

Analysis and Commentary

Stone Walls Do Not a Prison Psychiatrist Make

Ames Robey, MD (reprinted with an introduction by Abraham L. Halpern, MD)

Introduction

As reported by the editor of *The Forensic Echo*,¹ the number of applicants to the many forensic psychiatry training programs in this country has increased sharply. With the expanding corrections economy, "a bright idealistic generation" now has an opportunity to work with the "underbelly of society." It is at last possible to acknowledge openly that "Not every prisoner with a psychiatric past is a sociopath unlikely to benefit from individual psychotherapy," and to provide mental health services beyond the limited "occasional supportive ear, twelve-step programs, and maybe some medicine." The editor points out that "the responsibilities of psychotherapy mentoring would return forensic mental health professionals . . . to the roots that make our expertise helpful to the court in the first place." The new employment opportunities for skilled psychiatrists together with the high caliber of students entering fo-

rensic fellowship programs make it possible to bring to patients in a long-term setting treatment for their inability to relate to others, for their anger and their alienation.

It is precisely because of the burgeoning expansion of correctional mental health services that the reprinting of Ames Robey's 1971 *Newsletter* article² is both timely and vital. The article, described by the then *Newsletter* editor as "the finest piece of advice available on how to bring psychiatric services to the residents and staff of a correctional facility,"³ should be read (and reread) by correctional psychiatrists and students in conjunction with the three-part introduction to correctional psychiatry⁴ that commenced with Issue Number 3 of Volume 25 of the *Journal* and the article by Philip Candilis and Kenneth Appelbaum⁵ in the same issue.

With the current jail and prison population in the United States approaching 1.75 million persons, as reported by Metzner,⁴ 23 to 40 percent of whom require some form of psychiatric intervention during their incarceration, considerably more mental health professionals

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will be needed. The prospects are good for correctional budgets to include many new positions. In addition, the increasing number of forensic mental health training programs will facilitate the treatment of mentally disordered persons, utilizing traditional psychotherapeutic techniques.⁶

I am confident that the lessons contained in Robey's article will help correctional psychiatrists and other mental health professionals provide meaningful and effective services in a prison setting.

References

1. Welner M: Editorial: put psychotherapy in prison. *The Forensic Echo* 1(10):3, 1997
2. Robey A: Stone walls do not a prison psychiatrist make. *AAPL Newsletter* 3:26-34, 1971
3. Thomas HE: Editor's note. *AAPL Newsletter* 3:1, 1971
4. Metzner JL: An introduction to correctional psychiatry: Part I. *J Am Acad Psychiatry Law* 25:375-81, 1997
5. Candilis PJ, Appelbaum KL: Anatomy of a prison commission. *J Am Acad Psychiatry Law* 25:401-7, 1997
6. Welner M: Op. cit.

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The criminal justice system is a complex chain of organizations intended to protect society. Laws are promulgated defining that behavior which is unacceptable. If the law is broken, the system is designed to process the offender through identification, adjudication and disposition.

Society has decreed that if the defendant is found to be guilty, that is, if his errant behavior is the result of being "bad," then he shall be punished. On the other hand, if he is found to be "sick," some alternative disposition may be indicated. Well established in the law, al-

though statistically little used, is the concept of exculpability by reason of "insanity"; a disproportionately large amount of the literature has been spent on this issue. Far less attention has been paid to the problem of the convicted offender who is mentally ill. He has already been found guilty and sent to prison; he is not going to go unpunished. The public now has little concern over his mental state.

In most jurisdictions, if a prison inmate becomes psychotic, the law allows his transfer to a mental hospital because he is, for the moment at least, considered "sick." But the goal of treatment at the hospital is seldom more than to effect as quickly as possible his return to prison where his punishment for being "bad" can continue.

The original reason for the introduction of psychiatric services into the prison setting was to make diagnoses and effect transfer to a mental hospital of those who become acutely psychotic. With medication available to treat mental illness, the duties of the psychiatrist expanded to include continued therapy of those returned from the mental hospital as well as treatment for those who showed evidence of a milder degree of mental illness not requiring removal from the prison. Unfortunately, the role of many a prison psychiatrist stops at this point. He sticks rigidly to his medical model. The "sick" are his to treat; the "bad" are the responsibility of the correctional personnel.

If the psychiatrist should become restless or dissatisfied with his role and attempt to enlarge it, within the prison, he may run afoul of some very strong feelings concerning the time-honored ap-

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proach to the offender. "Correction" in practice means punishment through removal from society. Should the prisoner show any attitude but passive acceptance of his fate and deep repentance, he is punished further. He may be deprived of his few privileges and isolated from his fellow inmates. Occasionally, he may even be subjected to corporal punishment. "Rehabilitation" is too often based on nothing more than the application of sufficient control or force so that the "criminal" gives up his "bad" behavior, is deterred from further crime (as are others by example), and is reformed so that he is no longer a threat to society. The results of this approach are to say the least, unimpressive.

Should a psychiatrist entering corrections work express the opinion that the punitive approach is ineffective or wrong, the correction officers may respond, "You don't understand, Doc. These men are bad." If he argues that no man is truly "bad" and that they are in reality sick, victims of their upbringing, their environment, and society, he is labeled an impractical idealist. His psychodynamic deterministic approach evokes defensiveness and hostility. If he should demand a lessening or change in the retributive controls for an inmate, he is considered "soft" and easily manipulated and becomes a potential threat to the orderly running of the institution. If he persists in his attitudes; speaking of inhumane treatment and quoting recidivism statistics to buttress his arguments, effective communication may cease entirely. Referrals to him from the corrections staff become limited to those so overtly mentally ill

that continuation of their presence within the prison can no longer be tolerated. If he can even continue working within the prison, he is reduced to filling out transfer papers, writing reports, and taking long and lonely coffee breaks. That the institution has a psychiatrist at all becomes largely academic. His reports are ignored and serve only to build a paper fortress for the protection of the remains of his professional ego.

