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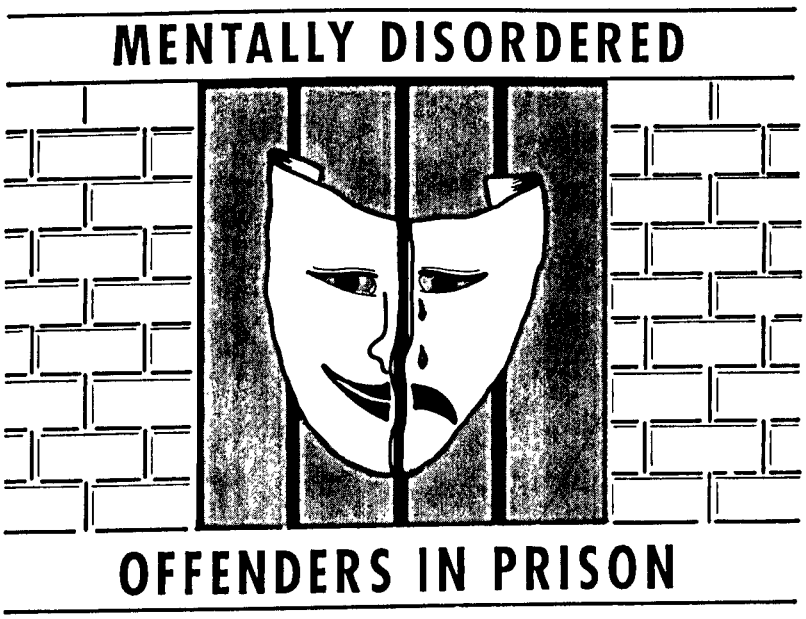

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APOLOGY

In Issue 80 of the *Prison Service Journal* an article was published entitled 'Behavioural Disturbance in Barlinnie'. Authorship of the article was attributed to David Cooke, PhD, FBPsS, Top Grade Clinical Psychologist at Barlinnie Prison.
The Editorial Board wish to make it clear that the article was jointly written by Mr Cooke, Mr Allan Walker and Mr Walter Gardiner. We apologise to Mr Walker and Mr Gardiner for the omission.

Comment

I was interested to read a report of a seminar at Holloway Prison on Opposite Sex Postings. Much of what was said echoed the very positive findings of tutors at the Prison Service College, who spent some time in the summer of 1989 checking out at a number of establishments, how women officers got on working in male prisons. Notice that it is senior male officers who are posted to womens' prisons but basic grade women officers in male prisons.

What everyone seems to have found is that behaviour amongst both staff and prisoners improved after the introduction of the opposite sex postings in those establishments where it occurred. Both in their conduct and their language staff and prisoners were much less aggressive. That is not to say that the effect was to suppress feelings but that the expression of feelings was done in a much more acceptable manner. Women officers especially are able in the skills of listening and demonstrating sympathy for prisoners without being overwhelmed or reacting negatively. They seem better as well at understanding the boundaries when dealing with male colleagues.

For men the difficulties in working in female establishments are as follows:

Isolation from colleagues who see it as unfair that senior officer posts are taken by men.

Potential allegations from within the prison by both prisoners and colleagues.

Potential allegations from their family about their behaviour in prison.

In some ways it is even more difficult for women in male establishments, and they have described the following areas of tension:

Sexual harassment from colleagues and prisoners.

Having to demonstrate that they are more than equal to the task, for example, being first to respond to the alarm bell.

Not allowed to do the full range of work.

On the whole experience tells us that the women we recruit to the Service are better educated and more able in the use of social skills. In other words they do the job better, hence it is somewhat surprising that Headquarters, rather than recruiting staff equally irrespective of gender, still are better at recruiting the 'old soldier'. Even more worrying is the trend for women to resign from the Service simply because they don't feel that they have the respect of their colleagues. An example of how women can be treated comes from an establishment not a hundred miles from York where during a turbulent period when staff were expecting violent confrontations with prisoners, there was a sudden appreciation of the value of having women officers to lower the temperature. The women accepted the role and while their male colleagues kept in the background, the women supervised the prisoners. It had the desired effect but later on that day it was decided that women were being placed in an invidious position and they were then withdrawn from the wings. However apocryphal that story, it does illustrate the ambivalence towards women which the Service demonstrates.

