THE PRACTICE OF PSYCHIATRY IN THE PRISON SOCIETY*

by

Bruno M. Cormier, M.D.+

Historical Perspective

Some understanding of the historical background of psychiatric services in penal institutions may be gained by first considering the pre-Kraepelin and pre-Freudian eras. Emil Kraepelin (1856-1926), the founder of psychoanalysis, out of which developed dynamic psychiatry, are so different in outlook and formulations that we sometimes forget that they are in fact contemporaries. Paradoxically, despite the great significance of their work and that of their disciples, they contributed relatively little to development of psychiatric services in prisons. On the whole, even to this day, psychiatry and its clinical application in penal institutions remains an underdeveloped field. This evidently requires explanation as Kraepelin and his followers were interested in forensic psychiatry, as were the Freudians, who wrote extensively on the psychogenesis and dynamics of delinquent behavior.

In forensic psychiatry the classic descriptive school became engaged in the debate between law and psychiatry centered on the

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+Associate Professor, Department of Psychiatry, McGill University
Director, McGill Clinic in Forensic Psychiatry

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concept of responsibility. Argument often became sharp, but we cannot say that the famous M'Naughten verdict in 1843 of "not guilty on the grounds of insanity" opened a new era between law and psychiatry; the problem which was already known in Roman law. It certainly polarized discussions on a non-medical problem, that of responsibility, but it did not in itself create the need for a special institution for the criminally insane, or for mentally ill prisoners. In fact, the M'Naughten Rules and the many variants that were to follow did not basically change the existing practice of holding in confinement, in special wings of mental hospitals, all those whose mental state did not permit them to stand trial or who were declared not guilty by reason of insanity, or who were mentally ill prisoners; the need came from another source. Since the Eighteenth Century, when punishments were still very harsh, there has been a continuous and irreversible trend towards a diminution of capital and corporal punishment and their gradual replacement by deprivation of liberty as the form of punishment. As a result, not only the healthy offenders, but also the psychiatrically ill were incarcerated in penal institutions.

Dynamic psychiatry, on the other hand, made a hopeful beginning, greatly influencing the treatment of juvenile offenders. Analytic concepts were applied to the understanding of criminal behavior, but measured in manpower, few psychiatrists actually worked in penal institutions. In reality, a great deal more was accomplished by physicians and psychiatrists working in the prisons during the Nineteenth Century than is possibly achieved at present.

Early Literature and Psychiatric Services in Prisons

About the middle of the Nineteenth Century a flourishing literature on the psychiatric services in penal institutions appeared. It was in Germany, the birthplace of two great psychiatric schools, the classical descriptive and the dynamic, that many studies on mentally ill prisoners were made following 1850. This rich early literature was summerized in 1910 by Nitsche and Wilmanns.[1] It was during this period that it was first recognized scientifically that the prevalence of mental illness and suicide among prison inmates was far greater than in the general population, a finding which still holds true.

It is appropriate perhaps to comment on one aspect of the psychiatric literature of the latter part of the Nineteenth Century. Conditions in most prisons of the time were squalid; solitary confinement prevailed in many, as was the case in many mental hospitals. The movement for prison reform begun by John Howard (1726-1790) and for reform of mental hospitals by Pinel (1745-1826) succeeded in effecting some improvements, but for the most part conditions remained unchanged.

It is noteworthy that physicians and psychiatrists attached to certain prisons laid great importance on the influence of the milieu, to the extent that they held that many psychiatric conditions encountered in prisons were created by the prison itself. They recognized before psychiatrists working in mental hospitals that syndromes and symptoms were related to the environment, and that they were artifacts rather than part of a defined

psychopathological process. Mention is often made of certain syndromes seen in overcrowded prisons where one encountered the most difficult prisoners, whereas in a freer kind of prison setting these syndromes did not appear.

