REFERRALS TO A PRISON PSYCHIATRIC CLINIC

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CHAPTER I

INTRODUCTION

Nature of the Study

A psychiatric clinic in a penal institution, like a psychiatric clinic in any setting, is dependent for its patients upon some kind of referral procedure. The patient comes or is brought to the clinic because somebody has referred him. The question, therefore, as to who refers and why assumes a high degree of importance. The extent to which the referral sources understand the purpose of the clinic goes a long way toward determining whether or not the resources of the clinic are being used to the best advantage.

The setting of this study is the Psychiatric Clinic at the State Prison of Southern Michigan, the specific concern being the referral sources. The object of the study is to find out how well the function of the clinic is understood by those who refer the patients.

It would be very difficult for the psychiatric clinic to prescribe exactly the type of patient or the type of problem it prefers because psychiatric services extend over a wide range of personal situations. But the clinic has found through experience that its efforts are more required and

more fruitful in certain cases than in others. Hence, because of limitations of time and resources, it has become necessary to turn down certain requests for services which may appear to be out of place, ill-timed, or of lesser importance.

It is assumed that the continued relationship with the clinic provides an opportunity for the referral sources to become more aware of what circumstances and needs of an inmate warrant a referral of that individual. It is then hypothesized that these referral sources are coming to have a better perception of the clinic's function and that this increased understanding is being reflected in more appropriate referrals.

Four different aspects of the referral process will be examined: the referral sources, the referral reasons, the disposition of the referrals by the clinic, and the clinic's psychiatric diagnostic classification of the patients referred.

Comparisons with Previous Studies

To a great extent, this study will involve comparisons with the study made by Mr. Kenneth R. Davis in 1956. The purpose of the present researcher, however, is somewhat different. Whereas, Mr. Davis' study was chiefly of an

exploratory nature dealing with the referral and intake procedure, this is a study focused upon a specific aspect of the referral process, the perception of the clinic's function by the referral sources. A brief explanation of the 1956 study as well as a similar study in 1954 is in order.

The year following the establishment of the clinic in 1953, a student doing his field work at the clinic conducted an exploratory study of the referral and intake procedure of the clinic, taking his data from the clinic files for the period of October through December, 1954. One of his recommendations was that the referral sources should be helped "to formulate more definite reasons for referral."[1]

Two years later, another graduate student whose field work was at the clinic made a study of the referral and intake procedure, taking his data from the files for the period of October through December, 1956.[2] The 1956 study was initiated with the intention of comparing the referral and intake procedure at that time with that shown in the 1954

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[1] John Eldon Davis, "An Exploratory Study of Referrals and Intake Procedure within the Psychiatric Clinic at State Prison of Southern Michigan" (unpublished Master's Research Project Report, Department of Social Work, Michigan State University, 1955), pp. 42, 43.

[2] Kenneth R. Davis, "An Exploratory Study of Referral and Intake Procedure within the Psychiatric Clinic at State Prison of Southern Michigan" (ubpublished Master's Research Project Report, Department of Social Work, Michigan State University, 1957).

study. However, the researcher of 1956 found that because of certain changes he could make only a partial comparison with the 1954 study. He did find, however, certain "distinguishable differences" in the intake and referral procedure of 1956 as compared with 1954. The sources of referral seemed to have a somewhat different conception of the clinic's functions. For example, the majority of referrals in 1954 were for "acting out" behavior while the 1956 study showed the majority of referrals to be for psychiatric evaluation and treatment. This discovery indicates that the referral sources were coming into a somewhat truer conception of the clinic's function.

The second major purpose of the 1956 study was to determine the effect which the newly created Reception-Diagnostic Center had produced upon the clinic's referral and intake procedure. This center, known as the "R-DC," is housed within the prison but serves the entire program of the Michigan Department of Corrections. Here men newly sentenced remain for an orientation period of 30 to 45 days, during which time social histories are taken, inoculations given, and psychological tests are administered prior to classification for transfer to one of the several state penal institutions. The study disclosed that most of the referrals from the R-DC required extensive services in the areas of psychiatric evaluations and treatments, leading the 1956 researcher to

conclude that the clinic's referral and intake procedure had been modified thereby.

The present study was decided upon after it was ascertained that the two-year period following the 1956 study was a sufficiently long period to make possible certain comparisons. By taking the data from the files for the period of October through December, 1958, and making direct comparisons with the 1956 study, it was thought that some trends might be pointed up that would help the clinic staff to understand better how its function is coming to be interpreted by the referral sources.

The Setting

The Psychiatric Clinic at the State Prison of Southern Michigan serves a community of some 5,000 inmates. The prison walls enclose an area of fifty-seven acres inside of which live approximately 3,500 inmates under conditions of maximum security. Outside the walls in the trusty division may be found something like 1,500 inmates who live under conditions of medium and minimum security. The clinic is housed within the fifth (or top) tier of cell block No. 6. The ward has seventy beds and is usually utilized to full capacity. The four lower tiers of this block accomodate around 300 ex-ward patients, medical patients, and other inmates who need special care. All these men require frequent contacts with

the clinic for treatment and general supervision.

Although housed within the prison, the Psychiatric Clinic is not by administrative structure a part of the prison. The director is responsible solely[1] to the Michigan Department of Corrections. At the same time, the clinic exists wholly to answer needs that arise from the inmate population. Though administratively separate, the clinic is engaged in a program that functionally ties in with the general operation of the prison. The lines of communication are kept open between the clinic and the proper prison officials. The director of the clinic may confer directly with the warden on matters of top-level concern. Communication is further enhanced through direct personal contact by certain clinic staff members, respectively assigned to coordinate clinic services with those of the other departments of the prison.

In 1958, at the time covered by this present study, there were thirteen civilian employees of the clinic. Of the three psychiatrists, one was the director who served only part-time, one a resident on full-time status and one a consultant on part-time. Two of the three psychologists were employed full-time, the third one being a part-time consultant. Three full-time social workers were on the staff, one being the director of psychiatric social services. In addition, there were two nurse supervisors, an electroencephalogram technician, and a secretary to the director,

all full-time. Twenty-seven inmates were employed by the clinic; of this number, fifteen were nurses while four served on the office clerical force. Most of the remaining inmate positions were filled by one individual each.

Definitions of Terms Used

Custody is that part of the administrative structure of the prison which is responsible for the safekeeping of the inmates and for the enforcement of the prison rules. The Reception-Diagnostic Center is a separate unit housed within the prison whose duties cluster around the inmates' orientation and initial classification. Classification means the classification committee which, as a part of the classification division of the prison, is responsible for the processing, reclassifying and reassigning of all inmates. The counselors function as a part of the classification division, one of their chief responsibilities being to help the inmates with their own personal problems. Self-referrals are those in which the inmate, himself, makes a direct request for the service by writing a note to the clinic.

A case of Re-referral is that in which the inmate referred has upon some previous occasion been a patient of the clinic. An In-patient is one who lives on the ward. An Out-patient is one who is a recipient of the clinic's services, but does not live on the ward. By Disposition is

meant the determination of whether or not a case referred to the clinic is to be closed with the initial interview or kept open for some kind of further services.

Psychotic disorders "are characterized by a varying degree of personality disintegration and failure to test and evaluate correctly external reality in various spheres. In addition, individuals with such disorders fail in their ability to relate themselves effectively to other people or to their own work,"[1] Personality disorders "are characterized by developmental defects or pathological trends in the personality structure, with minimal subjective anxiety, and little or no sense of distress. In most instances, the disorder is manifested by a lifelong pattern of action of behavior, rather than by mental or emotional symptoms."[2] The chief characteristic of a Psychoneurotic disorder "is 'anxiety' which may be directly felt and expressed or which may be unconsciously and automatically controlled by the utilization of various psychological defense mechanisms (depression, conversion, displacement, etc.)."[3] Brain Disorder "is a basic mental condition characteristic of

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[1] Diagnostic and Statistical Manual - Mental Disorders, American Psychiatric Association Mental Hospital Service (Washington: 1952), p. 24.

[2] Ibid., p. 34.

