon the number of contacts by resident students it becomes clear that the data are heavily skewed. Indeed, for five of the six months no individual counseling sessions were held and in one one-month period twelve were held. Fortunately, the out-patient pattern of individual counseling sessions appears to be far more stable insofar as the degree of fluctuation tends to be spread over time. In any case, if one calculates the relative mean number of sessions held per month, the data are not very encouraging. There are 1.7 such sessions for resident students and 4.4 for out-patient students.

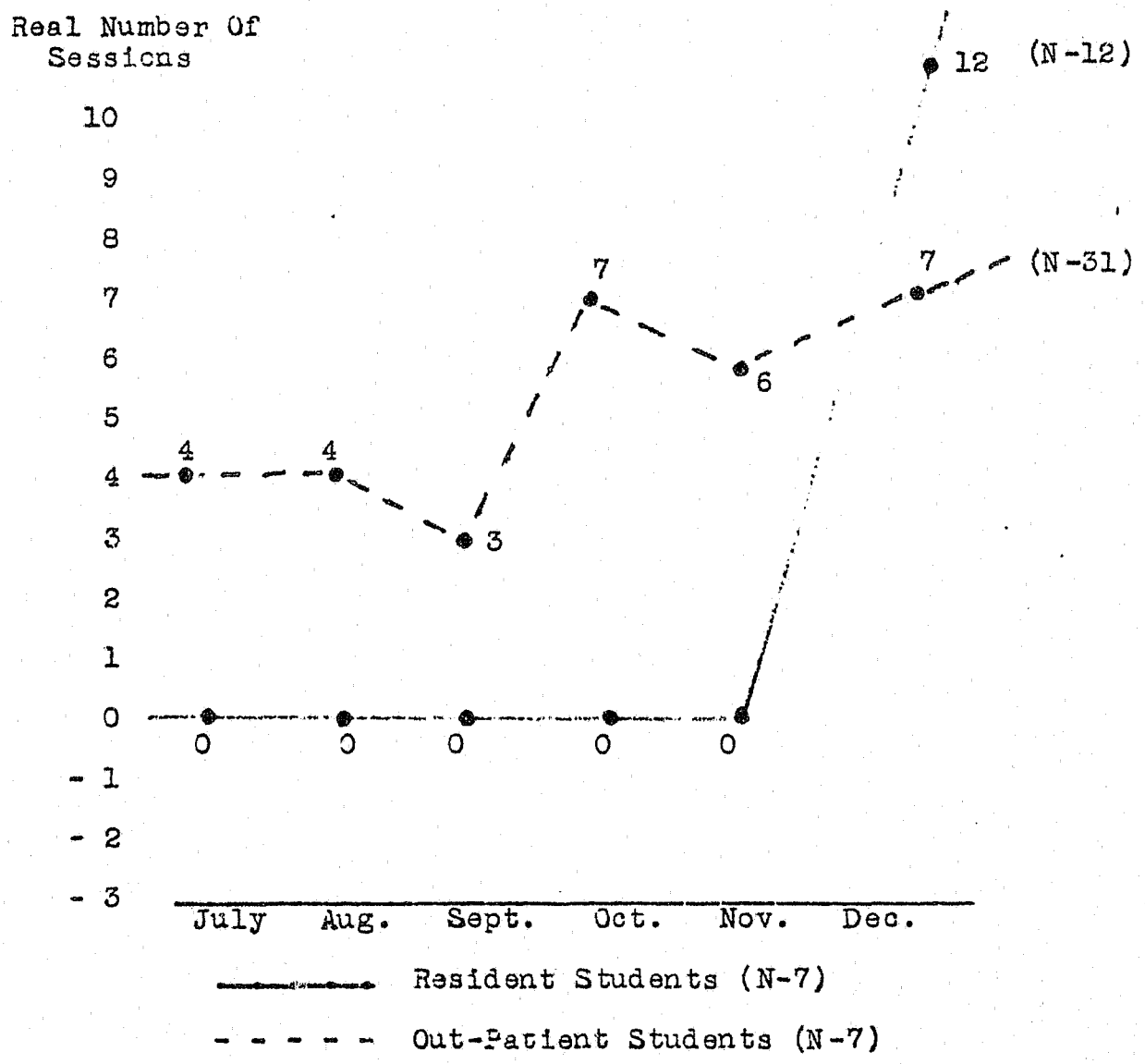
What the data imply is that once again the number of individual counseling sessions that are being held are heavily skewed. That is to say, a large number of such sessions are being directed at one or two individuals while the rest of the individuals are receiving pitifully lower numbers. In an effort to test this hypothesis, the data was rearranged as appears in Figure 18. Now Figure 18 represents a polygram distribution of the number of individual counseling sessions held with resident and day students in the Dover Program over a six-month period. An examination of the curve indicates very clearly that only three of the total number of students had a number of individual counseling sessions which exceeded the mean of 3.4. One notes that the mean of 3.4 individual counseling sessions per month per student is in itself remarkably low, low enough at least to raise the question in the minds of professional psychologists as to whether or not this number of sessions is sufficient to accomplish anything. In any event, taking the data as they stand, our initial hypothesis about the utilization of individual counseling sessions at a low level seem to be confirmed.

More importantly, or at least equally importantly, is the finding that even those number of individual counseling sessions that have been utilized tend to be focused on only three individuals. From this perspective one notes that a full 79.9% of the patients receiving individual counseling sessions receive less than the already insufficient number of 3.4 sessions. I think it unquestionable that the data here lend themselves very strongly to the interpretation that individual counseling as an adjunctive mechanism to the educational process and, further, as an adjunctive mechanism to the group therapy process simply cannot be considered to be an operational success.

These findings of insufficient numbers of individual counseling sessions per student per month when taken in conjunction with our earlier finding of an insufficient number of group counseling sessions indicates to this analyst that the entire counseling concept at the Dover project needs reevaluation in terms of what it is supposed to do and how it is supposed to accomplish its goal. As noted earlier in this report, some individuals in referral agencies and, indeed, even the chief psychiatrist and pscyhologist of the program, question whether or not group therapy and individual counseling as applied by para-professionals really is appropriate treatment for some of the individuals in the program. Further, they agreed that in many instances it was not. What this means is that the group and individual counseling therapeutic mechanisms are being employed often because they are the only ones available; but it means further that they are being employed in a way that cannot be regarded as positive insofar as they support the educational objectives of the Dover Program. Given the earlier comments about para-professionals and those made by the chief psychologist and psychiatrist with regard to the inappropriateness of group therapy, the risk is compounded that the poor utilization of an inappropriate therapeutic tool may in the long run cause more harm than good. From this perspective it is very difficult to conclude that the individual counseling component of the Dover impact design is in fact functioning in a manner that can actually be seen as contributing to the overall success of the Dover Program. Indeed, it may well be having a negative affect.

Figure 17

Real Number Of Individual Counseling Sessions For Residents and Out-Patients In Dover Program

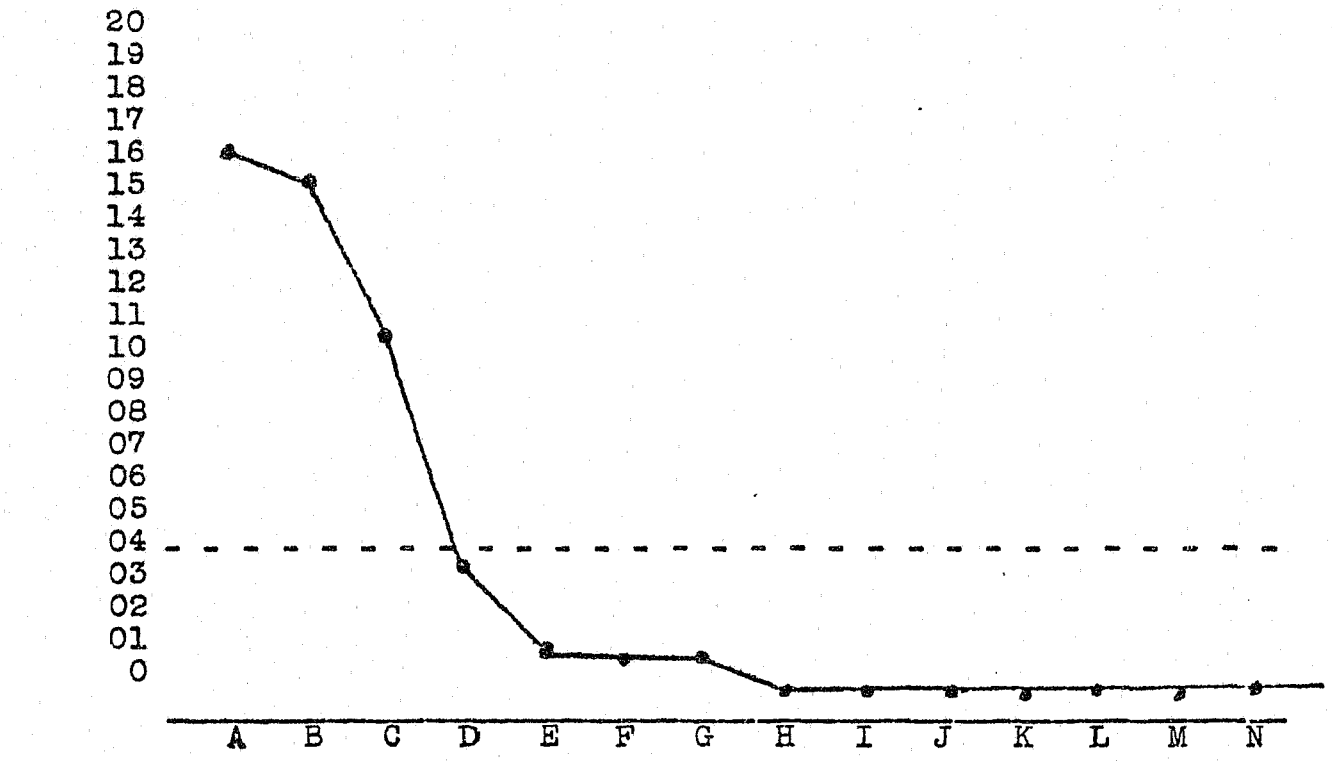


Mean # Of Sessions:

Resident: 1.7
Out-Patients: 4.4

Figure 18

Polygram Distribution Of Number of Individual Counseling Sessions Held With Resident and Day Students In The Dover Program



N - 47

Mean - 3.4

% Below Mean: 79.9%

Average Deviation - 4.2

IMPACT OF SIGNIFICANT OTHERS

Impact of Significant Others

A third adjunctive mechanism in support of the Dover educational program is the number of contacts made with "significant others" for both resident and day students in the Dover Program. The term "significant other" is one of those curious psycho-sociological concepts that no one seems to be able to truly define. In simplistic terms, however, a "significant other" may simply be regarded as either an adult, a peer, or a relative whom the individual cares about and cares about what he thinks. This concept appears very often in Harry Stack Sullivan's theory of inter-personal psychiatry which can be found in shortened form in Robert Presthus' book, The Organizational Society.

According to Sullivan, all individuals suffer from anxiety and in an effort to purge this anxiety, they will attempt to accommodate to individuals who are important to them. Now these individuals who are important to them are termed "significant others." For most individuals, it is easy to determine what individuals are significant to us. Obviously, some relatives are more significant than others; our parents are very significant to us; our brothers, sisters and our close friends. All of these individuals are significant in the sense that we care about what they think about us and, accordingly, the mere fact that we care about what they think sets upon us ceratin parameters which limits our behavior in terms of what might be regarded as acceptable. This has been called the law of anticipated reactions. In a word, because we know that their disapproval might be forthcoming on a certain action, we may well refrain from doing it. From a positive perspective, because we know their approval may be forthcoming on a certain action we may engage in it. Therefore, "significant others" become very important to the behavioral and motivational reasons which underly an individual's personality. Moreover, what with recent findings just published by the Federal Government indicating that at least in the area of juvenile crime, one of the major contributing factors, indeed far more important than either institutional experiences such as school and church and family experiences, is peer support. In this view, therefore, the concept of significant others becomes critically important.

