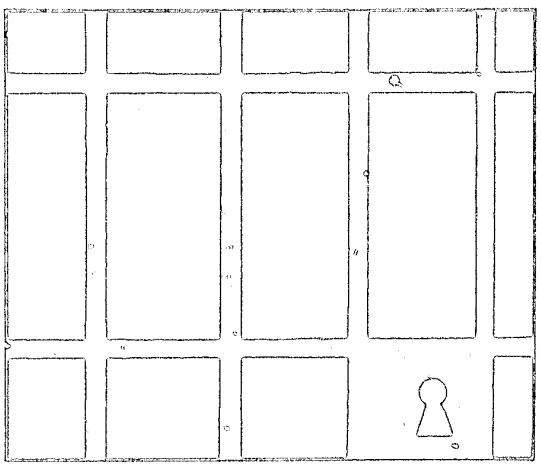
PROCEEDINGS

2nd National Conference on Medical Care and Health Services in Correctional Institutions



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THE CARE OF MENTALLY ILL, SUSPECTED MENTALLY ILL AND RETARDED INMATES: WHO SHOULD DO THE TREATING?*

As I stand before a conference sponsored by the American Medical Association, it seems somewhat incongruous to be asking, "Who should do the treating?" As most of you are aware, medical practice today is characterized by a proliferation of specialists, sub-specialists and super-specialists. If you work in a major medical center, there is no question who should repair lacerated tendons in the hand--obviously the hand surgeon. The pediatric cardiologist undertakes the treatment of a child with a congenital heart defect, and the oncologist manages the patient with a tumor. Why, then, are we meeting here today to talk of mentally ill and retarded patients and questioning, "Who should do the treating?"

You and I, of course, both know the answers. The term "mental illness" means many things to many people, and the label of "mental illness" has been attached to many individuals in the past as the result not of judgments made on the basis of scientific medical practice, but rather because of social, cultural or legal biases. Psychiatrists themselves, in many cases, cannot agree on precisely what is meant by the term "mental illness," and the addition of other theoretical approaches by psychologists, social workers and other professionals has not helped to clear up the picture. The psychiatric profession is in an identity crisis, and for a great number of us psychiatrists, its only salvation is in the return to the so-called "medical model." We are seeing today the fruits of the explosive growth of the community psychiatry movement, which elevated psychiatrists and other mental health professionals into an unearned and unwarranted position as experts in education, racism, poverty and international relations, just to mention a few. I am not saying that psychiatrists may not have expertise in these areas; however, that expertise is not derived automatically by virtue of their M.D. degree, nor from the completion of a psychiatric training program. The psychiatrist who chooses to work in the criminal justice system, be it either in a courtroom, jail or prison, must recognize his limitations and fight off the cloak of omnipotence with which society tries at times to place on him. Contrary to what many may feel, psychiatrists are rarely prepared by virtue of their formal psychiatric training to deal with issues of public protection and criminal behavior. It is imperative that the psychiatrist very clearly defines his area of expertise and directs his time to the attention of those patients who can receive the needed services from no other source.

If you look at varieties of services that the mental health professional is called upon to render in jails and prisons, it becomes clear that they fall into two basic categories: (1) Public Protection Services and (2) Treatment Services. The category of Public Protection Services includes those activities not geared toward the needs of the patient but rather primarily to the needs of the criminal justice system and the institution in particular. Such activites might include initial classification studies, evaluations of inmates as the result of rules infractions, particularly if they involve violence or sexual misbehavior, probation, parole and pardon reports, etc. The second category, which I am calling "Human Needs Services," is directed toward the needs of the inmate and includes such items as crisis intervention, counseling, substance

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abuse services, programs oriented toward personality change in the inmate with hopes for resultant reversals of criminal behavior patterns and, last but not least, treatment of the mentally ill.

For the purposes of this discussion, I would like to restrict the term "mental illness" to the conditions known as schizophrenia, manic-depressive psychoses, organic brain disease and endogenous depression. It is these conditions that are known to have, or are presumed to have, an organic basis and, except in the most deteriorated states, respond best to the medical approach through the use of chemotherapeutic agents or other organic modalities. We do not know the cause of schizophrenia, nor do we know the cure; but we can--under proper medical supervision--ameliorate many of the symptoms through the use of medication and, with the support of nursing, psychological and social work services, provide the best hope for the patient. It is for this class of patient that management by a physician is mandatory, yet it is this very type of patient who by the nature of his chronicity has often been most ignored. At this point you may object that this is too narrow a definition and that there are other inmates in need: men suffering from guilt, loneliness, fear, despair, and all the other devastating effects of imprisonment. What about those inmates with serious drug problems, sexual problems, and marital problems? How about those inmates who just need somebody to listen to them or want in some way to find meaning to their lives? These needs, of course, must be answered, but I do not believe the criminal justice system should expect to find the resources or the expertise to satisfy these needs by turning to psychiatry. The impact of the criminal justice system on any individual involves medicine only to a small degree when compared to the importance of social, cultural educational, religious and legal issues.

