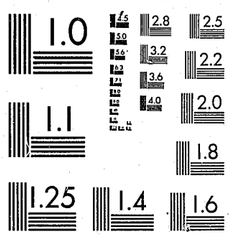

CASE MANAGEMENT MANUAL

NEW HAMPSHIRE STATE PRISON

EDITION — I
JULY, 1980

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NEW HAMPSHIRE STATE PRISON
Concord, New Hampshire

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CHAPTER I

PURPOSE

It is the purpose of the Case Management Manual to deliniate the case management process at the New Hampshire State Prison and to explain the various functions and components that go into the task of case management together with decisions and inter-relations relative to other units of the Treatment Directorate and other departments of the New Hampshire State Prison. Consequently, this manual provides both standards and procedures relative to the task of case management.

Case Management is a formalized method that focuses on the past, present and future of an inmate. It is based upon an orderly, prescribed procedure of individualized programming and planning. It is a systematic method that directs the flow of information to decision points that directly affect the inmate.

This information contributes to an orderly method by which varied inmate needs and requirements may be matched to solutions from initial incarceration to discharge.

The primary intent of Case Management is to prescribe individualized programs by being aware of each individual's needs and behavior. This is accomplished by an on-going interaction between the inmate and the Case Manager. This on-going contact throughout the inmate's stay in the institution is a means of assessing the inmates and the systems success or failure as defined by the inmate's progress through the institution and preparation for his return to society.

The Case Management System and Case Manager supervision contributes to the efficient operation of the institution while providing a quality of services to the inmate that does not loose sight of human values and individual needs. The assessing of needs and the coordinating of program functions that will address those needs contributes to an inmates rehabilitation. Finally, the whole thrust of the Case Management effort is goal-oriented toward efficient, effective, and realistic programming that will aid the inmate in his institutional adjustment, allow him to develop his full potential, and to be more socially responsible both before and after his release.

CHAPTER II

PROCESS OVERVIEW

The Case Management System set forth in this manual supplements the multiple existing and planned systems of the Prison. Standardized procedures will be followed when applicable. The Case Management System directly bears on the following as listed in the Classification Manual, Chapter II, Page 2:

A. Custody Grades (provides rationale input);

B. Housing Assignments (assesses assets and liabilities);

C. Special Statuses (creates or provides input);

D. Legal Conditions (appropriate awareness and requested involvement);

E. Work/Training Assignments (direct input as to rationale);

F. Educational Opportunities (assessment of correct fit and support of educational unit's goals and objectives);

G. Post-Release (initial referral and on-going input. Should work carefully with Unit with specific kinds of parole plans which include professional community resources and develop plans for follow-up in these areas);

H. Special Programs (involvement in entry and performance of these programs); and

I. Transfer (either assist or generate transfers appropriate to type and criteria of transfer).

Involvement in each of these component services will be described in further detail. Functions shall be governed by the operating procedures set forth in this Manual.

1. INITIAL CLASSIFICATION HEARING

Since the Case Manager is an integral part of the Prison's reception cycle, he will be present or arrange for a substitute for each of these initial hearings. A substitute will only be acceptable when the assigned Case Manager is not at the Prison on the day of the scheduled hearing. In addition, as outlined in the Classification Manual, the Case Manager will make available the initial case history, the psychological and educational

evaluation, vocational evaluation and an analysis of this material which is usually most useful in a format of strengths and weaknesses. The Case Manager's input will be instrumental in selecting the correct program for each new arrival.

2. CONTINUING REVIEW

At regular intervals (normally every 90-120 days and 60 days for Maximum Custody), the Case Manager will provide updated reports and if appropriate, an overview of these documents available to discuss with each Board. The Case Manager should be the individual most familiar with the inmate's needs and will provide a rationale for, continuing programs, adjustments, or complete changes. The inmate's long-term best interests will be the focus of Case Management efforts.

3. GENERAL PROCEDURES

The language of the Classification Manual is explicit: "Prior to each inmate's appearance before the Board in person, the inmate's Case Manager and the Classification Officer will present to the Board a short briefing detailing the individual's background, test results, and confinement experience." This must be in writing to provide historical documentation. This document, together with the inmate's input during the hearing, should become a treatment and advocacy tool located in the inmate's record. (Taping of these hearings may also be done in order that exact details are in storage for an appropriate use at a later date.) Clarity and brevity is stressed in these reports as opposed to length. Some, by demand of content, will obviously be longer than others. In addition, this documentation may be used by any decision-maker within the Prison.

4. ROLE OF THE CASE MANAGER IN CONCERT WITH THE PRE-RELEASE SECTION

Case Manager's should be available for Pre-Release consultation. In some cases, they will be able to provide current input which has not been entered into the inmate's file. Also at this time, the nucleus of a parole plan begins to be formulated with which the Case Manager will become actively involved.

The Case Manager, as well as Pre-Release, will help determine each inmate s eligibility for vocational rehabilitation services. In some cases, the Vocational Rehabilitation Unit will provide instructional materials, i.e., certain "learning kits", to be utilized while the inmate is still in the institution.

5. SUMMARY

The Case Management Process begins when the inmate comes through the front door and is inprocessed into the Prison and it runs throughout the inmate's entire confinement until he is actually released from Prison. The Case Manager is involved throughout and may in some cases (with the concurrence of the Warden), continue with some involvement after release via community resources.

CHAPTER III

RECEPTION PROCESS

Both the initial interview and the diagnostic process should occur as early in the orientation process as possible. Each Case Manager should be completely familiar with the description given in the Classification Manual, Reception Process, Page 5.

A. UTILIZATION OF CUSTODY

In many cases, valuable information can be obtained from the Custody Officer responsible for the initial orientation process. This officer observes behavior patterns in a new arrival to the Prison. The Case Manager should also double check to affirm that the inmate has in his possession, and completely understands, the "Inmate Manual."

B. MENTAL HEALTH OF INMATES

Therapy sessions may be incorporated into a Case Manager's schedule at the onset of an inmate's arrival at the Prison. Referrals may also be forwarded to the Chief Psychologist for appropriate transfer to the State Hospital. All referrals for the Consulting Psychiatrist will be coordinated through the Chief Psychologist, or in his absence, through the Director of Treatment. Even though referrals can develop at the onset of an inmate's tenure at the Prison, it is also an on-going option for a Case Manager. The Medical Unit may also make referrals to the Chief Psychologist, Director of Treatment, Consulting Psychiatrist, or in most cases, the Case Manager. When schedules are developed for individual and group therapy, appropriate time frames must be developed which do not interfere with institutional routines.

If bonafide therapeutic needs exceed the capability of the staff, consideration will be given by the Chief Psychologist to consultations with external experts on a schedule similar to the Consulting Psychiatrist. This activity will require the concurrence of the Business Office and approval of the Warden.

C. PHYSICALS

Even though the Classification Manual describes the process, it will be the Case Manager's responsibility to monitor and insure that the entire process is completed.

D. BUSINESS OFFICE

The Case Manager should double check to make sure the inmate understands the inmate accounts system which includes the inmate pay plan.

E. EDUCATION DEPARTMENT AND VOCATIONAL TRAINING

The Education and Vocational Training Units are very active in recruiting for their programs. However, the Case Manager must also accept this as an on-going and vital challenge. Individual inmate programs should be discussed with the head teacher and/or the unit head of Vocational Training. Conversely, these units' leaders should make referrals to the Case Managers to solve problems to avoid disciplinary reports or negative spot reports. The Case Manager will monitor the monthly work reports. Inmates should understand the Prison's On-the-Job Training Program, (Appendix E).

F. ALCOHOL AND DRUG

An Alcohol/Drug Counselor will conduct both individual and group therapy on a referral basis from the Case Managers. Progress reports will be provided the Case Manager by the Alcohol/Drug Counselor. The Alcohol/Drug Counselor will be the contact point for drug and alcohol related community resources. The Alcohol/Drug Counselor and the Case Manager will prepare a comprehensive plan for drug and/or alcohol dependent inmates. These plans usually take the form of institutional programs while incarcerated and in many cases, community programs following the inmates release. Some individualized plans can encompass the complete parole period, which may well result in a changed lifestyle for the inmate, Appendix B.