I look forward with interest to the investigation by the National Audit Office which is taking place with respect to Equal Opportunities in the Prison Service. They are to report in June 1991 on four areas of our work:

Policy Statements on Equal Opportunities
Recruitment of staff
Career development
Interviewing of those who leave the Service

The Journal is interested in hearing from readers how they see the policy on Opposite Sex postings working. ■

Police in Prison

Challenging Stereotypes

Whatton's Unique Initiative: A Treatment Perspective

How do police and prisoners view each other? Are they poles apart, or do they, despite the stereotypes, have more in common than they imagine? If they do, does a better understanding of each other's shared problems lead to more sensitive policing in the community? HMYOI Whatton attempted to answer some of these questions when Roger Banner invited the Nottinghamshire Police Training School at Epperstone Manor to become involved in groups at the prison. He, and Governor Mike Lewis, write of this experience, and David Saunders-Wilson, for the PSJ, interviewed Inspector Eddie Foulkes-Jones about the police response to this novel initiative.

M A Lewis (Governor)

The 'them and us' concept has, I suspect, always been a feature of society from the most primitive to the most sophisticated. An example of extreme polarisation in modern society is evident if one considers society in terms of the criminal and the non-criminal classes. Group identity is a necessary survival process for any group, it gives some cohesion to the group in question, identifies common goals and highlights similarities. In effect the group identity protects both the weaknesses and the strengths within the group's concern. By the same token and by the same process, groups or individuals who don't belong are also readily identified. The out group is a prime candidate for stereotyping.

Stereotyping does not only involve what a group looks like but more importantly, it concerns itself with behavioural considerations and behavioural patterns associated, or believed to be associated, with another group. The critical word here is 'believed' because stereotyping may not necessarily be based on fact. Assumptions rather than facts associated with another group are far more likely to be found if there is a low level of contact between different groups. Once having stereotyped another group or indeed having stereotyped itself, a group can feel safe and comfortable but this very process of adopting and accepting stereotypes presents a major obstacle to change. It may well be that the primary purpose of developing group identity is not to allow change but if, however, there is to be some expectation of change then stereotyping will operate to fix the individual in his or her original position.

Class Distinction

Stereotyping applies as much to the criminal as it does to other groups in any society. Further examination could, in elitist or criminological terms, describe two quite distinct classes in society, ie, the criminal and the non-criminal. The former are clearly the non-elite and the latter very much the elite. Without trying to be too complicated — and this is the danger, because we are also concerned with a minority and a majority group — it is possible to postulate the existence of a third class within the social structure. Operating at the interface between the criminal and the non-criminal groups. This third class, the rehabilitators, appear to have an obscure role at the interface between the criminal and the non-criminal classes, their task being to effect the conversion of the criminal classes to the non-criminal classes. The role of the rehabilitators is obscure because society at large expects the rehabilitator to convert the criminals into non-criminals despite the fact that there is no evidence anywhere in the world to suggest that any rehabilitative programme with criminals has ever worked. The police may also have a peculiar role here but in essence they appear clearly to be agents of the non-criminal group and concerned with the prevention of the criminal act and the identification and processing of the criminals, not changing them.

Police And Criminal Stereotypes

If one examines the stereotyping issue in detail, most would agree strong stereotyping is associated with both Police and with criminals. It is with this area that the Whatton initiative has primarily been concerned. This is not to suggest in any way that criminals, the rehabilitators and the rest of non-criminal society do not have stereotype images of other groups or themselves; they clearly do. Strong stereotyping, for example, is associated with race and with religion. Bearing in mind some exceptions, however, most stereotypical images are not perhaps as extreme as in the case of Police and criminals and are probably very much less easy to define.

In the most simplistic terms, Police and criminals are traditional enemies of each other.

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Polarized images are the order of the day in stereotyping mechanisms used by both groups. The Police may well see criminals as bad, dangerous, needing to be identified, caught and controlled for the benefit of the good. Prisoners may and often do see the Police as an intrusive, prejudiced and dangerous group who employ unfair methods against them. Many intelligent prisoners see the Police as agents of an equally unfair alternative society of which they are not a part. Both groups have a tendency to see each other in the most negative terms but curiously also claim to know each other well which is surprising because the simple fact is that there is little evidence that they have much dialogue with each other. On a person-to-person basis, contact other than formal professional contact is actively discouraged between some groups e.g. Prison Officers and prisoners outside of the sentence of imprisonment. It is in fact a disciplinary offence for Prison Officers to engage in such contact. The situation with the Police and prisoners is somewhat different and clearly there is an exception here in the case of the experienced detective. Even here contact is controlled and subject to formal and informal rules.