In these early studies we often find an attempt to identify what is a reactive state to the prison environment itself, that is, to distinguish between what is genuinely a psychopathological process and/or a reactive state, an adaptation to an abnormal milieu. I think we have a fair idea of what was once meant by the term, prison psychosis. When we first established psychiatric services at St. Vincent-de-Paul Penitentiary (near Montreal), patients were separated from other inmates and lodged in a cell block that formerly housed the punitive cells. Up to fifty-five psychiatric patients were cared for by a single physician, with consultant psychiatrists called in from time to time for diagnosis, advice and referral to a psychiatric hospital when necessary. When I arrived, five patients were kept in these punitive cells and there was an unwritten (but more or less accepted) rule that these patients could not be interviewed outside their cells. The symptomatology I was able to observe through the bars did not seem to fit any of the classical psychotic syndromes. It was during this period that D. O. Hebb was working on sensory deprivation at McGill University and I was acquainted with his work. From the scanty notes available on the patients, it was difficult to determine the original symptoms and diagnosis; i.e., agitated depression, psychotic reaction, etc.

On my second visit, it was agreed that these patients should be let out of their cells and allowed to move about during the

day. There was an immediate and dramatic improvement in three cases, to the point where they were able to be released from the hospital and allowed to rejoin the general prison population. In the other two cases, many symptoms disappeared and we were left with a symptomatology corresponding to what is observed in psychiatric states. From then on, we no longer thought in terms of "prison psychosis," but of "psychosis in prison."

Under the Nineteenth Century generic term, prison psychoses, are found syndromes described as prison paranoia, the paranoia of criminals, and others. These two terms, prison paranoia and paranoia of criminals, indicate that sometimes the accent was on the milieu and at other times on the criminals themselves. What emerges is the belief that is held today, that criminal behavior involves the whole personality and that the psychopathology giving rise to criminality gives rise also to any concomitant nondelinquent psychopathology.

The explanation that the mental state of psychiatrically ill prisoners was only a response to the dominant influence of the milieu was more than seriously doubted. In 1897, Baer wrote: "A specific mental illness among prisoners does not exist." This was not to say, however, that an abnormal setting cannot determine the content and the form of a mental illness. He summarized the different systems for caring for mentally ill prisoners. We will here give his findings and add our own.[2]

Baer described four methods to deal with mentally ill prisoners. The <u>first</u> is to transfer them to a mental hospital, and his comment was that this is seldom used because of the

difficulty in looking after potentially dangerous individuals on the same basis as ordinary mentally ill people. Interestingly, this objection is made today. One could offer as explanation the fact that mental hospitals are in fact more and more open, and the few closed wards are far from being maximum security. However, from Baer's remark in 1897, when mental hospitals were as closed as prisons if not more so, the same objection prevailed.

Today, as in 1897, there remains a tendency to treat all mentally ill prisoners as potentially dangerous, which is far from being the case, as our remarks below on the Baxstrom decision will serve to illustrate. In our opinion most of the acutely or chronically mentally ill prisoners could be treated without necessarily being hospitalized. Instead, most could attend psychiatric facilities within the institution or an outpatient basis. We will elaborate our views on psychiatric services in a penal society in the course of this paper. It is also our view that in a city or region where there are existing psychiatric services, offenders in need of treatment should be able to receive such help while on probation or parole.

Though the practice of treating mentally ill prisoners in ordinary mental hospitals was seldom used in Germany and other countries, in the United States several states had active laws providing that persons acquitted by reason of insanity could be committed to public hospitals. This was done in Worcester State Hospital after it was opened in 1832, and in Utica State Asylum in 1843; in fact in some states the state hospitals and almshouses became the only legal places of confinement for the

criminal insane, though the laws were never strictly observed and many mentally ill inmates continued to be kept in prison. The law met with opposition and protests because of the enforced association of criminal and non-criminal and also the chronic over-crowding which ensued.[3]

To meet these objections, some mental hospitals built special annexes for the mentally ill, accused and unable to stand trial, or those found not guilty by reason of insanity, or mentally ill prisoners. This practice was well-established in Europe in the Nineteenth Century in two well-known hospitals -- Bedlam in England and the Bicetre in France. This type of segregation is a second method described by Baer of dealing with mentally ill prisoners. His judgment was that these annexes tended to become more like a prison than a mental hospital. Moreover, they proved cumbersome to administer and there was difficulty in transferring prisoners to these institutions. (This holds true today where the practice still exists of transferring mentally ill prisoners to special wings of mental hospitals).

