Teaching General Psychiatry in a Sociolegal Clinic: Down from the Tower and into the Community†

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As a critical developmental experience all psychiatrists have shared, the education of the psychiatric resident has been of continuing interest to the profession. Those of us who entertain the hope of improving, enriching, and modernizing the experience for our colleagues-to-be are particularly cognizant of the need to search for exciting and contemporary vehicles for the delivery of the essential or core knowledge to be transmitted in the three years of basic residency training. The purpose of this paper is to point up the advantages of carrying out a portion of that training in a clinic established to serve those caught up in the criminal justice system. Residents have traditionally acquired their supervised clinical experience in a wide variety of settings, ranging from the inpatient unit for the acutely disturbed, through the emergency department, to the clinic, nowadays subdivided into many small enclaves of specialized knowledge such as the family and marriage clinic, the short term dynamic psychotherapy clinic, *et al.* For the most part, the budding clinician is surrounded by other more experienced clinicians of the same discipline. The concentrated exposure over time to a small number of teachers has long been recognized as providing the beginning resident with the opportunity to identify with an esteemed mentor, so crucial at this stage of his development. This pedagogic model serves admirably to nurture the young psychiatrist's shaky sense of professional self-worth while he learns the basics of diagnosis and patient care. In the past, this approach to training continued to set the pace throughout the residency. Psychoanalytic teachers, preeminent at many university training centers until recent years, steered the impressionable young psychiatrist to devote the bulk of his time to a small number of his healthiest patients. Those unable to benefit from this "best of all possible treatments" generally were given short shrift. Other treatment methods, though not so insistent on healthy ego functioning as the preceding one, still stressed the importance of motivation for change in such a way that the psychiatrist saw himself as responsible only for the patient who came knocking on his door, hat in hand. The patient's unsolicited and voluntary appearance was the necessary first step in

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giving evidence for his determination to change, and all those who came under any form of duress were regarded as suspect. In this ambience the resident easily developed the comforting, but erroneous, notion that a profession's role is determined exclusively by its members' interests. The insularity of this approach to teaching gave rise to the anxiety-reducing, but growth-limiting, bias toward overvaluing the potency of the treatment method, with its consequent undervaluing of the patient's capacity to cope (in some instances his ability to recover despite our treatment). Particularly troublesome was the exclusion of considerable numbers of those who might have benefited from our services on the basis of their presumed lack of sufficient motivation or ego strength. It was yet to be acknowledged that few patients seek us out without prodding from some external source and those suffering from certain conditions, by their very nature embarrassing and thus shrouded in secrecy, come to grips with the problem only when someone in authority has become aware of their plight. In time these problems were described by some in terms of the therapist's difficulties with transference and countertransference issues. The struggle has been effectively joined only as we have emerged from the protective intramural cocoon into the forbidding glare of the community.

Of course, the practice of psychiatry has changed dramatically in recent years. Much of this progress has been spurred by the unfolding of the community mental health movement in the 1960's. Zwerling[1] has described the three basic concepts underlying this movement; that of the catchment area, wherein it is now the psychiatrist's responsibility to find those within the designated geographical area who might benefit from any of the broad array of innovative services, rather than the patient's continuing responsibility for presenting himself in the doctor's office; that of mental health as something more than the absence of illness, with all its disturbing implications for a new responsibility to work toward improvement in the general quality of life; and that of the profound impact on behavior of other systems affecting the patient such as family, community, social class, and ethnic background. These concepts have spawned a new delivery system for mental health care and this has had major impact on our psychiatric residency training programs. Levitt and Langsley[2] remind us that professional education is always influenced more directly by changes in the practice of the profession than by theoretical or basic science advances. Thus, the resident in most programs today has the opportunity to be a part of a multi-disciplinary service team in his second or third year, and in some instances, to try his wings as consultant, rather than service provider, outside the protective confines of the hospital.

When this extramural setting has as its mission the delivery of health services, the resident may be guided by the familiar liaison model for providing consultation to patients on other services within the hospital. He will remember that the consultant must have a sound working

knowledge of the system to which he is consulting and must be an active participant in that system as well. Since someone else will always have final responsibility for resolving the problem around which his advice is sought, he must keep in mind that he *is* an advisor (and not always so highly regarded an advisor at that).