[3] Ibid., p. 31.

diffuse impairment of brain tissue function from any cause. It may be mild, moderate, or severe...."[1] Mental Deficiency "is primarily a defect of intelligence existing since birth, without demonstrated organic brain disease or known prenatal cause."[2]

Procedure

The system by which data was collected for this study followed very closely the plan used by the 1956 researcher. It was thought that using the same schedule would facilitate comparing the findings of the two studies. The only change in the schedule was adding an item in regard to out-patient group treatment, which type of treatment had not yet been initiated in 1956.

The first step was to examine the file cards listing the inmate numbers and dates of referral. All patients have a folder starting with their first contact with the clinic. Having thus obtained the numbers of the patients referred for the period of October through December, 1958, the next step was to examine the individual folders. There were found to be 228 referrals for the period. Certain of these referrals

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[1]Ibid., p. 14.

[2]Ibid., p. 23.

not being usable, the plan of elimination followed that of the 1956 study.

Re-referrals were included only if the patients were not already in an active relationship with the clinic. Some patients were in an ongoing process of evaluation or treatment at the beginning of October. Referrals of such patients were not included in the study, regardless of when the referral might have occurred during the period. There were seventeen such referrals. Also eliminated were twelve referrals in which, for some reason or other, the patient did not appear at the clinic for interview. Not included, also, were nine referrals which were only reports on previous contacts. Also in some of the clinic folders examined the data was incomplete, in others the contact had been through correspondence, and in a few other cases there were duplications. This miscellaneous group amounted to twenty-three. The total number of referrals eliminated was sixty-one. This left 167 referrals which were judged to be appropriate for the study.

It was intended for this study to make comparisons with the 1956 study in order to bring to light any changes and trends that may have occurred in two years. In great part, it has been possible to follow this plan. However, by including psychiatric diagnostic classification, the present study was able to go into an area not sufficiently open for

the other study. The findings here were limited as far as the search for changes in the two-year period was concerned, but it was thought that an examination of this phase of the referral process might contribute to the purposes of the study.

CHAPTER II

REVIEW OF LITERATURE

Introduction

The literature abounds with material on psychiatric clinics. It seems that practically every phase of clinical operation has been more or less adequately dealt with, but for one exception - the prison psychiatric clinic. Perhaps one reason for this is that it has been only in comparatively recent times that the change in penal philosophy has gotten under way. To look upon the offender as an individual who is in need of rehabilitation rather than of punishment requires an approach which society, as yet, is altogether too unwilling to accept. Hence we find that, by and large, the prison psychiatric clinic has not as yet achieved the place of importance in penology which it deserves.

The Readings

The readings divided themselves into three general types: first, those discussing the general problem of treatment in a total prison setting; second, those which are concerned with psychiatric clinics in general; and third, those having to do specifically with psychiatric clinics in prisons.

1. Treatment in a prison setting

Reckless observes that it has been over 400 years since the beginning of prison reform.[1] Not much progress was perceptible for a very long time. Though having been at the task much longer, it has been far more difficult for corrections than for family service and child welfare to inaugurate programs of treatment. The writer, however, senses encouragement. "As correctional institutions get personnel who are skilled in group therapy methods and begin trying out certain projects on a limited scale a grass roots experience will be built up and the possibilities and limitations of the technique will be understood."[2]

Judge Westover sees the post-prison environment as being responsible for the lack of success in the rehabilitation of offenders.[3] The released individual faces a hostile, indifferent and cold world where he is denied employment. The result is the undoing of whatever rehabilitation was begun or accomplished by the treatment facilities of the prison. Society should become concerned and provide the opportunities needed for earning a livelihood.

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[1]Walter C. Reckless, "Significant Trends in the Treatment of Crime and Delinquency," Federal Probation, Vol. XIII (March, 1949), pp. 6-8.

[2]Ibid., p. 8.

[3]Harry C. Westover, "Is Prison Rehabilitation Successful?" Federal Probation, Vol. 22 (March, 1958), pp. 3-6.

The question as to the extent to which inmates are actually reformed is quite in place. Vold points out that there is general agreement that the desired end of imprisonment is reformation.[1] But, as to the methods of bringing this reformation about, there is considerable controversy among penal authorities. The psychological and psychiatric services deal with deep-seated mental disturbances as they relate to misconduct. Treatment is patterned on that of a mental hospital and the recidivism is high. The other type of service is education and vocational training. Vold goes on to say, "The mere increasing of facilties and manpower to do better and more completely what we are now doing will not help much unless there is developed a comprehensive and deeply searching program of research as the springboard for new techniques of treatment."[2] Vold concludes his article by stressing that what is needed is more skilled research workers, the support of whom will be provided in the budgets. This can be attained only by selling top-level responsible administration on the idea.

Nagel sees penal institutions as expected to perform a dual service for the protection of society, namely, the

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[1] George B. Vold, "Does the Prison Reform?" Prisons in Transformation, ed. Thorsten Sellin, The American Academy of Political and Social Science (Philadelphia: 1951), pp. 42-50.

[2] Ibid., p. 50.

custody and reformation of the offender.[1] The warden is prone to feel that his success is largely measured by the fact there are no escapes and riots. What is too often forgotten is the fact that the services of caseworkers help to dispel anxiety and, hence, prevent trouble. Inmates need help around current reality problems. The emphasis should be on short-term treatment so that more inmates can get help. Institutional maladjustment or a violation of the rules creates anxiety that often stimulates the individual to seek help. Sometimes by helping to clear up an inmate's worry about his family, a caseworker gives a big assist both to custody and to treatment.

The uniqueness of prison society is pointed up by Miller.[2] The inmates carry their hostile attitudes and anti-social behavior into prison. They are unable to form interpersonal relationships or mutual trust and faith. The inmate is the result of a previous life experience of rejection. He is suspicious and finds it difficult to accept humanitarianism. A hierarchy of "pecking order" develops. To a great extent, the inmates make and enforce their own decrees,

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[1] William G. Nagel, "Custody and Treatment - Twin Aims of the Prison Social Worker," Casework Papers, 1957, Family Service Association of America (New York: 1957), pp. 91-102.

[2] Paul R. Miller, "The Prison Code," American Journal of Psychiatry, Vol. 114, January, 1958, pp. 583-585.

exercising a great measure of control through fear and fines. Control falls into the hands of the most manipulative, predatory inmates. The prison code, which is enforced by positive and negative sanctions evolved by the inmates themselves, is outside the regular, institutional rules. Acting to prevent resocialization the prison code is a deterrent to treatment. But custodial officials oftentimes use the code to their advantage, for if special privileges are granted to the strongest he helps maintain order and, thus, gives an assist to custody.

McCorkle and Korn also show how very difficult is resocialization of prison inmates.[1] The inmate social system becomes most useful to those who have become most independent of society's values. Those whose self-evaluations are dependent on the values of the non-criminal society have the hardest time adjusting to a social system whose major values are based upon the rejection of that society. Aggressive inmates exercise control through threats and rewards. Custody uses the inmate power structure as an aid in prison administration. Humanitarianism is not especially appreciated by the inmate because his system of adaptation creates within him a need to protest. In his role of the martyred

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[1] Lloyd W. McCorkle and Richard Korn, "Resocialization Within Prison Walls," Prisons in Transformation, ed. Thorsten Sellin, The American Academy of Political and Social Science (Philadelphia: 1951), pp. 88-98.

victim, he needs some place upon which to turn the hostility generated by his failure in human relations. He gains absolution from the sense of guilt by thinking of society's offense against him.

2. Community psychiatric clinics

Bradbury made a study based upon fifty random intake records taken from the periods of August, 1948 through January, 1949 and of August, 1950 through January, 1951.[1] The study was concerned with intake trends and efforts of the clinic staff to interpret its function to the referral sources. The areas examined were: reasons for referral, source of referral, presenting problem, tentative diagnosis and disposition of the case. The majority had been referred by other sources within the hospital. It was found that there was an increase in the number of psychotic patients and a decrease in neurotic patients. The greatest decrease, however, was in patients with somatic disorders. There was an increase in diagnostic evaluation and short-term treatment. The study showed that the clinic's interpretative activities had succeeded in the hospital but had had little effect in the community at large.