G. VOCATIONAL REHABILITATION

The Classification Manual, in positive language, states: "Interviews each inmate in an attempt to provide early identification of potential vocational rehabilitation candidates". Also: "During this session, the Vocational Rehabilitation staff will discuss the vocational rehabilitation program with each inmate. . ." The Case Manager should be aware of any action taken by Vocational Rehabilitation with inmates on his case load which will be a necessary part of the total continuity of service, both during and following the incarceration of that inmate.

H. INITIAL CLASSIFICATION HEARING

Upon completion of the Reception Process, the inmate will appear before the Classification Board for his initial classification hearing. At this point, certain assignments, such as custody grade, housing, special status, if any; to include his legal status, will be determined. He will be assigned to a work/training assignment and again encouraged to participate in appropriate educational opportunities. It is imperative that the Case Manager attend this session since it represents the beginning of services provided to a particular inmate. If for some overriding reason, the Case Manager cannot be present, a detailed written proposal will be prepared for use by the substitute Case Manager assigned by the Chief Psychologist.

CHAPTER IV

SOME SPECIFIC COMPONENTS

A. CUSTODY GRADES

At the Initial Classification Board Hearing, each inmate's custody grade is established. The Case Manager recommends a custody grade consistent with the degree of supervision or restraint required to insure the inmate's security and control. The Case Manager must be fully aware of all the implications in each custody grade described in the Classification Manual, Chapter IV.

MEDIUM CUSTODY

Since the majority of inmates are in this custody classification, most critical programmatic experiences receive their formulation here. These inmates do not regularly demonstrate dangerous or violent characteristics and do not constitute a sufficient escape risk to warrant classification in Maximum Custody. However, continuous custody supervision is usually required. Many inmates will be released from Prison from this classification who may in one form or another, resist the correctional process. The Case Manager will have to devote most of his time to this population. The most successful approach to the inmates in this custody grade is to maximize their involvement in the various habilitative resources of the Prison.

It must be very clear that release from this status is from physical constraint to freedom on the street. Without careful individualized planning, this population is especially vulnerable to failure. This is not to say that other inmates should be neglected. Each inmate regardless of their custody grade should have an individualized plan.

MAXIMUM CUSTODY

The Case Manager should realize that although inmates in Maximum Custody are regularly reviewed at 60 day intervals, it is sometimes difficult to identify positive facts to the Classification Board that merit custody change. Facts should be developed accurately and in detail if a proposed change in custody is to be supported. The Classification Board will review work reports and evaluations filled out by the Annex Correctional Staff. The Case Manager should work in concert with this staff. Many times, these resources can work together to resolve inmate problems* which have resulted in a maximum classification.

* Consideration toward release from Maximum Custody status must rationally address the basis for Maximum Custody in the first place and demonstrate why these conditions no longer exist or no longer require Maximum Custody.

The Case Manager must not be naive to circumstances which warrant Maximum Custody status. There are rare cases in which some inmates may remain in Maximum Custody until release. The Case Manager, in concert with Pre-Release, must have detailed plans for this type of inmate.

B. HOUSING

Case Managers must familiarize themselves with various housing assignments made by the Classification Board. Refer to the Classification Manual, Page 13-14.

C. SPECIAL STATUSES

All Case Managers must be familiar with special custody status as outlined in the Classification Manual, Page 14, Item C - Page 20.

The Case Manager must familiarize himself with all the facts and work with those involved but should never function in such cases independently. Uncoordinated action on the part of the Case Manager during investigative procedures undertaken by Custody could result in problem generation. The Classification Board's responsibility regarding Administrative Segregation is to review the facts and circumstances regarding the imposition of this segragation and will either order the inmate released from Administrative Segregation or will order continuation until such time as the Disciplinary Hearing and/or Judicial Tribunal can be scheduled. In any case, the Case Manager must provide those facts needed by the Board and be prepared to present them to the Board. Facts concerning an inmate's program at the time of an infraction is one important example of information needed as the Board convenes.

GUIDELINES FOR MEDICAL SEGREGATION

In addition to the comments delineated in the Classification Manual, Page 16-17, there are certain functional aspects involving Case Management. The following individuals can implement Medical Segregation: the Physician, Psychiatrist, Psychologist, and Director of Treatment only if one of the aforementioned is not available. The determination shall be made by the staff members based on an examination and/or reports from the Case Manager. These orders must be written and immediately placed in both the Medical and Inmate's Classification Files. Subsequently, Custody must be notified and thoroughly briefed as to the circumstances involved indicating the estimated duration of this classification.

Inmates held in Administrative Segregation/Medical shall be visited by the Psychiatrist or Psychologist or Case Manager as determined by the professional imposing the segregation. It is imperative that a plan be developed with defined time frames for the duration of the inmate's stay in Medical Segregation. The Case Manager is responsible to monitor these plans in regard to time frames, since the program elements of each inmate's stay at the Prison are the responsibility of the Case Manager and since he must constantly update the chronological record of each inmate assigned to his caseload. In many cases, the Case Manager will be eliciting

appropriate information from the Prison Physician and/or Charge Nurse. In some cases, the inmate may be able to work or participate in recreation. However, in such cases, other units within the Prison must be provided with rationale for this activity since it may in many cases, seem inconsistent.

In any case, the constraints and privileges associated with that condition for a particular inmate will be specified in detail and will become part of the correctional folder.

As was stated previously, if referrals or transfers should be made to other facilities for medical or psychological review, they must be approved by the Physician, Psychiatrist, or the Chief of Mental Health; and in their absence, the Director of Treatment. Except in obvious emergencies, transportation must be arranged with Custody with at least 48-hour notice. Transfers outside the walls of the Prison for other than routine treatment of less than 24 hours must have approval of the Warden or Senior Duty Officer. In all cases, chronological and comprehensive progress notes during this period of Medical Segregation may not be generated in all areas by the Case Manager himself, but he is responsible for assembling this information.

PROTECTIVE CUSTODY

"Protective Custody is a status assigned to an inmate based on his written request for personal protection". The Case Manager should discourage this status when unwarranted. The Case Manager should be aware of each request early since he may obtain facts that will contribute to the Classification Board and their recommendation which is made to the Warden. All available facts should be in the Warden's hands. It is the responsibility of the Case Manager to make sure the the Classification Board is provided with current facts so that sound decisions can be made.

The inmate must submit a request to his Case Manager if he wishes to be removed from this status. These requests require special effort since the Case Manager may have to work carefully with Custody and in some cases, validate some facts from outside resources. The Warden may remove this status either upon the inmate's request or over his objection following a due process hearing. Protective Custody exists only in Medium Custody. It does not apply in Maximum or Minimum Custody.

The Case Manager must not loose sight of the fact that Protective Custody inmates must be separated from all inmates who are not Protective Custody unless their activities are monitored closely by Custody Personnel or other staff, authorized by the Major.

The Case Manager must have a carefully designed plan each time a Protective Custody inmate is involved with the various programs within the institution. The Case Manager must accept this as a challenge since all of the Protective Custody inmates must be involved in individualized programs. Many are now involved in Prison industries, but every effort must be expended through careful scheduling of available resources to allow participation.

TEMPORARY CONFINEMENT OF AN INMATE TO HIS CELL

The Case Manager should refer to the Classification Manual #5, Page 19, for a complete description of this status.

Many times, a Case Manager will be called in this situation. Since this is a temporary situation, the Case Manager should assess the situation as quickly as possible. If the situation demands the Deputy's evaluation and the status is continued, the Case Manager will then prepare to assist if requested in a Classification Hearing.