With regard to the Dover Program, the way in which the significant other integrates with the program is as follows: individuals who feel they want to improve themselves in the educational program will be able to do so at a faster rate if there are individuals in their lives who are supportive. In this regard, one instance in the day program where the patient's parents are middle class, highly motivated, truly concerned, and are giving the individual overt support, that individual is achieving at a remarkable rate. Therefore, one can indicate the extent to which the educational program will be supported by the number of significant others that an individual has. One way

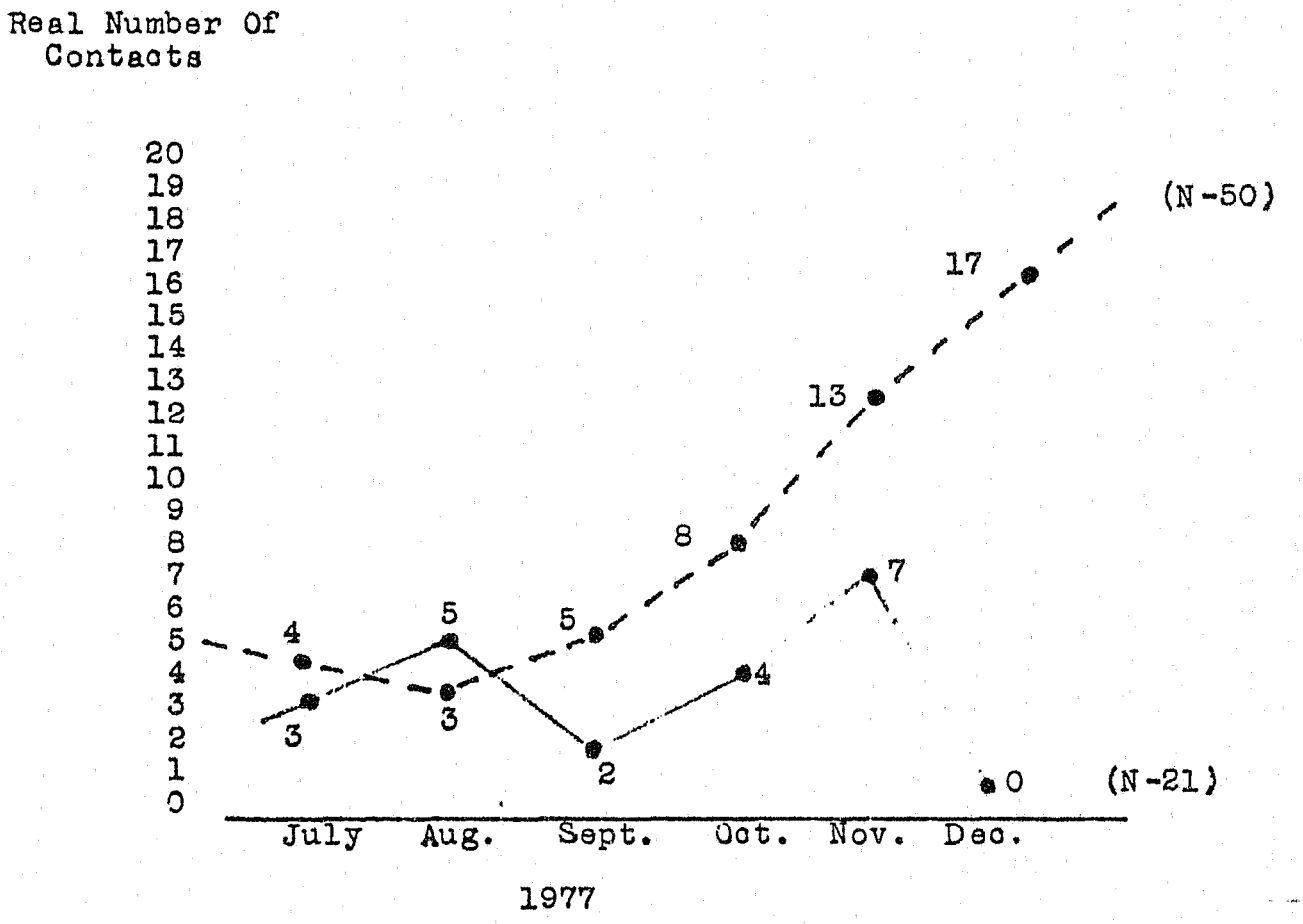
of getting at the number of significant others which the individual has is to measure the number of contacts that patients may have had with individuals defined as "significant others." We may hypothesize that the greater the number of contacts with significant others per student per month, the more that aspect of the program would serve as an adjunct to the educational element of the Dover Program. Conversely, the fewer the contacts per student per month, the less likely is this aspect of the program serving as an adjunct to achieving educational objectives.

In an effort to test the above hypothesis and to lend some insight into the success or failure of the significant other concept within the overall Dover design, data in Figure 19 delineate the real number of contacts with significant others by resident and out-patient students in the Dover Program. An examination of the data reveals immediately the suspicion that at least with regard to the resident students the number of contacts with siginificant others tends to be realtively low and highly skewed. Examining the pattern for out-patients, however, the pattern appears to be much more normal although it too seems to be skewed towards the high side of the scale. The fact that there may have been a greater number of real contacts with significant others for out-patients than for residents is understandable. The data indicate that out-patients on the average have more than twice as many contacts with significant others than residents. The figures are 7.1 contacts per month per student for out-patients and 3.0 contacts per month per student for resident patients. This is clearly understandable insofar as day patients only spend three hours a day at the program and therefore reintegrate into their peer and social groups daily thus increasing the possibility for significant other contacts. This finding, by the way, dovetails rather nicely with our earlier finding that resident students are learning at a slower rate than out-patient students. Apparently by linking both findings it would appear that the faster learning rate on the part of out-patient students may well be coupled with the fact that they have a greater number of significant other contacts. This suggests that the significant other contacts may well be supportive of the educational objectives that the individual seeks. In any event, the data in Figure 19 at least lend themselves to the suspicion that the number of contacts (at least for residents) tends to be pathetically low while for out-patients it tends to be relatively stable, averaging roughly two per week or seven per month. However, the data at least in regard to the resident students appears highly skewed and there is some need to control this skew in order to find out whether or not the number of significant others contact that in fact are being achieved is sufficient.

In an effort to examine this hypothesis, the data have been rearranged in polygram form in Figure 20. Figure 20 represents

Figure 19

Real Number Of Contacts With "Significant Others" For Residents and Out-Patients In The Dover Program

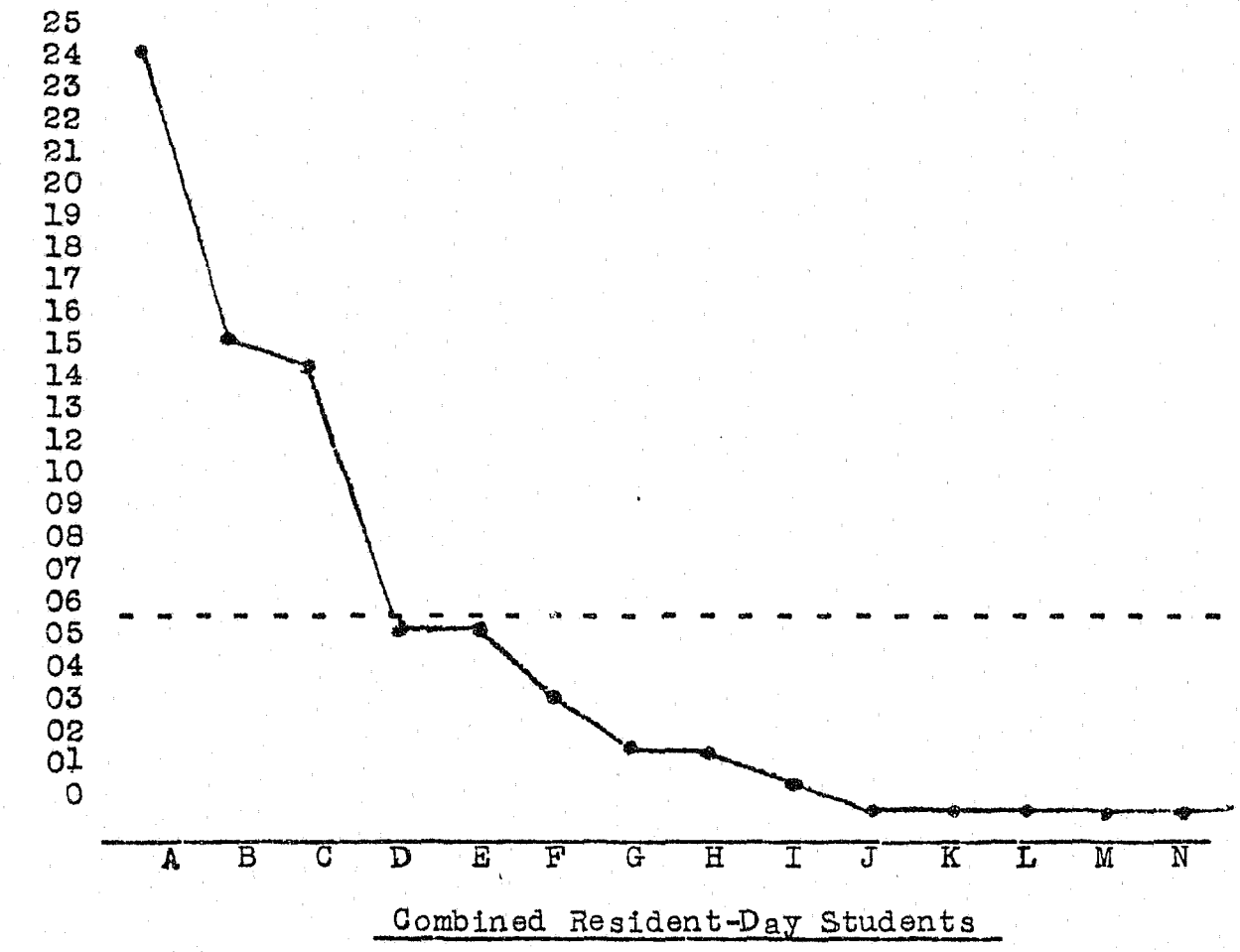


Mean # Of Real Contacts:

Residents: 3.0
Out-Patients: 7.1

Figure 20

Polygram Distribution of Number of Contacts With Significant Others By Residents and Day Students In The Dover Program



N - 71

Mean - 5.1

% Below Mean : 79.9%

Average Deviation - 5.3

the polygram distribution of the number of contacts with significant others for resident and day students in the Dover Program. It is immediately apparent upon inspection that the number of contacts to which individuals are being exposed throughout the program are insufficient. Indeed, three cases are receiving virtually all of the contacts. If one examines the number of students who are receiving a number of contacts below the mean of 5.1 per student per month which would average out to slightly more than one a week, it is noted that a full 79.9% of the students are being exposed to a number of significant others contact that are clearly below the mean. Accordingly, the data suggests rather strongly that the number of significant others contact to which both resident and day students are exposed is simply insufficient. It is understandable, however, regarding resident students that the number would be low because being resident students with restrictive visiting privileges and with rigidly controlled time, the fact of the matter is that the opportunity for contact with significant others is substantially reduced and almost always must be initiated by someone other than the resident himself. Such is not the case with the day student who is not in such a confined environment, and re-integrates with society every day. Indeed, not only is the potential pool of significant others increased geometrically, but the probability that he may initiate a contact is increased staggeringly. What is important, however, is that viewed in the sense that it is seen as an important aspect as an adjunctive mechanism in support of the educational thrust of the Dover Program, one cannot conclude that the significant other program element is operating as unqualified success.

Among the most interesting findings here are the fact that significant other contacts are almost twice as high among out-patients then residents and that the same out-patients are learning at a rate 19% faster than their resident student counterparts. Taken together, this suggests that the significant other program, at least for the resident student, is not operating in a manner contributory to the success of the educational component. Further, some severe re-examination of significant other contact mechanisms operant within the resident program should be undertaken in order to find some way of increasing the realm and scope of independent other contacts to which the resident is exposed. Indeed, this finding is supported by this analyst's interviews with the patients themselves. When asked what above all did they want to do if they wanted to do anything at all, almost every resident patient replied that they wanted to go back home and see their parents and friends. Now, this could be an indication that the individuals in the resident program feel that a major difficulty with the program is the fact that it does not allow them to contact their peers, parents, or other individuals whom they regard as significant to them. If so, then rather than receiving support from significant others, support is inadvertantly being withheld. Certainly, in such circumstances there is clear need for the Dover design to be re-examined in terms of the lack of impact that the significant other element of

the program is having. At present, the available data suggests that the significant other element of the program is not working very well for the resident student, but may be working relatively well for the out-patients. That is the lesson that well ought to be taken to heart and some effort ought to be made in attempting to apply the lesson and the results of the out-patient student experience to the situation in which the resident students must live

REFERRAL AGENCY IMPACT

Referral Agency Impact

A fourth element among the supportive adjunctive mechanisms of the educational program at Dover is that which addresses the question of referral agencies. As pointed out earlier in this evaluation, the problem of a good liaison with referral agencies is critical. With regard to the Dover Program, we have seen that the failure of Dover staff to make significant inroads to the Dover school system has resulted in their being cut off from a major source of referral. Furthermore, as a result of a myriad number of difficulties we have found that referral agencies that utilize the Dover Program do so for reasons that oftentimes are completely at odds with what the Dover Program itself feels it can do. Thus, one finds that referral agencies run the gamut all the way from perceiving the Dover Program as a mere holding facility to others which see it as a placement facility in order to reduce their own caseloads. Clearly, the kinds of contacts that the Dover staff maintains with referral agencies become critical in terms of at least communicating with those agencies what they feel they can do for the prospective referral.