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[1] Ruth S. Bradbury, "Intake Trends and Interpretation in a Psychiatric Clinic," (Strong Memorial Hospital, Rochester, N.Y.), Smith College Studies in Social Work, Vol. XXII, (July, 1951), p. 127.

The matter of long waiting lists and inability of a clinic to respond adequately to crisis situations received the attention of Coleman and Zwerling.[1] "Soon after the clinic is established a familiar pattern asserts itself: the overwhelming demands for service quickly gluts up the lines which feed into the clinic from the community." The sooner the individual's trouble is gotten to the better. Hence the need for early diagnosis and treatment. What is urgently needed is the ability of a clinic to offer a wide variety of immediate out-patient services.

Cooper notes that social workers lean toward the democratic philosophy of first come first served.[2] But intake workers must be alert lest they be manipulated. In the selecting of urgent cases look for the answers to certain questions. Is the client facing a new life crisis occasioned by environmental stress? Is he going through some developmental physical and emotional change? Are there new symptoms? Are there sudden and sharp regressions? Do the defenses appear to be shifting? Is the psychopathology spreading? Are there in the environment available people to lend support and help? A final question would be, is the individual

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[1]Donald M. Coleman and Israel Zwerling, "The Psychiatric Emergency Clinic, A Flexible Way of Meeting Community Mental Health Needs," American Journal of Psychiatry, Vol. 115 (May, 1959), p. 980.

[2]Shirley Cooper, "Emergencies in a Psychiatric Clinic," Social Casework, Vol. XLI (March, 1960), pp. 134-139.

liable to do harm to himself or others? The intake worker should get enough of the problem to weigh the urgency of the referral. He should be in a position to estimate the degree of "the push of anxiety" or the "pull of depression." The degree of reliability of the referral source should be considered. In essence, Cooper seems to say: when in doubt, give the appointment.

An experiment with acutely disturbed patients in an open ward is reported by Young.[1] The setting was a thirty-bed psychiatric ward in a community hospital. Previously the inmates were kept in single locked rooms because of the anxiety of the staff as to possible violence, escapes and suicides. Out of the experiment, which was considered a success, certain principles evolved:

1. keep open the lines of communication so that mutual understanding can be maintained among all the staff members and patients;

2. help patients use their strengths by working with the healthy parts of the personality;

3. foster group living by helping patients accept responsibility and become a part of the group; give each person one vote;

4. at group meetings examine feelings;

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[1]Calvin L. Young, "A Therapeutic Community with an Open Door in a Psychiatric Receiving Service," A.M.A. Archives of Neurology and Psychiatry, Vol. 81 (January through July, 1959), pp. 335-340.

5. by this group process, those patients admitted are examined and evaluated by the staff and a treatment plan set up for each.

Visher reports on an experiment in shortening the amount of time in psychotherapy.[1] In the 1950-1953 period each staff member of this clinic served 61.1 patients per year, averaging thirty-six hours per patient. In 1954-1955, with the emphasis on psychiatric diagnosis and group therapy, 121 patients were served with an average of twenty-four hours per treated case. The staff must be educated as to the possibilities of short-term treatment. In this case, the staff saw some patients who had been successfully treated in five to ten interviews. There was quite an administrative problem, however, in finding the most likely patients. The criteria of selection was: first, readiness for change; second, the nature of the presenting problem; third, environmental stability; and fourth, the reaction of the patient to the intake interview.

Brief psychotherapy, the writer points out, is not "a desperate expedient adopted by an overburdened clinic staff to dispose of as many patients as possible."[2] It is treatment of choice where the goal is to return to former

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[1] John S. Visher, "Brief Psychotherapy in a Mental Health Clinic," American Journal of Psychiatry, Vol. 13 (April: 1959), pp. 331-342.

[2] Ibid., p. 341.

functioning, not to arrive at normal expectation. To say it another way, the "goal of treatment is to relieve anxiety and to teach more effective ways of coping with problems which have temporarily overwhelmed the individual."[1] "From the standpoint of a mental hygiene clinic itself, brief psychotherapy, when available, is a potent weapon of the clinic staff in the attempt to meet the therapeutic needs of a diverse population."[2]

To what type of patient should group psychotherapy be extended? Leopard sees group therapy operating on many levels and as being a method of treatment which could be recommended for many types of patients.[3] It has been found effective for borderline and ambulatory schizophrenics. For some patients who are socially deprived and isolated, the group fulfills their need for belonging and establishing better social relationships. With other patients the transference in individual therapy is too intense and anxiety producing, and the group offers an opportunity for the release of tensions and the reduction of guilt feelings. Some patients are better able in this group to express hostile feelings than in the one-to-one relation. Homosexuals may

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[1]Ibid., p. 342.

[2]Ibid., p. 342.

[3]Harold Leopard, "Selection of Patients for Group Psychotherapy," American Journal of Psychotherapy, Vol. 11 (July, 1957), pp. 634-637.

begin to be able to establish better interpersonal relationships.

Leopard goes on then and gives some criteria for determining who should be in a group. The individual must be a person who (1) has full reality contact (2) can be reached emotionally in an interpersonal relationship (3) is sufficiently flexible to increase or decrease group tensions, and (4) may at times act as a catalyst for another member of the group. The individual who should not be in the group is he who (1) because of constant irrational productions cannot be reached by the other members (2) over a protracted period so monopolizes the group that all interaction is blocked (3) cannot cope with anxiety provoking unconscious productions - his own or those of others and, therefore, becomes a burden to the group, and (4) by his destructive impulse-ridden and anti-social behavior elicits fears in the other members of the group.

Leopard concludes by saying it is a mistake to use "diagnostic label and pathologic ramifications of the personality" as the only consideration. It is necessary to study the variables of the personality structure and also the group structure or, in other words, the "psycho-dynamics of the patient and the psychologic impact of the group."

Can group therapy and individual therapy be combined into one treatment program? Lipschutz advocates this as a

definite method of therapy and, when so used, the two types must be equated not one used to supplement the other.[1] Nor should this method be confused with the circumstances in which individual therapy is used to get the patient ready for group therapy or vice versa. In certain situations the combined method has much to offer. To some patients the expression of hostility toward the therapist in the group would mean the breakdown of the entire defense system, hence the need for the individual session. With other patients the transference in individual therapy is too strong. In the individual sessions the therapist becomes aware of current conflicts thus knowing what to look for in the group. The combined method offers the opportunity for the modification of transference and counter-transference. It provides a flexible way of handling a greater variety of problems.

3. Prison psychiatric services

That psychiatry as practiced in prison is different from that in other settings is pointed up by Powelson and Bendix.[2] The prevailing view is that the purpose of the prison sentence

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[1] Donald M. Lipschutz, "Combined Group and Individual Psychotherapy," American Journal of Psychotherapy, Vol. 11 (April, 1957), pp. 336-344.

[2] Harvey Powelson and Reinhard Bendix, "Psychiatry in Prison," Psychiatry, Vol 14 (1951), pp. 73-86.

is to punish the offender and protect society by putting the offender in safe keeping. It is necessary for the psychiatrist to come to an adjustment or compromise with this prevailing viewpoint. In prison the inmate is subjected to the final authority of the guard. The moral depravity of the prisoner being assumed there is a moral gulf between the prisoner and the guard. On the other hand, the psychiatrist recognizes that criminal tendencies exist in everybody - guards and officials as well as prisoners. There are times when the guard may be wrong. In regard to the motivation of the prisoner, custodial officials see him as wanting above all things to get out of the prison, be the means foul or fair. The psychiatrist sees the inmate as afraid of the outside world and adjusting all too well to the jungle. A psychiatrist with an authoritarian tendency fits better into a prison system. If he is otherwise he is ineffective.