If in the General Population, this hearing will occur within three days. A hearing could result in a General Population inmate being placed in Maximum Custody and if he is temporarily confined to his cell, his progress will be reviewed daily by the Case Manager who will submit a daily report to the Warden or Deputy Warden.

Any inmate placed in temporary confinement must be visited each day by the Case Manager and an accurate record kept of these visits. (A behavioral description of the inmate would be helpful.)

D. LEGAL CONDITIONS

There are a variety of legal conditions of which the Case Manager must be familiar. Refer to Classification Manual, Item D.M. 19.

1. Sentenced: An inmate who has been sentenced to a specific term by a New Hampshire State Court. The Case Manager must keep updated in the current methods of assessing "good time", i.e., when it is taken away, given, etc. The minimum release date is an important piece of information that each Case Manager must know about each assigned case.

2. Pre-Trial: An inmate who is being held for trial by a court and who is not serving a sentence. The Case Manager must keep updated on these inmates. In many cases, time can be saved at a later date since the inmates following trial become a sentenced prisoner with the original program being continued.

3. Parole Violation: Inmates returned from parole based on a particular breach of parole and who are being held pending a parole violation hearing. The Case Manager should try to relate failure on parole to a weakness that may be addressed by initiating some planned activity for the inmate.

4. Federal: An inmate not held under State authority but under Federal authority. Classification may be able to confirm in most cases the length of stay of this inmate. There are certain considerations such as major medical costs and others which need special approval for these inmates. If there are any doubts

in these areas, the Case Manager should contact the Classification Office. Most often, these individuals will be here only a short time.

5. County: A post-trial inmate held under county authority. In many cases, these inmates were management problems in the county facility. Again, certain arrangements must have approval from the county and if there is any doubt, the Classification Office should be contacted.

6. Transferee: An inmate who was originally sentenced and convicted in another state and who, under the Interstate Transfer Compact or by some other agreement, is now confined in the New Hampshire State Prison serving a sentence imposed by the authority of another state. The Case Manager must be familiar with each case's unique arrangement with the state involved. If there are any doubts, this should be discussed with the Classification Office.

E. WORK/TRAINING ASSIGNMENTS

A goal of the New Hampshire State Prison is to involve all prisoners, with the help of the Case Manager, in a type of individualized plan which will provide for participation in one of the programs of the Prison designed to assist the inmate in preparing for successful re-entry into society. This is the primary responsibility of Case Management.

Since the Prison is involved in developing and maintaining special programs, each Case Manager must familiarize himself with them and try to institute a program match with each inmate in the population. Case Managers are obligated to cooperate with work supervisors to maximize the benefits of each program. Each Case Manager must constantly re-assess his own philosophy along with the Prison philosophy so that inmates are programmed toward useful activity which will enhance the likelihood of his success.

The New Hampshire State Prison is relatively small, which should allow all employees to accept the responsibility of developing a model of cooperation, continuity and professionalism. The Case Manager must constantly consult Custody staff directly involved in their efforts, or they will fail. It will be the responsibility of each Case Manager to seek out methods whereby all employees will become a part of the scheme of habilitation.

CHAPTER V

CASE MANAGER DATA BASE

This section of the Classification Manual is written clearly and definitively. Some elaborations are mentioned in order to completely define the role of Case Management.

The data base on which the initial and subsequent Case Manager recommendations and decisions are based is a compilation of all relevant information that is available at the facility at the time that particular case management contact takes place. The information is examined in light of the various criteria for custody and programs to determine the custody grade and program the inmate should be placed in or encouraged to participate in. Should there be gaps or missing links in the data base, the Case Manager undertakes to fill these gaps by collection of the data from the appropriate source. The data is a mixture of information provided by people who have had contact with the inmate and by the inmate himself. This data base includes essentially the following items:

A. PSYCHOLOGICAL EVALUATION

A psychological evaluation is furnished by the Psychologist. It includes the Psychologist's impressions of the individual; a summation of the information furnished to the Psychologist relative to the confining offense and the individual's background; the inmate's desires, goals and interests; the results of diagnostic administered by the Psychologist; and any recommendations by the Psychologist relative to the individual's program in confinement and direction which seems useful for him in Pre-Release. In most cases, a format of strengths and weaknesses is more useful for Case Managers and Prison Officials.

B. SOCIAL HISTORY

Social History information is furnished by a Case Manager. It includes information largely obtained in interviews with the inmate. Items which are verifiable by a probation report or other factual data are verified or modified as appropriate by the Case Manager. Based on an interview with the inmate, the Case Manager is to make referrals to Medical, Dental or other appropriate activities. During the interview, the Case Manager should encourage the inmate to participate in appropriate programs. The social history statement is prepared by the Case Manager, and should include notations as to all such referrals and recommendations and should also include recommendations towards the prisoner's correctional treatment program and post-release plans. These should be written clearly and briefly.

C. EDUCATIONAL HISTORY

The Educational History includes both data furnished to the Case Manager by the inmate and the educational staff during the reception cycle. It includes results of tests administered and includes a recommendation as to the appropriate educational program for the inmate to follow while in confinement. The Case Manager should coordinate these reports with the individual responsible for instruction. However, the Case Manager is ultimately held accountable for this information becoming part of the inmate's file.

D. MEDICAL LIMITATIONS

Information regarding medical limitations identified by the Doctor in the reception physical is to be considered by the Case Manager in designing and implementing the inmate's program within the institution and in advising him with respect to post-release plans.

E. DRUG AND ALCOHOL HISTORY

The inmate's drug and alcohol history and his reaction and acceptance of or rejection of the existence of a drug/alcohol problem must be evaluated and assessed. If a drug/alcohol abuse history exists, he should be encouraged to participate in appropriate programs for counseling and rehabilitation. Such programs should be designed to monitor the inmate's progress with his particular problem. The Alcohol/Drug Counselor should advise the Case Manager of the inmate's progress on a regular basis, Appendix B.

F. INMATE'S INTERVIEW AND GOALS

The inmate's goals in life, work goals, family goals and other goals, his outlook on life and his motivation are discussed with the inmate by his Case Manager so that his input and the way he sees his future can be integrated in the correctional treatment plan. If the inmate's goals appear unrealistic, he is so advised and; where appropriate, he is counseled to seek assistance toward establishing more realistic goals for his future. Other information furnished by the inmate that is relevant may form the basis of decisions regarding placement into programs.

G. WORK HISTORY

Work history is largely furnished directly by the inmate to the Case Manager and involves the type of work he has done and with respect to his particular abilities, things which he has liked to do, work in which he has been successful and work in which he has been unsuccessful and an assessment of his relative abilities and relative skills. The work history is also based, to a degree, on work reports received by the inmate while at the Prison and sent to his Case Manager. Documentation of previous work history is important when it is possible to obtain this information. Inmates may also be given a battery of vocational tests during the quarantine process.

H. INMATE'S INSTITUTIONAL WORK RECORD

The inmate's institutional work record is considered during periodic discussions with his Case Manager. Also, the Case Manager should utilize the monthly work reports of the inmate. Certain inmate's will be carefully evaluated using a base-line method or something agreed to or both. It is the Case Manager's responsibility to return the Inmate's copy (pink) to each inmate after careful review.

I. CURRENT CONFINING OFFENSES

This information is obtained from legal documentation which accompanies the inmate to the Prison or is sent after admission. The Classification Officer is the point of contact between the institution and local police. When a report from the arresting agency is not available in the file, the Case Manager is responsible to follow-up and obtain same through the Classification Officer. It includes information concerning the inmate's conviction and the specifics of the offense committed. The Case Manager elicits from the inmate his version of the confining offense and determines what differences, if any, there are from the legal language and the actual confining offense charge. The Case Manager should never lose perspective of the inmate's criminal history. The Case Manager's decisions may be questioned based upon the extent of the inmate's previous criminal behavior.

J. PRIOR OFFENSES

This is determined by the Case Manager from information furnished by the inmate, information in the Prison files and information furnished by the F.B.I. and other criminal intelligence agencies. The Case Manager should have some assurance that the inmate's reports have validity. A lack of inmate validity may indicate the type of therapy and/or program planning for the inmate.