More important, however, than communicating the purposes of the Dover Program to the referral agencies in terms of attempting to ensure a steady stream of client referrals is the problem of trying to ensure that the kinds of referrals that are made are in fact appropriate for the Dover program. As has been noted in an earlier section of their evaluation, the Dover Program has not been particularly successful in assuring that the kinds of referrals they get are appropriate. To be sure, this is a breakdown not only in the referral agencies utilizing the Dover Program as a kind of "dumping ground" for their own caseloads but also as a result of the screening and testing process as utilized by the Dover facility. In any event it is clear that the number of contacts that the Dover Program maintains with the referral agencies becomes crucial to the ability of the student to function not only in the educational program, it becomes crucial to his ability to function once having succeeded in the educational program. Here what we are talking about, of course, is the ability to reintegrate into the social system or into the school system. The ability to reintegrate can be increased significantly if there is a running dialogue between the referral agency and the Dover Program regarding the progress of the student, regarding his difficulties and problems. However, as one examines the number of contacts with referral agencies, one finds that once again an adjunctive support element of the overall program design is weak.

The data in Figure 21 protrays the real number of contacts made with referral agencies by the Dover Program staff for resident and out-patients. Once again an examination of the number of contacts made reveals immediately that the data are highly skewed in that a small number of individuals tends to pull the total number of contacts

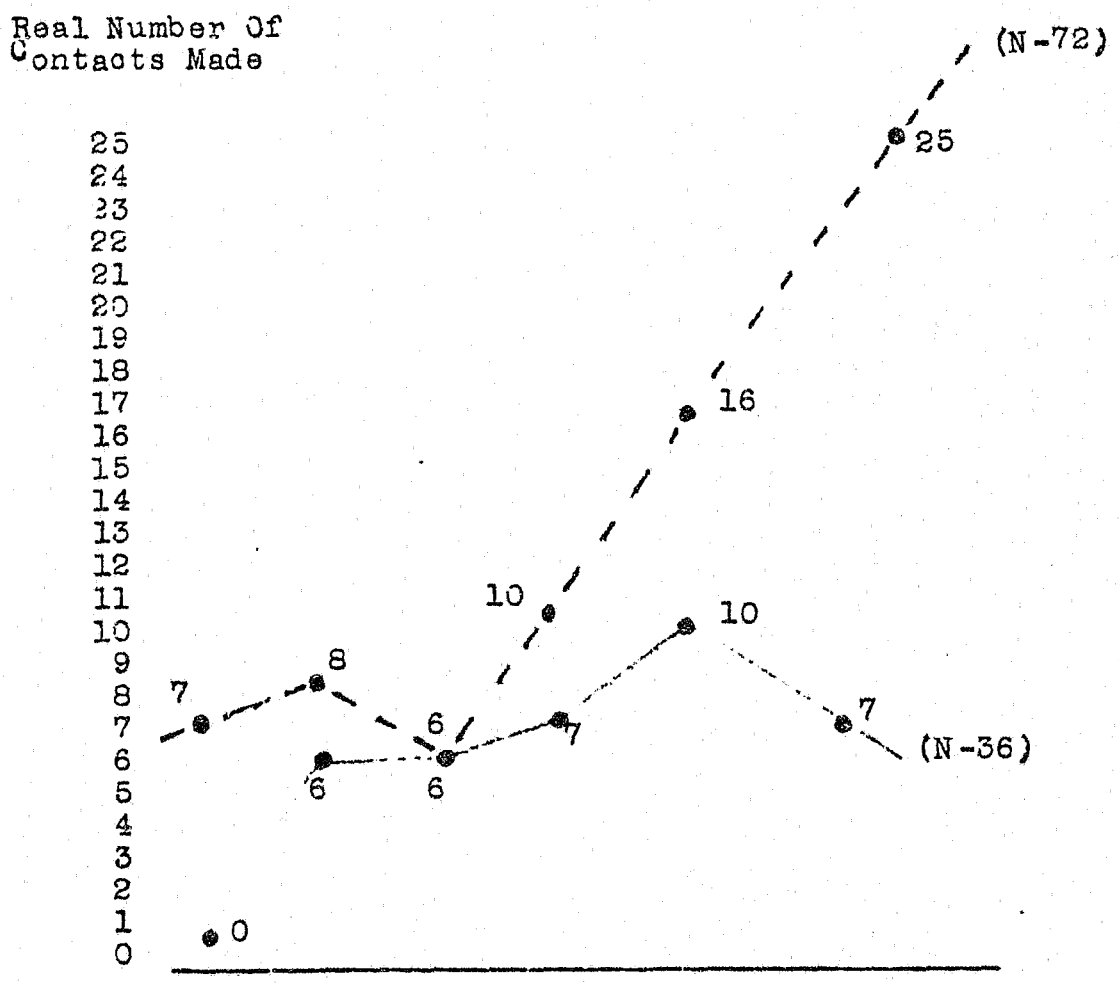
off center. The average number of contacts made per student per month for residents is 5.1 and for out-patients 10.3. The disparity in the number of contacts between resident and out-patients is easily understandable. Out-patient students have a rate of contact which is double that for resident students, and the reason is that most of these individuals are referred by Probation and are required to maintain at least weekly, sometimes twice weekly or thrice weekly contact with their referral agency. As a result, out-patients are in a more flexible environment and, therefore, are likely to have greater referral contact. Resident students, on the other hand, living in a resident facility have far less opportunity for contacts and are required to make far fewer contacts so that the disparity between the two is readily understandable.

Nonetheless, the problem still remains that the majority of contacts, or at least a substantial number of contacts may be being made by a tiny handful of patients and, as a result, they are pulling off the curve so that the mean numbers expressed in Figure 21 do not really become significant. In an effort to test this hypothesis, the data are re-arranged in Figure 22 which portrays a polygram distribution of the number of contacts for both resident and day students in the Dover Program by month. It is immediately obvious that our suspicions are confirmed. Four students are receiving the bulk of the contact attention with regard to referral agencies; and fully 71.9% of the students are receiving less than the mean number of contacts of 7.0 per month. Furthermore, it must be noted that contacts with referral agencies tend to be of a very informal nature especially as regards resident students. Such contact is likely to be a phone call or a casual visit more than it is to be a formalized mechanism that can have truly therapeutic results. By contrast the type of contacts that are likely to be made by referral agencies for out-patient students are likely to be in a formal setting which can have some therapeutic importance.

The data clearly suggest that with regard to the number of contacts made by referral agencies fully 71.9% of the students are receiving less than the mean number of 7.0. This indicates very clearly that the ways in which contacts are being conducted are not in general done in a manner which could be described as equitable. Some students are getting more attention than others. To be sure, this is something that is likely to be beyond the control of the Dover staff in some instances. But what is most important is that the resident students are not being exposed to either the number of contacts with their referral agencies or the type of contacts with their referral agencies that are being experienced by the out-patient student. Thus, the gap between out-patient and resident student begins to grow in terms of the benefits that they are receiving from the various adjunctive mechanisms. It will be recalled that the number of group counseling sessions, the number of individual counseling sessions, the number of significant other contacts and now the number of referral agency contacts

Figure 21

Real Number of Contacts Made With Referral Agencies By Dover Program Staff For Resident and Out-Patient Students In Dover Program

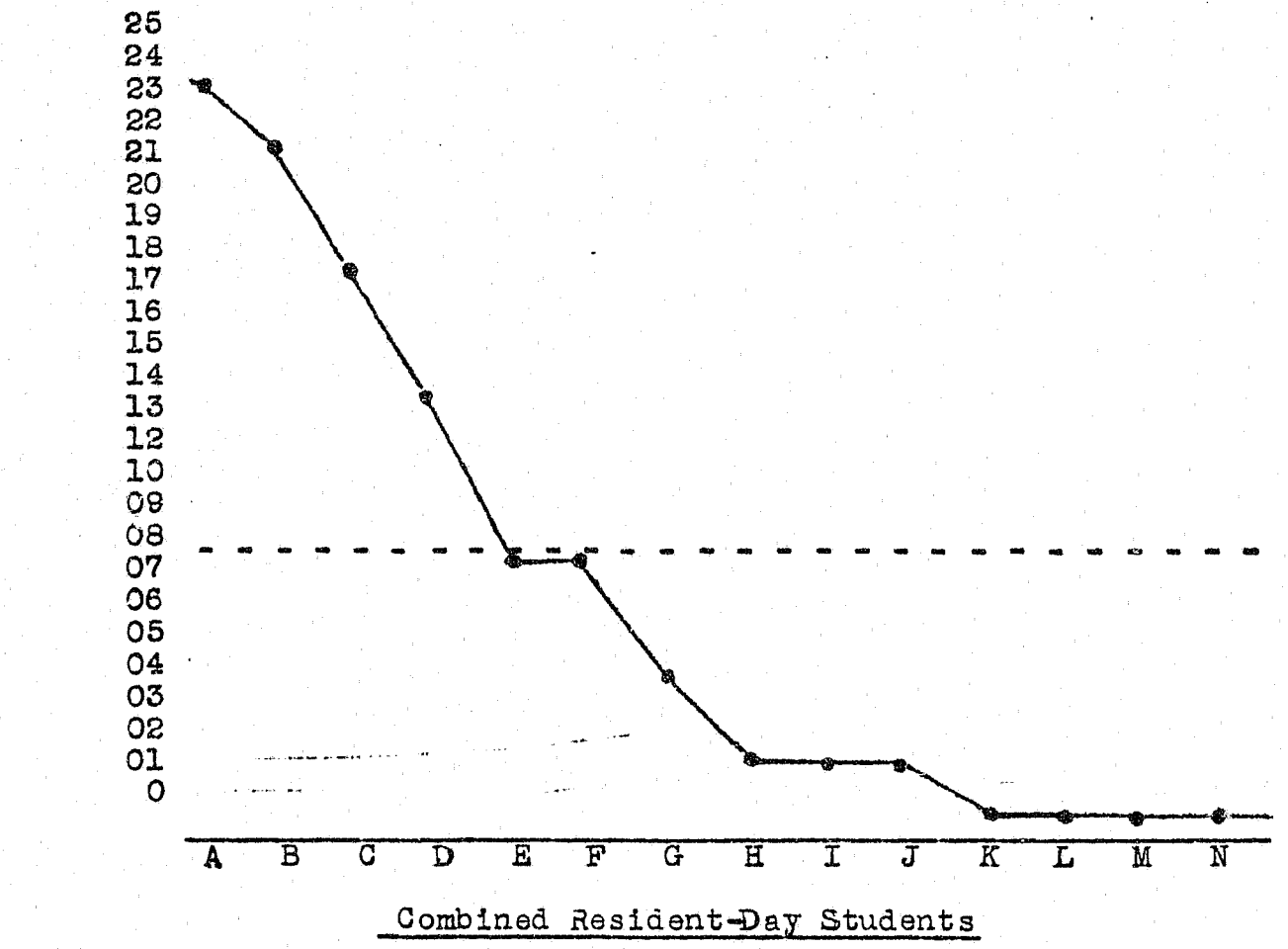


Mean # Of Contacts:

Residents: 5.1
Out-Patients: 10.3

Figure 22

Polygram Distribution of Number of Contacts With Referral Agencies By Residents and Day Students Of The Dover Program



N - 98

Mean - 7.0

% Below Mean : 71.9%

Average Deviation - 6.0

are always higher on the part of day students than on the part of resident students. And again one notes that the rate at which day students are learning is some 19% faster than resident students. What this suggests is that the impact of the adjunctive mechanisms on the educational program are highly differential and that they are differential in favor, paradoxically, of out-patient students rather than the resident patients. And from this perspective the data are beginning to take shape in a manner that suggests that the resident facility is not operating as well as the out-patient phase of the program, at least if measured in terms of the adjunct mechanisms that support the central educational thrust of the Dover Program.

THE IMPACT OF FAMILY CONTACT

The Impact of Family Contact

A final adjunctive mechanism relative to the Dover educational program is family contact. Now the Dover program seems to reflect a kind of organizational schizophrenia with regard to the role of family contacts in the overall policy design. In this analyst's conversations with Dover staff, it was made very clear that they do not, as a rule, expect reintegration into the family to occur on the part of successful graduates of the Dover Program. The reasons offered are relatively basic, namely, that the home environment from which these patients are drawn tend to be highly traumatic, essentially unstable and relatively fragmented so that to take an individual who has raised his educational skills and place him back into the same environment is likely to have no positive value whatsoever. Indeed it is to run the risk of a tremendously negative experience undoing much of the educational achievement. As a matter of informal policy, then, the Dover staff is not overly optimistic about its ability or, indeed, even its desire to reintegrate its patients back into the family environment for as a rule they are not healthy environments. It might be added here that this analyst's examination of the backgrounds of the patients involved in the program does tend to confirm the hypothesis that the backgrounds from which they come are traumatic and unstable so that it might well be foolish to try to reintegrate them back into that environment. Nonetheless, the problem of contacts with the family remains an important one if for no other reason than the patients themselves often hold out as one of their major goals the desire to go back to their families regardless of whether or not their families want them. This is a paradox that may be sad, but nonetheless is quite true.

In an effort to analyze the number of family contacts that are made per patient per month, Figure 23 plots the real number of contacts with the families by month for resident and out-patients of the Dover Program. It does not require much insight to see that upon inspection the data are heavily skewed. Attention is drawn to the total end figure for resident students of 242 contacts with families in a six month period. For a corresponding number of contacts, one notices the number of 71 on the part of outpatient students. This suggests very clearly that some skewing is going on in that a handful of individuals tend to pull the data off the mean point. And indeed as one checks for the possibility of skew, one finds that 192 of the 242 contacts enjoyed by the resident students were in fact made by one patient! Also, 51 of the 71 total contacts were made by one student in the day student program! The evidence is overwhelming that the data portrayed in Figure 23 are misleading in terms of the actual number of family contacts that are occurring per student per month.