Such a fate for the psychiatrist is far from inevitable. However, to avoid it, he must be willing to invest in the system and function well in a variety of roles. He must work to ensure his acceptance by the correctional staff; only then will his abilities and knowledge be considered worthy of attention.

When the new psychiatrist starts his first day at the prison, he will be carefully observed by staff and inmates alike. As he makes his initial tour of the institution, the "grapevine" will quickly pass around any available information on him, drawing upon his appearance, manner, how he relates to both staff and prisoners when approached, any passing comments he makes, and even from material contained in his confidential personnel folder. The type of car he drives and how he handles it will be noted, how he likes his coffee, and where, what, and how much he eats. Little escapes the watchful eyes of his observers. Although exchange of information between the corrections officers and the inmates may be limited, it is still but a brief period of time before both groups have formulated opinions concerning this newcomer.

The psychiatrist will have barely set-

tled into his office before the testing period begins. A staff member may present a problem-convict, without mentioning that he has been previously diagnosed. An inmate will request to see the psychiatrist and ask for barbiturates, amphetamines, or other medication that he knows is not in the prison pharmacy. The psychiatrist's integrity will be challenged; he will be told about a breach in the rules, and notation will be made as to whether the information is passed on or retained as privileged. The corrections officers will probe with both subtle and direct questioning to ascertain his attitudes toward punishment. Can a violent inmate be placed in solitary confinement? What do you do with the prisoner who floods his cell or burns his mattress, publicly masturbates or cuts his wrist? How do you handle the problems of homosexuality, violence, and contraband?

The psychiatrist is most probably aware of this testing during his initial period of getting to know the institution, its staff, and the inmates. He must field the questions and respond without becoming either overly technical or condescending. He must recognize the covert suspicion that is inherent in the system and not react with defensiveness or hostility. When he takes a coffee break, it would be politic to use this opportunity to sit with others and begin to establish communication. It behooves him to become acquainted with the corrections officers and sound out their feelings without giving them the impression they are being analyzed. Most importantly, he must recognize the concerns of the prison staff about the inmates without labeling them

fears; he may become more approachable by admitting some of his own concerns. He should allow in his conversations that there are some "bad" people in the world, but at the same time slowly and carefully erode away the conceptual dichotomy that the offender is either "bad" or "sick." He can perhaps propose that there are people who are bad *and* sick, thus creating an atmosphere in which the relative degree of badness and sickness can be evaluated. Slowly, he can introduce the idea that perhaps neither term is appropriate, and that while labels are convenient, they are not essential, and are often very destructive.

When he teaches, it must not be as professor to student, but as professional to professional. What he teaches must be common sense and applicable to the situation at hand. He can gradually enlarge the scope and number of staff included in discussions so that in effect group study of the system begins. These sessions can then even be formalized by obtaining scheduled time for them from the Warden or Commanding officer. He may then give specialized material in the recognition of emotional disease and the problems which can create it, and begin to train the correction officers in treatment concepts with the ultimate purpose of utilizing them in case-finding and rehabilitation. As results are shown, the program strengthens and becomes a permanent and integral part of the prison system.

To the inmates, he must show a solid core of understanding firmness and be of unquestionable integrity. He cannot allow himself to be pressured or manipulated. He must be able to distinguish between

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the malingerer and the mentally ill and take appropriate action with both. It is advisable that he recognize the misuse and traffic in certain medications and either establish effective controls or find appropriate substitutes. He may be asked to provide some assistance to the parole board in their deliberations, but before making any recommendations he must be able to determine whether the patient is really interested in solving some personal problems or only wishes to find support for his early release. It is important that he be fully aware of the nature of the closed society in which his patients live and incorporate this knowledge into his diagnostic efforts.

The trust of both the inmates and the correction officers, which he earns by his efforts, allows him to be an effective mediator and potent force in causing change in both the system and its charges, but it is imperative to his position that he move slowly and recommend innovation with care.

Available to him is a wealth of material, and he should undertake research on methods, problems, and statistics within the prison. He can study the inmates and their offenses, follow their progress when they are released to society, and understand and document the reasons for recidivism, should they return to prison.

Through all of this, the psychiatrist must continue to provide direct service to

the mentally ill, utilizing medication, individual and group therapy, and any other treatment modality available within the system. The one-to-one doctor patient relationship is not obsolete by any means, but it may have to share a large amount of time with a new relationship between members of an integrated "team." The work can be exciting and rewarding.

The correctional system has been a part of our civilization for almost as long as society has existed. Because we in the mental health sciences are recent arrivals on the prison scene, the responsibility for integration into the system falls on us. In a closed community, an effective relationship between psychiatry and the disciplines involved in the criminal justice system is essential. We must protect our professional identity neither too much nor too little. The former tends to accentuate philosophical differences and increase rivalries and mutual distrust. The latter destroys identities and reduces the usefulness of the knowledge each individual in his own area of training brings with him. To function effectively within the correctional system and the closed society it represents, we must remain individuals but still be able to work within an alien environment in achieving a common goal—the creation of an integrated system to assist in the treatment, rehabilitation, and *correction* of those in our care.