K. SENTENCE LENGTH

The length of the inmate's sentence has a definite bearing on the types of programs for which he is eligible and the timing of those programs. The inmate's sentence length must be considered by the Case Manager in determining the appropriate program. Timing is very important within a Prison setting.

L. ESCAPE RISK ASSESSMENT

An escape risk assessment must be provided by the Case Manager with respect to each prisoner at the Initial Classification Hearing based on a careful evaluation of a variety of factors. Since it is presumed that most inmates would escape if given an easy means of escape, the issue is not whether an inmate would escape if provided the opportunity to do so, but rather to what lengths he would go to escape. The information considered by the Case Manager in making the assessment includes the length of the sentence, any documented

propensity towards violence or escape, any current family problems which might be considered by the inmate as to require his presence at home, previous examples of minimal supervision, and any other matters which would help the Case Manager to determine the likelihood that the inmate will attempt to escape. The Case Manager will review the original assessment of an inmate's escape potential during each updating of the inmate's file.

M. INSTITUTIONAL VIOLENCE RISK ASSESSMENT

The Case Manager is also responsible for assessing the likelihood that particular inmates will engage in violent conduct while in the institution. The criteria for assessing the inmate's "violence risk" include the frequency, severity and circumstances of previous violent acts, if any. It is essentially a determination as to whether he poses a substantial risk of violence while in confinement. The same criteria should be used to update this risk during the inmate's tenure at the Prison. Written documentation of this assessment is usually necessary for decision-making by the Administration and various boards. If there are doubts in this area, the Case Manager should consult with the Chief Psychologist.

N. INSTITUTIONAL BEHAVIOR

At all such hearings, the inmate's institutional behavior pattern is considered as is available and compared to prior confinement experience at the New Hampshire State Prison or if other confinement institution records are made available. The likelihood of the inmate being able to serve his confinement with a minimum of violence while at the institution is assessed initially and on an on-going basis.

O. CO-DEFENDANTS, INFORMANTS OR VICTIMS

Because of the interaction among inmates within the institution, the potential danger of having present in the same institution, co-defendants in the same crime who may have testified against each other, or informants whose testimony helped convict others in the Prison, or victims of offense, whether committed within or without the institution, and the type and circumstances of the offense must be considered in determining the appropriate custody grade and living accommodations for individual inmates. The Case Manager should attempt to assist Classification in validating this information.

P. PRE-SENTENCE REPORT INFORMATION

Pre-sentence report information furnished by the Probation Officer is often available to the Case Manager to be studied. This data is particularly useful and while not always absolutely accurate, it does provide some additional information for the Case Manager's recommendation along with data provided by the inmate and it may shed additional light on the inmate's pre-confinement social history.

Q. POLICE REPORT INFORMATION

Information furnished by the Police to court for the committing trial itself and information contained in Police files about a particular inmate may be helpful in illuminating the inmate's background and past behavior patterns. This information may enhance the possibility that a successful correctional treatment program can be developed for the inmate, which in turn, will help preclude future criminal acts. Police report data sometimes contains unsubstantiated allegations which cannot be supported by fact. Such data considered relevant will be assessed carefully by the Case Manager. The inmate's version of these incidents should also be considered.

R. THERAPEUTIC COUNSELING

If during the initial contact with the inmate and based upon data received from various sources, the Case Manager believes that an underlying personal or emotional problems exists, the Case Manager should make a recommendation that the inmate participate in an appropriate counseling program. Since motivation plays a vital role and determines the degree of progress made in any counseling relationship, it is necessary that the inmate concerned accepts the premise that a problem exists and agrees to enter into counseling. The Case Manager on the basis of this agreement, will then as part of the Mental Health Unit, accept the individual and schedule regular counseling sessions or refer the matter to the Chief of Mental Health for assignment to another member of the Mental Health Unit staff. Again, careful scheduling can minimize request slips and custody problems. In the event an inmate will not admit to a problem initially, the Case Manager should schedule this person for at least weekly contact in his role as Case Manager; not Mental Health Counselor, in an attempt to gain the inmate's confidence so as to guide him into the appropriate mental health program.

S. CHIEF OF MENTAL HEALTH

The overall functions of the Mental Health Unit of which Case Management is a part is under the supervision of the Chief of Mental Health. Inmates considered by the Case Manager as needing to be committed to the New Hampshire Hosptial or to be placed in Medical Administrative Segregation will be referred to the Chief of Mental Health for final action. Any other issues or problems that are considered to be of an unusual nature or requiring additional input should be referred to the Chief of Mental Health for consideration and disposition. The Case Manager as a member of the Mental Health Staff and particularly in the role of a counselor, should feel free to consult with the Chief of Mental Health regarding problems related to the counseling process or any other issues associated with the total Case Manager/Counselor role. Confusion in this area without seeking the advice and counsel of the Chief of Mental Health will not be a reason to neglect responsibility.

T. DATA COLLECTION

See Appendix F for a description of the data base that will be programmed and stored in the computer for immediate access. This data will assist in the selection of proper custody grades, individual programming, parole recommendations, etc.

CHAPTER VI

CLASSIFICATION BOARD PROCEDURES

The Case Manager must be completely familiar with Chapter VI of the Classification Manual.

The composition of the Board is very important if the Classification Board is to have validity (that it does what it purports to do with maximum utility). The facts of each case are to be accurately represented at each Board proceeding. Since the inmate can and will be encouraged to submit matters either orally or in writing for the Board's consideration and will be expected to participate in the Board proceedings but will not be present for the discussion of his case or while members are voting on the action to be taken, it is necessary that the Case Manager either contribute to the composition of the Board or be present to present current information germane to the problem at hand. The Board may also convene if the inmate for some reason is not present. Without the Case Manager's input, the Board will have difficulty in arriving at the best recommendation. The Case Manager can facilitate the inmate's communication to the Board, if appropriate. It will be necessary for each inmate's Case Manager to attend each hearing or an authorized substitute appointed by the Chief of Mental Health. Substitutes must be approved in advance and have the data from the Case Manager so as to be effective.

A. BOARD COMPOSITION

The Board composition will always include the Case Manager or a substitute present for each hearing. Refer to the Classification Manual, Page 27, Item 13 for a description of Board composition.

B. AUTHORITY OF THE BOARD

The Board has the authority to review the circumstances of an inmate at any time it seems worthwhile. EXAMPLE: A work supervisor who feels that he has been unable to cope with an inmate problem may, through the Case Manager, request that the inmate be seen by the Classification Board. After the Case Manager has thoroughly reviewed the case and if the supervisor and Case Manager cannot resolve the problem, a hearing will be scheduled. Resolution without a hearing must become a matter of record signed by the inmate and work supervisor. In some cases, a mini-contract (agreement) may be necessary to avoid a repetition of the same problem and to provide a written record of the event and circumstances.

Other than requests from the Warden or Deputy Warden, the Classification Office will not schedule special hearings without the involvement of the Case Manager and those involved in the problem. A Case Manager

must recognize the necessity for punishment as well as rewards in the rehabilitative process. Failure to recognize necessary punitive aspects during incarceration will represent a lack of professional awareness. Most Board actions will seek positive solutions to problems.

The Classification Board takes no final action by itself but rather recommends action to the Warden. As outlined in the Classification Manual, Page 28, the Warden's decision will be written, in the form of an endorsement, on the Board's recommendation regardless of whether he affirms or alters the Board's decision. The Case Manager should be prepared to discuss a case with the Warden upon request, and Case Managers can discuss cases with the Warden or Deputy at any time although the Chief of Mental Health should ordinarily be consulted first.

In addition, the Case Manager is responsible to insure that the Classification Board review his maximum custody inmates at 60 day intervals, at which time the Case Manager will provide a current report of the inmate's behavior which should be directly related to previous behaviors. Current vs. previous behaviors are important at these hearings.