In an effort to provide a more detailed and more exact measurement of the actual number of contacts occurring per patient per month,

Figure 24 factors out the two extreme cases in both the resident and day patient program and plots the mean number of contacts with families by month for each resident and out-patient. This provides the analyst with a far more adequate idea of the number of actual contacts that are being conducted on a monthly basis for each type of student over a six month period. The center line, of course, stands for the mean number that are being performed.

In an effort to test the hypothesis that the skew in the number of contacts is so severe as to virtually render the data meaningless, Figure 25 plots the polygram distribution of the number of family contacts made by residents and day students in the program. Upon inspection it is clear that two individuals are pulling off the entire curve so that all but two individuals fall below the mean number of family contacts per student per month which is 22.4 and is indicated by the dotted line. Indeed if one examines the number of individual patients that fall below the mean number of family contacts, one finds that fully 85.7% of those students involved in both programs are receiving a number of family contacts considerably below the mean!

Just what this data indicate is somewhat unclear. If the program itself does not stress family contact and family counseling because it does not believe that reintegration into the family is a "viable alternative" to an individual who has gone through a highly structured residential or out-patient educational experience, then it certainly makes sense that the program staff will try to minimize its contacts with the family. So that when one notes that the number of family contacts is relatively low, the fact of the matter is that this might be low deliberately, that is that the program itself simply does not put a premium on family contact. And accordingly, if they don't occur then no real effort is going to be made in terms of expanding family contacts. Given this proposition, one must seriously question whether or not the data indicate that the lack of family contacts are really an insufficient or unsuccessful element of the entire program design when in fact the evidence indicates it may never have been designed to be a success to begin with. On balance, it is fair simply to reserve judgment on the role of family contacts at least as far as the data can address them. The question is not really whether or not family contacts are too high or too low, and that is all that the empirical data address, but the critical question is a central one of therapeutic design--namely, whether or not family contacts ought to be stressed or ought not to be stressed. That is a fundamental question and one that has been answered in the negative by the program staff. Thus, from that perspective, one can say that family contacts have not been an overly successful element in the total program design simply because the staff has not considered it as an element worth pursuing. This is a far more important observation than the empirical observation that the data show a low number of family contacts. In the end the point is that the data reflect a low number because that is what the program intended the numbers to reflect. In correlary, family contacts cannot be seen to be a very successful adjunct to the therapeutic

thrust because it was never intended to operate as a major adjunctive mechanism.

Figure 23

Real Number Of Contacts With Families
By Month For Residents and Out-Patient Students
In Dover Program

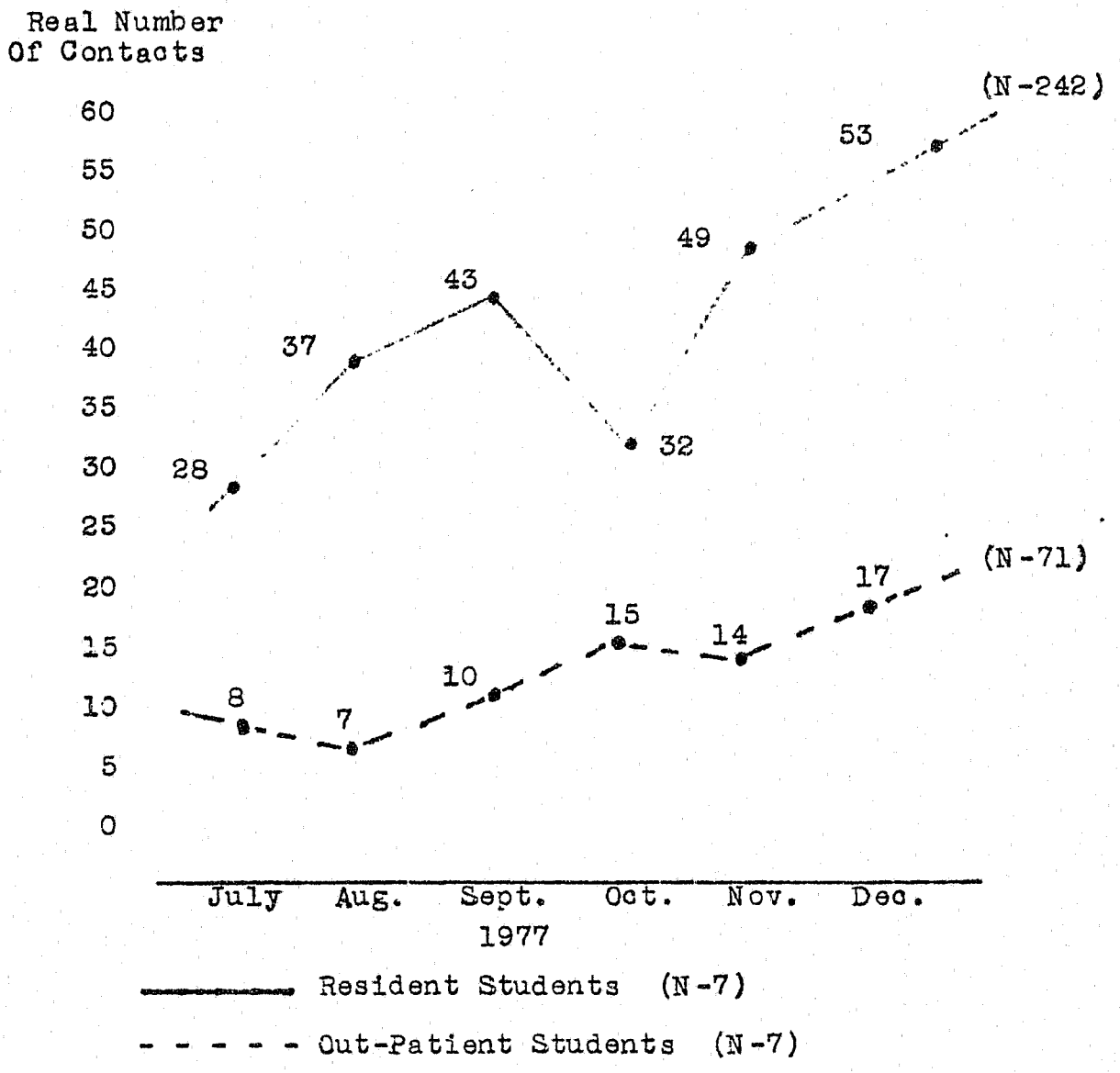


Figure 24

Mean (Average)
Number of Contacts With Families
By Month For Resident and Out-Patient Students
In Dover Program

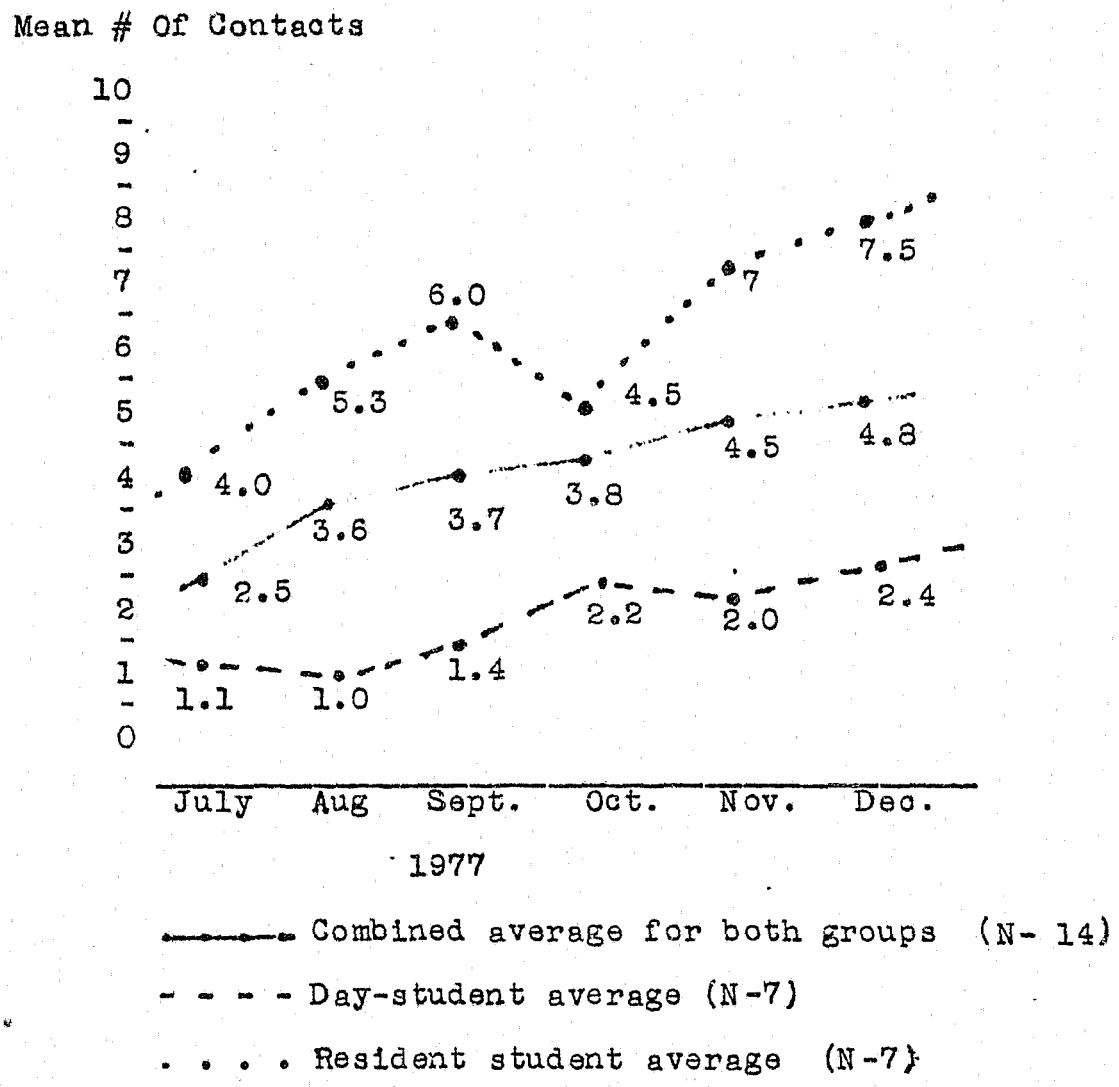
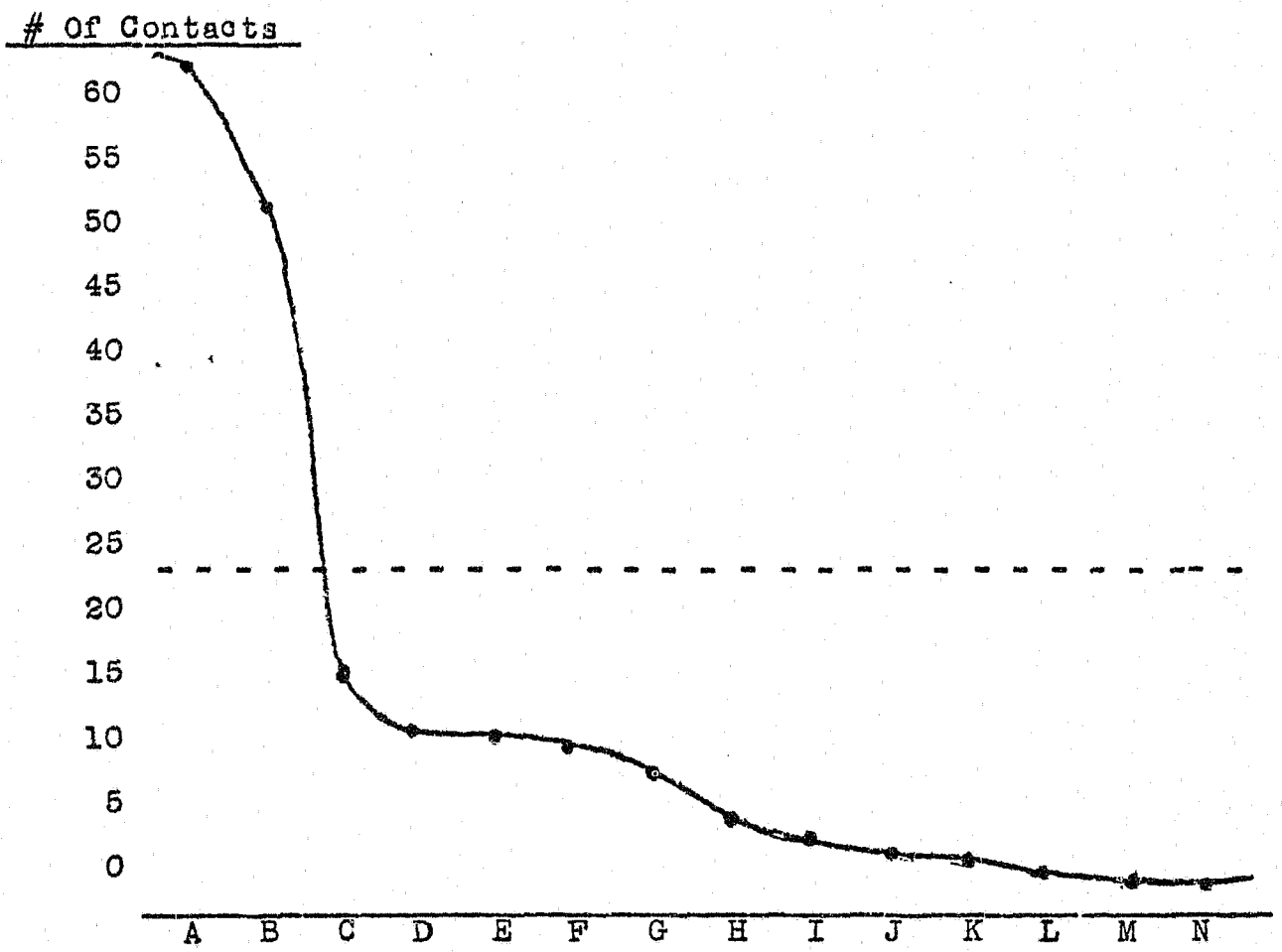