A Catalyst For Change

During the first Prison Officers dispute, many Police not only held prisoners on remand for long periods but some held prisoners for the total duration of their sentences. During this time the attitude of many Police Officers, to the prisoners in their charge, changed dramatically. This was simply because the increased numbers of Police Officers involved in jailer duty had prolonged contact with prisoners for the first time. Prisoners and Police actually engaged in dialogue outside the highly charged, frightening, and dangerous situation of pursuit and arrest. Formerly Police contact with criminals in custody was extremely sparse and in most circumstances amounted to less than 24 hours contact time of which the greater part was at night. This is the period between arrest, charging and the first court appearance usually the next morning. Notwithstanding this, Police Officers frequently regarded themselves as experts in terms of custody and it was nothing unusual to observe Police spokesmen speaking on prison matters, treatment and rehabiliation etc. After this period many Police Officers experienced in this area were quite willing to admit that they knew nothing about the custody process and very little about rehabilitation and its possibilities. The real strength of the Police Officers, of course, was knowing about detection, arrest of the criminal and his habits and behaviour in the community.

These were not the only revelations at this time, however; others involving Prison Service personnel and prisoners themselves were equally interesting. Prison staff, for example, were more ready to admit that although they knew a lot about prisoners in custody, they knew next to nothing about the criminal in the community. Prisoners who had been subjected to long periods in Police custody frequently expressed more positive and more rounded attitudes towards the police. Typical comments were: 'Some of them are good blokes', 'You've got to realise they are doing a job', 'Nothing personal', 'He's an interesting chap to talk to', 'Pity there will be no contact when I'm out', 'He helped me a lot', 'My family see him as someone they can go to for help'. Comments such as these were not unusual. Again it is necessary to exclude from this generalisation the specific experiences of many detectives who are very familiar with this area.

Anecdotal experiences are notoriously difficult to evaluate. Notwithstanding this, for a short period during the Prison Officers strike profound attitude changes took place involving both Police and prisoners. There is evidence to support the premise that because Police are agents of society, these profound changes in the prisoner's attitude were translated to some extent into the prisoner's attitude to society at large and certainly to authority figures. A number of Prison Service practitioners had no doubt that at this time of close contact between Police and prisoners some important stereotypes were dismantled and this process created a climate in which some prisoners could see the value of re-entering society as a non-criminal. However, there is very little doubt amongst practitioners that this phenomenon was extremely short-lived once the reversion to the old system of short remand in Prison custody had taken place. Old stereotypes were very quickly re-erected and the 'status quo' maintained.

Appearances Can Be Deceptive

Although this paper is primarily concerned with Police and prisoners and stereotyping involved, it is accepted that this is far too simplistic an analysis and there are some other very complicated and subtle interactive mechanisms also in operation. These are the mechanisms which have quite a significant effect on the relationship between prisoners and others, Police and Prison Service personnel included. A classic example of one of these negative mechanisms is the exclusive club phenomenon. This may well operate between Police and criminals but it is particularly evident between prison staff and prisoners. In this situation prison staff and prisoners exclude everybody else from the relationship as if they were members of some prestigious club. The mechanism allows a fair degree of contact between very different

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groups but unfortunately, it is usually only the superficial contact that is allowed any degree of expression i.e plenty of contact but very little substance. It is possible that this mechanism is necessary because with frequent contact the alternative could be one of constant hostility. Stereotypical images, however, are not eroded if this mechanism operates and if it does operate attitude change is unlikely. Within the prison situation there are of course numerous examples where this mechanism does not occur and good, significant and longstanding relationships develop between prisoners and prison staff. For all that, one should not under-estimate the power of the exclusive club mechanism in preventing real contact and dialogue, and hence subsequent attitude change. Clues to the operation of this mechanism can be found where prison officers say, for example, 'I never look at their record, I prefer to judge the man' or 'If he does what he is told and causes me no problems, he's a good con.' In this situation the prison officer and the prisoner are keeping each other at arm's length, stereotypes are not challenged and in treatment terms the effect is quite disastrous because stereotypes are maintained or reinforced. Prison staff are required to challenge criminal behaviour but this process is emotionally demanding and a number of staff opt for a quieter life.

