AN EXPLORATORY STUDY OF REFERRALS AND INTAKE PROCEDURE WITHIN THE PSYCHIATRIC CLINIC AT STATE PRISON OF SOUTHERN MICHIGAN

by

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CHAPTER I

INTRODUCTION

The development of psychiatric clinics and hospitals in prisons is relatively new, and such facilities are limited in number. This is particularly true of adult male correctional institutions. In the establishing of a new service in an authoritative setting, it is important that function be clearly defined, flexible, and changeable in the light of new facilities, new knowledge, new problems, and new needs.

Until an agency has its function defined with clarity, there are probably many different concepts of what its function is. None of these concepts necessarily reflect the actual workings of the agency. One of the indications of how a psychiatric clinic or hospital is performing or functioning in carrying out its normal or expected activity is given through the intake procedure.

Intake literally means taking in or that which is taken in. The intake process in social agencies is not universally agreed upon. It is very difficult to reach agreement on when it begins, when it ends, and what it includes. It is not difficult to reach agreement that it is an important process. Intake can be thought of as the initial contact or all interviews until treatment plans are formulated. Intake may merge

with treatment until the two are inseparable. Intake can start before the initial interview, and the final steps may extend well beyond the initial interview.

Generally, the purpose of the intake interview is to explore the nature of the request, to secure relevant factual data, to determine the appropriateness of the request to see if it falls within the function of the agency, to explain agency services to client, and to estimate the person's difficulties and ability to use the services offered.[1]

There are many differences in intake practices among the numerous social agencies and even among psychiatric clinics and hospitals. Some of the agencies use staff personnel solely as intake workers. Other agencies use a rotating system where workers serve as intake workers periodically. In still other agencies the person who has the initial contact is the one who carries the case for continued service.

There are many factors that affect the intake process. The structure, program, and function of an psychiatric clinic or hospital affect intake procedure and the division of professional responsibility. Another important factor affecting intake is the setting in which the clinic or hospital operates. The clients served and the sources of referral would be dependent on the setting.

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[1]Gorden Hamilton, Theory and Practice of Social Case Work (New York: Columbia University Press, 1951), p. 179.

With the preceeding as a frame of reference, the purpose of this study was to make an exploratory investigation of the referrals and intake procedure of the Psychiatric Clinic at the State Prison of Southern Michigan.

Reason for Study

This writer, being a student social worker in the Psychiatric Clinic at State Prison of Southern Michigan and having begun his work there one year after the clinic was formally organized, became particularly interested in exploring the referrals to the clinic in terms of sources and reasons, and also in identifying the intake process as it was currently being practiced.

It was thought that the information obtained through doing a study of this nature would be of use to the clinic now and in its future planning. It was also thought that because of the setting and the many factors inherent in the setting the study might have implications for Social Work practice. Another reason for the study was the feeling that it would indicate other areas suitable for more definitive research in the future.

Review of Literature

It was recognized by this author that considerable study had been given to intake in psychiatric clinics and hospitals and other social agencies. As far as this author could determine, there were no available studies or literature directly

concerned with intake in a psychiatric clinic within an adult male correctional institution.

There is a vast amount of literature on crime, its causes, and cure. Recently there is more available literature regarding psychiatric and psychological services to inmates. Surveys have shown a surprising deficiency in psychiatric services in prisons throughout the country.

There are only six psychiatric clinics in adult male prisons in the United States which have a professional staff of psychiatrist, psychologist and social worker practicing the "team" approach.[2]

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[2] Robert L. Currie, "An Exploratory Investigation of Personel Standards, Social Service Practices, and Current Trends Within the Psychiatric Clinics in Selected United States Adult Male Prisons" (Unpublished Master of Social Work thesis, Department of Social Work, Michigan State College, 1955), p. 24.

CHAPTER II

PROBLEM, ASSUMPTIONS, METHODOLOGY

Problem

The study was an investigation of the referrals and intake procedure within the Psychiatric Clinic at the State Prison of Southern Michigan. The essential problem was the identifying of the intake procedure as it was currently being practiced in the clinic. Concomitant to this was the examination and review of the referrals to the clinic in terms of who made them, why, what for, and what happened to the inmates following the referral.

There were many factors that affected referrals and intake procedure in this particular psychiatric clinic. The past history, staff, authoritative setting, clientele, and the nature of the referral sources were some of the more readily apparent factors that affected the mode of operation and contributed to the complexity of the problem.

The problem was not to evaluate the effectiveness of the intake process or the appropriateness of the referrals, but to review the referrals and identify the intake process.

Assumptions

There were general assumptions regarding the value of clearly defined function and the importance of the intake process.

Specifically related to this setting and study was the primary assumption that there were many sources of referrals to the clinic. In conjunction with this was the assumption that there were various reasons for these referrals. On the basis of these assumptions and general knowledge of the clinic, the following questions were developed to guide this author.

1. How many referrals were made to the clinic, from what sources, and why were they referred?
2. What was the relationship between referral sources, referral reasons, and the prior status of these referrals to the clinic?
3. Did these referrals receive psychological tests or have social histories taken? If so, how many and which ones?
4. Were there diversities in the intake procedure of the clinic?

Methodology

Following the definition of the problem and the developing of the questions used to guide the author of this study, it was necessary to select the methods and procedures to be used in the study.

Through consultation with the Director of the Clinic and faculty of the Department of Social Work of Michigan State College, it was decided to study the referrals made to the clinic during the last quarter of 1954.

There were several factors that influenced the selection of this particular time period. First, the clinic had been in operation one year. Secondly, the clinic made no staff changes during this time, and in that respect it was a relatively stable period. Thirdly, this time period covered the first three months of this author's employment at the clinic.

On the basis of clinic monthly reports, which indicated the number of admissions to the clinic, it was thought there would be at least one-hundred referrals on which to base the study. It was also thought that this would be sufficient number to indicate intake procedure, general groupings of referral sources, and reasons.

The next step was to further limit the study to exactly the referral cases which were to be used. It was decided to use all referrals made to the clinic during the selected time period with the exception of those clinic patients who were being carried as open cases at the time this study began. By open cases is meant those inmates who were receiving some kind of psychiatric treatment or service.

All inmates have numbers, and individual patient records are filed under this number. The numbers of all the inmates referred to the clinic during the last quarter of 1954 were secured, and the appropriate case records were studied. After reading about 35 of these records, a schedule was devised as an aid in the compilation of the data. It was devised with the purpose of the study in mind and on the basis of the 35

records previously examined. The function of the schedule was to delimit the scope of the data collected and to insure concentration on the circumscribed elements.

The actual mechanics of procuring the necessary patients' file numbers needs explanation. No regular record had been kept, and no system had been in use for keeping a readily available list of all referrals and inquiries. The numbers of the inmates who had been referred and kept as in-patients were readily available. To secure the numbers and records of all the inmates who had been referred to the clinic during the last quarter of 1954 and not kept as in-patients was difficult.

Each staff member, except the chief psychologist, keeps a personal file in which is kept a chronological record of all his dictation. Presumably all or most of their contacts would be in these files. There is a copy of this same recorded material in the inmates clinic file. Each staff person's file was examined and a list of the numbers of all inmates with whom they had had interviews during the time of the study was secured.