Figure 25

Polygram Distribution of Number of Family Contacts Made By Residents and Day Students Of The Dover Program



Combined Resident-Day Students

N - 313

Mean - 22.4

% Below Mean : 85.7%

Average Deviation - 28.0

SUMMARY OF ADJUNCTIVE IMPACTS

Summary of Adjunctive Impacts

In an effort to arrive at some evaluative assessment of the impact that the adjunctive mechanisms are having upon the educational program, one must first of all be able to examine in a rather rapid manner the effectiveness or lack of effectiveness of each of these particular mechanisms. The data in Table 8 aims at portraying a service profile for any given patient within the program relative to each impact category. Accordingly, if one reads the data in Table 8 vertically then a service profile on any given patient can be obtained and one can immediately begin to locate those areas in which there are deficiencies for individual patients. If one attempts to assess the impact of the category of services, then one ought to read the table horizontally. In any case, I think it is clear that a mere examination of the data in Table 8 suggests that the impact of each service category is likely to be spotty and highly differential relative to any given patient simply because the number of patients within each impact category who have received either a low number of contacts or no number of contacts at all is fairly large. Obviously, if mechanisms are designed to operate through interpersonal interaction, then clearly the number of interpersonal interactions becomes an important indicator of the extent to which they are operating and, hopefully, an extent of the degree of success with which they are operating.

The data in Table 8 suggests very strongly that the service categories for both types of patients are simply not operating with the degree of impact that would be expected had the program been more tightly designed and more tightly controlled. In a word, services are being provided in too uneven a manner to ensure a relatively stable degree of success for any given student. What the evidence suggests from Table 8 is that relative to the impact categories the Dover Program is not servicing its clientele in a stable and relatively equitable manner. Rather, the tendency is for a few students to reflect all the contacts thus throwing off the mean number of contacts for the rest. The additional students in the program tend to be considerably below the mean in terms of every service category. Indeed, they tend to be below the mean in so many instances that is should be regarded as demonstrating unacceptable limits for success.

In attempting to assess the impact of the adjunctive mechanisms of the educational program, namely group counseling, individual counseling, significant other kinds of contacts, contact with referral agencies and family contacts, it is difficult to escape the impression that none of the five impact categories is servicing the total clientele in an acceptable manner. Indeed, taken in the aggregate, it appears that the service categories simply are not functioning as positive adjunctive mechanisms in support of the educational thrust of the Dover Program. And from this perspective it is difficult to conclude, therefore,

that these elements of the program have been successful. They have been in place, they have been operating in a kind of haphazard, unstable and desperate manner, but their impact as far as can be measured from available data appears not to be substantively significant.

This finding, however, must be balanced with an additional finding which addresses the relative success rate of the individual patients in the day and resident programs. If the earlier analysis is recalled, it will be noted that although both groups of students, day and resident, were obtaining approximately the same grade level of achievement (roughly 2.2 to 2.3 grade levels for roughly 55 days average time on the auto-tutor) and if one controls for the type of student, it becomes clear that the day students are learning at a rate some 19% faster than the resident students. The factors which account for this, as we have indicated, are somewhat obscure. But it is interesting to note that in terms of measuring the impact of the adjunctive elements upon the educational program, that in three of the five adjunctive categories, that of significant other contacts, that of individual counseling sessions and that of the number of contacts with referral agencies, the number of contacts per students per month in all three categories tends to be far higher for day patients than it is for resident patients. What this suggests, of course, is that at least for the day students, three of the five adjunctive categories may well be having a positive impact. Fundamentally, however, my feeling is that the critical role being played by these three categories is largely a result of the unstructured environment in which the out-patient may operate once departing the Dover facility for the day. Whereas the residents are in a continually structured environment, the out-patient may well interact with his peers, significant others, and his referral agency while still taking part in the counseling sessions on an individual basis. What this implies, but by no means proves, is that some aspects of the resident program are not nearly as successful as are aspects of the out-patient program. Furthermore, the unstructured environment of the out-patient program may in fact be contributing more to academic success than any of the five adjunctive mechanisms which were built into the design group.

Such findings are, of course, not beyond question and based on data which itself is subject to interpretation. Nevertheless, to the extent that it is a correct assessment of what is happening, rethinking of the resident concept as a mechanism for supporting educational achievement through the use of the auto-tutor program certainly seems evident. Moreover, if in fact out-patients who are in a far less confined situation are learning at a rate faster than those in a confined situation, what is implied is that the applications of auto-tutor teaching mechanisms may be far wider than heretofore thought. It may not necessarily be that one then must have a resident facility coupled with an auto-tutor teaching plan. Rather it may simply be that one can make the auto-tutor plan available on a totally out-patient basis and get apparently the same rate of success or indeed get the same level of success at a faster rate which is what the data indicate. In any event, for any future application of the Dover Program, this point is most seriously worth exploring.

Table 8

Number of Contacts In Each Impact Category Made By Each Student Over A Six Month Period (July-December) In Dover Program

Impact Category	Day Students							Resident Students						
	A	B	C	D	E	F	G	H	I	J	K	L	M	N
Family Contacts	51	3	8	0	4	8	0	192	14	9	9	4	9	5
Referral Agency Contacts	0	2	13	23	7	17	0	21	7	4	0	0	2	2
Significant Other Contacts	24	0	5	14	2	5	0	0	2	1	15	3	0	0
Individual Counseling Sessions	15	0	16	1	0	0	3	0	10	1	0	1	0	0
Group Counseling Sessions	30	1	7	23	3	4	0	30	9	15	25	6	8	5

Note: For service profile for any given student, the table should be read vertically; a service profile for any given impact category can be obtained by reading horizontally

SUCCESS AND FAILURE RATES

Success and Failure Rates

In attempting to assess the impact of the Dover Program upon its individual clientele, some effort must be made to attempt to gauge the success or failure of the program relative to each individual participant. This is not to say that aggregate rates of failure or success as addressed to the entire program are improper statistics. Not at all. It is rather to suggest that success or failure is likely to be a highly personal thing, in which regard, it becomes difficult to address success or failure not only in individual terms, but also in terms of the program as a whole.

What then are we to regard as success and what are we to regard as failure? I think that in terms of the original grant application and program design of the Dover Program, "success" can be defined in terms of two basic indicators. One, of course, is obtaining either the high school diploma or the equivalent high school diploma, the GED. The second indicator of success would be those individuals who were not old enough to obtain the GED but were doing poorly educationally and were able to raise their grade levels sufficiently enough to reintegrate into the public school system from which they came. A third indication of success might well be those individuals who raised their grade levels but did not get their GED, did not return to school but were able to obtain gainful employment. So, utilizing these three indicators as a measure of program success, it seems a fair question to raise as to what the success rate of the Dover school program has been.

Table 9 details the success and failure profile for day students in the Dover Program. It will be immediately noted that of the ten individuals in the day program over a period of approximately nine months there have been four successes. Of those four successes, two obtained their GED, one is currently working, and one is not. Two additional individuals have returned to school, one has reintegrated into the Derry High School system and the other has reintegrated into the Manchester West High School. Interviews with both individuals and their guidance teachers indicates that in terms of the individuals who have returned to school, one individual is doing very well and remains on the honor roll. The other individual is doing what might be considered average to marginal work and, in fact, has been involved with the police in one instance since his return from Dover (Appendix C contains the "before/after" records of the first individual.). In any case, one feels justified that these individuals can be regarded as successes. As regards the two individuals who obtained their GED's, one is currently working full-time and the other is not working but is attempting to acquire the financial means to go to college. In general, then, it seems fair to conclude that with regard to the day student program, Dover has had four clear-cut clinical successes.

With regard to failures, however, it is equally clear that the Dover Program judging from the data in Table 9 has also had four very clear failures. One individual has been transferred to Hampton for chronic problems that could not be handled at the resident facility in Dover suggesting, of course, that he may well have been an inappropriate referral to begin with. Another individual was unable to adjust to the program and has been sent to the Youth Development Center and thus represents a clear case of failure. One individual has left the program completely; that is to say, he simply ran away and his status at the present time is unknown. Probation is checking into this case and, undoubtedly, when the patient is apprehended, he will not be allowed back into the Dover Program. The final individual was discharged from the program for drinking which violates a cardinal rule of the program. Thus, taken in terms of tht totality of the day patients there have been four successes and four failures. Two individuals remained undetermined insofar as they have been in the Dover Program an insufficient amount of time to justifiably judge whether or not they will be successes or failures. With regard then to the success rate, one finds that bout 40% of the patients have been successes as expressed in terms of the program's definition of success and about 40% have been failures; 20% remain undetermined. Indeed, looking at the existing rate of success or failure, one might figure that approximately one student would succeed and the other three would either remain undetermined or fail.

With regard to the cost per student success and per student failure, the average cost spent per day student is $3,500, whereas the cost per success per day student averages $8,750. It is worthy to note here that the calculations of cost effectiveness of success or failure are based upon only GCCD funds which have been supplied to the Dover program and which total about $35,000. If one were to calculate the success or failure rate as the percentage of the total budgetary funds which exceed $90,000, the cost per success or failure as cost per student would rise dramatically. In any event, it strikes this analyst that the more accurate figure from our perspective is the cost per success and cost per student as a percentage calculated from the baseline of GCCD provided funds.

The data comprised in Table 10 details the success and failure profile for the resident students in the Dover Program and contains exactly the same kind of information that was contained in Table 9. An examination of the data indicates that there have been three working successes. Three individuals have obtained their GED's, while two are holding down full-time jobs and one is going to college at St. John's University in NYC through the JET Program sponsored by Odyssey House. There is no doubt that these individuals can be defined as successes. Equally true is the fact that failure rates are correspondingly high. In examining individual failure on a case-by-case basis, we find one patient who was discharged for glue sniffing who represents a truly tragic case. This individual comes from a highly fragmented family background. He was able to complete the Hampton Program

Table 9

Success-Failure Profile For Day Students In The Dover Program

Student	Status	Sucess	Failure
A	GED	X	---
B	GED	X	---
C	Trans.Hamtpon	---	X
D	Sent YDC	---	X
E	Split Program	---	X
F	Dis. for Drinking	---	X
G	Return to School	X	---
H	Return to School	X	---
I	Odessey School	---	---
J	Odessey School	---	---

N - 10

Success Rate: 40% (N-4)

Failure Rate: 40% (N-4)

Undetermined: 20% (N-2)

Cost Per Day Student: $3,500.00

Cost Per Success: $ 8,750.00

Table 10

Success-Failure Profile For Resident Students In The Dover School Program

Student	Status	Success	Failure
A	Disch./Glue Sniffing	---	X
B	Transfer to Hampton	---	X
C	Transfer to Hampton	---	X
D	GED/ Working	X	---
E	GED/ College	X	---
F	GED/ Working	X	---
G	Odessey School	---	---
H	Odessey School	---	---
I	Odessey School	---	---
J	Odessey School	---	---
K	Odessey School	---	---
L	Odessey School	---	---
M	Odessey School	---	---

N- 13

Success Rate: 23% (N-3)

Failure Rate: 23% (N-3)

Undetermined: 54% (N-7)

Cost Per Resident Student:

$2700.00

Cost Per Success:

$11,665.00

and the Dover Program raising his academic skill levels and was reintegrated into Berwick Academy. In credit to the Dover personnel, they were able to scrape together sufficient funds to pay his tuition. Additionally, a heavy psychic investment was made in this individual's success. In the course of this evaluation, while this writer was putting together the data, the individual was arrested for glue sniffing and has since been summarily discharged from the program. Accordingly, he represents all too clearly a case of an unsuccessful attempt to reintegrate an individual into the school system. Two other patients were transferred from the Dover resident program to Hampton, both for repeated cases of "splitting" and other violations within the resident facility. All in all, the remaining individuals, seven in all, are still within the Odyssey Program and have been there for differential rates of time. It would be impossible at this time to determine their success. On the other hand, one can reasonably project that of the seven individuals, probably two or perhaps three at the most will be successes while the rest will remain either undetermined or will be failures.