Achieving Real Change

The significance of Roger Banner's work at Whatton has, in the view of many experienced practitioners, significantly pushed back the treatment boundaries within the penal setting. It has done so simply because it has enabled stereotype images, often very negative ones, to be challenged in a controlled and safe environment. It has brought together very different opposed groups and via the group pressure process and interaction has given them opportunities to talk and get to know each other as individuals. In effect it has structured confrontations in a safe way by refereeing them using Prison Service personnel as the agents and facilitators of change.

This latter is significant in itself because the facilitators themselves have not been unaffected by the process. This is evident in two ways, (i) that their own stereotype images have been challenged by the very process of change in others and (ii), that because of this change they have been perhaps more adventurous in pursuing a more dynamic treatment role.

It is important to stress, however, that the Whatton Initiative is designed to enable prisoners to change and not as a treatment or improvement process for either Police or Prison Officers. The fact that it might have this spin-off function is incidental and is not the primary objective of the process. The irony of the programme mechanism is, however, that unless the prisoner in the group situation perceives some movement in the attitudes of the Police Officer he will not have the confidence to lower his defences. The group dynamic processes that we are concerned with here are highly complicated and very powerful indeed.

It is quite clear that some elements within the process at Whatton of challenging stereotypes are not new. A number of rehabilitative programmes have components which involve the examination of authority, the individual's relationship to society etc. None of them, however, appears to have utilized the group setting and group dynamics as a means to achieving meaningful individual-to-individual contact and relationship development as a precursor to stereotype challenging. It is, therefore, not surprising that the Whatton initiative has been successful because of the very nature of the way in which it has addressed this critical issue. Neither is it surprising that most of the other programmes have had limited success because it is simply not possible to lecture people about relationships with authority, about feelings, without actually testing these out. Equally, and for the same reasons, it is extremely difficult to make any progress with an individual about his or her perception of a third party, if that third party is not present. Certainly from the prisoner's point of view simply telling him that society wants him and that the Police and other authority figures have a role as helping agencies, will cut absolutely no ice at all if his experience to date has reinforced the opposite view. There is also something very attractive and neat about the argument that suggests that group pressure should be used to combat group pressure. It is very easy to forget that prisoners use group pressure amongst themselves to reinforce the stereotype images that they have of authority and of their own criminal subculture. Particularly with the young and with the pack mentality of the juvenile and younger offender it is unlikely that face-to-face contact and the lecture-type situation, or even the discussion group scenario, is going to be as effective as group dynamics in changing attitudes.

The Future For Stereotype Challenging

Thus the Whatton initiative is probably more important in treatment terms than it was thought to be initially. It could well emerge as a single most important treatment initiative that has occurred in the Prison Service in the last decade. In the very same way that the concept of the constructive use of leisure time has been packaged and incorporated into virtually every worthwhile rehabilitative programme, so I think the Prison Service

must accept, design and use the concept of stereotype challenging. There are great similarities between the two concepts: neither is original in terms of component or philosophy but in package form they represent an increasingly important tool to be used within the treatment process.

What is most significant about the philosophy of stereotype challenge is that it is central to the throughcare process and the preparation for release. This is so simply because it is so closely concerned with attitude change, and the relationship of the individual to society. Although the validity of including a stereotype challenge package in all treatment programmes in institutions could easily be justified, some warning bells need to be sounded. The form of such a package would have to be very, very carefully designed to fit individual establishments and their treatment programmes. What has worked at Whatton will certainly not work everywhere, a simple copy of our programme would be far too dangerous to introduce. Some other programme might well work in other institutions but one must always be aware of the dangers inherent in confrontation mechanisms and the power of group dynamics. A badly designed scheme or using unskilled personnel could be quite disastrous and would almost certainly court failure and serve only to reinforce the negative stereotype — the exact reverse of the intention of the Whatton initiative.