These numbers, with the in-patient list, provided a complete list of all contacts had by clinic personnel during the selected time period with the one exception noted above. It was important to secure a list of his contacts because by virtue of his position as Chief Psychologist he had had many of the initial contacts for the clinic.

It was then discovered that the inmate clerk who arranges for the inmates to get to the clinic had a calendar pad for 1954 with the numbers of all inmates who had been put on "call" by any staff person during the selected time period. Being put on call is the necessary administrative and custodial prerequisite for getting to the clinic from any other part of the prison.

With the in-patient numbers, the numbers of all inmates seen by the staff personnel, and the numbers of all men put on call by the clinic staff, there was now a complete list of every inmate referred to the clinic during the last quarter of 1954. These lists served as good cross-checking lists to eliminate the duplicated numbers and make sure there were no ommissions. After the duplicated numbers were eliminated, there were 190 records to be examined and the useable ones selected. After elimination of the records which did not fit the criteria of time and prior status, there were 135 records remaining on which this study was based.

With the use of the schedule, the data was collected, tabulated, and analyzed for groupings, series, sequences, or relationships that were appropriate and significant to this study.

CHAPTER III

SETTING

History of Clinic

The Psychiatric Clinic and Hospital at State Prison of Southern Michigan has a relatively short history. Even in a short time there have been many changes. Some of these changes have been radical ones.

In 1946, the Mental Ward, as it was called then, was in the classification division under the supervision of the Parole Board Psychiatrist. It included only 60 cells, and the actual supervision of the mental patients was done by a psychologist with the help of inmates. In 1949, the Mental Ward was shifted to the Medical Department, and there were two psychologists to supervise and care for the mental patients. In 1951, the rotunda portion of the Mental Ward was opened for use by the mental patients. From that time until the formal organization of the clinic, there was a gradual expansion in the facilities of the Mental Ward for care of the mental patients.

The Psychiatric Clinic at State Prison of Southern Michigan was formally established on October 1, 1953. Although there had been a great need for a psychiatric clinic to serve the Michigan Corrections system, the need was not sufficiently recognized until after the prison riot at State Prison of

Southern Michigan in April of 1952. During the investigation of this riot, it was publicly disclosed that there were a great many psychotic prisoners housed at State Prison of Southern Michigan without any semblance of adequate psychiatric treatment being available. It was also disclosed that a great many unstable and dangerous psychopaths were at large in the prison population who it was felt should have been segregated within a closely supervised psychiatric unit. It was further disclosed that there was inadequate screening of newly admitted prisoners so that mental patients were not being detected and isolated from the general prison population. These factors influenced the state legislature to allocate funds in 1953 for salaries for professional people to staff the Psychiatric Clinic at the State Prison of Southern Michigan. Corrections Commissioner Brooks then approached Dr. Raymond Waggoner, Chairman of the Department of Psychiatry at the University of Michigan Medical School, for guidance in the proper selection and utilization of personnel for this clinic and the general organization of the clinic.

Dr. Waggoner approached Dr. Warren S. Willie, then instructor in psychiatry at the University of Michigan Medical School, to become the Director of the newly formed clinic. A meeting was held in Detroit, Michigan, in September, 1953, between Dr. Waggoner, Dr. Willie, Mr. Brooks, the members of the Corrections Commission, and Mr. Gus Harrison, Director of the Department of Corrections. The general outline of the clinic was formally established at that time.

Dr. Willie started working at the State Prison of Southern Michigan on October 1, 1953. Fifty thousand dollars had been appropriated in 1953 for the purpose of getting the clinic started. Before this time there had been no professional personnel to look after the psychotic patients at State Prison of Southern Michigan except for two psychologists. An additional clinical psychologist was employed. Dr. Willie also employed a psychiatric social worker, a consultant in Psychiatry from the University of Michigan, a consultant in Clinical Psychology from Michigan State College, and a secretary.

A program was established with Michigan State College for the training of clinical psychology students working on their Doctor's Degree and Graduate students in the Department of Social Work. By July 1, 1954, the two student psychologists had begun working at the clinic. By October 1, 1954, the two student social workers had begun their work at the clinic. In June of 1954, funds were appropriated by the State Legislature for the hiring of an Electroencephalogram technician and two civil service male nurse supervisors to supervise the inmate nurses on the clinic ward.

It is planned to increase the staff during the coming year by hiring a resident psychiatrist from the University of Michigan Medical School to work full time at the Psychiatric Clinic. A training program has been set up with the University of Michigan Medical School Psychiatry Department for the training of psychiatric residents of advanced experience

in Forensic Psychiatry. It is also hoped that the staff and facilities can be further expanded to include adequate in-patient and out-patient care, not only for the State Prison of Southern Michigan, but also for the reception center and other institutions in the Department of Corrections.[3]

Physical Plant and Facilities of Clinic

The most outstanding feature about the State Prison of Southern Michigan is its size. It has the largest inmate population of any walled maximum security prison in this country. Construction was started in 1924 and completed in 1933. It is practically a self contained city, covering a total of 57 acres inside the walls. Surrounding it are approximately 4,700 acres of farm land and two cell blocks for "trustys" who live and work ouside the walls.[4] There are also farm camps and a pre-parole camp adjoining the prison site.

As Figure 1., ground plan of the prison, demonstrates, the walled enclosure has the shape of a triangle without a base imposed on a rectangle without a top.[5] Cell Blocks 1 to 10 inclusive form the two sides and the bottom of the rectangle. Cell Block 1 to 5 inclusive are known as the North Side, and Cell Blocks 6 to 10 compose the South Side. Between Cell

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[3]Dr. Warren S. Wille, Clinic Director, written communication.

[4]Trustys are those inmates who are not locked within walls.

[5]See Figure 1. p. 49.

Blocks 5 and 6 there is a rotunda. This rotunda is known as the Hall Office and is the institution's central control station. In the center of the rectangle there is a large building housing the kitchen, mess hall, auditorium, gymnasium, and various maintenance services. This building is joined to the rotunda by a corridor flanked by offices and classrooms.[6]

In the North Yard is Cell Block 15, the disciplinary segregation building. The hospital is in the South Yard, a short distance from the central building. Also in the South Yard and lying parallel to Cell Blocks 6 and 7 are Cell Blocks 11 and 12. From the end of Cell Block 1 on the North side and Cell Block 10 on the South Side high concrete walls extend back to the East Gate and form the triangle referred to. The industrial buildings and the railroad sidings lie parallel to these walls. The power house stands near the point of the triangle. The athletic field occupies nearly half of the clear area in the triangle and the remaining area is generally unused.

There are special facilities which may be briefly described. The four lower tiers of Cell Block 6 are used as the Quarantine or Receiving Block. State Prison of Southern Michigan serves as the receiving center for all prisoners under state prison sentence from the lower penisula of Michigan. Cell Block 12, which contains 360 cells, is not under the

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6The Michigan Prison Riots, A Report of the Special Committee to Study the Michigan Department of Corrections (1953), p. 10.

jurisdiction of the hospital or clinic but many of the prisoners in 12 Block are medical cases. Housed in 12 Block are cripples, seniles, epileptics, tubercular patients, former mental patients, and out-patients from the Psychiatric Clinic.