Expressed in terms of a rate of success for the resident patients, one finds that 23% of the students can be regarded as successes and 23% can be regarded as failures, while 54% can be defined as undetermined. With regard to cost per student, the cost per student in the resident student program is approximately $2,700 which is again calculated from a baseline of only those funds provided by the GCCD; whereas the cost per success is some $11,665 again calculated from the same baseline.

In terms of looking at success and failure rates, it is interesting to observe that the success rate for Dover resident patients is slightly more than half the success rate that can be expected in the day program. On the other hand, this is offset somewhat by the fact that the failure rate is also half that of the day program. In attempting to come to grips with which side of the program, day or resident, is more successful, one must make such judgments depending upon what point of view one assumes. In this regard, the critical question is: are we calculating those patients whom were saved from further failure or are we counting those patients who have actually succeeded? Depending upon one's perspective, one will get different answers. Focusing upon the success rate, clearly the Dover day program is operating at a much better rate; whereas if concentration is placed upon the failure rate, then clearly the resident program is operating at a better rate. On the other hand, success must always be defined largely in positive terms, that is to say, in terms of the actual gains made by the individual. In this regard, it is very clear from an examination of the data in Tables 9 and 10, that not only is the success rate higher in the day program, but the cost per success is in fact almost 30% lower than for the resident program.

When these results are taken in conjunction with the results presented earlier, namely that day students are learning at a faster rate, some 19% faster; that day students have a greater number of contacts with their referral agencies and significant others; they have a greater number of individual counseling session; the data seem

to point toward the conclusion that the day program at Dover is categorically more successful than the resident program. This is a strange paradox because as originally envisioned it was assumed that the resident facility would be more successful. Indeed one can raise very serious questions here that if the day program is more successful then perhaps applications to other areas of social programs might well take this fact into consideration in whatever designs that they are attempting to evolve. In any case, while the data are by no means definitive, what evidence we have been able to marshall suggests that the day program is sustaining itself in terms of success and cost rates at a pace somewhat better than the resident program.

If the entire program is examined in terms of combined day and resident patient successes and failures, one can produce the kind of data presentation that is set forth in the data in Table 11. The data in Table 11 present the combined resident and day patient success and failure rate relative to costs incurred. In this regard, the success rate is approximately 28%, the failure rate 28%, while 44% are undetermined. The cost per patient served is about $1,400 and the cost per patient success is about $5,000, again as calculated from the baseline of monies provided by the GCCD grant only. Thus, a success rate of 28% with a cost of $5,000 per student has to be set against the background of whether or not this is cost effective. The fact of the matter is there is no national standard of success or failure in these kinds of programs when one recalls that the name of the game primarily is to raise academic skill levels. In the absence of a national standard, it does become very difficult to ascribe success or failure to this program as a whole. However, it does seem to this analyst that the rate of success is relatively low certainly when compared to the rate of failure. Additionally, the cost of each success borders on $5,000 and the cost figure would go even higher if we were to calculate it as a result of the total grant funds. This suggests that the Dover Program may well be approaching the parameters of cost ineffectiveness.

Fundamentally, the question of whether or not $5,000 is too much money to spend on saving an individual patient is the kind of policy decision that really eludes empirical definition. It is the kind of decision that is made by policy makers and rooted not only in political considerations but also in the mores and ethics of the society of which the program is only a reflective part. Accordingly, this analyst cannot in any meaningful sense address the question of cost effectiveness simply because it is impossible to assess in the current context of the social mores of the State of New Hampshire just what the cost of a single human life is to be relative to the numbers of dollars to be spent to save it. From this perspective one can only suggest but never demonstrate that a success rate of 28% at a cost of $5,000 may simply be too high for the socio-political context to tolerate in terms of cost effectiveness. In which case, a judgment as to the impact of the program specifically in this area must be made by persons other than this analyst.

Table 11

Combined Resident and Day Student Success
And Failure Rate Relative To Costs

Sucess Rate	Failure Rate	Undetermined
28.0%	28.0%	44.0%
(N-7)	(N-7)	(N-11)

---

* Cost Per Student Served:

$1,400.00

Cost Per Student Success:

$5,000.00

* Calculated from a baseline of monies provided by GCCD grant only

FOLLOW-THROUGH

Follow-Through

One of the ways in which one attempts to assess the effectiveness of a program in terms of impact is to examine the ability of the program design to "track" those individuals who have gone through the program and who have exited. The ability to track such individuals is critically important because only through the development of a tracking system is it possible to obtain information that can function as a feedback loop. This information can then be utilized to modify certain segments of the program to either increase the ability of each program element to perform its function and to measure the impact of each element upon the impact of the total program so as to be able to continually improve the program as it evolves. In short, the system is never really regarded as auto-adjusting, but it is regarded as management adjustable given the information to accomplish this task. From this point of view it becomes critical, therefore, to have some type of mechanisms to track individual patients over time who have penetrated the program, who have exited the program, and who thus create "track records" which can be used as a basis for making judgments about particular program elements. In short, there is a need for a follow-through system.

The analysis of the follow-up system is placed under program impact rather than under the summative analytical components for a very good reason: The lack of an ability of a follow-up system to operate impacts upon the program in that it remains the major mechanism for providing information to undertake corrective action. If a program is failing or doing only moderately well, it can never correct itself if the follow-up system is inadequate or, indeed, non-existent. So, in short, when addressing the impact of the follow-through system, one must address it in terms of its impact upon the larger program design. In correlary, it is an impact component far more than it is a summative component.

In examining the follow-through system of the Dover Program, this analyst is forced to conclude that there is no on-ground system which effectively functions as a follow-through mechanism. What is evident is what is called a "group out" which is held every two weeks for graduates of the Dover and Hampton program. It is conducted by Mr. Jozitis at the Hampton facility and began in December, 1976. Indeed, my investigations suggest that it is not overly successful for the very basic reason that transportation to the meeting site represents a substantial problem. How, for example, is an individual from Manchester or a small town in the northern part of the state going to get to Hampton on his own when he lacks other more basic resources? In any case, this remains the only kind of mechanism for follow-through. In my conversations with the departing Director of the program. Mr. Legg, he indicated very clearly that there is no follow-through system that the out-patient group mechanism is not really serving as a follow-up system. He indicated further that the reason why they do not have such a mechanism is that there is no budget provision for it, there is no

staff for it, and, as a result, there is no formal tracking system or even formal record tracking system that can be utilized to provide feedback to the system in order to allow it to make adjustments within its own organizational design. There is some indication that there will be requests for funds in future proposals to provide for such a tracking system, but at present, there is no such system.

It is important, therefore, to note that there is no follow-through program operating in the Dover Program. There has never been one operating. At best what there has been has been the ability and willingness of the staff to keep track of individuals on an ad hoc basis and to keep in their memories the status of individual graduates. This simply will not do. It does not allow for the kind of empirical investigation that is necessary to establish feedback gained through a follow-through mechanism so as to "fine tune" the behavioral design of the system. I think it fair to say that in terms of gaining information through its own experiences as to what it can do to make its system better, the Dover Program is literally paralyzed. It is groping in the dark because it has no feedback look and, accordingly, this represents not only a major shortcoming of the system in terms of impact components but also in terms of management components as well. There can be no justifying the lack of a follow-through system in a program such as this which requires excrutiatingly detailed information concerning individuals and their experiences and their possibilities for success or failure. Denied the ability to track, the system cannot correct itself. All it can ever hope to do is not make the same mistakes more egregiously. That it will make the same mistakes in the absence of feedback information is virtually guaranteed. And certainly Dover has made the same mistakes time and time again and will continue to do so until a follow-through system is placed on-ground.

THE RYAN STUDY COMPONENTS

The Ryan Study Components

In analyzing this section of the program evaluation, it is necessary to again refer to the Ryan study because it will be noted that two of the objectives which were outlined in the Ryan study as evaluation design objectives have not yet been addressed by this particular evaluation. In the interests of completeness and accuracy, it is necessary to examine each of those objectives and their data requirements and to point out exactly why they have not been included here. In reference to objective three of the Ryan evaluation component study in which the author notes that the objective was to retain at least an unspecified percentage of Odyssey alternative education program students at least one full year after completion of course work in the Dover Program within the Dover public schools. Clearly the extent to which this objective has been obtained simply cannot be addressed because the measures of effectiveness which Mr. Ryan evolved simply do not apply to the available data. For example, the measures of effectiveness relative to the attainment of this objective would require the analyst to calculate the percentage of students enrolled in the Odyssey alternative education program who re-enroll and remain enrolled for one full year upon completion of the above program in the Dover public schools. The first difficulty here is, of course, limiting this to the Dover public school system. The fact of the matter is as the earlier evaluation points out we have only had one referral from the Dover school system and that patient is too recent to allow for evaluation. In any case, this measure of effectiveness should never have been limited to the Dover school system but since the program draws its clients from all areas of the state their reintegration rates should be measured in all areas of the state. Even here, however, it is noted that only two individuals have re-entered public school systems. One individual has been re-enrolled for about four months and the other individual for about four and one half months. One is doing very well and one is barely holding his own. Thus, it is noted that this is the only available data we have to address this measure of effectiveness and, accordingly, it is unrealistic to attempt to make projections from two cases.

With regard to the same objective, one notes that the measure of effectiveness required would be to establish the percentage of patients who leave Odyssey alternative education programs after enrollment but upon completion. This is simply a convoluted way of asking what percentage of patients have obtained their GED or high school diplomas. We have already pointed out that five such individuals have obtained their GED diplomas. More detailed information on success and failure rates is included in the earlier parts of this evaluation.

Finally, we are asked by Mr. Ryan's study to calculate the percentage of students who complete the Odyssey alternative education program and return to public schools but do not remain enrolled for a full year due to referral to juvenile court, health reasons, moving, or finding full-time employment. Again, we cannot calculate those

individuals who return to the public schools and who leave for the above reasons simply because we have only had two individuals return to public school and both are still there. One individual did return to Berwick Academy where he was originally classified as a success but has since been arrested for glue sniffing. Once again the data available in terms of measuring effectiveness are simply insufficient.

With regard, then, to the third objective Mr. Ryan sets forth in his study, that is to try to measure the extent to which the program could retain a given percentage of patients at least one full year after their completion of the courses work, we note that there is not enough data to calculate this percentage. And indeed, even if the data were available, this measure of effectiveness would be a curious one relative to what it purports to measure. The fact of the matter is that reintegration with the school system has not been a particularly successful venture for the Dover Program. This can be estimated by looking at the number of individuals who have been re-integrated, namely only two. There does not strike this analyst as being any necessity to go beyond this in addressing objective three.

With regard to objective five as outlined in the evaluation completed by Mr. Ryan, this objective requires some way to measure the extent to which juvenile court referrals, including truancy for all youth serviced, have been reduced by the Dover Program. A complex formula is developed by Mr. Ryan in which the analyst calculates the average number of court referrals per month during enrollment by taking the total number of referrals while enrolled over the number of days enrolled and then multiplying by 30.4. In short, what he is attempting to do here is to discern how many individuals were referred back to court after being exposed to the Dover Program compared to those who had been in the program for a year. The difficulty is, of course, that the program has only been in operation for nine months and that in order to make this aspect of the evaluation component work, the program would have had to be in operation for at least two years. One can measure the year in which the patient participated in the program and one can measure the year he exited the program. Accordingly, the program simply has not been in existence long enough to utilize this particular aspect of the Ryan evaluation design.

Finally, there is the requirement in the Ryan evaluation design that a project history log be kept in which the Project Director will maintain an up-to-date project history log containing summaries of any event significant to the operation of the program to include personnel changes, lack of supplies, inter-program communications, inter-program modifications, etc., which might affect the outcome of the program. The log should also indicate a discussion of experience gained which might aid in replicating program approaches elsewhere. This log is in fact being kept in the form of the quarterly reports which are now being maintained in a separate folder marked "project history log."

I find that in conducting a content analysis of these quarterly reports they do in fact contain all the information that a project history log should. Accordingly, one notes that this requirement of the Ryan evaluation component is in fact being met.

IMPACT SUMMARY

Impact Summary

In attempting to summarize the impact of the Dover Program upon its clientele, one fact is indisputable and that is that the Dover Program is succeeding in raising the academic skill scores of its clientele. The data which were presented earlier very clearly demonstrates that, on the average, 2.2 full year grades are being achieved in about an average of 55 instructional days. There is no avoiding the fact that the major educational thrust of the Dover Program is in fact being accomplished and being accomplished with relative efficiency. Although there is a differential in terms of the learning rates between the resident and out-patients with the out-patients learning some 19% faster, the fact of the matter is that both groups are certainly obtaining their educational goals within the predicted time parameters set forth by the original Dover Program. Thus, in any impact evaluation of the program one must start with a recognition of the fact that academic levels are being raised.