However, when the system to which he is consulting serves ends other than the delivery of health services, *e.g.,* the criminal justice system, the resident is truly in foreign territory. Because of the different ideologies and basic assumptions of such systems, he is forced to apply his clinical knowledge in a non-clinical context, to translate this knowledge into terms understood by those outside our field, and to work effectively in a setting in which his is not the last word.[3] This introduction to the second critical phase in the process of becoming a psychiatrist is often viewed by the trainee as a perilous passage to be avoided at all costs, rather than as an opportunity. Morrison *et al.*[4] describe it as "culture shock" leading not infrequently to regressive trends. And it is indeed chastening, even humbling, to see our preciously articulated formulations on prognosis or the origins of aberrant behavior held as unresponsive to the question at hand, or even worse, dismissed as gobbledegook. It is equally disquieting to learn that others outside our profession are so much more concerned with the bad than the mad (and with those suffering from the less visible varieties of mental disorder, hardly at all). Worse yet, they rather stridently put it to us that we should take far greater interest in the character disorders with antisocial propensities, the organic brain syndromes prone to violent outbursts, and in those who kill and rape for no apparent reason. (A few never succeed in working through the trauma of this exposure to the community and, bedeviled by the ineluctable return of the repressed, become forensic psychiatrists.) Cotton and Pruett[5] have described their affective experiences as residents assigned to an extramural setting. The ambiguity of the roles assigned, and the coolness with which they were received, generated feelings of anxiety, loneliness, anger and disappointment. They conclude on the hopeful note that, by dealing with these feelings in supervisory sessions with both peers and faculty, the resident may be able to surmount this challenge by developing new approaches to clinical problems as well as the equanimity necessary for effective functioning in the community.

I would like to turn now to a description of one such extramural setting and the residency training program of which is is a part.

The Department of Psychiatry at the University of Rochester, and its residency training program, were established in 1946 by John Romano. Of modest size in its earlier years, and almost exclusively intramurally based, the department grew rapidly in the 60's with the establishment of a community mental health center within its midst. The number of residents in the program mushroomed to a high of 48 and the opportunities for community-based training were expanded apace.

One such opportunity grew out of the joint efforts of the Department and the County Board of Mental Health to establish a mental health clinic in the Hall of Justice in 1963. Initially a small operation occupying borrowed space on a part time basis, it has grown to its present size of five full-time staff plus four part-time psychiatrists, and a referral load of approximately 1000 new cases per year. In addition to the education and case-centered consultation provided judges, probation officers, and others during the earlier years, the expanded staff now is responsible for all diagnostic and treatment services for both sentenced and unsentenced prisoners in the Monroe County Jail, a population averaging about 325 on a given day. Three public health nurses and a masters-level social worker man the front lines, with a clinical psychologist and the psychiatrists providing consultative and additional diagnostic and treatment services on referral from the primary care workers. An attorney from the Public Defenders Office serves as part time guide and translator and makes an invaluable contribution to our efforts to teach this transcultural discipline that is forensic psychiatry. He, along with the rest of the staff, have clinical appointments in the Department of Psychiatry, in recognition of their contribution to the residency training program. Most of the referrals are for diagnosis and treatment but the staff also provides all the evaluations for competence to stand trial and is often called on for opinions on dangerousness, prognosis, *etc.*, and, less frequently, on such issues as criminal responsibility and child custody.

Two of the psychiatrists referred to above have full-time University appointments, while another is a third-year resident from the University's program. This is one of the mandatory slots in the last year and is filled by two residents, each for a six-month block. Of greater relevance to the clinic's place in the general education of the psychiatric resident is the fact that all second-year residents spend one morning a week with us for four months. This is no more than a third of the time we once had, but the many subspecialty areas that have cropped up in recent years, from family to behavioral to pharmacotherapy have made substantial inroads into the resident's time. I am reminded of Zwerling's query, "How are we to protect against a diffusion of training so that our trainees do not end up learning less and less about more and more."[1] He did not, as you might imagine, have a ready answer. Close to 150 residents have rotated through the clinic over the past 15 years. Several have gone on to devote a major share of their time to forensic and community psychiatry.

The resident who comes to us early in his second year has just completed a year of what he has come to regard as involuntary servitude on the inpatient floor (this is up to 16 consecutive months if he takes our internship or PGY-I program). He begins to step up his hours in the Emergency Department, but devotes the bulk of his time to the outpatient clinic. Attached to one of the multidisciplinary service teams, he begins his supervised experience with families, groups,

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children and the general run of ambulatory patients. And so, he comes to the Sociolegal clinic at a nodal point in his development as a psychiatrist, at a time when he is beginning to cast off the xenophobic attitude which pervades the inpatient service, and to experience firsthand the many other social systems outside the psychiatric hospital in which his patient is caught up. In short, he is beginning to learn of the varied settings in which patients may appear and, already divested in part of his faith in the potency of psychotherapeutic interventions, has a greater interest in learning to work within and influence these settings for the benefit of his patient. During their stay with us, the residents perform supervised evaluations in the clinic or the adjacent jail and work out a disposition with the referrer. This is followed each week by a seminar on a topic in forensic, community, or even general psychiatry. We begin our didactic work by describing the passage through the criminal justice system, exposing the resident to the set (from the station house to Attica) and introducing the cast of characters (judges, prison administrators, sheriffs, lawyers and the people who make the whole system go — probation officers, court clerks, jail guards and rehabilitation officers, police, *et al.*). This introduction is carried out over the course of the entire rotation and provides a sobering, and sometimes suffocating, view of our balky, ponderous, and at times quite unjust system of dispensing justice. In their contacts with those with whom we share responsibility for patient-defendants, the residents are introduced to the art of consulting and, of course, chafe under the constraints imposed on them by the alien rules of another system. We do our best to curb fractious enthusiasm for instant change, without causing them to lose sight of the constructive and gratifying role of the psychiatrist in this arena. What seems to make it all work is that this process occurs in the broader context of clinical evaluation of patients. Each referral, whether to determine need for psychiatric care, competence to stand trial or whatever, receives a thorough clinical evaluation including psychological, medical, and neurological testing where indicated. Information is gathered from other sources by the resident or the primary care workers, and every effort is made to gain as broad an understanding as possible of the patient's presenting complaints. Forensic questions are then addressed in those cases where they have been raised and a report is prepared. The resident is introduced to the pre-evaluation referral conference, a tool of vital importance in evaluating referrals from those outside the health care system, because of our lack of a common language. This conference also serves as a practical vehicle for gathering additional information about the patient, for gaining some understanding of the rules under which the legal issue, if any, will be decided, and whether an evaluation of the defendant is appropriate in the first place. Often a discussion of the issues posed obviates the need for an examination. No doubt the biggest plus associated with these conferences is the opportunity to