Cell Block 6 is floored off above the fourth tier, and the fifth tier is known as "Top 6". This space, with the adjoining area on the upper floor of the rotunda, houses the Psychiatric Clinic and Hospital.

As Figure 2., the floor plan of the clinic, indicates the clinical facilities include a hundred bed ward.[7] Fifty-eight of these are individual cells, forty-two are dormitory style in the rotunda. There are offices for the professional staff, the nurse supervisors and the secretary. There are also offices for the inmate clerical staff, inmate nurses, and custodial officers who are on duty in the clinic. The rotunda with its offices, dormitories, and recreational area is separated from the cells by a dining room where the clinic patients eat. Quarantine inmates also eat in this dining room. On one side of the dining room is the occupational therapy room. On the other side is a day room for the use of the patients. There are Electro Convulsive Shock Therapy facilities and Hydrotherapy facilities at the extreme end of the cells.

The entrace to the clinic is by elevator from the main floor rotunda to the clinic rotunda. Entrance is made directly

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[7] See Figure 2, p. 50.

(via iron gate) into the rotunda where the clinic in-patients carry on their daily activities. This area also serves as a waiting room for all inmates and out-patients who come to the clinic for interviews.

Clinic Personnel

There were a total of forty people on the clinic staff at the time of the study. Sixteen of these were non-inmate employees. Most of them were Civil Service employees of the state. There were two psychiatrists, one serving as director of the clinic on a two-thirds time basis; the other serving as a consultant in Psychiatry from the University of Michigan who was there two days per month.

There were six psychologists employed by the clinic. Three of them were full time; the minimum training being a Masters' degree in Psychology. Two of the psychologists were there one-half time on a work study program, as Doctoral degree candidates from Michigan State College.

The sixth psychologist served as a consultant in psychology from Michigan State College.

The social work staff consisted of three social workers. One of them was a full time Psychiatric Social Worker who was responsible for the Social Work Department of the Clinic and supervised the social work students. The two social work students were there on a half-time basis on a work-study plan from the Graduate School of Social Work of Michigan State College.[8]

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[8]Work-study plan -- an arrangement whereby students are employed for training in their profession while completing their studies.

Other non-inmate staff included an Electroencephalogram technician, two male nurse supervisors, and one secretary. The remaining 24 people employed by the clinic were inmates. There were a total of 16 inmate nurse attendants working on two shifts so there were nurses on duty at all hours. There were three inmates on the clerical staff who typed and filed all manner of clinic records. They also performed many other routine office duties. There were two inmate employees who supervised the patients in their occupational therapy activities. One inmate supervised the recreational activities of the patients. One inmate was in charge of hydrotherapy, and the other inmate employee was a "runner" who carried the mail and other supplies to and from the clinic.

CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

The 135 clinic records used were almost evenly divided between those never previously seen and those seen before. The first group of 67 had never been previously known to the clinic. There was no information in the clinic files regarding these inmates, prior to referral. The second group was 68 re-referrals who had been known to the clinic prior to the time of the study. There were variations in the type of service these re-referrals had received and the length of time they had maintained contact with the clinic. Some of the 68 had contacts with the clinic only in the preceeding year which was the first year of formal clinic operation. Some of the others had contacts only prior to the preceeding year. Some of the re-referrals had contacts during both of these periods. Some of these 68 re-referrals had been seen once, some for a series of interviews, and some had been former "in-patients." There was some information in the clinic concerning all these inmates who had been previously known to the clinic. It was sometimes a brief memorandum and sometimes an extensive case record, but there was considerable variation between these two extremes. The significance of this information was the fact that the referrals were divided into two equal groups.

There were 39 or 28.9% of the referrals made in October of 1954, 52 or 38.5% of the referrals made in November of 1954, and 44 or 32.6% of the referrals made in December of 1954. There did not appear to be any variations great enough to warrant a belief that this fluctuation in monthly intake during the study was unusual or of any significance.

Sources of Referrals

The following table shows these sources as collected and tabulated from the clinic records on the basis of the 135 cases used.

TABLE 1

REFERRAL SOURCES, PSYCHIATRIC CLINIC,
SOUTHERN MICHIGAN STATE PRISON,
OCTOBER 1, - DECEMBER 31, 1954

Referral Sources	Number and Per Cent of Referrals	
	Number	Per Cent
TOTAL	135	100
Custody	44	32.6
Self	37	27.5
Medical Hospital	11	8.2
Parole Board Psychiatrist	9	6.7
Other Institution	7	5.2
Warden	6	4.4
Counselors	5	3.7
Parole Eligibility Examiner	2	1.5
Other	14	10.3

Table 1 shows the nine major sources of referrals to the clinic. It also shows the number and percentage of referrals

that each source made to the clinic. Some of the sources made only a few referrals to the clinic but were included as a separate grouping because of the nature of the source.

Custody was the largest single source of referrals with 44 or 32.6% of the number referred. Custody included any officer serving in a custodial capacity from the Deputy in charge of custody to the lowest ranking corrections officer in the Cell Blocks. They are the group who would have the most contact with the inmates because they see them every day in their routine living. Custodial referrals included six referrals from the Disciplinary Block and four from the Receiving Block.

The next largest group was self-referrals with 37 or 27.5% of the total referrals. Inmates who refer themselves must write a note to someone on the clinic staff and request an interview. Then someone on the clinic staff has to put them on "call".

Custodial referrals and self-referrals together totaled 81 or 60% of the referrals.

The next two groupings were the Institutional Medical Hospital with 11, and the Parole Board Psychiatrist with nine.

The next four sources of referrals accounted for 14.7% of the referrals and were included as separate groupings because of their function or position in the prison structure. The Warden of The State Prison of Southern Michigan referred six. Seven referrals came from other institutions in the Corrections Department, (three from Ionia Reformatory, and four from

Marquette Prison in the Upper Penisula of Michigan). There were five referrals from the counselors.[9] There were two from the Parole Eligibility Examiner in the Department of Corrections.[10]

"Other" sources was the third largest classification with 14 referrals. This group actually included a wide variety of sources and some of them were unknown. It was felt that none of these sources were large enough or important enough to warrant a separate grouping.

Stated Reasons for Referrals

The stated reasons for referrals as shown in Table 2 were grouped under eight headings. These groupings were taken from the clinic records and in many cases was the terminology used by the referral source. This was not true in all cases, and the author had to assume the responsibility for putting them into these groupings. These groupings reflect the professional discretion of the writer, particularly in the groupings of the less clearly defined reasons.

The reason stated most often for referral to the clinic was Psychiatric Evaluation. For this reason 38 or 28.1% were referred. Psychiatric Evaluation undoubtedly meant different things depending on the source of referral. Generally, what was wanted was a report from the clinic as an aid in deciding

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[9]There were ten counselors in the Individual Treatment program at State Prison of Southern Michigan. Their primary function was to look after the inmates institutional welfare.

[10]The Parole Eligibility Examiner was mainly concerned with the welfare of the men who have life sentences.

on a plan of action for an inmate. It was also used to get an inmate to the clinic who badly needed treatment.