It grew to be so inefficient and inadequate to the need that a solution had to be found and that was the creation of special institutions, or, to employ the term of the time, asylums, built exclusively for the care of mentally ill prisoners, as well as persons accused but unable to stand trial and those found not guilty by reason of insanity. This was Baer's third method. It became a method of choice and still is to a great extent in both Europe and North America. Broadmoor in England, which opened in 1863, is the best known of such hospitals. It is not, however,

historically the first, as Auburn predated it. Of Auburn, Deutsche says: "New York State was the first to attempt a solution of the problem of properly disposing of the criminally insane, and insane criminals by providing a separate institution for their custody and care." Until 1859, convicts who became insane were regularly transferred either to Utica State Hospital or else to the special wards or buildings of penal institutions. In that year the State Lunatic Asylum for insane convicts was opened at Auburn, a site adjoining the Auburn State Prison. As the name implies, it was originally intended only for the reception of insane convicts, but in 1869 the institution began to receive criminally insane persons committed directly from the courts as well as insane criminals transferred from general institutions.[3]

Auburn soon became densely overcrowded and in 1892 it was removed to Matteawan, which in its turn soon proved insufficient to cope with the problem. Eight years later, in 1900, Dannemora State Hospital was opened in Dannemora, New York: "The organic law of this hospital limited admissions to persons declared insane while confined in a penal institution for felony."[3]

The creation of special hospitals has not solved the problem. It is no overstatement to say that many became a catch-all for various types of mental and social problems: they were overcrowded, understaffed and, unfortunately, detention became more or less indeterminate, with an almost universal disregard for human rights. When these special mental hospitals were created, the rights of the accused and the condemned were not as clearly

defined as they are today and they could, though unintentionally, be easily overlooked; for example, through lack of foresight in planning what to do with mentally ill prisoners when legal sentences terminated.

Daniel M'Naughten, from whose trial emerged the famous M'Naughten Rules, was committed to Bethlem Hospital in 1843 but relatively little is known about what occurred to him afterward. Bernard Diamond's paper on "Isaac Ray and the Trial of Daniel M'Naughten"[4] provides some historical information that may illustrate that in retrospect the building of special correctional hospitals and the policy guiding commitment and the length of commitment to these hospitals could well have been thought of long before the Baxstrom decision.

Committed to Bethlem Hospital in 1843, Daniel M'Naughten was transferred to Broadmoor some twenty-one years later, in 1864. An entry in his record in 1854, eleven years after his trial, showed that his mental state had considerably changed and in describing this, mention was made of his delusional state, with its political content. From the description, one could well imagine that at that stage he was very withdrawn, possibly depressed and paranoid, but one could not think of him as a dangerous patient:

> He is a man of so retiring a disposition and so averse to conversation or notice of any kind that it is very difficult even for his attendant to glean from him any information as to his state of mind or the character of his delusions, but one point has been made, that he imagines he is the

> subject of annoyance from some real or fanciful being or beings; but more than this is not known for he studiously avoids entering into the subject with anyone. If a stranger walks through the gallery, he at once hides in the water closet or in a bedroom, and at other times he chooses some darkish corner where he reads or knits. His crime created great commotion at the time. In mistake for the late Sir Robert Peel he shot Mr. Drummond as he was going into the Treasury or some Government office and at that time imagined that the Tories were his enemies and annoyed him.

At the time of his transfer to the newly opened Broadmoor Hospital, Diamond quotes another entry from his record, dated 28 March 1864:

> A native of Glasgow, an intelligent man, states that he must have done something very bad or they would not have sent him to Bethlem; gives distinctly the Sentence of the Chief Justice, "Acquitted on the ground of insanity, to be confined during Her Majesty's Pleasure." When asked whether he now thinks that he must have been out of his mind he replies, "Such was the verdict, the opinion of the Jury after hearing the evidence."

It is a point of irony that some twenty-one years after his trial, Daniel M'Naughten was transferred to a hospital that was

built especially for cases such as his but the note at the time of the transfer certainly indicates that there was no clinical need to transfer this man to a hospital for the criminal insane, that he had passed well beyond the stage of dangerousness. In fact, judging by this note alone, one might even say that he could have been released to a convalescent hospital of some sort with minimal custody. In fact, he died a year later of heart and kidney disease.