In conclusion, therefore, the Prison Service would be well advised to take on board some form of treatment package involving stereotype challenging. Feedback from various sources and groups suggests it may well prove to be a highly significant intervention treatment mechanism. Whatever may develop on these lines, great care must be exercised not to introduce any programmes without careful planning and training of personnel if the considerable risk factors involved are to be avoided. It is evident at this stage that the Whatton initiative has captured the interest of numerous groups including the Prison Service, Police, Educationalists, Probation, Social Services and latterly the Butler Trust panel. Additionally interest has been shown by Universities and one in particular is most anxious to have a greater involvement and perhaps some ownership of the Whatton initiative. The feeling at Whatton is that it would be a pity indeed if we allowed this to happen without the primary participants, i.e. the Prison Service and the Police themselves giving greater recognition and ownership to what is viewed by outsiders as a significant initiative in the field of intervention treatment, and one of which we should be justly proud.

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An Interview With Nottinghamshire Police Trainees

Dr. David Saunders-Wilson

Inspector Eddie Foulkes-Jones and Sergeant Sue Hudson, of the Nottinghamshire Police Training School at Epperstone Manor, agreed to be interviewed about their participation with HMYOI Whatton's 'Police in Prison' programme.

David Saunders-Wilson: Can you describe for me how this relationship with HMYOI Whatton got started?

Sue Hudson: Yes, it all started — before my time — in April 1987 as part of a larger community relations package at the Training School. We recognised that to assist in the production of an effective police officer, we had to try and involve new recruits with outside agencies working with offenders. Actually, I think it was one of those occasions when a police officer knew someone who worked at Whatton and that's how it all got started.

DSW: You must have thousands of suggestions of initiatives between the police and the local community. Was the advantage in this programme the belief that this would help create 'an effective police officer' — how did you envisage this happening?

SH: I obviously can't speak for people who went on the programme before I became involved, but the 1987 programme was extended to include probationary constables actually attending Whatton on 2-day assignments. We wanted to broaden

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their horizons and take the blinkers off police officers, to 'de-police-ify' them if you like, by breaking down their 'canteen culture'. We wanted to look at the stereotypes we have about offenders in institutions.

DSW: 'Stereotype' is a word that crops up time and again, what is a policeman's stereotype of an offender?

SH: Oh dear, that's difficult.

Eddie Foulkes-Jones: It becomes a bit of an 'us and them' situation. The offender is somebody who is just an end product of the offence. Our concern is merely to convict and forget until the offender is released. There is therefore a tendency to look no further than that, and what we — the police — should be concerned about is not simply stopping crime but also preventing crime. To do that we have to start understanding more deeply who an offender is.

DSW: Two things you say there interest me. The first thing is in terms of stereotyping. In reading the articles that have come out of Whatton about the programme, it seemed possible to argue that if you take two groups of 19-21 year olds — one offenders, the other policeman — there must be a tremendous number of similarities between them. What was the case?

SH: Yes, I feel there are similarities — pop groups, etc. They come from the same background.

DSW: Did they know each other from the community?

SH: No, but in terms of the stereotyping, it was important for the police constables to realise that they weren't arresting 'thieves' — even though a theft had been committed — but people from the local community, a product of their environment, with reasons for why they had offended.

DSW: And so did that lead to greater sympathy between the police constables and the offenders, given that there were those similarities?

SH: It is not always a positive reaction we get. I've got to say that on the odd occasion police officers who go to Whatton, or to Lowdham Grange, come back thinking that there should be more discipline or punishment. So I'm not saying we succeed all the time by any means, and indeed sometimes the experience merely serves to harden attitudes. On the other hand the programme has often been very successful. And we did have one officer who arranged to meet one of the offenders from Lowdham after he'd been discharged. I thought that was great.

DSW: That would seem to underscore the need to place the programme within a general training package about prisons, and our aims. I'm presuming you do that anyway.

EFJ: No — we don't.

DSW: Well I can understand someone going into the DC for the first time expecting it to be very short, sharp and shocking, and being very surprised when it wasn't.

EFJ: Yes, I think that that comment identifies a gap in our curriculum. Again it is trying to see things in a wider context, and taking the 'blinkers' off. However, you've got to realise that our training is guided nationally by our central planning unit, so that we have to train according to their guidelines, and the Whatton programme was only a local initiative. Perhaps I could look at that in the future.

