The Concept of Treatment in a Correctional Setting

P. L. NOKES

ONE of the main recommendations of the recent A.C.T.O. report (*The organisation of after-care: Report of the Advisory Council on the Treatment of Offenders*) is the employment of professional social workers, both within and outside all prisons and some other penal establishments, with a view to securing continuity in the treatment of offenders. Paragraphs 91 to 94, however, indicate that such an arrangement is not recommended for borstal institutions, for although

'Most housemasters are not particularly well equipped by training and experience for after-care functions. Their training deals mainly with the administration of penal institutions and not with social casework . . . . . ' (paragraph 93)

it was felt by the Committee that a borstal housemaster, i.e. an Assistant Governor Class II, has a close personal contact with his boys that renders him the most suitable person to deal with after-care agencies outside the borstal:

'The housemaster . . . is, under the governor, responsible not only for the general administration of his house, but also for the personal training and guidance of each of the fifty or more boys comprising it. Thus the basic responsibility for the success of borstal training rests upon his shoulders; he must know each boy and his home background: he must be aware of the outside influences that may have some bearing on the boy's delinquency or affect his attitude to society, and with which the boy may have to contend when he goes out. The housemaster is thus well placed to fulfil, as a natural extension of his present training functions, the after-care functions performed in prison by a specialist social worker. We believe it to be possible and desirable to entrust the main social casework functions in boys' borstals to the housemaster, *provided their recruitment and training are revised with these extended duties in mind.*' (Italics supplied.)

Thus training in methods of social casework is recommended for Assistant Governors Class II. This provision attracted the following comment from the weekly *New Society* on 17th October, 1963:

'More doubtful are the proposals for the training of assistant borstal governors in social work. It would be more logical to have really professional social workers in all borstals and not just in some, and to recognise that assistant governors are junior managers working closely with inmates and staff and train them as such. This would make major re-training on promotion less necessary, obviate role-confusion (and infuriate the Old Guard).'

Underlying this comment there seems to be a body of assumptions about the nature of the 'treatment,' or type of influence, to which

inmates are exposed in establishments like prison and borstals and, for that matter, other kinds of establishment too — residential special schools for example. It is the purpose of this paper to examine these assumptions.

What, then, is to be understood by the 'treatment' of offenders in correctional establishments? The fact that a word with overtones of medical practice is regularly used in discussions of penal policy, and has even found its way into the title of an advisory council, suggests that it might be useful to find out in exactly what sense it is being used. A useful first step is to examine the various meanings of the word in frankly medical contexts, and for purposes of comparison with the prison or borstal setting it is as well to focus on clinical practice in the setting of a hospital.

A sociologist studying hospital practice finds it useful to examine treatment methods according to a number of criteria: the time-dimension, or the duration of treatment; the space-dimension, or the setting of treatment; social relations between treatment team and patient, and social relations within the team.

The Time-dimension.

When does treatment take place? It is of crucial importance in understanding the treatment situation to know whether treatment is seen as occupying only a brief space of time in a patient's career in hospital, or whether treatment is something that takes up a substantial part of the stay, being co-extensive in the extreme case with the whole time that the patient is in hospital. Thus a surgical operation may take only a matter of a few hours, or even minutes, and thus represents only a small fraction of the time a patient is in hospital. To be sure, pre- and post-operative care is part of the 'treatment' too, but surgery is none the less characterised by the presence of a *critical act*, that is supposed in itself to set in motion the desired changes in the patient's condition.

Such critical acts are also found on medical wards, i.e. in the fact of commencing medication, but here they have a less dramatic quality by virtue of being repeated at regular intervals. A patient receives a *course* of medication. In psychiatric hospitals, or on the psychiatric wards of the new district general hospitals, such critical acts may take the form of electro-convulsive therapy, or the administration of drugs, but there tends in psychiatric hospitals to be present an attitude of mind that sees a patient's treatment as commencing the moment he sets foot in the hospital and as being co-extensive with the duration of his stay there. This is particularly likely to be the case where the orientation is explicitly psychotherapeutic, and where the use of surgical and medical techniques is seen as only one of the

many types of influence that may be brought to bear on a patient.

The Space-dimension.

Where does treatment take place? It is equally important to distinguish between those contexts where treatment is seen as taking place in only a limited number of locations within the hospital, and those where treatment is not so localised. In the extreme case, again, the location of treatment may be seen as co-extensive with the whole institution so that it may sometimes be said that the hospital, rather than any particular facilities within it, is itself the treatment. (The Henderson Hospital is one place where this is said.)