Speaking from his experience as staff psychiatrist in a medium security psychiatric ward of a Federal prison hospital, Graft maintains that inmates respond favorably to humane treatment.[1] "The climate of the ward changed despite a residue of chronically ill patients. The unit won the softball league championship. The year before they were not permitted

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[1] Norman Graft, "Experiences in a Prison Hospital," Bulletin Menninger Clinic, Vol. 20 (March, 1956), pp. 85-91.

to use a full-size bat because it was considered a lethal weapon. The unit became cheaper to operate because of the decrease in breakage."[1] The officers in charge got the spirit and cooperated in improving the ward. Graft is convinced that "a schism between the goals of custody and therapy is not inevitable if the attempt is made to educate custodial personnel to the value of an active therapeutic milieu in terms of greater job satisfaction for them."[2] "An effective therapeutic program in a prison hospital...cannot succeed without the cooperation of the administrative echelons of custody and therapy at higher levels."[3] To succeed the program necessitates an in-service training program for the custodial officers.

To what extent does a prisoner feel free to discuss with the therapist any phase of his career? MacCormick stresses the fact that a prisoner has as much right to a confidential relationship with his therapist as with his attorney or clergyman.[4] Group settings should foster freedom of expression unhindered by a fear that any new knowledge will be added

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[1]Ibid., p. 90.

[2]Ibid., p. 91.

[3]Ibid., p. 91

[4]Austin MacCormick, "A Criminologist Looks at Privilege," American Journal of Psychiatry, Vol. 115 (June, 1959), pp. 1068-1070.

to the inmates' records. "Unless they can be sure that whatever they reveal in therapy will not be reported to the institution administration or parole board the effectiveness of the psychotherapy will be disastrously impaired."[1]

Based upon an experiment in a California state hospital, Rood concludes that more effective therapy for certain non-psychotics can be provided in a non-prison setting.[2] Group therapy of sexual psychopaths was conducted by psychiatrists, psychologists and social workers. The hospital is a better setting for psychotherapy than a penal institution because of the spirit of acceptance of the entire staff as against the punitive philosophy of the prison. Absent is the cold war which exists in a prison setting and, hence, the atmosphere is more relaxed.

The Psychiatric Clinic of the State Prison of Southern Michigan is mentioned in an article describing the work of the Michigan Department of Corrections.[3] The purpose of the clinic is described as being primarily that of providing diagnostic and short-term treatment services.

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[1] Ibid., p. 1070.

[2] Reginald J. Rood, "The Non-psychotic Offenders and the State Hospital," American Journal of Psychiatry, Vol. 115 (December, 1958), pp. 512-513.

[3] Gus Harrison, "Michigan Corrections Department," American Journal of Correction, Vol. 20 (July-August, 1958), pp. 6-7, 27-33.

The most complete study concerning prison psychiatric facilities is that of Dr. Wille, which was completed in July, 1954.[1] Note is first made of a survey conducted in 1927 by the National Crime Commission through its Sub-committee on the Medical Aspects of Crime. This earlier study covered Federal as well as state penal and correctional institutions. It included juvenile institutions, farms, and criminal courts and jails. The responses to the survey showed nineteen full-time and twenty-four part-time psychiatrists active in this field. But twenty-four states and thirty-four prisons had none. Federal prisons reported three full-time and one part-time psychiatrists.

In Dr. Wille's study, questionnaires were sent to the 315 state and federal prisons and correctional institutions listed by the American Prison Association. Of this total number, 167 were prisons or reformatories for adult or young-adult offenders. The responses from these latter sources totaled 121 or seventy-two per cent.

Of the 150 state prisons and reformatories, 104 reported showing eighty of these institutions as having psychiatric services. Nineteen had a full-time psychiatrist, twenty-eight had the regular part-time services of a psychiatrist,

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[1]Warren S. Wille, "Psychiatric Facilities in Prisons and Correctional Institutions in the United States," The American Journal of Psychiatry, Vol. 114 (December, 1957), pp. 481-487.

and thirty-six had consultation services only. Ten states had no psychiatric services at all for their correctional institutions. Thirteen others made use of only occasional psychiatric consultation.

The eighty state institutions with psychiatric services employed thirty-one full-time psychiatrists, thirty-four part-time psychiatrists, and forty-two psychiatric consultants. Federal institutions showed twelve full-time and five part-time psychiatrists with nine consultants. The grand total of psychiatrists, including consultants, for federal and state institutions was one hundred and thirty-three.

There is a great variation among the different states. One state had a seventy-five bed ward but no services of a psychiatrist. The patients were examined once per year by a state hospital psychiatrist. Some states were making use of regional mental out-patient clinics for psychiatric evaluation. Other states were developing central psychiatric services.

Six prisons, including the State Prison of Southern Michigan, were using psychiatric residents through arrangements with medical schools. Forty-seven institutions had psychiatric wards within the prison hospital, but only ten had more than twenty-five beds. Eleven of these wards had no trained civilian nurses. Nineteen had either trained civilian

nurses or nurse supervisors and ten had only civilians on the nursing staff.

In seventeen institutions, the staffs of the psychiatric services carried on individual psychotherapy while twenty-eight others provided only for group psychotherapy. In other institutions only emergencies were attended to by the meager psychiatric staff. Thirty-one institutions had psychiatric reference libraries and twenty-eight had diagnostic files. There were eight institutions with electroencephalographic laboratories.

Eighty-five psychologists and ninety-eight social workers were employed in state institutions. In federal prisons, there were five psychologists and sixty-six social workers. In thirty-four cases regular use was made of the teamwork type of clinical approach.

Dr. Wille concludes his article by saying that "Despite the increasing recognition that many repetitive offenders are mentally ill and that criminal behavior stems from unconscious conflicts very few criminals actually receive thorough psychiatric study or treatment."[1]

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[1] Wille, op. cit., p. 487.

CHAPTER III

PRESENTATION AND ANALYSIS OF DATA

Referral Sources

The 1956 study found self-referrals heading the list, followed by referrals from custody. The same two sources though in reverse order ranked first and second in the 1954 study.

This present study shows a considerable shifting of relative positions in the rankings of the referral sources. That the counselors moved from midway to the top place can partly be accounted for by the fact that by the time of the 1958 period self-referrals could be only re-referrals. An inmate without previous contact with the clinic had to be referred by some person in official capacity. If he desired some clinic service he could discuss the matter with some official, usually his counselor, who might deem it appropriate to grant his request to be referred, or the counselor, himself, might handle the problem. This change in procedure apparently has helped to eliminate some needless self-referrals.

Classification, which ranked next to the last in the 1956 period studied, attained second place in the 1958 period. The increase in referrals from classification can be largely

accounted for by the fact that the referrals from the Reception-Diagnostic Center reach the clinic through the classification committee. It was found to be difficult to select out the referrals from R-DC since the origin of the referral was not always stated on the referral sheet. Hence R-DC was not included as a referral source. As the inmates pass from R-DC to classification those the former recommends to the clinic are not always referred immediately.

Two other referral sources which had increased their proportions of the referrals were the parole board and warden. Examining Tables 2 and 3 we see that what probably contributed to this increase was that both referral sources were making greater use of the clinic for psychiatric evaluations.

The three referral sources that showed decreases were self, custody, and the hospital. The drop in self-referrals, as already noted, was due to a change in the clinic's policy. Many inmates had come to enjoy going to the clinic on the slightest excuse because of the friendly atmosphere there. Others who had never been to the clinic wanted to satisfy their curiosity. Hence controls had to be set up for self-referrals. There were to be no new self-referrals. As for a re-referral, an inmate could send a note to the clinic asking for an interview or a service. He might or might not be accepted, depending on the clinic's decision based upon prior knowledge of that inmate.

TABLE 1

COMPARISON OF REFERRAL SOURCES - 1958 & 1956

Referral Sources	1958		1956	
	No.	Per Cent	No.	Per Cent
Total:	167	100	198	100
Counselor	35	21	15	8
Classification	30	18	8	4
Parole Board	21	13	10	5
Self	21	13	42	21
Warden	18	11	5	3
Custody	16	10	39	20
Hospital	12	7	31	16
R. D. C.	x	x	29	15
Other Institutions	x	x	10	5
Miscellaneous	14	8	9	5

In those columns above where the percentages posted total more than 100, fractional parts of certain individual percentages have been carried to the next largest whole number.