The 1966 decision of the U. S. Supreme Court in the case of Baxstrom, who was defended both by the American Civil Liberties Union and the Legal Aid Society, illustrates how such hospitals create both an insoluble psychiatric problem and an equally severe legal one. Although the Baxstrom decision affected only two specific hospitals, Matteawan and Dannemora State Hospital in New York, there is no doubt that as a result of this historic decision many such institutions had to review and revise their policies. When the Supreme Court of the United States handed down the decision that Baxstrom was illegally detained, some nine hundred sixty-nine patients in Dannemora and Matteawan had to be transferred to civil mental hospitals as their detention in these two hospitals now became illegal.

Following the Baxstrom decision, the Dannemora State Hospital population dropped from nine hundred ninety-four on 28 February 1966 to four hundred eighty-seven some six months later. The Matteawan population dropped from one thousand four hundred sixty-five on 28 February 1966 to eight hundred four by October of that year. As a direct result of this decision, the overall population

of these two hospitals decreased by 39.4 percent within six months.

Had a psychiatrist suggested prior to the decision that this number of patients should be transferred to civil mental hospitals, he would have been considered utopian and his advice looked upon as impractical and unrealistic, but the transfers were made without any of the disastrous consequences that would have been predicted in such a case.

The release into society of the Baxstrom patients, as shown today by followup studies of them, has proved remarkably uneventful as regards major incidents.[5,6]

The Baxstrom decision was only a first step in redefining psychiatric facilities in a correctional system. In 1970, patients hospitalized in correctional facilities in New York State were made subject to review boards, like their counterparts in civil hospitals. We do not have the total number of patients who were returned to ordinary penal institutions from Dannemora and Matteawan, but we can state that it was significant, to the point that Dannemora State Hospital was closed in 1972 and the balance of its patients transferred to Matteawan.

In these two moves, which we feel are decidedly in the right direction, it is to be noticed that the impetus to reduce the patient population in correctional hospitals came not from psychiatric initiative but from the American Civil Liberties Union, the Legal Aid Society, and through establishment of review

boards. We would have liked to be able to state that the important changes that took place in Dannemora and Matteawan were fostered by psychiatrists, but such was not the case. However, as psychiatrists we must be cognizant of the importance of the Baxstrom decision and the fact that the same rights have been extended to prisoners hospitalized in correctional facilities as those enjoyed by their civilian counterparts. We can assume that in the years to come the criteria for hospitalization in psychiatric facilities in a penal system will have to be exactly the same as those that justify such hospitalization of free citizens. Any system that does not recognize this new and welcome reality will, in my view, be legally reminded of it.

While the necessity for the building of special hospitals for mentally ill prisoners is seriously questioned by some, our own approach is that such a setting is a necessity wherever a concentration of population justifies it. Such a hospital, however, is bound to become a center of detention rather than a hospital if the criteria for admission are not strictly defined and scrupulously adhered to, including the question of legal status of the inmate. Equally important is that such a hospital become a treatment and research center affiliated to a university. This conclusion was reached by a special committee on forensic psychiatry set up by the psychiatric services of the Province of Quebec, whose report was accepted and led to the creation of the Institut Philippe Pinel.

As ordinary mental hospitals cannot cope with mentally ill offenders, and special wings of mental hospitals are no solution,

nor are special psychiatric hospitals the answer for most mentally ill offenders, we are faced with the question of where to treat them. It was rewarding to find that as early as 1897 Baer stated that many authorities favored that they should be treated by the medical services of the prison. In describing this fourth method of dealing with mentally ill prisoners, Baer and those who felt like him were far ahead of their time. In fact he reached a formulation which became a reality much later in psychiatric practice, that is, the integration of medical and psychiatric services, first initiated in the 1930's and 1940's and which has since become a common practice in general hospitals.

PSYCHIATRIC SERVICES IN THE REGIONAL DISTRICT OF QUEBEC - 1955-1971

In considering the establishment of psychiatric services in penal institutions serving the community, one must first ask if it is possible and desirable to establish within a major institution psychiatric services similar to those supplied to the community at large. Based on theoretical considerations and actual experience, we believe that this is not only possible but highly desirable. Generally speaking, a large penal complex contains within it at least one maximum security resource where medical and surgical services are available; to these, psychiatric services should be added. We will describe our experience in one such major penal complex.