Thus surgical operations are peculiarly localised. What goes on in the theatre is the treatment itself; what goes on in the ward is a process of preparing the patient for treatment or looking after him after treatment until he is finally discharged. Medical wards, however, are characterised by an enlargement of the area of treatment activity, though here again it is possible to point to places where treatment is *not* carried on, e.g. the sluices, or sister's office. The confinement of a patient to bed, incidentally, has the effect of virtually reproducing the situation of the operating theatre, and defines rather larger areas as neutral ground in respect of treatment. In psychiatric hospitals there may be a room set aside for E.C.T. Where, however, a small ward is taken over temporarily, this will be closed for everyday ward purposes because 'it is being used for treatment,' i.e. the ward at other times is not a treatment area, and other wards at the same time are not treatment areas.

In many hospitals there are special 'treatment rooms' set aside for psychotherapy or occupational therapy, and in such hospitals it is common to find patients not only defining what takes place outside these areas as not treatment but (returning to the first criterion) sitting outside the door *waiting for treatment to begin*. Increasingly, however, it is common to find inroads being made on this notion of spatially defined treatment, at least in psychiatry, and in those institutions where it is said that treatment begins the moment a patient crosses the threshold, it will often also be said that treatment is not something that is localised in an occupational therapy room or a doctor's office, but is the totality of influence brought to bear on a patient wherever in the institution he may be at any time.

Social Relations between Treatment Team and Patient.

Is treatment something which is *done* to or *given* to a patient, or is it something to which he is necessarily obliged to contribute himself, and perhaps even to play a major part? Specifically, what part is played by the idea of the patient's co-operation? The patient's co-operation in surgery is minimal; as like as not he will be anaesthetised.

He is socially neutral, and during an operation the surgeon's relation to him is descriptively similar to that of a mechanic towards the car he is repairing. Surgeons do, in fact, refer to themselves from time to time as mechanics or plumbers.

In medicine too the treatment tends to be something that is *given* though the fact that the patient is likely to be conscious presents the possibility of more complex relationships between doctor and patient, that have been the subject of frequent discussion. Thus a physician may on the one hand utilise the possibility of a social relationship to the end of treatment, as when it is felt that a patient needs encouragement, or perhaps reprimand; on the other, it is often felt that this possibility presents dangers, in the form of 'involvement,' that may jeopardise the treatment process, so that a strictly 'professional' relationship becomes the ideal.

Such conflicts are, of course, magnified in psychiatry. The loss of detachment on the part of a therapist presents considerably greater dangers because of the markedly social component of much psychological illness, yet precisely because of the equally marked social component in psychotherapy, it is in psychiatry where it is most difficult to preserve.

In long-term psychotherapy in particular the treatment setting is such that the development of social relationships of a kind no different from relationships outside the treatment setting can hardly be avoided, and the theoretical question becomes one of how to guide a social relationship that has, by definition, elements of spontaneity in its development. Thus the therapist is forced into the schizoid position of observing himself in social interaction, something that a surgeon is not required to do. It is scarcely possible to conceive of a treatment situation in which the relationship between patient and therapist might become completely spontaneous and yet remain in any accepted sense a treatment relationship, so this polar position on the continuum is necessarily unoccupied. Yet where, as in psychoanalysis a patient may be of very high intelligence and have problems no more acute than those of his analyst, this extreme is approached, and tales are told of the patient taking over and analysing the analyst.

Social Relations within the Treatment Team.

In whom is 'treatment' located? Is it in the hands of an expert, or therapeutic virtuoso who is assisted in a supportive or ancillary capacity by people of lesser expertise? Or is it located in a wider group? The conduct of a surgical operation tends to be shaped by the decisions and actions of a single expert, uniquely qualified to perform the critical act already discussed, and notwithstanding their own expertise in other capacities the roles of anaesthetist and theatre sister are

seen as supportive or facilitative. On a medical ward, however, the nursing staff may take a much more active part in the 'giving' of treatment in so far as the critical act has been replaced by a series of events, and the relationship between nursing and medical staff is subtly changed.

A personal impression is that physicians are required to *consult* the ward sister, for example, to an extent that is not true of surgeons. But though the source of treatment is now located in a group rather than in an individual it is still possible quite clearly to define who is not a member of this group. The clinical team consists of the doctors and the nurses, but not the cleaners or the ladies from the W.V.S. who come round with the library books. Yet where the patient is a child, or where the patient's condition is felt to have a psychosomatic component, even this distinction may nowadays be felt to be arbitrary, and in children's hospitals, sanatoria, geriatric wards and on the medical wards of some general hospitals, attention is now being given to the therapeutic or anti-therapeutic potentials of non-clinical staff, and even of other patients.

