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LETTER TO THE EDITOR

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Dear Dr. Thomas:

I have read with a great deal of interest the Newsletter of April 1972, and having been a prison psychiatrist for many years, was stimulated to a great many thoughts and some feelings as well. Your editor's note that there is developing from a new source a demand for discarding the correctional approach in prisons and returning to a strictly penal one, certainly seems accurate. This new source, moreover, is people with concern for the prisoner in contrast to the older source -- people who feel that prisoners should not receive attention because they do not deserve it. At one time in my career, a colleague asked me how I could justify putting my psychiatric abilities, acquired in public-supported institutions, to the care of public enemies in prison. This point of view could be countered with the fact that prisoners, if they had at times behaved like enemies of others, were likewise the victims of others, and that in fact the bulk of men in prison were primarily enemies of themselves, who had inflicted very little damage on others as compared to many other free citizens. I must admit that having settled in my own mind this and other related objections to being a prison psychiatrist, it was startling to be taken on the other flank with the objection that it is unjust to put psychiatric

techniques and capabilities on the side of society "against" its prisoners. Another colleague has recently written in an article addressed to prisoners throughout the United States and especially to those at the institution where I practice, warning them to beware of me for fear I will turn them into mindless automatons at the "system's" behest!

Actually, none of this should be surprising because prison is, by its nature, a sort of no-man's-land between the individual and society, and if one persists in standing here, one must expect to be shot at from all sides. It should not have been surprising either, because I well know that the psychiatrist in prison is functioning in a field of conflicting forces and must daily examine his judgments and actions for evidence that they are not being unduly influenced in one direction or another away from the professional stance. Yet, it has not seemed to me such a difficult place to practice, as it must seem to many others, judging from the difficulty one encounters in recruiting psychiatrists to work in this setting. Dr. Rundle's article in the Newsletter brought this point out in describing his feelings of depression on the first day of his employment at Soledad (before he could have evaluated his position) and his rapid decision to make of himself a "foreign body" soon to be extruded. He continues to work from outside for improvement of prisons, but I think the profession is most subject to criticism from the fact that in spite of much talk and writing by psychiatrists, so few have been willing to do any work in prisons. Dr. Rundle did not mention in his article the fact, which I happen to know,

that he was the first psychiatrist to take the regular staff position there for many years, and to my thinking, part of the conditions he deplores must be attributed to this lack of psychiatric care and general contribution to the institutional community and administration.

Prisons need to have psychiatrists for several different reasons. One is that prisoners have as high, if not higher, incidence of illness as any population, and they have a right to services comparable to what they could receive if free. The second is that prison can be a most unhealthy environment for some people, and prison administrators need consultation from a psychiatrist as to overall policies as well as to day-to-day decisions on individual prisoners. So long as many psychiatrists' posts in prisons remain unfilled, I think our criticisms of the running of penal institutions lacks force. As pointed out in a separate article in the Newsletter, psychiatrists tend to avoid the difficulties of combining treatment with security, whether in the mental hospital or in the prison and neglect that population of mentally ill which demands both.

The third function of the psychiatrist in corrections is a more direct interplay of psychiatry and corrections. It includes the encouragement of a scientific approach to corrections and a professional standard to the relationship between prisoner and keeper. This function involves the medical model for penology and is, I think, the psychiatric function which Dr. Irwin thinks should be stopped. His remarks were not reported in

detail, but my own critique of this function would probably bear some resemblance to his. My conclusion, however, is not for tossing out the "medical model," but for using it to the degree to which it is applicable. My experience has not been that law and *penology* have ever, even in progressive California, applied the "medical model" exclusively. Men are sentenced and their terms of imprisonment fixed by considerations which include punishment, segregation, and rehabilitation in a mix which is and should be individual.

I recall a case of a man who had been found guilty of second degree murder and was sent by the court for evaluation under a law intended to provide diagnostic evaluation for probation. The diagnostic team (including a psychiatrist) found the prisoner to be quite suitable for probation in terms of his best interest and for the protection of others, and so reported to the court. The court was outraged at this recommendation stating that murderers cannot be let go without some punishment. Our point of view was that to the degree that a medical model (diagnosis and prognosis) was applicable to this case that probation was appropriate. Had we reported otherwise, we would have been, in my opinion, subverting the medical model. There is sometimes considerable pressure to do just this, and, if yielded to, injustice can result from confusion as to the goals of incarceration. Such pressures seem strongest to me outside the criminal justice system in the case of special civil commitments under such laws as the sexual psychopath laws of many states. The criminal justice system keeps explicit the

punishment aspect of incarceration and provides more safeguards against injustice.