The Canadian Federal Penitentiary complex referred to here is contained within the regional district of the Province of

Quebec and comprises a maximum security penitentiary of about seven hundred to eight hundred inmates, three medium security institutions of four hundred to five hundred inmates each, and the remainder of the inmates detained in a minimum security industrial annex, and farm camp, housing about one hundred inmates each. The medical, surgical and psychiatric facilities are located in the maximum security institution and the others have medical facilities for first aid, and treatment of minor illnesses. This maximum security prison (St. Vincent-de-Paul Penitentiary) is an old Pennsylvanian-type of structure built in 1870. Needless to say, medically facilities are far from materially adequate. The psychiatric hospital is located in a wing that has been isolated from the rest of the prison, to which was added a pre-fabricated construction for offices, occupational therapy, nursing post and treatment rooms. Despite the rather poor material resources, it has been possible to establish a comprehensive psychiatric service.

When psychiatric services were first undertaken in 1955 it was decided to set up facilities similar to those in the free community; that is, provision for full hospitalization, for day and night services, as well as an outpatient clinic. This was felt to be the correct approach. It was one of necessity as well as choice, as it was nearly impossible to transfer psychiatric patients to other mental hospitals. Getting this policy accepted, however, was no easy task as administration and correctional officers were of the opinion that psychiatric cases should be removed from the penal institution. A good deal of education

and persuasion had to be undertaken to convince those concerned. It was in the end agreed that we concentrate all efforts to treat locally, employing all the modern methods available despite primitive facilities.

To point out the results of the experimental psychiatric service, the following table gives statistics for the years 1966 to 1971, but we will comment only on the statistics for the year 1967-1968, that is thirteen years after the installation of the first psychiatric services in a federal penitentiary in the Province of Quebec.

	1966-67	1967-68	1968-69	1969-70	1970-71
No. of patients:					
Hospitalized(once)	104	115	108	113	112
" (twice)	19	15	29	53	33
" (3 times)	4	4	13	17	8
Total number hospitalized	127	134	150	183	153
Total no. of hospitalizations (admissions and readmissions)	154	157	195	270	202
Total days of hospitalization	17,315	15,694	15,318	18,330	13,219
Average days in hospital per patient	136.34	117.12	102	100	87
No. assigned to work during hospitalization	68	64	65	73	107
Days worked by hospitalized patients	3,785	3,192	3,507	2,932	5,673

In studying these figures it is interesting to note that though there was a total of 134 patients, the average number of patients hospitalized at one time was between 40 and 45. This in itself indicates a great deal of movement, which becomes more evident when we analyze the total number of days of hospitalization, 15,694, and the average number of days in hospital per patient, 117.12. Furthermore, one has to take into account that there were six patients who were hospitalized throughout the year though they worked during the day. The six who were fully hospitalized are evidently chronically ill patients, for three of whom we would, if their sentence were now terminated, recommend transfer to an ordinary hospital. For the three others we would recommend transfer to the Institut-Philippe-Pinel. Taking into account these six chronically ill patients and the six who remained in the psychiatric wing for the whole year, though they were able to work in the prison during the day, the average stay of the others is slightly under 100 days.

It is important to stress that 24 patients, though hospitalized, were not withdrawn from their work. Sixty-four were reassigned to work while hospitalized. As treatment progressed they were able to take work responsibility in the regular shops in the penitentiary. It is our feeling that an even greater number of patients could have worked had there been a sheltered shop established for them.

Another important finding is that during the year six patients were transferred to mental hospitals in the community

other than Institut-Philippe-Pinel, as it was felt that at the expiration of their sentence, this was the most appropriate plan. A seventh patient was transferred to Pinel in the course of serving a long sentence. Thus, in only two cases was a transfer to Pinel judged necessary.

The total number of patients treated in the outpatient clinic during the year was 218, consisting both of discharged patients and others receiving treatment only on an outpatient basis.