TABLE 2

STATED REASON FOR REFERRAL TO PSYCHIATRIC CLINIC,
STATE PRISON SOUTHERN MICHIGAN,
OCTOBER 1, - DECEMBER 31, 1954

Stated Reasons for Referrals	Number and Per Cent of Referrals	
	Number	Per Cent of Total
TOTAL	135	100
Psychiatric Evaluation	38	28.1
Bizarre Behavior	25	18.5
Emotionally Disturbed	17	12.6
Inability to Adjust	11	8.1
Non-clinical Personal Inquiry	12	8.9
Treatment	11	8.1
Nervous	9	6.7
Other	12	8.9

Bizarre Behavior was the reason given for 25 or 18.5% of the referrals. Examples of Bizarre Behavior would be "stuffing a blanket in a toilet bowl", "sleeping under the mattress", or "slashing wrists".

Emotionally Distrubed was the reason given for 17 or 12.6% of the referrals. Examples of this would be "crying jags", "thinking people were trying to kill them", and being "wired for sound".

The other five groupings included approximately the same number of referrals. There were 11 referred for Inability to Adjust. Twelve were referred for Non-Clinical Inquiry and

were without exception self-referrals. There were 11 referred for Treatment. The smallest group of nine was referred for being Nervous.

"Other" reasons was a vague grouping of 12 unknown and undifferentiated reasons that did not fit into any of the categories.

Cross-Tabulation of Referral Sources and Reasons

To understand fully the significance of referral sources and stated reasons for referral, it was necessary to cross-classify them. This procedure highlighted some significant sequences and relationships in the referral data.

Table 3 clearly shows that custodial referrals, the largest single source of referrals, were made primarily for three stated reasons. Custody made 21 referrals for Bizarre Behavior, nine for Emotionally Disturbed, and eight for Inability to Adjust. These were the three reasons for which custody made 38 of their 44 referrals. Interestingly enough, these reasons might be considered similar in many respects.

Table 3 also indicates that self-referrals, the second largest source of referrals, referred themselves primarily for four stated reasons. The self-referrals accounted for all 12 of the referrals in the Non-Clinical Inquiry group. All but one of nine referrals in the Nervous group were self-referred. A majority of the 12 from the Other classification and a plurality, 5 out of 11, from the Treatment group were self-referred.

TABLE 3

SOURCES AND REASONS FOR REFERRALS, PSYCHIATRIC CLINIC, STATE PRISON SOUTHERN MICHIGAN
OCTOBER 1, TO DECEMBER 31, 1954

Source of Referral	Total	Stated Reason for Referral							
		Psychiatric Evaluation	Bizarre Behavior	Emotionally Disturbed	Inability to Adjust	Non-Clinic Inquiry	Treatment	Nervous	Other
TOTAL	135	38	25	17	11	12	11	9	12
Custody	44	3	21	9	8	0	1	1	1
Self	37	2	0	2	1	12	5	8	7
Medical Hospital	11	6	1	3	0	0	0	0	1
Parole Board Psychiatrist	9	8	0	0	0	0	0	0	1
Other Institutions	7	4	1	2	0	0	0	0	0
Prison Warden	6	6	0	0	0	0	0	0	0
Counselor	5	3	0	0	0	0	2	0	0
Parole Eligibility Examiner	2	2	0	0	0	0	0	0	0
Other	14	4	2	1	2	0	3	0	2

The next six groupings of sources comprised only 30% of the total referrals. It is worthy of note that these six referral sources referred a majority for Psychiatric Evaluation. The medical hospital referred six of 11 for Psychiatric Evaluation. The Parole Board Psychiatrist referred eight of nine for Psychiatric Evaluation. The counselors referred five, and three of them were for Psychiatric Evaluation. From other institutions there were seven referred and four of them were for Psychiatric Evaluation. The Warden referred six and they all were for Psychiatric Evaluation. The Parole Eligibility Examiner made both of his referrals for this same reason. Twenty-nine of the 38 referrals for Psychiatric Evaluation were made from these six sources.

In the classification "Other" sources there were 14 referrals. Because of the small number and the wide distribution there appeared to be nothing significant about the referrals in this classification.

There do appear to be some significant relationships between the sources and stated reasons for referral. We see custody referring for three reasons, which are unlike the reasons which other sources used. This might well indicate what custodial officers consider reason for referral to a clinic and how they see the role of a psychiatric clinic.

It should also be noted that the self-referrals were predominantly found in four groups of reasons and composed a majority of these reasons. In addition to self-referrals being

predominantly found within four groups of reasons, they also used different reasons for referral than did custody or any of the other sources of referral. This might be an indication of how the inmates view the role of the clinic. There is also reason to speculate on why the inmates chose the terminology they did in referring themselves. They seemed to have chosen a reason that was "acceptable" and could be used without loss of status or prestige in the general prison population.

The six other groupings of referral sources used different reasons for referral. Again, the terminology used by these sources might be a reflection of the concept they had of the role of the clinic.

On the basis of referral sources, there were the same number of referrals who had never been known to the clinic as those who had been known to the clinic prior to the study. Three of the referral sources with a relatively small number of referrals made a few more new referrals. These were the Parole Board Psychiatrist, Other institutions, and the Parole Eligibility Examiner. More of the self-referrals had been previously known to the clinic. Consistent with this, there were more new referrals for Psychiatric Evaluation and more re-referrals for Nervousness and Non-Clinic Inquiry.

Professional Person Representing Clinic at Initial Contact

The professional person who represented the clinic in the initial interview was either a psychologist, social

worker, or psychiatrist. The total of initial contacts used in the study was 135. The psychologists represented the clinic in 105 or 77.8% of these initial contacts. The social workers represented the clinic in 15 or 11.1% of these initial contacts. The psychiatrist who was director of the clinic represented the clinic in 15 or 11.1% of the initial contacts.

This is not the usual division of professional responsibility for intake contacts in other psychiatric clinics. There were many reasons for this division of professional responsibility. There were five psychologists on the staff, three full time and two half-time. There were three social workers on the staff, one full time and two half-time. There was one psychiatrist two-thirds time. This does not include the consultants who had no responsibility for initial contacts. The second factor that had immediate bearing on this situation was the role of the chief psychologist who had been at the clinic two and one-half years prior to the study. It was his role to handle many of the administrative details and he was well known throughout the entire prison. Another psychologist had been there over three years when this study was undertaken, and he too was well known throughout the entire prison. The two psychologists had known previously many of the inmates who came as re-referrals to the clinic and would have interviewed them as they were familiar with the men's difficulty and would be able to handle their problems with expediency and might be in a more advantageous position to evaluate the need

for clinic service. Many of the self-referrals with a non-clinical inquiry would also have been seen by these two men because of their familiarity with the prison regulations and administration.

Referral Status Following Initial Contact

Table 4 indicates that 86 or 63.7% of the 135 referrals were kept as open cases following the initial interview. Forty-nine or 36.3% of the cases were closed following the initial interview.

TABLE 4

REFERRAL STATUS AFTER INITIAL CONTACT

Referral Status	Number and Per Cent of Referrals	
	Number	Per Cent
TOTAL	135	100.0
Open Cases	86	63.7
Closed Cases	49	36.3

The 86 referrals which were open cases following the initial interviews were either in-patients or out-patients. If they were kept as in-patients, they were not returned to the general prison population but were confined to the clinic.