In the case of many criminals, however, the medical model is the only one which makes any sense. The eleventh-term bad checkwriter, the repetitive robber or burgler, or assaultive offender frequently are men or women for whom the simple penal model "you have done wrong and we will exact so and so many days in prison to balance the scales" is entirely inappropriate. Many such people ask for rehabilitation to begin with, and many more who would not ask will accept gladly what is offered.

However, what does rehabilitation amount to? It certainly has become clear that an initial enthusiasm that correctional programs modeled after psychotherapy would produce great reductions in recidivism has not been borne out. There has, indeed, been a need to revise downward expectations of sustained personality change from psychotherapy in all settings in psychiatry. Some misuse of psychiatry has been a product of an overly optimistic expectation that "treatment" would solve every problem and that without treatment, no problem would be solved. This has been especially pernicious in situations where there was in fact inadequate treatment personnel and no capability to even attempt to work with the volume of people. Accumulating research and experience gives us now, increasing ability to put treatment in proper perspective. Even in our state of ignorance and excessive expectation, however, I do not believe that the treatment model had an overall effect of increasing the injustice in the criminal justice system. If it has sometimes led to longer

imprisonment for the treatment, it has also led to probation reports for sentencing, increased probation and parole programming which have prevented or shortened the imprisonment of a much greater number. In addition, the "medical model" (which means to me a scientific and professional approach to human problems) provides a basis for accumulating knowledge and applying it to correct our errors when no such basis for improvement of fairness or effectiveness exists in the "penal model."

Psychiatric reporting to courts and parole boards is a special case of the interplay of psychiatry and corrections. In this role, the psychiatrist sometimes is simply supplying information about mental illness, but in others is simply putting the techniques of psychiatric diagnosis to the prognostic tasks of courts or boards. The psychiatrist in the criminal justice system is frequently called upon to make predictions about future behavior. I have come to view these opportunities as flattering, but to be approached most humbly. When such tasks are thrust upon me, I approach them with the attitude that anyone can do anything in the future and that one can only estimate odds, taking into account the number of options available to an individual and the proportion of those which do not lead into familiar criminal patterns. There is no unitary relationship between personality variables and behavior. Injustice may result when psychiatrists assume the preferred mantle of "fortune teller" and assert too confidently their opinion as to whether a prisoner should be paroled because of what they "know" about his future behavior. With accumulating knowledge of the

potential of psychotherapy, we know that its effects are much less predictable than we had hoped, and that even when desired changes in personality functions are accomplished and recognized, it remains problematic whether past criminal behavior will recur again in some future circumstance. Men who appeared unchanged in personality are seen to make dramatic changes in life style, and others who appeared much changed, rapidly return to the same life style. Nonetheless, judgments about the future are an indispensable part of the criminal justice system, and I do assert that my predictions are more valid than many. It is, in my experience, quite possible for me to present them to courts and parole boards so that they are unlikely to be misused and susceptible to being tempered by considerations of justice and common sense, which may have eluded me in my clinical zeal. Again, in this respect, the involvement of psychiatry in criminal justice can give the individual more protection and humanity than is available in a system dominated by a single philosophy such as the penal one.

The ethical problems of prison psychiatry are also frequently being raised now. There is and should be a high level of public concern that men incarcerated not be abused. At the California Medical Facility in Vacaville, California, we have recently had a demonstration, however, that this concern can lead to distortion and misinformation being very widely disseminated in the public press. In this instance, the fact that three patients with psychomotor seizures had temporal lobe surgery (stereotactic anygdalotomy) to improve their neurological

condition was widely misinterpreted to be the beginning of a program of psychosurgery for personality change. A report of employment of aversive conditioning in eighteen cases (with primary indication being self-mutilation) also was viewed as the forerunner of a major aversive-conditioning program to change personality and behavior of prisoners. The implication in these reports was that such techniques were being used to still protests from politically active prisoners rather than to help prisoner-patients.

In my opinion, prisoners have a right to the best medical care, including in some cases, new treatments as they become available in the community. Otherwise, one is in the position of keeping people out of free society because of their dangerous behavior and denying them access to treatment available in the community, which could reduce the threat. On the other hand, it cannot be denied that there is a potential for abuse as regards coercion to accept treatment to which the individual might not really consent. There is no avoiding these ethical decisions; however, since doing"nothing" frequently means continued incarceration. I think the present state could be improved by providing more alternatives for prisoners and freer access to consultation so that their consent to a certain treatment is more of an informed choice. In recent years, the state and federal courts have allowed inmates access more freely to pursue complaints or demands. This has provided desirable controls and safeguards. Either of these improvements require greater

involvement by psychiatrists in penal and correctional treatment situations rather than less.

Very truly yours,

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