As the psychiatric hospital is located in the maximum security institution, we became more and more conscious of the fact that it was discriminatory to keep some patients there solely because they were psychiatric patients when they would otherwise have been eligible for transfer to one of the medium security institutions. It is now accepted that such patients can be transferred to a medium security institution located within less than a mile of the maximum security one. These can be treated by the physician in charge, and either pay regular visits to the psychiatric hospital for checkup or medication, or the psychiatrist himself visits the medium security institution at regular intervals. If a patient becomes acutely ill, he is immediately sent back to the psychiatric hospital on a temporary transfer and returned to medium security on recovery if there is no contraindication.

Considering that this experiment took place in an ancient bastille, one does not hesitate to conclude that it has been more

than successful. If, with primitive psychiatric facilities, we could achieve these results, one wonders how much more might have been done in a modern penitentiary where medical, surgical and psychiatric facilities are well integrated and located within the penal complex and with a sheltered workshop for patients who can use it. There is little doubt that the results would show even more conclusively the necessicy to establish psychiatric services within a penal institution itself rather than transferring psychiatric casualties to a special correctional hospital, usually some distance away, and thereby avoiding the disorganization and dislocation that accompany such a transfer.

PSYCHIATRIC SERVICES IN THE REGIONAL DISTRICT OF QUEBEC - 1972

Up to the fiscal year 1970-71, psychiatric services for the federal penitentiaries of the Province of Quebec were rendered as described, but the overall situation has changed somewhat since then. The inmates are now distributed in five major penal institutions of about 400 inmates each. One of these is a maximum security institution, while the others are medium security; there are also inmates in minimum security annexes located in the immediate vicinity of these institutions. Our proposals were that every major penal institution have its own integrated medical-psychiatric services and that a medical-psychiatric center be located in the maximum security institution where those in need of hospitalization could be treated. It was quite explicit that the medical-psychiatric facilities should not be separate from a penal institution in order that patients in need of hospitalization could benefit from all services while hospitalized and eventual

progressive discharge by such means as night hospital, day hospital and outpatient services.

We felt that if psychiatric services were available in every penal institution, the majority of inmates in need of psychiatric care could receive it on an ambulatory basis, using all forms of treatment available, psychopharmacological, individual and group therapy, as well as other techniques of treatment involving re-socialisation programs. If this plan had been implemented, it is our feeling that the average of hospitalized patients would have decreased considerably. Our forecast was that the number would have been maintained at between 20 to 30 patients while the rest could be treated as outpatients.

On completion of the new maximum security institution, the old one was closed and it was decided to use these facilities to establish a psychiatric center with a capacity of over 100 patients. This plan is now in process of being established, and whereas the average number hospitalized in the five years previous seldom reached more than 45, the average is now over 60. Our prediction is that within a year the number of patients hospitalized will be over 100. We were very disappointed that despite the experimental psychiatric services established in 1955, which had as their basic philosophy that services in a penal society should be rendered according to the standards prevailing in free society, the Canadian Penitentiary Service decided to establish what amounts to a correctional psychiatric hospital within the penitentiary system.

We will not comment further on this other than to say that putting patients in such a hospital which is not attached to a penal institution amounts to further segregating psychiatric patients who are already segregated by imprisonment. We can already foresee the difficulties that the creation of a closed correctional psychiatric hospital within a penal system will have to face within a few years and possibly a matter of months. The inmate population of federal institutions within the Province of Quebec amounts to about 2,200. As we have already said, with psychiatric services equivalent to those in free society, and with the same criteria of admission, the number of hospitalized inmates for a population of 2,200 should not go beyond 30. The facilities now planned will, however, accommodate upwards of 100 patients, a fact which raises a serious question as to the type of diagnosis under which these patients will be admitted, to say nothing of the serious legal question as to the rights of the patients, a point which merits some comment.

A new trend in correctional systems is the definition of the rights of the inmates, including the right to the same quality and standard of medical and psychiatric care provided in free society. If our forecast materializes -- as we think it will -- sooner or later the penitentiary services will be challenged as to its reason for keeping patients in a closed correctional hospital when they could be more readily cared for on an outpatient basis within the penal society and at the same time be accessible to resocialisation programs.