TABLE 2

REFERRALS AND RE-REFERRALS BY SOURCES - 1958

Referral Sources	Total	Per Cent	New Referrals		Re-referrals	
			No.	Per Cent	No.	Per Cent
Total:	167	100	75	45	92	55
Counselor	35	100	20	57	15	43
Classification	30	100	21	70	9	30
Parole Board	21	100	11	52	10	48
Self	21	100	X	X	21	100
Warden	18	100	5	28	13	72
Custody	16	100	3	18	13	82
Hospital	12	100	7	58	5	42
Miscellaneous	14	100	8	57	6	43

TABLE 3

REFERRALS AND RE-REFERRALS BY SOURCES - 1956

Referral Sources	Total	Per Cent	New Referrals		Re-referrals	
			No.	Per Cent	No.	Per Cent
Total:	198	100	107	54	91	46
Self	42	100	19	45	23	55
Custody	39	100	13	33	26	67
Hospital	31	100	21	68	10	32
R. D. C.	29	100	26	90	3	10
Counselor	15	100	7	47	8	53
Parole Board	10	100	5	50	5	50
Other Institutions	10	100	4	40	6	60
Classifications	8	100	6	75	2	25
Warden	5	100	0	0	5	100
Miscellaneous	9	100	6	67	3	33

Most of custody's personal involvement with inmates is in the case of acting-out behavior. An inmate who has been a patient in the clinic is not to receive severe discipline without the consent of the clinic. If this written permission has not already been entered in the inmate's folder in the main record office, the officer's first impulse may be to send the offending inmate to the clinic. Table 2 shows most of custody's referrals to be re-referrals. From preceding Table 1 it is to be seen that there has been a very great drop in referrals from custody. It is quite evident that what has happened is that custodial officials instead of immediately referring an acting-out inmate to the clinic are coming to find that they themselves can often handle the situation. Sometimes all that is needed is firmness and understanding.

Referrals from the hospital also showed a very considerable decrease. From Table 4 and Table 5 it is seen that the hospital was taking care of a number of cases of bizarre behavior and emotional upset which it formerly would probably have referred to the clinic.

A referral source from which there were no referrals in this study was "Other Institutions". It is known that the other correctional institutions were still referring a few cases but during this three-month period there just happened to be no referrals from this source. It can be seen from Table 11 that most of these patients were transferred from other institutions for in-patient care. The great reduction

TABLE 4

REFERRAL SOURCES AND REASONS FOR REFERRAL - 1958

Reason for Referral			Counselor		Classification		Parole Board		Self		Warden		Custody		Hospital		Miscellaneous	
	Total	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent
Total:	167	100	35	100	30	100	21	100	21	100	18	100	16	100	12	100	14	100
Psychiatric Evaluation	99	59	19	54	18	60	19	90	3	14	15	83	8	50	8	67	9	64
Treatment	31	19	7	20	11	37	2	10	8	38	-	-	-	-	2	17	1	7
Emotional Disturbance	17	10	4	11	1	3	-	-	3	14	1	7	4	25	2	17	2	14
Bizarre Behavior	6	4	2	6	-	-	-	-	-	-	-	-	3	19	-	-	1	7
Non-Clinic Inquiry	5	3	1	3	-	-	-	-	4	19	-	-	-	-	-	-	-	-
Other	9	5	2	6	-	-	-	-	3	14	2	11	1	6	-	-	1	7

In those columns above where the percentages posted total less than 100, fractional parts of certain individual percentages have been omitted.

TABLE 5

REFERRAL SOURCES AND REASONS FOR REFERRAL - 1956

Reason for Referral			Self		Custody		Hospital		Reception Diagnostic Center		Classification and Counselor		Parole Board and Warden		Other Institutions		Miscellaneous	
	Total	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent
Total:	198	100	42	100	39	100	31	100	29	100	23	100	15	100	10	100	9	100
Psychiatric Evaluation	77	39	4	10	12	31	17	55	18	62	11	48	11	73	3	30	1	11
Treatment	26	13	2	5	-	-	4	13	7	24	7	30	2	13	3	30	1	11
Non-Clinic Inquiry	24	12	24	57	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Nervous	20	10	6	14	5	13	3	10	1	3	3	13	-	-	-	-	2	22
Bizarre Behavior	18	9	1	2	8	20	3	10	1	3	-	-	1	7	4	40	-	-
Emotionally Disturbed	17	9	2	5	8	20	3	10	1	3	-	-	-	-	-	-	3	33
Inability to Adjust	9	5	1	2	5	13	-	-	1	3	1	4	-	-	-	-	1	11
Other	7	4	2	5	1	3	1	3	-	-	1	4	1	7	-	-	1	11

In those columns above where the percentages posted total more or less than 100, fractional parts of certain individual percentages have been carried up to or dropped to the next largest whole number.

in such referrals was apparently due to the fact that the in-patient capacity of the clinic was now having to be almost wholly utilized for chronic patients of the local prison.

An explanation would help to clarify the reason for the clinic's inability to respond to the need for custodial care of psychotic patients. The state facilities for the care of the mentally ill offenders are becoming very crowded. When it was no longer possible to move some of the in-patients to other institutions, the in-patient group tended to become composed of a high proportion of chronics who need longer care. Hence admissions to the ward had to be carefully screened.

As for the "Miscellaneous" listing the chief referral sources were the work supervisors and the chaplains who also were represented in the 1956 study. There were not enough referrals here to justify trying to make comparisons.

It is quite apparent that in the intervening period between the two studies there was a considerable shift in the relative proportion of referrals among the various sources. In most respects the changes were greater than in the period between the 1954 and 1956 studies. For instance, the 1954 study showed sixty-eight per cent of the referrals coming from the three sources of custody, self, and the hospital. The 1956 study found fifty-seven per cent coming from the same three sources. But this researcher found these sources accounting for only thirty per cent of the referrals.

To complete this picture of the reversal in referral sources the present study found sixty-three per cent of the referrals coming from the counselors, classification, the parole board and the warden. The 1956 study revealed that only twenty per cent came from these sources. The 1954 study showed that these sources accounted for fifteen per cent of the referrals, with none at all reported from classification.

By way of summary it can be said that comparison with the 1956 study along with a few references to the 1954 study shows that considerable changes were taking place among the referral sources. Furthermore, these changes especially in some cases were of a type that seemed to indicate that the referral sources were coming to have somewhat of a better understanding of the clinic's purpose and limitations.

Reasons for Referrals

In trying to categorize the reasons for referral as given by the referral sources it was found necessary to resort to a measure of interpretation. While in the great majority of cases the reason was explicitly stated, in some instances it was not clear exactly why the referral had been made and it was sometimes necessary to examine the dictated interview in order to arrive at a decision as to what category to ascribe the reason for referral.

For example, in this study the category of "emotional disturbance" is used also to include certain types of behavior that the two previous researchers most probably classified as "nervous" and "inability to adjust". In a few cases some self-referrals specifically stated "I am nervous" and other referrals indicated an inability of the inmate to adjust to a prison routine. A further reading of these records seemed to justify the inclusion in the emotional disturbance category.

Regardless of any change which this study made in eliminating the categories, the fact remains that referrals for "nervousness" and "inability to adjust" had declined very appreciably from the number reported in Table 5 for the 1956 period.

As has just been noted, it is difficult in certain instances to differentiate among the stated reasons for the referrals. It is still more difficult to determine the actual reason which lies behind the referral. For example, an inmate may be acting strangely or anti-socially. He is referred to the clinic. One referral source might state that the patient is emotionally upset, while another might simply request psychiatric evaluation.

Also, it should be remembered that although different referral sources may give identical or similar reasons for the referral, it can by no means be assumed that they all mean the same thing. What is meant by psychiatric evaluation, for

example, depends upon the referral source and the purpose behind the referral. The parole board wants an evaluation of an inmate in regard to his possible return to society. Classification asks for evaluation so as to better understand how to get the inmate into the proper prison program, as regards such things as job, education, and cell block, to which to assign him. Then the counselor may suggest evaluation with possible therapy in view. To the clinic psychiatric evaluation is very flexible and is guided by the specific circumstances surrounding the referral.