Records of the Classification Board serve as the institutional memory relative to an inmate's status changes. The Case Manager when appropriate, must see that interim reports are placed in the inmate's file. The Case Manager should be aware that the Board will assess chronological entries.

C. ROUTINE BOARD PROCEDURES

In a typical case, a background sketch is provided to the Classification Board by the Case Manager. Quality will be emphasized as opposed to quantity. The Board shall review particular information provided by Custody or other Board members. The Board is then qualified and obligated to explain possible changes which may occur as a result of Board action. Subsequently, after the inmate is dismissed from the Board, a recommendation is made relative to each of the program components including custody grade. Voting occurs and a recommendation is prepared for presentation to the Warden. A majority vote is necessary to affect change. However, a minority opinion along with the Case Manager's statement, can be presented to the Warden by any Board member who does not believe a particular program or component serves the best interest of the inmate. All of the material in the case is presented to the Warden for a final decision and then is returned to the inmate's file.

D. ANNOUNCEMENT OF ACTION

Following final action of the Warden, it is the Case Manager's responsibility to reveal the decision to the inmate in writing. The Case Manager will summarize the decision to determine if full disclosure would be considered detrimental to the inmate's best interest.

If a summary is used, a narrative of the summary must be placed in the inmate's file. However, to avoid possible litigation, the inmate must indicate that the results are understood even though he may not concur.

Inmates who are not satisfied with or don't understand the results of the Board, may request via an Inmate Request Slip to Classification, who will refer the matter to the Case Manager if necessary. If the Case Manager cannot resolve the problem, an audience with the Chairman of the Board may be appropriate. If the Case Manager does resolve the problem, a report of the resolution must be provided the Board Chairman with a copy placed in the inmate's file. In any case, complete resolution must be on record. If the inmate still does not accept resolution of the problem, he may send a written appeal to the Warden or Deputy Warden on an Inmate Request Slip. At this point, the Warden or Deputy Warden may ask for a comprehensive report from the Case Manager in order to resolve the problem.

CHAPTER VII

INMATE SCHEDULING

The Case Manager should also be aware of "Special Classification Board" hearings that may occur out of normal sequence for such reasons as a custody change. The Case Manager must notify the inmate at least three working days prior to his appearance before the special board. The Case Manager is responsible for any current information both positive and negative which will have relevant importance to this hearing. The Case Manager is held accountable for this information. Since these board hearings are "special" board hearings, the Case Manager should sample all resources for information, i.e., each activity the inmate is involved in, including custody.

On-going scheduling is an integral part of an inmate's total period of incarceration. Every inmate's progress in his individualized program is reviewed with him at regular intervals. It is the Case Manager's responsibility to help him plan these programs such that appropriate placements are made within the evaluations.

Again, by way of review, an inmate should, with the help of the Case Manager and in concert with the Pre-Release Unit, begin to make plans approximately eight to nine months from the inmate's minimum release date. The Case Manager is responsible to assist the inmate and the Pre-Release Unit with the implementation of these plans. These plans must be realistic and not geared toward failure. In difficult cases, the inmate must be made aware of the realities of his situation.

As stated in the Classification Manual, Cahpter VII, Page 31, " . . if he (the inmate) has not or is not likely to be transferred to the Minimum Security Unit or the Halfway House, he will be encouraged to participate in programs and activities dealing with post-release, job and living arrangements which, along with the Parole Department, will assist him in the preparation of a Parole Plan. Some plans must have continuity from the Prison to other resources within the community.

CHAPTER VIII

ADMINISTRATIVE BYPASS OF THE BOARD

In some cases, an inmate desires to change his living accommodations or his work assignments during periods of time between regularly scheduled Classification Boards. The Administration has a mechanism for this process.

An inmate must initiate an Inmate Request Slip which has to be approved by the Activity or area out of which he wishes to transfer, into which he wishes to transfer, custody and the Case Manager. The Case Manager must then contact the Classification Office to register their approval that no Classification Board is necessary. If the Case Manager does not receive consensus of all parties, the Case Manager must inform the inmate within three days. Should the inmate still wish to pursue a transfer, he must address this request to the Case Manager who will arrange a Board hearing. At this point, the Case Manager is obligated to write a brief description of all relevant facts of the case in preparation for the Board. The Case Manager must follow the guidelines outlined in the Classification Manual, Chapter VIII, Page 32.

CHAPTER IX

INMATE REQUESTS TO APPEAR BEFORE THE BOARD

The Case Manager will refer to the Classification Manual, Chapter IX.

The Case Manager will attempt to resolve the problem and enter the results in the inmate's file. If the Case Manager cannot resolve the issue and the request is sound and sensible, the Case Manager will schedule the inmate to appear before the Board and inform the inmate. The Case Manager will immediately update the inmate's progress and help make preparation for the inmate to appear before the Board. The Case Manager should not hesitate to explain to the inmate when the request is inappropriate or unreasonable. Disapproval by the Case Manager should be accompanied with a statement that the matter which the inmate seeks to bring before the special board will be considered at his next regular board hearing. This statement must be signed by the inmate.

CHAPTER X

ADMINISTRATIVE PROCESSING

In the normal process, notification of a Classification Board hearing will be sent to the inmate, the Case Manager, work training supervisors, custody supervisors, investigation branch, education branch or to any other activities of the Prison which may have information relative to that particular inmate. It will be the Case Manager's responsibility to assemble these documents and provide updated overviews at the Classification Board hearings. All of the documents involved will be placed in the inmate's file.

Reference must be made to the Classification Manual, Chapter X.

SECTION A

CASE MANAGER PROCEDURES

INITIAL INMATE CONTACT

Inmates, while in quarantine status, are assigned a Case Manager on a rotating basis by the Unit Secretary. These assignments are monitored by the Chief of Mental Health.

The intake interview and psychological testing will be done in the Mental Health Unit. This is to facilitate the gathering of information that is necessary for current and future case management. It will also acquaint the inmate with the Mental Health Unit and its' facilities.

A Case Manager who wishes to see an inmate will notify Control by use of a "Request to See" slip. The inmate will be received at Control and escorted by the Case Manager to the Mental Health Unit. Upon completion of the staff contact, the inmate will be escorted back to Control for return to quarantine status.

INITITIAL CLASSIFICATION CONTACT

The intake and psychological data are evaluated with recommendations made to the respective Case Managers for programs based upon expressed and evident needs of the inmate. This data will be presented and discussed at a regularly scheduled Classification Board meeting. An intake summary form will accompany the program review form for the Warden's review and consideration.

ANNEX CONTACT

The Case Manager will call the officer in charge of the Annex to arrange a time for specific inmates to be seen that day. The vestibule or another designated area will be used as the primary area to see an inmate unless the Case Manager considers the reason for the inmate contact to be of such a nature that the inmate could be conveniently seen in his cell or on the tier.

A Case Manager involved in a crisis intervention situation will consider the issues of security and control as it involves a particular inmate's behavior and emotional condition. If an assessmentof the facts as presented by the officer in charge indicates that an inmate seen out of his cell would create an undue hazard, the Case Manager will see that particular inmate on the tier.