If they were carried for psychiatric service or treatment as out-patients, there was a variety of plans by which

this was done. They could be "12 Block out-patients" which means they lived in 12 Block and were seen by clinic personnel at least once weekly. They could be out-patients and live anywhere in the prison population. In cases like this they were either on a "call" basis or a "kite" basis. The "call" basis is a plan usually worked out with the inmate and a regular schedule of interviews is established. This "call" plan was also used when an inmate was being seen by several staff members for a psychiatric evaluation. The "kite" method leaves the primary responsibility to the inmate to determine when he needs to come to the clinic for an interview. The inmate writes a note to the clinic and is then seen by someone on the clinic staff. The staff person who sees him is usually the one who had the initial interview, although sometimes they are seen by whichever staff member has the time.

There were approximately the same number of those known to the clinic previously and those not known to the clinic previously which were kept as open cases following the initial interview.

Use of Diagnostic Tools

In 48 of the 135 referrals there was either a social history taken or psychological tests administered.[11] There

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[11]Tests as used in this study referred to a battery of tests and not a single test. The tests used were the Bender-Gestalt, Draw a Figure, the Rorschach, and the Wechsler-Bellevue Adult I.Q. Scale. Social History, see outline, p. 48 . The Social History was taken from the inmate and was done by the Social Work Staff.

were 23 in which only tests were administered and ten in which only social histories were taken. There were 15 in which both were done. There was a total of 38 referrals that received tests, and 25 on which social histories were taken.

The 86 or 63.7% of the cases that were kept open received 39 or 81.3% of the social histories and tests. The 49 or 36.3% which were closed received nine or 18.7% of the tests given and social histories written. It should be mentioned here that six of the cases which were closed were evaluated by the Clinic Director in an interview with the inmate, for that specific purpose.

Cross-Tabulation of Referral Sources, Case Status, and Diagnostic Studies

Table 5 shows the relationship of referral sources to status of referral following initial contact and the use of social histories and psychological tests.

Eighty-six of 135 referrals were carried as open cases following the initial interview. Custodial referrals, Medical Hospital referrals, referrals from the Parole Board Psychiatrist, Other Institutions and the Parole Eligibility Examiner had a high ratio of cases kept open following initial interview.

There were 44 custodial referrals and 37 of these were kept open. The Medical Hospital had eight referrals kept open out of a total of 11. The Parole Board Psychiatrist had six of nine referrals kept open. From Other Institutions seven were referred and all seven were kept open. The Parole

Eligibility Examiner referred two and they were both kept open following the initial contact.

TABLE 5

REFERRAL SOURCES, STATUS OF REFERRALS FOLLOWING INITIAL CONTACT, USE OF DIAGNOSTIC STUDIES

Source of Referral	Total		Open Cases		Closed Cases	
	Number of Cases	Diagnostic Studies	Number of Cases	Diagnostic Studies	Number of Cases	Diagnostic Studies
TOTAL	135	48	86	39	49	9
Custody	44	16	37	16	7	0
Self	37	6	18	4	19	2
Medical Hospital	11	2	8	2	3	0
Parole Board Psychiatrist	9	7	6	6	3	1
Other Institutions	7	4	7	4	0	0
Warden	6	3	1	1	5	2
Counselors	5	2	1	1	4	1
Parole Eligibility Examiner	2	2	2	2	0	0
Other	14	6	6	3	8	3

Self-referrals, referrals from the Warden, Counselors, and "Other" referral sources had a low ratio of referrals kept as open cases following initial interview.

There were 18 self-referrals kept as open cases out of a total of 37. The Warden referred six and only one of these was kept as an open case. Two of the five referrals from the Counselors were kept as open cases. There were 14 referrals from "Other" sources and six of them were kept as open cases following initial contact.

Referrals from the Parole Board Psychiatrist, other Institutions, the Warden, and the Parole Eligibility Examiner received a high ratio of the psychological tests which were administered and of the social histories which were taken.

Of the nine referrals from the Parole Board Psychiatrist, seven of them had tests done or social histories taken. There were seven referrals from other Institutions and four of them had tests or social histories. Three out of six referrals from the Warden received tests or had social histories taken. The two referrals from the Parole Eligibility Examiner received both social histories and psychological tests.

Self-referrals and Medical Hospital referrals received a very low ratio of the social histories and tests which were done. There were 37 self-referrals and only six of them had tests done or social histories taken. Eleven referrals were from the Medical Hospital and two of them were given tests or had social histories taken.

There were five referrals from the counselors and two of them had social histories or tests. This was about the same ratio of tests and social histories as there were referrals.

Six of the referrals from "Other" sources had tests or social histories which was approximately the same ratio of tests and histories as was done on the total referrals.

Cross-Tabulation of Reasons for Referrals, Case Status, and Diagnostic Studies

Table 6 shows the relationship between the stated reason for referral, the status of the referrals following initial interview, and the number of psychological tests administered and social histories taken.

TABLE 6

REFERRAL REASONS, STATUS OF REFERRALS FOLLOWING INITIAL CONTACT, USE OF DIAGNOSTIC STUDIES

Reason for Referral	Total		Open Cases		Closed Cases	
	Number of Cases	Diagnostic Studies	Number of Cases	Diagnostic Studies	Number of Cases	Diagnostic Studies
TOTAL	135	48	86	39	49	9
Psychiatric Evaluation	38	19	18	14	20	5
Bizarre Behavior	25	10	21	10	4	0
Emotionally Disturbed	17	7	17	7	0	0
Inability to Adjust	11	4	9	3	2	1
Non-Clinical Inquiry	12	1	3	0	9	1
Treatment	11	2	6	2	5	0
Nervous	9	2	8	2	1	0
Other	12	3	4	1	8	2

Referrals made for Bizarre Behavior, Emotionally Disturbed, Inability to Adjust, and for Nervousness had a very high ratio of open cases following initial contact.

Twenty-one of the 25 referrals for Bizarre Behavior were kept as open cases. There were 17 referrals for Emotionally

Disturbed and all 17 of them were kept as open cases. Nine of the 11 referrals for Inability to Adjust were kept as open cases following initial contact. There were nine referrals made for Nervousness and eight of them were kept as open cases following initial interview. This is an exception worthy of note. Eight of the nine were self-referrals and the self-referrals did not have a high ratio of open cases following initial interview.

When the stated reason for referral was Psychiatric Evaluation, Non-Clinical Personal Inquiry, or Treatment there was a low ratio of open cases following initial contact.

Eighteen of the 38 referrals for Psychiatric Evaluation were kept open and twenty of them were closed. There were 12 Non-Clinical Inquiry referrals and three of these were kept open and nine of these were closed. Eleven were referred for Treatment and six were kept open and five were closed. There were 12 referred for "Other" reasons and four of these were kept open and eight were closed. This was also a low ratio of open cases following initial contact.

Referrals made for Psychiatric Evaluation, Bizarre Behavior, and Emotionally Disturbed had a high ratio of social histories taken and tests given.