develop personal relationships with the referrers. Such relationships, when based on mutual respect, if not always understanding, sometimes provide the only possible vehicle for resolving the conundrums so frequently generated by our efforts to work together on the same patient-defendant at the same time. While such conferences are by no means always necessary, they are considered whenever the question(s) are of sufficient complexity to defy efforts to reduce them to a single paragraph. Post evaluation conferences are also helpful at times, conveying more accurately the nuances of our conclusions and recommendations and providing an opportunity to devise "joint management plans" with probation officers when indicated; but the guardians of the law, with their passionate thirst for unambiguous, conclusory statements, do not always attach the same value to these conferences as we do.

The residents for the most part have been eager participants, and attribute this primarily to three factors: (1) Most of the teaching is conducted by full-time faculty with whom they readily identify (we may have already supervised a couple of them in their first year and deliver their introductory lectures in psychopharmacology as well as supervising their work in the Affective Disorders Clinic; (2) The meetings with referrers are conducted jointly by residents and faculty, as opposed to the resident going it alone and later bringing his experiences, and sometimes his battered psyche, to supervisory sessions; (3) the clinic's orientation is toward caring for patients, and the resident, still at an early stage in his professional development, identifies most readily with the psychiatrist as therapist rather than as consultant, educator, or administrator. Morrison *et al.*[4] have noted that the beginning resident tends to describe himself simply as "not the patient"; thus, in order to function, he requires someone else who is assigned, or better yet, accepts, the role of patient. Looking first to the individual as a patient, seems to pique the resident's interest in the defendant's involvement with the criminal justice system. This, of course, opens the door for an introduction to forensic issues, and we include, in addition to criminal matters, such basic topics of concern to all psychiatrists as involuntary hospitalization, competence in its broader sense, and the various sources of the avalanche of regulations affecting, and often impeding, our care of patients.

Returning to the assumption stated at the outset, what are some of the advantages of conducting a portion of general residency training in this kind of setting? The residents' initial bias toward the population they encounter, reflected in the overdiagnosis of antisocial personality and no mental disorder, gives way to a better rounded understanding, and better quality care, of the patient-defendant. Personal contact dispels the comforting stereotype of the willful predator, and pierces the resistance to empathizing with the raw misery of these multiply handicapped patients. The resident is surprised to learn that the

diagnosis of schizophrenia is made with the same frequency in the clinic as in the community over all. We've had the good fortune to be able to maintain a cumulative psychiatric case register in Rochester since 1960 and have compared the diagnoses made in the clinic with those reported by all other mental health care givers in the county. Many of these patients, of course, have committed serious crimes and so are fated to spend a fair amount of their future firmly in the grip of both criminal justice and mental health systems. But many more are charged with minor crimes, largely because the officer called to the scene finds it simpler and often more effective to book the person rather than navigating the perilous straits of the psychiatric emergency department. Our task in these cases is to arrange for withdrawal of the charges while admitting the patient for in-hospital care.

Through promoting the care of patients tenaciously enmeshed in other systems, the experience provides the resident with a model for the psychiatrist as advocate for his patient, as well as therapist. This kindles an interest in constructive interaction with those who frame the rapidly increasing number of constraints on the physician's care of his patient. Finally, since all the clinical work is done collaboratively with the clinic psychologist, social worker, and public health nurses, the resident is exposed to the many added diagnostic and treatment capabilities of the multidisciplinary team. Many of our residents have had their only experience with home visits while on this rotation. They learn firsthand of the added information of use in diagnosis and treatment planning that such visits provide, as well as the capabilities of the public health nurse and other community workers in delivering care to the chronically ill in their homes. Perhaps the greatest revelation, however, is the small corner of the cosmos psychiatry actually occupies in the delivery of care to the mentally afflicted in the community. The sobering fact is that the great bulk of this care is provided by other mental health professionals and non-professionals who have been isolated from psychiatrists. Most importantly then, the resident emerges from this initial exposure to the community with some measure of humility and, therefore, an important new perspective on his role as psychiatrist.

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