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PSYCHIATRIC CLINICAL SERVICE FOR PENOLOGY: COMMENTS ON RECENT GUIDANCE CENTER TRENDS

Harry L. Freedman

Dr. Freedman, a Fellow of the American Psychiatric Association and an elected Member of the National Committee for Mental Hygiene has had long experience in the field of criminology and penology. While on military leave of absence from his post as Director of the Classification Clinic, Clinton Prison, Dannemora, N. Y., which he has held for many years, Dr. Freedman has been credited with establishing the first Mental Hygiene Unit in the Army. He has authored many important papers as a result of his experience with soldier maladjustment including violators of military law. He is considered an authority on the adaptation of the psychiatric clinic to an administrative setting.—
EDITOR.

The organizational and functional operation of the Guidance Center of the Department of Corrections, San Quentin, California, as this process has been recently described, suggested the need for a critical examination of the method in which the structure and basic philosophy of such clinics or "Centers" have been, or may be, translated into practice.¹

These comments are stimulated by the significant statements which have appeared in *The Prison World*:

1. "California's New Penal and Correctional Program" by Richard A. McGee, Director of Corrections, Sacramento, California, May-June, 1945, Vol. 7, No. 3.

2. "The Process of Reception in the California Prison System," by Norman Fenton, Chief, Guidance Center, San Quentin Prison, California, September-October, 1945, Vol. 7, No. 5.

In regard to the first article, attention is invited particularly to the statement on page 14 to the effect that a "psychiatric and diagnostic clinic" has been set up for the California State Department of Correction:

"Of unusual interest to the advocates of better classification in penal and correctional institutions is the provision in the law which requires that the Director of Corrections shall establish a psychiatric and diagnostic clinic for the purpose of making a careful study and examination of each person committed to a State Prison. The Adult Authority, which is the quasi-judicial and casework agency of the Department, has supervision over the functions of this clinic. The clinic was established in September, 1944, at the San Quentin Prison, which at present is the receiving center for all newly admitted adult offenders. The clinic is known as the Guidance Center of the Department of Corrections. It is headed by a chief, who is a clinical psychologist, and its work is divided into four major divisions, each headed by a competent staff officer. The divisions are: 1, Medicine and psychiatry; 2, Sociology and case work; 3,

¹ "The Role of Psychiatry in Prisons" by Harry L. Freedman, M.D., in *Journal of Criminal Law and Criminology*, Vol. 29, No. 3, Sept.-Oct., 1938, pp. 358-361.

Psychology; 4, Educational and vocational counseling. Newly admitted inmates are under the twenty-four hour-a-day observation and supervision of the Guidance Center staff for a period of from four to seven weeks, after which they are referred to the Adult Authority for transfer to the several institutional facilities of the Department."

The above reference indicates the authority for the existence of a "psychiatric and diagnostic clinic" (called Guidance Center), described in the second article; it is also referred to by the Governor of the State of California in his "Guest Editorial" on "Basic Essentials of Good Government" in *The Prison World*,² wherein he states:

"Certain facilities which the members of the Adult Authority will need in performing their functions are provided specifically by the new law. One of these is a psychiatric and diagnostic clinic which will provide the information on which the Adult Authority can base its decisions."

Under California Law, the Guidance Center is also known as a "Reception Center";³ in other instances they are called Diagnostic Depots,⁴ Classification Clinics,⁵ "psychiatric and diagnostic clinic,"⁶ etc., but in any event they are a psychiatric clinical service. The following comments should form the basis of a discussion of any such a program as may be described in operation.

The author is to be congratulated on the candor with which he presents the beginning experience of the Guidance Center established at San Quentin. In an unpretentious exposition he points the way for an examination of this progressive step in the field of penology, and makes available an experience which might profitably be evaluated by those who are interested in a forward looking penology.⁷

As is indicated in the context, such a program will operate under severe handicaps of personnel and pressure. Even under these circumstances, however, there can be a studied attempt at exploration of the process which by the very nature of presentation offers itself for critical evaluation. Whether by reason of oversight or focus in presentation, the most glaring need, which will be made apparent by the content, is the administrative responsibility which each of the members is presumed

² "The Prison World," Sept.-Oct., 1944, issue, Vol. 6, No. 5, p. 3.

³ "Philosophy, Principles and Program of the California Adult Authority" issued by the Adult Authority, Department of Correction, Sacramento, California, April, 1945, p. 3.

⁴ Two established in 1933 in Illinois State Penitentiaries.

⁵ "The Classification of the Prison Inmates of New York State," by V. C. Branham, M.D., Addendum II, Supplemental Report to Commission to Investigate Prison Administration and Construction, State of New York, 1930.

⁶ First established in Sing Sing Prison by Laws of New York State, July 1, 1929, Chapter 242, and also known as "Classification Clinic."

⁷ "The Psychiatrist Looks to the New Penology," by Harry L. Freedman, M.D., in the *Journal of Criminal Psychopathology*, Vol. III, No. 3, pp. 430-440, Jan. 1942.

to be capable of fulfilling. This must become the point of departure in the evaluation of all similar programs, since it is generic to inquire into the training and experience of the personnel who are discharging various functions and administrative responsibilities, prior to examining the competence with which they perform a job, for which they may, or may not, be trained. The responsibility for the direction of this clinical service would be the apex of such inquiry.

Since the first article states that there is a provision in the California Law "which requires that the Director of Corrections shall establish a psychiatric and diagnostic clinic," it would be presumed that such a clinic would be under the direction of a psychiatrist. However, in this instance a clinical psychologist is placed in charge. There can be no justification for this in the light of psychiatric experience in diagnostic and treatment programs. A psychiatric clinical service must be directed administratively by a psychiatrist. To make a psychiatrist technically responsible without giving him the administrative responsibility which would make it possible to insure a professionally competent service is obviously unsound.