Now the fact that academic skill levels are in fact increasing is in and of itself an important fact. However, it may well be that education levels are increasing not because of the operation of the program, but rather in spite of it. Indeed, when one begins to examine those adjunctive mechanisms which were designed to provide therapeutic support for individuals attempting to increase educational skill levels, it was found that of five such mechanisms at least four can legitimately be considered failures. This is probably irrelevant given the school process. In specific terms, however, we note that group counseling, the number of individual counseling sessions, the significant other contact levels and contact with referral levels all occur at rates considerably below the mean expected rate. This strongly suggests that the impact of these particular adjunctive mechanisms is highly differential tending to be concentrated upon a few individuals leaving more individuals in the program under-exposed to their impact. What this further implies, although by no means conclusively demonstrates, is that the adjunctive mechanisms may be having no impact at all on the raising or lowering of educational skill levels. Most certainly, our data suggest that they are not having a positive impact. Taken in this context, the conclusion is not at all unwarranted that educational achievement scores may be being raised because the original adjunctive mechanism are simply irrelevant to the impact design envisioned by the original program proposal. Such an interpretation certainly is consistent with our findings.

If it is true that the skill level achievements are unconnected or at least only tangentily connected to the operation and impact of the adjunctive mechanisms which have been heretofore addressed, it is equally clear that the success rate at which this program is operating is probably too low to be considered acceptable in a state with the

economic and ethical climate of New Hampshire. Such is to suggest that the predominating social ethos of the state is such as to expect simply more for its social impact dollar than would normally be the case in, let us say, New York, a state used to a whole host of programs, adequately funded, which operate at atrociously low levels of success. The point is that the success rate of the Dover Program which is approaching some 28% is likely to be considered too low. At the same time, the cost per individual patient is likely to be considered staggeringly high. One begins to look in terms of an average cost per patient of $1,400 which is probably tolerable; however, the average cost of success is almost $5,000 which is not likely to be regarded as cost effective within the context of the socio-economic characteristics of the state.

When attempting to assess program impact it is important to examine the service rate of mechanisms within the program. We have already made the point that the adjunctive mechanisms probably are irrelevant to the original design of the program in terms of anticipated impact and certainly our data suggest the validity of this conclusion. But whether such adjunctive mechanisms are relevant or not, the feeling remains that they should at least be employed in a manner which is stable and consistent so as to ensure that each patient in the program is exposed to such adjunctive mechanisms in a relatively consistent and equitable manner. As we have shown by our data, the rate at which patients are exposed to the adjunctive mechanisms tends to vary staggeringly, in one instance from a high of 192 contacts to a low of 0 contacts. This suggests that the number of patients who tend to fall below the mean of adjunctive service mechanisms is so high as to suggest that the patients simply are not being serviced for the cost of the $1,400 that is being paid. Accordingly, we once again find that there is a problem of success rates expressed in terms of the extent to which services are being provided.

With regard to the lack of a follow-through system, the impact upon the program is rather obvious. There is no tracking system and as a result there is no feedback loop and as a result the system is incapable of correcting its own mistakes. This has resulted in the probability that it will make the same mistakes and certainly not learn from its past errors. It is very difficult to condone the operation of a program that has no mechanisms for tracking its own successes or failures. In this respect, one must clearly affirm that the failure to establish a thorough follow-through program is among the most serious shortcomings of the Dover Program.

Taking all of what has been said together, it is evident that data cannot be overlooked. Thus, the rates of academic skill levels are indeed going up as much as 2.5 grades per 55 days of educational instruction time. At the same time the rates of learning in the various educational areas seem to be highest in the area of English language skills which are, of course, crucial to the reintegration of patient into society. Second, there is no doubt that the out-patients are

learning faster at a rate of some 19% than the resident patients. Finally, it is clear from the data that the success rate is almost twice as high among day students than among residents which is to suggest that the day program is operating in a more effective manner. When one attempts to assess the meaning of this kind of information it lends itself to the conclusion that in terms of impact the Dover Program has been differentially effective and that the day patients are getting more out of their experience at least as indicated by measurable empirical indicators. What this does, of course, is to call into serious question the whole philosophy of utilizing Dover as a stepping stone between Hampton and the community at large. The data simply do not support the proposition that Dover is effectively being used as a stepping stone. Rather what the data do suggest is that if one is interested in increasing educational levels and integrating individuals back into society the best way to do it is through a day program. In short, the data seem to support the proposition that if one is going to be concerned about learning rates, the extent to which grade level improvement is achieved, and success rates relative to cost, one might be better off in constructing a program in which individuals would be allowed to enter the program say in the morning for 2½ hours through which they would receive intense educational exposure and then be allowed to reintegrate back into the community to enjoy an increased number of significant other contacts. At least the available evidence suggests that the day patient program is working better than the resident program all things being equal.

On the other hand, these findings must be balanced with the knowledge that the successes in both areas of the program, that is the successes which emanated from the resident program and those from the day program, have simply not been out of the program long enough for an analyst to get a definitive idea as to what the long-term results of the program are likely to be. When we address obtaining the GED as a goal, the danger is that these individuals may be so programmed to focus upon the GED that they may expect life to be significantly different after they obtain the GED. Because we live in an extremely complex society, the fact of the matter is that while it is a severe disadvantage to be without a high school diploma or its equivalent, it still remains that one does not enjoy an advantage relative to other groups in the society by simply possessing a high school diploma. What the implication here is, of course, that the successes have not been out of the program long enough for any analyst to evaluate them obtaining of a high school diploma as an indication of success relative to the overall stability of the individual as a successful participating citizen in this community. Second, the fact that individuals have not been out of the program long enough calls into question how successful they have been at employment. From what we know of those individuals who have graduated, both are working at what we would call marginal economic jobs. We know that individuals with unstable family backgrounds who tend to work at marginal jobs are likely to have continual difficulties with the police. They are likely to represent continual problems within the society for very

basic reasons, that is to say, having overcome their initial difficulties they expect significant increases in their status of living and their status in the community only to discover that such things are not forthcoming as a consequence of their low occupational status. Accordingly, the possibilities for frustration in an individual increases. This, of course, does not address what would happen if the person had not obtained the GED. In any event, the facts remain that the mere fact a few graduates are working proves nothing at this point simply because we have not had enough time over which to track them.

Finally, there is the question of reintegration into public school systems. As noted earlier, the Dover staff, although it mentions as part of its program design the desire to integrate individuals back into the public school system, does not appear to place a high priority on such reintegration simply because it has had difficulty in trying to relate the process of reintegration with keeping the patients from an environment that tends to be highly traumatic and disruptive to school achievement. Taken from this perspective, we simply do not know how successful patients reintegrated into the school system will be over time. We do know that of the three individuals who have returned to school, one has been thrown out for glue sniffing, one has been an unqualified success in that he has been on the Dean's list, and the third falls somewhere in between where he is just keeping up by doing average work and has in fact gotten into trouble once again. So, the data simply are not projective enough for us to indicate definitively how the program is truly impacting over the long run. Indeed, this is one of the reasons why intensive evaluation normally requires a program that has been in operation for at least two years in order to be able to at least test some of these projective aspects. Clearly since this program has been operating only nine months it is difficult if not impossible to evaluate its projective aspects.

In conclusion, however, it is fair to suggest that, on the whole, the impact of the Dover Program on the educational skill levels of its clientele has been generally good but highly differential. The impact of adjunctive mechanism has also been highly differential and generally unsuccessful. Taken in its totality, the rate of success is about 28% of those patients exposed to both programs. Relative to the cost involved, approximately $5,000 per success is probably unacceptably high to the average policy maker who must function in the context of the economic conditions and social mores of this particular state. It just does not appear that this success rate can be defined as adequate given the success rates of other programs which have gone before it in at least adjunctive areas. From this perspective, one does not have much hope that the data evident from a thorough examination of the Dover Program will really lead to the ability to develop a convincing case in favor of maintaining the program. The data are, to be sure, mixed; but the preponderance of the data does lean heavily toward the conclusion that the program is not performing as well as it

could and is not achieving its goals at least through the mechanisms originally designed to achieve them. The single exception is the program's ability to raise educational levels which must be regarded as an unqualified success. Beyond that, however, the program remains steeped in serious summative and impact difficulties and lacking a follow-through program it seems unlikely that the system will be able to repair itself, if allowed to continue to function. This alone might provide a sufficient case for not renewing funding for the Dover Program.

RECOMMENDATIONS

Recommendations

(1)

In an effort to cure chronic staff instability and to ensure a level of administrative competence needed to integrate all aspects of the highly complex Dover Program design, a full-time professional administrator is required in the post of Program Director. It is strongly urged that such an individual should be hired from outside the program rather than from within the normally utilized Hampton-Odyssey channel.

(2)

As a minimum condition of further operation, the Dover Program must obtain its certification as an alternative educational facility from the New Hampshire Department of Education. While it is unlikely that such certification will cure all the ills associated with the referral program, it is only in this way will the program's legitimacy increase in the perception of other social service agencies, most particularly the Dover school system.

(3)

Communication with referral agencies must be improved and stabilized so that all such agencies are accurately informed as to the nature of the services that the Dover Program can realistically perform. Currently confusion among referral agencies as to the true nature of the Dover Program's capabilities increases the probability that inappropriate referrals will be made and accepted.

(4)

Prior to the acceptance of any individual into the Dover Program a formal agreement with the relevant school system must be concluded so as to assure all concerned that any educational progress which an individual may make while within the Dover Program will be recognized and accepted by the school system into which he can be expected to reintegrate. In the absence of such an agreement the Dover Program cannot meet its educational objectives and only marginally meet its other goals.

(5)

Referral bottlenecks must be removed, especially in the case of the Dover school system's refusal to refer any students to the Dover Program. Given the program design, the schools are in the best position to provide the kinds of early referrals of largely educational problem children that the Dover Program is in the best position to deal with. Accordingly, continued liaison and negotiation must be carried out so as to convince the Dover school system to accept the program and refer students to it. Without such cooperation, the Dover Program simply cannot succeed.

(6)

The intake and screening and testing processes upon which so much of the Program's success depends must be refined, strengthened and made more rapidly and consistently applicable so as to function to successfully screen out those referrals which are inappropriate for the Dover Program. At present, the system is clearly failing to adequately locate, define, and reject inappropriate referrals.

(7)

The decision making process for admitting a referral to the Dover Program should be tightened. In present circumstances the process is largely informally decentralized among several staff persons and is only tangentally affected by the results of psychological and psychiatric testing. It is recommended that a formalized process be developed in which the special education teacher, the psychologist, the psychiatrist and the director along with a representative of the referral agency all meet at one session and render a formal decision on acceptance. In this manner the probability that an inappropriate referral will be accepted to the program ought to considerably diminish.

(8)

The establishment of a formal intake policy specifying the amount of time required before a formal decision on acceptance is rendered should be undertaken. Central to such a policy is the recommendation that <u>all</u> potential patients be tested by the Dover special education teacher, the psychiatrist, and the staff psychologist. No acceptances are to be made unless such testing is first conducted and reliance upon existing records or past tests should be minimized wherever possible.

(9)

If immediate testing cannot be accomplished prior to the acceptance of a patient to the Dover Program then clearly some formal policy regarding what to do with the patient while he is awaiting testing must be established. Both in the resident and out-patient phases of the program no such policy is presently in force resulting in a highly differential treatment of the individuals concerned with some being allowed to remain at the Dover House until testing is completed while others are not. Consistency in this policy area is needed rapidly.

(10)

Serious consideration should be given to accepting only those patients into the Dover Program who have previously been exposed to the Hampton Program thus eliminating entirely from the resident phase of the program patients referred directly from other outside agencies. Such a program change would likely minimize the problem of inappropriate referrals and acceptances.

(11)

There is a need to address a major change in the grant design. If, as presently indicated, the Dover Program places some emphasis upon family counseling, then it is required that a mechanism to effectively achieve family counseling be developed. If, as the staff openly admits, family counseling is not important as there is no real effort to reintegrate the patient with his family because of highly traumatic family environments, then the family counseling component of the program ought to be dropped. In any case, a mechanism addressing family counseling must either be rapidly developed and set in place or the program design modified accordingly to reflect its absence.

(12)

In an effort to comply witb both state and federal laws, the Dover Program must immediately establish, promulgate and enforce a policy of records destruction for those individuals who, upon leaving the status of a minor person, have a right to have their juvenile records expunged. No such policy is presently in existence or in force within the Dover Program and should be given substantive priority in its establishment.

(13)

A formal access policy regarding all school records of the Dover Program must be established. The informal policy presently in force does contain all the elements necessary to an effective restriction policy; nonetheless the need to formalize the policy remains.

(14)

The two board-like mechanisms charged with conducting public relations in support of the Dover Program are largely paper constructs. If true community rapport is to be built, strengthened, and maintained over time, a more integrated, centralized, and active public relations effort will be required.

(15)

A full-time, live-in, group counselor, such as was originally envisioned by the grant application, should be hired and placed in the Dover resident facility.

(16)

Level Four personnel should not be allowed to act as paraprofessionals in the conduct of the group therapy process without strict supervision by a qualified psychologist or psychiatrist. In the opinion of two psychologists, the group process as presently structured exacerbates the risks of producing negative effects upon its participants.

(17)

Special projects, as an adjunctive mechanism to the educational component of the Dover Program, is sorely underdeveloped in that it does not provide even a moderate range of activities for the resident patient. It is recommended that special project activities be upgraded to provide more diversity and interest in its offerings and that more of a truly recreational nature be done.