If the psychiatrist backs out, who will take his place? Well, the very same people who have been doing it all along the line--the teachers, case workers, priests, ministers, correctional officers, wardens, work supervisors and correctional psychologists. It is my opinion that it is these individuals who are better trained and better equipped by virtue of their experience to assist the new inmate in adjusting to prison or in learning to deal with the threat of sexual assault or in developing the skills for getting along with others in an adult role.

This is not, as I see it, an abandonment of psychiatry's role but rather a re-definition of who the psychiatrist is and what his training is, thereby being able to utilize his resources most effectively. I firmly believe that the vast majority of the "Human Services Needs," exclusive of the treatment of the mentally ill, can be provided as effectively--if not more effectively--by a non-psychiatrist and, given the premium that the psychiatrist demands by virtue of his status as a physician, more economically. In these days of tax limitations, the wise use of tax dollars must be a priority with every public administrator. Another significant effect of the return of the psychiatrist to the medical model is that it, in effect, will strip away the mystique, the aura surrounding the practice of medicine which has been assumed by many non-medical professionals. The time has come for psychologists, social workers and other professionals to stand on their own and demonstrate the value of their disciplines independent of medicine and to rid their vocabulary of its medical terminology. In the practice of medicine we have no difficulty in understanding the word "treatment" and surely ought to, in most cases, be able

to predict the results of such treatment. Unfortunately, as they become applied outside medicine, the words "treatment," "therapist," "clinician" and "therapy" have lost their meanings.

What is treatment? I know what it means in reference to something I do to a person with a strep throat; I do not believe that same medical term should be applied to services provided to the individual who has violated the law by commission of an armed robbery, murder, rape or embezzlement. The term "treatment" has been used repeatedly in the correctional literature, yet more and more we realize that the use of the term has held out a promise, not only to the individual, but to the courts and the general public as well, that something was being done to "cure" the inmate. We cannot treat the criminal for his personality disorder, because treatment implies activity on the part of the treating person and, to a certain extent, inactivity on the part of the patient. The physician is responsible for treatment, while the patient, as in a surgical procedure for instance, may be a totally passive participant. There is no question in my mind that terms used in corrections such as "treatment teams," "treatment plans" and "treatment programs" ought to be replaced and that such services be defined more clearly as psychological, counseling or guidance services. If we do away with the term "treatment" for the vast majority of services provided to inmates, we should also, of course, do away with those time-honored and prestigious but ill-defined terms such as "clinician" and "therapist." I frankly do not know what a clinician is or what a therapist is. I do know what a social worker is; I do know what a psychologist is; I do know what a prison counselor is; and, more important, I know and other responsible individuals in the criminal justice system know what psychologists, social workers and prison counselors do and are expected to do.

As an ethical issue, it is even more important for psychiatrists and the psychiatric profession to divest itself of what I consider an over-involvement in the management of the offender. Classification studies, parole board reports, pardon hearings and the like are not issues directed toward the welfare of the patient. They do involve the protection of the public and unless the individual is mentally ill, they should not concern the practice of medicine. This is especially true in view of the growing realization that psychiatrists are in general poor predictors of violence and dangerous behavior. Because of the weight given to a psychiatric report by various decision-making bodies, the potential for harm to an individual who is the subject of such a report is great. Physicians should avoid being drawn into such activities, particularly when the individual is not mentally ill and the issues can be addressed by a non-medical professional. Most certainly psychologists by virtue of their training are often far better equipped to speak of the concept of personality assessment and development.

My answers, then, may sound simplistic but let's be realistic. Psychiatric resources are extremely limited, and it is the rare state or county correctional system which has adequate psychiatrists available. The psychiatrist as a physician has a responsibility to the treatment of the schizophrenic, the manic-depressive, the individual with organic brain disease or with severe depression. He has a responsibility to these patients because no one else can take his place, and until these patients are receiving adequate services, he ought not to be involved in other albeit more stimulating endeavors.

The psychiatrist must closely align himself with the medical staff at the institution and assist them in the diagnosis and management of those complaints which have a very strong psychological component. He must at the same time encourage the medical staff to refrain from an over-dependency on medications where the problems are basically of a psychological nature. The psychiatrist must work collaboratively with other institutional staff, keeping in the forefront the realization that his time and talents are limited and will be rapidly over-extended of he attempts to take on responsibilities which in reality belong to others.

The delivery of human services programs should be under the supervision of psychologists or social workers and divorced from the medical department. Their clients should be recognized as individuals who are not mentally ill and whose crimes are the result of the interaction of many forces. We have heard again and again that the medical model does not work. On the contrary, the "medical model" does work but only when applied to medicine. The "medical model" will not work when applied to social, education, cultural or legal problems. The failure is not in the "medical model" but in its application outside of medicine. The "Mental Health Marching and Chowder Society" bandwagon has gone too far. It has confused our language, misdirected our goals and promised the moon, but delivered much less, except for high costs to the taxpayer and disappointments to many.