With these explanations the data in Tables 4 and 5 still can be seen to give considerable information about reasons for referral. More sources are giving psychiatric evaluation and treatment as the purpose of the referrals. To simplify a referral by stating that the patient was "emotionally disturbed" or "acting queerly" is not practiced by the referral sources nearly so much as it once was. However, it should be pointed out that though the referral source gives psychiatric evaluation or treatment as the reason for referring, there oftentimes is an accompanying description of behavior. As for priority, emergency referrals, such as acute situational episodes, get immediate attention.

The drastic reduction in the number of referrals for non-clinic inquiry can be accounted for by the restrictions placed upon self-referrals as heretofore mentioned. New referrals

from self can no longer be made. Re-referrals from self are carefully scrutinized before being accepted. The clinic prefers not to expend its resources of time and effort on requests and inquiries the answers to which clearly fall within the function of other departments of the prison.

It is to be noted that with a few exceptions the changes between 1956 and 1958 in referral reasons are rather modest. The general tendency is for the referral sources to continue giving the same reasons for their referrals. But there is perceptible a small overall shift in the direction of referral sources giving psychiatric evaluation and treatment as the reasons for their referrals.

Table 4 shows what proportion of the total number of referrals is represented by each referral reason. Roughly, out of every ten referrals, six were for psychiatric evaluation, two were for treatment, and one was for emotional disturbance.

Comparing the individual sources with the general average percentage for each reason the extent of some deviations is noticeable. The parole board is high on psychiatric evaluation and low on treatment with none for emotional disturbance. The warden is high on psychiatric evaluation, low on emotional disturbance, with none for treatment. Classification is high on treatment and low on emotional disturbance. Self is low on psychiatric evaluation and high on treatment. Custody is low on psychiatric evaluation and extremely high on emotional

disturbance and bizarre behavior with none for treatment. The hospital is high on psychiatric evaluation. The source varying the least from the general average is the counselors.

What we see here is that emergency referrals tend to come from those sources closest to the inmate in his everyday life. Re-referrals from custody are chiefly for emotional disturbance and bizarre behavior. The counselors and the hospital who are a little farther removed from the inmates than custodial officers are fairly well represented in the emergency referrals.

Referrals that result from a fair degree of deliberation and planning tend to come from sources with whom the inmate has only very rare contact. That referrals for psychiatric evaluation ran high for the parole board and warden reflect the fact that these two sources need the clinic's psychiatric appraisal of an inmate who is being considered for parole or is coming up for discharge.

As for treatment classification ranked very high. This we would expect when remembering that classification gets the inmate at the beginning of his confinement and sees him in possible need of a treatment program.

The counselors who made a moderate number of referrals of an emergency emotional nature also attained an average rating in referrals for psychiatric evaluation and treatment. This rather balanced type of referrals from this source reflects the diversity of inmate problems with which the counselors deal.

Disposition of Referrals

After the initial interview the referral can be classified as either a closed or an open case. The clinic's decision whether to terminate or continue a case depends upon the purpose of the referral, the patient's needs and his capacities and the resources of the clinic. If in its disposition of the case further contact seems necessary or advisable the services offered are usually either in the area of further evaluations or of treatment.

The appropriateness of a referral is not necessarily based upon the fact as to whether or not the referral was kept as an open case or closed with one contact. If the immediate problem concerned treatment and it was decided to take the patient into treatment, undoubtedly this referral could be considered quite appropriate. But if the patient was not taken into treatment and the case was terminated in one contact the referral might still be considered quite in place if through it the referral source or the patient received some answer they sought.

As already emphasized psychiatric evaluation is a general term that covers a broad area. It would be difficult to set the boundaries to the diagnostic services in the clinic. Many patients through one contact receive the requested service. However, it is most reasonable to assume that it would be among the one contact referrals that the less appropriate referrals would be found.

Proceeding upon this assumption and comparing Tables 5 and 6 we may be met by an immediate surprise to find that the proportion of single contact referrals was greater in the 1958 period studied than in the 1956 period. The explanation is found when we look at the in-patient situation. Comparing Tables 10 and 11 we see the very immense drop in the in-patient admissions to the ward. This has been referred to and explained earlier.

Although the clinic perceives its function to include in-patient care and treatment, it is moving in the direction of expanding its out-patient treatment program. Comparing Tables 10 and 11 there is shown to be a considerable increase in these services. This the clinic has been able to do by accepting more patients into out-patient group therapy. At the same time the out-patient program of individual therapy continues. Although all in-patients are considered as being in treatment, there are many chronics on the ward for whom the clinic can provide little more than custodial care. Considering the entire treatment program, the clinic considers itself to be doing more actual treatment than in the 1956 period. The referral sources are doing their part by referring new prospects to be received into therapy as the treatment load and resources of the clinic permit.

Comparing from Table 6 the individual referral sources with the general average for further contact it is noted that

TABLE 6

REFERRAL SOURCES AND STATUS OF REFERRALS FOLLOWING INITIAL CONTACT - 1958

Type of Contact			Counselor		Classification		Parole Board		Self		Warden		Custody		Hospital		Miscellaneous	
	Total	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent
Total:	167	100	35	100	30	100	21	100	21	100	18	100	16	100	12	100	14	100
Single Contact	100	60	21	60	16	53	15	71	12	57	11	61	8	50	7	58	10	71
Further Contact	67	40	14	40	14	47	6	29	9	43	7	39	8	50	5	42	4	29

TABLE 7

REFERRAL SOURCES AND STATUS OF REFERRALS FOLLOWING INITIAL CONTACT - 1956

Type of Contact			Self		Custody		Hospital		Reception Diagnostic Center		Classification and Counselor		Parole Board and Warden		Other Institutions		Miscellaneous	
	Total	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent
Total:	198	100	42	100	39	100	31	100	29	100	23	100	15	100	10	100	9	100
Single Contact	102	52	29	69	14	36	16	52	13	45	14	61	9	60	-	-	7	78
Further Contact	96	48	13	31	25	64	15	48	16	55	9	39	6	40	10	100	2	22

TABLE 8

REFERRAL SOURCES AND TYPE OF FURTHER CONTACT - 1958

Type of Further Contact			Counselor		Classification		Parole Board		Self		Warden		Custody		Hospital		Miscellaneous	
	Total	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent
Total:	67	100	14	100	14	100	6	100	9	100	7	100	8	100	5	100	4	100
Evaluation	24	36	4	29	3	21	4	67	1	11	4	57	5	63	1	20	2	50
Treatment	43	64	10	71	11	79	2	33	8	89	3	43	3	37	4	80	2	50

TABLE 9

REFERRAL SOURCES AND TYPE OF FURTHER CONTACT - 1956

Type of Further Contact			Self		Custody		Hospital		Reception Diagnostic Center		Classification and Counselor		Parole Board and Warden		Other Institutions		Miscellaneous	
	Total	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent
Total:	96	100	13	100	25	100	15	100	16	100	9	100	6	100	10	100	2	100
Evaluation	25	26	5	38	4	16	4	27	1	6	6	67	3	50	1	10	1	50
Treatment	71	74	8	62	21	84	11	73	15	94	3	33	3	50	9	90	1	50

TABLE 10

REFERRAL SOURCES AND TYPE OF TREATMENT - 1958

Type of Treatment			Counselor		Classification		Parole Board		Self		Warden		Custody		Hospital		Miscellaneous	
	Total	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent
Total:	43	100	10	100	11	100	2	100	8	100	3	100	3	100	4	100	2	100
Out-patient	28	65	8	80	9	82	2	100	4	50	-	-	2	67	1	25	2	100
In-Patient	15	35	2	20	2	18	-	-	4	50	3	100	1	33	3	75	-	-

TABLE 11

REFERRAL SOURCES AND TYPE OF TREATMENT - 1956

Type of Treatment			Self		Custody		Hospital		Reception Diagnostic Center		Classification and Counselor		Parole Board and Warden		Other Institutions		Miscellaneous	
	Total	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent
Total:	71	100	8	100	21	100	11	100	15	100	3	100	3	100	9	100	1	100
Out-Patient	13	18	5	63	1	5	3	27	-	-	2	67	-	-	1	11	1	100
In-Patient	58	82	3	37	20	95	8	73	15	100	1	33	3	100	8	89	-	-

classification and custody are high and the parole board low. Otherwise, there is little deviation among the various sources. That the referrals from classification tend to get further contact would be expected since Table 8 shows these referrals running strongly toward treatment. This is because these are mostly newly-received inmates whom R-DC has recommended for treatment. That the parole board's referrals tend to be closed with a single contact is due to the fact that these referrals are chiefly for psychiatric evaluation as shown by Table 8.