DSW: All I'm doing is making a case for you to invite me back, give me lunch and I'll do an input about prisons! I said there were two things that interested me in one of your earlier responses. The first was stereotyping and the second stemmed from something you said, Eddie, about training policemen to prevent crime, as well as detecting crime. Was the programme at Whatton really a grand crime prevention package, and if that observation is fair, how on earth would that work?

EFJ: Really we've got to go back to the MacDonald report about how we do police training. MacDonald maintained that we concentrated our training too much on the Law, and that we should broaden our horizons and become less insular. This inevitably meant looking at the work of other agencies and establishing how we could work together. It involves the police becoming part of their community, not separate from it, and obviously respected by the community for the work that they do. After all we rely heavily on the public to give us the information we need to detect crime, and we can't do that if we keep an 'us and them' outlook.

DSW: Is that what you're saying the programme at Whatton proved? That stereotypes were broken down, and that there was a better sense of understanding about each other's positions?

SH: Yes, although I can't really speak for the detainees, but barriers did come down, and people started to learn about each other.

DSW: Of course Whatton has recently changed its role. Does that mean your association has now stopped?

SH: Yes, I've spoken to Roger Banner and we think given the changes we should put things on ice at the moment.

DSW: But you're still at Lowdham?

SH: Yes.

EFJ: And remember we are now using a new type of training which is less prescriptive, and which allows the constables to chose to go into prisons if they wish.

DSW: Accepted, but what seems sad to me is that this scheme obviously has potential and it might be in danger of fizzling out.

SH: It is a bit, at the moment.

EFJ: Well remember there was also a

backlash from Strangeways as inmates from there went to Whatton. It would be impossible to do the programme in those circumstances. So perhaps it is not so much fizzling out, as going on ice, and it is our responsibility to re-kindle it when we can. We are very supportive of the programme and would want it to continue when it can.

DSW: The Whatton programme, as you described, is a small, valuable part of a police constable's training. Could you describe the rest of the training course for police constables?

SH: Oh, I could go on for ever.

EFJ: It might be helpful to give a bit of history, as that'll explain some of the jargon that's used. As I said earlier, as a result of Lord Scarman's enquiry the government used Prof. MacDonald to look at Police training. As a result of his recommendations, 'Stage 1' increased initial training from 10-14 weeks at District Training Centres, and introduced 'Progress and Monitoring' courses, which are three, two-week courses in the two year period. Thereafter we introduced 'Stage 2', which completed the implementation of the MacDonald recommendations, and provides a Foundation and a Post-Foundation Course which last two years — in effect the complete training of a police constable.

DSW: And so where does posting come in?

EFJ: At the date of appointment.

DSW: Oh, I'm confused. In 'Black in Blue' they got their postings in Episode five. Why was that?

EFJ: 'Black in Blue' is the Metropolitan Police, and they have a separate training system, and that programme is two years out of date! Now the Foundation Course — do say if I'm boring you — has seven modules. The first module takes place here, and is a basic introduction to what we do. Thereafter the probationer is attached to his/her sub-division, where he/she will find out about their sub-division. They will then come back for a week, and be de-briefed about what has gone on.

DSW: And this is still module 1?

EFJ: Yes. Module 2 takes place at the District Training Centre which is a 10-weeks course dealing with the Law, and inter-personal skills. Having done that, they go back to sub-division, and go on patrol with a 'tutor-constable' learning the basic skills of a policeman.

Module 3 is another five weeks at the District Training Centre, as is Module 4, aimed at debriefing and linking-up what has been learned from Module 3. Module 5 is a week's leave.

DSW: Module five is a week's leave!

EFJ: Yes, I know it sounds funny. Module 6 sees them returning to the sub-division, and the final Module has them returning here to look at needs and performance.

DSW: What sort of needs do they identify?

SH: Oh practical things like procedures, statement taking, or how to interview children.

DSW: And can someone be thrown out at any stage?

EFJ: Bear in mind that this is the first of the new courses, and that has not happened yet. It would have to be something serious, and long before it got to that stage we'd be trying to help with 'Action Plans', etc.

DSW: Can you give an example?

SH: Yes — say someone lacked confidence dealing with motorists. The 'Action Plan' would perhaps have that probationer attach himself/herself to a traffic officer, and to deal with motoring offences. It would also include finding out about cars, and it would have an achievable goal.