Nineteen of the 38 referrals for Psychiatric Evaluation were either given tests or had social histories taken. Bizarre Behavior was the reason for 25 of the referrals and ten of them had either tests given or social histories taken.

Referrals made for Non-Clinical Inquiries, Treatment, and Nervousness had a very low ratio of tests given and social histories taken.

Only one of the Non-Clinical Inquiries had a social history. Of the 11 referred for Treatment, two were tested or had a social history taken. Nine were referred for being Nervous and two of them had tests given or social history taken.

There were 12 referred for "Other" reasons with three of them receiving tests or having social histories taken.

The 11 referred for Inability to Adjust had approximately the same ratio of tests and social histories as did the entire 135. There were four of these 11 which were tested or a social history taken.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The study was undertaken to investigate referrals and intake procedure in the Psychiatric Clinic in the State Prison of Southern Michigan. This was done by examining the clinic records on all referrals made to the clinic during the last quarter of 1954.

A schedule was used as an aid in the collection of the data. The data was tabulated and revealed the following information in answer to the questions that this study posed.

The first question was concerned with the number, sources, and reasons for referral to the clinic.

The author found that the clinic received 135 referrals during the last quarter of 1954. These referrals were evenly divided between those referrals previously seen and those referrals that were new to the clinic.

The study revealed nine classifications of referral sources. The two largest groupings, which comprised sixty per cent of the referrals, were custody and self-referrals. Thirty-two per cent were custody referrals and 27% were self-referrals. The balance of the referrals was distributed among the other seven classifications.

The writer found eight classifications of stated reasons for referral to the clinic. The three referral reasons stated most often by the referral sources were Psychiatric Evaluation (28.1%), Bizarre Behavior (18.5%), and Emotionally Disturbed (12.6%). These three groups comprised 59.2% of the total. The balance of the referrals was almost evenly distributed among the other five classifications of stated reasons for referral.

There were interesting trends shown in the cross-tabulation of sources and reasons. It was apparent that custody made nearly all of their referrals for Bizarre Behavior, Emotionally Disturbed, and Inability to Adjust, while self-referrals were made primarily for Non-Clinical Inquiry, Treatment, Nervousness, and "Other" reasons. The remaining sources of referral most frequently gave Psychiatric Evaluation as the reason for referral.

In answer to the second question regarding the relationship between the referral sources, reasons and the prior status of the referrals, it was found that the Parole Board Psychiatrist, the Parole Eligibility Examiner, and other Institutions made more new referrals than re-referrals. Consistent with this, more new referrals were made for Psychiatric Evaluation. More of the self-referrals had been known to the clinic previously and came for Non-Clinical Inquiry or Nervousness.

The third question was focused on the frequency with which these referrals had psychological tests administered, social histories taken and which of the referrals remained

open following the initial interview. The author found that 63.7% of the referrals remained open following the initial contact with a clinic staff person, and 36.3% were immediately closed following initial contact. There were approximately the same number of new referrals as re-referrals kept open following the initial interview.

Referrals from Custody, Medical Hospital, Parole Board Psychiatrist, Other Institutions, and the Parole Eligibility Examiner had a high ratio of open cases following initial interview.

The referrals from the Counselors, Warden, Self-referrals and Other sources had a low ratio of open cases following the initial interview.

When the stated reason for referral was Bizarre Behavior, Emotionally Disturbed, Inability to Adjust, or Nervousness, a high ratio of these referrals remained open cases following the initial interview. Referrals made for Psychiatric Evaluation, Non-Clinical Inquiry, Treatment, or Other reasons had a low ratio of referrals kept open following initial interview.

The study showed that there were either social histories taken or psychological tests administered to 48 of the 135 referrals. There were 25 social histories taken and 38 batteries of tests administered. In 15 of the cases both were done. The cases that remained open had a much higher ratio of social histories taken and tests administered than did the cases that were closed.

There appeared to be some relationship between the referral sources, referrals reasons, and the number of tests administered and social histories taken. Referrals from the Parole Board Psychiatrist, Warden, Parole Eligibility Examiner, Other Institutions, and Custody had a high ratio of tests administered and social histories taken. Self-Referrals and referrals from the Medical Hospital had a low ratio of tests administered and social histories taken. The two remaining classifications of sources, Counselors, and Other Sources, had approximately the same ratio of tests and social histories as did the entire number of referrals. Consistent with the above, it found that referrals made for Psychiatric Evaluation, Bizarre Behavior, and Emotionally Disturbed, had a high ratio of tests administered and social histories taken. When the referrals were for Non-Clinical Inquiry, Treatment, Nervousness, and Other reasons, there was a low ratio of tests administered and social histories taken. In the remaining classification, Inability to Adjust, there were the same ratio of tests administered and social histories taken as in the entire referral group.

This brings us to the fourth and final question which was directly concerned with the intake procedure as it was currently being practiced.

The clinic intake procedure actually starts with a telephone call or written correspondence from a prison staff person or, in some cases, someone in the Corrections Department not directly at the prison. In the case of inmates a "kite" is written to the clinic.

These calls, memorandums, or "kites" are sometimes addressed to a specific staff member with which the referral source is acquainted. If this happens, then the inmate is usually seen by that staff member although it might be arranged that some other staff person interview him. Most of the referrals are channeled through the Chief Psychologist who either sees the inmate or assigns him to some other staff person for service. The Clinic Director also received some of these general referrals and follows the same procedure of either seeing the inmate or assigning him to some other staff person.

Following the assignment of the referral to a staff member, the inmate is put on "call", procures a pass from a custodial officer, and comes to the clinic at the appointed time for the initial interview. There is then a report dictated and a record folder made for this inmate. This record is then filed in the clinic files. There are also emergency admissions to the clinic at night or on Saturdays and Sundays when no clinic personnel are on duty. These must first be cleared with designated clinic personnel and these inmates are seen as soon as possible.

There was another integral part of the intake procedure which was considered for inclusion in this study. It was planned to include the data in the clinic records regarding the "staffing" of the clinic patients. It was omitted because there was not sufficient information in the clinic records examined to justify analysis of this data.

Conclusions

The author was well aware that the intake process was a complex one and therefore the conclusions should be considered as tenative ones. This study was exploratory, and it would not be valid to attribute to one factor what might well be the result of several factors. The results of this study did lead the author to make the following tenative conclusions.

There did not appear to be a consistent, well planned integrated intake procedure operating during the time of the study. Conversely, there appeared to be diverse and variable patterns of intake procedure being practiced.

In the taking of social histories and the administering of psychological tests, there was apparently no established criteria for determining on which referrals it would be most advantageous and helpful to have tests administered or social histories taken.

There were some interesting correlations and relationships indicated by this study, although they were not of primary concern to this author, among referral sources, referral reasons, the status of the referral following initial interview, and the referrals from which social histories were taken and to which tests were administered.

Custody referrals tended to be made for overt manifestations of extremely disturbed behavior. Referrals from other prison staff were generally stated as needs Psychiatric Evaluation.

It could also be concluded from the study that many of the referrals to the clinic were appropriate and that the overt symptons of mental illness were well recognized by most referral sources.

Finally this study suggests that the self-referrals did not receive adequate study and evaluation as they tended to have a single interview, and no diagnostic tools such as social histories or tests were used.