There was a clearcut division among the referral sources in regard to the type of further contact given to the patient referred. Ranking high in treatment were self, hospital, classification and counselor, while ranking high in evaluation were the parole board, custody and the warden.

Comparison of individual referral sources with those of the 1956 period in regard to single and further contacts is difficult because in large part Table 6 and Table 7 are too different to compare.

Reasons for referrals seem to carry strong implications as to disposition as shown in Table 12. Referrals for psychiatric evaluation tend strongly (3 to 1) to be closed with one contact. Referrals for treatment and emotional disturbance tend (2 to 1) toward being accorded further contact. Referrals for bizarre behavior are very likely (5 to 1) to be kept open for further contact. These correlations suggest considerable

TABLE 12

REASONS FOR REFERRALS AND STATUS OF REFERRALS - 1958

Reason for Referral	Total	Single Contact	Further Contact No.	Cases Given Further Contact					
				Types of Contact		Types of Treatment			
				Evaluation	Treatment	Unscheduled Out-Patient Individual Treatment	Scheduled Out-Patient Individual Treatment	Scheduled Out-Patient Group Treatment	In-Patient Treatment
Total:	167	100	67	24	43	13	11	4	15
Psychiatric Evaluation	99	74	25	16	9	4	1	1	3
Treatment	31	10	21	3	18	6	8	3	1
Emotional Disturbance	17	6	11	1	10	2	2	0	6
Non-Clinic Inquiry	5	2	3	1	2	0	0	0	2
Bizarre Behavior	6	1	5	3	2	1	0	0	1
Other	9	7	1	0	2	0	0	0	2

knowledge of the clinic's function on the part of the referral sources.

Referrals and Diagnoses

The psychiatric diagnostic classification used by the clinic follows the nomenclature of the manual prepared by the American Psychiatric Association.[1] In this study only the general classifications are used.

The psychiatric diagnosis may be made immediately following the interview. Sometimes the staff member may want more time to make his decision. If he feels he needs help, he seeks consultation and if necessary brings the case to staff meeting. When the diagnosis is arrived at, entry is made in the patient's folder which is kept in the record office. At the time of the 1956 period studied this data was not in a sufficient state of completion to be usable, hence in this area there can be no comparisons with that study.

From Table 13 it can be seen that personality disorder and psychotic disorder dominate the distribution. Only a few of those diagnosed as psychotic disorders are currently in a state of psychosis. Many of them are scattered among the general population. Some are considered potentially dangerous,

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[1] Diagnostic and Statistical Manual - Mental Disorders, American Psychiatric Association Mental Hospital Service (Washington: 1952).

TABLE 13

SOURCES OF REFERRALS AND THE DIAGNOSIS - 1958

Diagnosis			Source of Referral															
			Counselor		Classification		Parole Board		Self		Warden		Custody		Hospital		Miscellaneous	
	Total	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent
Total:	167	100	35	100	30	100	21	100	21	100	18	100	16	100	12	100	18	100
Personality Disorder	60	36	12	34	9	30	12	57	6	29	2	11	6	38	8	67	5	36
Psychotic Disorder	45	27	6	17	7	23	6	29	7	33	10	55	4	25	1	8	4	29
Brain Disorder	16	10	5	14	1	3	0	0	4	19	1	6	1	6	1	8	3	21
Mental Deficiency	12	7	4	11	2	7	1	5	1	5	3	17	1	6	0	0	0	0
Psycho-neurotic Disorder	8	5	3	9	0	0	0	0	0	0	0	0	2	13	2	16	1	7
Diagnosis Deferred	26	16	5	14	11	37	2	10	3	14	2	11	2	13	0	0	1	7

In those columns above where the percentages posted total more or less than 100, fractional parts of certain individual percentages have been carried up to or dropped to the next largest whole number.

TABLE 13

SOURCES OF REFERRALS AND THE DIAGNOSIS - 1958

Diagnosis			Source of Referral															
			Counselor		Classification		Parole Board		Self		Warden		Custody		Hospital		Miscellaneous	
	Total	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent
Total:	167	100	35	100	30	100	21	100	21	100	18	100	16	100	12	100	18	100
Personality Disorder	60	36	12	34	9	30	12	57	6	29	2	11	6	38	8	67	5	36
Psychotic Disorder	45	27	6	17	7	23	6	29	7	33	10	55	4	25	1	8	4	29
Brain Disorder	16	10	5	14	1	3	0	0	4	19	1	6	1	6	1	8	3	21
Mental Deficiency	12	7	4	11	2	7	1	5	1	5	3	17	1	6	0	0	0	0
Psycho-neurotic Disorder	8	5	3	9	0	0	0	0	0	0	0	0	2	13	2	16	1	7
Diagnosis Deferred	26	16	5	14	11	37	2	10	3	14	2	11	2	13	0	0	1	7

In those columns above where the percentages posted total more or less than 100, fractional parts of certain individual percentages have been carried up to or dropped to the next largest whole number.

but as has been clarified before in this report there is not nearly enough room for them all on the ward.

Except for personality disorder all the categories are represented in much greater proportion than they occupy among the general prison population.

There is very little in the psychiatric diagnostic classification that helps to establish whether or not the referral was appropriate to the clinic's function. Any inmate, whatever his psychiatric diagnosis, may at any time have the type of problem for which he should be referred to the clinic. On the other hand even many classed under psychotic disorders may go for long periods of time with no special need to contact the clinic.

From Table 13 we can determine whether among the various referral sources there are any marked deviations from the general average in each diagnostic category. For personality disorder the parole board and the hospital are high and the wardem low. For psychotic disorder the warden is high and the hospital low. For brain disorder the counselors and self are high, classification low and the parole board none. For mental deficiency the counselors and the warden are high and the hospital none. Psycho-neurotic disorder was high for custody and the hospital with the only other source being the counselors.

From Table 14 we can find the referral reasons for each diagnostic category. Were there any marked deviations from

TABLE 14

REASONS FOR REFERRALS AND THE DIAGNOSIS - 1958

Diagnosis			Reasons for Referral											
			Psychiatric Evaluation		Treatment		Emotional Disturbance		Bizarre Behavior		Non-Clinic Inquiry		Other	
	Total	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent
Total:	167	100	99	100	31	100	17	100	6	100	5	100	9	100
Personality Disorder	60	36	35	35	13	42	9	53	2	33	-	-	1	11
Psychotic Disorder	45	27	30	30	4	13	2	12	3	50	3	60	3	33
Brain Disorder	16	10	11	11	3	10	-	-	-	-	-	-	2	22
Mental Deficiency	12	7	8	8	2	6	1	6	-	-	1	20	-	-
Psycho-neurotic Disorder	8	5	2	2	2	6	3	18	-	-	-	-	1	11
Diagnosis Deferred	26	16	13	13	7	23	2	12	1	17	1	20	2	22

In those columns above where the percentages posted total more or less than 100, fractional parts of certain individual percentages have been carried up to or dropped to the next largest whole number.

TABLE 14

REASONS FOR REFERRALS AND THE DIAGNOSIS - 1958

Diagnosis			Reasons for Referral											
			Psychiatric Evaluation		Treatment		Emotional Disturbance		Bizarre Behavior		Non-Clinic Inquiry		Other	
	Total	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent
Total:	167	100	99	100	31	100	17	100	6	100	5	100	9	100
Personality Disorder	60	36	35	35	13	42	9	53	2	33	-	-	1	11
Psychotic Disorder	45	27	30	30	4	13	2	12	3	50	3	60	3	33
Brain Disorder	16	10	11	11	3	10	-	-	-	-	-	-	2	22
Mental Deficiency	12	7	8	8	2	6	1	6	-	-	1	20	-	-
Psycho-neurotic Disorder	8	5	2	2	2	6	3	18	-	-	-	-	1	11
Diagnosis Deferred	26	16	13	13	7	23	2	12	1	17	1	20	2	22

In those columns above where the percentages posted total more or less than 100, fractional parts of certain individual percentages have been carried up to or dropped to the next largest whole number.

the general average? For personality disorder treatment and emotional disturbance are high and bizarre behavior low. For psychotic disorder, bizarre behavior and non-clinic inquiry are high. Cases of brain disorder were referred only for psychiatric evaluation and treatment. For mental deficiency non-clinic inquiry is high, with bizarre behavior none. For psycho-neurotic disorder emotional disturbance was high, with bizarre behavior none.