NEW HAMPSHIRE STATE PRISON

INTAKE SUMMARY

NAME:_____AGE:___D.O.B._____MRD:_____

DATE:_____PREPARED BY:_____

SUMMARY OF SOCIAL AND EMOTIONAL FUNCTIONING:

RECOMMENDATIONS:

INTAKE DATA

MITTIMUS

CRIMINAL HISTORY

PSYCHO/SOCIAL HISTORY

EDUCATION	MILITARY	RELIGION

DRUG & ALCOHOL

OCCUPATIONAL

MEDICAL/DENTAL

MENTAL HEALTH BACKGROUND

PLANS & GOALS

OTHER:

CASE MANAGER DATA SHEET

INMATE: _____ DATE: _____

WORK REPORTS AND COMMENTS						
DISCIPLINARY REPORTS						
INCIDENT REPORTS						
SPOT REPORTS						
EDUCATION REPORTS AND COMMENTS						
VOCATIONAL-ED. AND COMMENTS						
CUSTODY CHANGES						
PRE-RELEASE						
VOC-REHAB						
GROUP PARTICIPATION						
OTHER						
CLASSIFICATION APPEARANCES AND RESULTS						

SECTION B

ALCOHOL/DRUG COUNSELING PROGRAM

REFERRAL-ASSESSMENT CONSULTATION SERVICES

A. Case Manager Referral for Assessment Evaluation

1. Case Manager refers inmate when court recommendation or stipulation is discovered upon intake.

2. Case Manager refers inmate when in the inmate's and/or Case Manager's opinion the inmate is in need of services.

3. Referrals should include rationale for referral and expected service needs of client.

4. Referrals work be accepted from Case Managers only. Referrals from other sources will be redirected to the Case Manager.

B. Referral is received by Alcohol/Drug Counselor and an appointment will be scheduled for referred inmate. Inmate is then notified of appointment date and time. Referral form filed in inmate's mental health file.

C. Assessment of Dependency and Readiness for Treatment

1. Confer with referring Case Manager.

2. Review of Institutional records;

a. Psychological Evaluation
b. Social Intake Profile
c. Previous treatment records
d. Classification file

3. Assessment Interview

a. Assessment questionnaire administered (Attachment A)
b. Assessment interview for treatment plan development administered (Attachment B)
c. Multiphasisc Matrix for the Diagnosis of Alcoholism Scoring Profile is completed (Attachment C)
d. MMDA Narrative Statement is completed (Attachment D)

4. Assessment interview results returned to referring Case Manager for review with inmate.

a. Case Manager then places results in inmate's mental health file.
b. Case Manager and inmate determine what information will be released and to what agencies or departments.

5. Case Manager and inmate discuss and determine if alcohol/drug counseling services are needed.

   a. If involvement is determined to be appropriate, statement referred back to Alcohol/Drug Counselor for program scheduling.

   b. If involvement is determined to be inappropriate, statement to that effect should be placed in the mental health file.

6. Upon referral for services, Alcohol/Drug Counselor and inmate discuss options and needs and complete treatment.

7. Treatment Planning Guide Outline is placed in mental health file.

ALCOHOL/DRUG COUNSELING PROGRAMMING COMPONENTS

A. Alcoholics Anonymous Weekly Meetings

   1. General Population Meeting - Thursday, 7-8:30 p.m.
   2. Minimum Security Unit Meeting - Thursday, 7-8:30 p.m.

B. Substances of Abuse Education Class

   1. Will meet twice a week in six week cycles
   2. Will be worth 1/4 credit toward education requirements
   3. Maximum number of participants will be twelve (12)
   4. Will meet in Classroom #2 at 2 p.m. on Tuesdays and Thursdays
   5. Tentatively scheduled for closed circuit T.V. broadcast to Protective Custody and Maximum Custody inmates.

C. Group Counseling Program

   1. Protective Custody - Substance Dependency Group

      a. Will meet in Industries Building (P.C. Classroom)
      b. Will meet at 3 p.m. on Tuesdays
      c. Maximum number of participants is ten (10)

D. Individual Counseling

   1. On a one-hour a week basis
   2. Maximum number of participants is ten (10)

ALCOHOL/DRUG COUNSELOR -- WEEKLY TIME EXPENDITURE APPROXIMATION

A. Individual Counseling. . . . . 10 hours per week

B. Group Counseling . . . . . 2.5 hours per week

C. Education Class. . . . . 2 hours per week

D. Supervision of A.A. Meetings . . . . . 3 hours per week

E. Referral and Assessment Services . . . . . 10 hours per week

F. General Institutional Assistance . . . . . 10 hours per week

i.e., 1. Inputs for Classification Board hearings
2. Input for Parole Reports
3. Input for Parole Board hearings
4. Court correspondence
5. Correspondence with and coordination of community alcohol/drug treatment resources.

Attachment A

ASSESSMENT QUESTIONNAIRE

INTERVIEWER: Determine the answers to questions 22 and 23 for client during the past 30 days (if client drank during the past 30 days) *OR* for the most recent 30-day period when client was drinking.

22. DRINKING QUANTITY AND FREQUENCY *(Be sure to complete quantity for each type of drink)*

	BEER	WINE	LIQUOR
(a) About how often did client drink? FREQUENCY:	1 ☐ Every day 2 ☐ 5-6 days a week 37 3 ☐ 3-4 days a week 4 ☐ 1-2 days a week 5 ☐ Less often than weekly 6 ☐ None	1 ☐ Every day 2 ☐ 5-6 days a week 38 3 ☐ 3-4 days a week 4 ☐ 1-2 days a week 5 ☐ Less often than weekly 6 ☐ None	1 ☐ Every day 2 ☐ 5-6 days a week 39 3 ☐ 3-4 days a week 4 ☐ 1-2 days a week 5 ☐ Less often than weekly 6 ☐ None
(b) About how much did client drink in a typical day in which he drank? QUANTITY:	1 ☐ 6 quarts or more 2 ☐ 5 quarts or more 3 ☐ 4 quarts or more 40 4 ☐ 3 quarts or more 5 ☐ 1-2 quarts 6 ☐ 1-3 glasses 7 ☐ None	1 ☐ 5 fifths or more 2 ☐ 3-4 fifths 3 ☐ 2 fifths 41 4 ☐ 1 fifth 5 ☐ 2 water glasses or 3-5 wine glasses 6 ☐ 1 water glass or 1 or 2 wine glasses 7 ☐ None	1 ☐ 4 pints or more 2 ☐ 3 pints 3 ☐ 2 pints 42 4 ☐ 1 pint 5 ☐ 8-10 shots or drinks 6 ☐ 5-7 shots or drinks 7 ☐ 3-4 shots or drinks 8 ☐ 1-2 shots or drinks 9 ☐ None

NOTE TO INTERVIEWER: 1 quart = three 11 oz. bottles (cans) or four 8 oz. glasses. 1 fifth is a standard size bottle and is equal to about three 8 oz. water or six 4 oz. wine glasses. There are 5 fifths in a gallon or 2½ fifths to a half gallon 1 pint = 16 oz. or just over ten 1½ oz. shots. There are 2 pints in 1 quart and a little over 1½ pints in a fifth.

(c) Did client use other substances which affected him like alcohol during the past 30 days? 1 ☐ Yes 2 ☐ No

23. BEHAVIORAL ASPECTS OF DRINKING *(In the past 30 days period of client drinking)*

43	(a) Number of times drunk	1 ☐ None	2 ☐ 1-4	3 ☐ 5-10	4 ☐ More than 10
44	(b) Longest period between drinks	1 ☐ 12 hrs or more	2 ☐ – – –	3 ☐ Less than 12 hrs	4 ☐ ———
45	(c) Longest period of continued drinking	1 ☐ Less than 6 hrs	2 ☐ 6-12 hrs	3 ☐ More than 12 hrs	4 ☐ – – –
46	(d) Number of days had drink upon awaking	1 ☐ None	2 ☐ 1-4	3 ☐ 5-10	4 ☐ More than 10
47	(e) Meals missed because of drinking	1 ☐ None	2 ☐ 1-4	3 ☐ 5-10	4 ☐ More than 10
48	(f) Drinking alone or with others		2 ☐ Mostly with others	3 ☐ Sometimes alone, sometimes with others	4 ☐ Mostly alone
49	(g) Number of memory lapses or "blackouts"	1 ☐ None	2 ☐ 1-2	3 ☐ 3-5	4 ☐ More than 5
50	(h) Number of times had the "shakes"	1 ☐ None	2 ☐ 1-2	3 ☐ 3-5	4 ☐ More than 5
51	(i) Number of nights had difficulty sleeping	1 ☐ None	2 ☐ 1-2	3 ☐ 3-5	4 ☐ More than 5
52	(j) Number of quarrels with others while drinking	1 ☐ None	2 ☐ 1-2	3 ☐ 3-5	4 ☐ More than 5
53	(k) Drinking while on job/during daily activities	1 ☐ No	2 ☐ – – –	3 ☐ Yes	4 ☐ – – –
54	(l) Days of work missed/days of inactivity because of drinking	1 ☐ None	2 ☐ 1-2	3 ☐ 3-5	4 ☐ More than 5
55	(m) Number of times had hallucinations or DTs	1 ☐ None	2 ☐ 1-2	3 ☐ 3-5	4 ☐ More than 5
56	(n) Number of illnesses due to drinking	1 ☐ None	2 ☐ 1-2	3 ☐ 3-5	4 ☐ More than 5
57	(o) Number of times lost control of drinking	1 ☐ None	2 ☐ 1-2	3 ☐ 3-5	4 ☐ More than 5

24. CLIENT SELF-PERCEPTION OF DRINKING

NOTE TO INTERVIEWER: Question 24 is to determine client's view of his drinking. Do not give your opinion.