Recommendations for Consideration

These recommendations are offered for consideration on the basis of what this study revealed, and in the hope that they might prove helpful as the clinic continues its expansion and progress toward adequate psychiatric services for all inmates.

First, the author recommends that there be a continued and increased effort to develop a coordinated, integrated, well-planned intake procedure that will insure prompt handling, adequate screening, and thoughtful evaluation of all referrals. This intake procedure should also facilitate the appropriate use of the clinic facilities and aid in the most effective utilization of the particular skills of the professional staff.

Secondly, the writer suggests that the use of a face sheet be given consideration. This face sheet would be routinely completed on all referrals made to the clinic. This might facilitate the gathering of essential information and would serve as an expedient way of emphasizing essential data that is frequently needed.

Thirdly, consideration should be given to the value of recording and filing in the patient's folder the pertinent information which results from the "staffing" of a case by the clinic staff.

Fourthly, consideration might well be given to expansion of the monthly report to include all open cases. It might have value for future planning.

Finally attempts to help the prison staff formulate more definite reasons for referral, so assignment for intake interview might be more appropriately delegated should be considered.

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APPENDICES

SCHEDULE USED IN COMPILING DATA OF CLINIC CONTACTS, October 1, 1954 to 1/1/55

1. Number _____

2. Date of Referral _____ 3. Who Made Referral? _____

4. Stated Reason for Referral: _____

5. Initial Contact _____ Date of I.C. _____

6. Prior Contact During Preceding Yr. _____

A. If so, Nature of Contacts _____

B. Reason for Contacts _____

C. Disposition of Case _____

7. Chronic Mental Patient _____ or Series of Contacts Prior to Oct., 1953 _____

A. Prior Status in Clinic _____

B. Disposition of Case _____

SECTION II. This Information Applies only to Contacts of Three Months Period, October 1, 1954 to January 1, 1955

1. Who Had Initial Interview? _____

2. Further Contacts _____

3. Same Person _____

4. If Yes, When _____ By Whom? _____

For What Purpose? _____

5. Was Case Staffed? _____ When _____ Formally _____ Informally _____

6. Status of Case During This Time _____

A. Call Basis _____ B. Visitor _____

C. Out Patient _____ D. In-Patient _____

7. Disposition _____ A. Released _____

B. Carried on Caseload ____ C. Treatment _____
By Whom?

8. Diagnosis _____

(8-20)

APPENDIX B

SOCIAL SERVICE MEMORANDUM

SUBJECTIVE SOCIAL HISTORY OUTLINE (From Patient)

I. Sentence & Record.

II. Referral & Problem.

III. Parental History.

IV. Siblings.

V. Education, Employment & Military.

VI. Marital History.

VII. Personality & Social Adjustment (Optional).

VIII. Observations & Conclusions.

OBJECTIVE SOCIAL HISTORY (From Relatives)

I. Informants.

II. Parental History.

III. Siblings.

IV. Birth & Early Development.

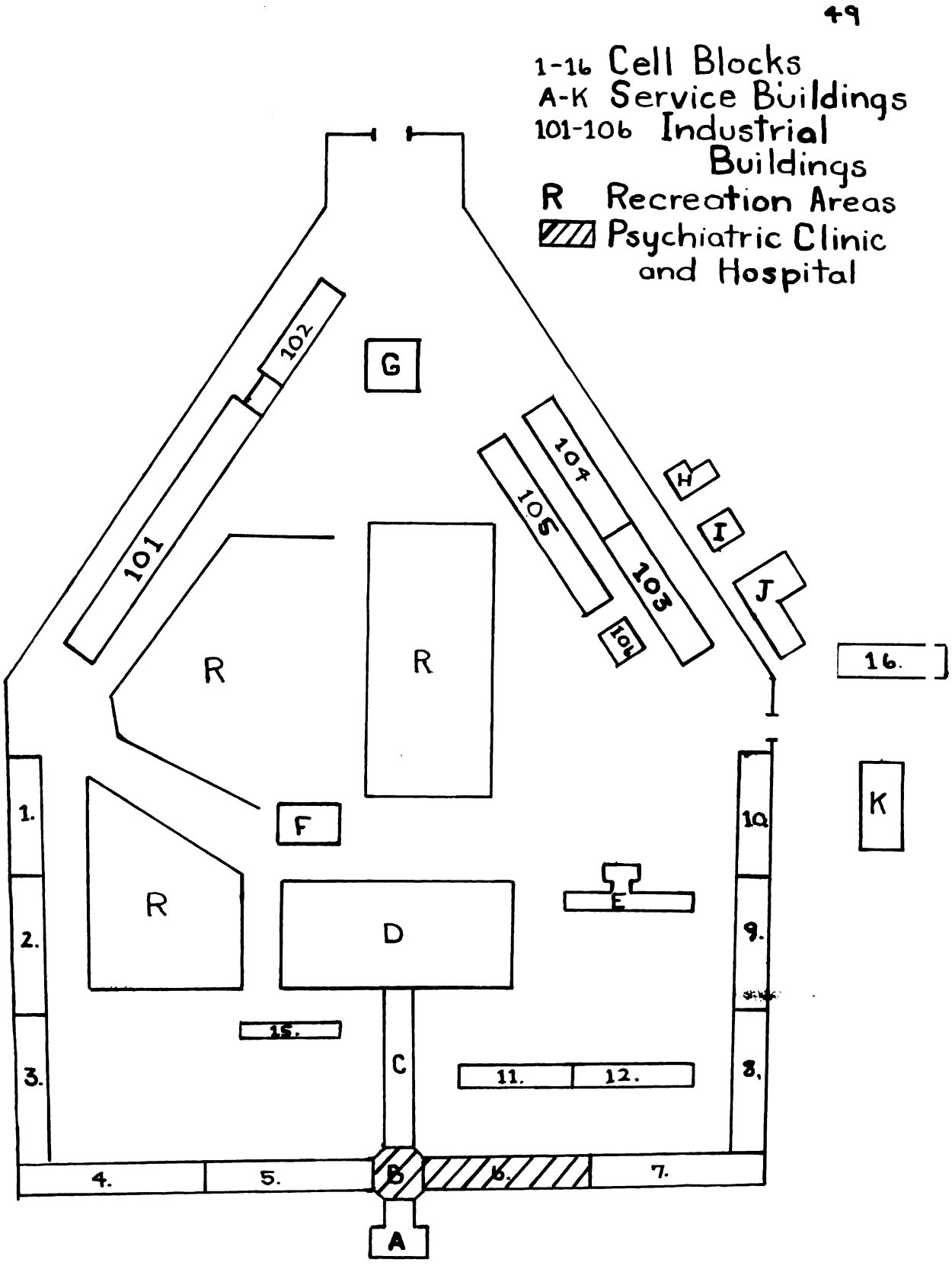
V. Education, Employment & Military.

VI. Marital History

VII. Informants Version of Record & Hospitalization.

VIII. Personality & Social Adjustment.

IX. Observations & Conclusions.



Ground Plan, State Prison Southern Michigan

Figure 1.

Ground Plan, State Prison Southern Michigan

Figure 1.