From Table 15 we can find the disposition for each diagnostic category. From Table 6 we saw that two out of five referrals were kept open for further contact. Were there any pronounced deviations? Personality disorder and brain disorder were low. Psychotic disorder and psycho-neurotic disorder were high.

Of those receiving further contact about what proportion in each diagnostic category was placed into treatment as against further evaluation? Personality disorder comes first with two out of three. The other categories divide about equally between evaluation and treatment as the type of further contact. An interesting observation is that the proportion getting treatment is with the exception of brain disorder almost exactly one-fourth of the total number in that diagnostic category.

As for the type of treatment personality disorder and psycho-neurotic disorder run strongly toward out-patient

TABLE 15

DISPOSITION OF REFERRALS AND THE DIAGNOSIS - 1958

Diagnosis	Total Cases	Single Contact	Further Contact	Type of Further Contact		Type of Treatment	
				Evaluation	Treatment	Out-Patient	Out-Patient
Total:	167	100	67	24	43	28	15
Personality Disorder	60	38	22	7	15	12	3
Psychotic Disorder	45	24	21	10	11	3	8
Brain Disorder	16	13	3	2	1	-	1
Mental Deficiency	12	7	5	2	3	1	2
Psycho-neurotic Disorder	8	3	5	2	3	3	-
Diagnosis Deferred	26	15	11	1	10	9	1

treatment. In accord with what would be expected, psychotic disorder and mental deficiency run decidedly toward in-patient treatment.

CHAPTER IV

CONCLUSIONS AND RECOMMENDATIONS

The writer was interested to find out if the resources of the Psychiatric Clinic of the State Prison of Southern Michigan might be used to better advantage. The approach that was chosen for this particular study was that of examining the referrals, since the clinic must work with patients whom somebody else decides to send to it.

Although it turns down a few requests without seeing the patient, for the most part the clinic grants the referred patient an interview. In determining what patients are to claim the clinic's time, the referral sources assume a place of vital importance to the clinic's program.

The basic assumption of this study was that through the continued relationship with the clinic, the referral sources were provided with an opportunity to become more aware of the particular needs of an inmate which warranted a referral to the clinic. The hypothesis was that the referral sources are, in fact, coming to have a better perception of the clinic's function, which increased understanding is being reflected in more appropriate referrals.

A problem that was immediately met was that of deciding what was an appropriate referral. The clinic has never set up

any standard by which the referrals can be measured as to suitability. It was believed, however, that an examination of some of the factors of the referral process might throw light upon the question of the referral sources' understanding of the clinic's function. An important part of the study was that of making comparisons with a study of referrals which was made two years previously to see if changes had occurred in regard to referrals and if so to try to determine whether or not these changes indicated that the referral sources were making more appropriate referrals than formerly.

The comparison with the 1956 study showed considerable change among the referral sources in regard to the number of patients referred from each source. Of the seven different sources referring during the period, four greatly increased the number of their referrals while three had quite a considerable decrease. While in some cases the reasons for these changes are rather apparent, in other cases the reasons are not clear.

The sources which had increased their referrals were the counselors, classification, the parole board and the warden. In the case of classification most of the referrals had been recommended by the Reception-Diagnostic Center and in the case of the parole board, by the board's psychiatrist. The sources whose referrals had decreased were self, custody, and the hospital. On the whole those sources with increases had

personnel whose training better equipped them to make proper referrals than did those sources with decreases. It could be inferred that this observation supports the hypothesis, but on this point the findings offer little help.

Turning to the sources with decrease in referrals, we find in two cases something quite concrete and pertinent to this study. The great reduction in self referrals reflects a policy inaugurated by the clinic to cut down on the number of referrals of an unsuitable nature which were coming from the inmates themselves. Here the hypothesis is supported since self-referrals are more appropriate than formerly.

Practically all the referrals from custody are due to situational episodes and usually related to some infringement of prison rules. As a rule the clinic prefers not to become involved in these situations, though it will not refuse the referral. The reduced number of referrals of this nature indicates that custodial officials are coming to recognize that the resolution of this type of a problem falls to them. Here we see definite support for the hypothesis.

As for the reasons which the referral sources give for the referral there was a decided change. Referral sources in 1958 tended much more strongly than in 1956 to state the reason for the referral as being either psychiatric evaluation or treatment. But here caution should be exercised in interpreting the findings. The trend away from "emotional disturbance" or

'bizarre behavior' as the referral reason may be more apparent than real because a referral for psychiatric evaluation may actually stem from some sort of emotional upset or from strange behavior. At any rate, referrals for emotional problems may in certain cases be quite in place. Hence here the findings are inconclusive.

There is one instance where the findings in regard to referrals and reasons make a definite contribution. The great reduction in referrals for non-clinic inquiry supports the hypothesis.

We might be inclined with some justification to feel that one test of the appropriateness of a referral is the disposition accorded it by the clinic. Referrals which after the initial interview were kept open for further services could in most cases safely be called appropriate referrals. It must not be overlooked, however, that quite often one contact is all that is necessary for the purpose of the referral. But the fact remains that the less appropriate referrals tend to be closed after the one contact. The slight increase in some cases kept open for further evaluation lends some support to the hypothesis.

But this is an area where the findings need some interpretation. Among the referrals in 1956 a greater proportion got further contact than did the referrals in 1958. The comparison between the two periods, however, is thrown askew by

the fact that the in-patient admissions in 1956 so greatly exceeded those of 1958. Considering the out-patient treatment program which the clinic had come to emphasize, more patients were in actual treatment in 1958 than in 1956. Since patients taken into treatment usually represent appropriate referrals, the change here from 1956 supports the hypothesis.

The psychiatric diagnostic classification showed five general categories covering the patients referred for the period. Personality disorder followed by psychotic disorder predominated. The other three categories were brain disorder, mental deficiency and psycho-neurotic disorder. The diagnostic classification here indicates that most of these patients were either pathological or borderline. But this does not help us in interpreting the appropriateness of the referrals, since the need of a patient for the services of the clinic depends neither upon the nature nor the extent of his psychopathology.

To summarize, we can say that considerable changes were found to have occurred in certain areas of the referral process. While from most of these changes few conclusions bearing directly upon the writer's hypothesis could be drawn, there did emerge from the findings in a few instances some facts that indicated some support for the hypothesis.

As a way by which the referral process might be improved, the writer would suggest first, that the clinic attempt to communicate to the referral sources what it considers to be unquestionably inappropriate referrals, and, second, that the clinic attempt to get more information about the behavior of the patients which prompted the referrals.

As an area for further research the writer feels that a study of the out-patient group treatment program would commend itself.

REFERRALS TO PSYCHIATRIC CLINIC

October 1, 1958 - December 31, 1958

1. Number_____ New Referral_____ Re-Referral_____

2. Referral Date_____ Referred by_____

3. Stated Reason for Referral_____

_____

4. Date of Initial Contact_____ With Whom_____

5. Single Contact____ Further Contacts (within 3 months)____

With Whom_____

(a) Types of Contacts:

1. Evaluation_____
2. In-Patient Rx____
3. Scheduled Op Rx_____
4. Unscheduled Op Rx____
5. Op Group Rx_____

6. Length of Time Between Referral and First Contact_____

7. Did Psychiatric Clinic Contact Referral Source_____

If yes, was it:

(a) Within two weeks after Completion of Services_____

(b) More than two weeks after Completion of Services_____

8. Diagnosis_____

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