It is regrettable that a correctional service would still take the initiative of rendering psychiatric services in a manner that might have been justifiable twenty-five years ago, but no longer fulfills the needs or takes account of recent advances both in psychiatric treatment and in the definition of human rights vis-a-vis the way in which a man is entitled to receive medical and psychiatric care. I am well acquainted with the classic objection -- which is not new, incidentally; in fact, centuries old -- that treatment is not possible in penal institutions. I am surprised that psychiatrists still accept this objection nowadays and are ready to build closed psychiatric correctional settings on the basis of it. It is particularly disconcerting in view of the fact that when we faced similar problems in regard to closed mental hospitals which were as dehumanizing as prisons or penitentiaries, our reaction was not to accept such a statement but to challenge it and dig into the reality of our mental hospitals, and we know that where there was serious searching for answers, these hospitals underwent a tremendous amount of change.

The aim of this paper is not to elaborate programs that may lead to radical changes in penal institutions. If it is possible to achieve such changes, we might have to question the meaning of deprivation of liberty as a form of punishment and we may well have to amend our laws and change our practices in sentencing. Certainly, in this search the priority would be to find solutions or alternatives to prison, and where such solutions have been sought, they have been found. A number of countries in Europe

have systems that are far more progressive than ours, and it is certainly true that the socialist systems -- quite apart from one's political feelings about this form of government -- have devised better solutions than ours for their non-political criminals. On the North American continent there is definitely a search for alternatives to imprisonment. It may well be that alternative solutions to prison might not fulfill all our hopes, but a rational reform based on the knowledge of criminological diagnosis and processes and on the natural history of these processes including diagnosis and prognosis with all available forms of treatment, from psychiatric to social welfare assistance and social policy reform at the rational level will do much to decrease the number of inmates in our penal institutions. Approached in that light, penal institutions would eventually be transformed in the same way that our most progressive mental hospitals have changed over the past quarter of a century.

In anticipation of these changes and while actively working towards them, we should not be afraid of civil liberties movements, alert citizens who demand drastic changes in our penal institutions, or of the fact that we have been and will be challenged in court about our present practices, including the rendering of psychiatric care to inmates. We should, on the contrary, rejoice that we are being challenged and if we are not, we should ourselves take the initiative of asking for rulings where correctional systems refuse to go along with necessary changes based on human knowledge, rational policy and human rights.

I would have liked to concentrate on the relationship of human behavior, especially delinquent and criminal behavior, and the psychopathological entities found within psychiatry, but I have deliberately selected the manner in which psychiatric services should be rendered. Right from the first day that I entered the service of a penal institution, I was forced to recognize that the absence of standards of psychiatric services were obscuring the real medical psychiatric issues. It was only in taking a deliberate stand right from the beginning about rendering services in a penal institution on the same basis as available in free society that I realized that psychiatrists in prisons may unwittingly become caretakers rather than being actively involved in using all their available knowledge both for the psychiatrically ill and the inmates at large.

CONCLUSIONS

1. Psychiatric and medical services in correctional services should be integrated. The psychiatric services in correctional services should not be separated from a major penal institution and should operate as they do in the free community, offering facilities for full hospitalization, day and night hospital, and outpatient clinic.

2. The creation of special closed psychiatric hospitals for mentally ill offenders has proven to be a failure, both historically and practically. Any further plan to build such separate hospitals should be carefully scrutinized and questioned in view of past performance.

3. Psychiatric services in penal institutions should have close relationships with their counterparts in free society; i.e., exchange of staff, consultation services, etc.

4. Psychiatric services in penal institutions should be affiliated, wherever feasible, with departments of psychiatry or teaching hospitals within the region. Where this is not possible, they should work with the nearest psychiatric services in the region where the penitentiary is located.

5. Inmates who are mentally ill can be treated with the same types of service they would receive if they were in the community at large. Their right to receive treatment of a standard equivalent to that available in free society should be recognized.

6. Though recognizing that there are offenders who are dangerous when psychotic, our experience is that most are not. The difficult offender is not generally found among the psychiatric ones but among the severe character disorders. Thus, the oft-made claim that special hospitals are needed because of the dangerous mental prisoner is far from justified in our experience. In any case, dangerousness in a correctional system is generally more related to unsatisfactory conditions of detention.

7. An inmate who was in need of or receiving medical or psychiatric care prior to imprisonment should be assured of the continuation of such treatment; similarly, treatment following release should be available to him. In order to ensure this continuity, psychiatric services in penal institutions should be closely integrated with services responsible for mental health care in the community at large.

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