In psychiatric hospitals where exclusive reliance is placed on medication it may be possible to restrict the notion of who is giving treatment to clinical staff only; much more common today, however, is an awareness of the therapeutic potential of anyone with whom the patient comes in contact. In the extreme case where no form of medication is used at all, 'treatment' becomes equivalent to 'influence,' and the fact that influence may be exerted from any direction may well become the foundation of treatment philosphy. Far from being a therapeutic virtuoso the doctor becomes *primus inter pares*, the co-ordinator of a therapeutic team that may extend to include the patients themselves, and himself distinguished only by a greater degree of sophistication in interpretation, and by an ultimate clinical responsibility for the outcome of events.

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Such an analysis raises the question of which of the two polar extremes, surgery or psychiatry, seems to be most in mind when the word 'treatment' is used in penal contexts.

It is supposed that 'treatment' within a penal establishment will take the form of a critical event or relatively short series of events that will themselves initiate change in a desired direction, or is treatment thought of as a multiplicity of influences and experiences extended over a much longer period?

Secondly, is treatment something localised within the establishment in the form of something equivalent to a treatment room or an operating theatre, or is it thought of as being equivalent to the total experience of being present within the institution?

Then is treatment seen as something that is 'given' to an inmate, or is it something that will involve the formation of a social relationship with him and perhaps require co-operation and effort on his part?

Finally, is this treatment seen as in the hands of a restricted number of experts skilled in relatively esoteric techniques, or is it thought of as being located in a much wider group of people defined by their capacity to exert desirable forms of influence?

To ask one of these questions is virtually to ask them all, for the four criteria are functionally related. The nature of surgical activity, for example, is such that it prescribes a certain social structure within the treatment team and a certain relationship with the patient. Conversation with the patient would probably not materially add to the surgeon's stock of useful knowledge, and this may be one reason for the use of general anaesthetics (even where local anaesthetics would be manageable). On the other hand conversation is the essence of a psychiatrist's activities, and in so far as his expertise consists less in esoteric manipulative skills than in a more sophisticated grasp of a kind of knowledge that is otherwise quite public, the possibility of a marked social distance between psychiatrist and non-psychiatrist is by that much reduced.

Similarly in the matter of the location of treatment the surgeon's technical skills are exercised in the use of technical equipment that is not to be found in any odd corner; the non-manipulative skills of the psychiatrist, on the other hand, do not require specialised locations to anything like the same extent. The question is which of these total settings most resembles that of penal practice?

In respect of the social relationship between therapist and client the tradition in penal practice has tended to be emphatically towards the psychiatric end of the continuum. That it is impossible to do anything with or for an offender unless a working relationship is formed with him is a penological commonplace. In respect of the space and time criteria also there seems to be much in the situation of correctional practice that resembles mental hospital psychiatry. Certainly the treatment, whatever it is, is not such that anyone can designate any particular locality within the establishment as where it takes place. Nor can anyone point to any clearly defined critical act that will itself precipitate change. Critical events may and do occur in the careers of some inmates that seem to exert a quite disproportionate influence on them; the point is that such experiences cannot be planned for.

But this is to beg the question, for whether there is any place in penal practice for critical acts analogous to those of surgery or medicine, and by extension for the

virtuoso performer, is exactly the point at issue. For notwithstanding the previous paragraph what seems to be at the back of their minds when many people talk of the treatment of offenders is exactly such a form of virtuoso activity. And such a notion would not be without precedents in the history of penology.

The religious and ethical roots of penal practice, for example, have always tended to encourage a habit of thinking in terms of critical events, of an inmate suddenly 'seeing the light,' or undergoing a dramatic experience equivalent to a conversion. Moreover such a notion offers scope for genuinely virtuoso activity: one form of treatment regularly employed is, after all, the Sunday service. And the religious tradition apart, such a notion corresponds to fairly widespread assumptions about the importance in correctional work of charismatic individuals, possessed of rare qualities of personal magnetism.

The assurance of being such an individual is something we all pass through. A not uncommon problem in correctional establishments is that posed by the newcomer, or the visitor, or the approved school manager who feels sure that by having a few words by himself with a boy, or speaking to an inmate as man to man he can set him on the right lines or otherwise achieve unique results.

In view of this tradition, and in view of the fact that refereeing football matches, supervising meals and getting inmates into and out of bed have little appeal to many people who would otherwise like to feel part of the treatment process, it is not entirely astonishing that thoughts should turn from time to time to the possibility of a form of virtuoso therapy that brings about desirable changes in a borstal boy by some means other than prolonged and intimate contact with him in daily life.