The expressed philosophy of a Guidance-Reception penal and correctional program uses as its keynote the diagnoses and treatment of offenders whose behavior reflects personality maladjustment in which there is thought to be a cause and effect relationship. Proceeding from this hypothesis, it would be expected that the determination of the causal factors of the offender's behavior would be but one step in the total program. This is expressed in the content of the author's discussion. However, in the text, whether through pressure or organization of the Guidance Center, it never does become clear how this formulation is determined, other than by the "democratic process" in a case conference, which is admitted to be inadequately brief because of pressure of work and limitation of personnel. While the "democratic process" is desirable as a political philosophy, as proposed in this situation it cannot be considered sound or effective. The process required must have as its basis scientific validity rather than political philosophy. That to use other than the described process would be to have the case conference "dominated" by an individual is an implication which ignores the primary objective — competent treatment of the offender, not merely the question of control of the conference. Thus, it can be seen that where there is more concern centering around who directs the conference than around the professional competence of the chairman of the conference, the objective of diagnoses and treatment becomes a secondary consideration. A discussion of the difference between professional leadership, domination, and differing responsibilities

might become profitable for anyone having the responsibility for the development of clinical services in a penal program.

The preceding paragraph lays the cornerstone on which the criticism of an entire operation of the process of reception should be evaluated. Since it has been agreed that the philosophy on which the need for a clinical service is based is sound, and since it is also agreed that this is a forward and progressive step, the consideration should now become, how and by whom can this philosophy be scientifically and practically translated into a realistic program, which will help toward achieving the objective of rehabilitation. There may be, in similar programs, mention of a number of specialists, including sociologists, clinical psychologists, psychiatrists, vocational counselors, and "others." There may also be mention of a number of functions, including social history, routine psychiatric, psychological and medical examination, etc. What has been the attempt to define the individual functions of these professional specialists? The method of integration and coordination is more often than not singularly omitted in the discussion of the "process." This omission is particularly serious in view of the long established practice of psychiatric social workers and clinical psychologists functioning under the direction of a psychiatrist, as members of a clinical team.⁸ If this classical psychiatric clinical unit could be successfully adapted to civilian public and private agency administration and to the structure of military administration,^{9, 10} then it can easily be incorporated into civilian penal administration. Without a clear definition of the structure of a Guidance or Reception Center, which would include the professional training and experience of the personnel, their individual functions, and the manner in which they should be interrelated, discussion and presentation of a diagnostic and therapeutic process is academic. In such an academic discussion of a program, one should raise a question, among others, as to the validity of approaching the prospective inmate while he is still under the jurisdiction of a county jail. Such a procedure is questionable not only from the point of orienting the individual prior to his coming to a State Prison, but it also usurps a function which, if properly defined and incorporated into a total program the objective of which is rehabilitation, should properly fall within the functional orbit of the county jail.

⁸ "The Unique Structure and Function of the Mental Hygiene Unit in the Army," by Major Harry L. Freedman, M.C., in *Mental Hygiene*, Vol. 27, pp. 608-653, Oct. 1943.

⁹ "Mental Hygiene Clinics in Military Installations" in *Manual of Military Neuropsychiatry*, Chapter 39, by Major Harry L. Freedman, M.C., published by W. B. Saunders Co., Philadelphia, Pa., 1943.

¹⁰ "Mental Hygiene Frontiers in Probation, Penology and Parole," by Major Harry L. Freedman, M.C., and S/Sgt. Myron J. Rockmore, in 1945 *Yearbook of the National Probation Association*, New York.

Throughout the field there is a decidedly loose usage of words and terms which may be confusing to professional as well as lay readers. To be deplored is the vague usage of complicated concepts such as "education," "adjustment," "treatment," "psychosomatic," "psychoanalysis," "group therapy," and "casework," some of which are even used interchangeably and without giving a clear conceptual picture of the essence of these essential elements to a penal program. That there is a need for each and probably all of these terms in any discussion of progressive penology is quite evident, as is seen in the voluminous literature on the subject. However, a careful delineation of these terms as related to the objectives of a program must be had lest their validity as professional concepts be watered down and become a philologist's nightmare. "Observation" can so easily be equated with both "custody" and "doing time" that one must be extremely careful to define the objectives of observation clearly. No less important should be the orientation of those who are doing the observing. In a similar sense the "group" should not be thought of synonymously with therapeutic objectives, no more than should a "kangaroo court" be equated with the democratic judicial process of self government. The glibness with which "individual and group therapy" is introduced is to be deplored, since such loose definition, or lack of definition, may offer those who are not in sympathy with the philosophy expressed by the reception center plans, invaluable evidence of the lack of validity of such an approach. In a like manner glibness can do a more damaging disservice in that it may make this approach equally unacceptable to those whose understanding and use of such concepts is extremely well developed and specific.¹¹

A treatment program whether for adolescents or for adults must find its roots in sound, professionally acceptable clinical practice. Neither this, nor the development of "Centers" is a revolutionary or pioneering movement. Therefore, a constant vigilance must be exercised to maintain a perspective in achieving the long term objective.

These comments are, therefore, offered in the firm belief that the philosophy of administratively utilizing a psychiatric clinic in a penal setting has for years been a basically sound forward step. However, in the recent and present available descriptions of the process, the translation of that philosophy into practice goes far afield from what can be accepted as professionally sound. It would, indeed, be a severe set-back to a forward looking penology to have its philosophy stand or fall on the basis of these applications.

¹¹ "Psychiatric Case Work as a Military Service," in *Mental Hygiene*, July 1945, Vol. 29, No. 3, by Technical Sergeant Frank T. Greving, A.U.S., and Staff Sergeant Myron John Rockmore, A.U.S.