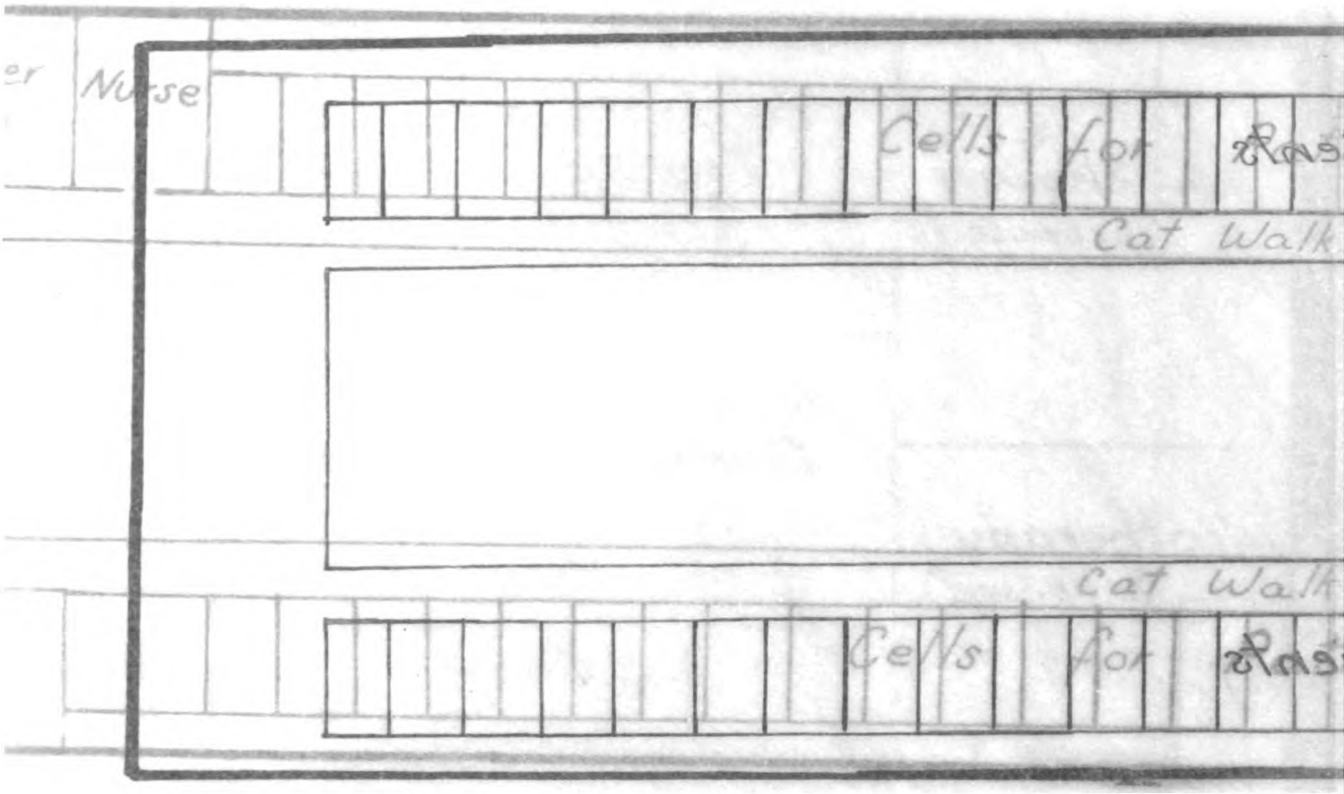

Nurse
Cells for
Cat Walk
Cat Walk
Cells for

Figure 2. Floor Plan, Psychiatric Clinic and Hospital

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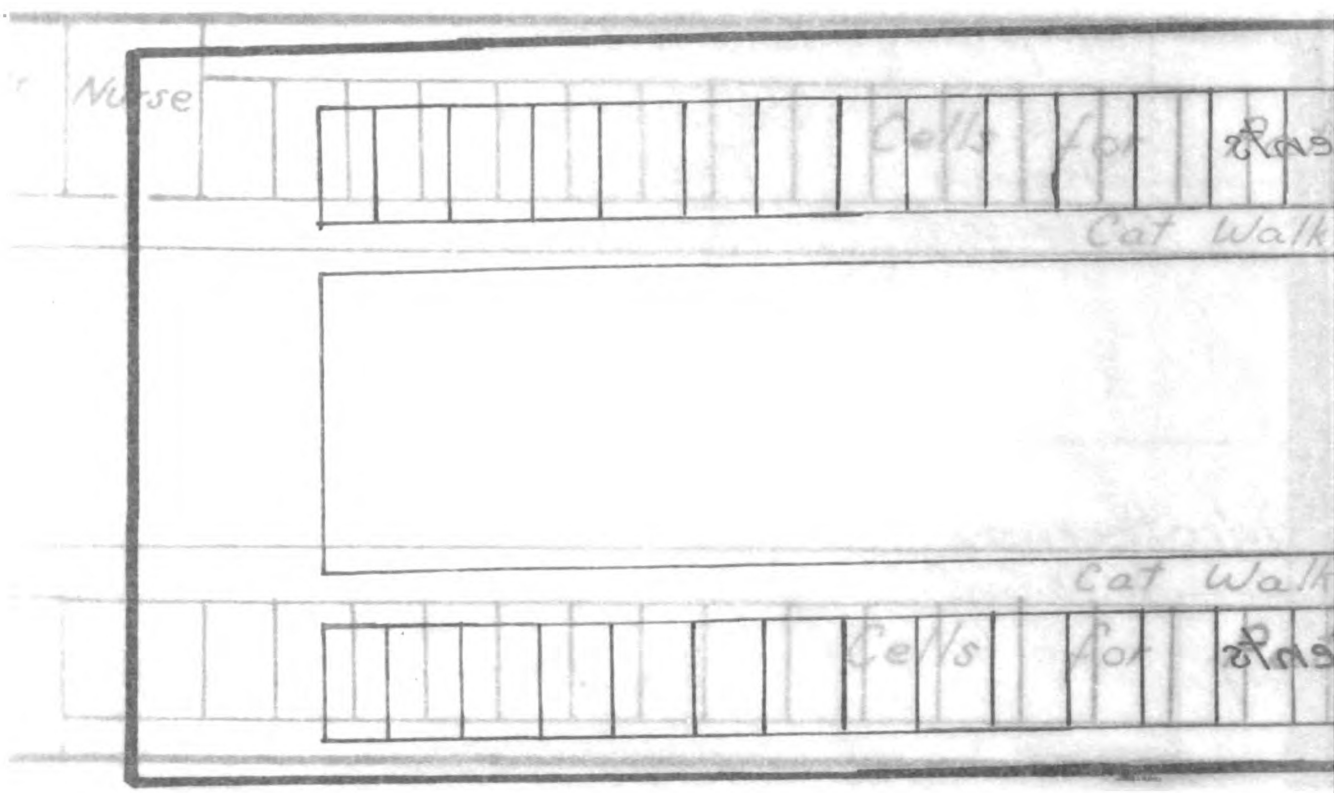
Ground Plan, State Prison Southern Michigan

Figure 1.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Cells for
Cat Walk
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Figure 3. Floor Plan, Psychiatric Clinic and Hospital