How would you describe your drinking behavior at the present time?

58
1 ☐ No problem
2 ☐ Slight problem
3 ☐ Moderate problem
4 ☐ Severe problem

25. INTERVIEWER PERCEPTION OF CLIENT'S DRINKING

(a) Based on this interview and your knowledge of the client, how would you assess the client's drinking behavior?

59
1 ☐ No problem
2 ☐ Slight problem
3 ☐ Moderate problem
4 ☐ Severe problem

(b) Based on this interview and your knowledge of the client, how would you assess the change in this client's drinking behavior since intake? *(Ask ONLY at follow-up)*

60
1 ☐ Worsened
2 ☐ No change
3 ☐ Moderately improved
4 ☐ Greatly improved

79 | 2 | 2 |

ADM 429–2
Rev. 11-75

The information entered on these forms will be handled in the strictest confidence and no individual patient records containing information concerning the identity of the client will released to unauthorized personnel.

CIFF–3

Attachment-B

OUTLINE FOR CLIENT ASSESSMENT INTERVIEW FOR TREATMENT PLAN DEVELOPMENT

I. Client Readiness for Treatment

A. What brought the client to treatment?

1. What ways did your family influence you to seek counseling?

2. What does your family think about you receiving counseling?

3. Were you referred by someone?

4. What, if any, institutional pressures brought you to counseling? (Parole Board, etc.)

5. Have any of your friends been involved in this program?

6. What, if any, medical problems influenced you to seek counseling?

7. Did you decide to come here on your own?

8. What were the reasons for your decision?

9. What caused you to seek counseling now rather than earlier?

10. What has changed?

B. What does the client expect from the program?

1. What type of help do you expect from this program?

2. Do you expect to change before you leave this program?

3. What makes you expect these things to happen?

4. How long do you expect to be part of this program?

5. What do you expect to give you the most trouble in this program?

6. How do your friends feel about you being in this program?

7. What things are working against you?

8. What things are working for you?

9. Who do you think really cares about what happens to you?

10. How are things and people going to change after you complete this program?

C. Has the client had previous counseling experience?

1. What previous counseling experience have you had?

2. How long did you participate in this counseling program?

3. What was it like?

4. What did you like about that program of counseling?

5. What did you dislike about that program of counseling?

6. Why did you discontinue your involvement in that program?

D. Who are the persons to whom you have been closest?

1. Who is the person you feel closest to?

2. How do you feel about them?

3. What do you like about your relationship with this person?

4. What do you dislike about your relationship with this person?

5. What do you do together?

6. How long have you known this person?

7. Do you associate or keep in touch?

E. Quality of client/family member relationships?

1. Tell me about each of your family members:

a. Wife (if any)

b. Children (if any)

c. Mother

d. Father

e. Step-parent

f. Siblings (natural, foster, step, etc.)

2. Has there been any adverse family conditions? (Drug abuse, alcoholism, brutality, incest, unusual sexual behaviors, etc.)

F. Quality of client's relationships with opposite sex and same sex:

1. Do you have many male friends?

2. Which do you enjoy being around more--same sex or opposite sex?

3. Which of the sexes do you get along with better?

4. What is your major sexual orientation? (Gay, straight, bi-sexual)

5. What do you feel is the most important factor that holds marriages or relationships together?

G. Substance abuse history:

1. What types of substances have you used a great deal of?

2. When do you tend to use these substances?

3. Why do you feel you use these substances?

4. What affect does your use of these substances have upon your ability to work and/or maintain a job?

5. What affect does your use of these substances have upon your family relationships?

6. Do you feel that you can control your use of these substances?

7. Physical symptoms related to substance use during last 30 days period of use.

A. Number of hangovers.

B. Number of morning after "nervous stomach" (with or without vomiting).

C. Physician has warned patient to stop or limit his drinking.

D. Ptysical injuries related to drinking (cuts, bruises, sprains, broken limbs).

8. Loss of personal control while using substance during last 30 day period of use.

A. Number of incidents of maudlin behavior (i.e., crying jags)

B. Number of incidents of overly gregarious behavior.

C. Number of incidents of physicial fighting.

D. Number of incidents of sexual promiscuity.

E. Number of incidents of noninterest in one's physical appearance.

F. Number of D.W.I arrests and length of subsequent incarceration.

G. Personal or property damage while drinking.

H. Arrests for disorderly conduct, public nuisance and length of subsequent incarceration.

I. Fugue-like state.

J. Larcenous behavior andlength of subsequent incarceration.

K. Suicide attempts.

L. Impulsive spending or gambling while useing substance.

M. Placement in a "detox" facility (involuntary)

9. Do you feel that you have a substance abuse problem?

10. How do you usually obtain these substances?

11. How do you usually obtain the financial resources in order to obtain these substances?

12. Is your current offense related to the use and abuse of these substances; if so, how?

"MULTIPHASIC MATRIX FOR THE DIAGNOSIS OF ALCOHOLISM"

Alcohol Health and Research World, National Institute on Alcohol Abuse and Alcoholism, Vol. 3., No. 4., 1979

Multiphasic Matrix for the Diagnosis of Alcoholism

Scoring Profile

Inmate's Name_____

	Score - 0	Score - 1	Score - 2	Score - 3	Score - 4
	Abstinence	Mild	Moderate	Serious	Extremely Serious
Category I Amount of Alcohol Ingested per day (average					
Category II Drinking Pattern					
Category III Physical Symptoms related to drinking					
Category IV Social Interactions					
Category V Loss of personal control related to drinking					
Category VI Occupational Adjustment					
Category VII Family Relationships					

TOTAL SCORE:_____

TOTAL SCORING PROFILE:
28 to 22 = Extremely Serious
21 to 15 = Serious
14 to 8 = Moderate
7 to 1 = Mild
0 = Abstinence

Attachment C

MULTIPHASIC MATRIX FOR THE DIAGNOSIS OF ALCOHOLISM

NARRATIVE STATEMENT

NAME:_____ DATE OF EVALUATION:_____

TYPE TEST ADMINISTERED:

SCORING PROFILE:

PHYSICAL SYMPTOMS:

SOCIAL INTERACTIONS:

OCCUPATIONAL ABILITIES:

CONCLUSIONS & RECOMMENDATIONS:

MICHAEL TORCH, ALCOHOL/DRUG COUNSELOR

TREATMENT PLANNING GUIDE OUTLINE

DATE OF NEXT REVIEW: _____

CLIENT NUMBER: _____ COUNSELOR: _____

DEFINITIONS

Goals: The aims, purposes, or end products to be accomplished as a result of treatment, based upon the client's needs and the program services.

Tasks: The activities, actions, behaviors, or steps the client must do or take in order to reach the goal. These are objective and observable, and become the basis upon which progress notes are written.