(18)

All aspects of the group and individual counseling therapeutic mechanisms must be thoroughly reexamined to ensure that an adequate number of sessions is being provided for each resident and out-patient. Further, the use of para-professionals, especially Level Four's, should be curtailed in this role unless greater on-ground supervision by a trained psychologist can be assured.

(19)

Records keeping functions should be centralized under the office of the professional administrative Program Director. At present, the decentralization of record-keeping functions and responsibilities has led to haphazard, inaccurate, incomplete and out-of-date maintenance of operational records.

(20)

More stabilized and equally distributed employment of resources must be accomplished in the area of those adjunctive therapies supportive of the educational component of the Dover Program. At present, unstable and poorly distributed services are being provided in the areas of "significant other" contacts, referral agency contacts, family contacts, group therapy and individual counseling sessions. Each patient must be assured of a relatively equitable amount of these services rather, as the data indicate, having a few students monopolize most of the services.

(21)

The failure to stabilize the food supply by ensuring proper real-time receipt of food stamps with which to purchase food for the Dover House is chronic. It must be corrected immediately, perhaps as part of the centralization of administrative functions under the control of a professional administrative director.

(22)

As presently constituted, the program system cannot "track" its successes or failures as a means of obtaining "feedback" through which the system's program components may be adjusted when confronted with its own errors. An effective follow-through program must be established immediately as a minimum basis for continued funding.

(23)

Given the present analysis, the Dover Program cannot realistically be expected to accomplish all suggested changes, or even the more important ones, without substantially altering ingrained practices or its program design. Even if such changes could be achieved, they could not be accomplished within a realistic time frame. From this perspective, then, it is recommended that the Dover Program not be refunded for another year and that Dover personnel abandon the present program design.

SOME SUGGESTIONS FOR

ALTERNATIVE APPLICATIONS

Perhaps the two most important findings of this study as far as they relate to understanding how the auto-tutor teaching mechanism may be utilized in alternative program settings are the following: first, the data clearly indicate that the teaching machine approach to raising the academic skill levels of individuals with delinquent or pre-delinquent backgrounds is highly effective. The data from the Dover Program are undeniable in this regard. Additionally, similar success with auto-tutors has been achieved in other states, most particularly in the Georgia Earned Release Program. Second, the experience drawn from the Dover Program and also buttressed by similar findings in the Georgia program suggest rather strongly that the type of program in which the auto-tutor is employed as a teaching tool is not a relevant variable in determining the degree of success for any given individual. Whatever other variables may be impacting upon learning rates, the program setting is most certainly not a major one.

The implications of these findings are important for they suggest rather clearly that auto-tutors as teaching devices may indeed be utilized in a variety of program settings without seriously impairing their ability to raise the academic skill levels of individuals involved. Further, the inherent flexibility of the auto-tutor as a teaching tool opens up further possibilities for reducing costs of operation by combining it with already existing programs. Thus, it is at least plausible to suggest the following five alternative settings in which the auto-tutor may be used at reduced costs:

1. Prisons
2. Youth Development Center
3. Group Homes
4. Halfway Houses
5. Community Diversion Centers

Importantly, since auto-tutors use "packaged" learning prescriptions, that is pre-programmed sets of tapes which are matched to skill levels as measured by performance on the California Achievement Test, there is no real requirement that full-time, special education teachers be utilized. Rather, a more cost-effective means of employing the auto-tutor in a variety of institutional settings would be to train and use para-professionals or, as another approach, to hire one teacher and have her circulate among the various sites spot-checking as she goes. In any case, the ability to utilize other types of personnel to operate the auto-tutor program certainly presents an avenue to be explored.

Appendix A

INTERVIEW LIST

Dave Sandberg, Director, State Odyssey House, Inc.

Bernard Litvin, Regional Director, Odyssey, also Director, Dover

Bruce Dupuis, Acting Director, Dover

Jackie Adams, Special Education Teacher, Dover

Marc Gipson, Level IV, in charge of Dover special projects

Warren Bruney, Level IV, teacher's aid on auto-tutor

Gregg Butterfield, Dover High School Guidance Counselor

Marilyn Viccairo, Somersworth School District case worker

Leon Yeaton, Member Dover Liaison Committee

Chief Charles Reynolds, Member Dover Liaison Committee

Cpt. Joseph McCarthy, Member Dover Liaison Committee

William Collis, Juvenile Officer, Dover PD

Robert Kennedy, Certification Branch, N. H. Dept. of Education

Martha Barrows, Dover Youth Services Officer, Dover PD

Dr. Steve Seeman, Chief Psychologist, Hampton House

Dr. Rowan Hochstedler, Chief Psychiatrist, Hampton House

Denise Trahan, Community Liaison Officer, Dover

Kathy Kelley, Director, Dover Youth Services Program

Donna Bolian, Chief Psychologist, Dover School District

Bernard Rider, Superintendent, Dover School System

Floyd Jozitis, Chief of Group Therapy, Dover

Calvin Legg, Director, Odyssey Dover Program

Alan Reed Erickson, Probation Officer, Dover

Debbi Parker Bennet, Probation Officer, Dover

Ruth Farrel, Volunteer tutor for Dover program

Kathy Whyte, UNH special education intern/Dover ed program

Marie Houston, UNH special education intern/Dover ed program

Steve McCardy, Level 3, Utah Odyssey

Stanley Syrek, Resident, Dover House

Victor Smith, Resident, Dover House

Greg Clough, Resident, Dover House

Darrin Paige, Resident, Dover House

Paul Gammelin, Resident, Dover House

Mike Casey, Resident, Dover House (newest resident)

George Stone, Resident, Dover House

Mr. Howard Kimball, Secondary School Services, NH Dept. of Education

Dr. John Moody, Psychologist

Professor Richard Hechtl, Psychologist

Professor Robert Kelley, Psychologist

John Lawton, Supervisor Field Services, NH Welfare (Dover)

Susann Fearnon, NH Welfare (Dover Office)

Joanne Maynard, NH Welfare, Dover Office

Virginia Upton, NH Welfare, Dover Office

Betty McGlown, NH Welfare, Dover Office

Dotty Jones, Graduate of Dover School, GED level

Stanley Syrek, Resident, Dover Odyssey Program

Victor Smith, Resident, Dover Odyssey Progarm

Mark Fernele, Resident, Dover Odyssey Program

Mr. Ralph Van Nostrand, Guidance Counselor, Derry High School

Mr. Ronald Royer, Guidance Counselor, Manchester West High School

Ross Hammett, Day Patient, Dover School

Rusty Dunnell, Day Patient, Dover School

Robert Lambert, Day Patient, Dover School

Appendix B

DOVER RESIDENCE HOUSE

SAMPLE MENUS

MOND.Y	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
BACON & EGGS TOAST COFFEE	EGG OI EMETTE TOAST OR NGE JUICE	COLD CEAREL BANNANAS COFFEE	WOODMANS DEI IGHT TO..ST ORANG'. JUICE	OATMEAL TO ST COFFEE	PANCAKES DONUTS ORANGE JUICE	WAFFLES HOT DONUTS COFFEE
TUN.. FISH SANDWICHES SOUP KOOL-AID	BOLOGNA & CHEESE SANDWICHES SOUP KOOL-AID	RAVOLIA BREAD MILK	PEANUT & FLUFF BUTTER SANDWICHES KOOL-AID	HOT DOGS & BEANS BREAD KOOL-AID	SALAMI ✓ SANDWICHES SOUP KOOL-AID	GRILLED CHEESE SANDWICHES KOOL-AID
HAMBURGERS FRIED POT..TOES MILK	LIVER/ONIONS ✓ BAKED POTATOES GREEN BEANS BREAD MILK	CHINESSE PIES BREAD MIIK	HAM & BEANS FRIED POTATOES MILK	FIIET FISH ✓ CARROTS BREAD MILK	PORK CHOPS MASHED POTATOES GREEN BEAN MILK	MEAT LOAF BAKED POTATOES MILK

MENU FOR THE WEEK OF FEB. 1, 1977 to FEB. 7, 1977

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
COLD CEAREL BANNANAS TOAST ORANGE JUICE	BACON & EGGS TOAST COFFEE	WAFFLES HOT DONUTS ORANGE JUICE	OATMEAL TOAST COFFEE	PANCAKES DONUTS ORANGE JUICE	COLD CEATEL EGGS TOAST COFFEE	[illegible] DELIGHT TOAST ORANGE JUICE
TUNA FISH SANDWICHES SOUP KOOL-AID	GRILLED CHEESE SANDWICHES KOOL-AID	BEEF-A-RONI BREAD KOOL-AID	BEANS & HOT DOGS BREAD KOOL-AID	BOLOGNA & CHEESE SANDWICHES S UP KOOL-AID	SPAGETTI & MEAT BALLS BREAD KOOL-AID	EGG SALAD SANDWICHES SOUP KOOL-AID
LIVER/ONIONS ✓ MASH POTATOES GREEN BEANS MILK	MEAT LOAF CORN BREAD MILK	PORK CHOPS GREEN BEANS BAKED POTATOES MILK	CHEESEBURGERS FRENCH FRIES MILK	MEAT PIES MASHED POTATOES BEETS ✓ PUNCH	FILET FISH ✓ CARROTS BREAD MILK	FRIED CHICKEN BAKED POTATOES GREEN BEANS MILK

MENU FOR THE WEEK OF JAN. 24, 1977 to JAN. 31, 1977

Appendix C

"BEFORE-AFTER" SCHOOL RECORDS OF A SUCCESSFUL DOVER DAY PATIENT

MANCHESTER WEST HIGH SCHOOL, 9 NOTRE DAME AVE., MANCHESTER, N.H. 03102

Telephone 622-5513

STUDENT GRADE REPORT

STUDENT NAME

STUDENT NO. 795211 | YR. GRAD 1979 | E H R | SCHOOL YEAR 1975-76

ATTENTION/ADDRESS

HAVE A PLEASANT SUMMER AND GOOD LUCK TO ALL

			FIRST SEMESTER				SECOND SEMESTER					
	SUBJECT/TEACHER	1ST MARK	2ND MARK	3RD MARK	SEM. AVG.	1ST MARK	2ND MARK	3RD MARK	SEM. AVG.	COMMENTS	CREDITS
10	PHYS ED FOR MEN MR KERRIGAN					F	W	W	W		.00
13	L-1 LANG + COMM MISS LANDRY	C	F	F	F						.00
14	L-1 LIT + PR WR MISS LANDRY					F	F	W	W		.00
01	L-2 SHOP MATH MR KULAGA	C	B	F	F						.00
02	L-2 SHOP MATH MR KULAGA					F	F	F	F	20 OR MORE CLASS ABSENCES	.00
12	L-1 LIFE SCIENC MRS SABEAN					F	F	W	W		.00
17	L-2 PHY SCIENCE MR RAY	C +	D	F	F						.00
17	L-2 PERSNL TYPE MR MULLEN		F	F	F						.00
01	L-2 IND ARTS 1 MR KLAXTON	C	F	F	F						.00
02	L-2 IND ARTS 1 MR KLAXTON					F	F	F	F	20 OR MORE CLASS ABSENCES	.00

	1	2	3	4	5	6
TIMES TARDY	00	00		00	04	00
TIMES ABSENT	00	00				
TIMES DISMISSED	00	00	00	00		

GPA MP	.0
CAREER GPA	.00

CREDITS EARNED	.00
PREVIOUS CREDITS	.00
TOTAL CREDITS	.00

MANCHESTER WEST HIGH SCHOOL, 9 NOTRE DAME AVE., MANCHESTER, N.H. 03102

Telephone 622-5513

REPORT OF

STUDENT NAME

STUDENT NO. 804180 | YR. GRAD. 1980 | E H R | SCHOOL YE 1976-7

MAIL TO

PARENT NAME / ADDRESS

HONOR ROLL

OFFICIAL ATTENDANCE RECORDED IS THROUGH NOV. 19TH
LET'S MAKE 1977 BETTER BY TRYING HARDER.
PRIVILEGES HAVE CONCOMITANT RESPONSIBILITIES.

			FIRST SEMESTER				SECOND SEMESTER				
SEM.	COURSE SEC.	SUBJECT/TEACHER	1ST MARK	2ND MARK	3RD MARK	SEM. AVG.	1ST MARK	2ND MARK	3RD MARK	SEM. AVG.	COMMENTS
F	11315	L-2 LANG/COMM MR SULLIVAN	B	B							
F	40203	L-2 GEN MATH 1 MISS VALAVANE	B +	A							
F	50211	L-2 PHY SCIENCE MR SCHRICKER	A	A							
F	70103	L-2 IND ARTS 1 MR TUNBERG	A	B +							
F	81001	L-2 ARTS/CRAFTS MRS EATON	B +	B +							EFFORT IS GOOD

	1	2	3	4	5	6
TIMES TARDY	0	0	0	0		
TIMES ABSENT	0	1	0	0	0	0
TIMES DISMISSED	0	0	0	0	0	0

GPA/MP 3.6
CAREER GPA

CREDITS EARNED
PREVIOUS CREDITS
TOTAL CREDITS

END