The A.C.T.O. report recommends the appointment of social workers in all prisons because no other grades of staff are specifically charged with welfare responsibilities. The *New Society* note, however, appears to recommend the appointment of social workers in borstals on quite other grounds, that although a housemaster has day to day contact with a boy there is an acknowledged form of expertise in the treatment of offenders that he lacks but which social workers possess. One wonders what this may be.

Certainly there seems to be no longer any general assurance among psychiatrists that any form of intermittent contact that does not involve the use of surgery or medication has a particularly crucial effect, except where such contact is founded on a quality of personal relationship between therapist and client that is by no means inevitably present and which is not entirely the outcome of training.

In their well known study of Chestnut Lodge Sanatorium,

Doctors Stanton and Schwartz indicate that the influence of the 'therapeutic hour' was by no means paramount when compared with the influence of nurses, aides and other patients with whom an inmate had contact over the remaining 23 hours. In this country the effectiveness of a psychotherapeutic interview once a month in an outpatient department is now by no means taken for granted, and effort in many places is now focussed on more continuous contact by means of an enlarged staff of social workers. Correctional establishments, perhaps due to dissatisfaction with the religious and ethical orientations of former years, now seem to be run with one eye on medical practice. It would be odd if the prison and borstal services were to lose their faith in personal long-term contact and seek a kind of virtuoso professionalism exactly at the moment when opinion in many medical fields (children's hospitals, domiciliary and maternity services, general practitioner services) seems to stress the importance of going the other way.

It is difficult, however, to imagine what the content of such an expertise might be, and one would like guidance on what it is envisaged that specialist caseworkers would actually do that only they are qualified or competent to do.

In fact, Assistant Governors receive a training that is recognisably a variety of social work training. The statement that the training of A.Gs. II 'deals mainly with the administration of penal institutions and not with social casework' makes rather chastening reading to those lecturers at the Prison Staff College and at Leeds University who are concerned with organising this training. Since for the last four years two-thirds of the training time has been devoted to social sciences (sociology, psychology, human growth and development, social casework and criminology) and only one-third to matters of penal administration, one wonders how carefully the Committee inquired into what actually goes on at Wakefield.

The note in *New Society*, however, betrays a misunderstanding of what borstal housemasters do that is positively wilful. The term 'junior manager' with its overtones of industry and commerce, sheds no light on the complexity of relationships within any establishment where the primary task has to do with people, indeed there seems to be implied a sharp distinction between 'management' and 'treatment' that is quite spurious.

Dr. Terence Morris, in a recent television interview, made a similar distinction between administration and treatment when he suggested that the prison service might take a leaf out of the hospitals' book and create a separate grade of prison administrator so that other members of the staff might be left free for treatment duties. But the sharp separation of medical and administrative functions on which

his argument rests is in fact found only in acute general hospitals, i.e. those hospitals which least resemble a correctional establishment. In a psychiatric hospital, or a mental deficiency hospital, or a sanatorium, or indeed any long stay hospital, a hospital administrator will as a rule be very closely involved in the treatment programme because decisions about purchasing, building, recruitment, the deployment of staff, the use of hospital grounds and a host of other things have direct therapeutic implications. Similarly, in a borstal, decisions about recreational and educational activities, vocational training, staffing, and the composition and size of houses have a direct bearing on 'treatment.'

The crucial question, however, is where in the power structure of an establishment a separate grade of therapists or caseworkers might fit. In a hospital setting the scope given to treatment staff is guaranteed by the fact that they assume ultimate responsibility for the client's welfare. In a correctional setting this responsibility is assumed by the non-clinical staff, and to introduce a separate role of therapist is therefore to attempt to divorce power from responsibility.

This has, of course, been tried—and there is a certain amount of experience available from some American penal establishments and, in this country, from the approved school service of what is involved in introducing separate therapeutic roles into non-medical establishments. For just as an administrative decision has clinical implications, clinical decisions regularly affect the administration of an institution and the result seems generally to be a conflict of interests with an outcome either in the complete undermining of the administrative framework or in the subordination of treatment staff to purely residual functions. The conflict may be resolved by appointing a clinician to be the administrative head, but this seems as often as not to result in his becoming sharply aware that in an institutional setting treatment is largely carried out in terms of administrative decisions.

Indeed the arguments for introducing specifically clinical or therapeutic grades of staff seem often to rest on a lack of first-hand knowledge of what is involved in carrying on any form of psychiatric or similar treatment in an institutional setting. Part of the trouble lies in the fact that the role of the virtuoso performer is one that is well understood by the interested public. The role of a member in a treatment team is not so generally understood and attracts little theoretical interest.

Institutional treatment is peculiarly something that cannot be picked up in the course of a few visits of observation and on this matter of social casework, as on many others, one would like to hear rather more than one does from the professionals within the service.