I. TREATMENT

Current Treatment Model _____

_____

Medication: _____

_____

Type and Frequency of Counseling: _____

_____

_____

_____

Other Supportive Services and Activities: _____

_____

_____

_____

II. LONG-TERM GOALS: _____

_____

_____

_____

_____

_____

_____

_____

III. SHORT-TERM GOALS (90 days or less):

GOALS	TASKS

IV. COMMENTS (REASONS FOR PICKING THESE GOALS): _____

_____

_____

_____

_____

_____

_____

_____

SECTION C

BIOFEEDBACK PROGRAM

INTRODUCTION

A major problem in Prison is the anxiety and tension experienced by inmates. There are numerous causative factors that contribute to such feelings. They cover areas such as personal-family problems, inability to adjust to an all-male environment, developing concern about possible underlying reasons that encourage violation of the law and the fear of physical assault or injury.

These feelings influence and effect behavior of inmates. The behaviors often shown are irritability, insubordination, overt acting out and an inability to sleep. These among other factors lead to an increased demand for tranquilizing and sleep medication. Most often there is no evident or direct attempt to combat and reduce these tensions. Ineffective diverting actions or medication are the attempted common route.

BACKGROUND

A program of training in tension reduction and feeling awareness is an evident need. A common factor that is seen in a counseling or psychotherapeutic relationship is an inmate's inability or fear to identify and discuss feelings or to deal with anxiety in a productive manner. There is an avoidance and often a deliberate attempt not to confront feelings and emotions. These feelings quite often influence an inmate's behavior and his reaction to his immediate environment. The habit of avoidance can be a factor that prevents constructive interpersonal relationship and causes problems of adjustment when released.

If an inmate shows evidence of being unable to openly confront his feelings through the usual method of a give-and-take conversation, a conditioning program can be developed as a therapeutic aid to allow him more accessability to discussing his tensions and feelings. Any type of conditioning program as in any attempt at behavioral change, requires motivation and a personal commitment by the inmate to make a sincere effort to develop more productive habits of dealing with anxiety and tension.

One method of tension reduction and an aid in developing an awareness of feelings is through the use of biofeedback instrumentation. It provides immediate visual and auditory indications through the sensitive monitoring of body signals associated with emotional reactions. This provides both therapist and inmate a literal indication of an emotional reaction taking place within the inmate which then provides a base from which to start an exploratory conversation as to possible causes and reasons for the reaction.

Along with feeling awareness, is the use of biofeedback to develop programs for relaxation and tension reduction. Training in relaxation is a conditioning process that once learned can be used by the inmate to monitor and effectively deal with internal stress. It allows the development of a personal sense of responsibility and control over the inmate's personal self.

PROGRAM OUTLINE

The biofeedback program is under the direct supervision of a Ph.D. Psychologist and is available to those inmates who on the basis of an overall assessment by the Chief Psychologist, Mental Health Case Managers, and the Consulting Psychiatrist are evidencing symptomatology that would respond and profit by participating in a biofeedback program. Also, prior consultation with the institutional physician is made to rule out the possibility of any underlying physical reason that might be present that would be contributing to the inmate's symptoms.

Once approved, participation in the program is initially based upon the inmate's evident and implied motivation. While in the program, his progress is monitored and evaluated by his Case Manager. The biofeedback activity is performed by the inmate's Case Manager or a designated Mental Health staff member. Whether to continue a particular inmate in the program is made by the Case Manager. Periodic progress presentations are made at regularly scheduled Mental Health staff meeting for review and assessment.

The number of inmates seen is based upon assessed need, staff availability and equipment resources. Individual staff offices are used or a specific area is designated for the most effective use of equipment and to encourage maximum involvement.

SECTION D

SEXUAL OFFENDER PROGRAM

INTRODUCTION

As part of providing a broad range of professional services, a specific reference to inmates who have been convicted of sexual crimes is considered necessary due to the particular nature of the offense.

Deviant sexual behavior is most often the response to an impulse by an emotionally immature individual who has conflicts regarding his masculine image and his sexual capabilities. He usually has difficulty recognizing or expressing anger relative to important women in his life. There is also anxiety and confusion as to what is a legitimate sexual response and what is appropriate sexual gratification. His actions and reactions are dominated by feelings of quilt.

BACKGROUND

The extent and degree of pathology can vary relative to criminal sexual acts of a similar nature. Varying motivations, provocations and circumstances are to be taken into consideration along with underlying personality components of each individual. This is not to qualify or to justify the act but to gain a more objective understanding of all the relevant factors associated with the act.

In order to provide an effective program with the potential to accomplish the greatest good, first it is necessary that a detailed assessment be made of each inmate convicted of a criminal sexual act. It is required that we delineate and categorize individuals based on the specific sexual acts, explore the circumstances and factors associated with the act and finally determine the degree of motivation on the part of the inmate to participate in a sexual offender program.

No matter what type of treatment program is made available to the inmate, success or failure as it relates to the person or to the program depends on the level of involvement and the degree of motivation on the part of the participant.

Other factors relating to a readiness to change or modify a particular sexual behavior are related to the age the behavior began, the particular nature of the sexual act, the length of time the act had been practiced and the frequency of the practice.

Deviant sexual behavior that has developed into a long-term habituated pattern of behavior provides more of a challenge relative to altering or extinquishing that behavior. The more passive types of sexual acting out such as exposing oneself, or window peeking has a better potential to profit from treatment counseling in comparison to long-term overt acting sexual behavior such as rape.

PROGRAM OUTLINE

The sexual offender program is under the direct supervision of a Ph.D. Psychologist and is available to all inmates who, on the basis of an overall assessment by the Chief of Mental Health, Mental Health Case Managers, and the consulting psychiatrist are considered to have an identifiable sexual problem of a deviant nature.

Entry into the program is based upon the inmate's willingness to recognize that he has a sexual problem and is sufficiently motivated to do something about it.

Various approaches are available through individual and group therapy, the use of films and literature as part of sex education seminars and discussions of family relationships and sexual attitudes associated with the roles of men and their relationship to women, children and other men.

The Chief of Mental Health is available to provide direct treatment services. He also assigns to specific Mental Health Case Managers those inmates whom he believes can benefit the most from a particular staff/inmate relationship. Conditioning techniques are also used to reduce anxiety and physical tensions. Aversive conditioning, covert sensitization and relaxation programming is used as part of the conditioning process. Therapeutic programs are structured and implemented based upon an inmate's particular problem and needs.

An integral part of the treatment program is the development of a Pre-Release program plan whereby outside supportive resources are used, such as the New Hampshire Hospital, Community Mental Health Clinics, and Alcoholics Anonymous.

Treatment programs and resources are under continuous review and assessment. This is to maintain a level of services that will offer inmates the opportunity to demonstrate their willingness to examine their past behavior, gain an understanding of that behavior, and to develop healthier sexual attitudes and behavior that should contribute to a more positive change in their lifestyle.

NEW HAMPSHIRE STATE PRISON

INTAKE SUMMARY

NAME:_____AGE:_____D.O.B._____MRD:_____

DATE:_____PREPARED BY:_____

SUMMARY OF SOCIAL AND EMOTIONAL FUNCTIONING:

RECOMMENDATIONS:

INTAKE DATA

MITTIMUS:

CRIMINAL HISTORY:

PSYCHO/SOCIAL HISTORY:

EDUCATION: MILITARY: RELIGION:

DRUG AND ALCOHOL:

OCCUPATIONAL:

MEDICAL AND DENTAL:

MENTAL HEALTH BACKGROUND:

PLANS AND GOALS:

OTHER:

CASE MANAGER DATA SHEET

INMATE: _____ DATE: _____

WORK REPORTS AND COMMENTS						
DISCIPLINARY REPORTS						
INCIDENT REPORTS						
SPOT REPORTS						
EDUCATION REPORTS AND COMMENTS						
VOCATIONAL-ED AND COMMENTS						
CUSTODY CHANGES						
PRE-RELEASE						
VOC-REHAB						
GROUP PARTICIPATION						
OTHER						
CLASSIFICATION APPEARANCES AND RESULTS						

END