EFJ: During this 2-year training period we also have inputs on subjects like racism, sexism, child abuse, the use of inter-personal skills, and so on.

DSW: What percentage of your recruits are Black?

EFJ: Roughly about 2%, although remember in Nottinghamshire, which we try and reflect the ethnic minority population is 4%.

DSW: What did you think of 'Black in Blue'?

EFJ: I didn't watch it, but I do think racism is something we should be responsive to.

DSW: So how do you respond to it?

SH: In class we would take up any comments which were made, and open them up to discussion. We also have a sergeant in the Training School who is a Community and Race Relations Liaison Officer who makes an input. There are further inputs at the District Training Centre, and we try to utilise active assignments with ethnic minority groups in Nottinghamshire.

DSW: Have you both had training in race relations?

SH: No, I haven't. But we are currently running an equal opportunities seminar for the training staff here at the School.

EFJ: Yes, it has been part of my training.

DSW: The Prison Service has recently adopted your 'Fast Stream' model. How does that work?

SH: Well it is not simply a responsibility of the Training School.

EFJ: But we are required to identify people who have the ability to make higher ranks.

DSW: And does it produce results?

EFJ: Oh dear, I think some could say the Special Course has had a chequered history with both its critics and supporters. Its history actually goes back to the time of Sir Robert Peel who believed that the Senior officers of the Police Service should progress through the ranks from constable. I believe the actual Special Course itself was set up in 1962 and selection was on academic ability but it has since changed over the years and it now has a much wider selection procedure aimed

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at selecting officers who are believed to have wide capabilities including management skill and potential to reach any senior ranks within the service

The course, which incidentally is a sandwich course now, I understand is also levelled at more practical operational skills such as commanding major events or disasters a quality possibly lacking at Hillsborough for example.

I am also conscious, particularly in this force, that a number of Special Course students have not been too successful.

I believe we have to have a balance of young capable managers and perhaps older and more experienced officers to lead the Police Service today with an emphasis on square pegs in square holes.

Of course, there is another alternative and that is recruiting civilian managers into senior posts of the service i.e. direct entry!!

DSW: That's what we've just got rid of!

EFJ: Oh! There's also got to be a way of identifying 'late developers', who blossom once they've established themselves in the job.

DSW: I must ask you about 'The Chief'. Have you been watching it?

EFJ: No — do you watch 'Prisoner in Cell Block H'?

DSW: Watch it — we live it. It is modelled on Grendon!! Seriously though, I asked about 'The Chief' as in the first episode Tim Piggott-Smith managed to quell a prison riot, and I just thought — that episode notwithstanding — you must get heartily pissed off dealing with all our problems. Riots, and remand prisoners places being the most obvious.

EFJ: Well it wasn't too bad here during the latest disturbances. Anyway it was prison staff who went in at Strangeways, and we were there only to prevent the wall being breached. You know when I worked in the remand cells the thing that struck me most was the need to establish a good relationship with the prisoners to get anything done.

DSW: What did you think of the Police Federation giving the Home Secretary the 'silent treatment'?

SH: I was embarrassed.

EFJ: From a personal point of view, I've never wanted to strike. I joined the Police knowing that was a condition of my service, and so I've never believed it was an option open to me. ■

An Intervention Programme

The author describes the development and implementation of the Police in Prison Intervention Programme at Whatton YOI, assesses its effects and discusses its future. His work has been distinguished by a Butler Trust award.

Dr Roger Banner, HM YOI Whatton, a member of the education department.

Intervention Programming Within A Penal Environment

On 11 January last year six inmates currently serving sentences at HM Young Offender Institution Whatton were successfully placed onto the Progress and Monitoring Course of Second Year Probationary Constables, at Nottinghamshire Force Training Centre. This first 'Centre Placement' marks the culmination of four years' integrated programming designed to address the violence and alienation that exists within the complex relationship between formalised authority and the criminal sub-culture.

The eight-hour Placement incorporated components of physical activity, basic group analysis, and personal and social education. Throughout the day emphasis was placed on collective negotiation and experiential learning. Once both groups had overcome initial reticence, they responded well to the schedule of agreed tasks. As the Placement progressed the group became homogeneous and enthusiastic and quickly gained the confidence to identify and introduce issues of mutual and fundamental concern. Subsequent debriefing of the participants and their training staff suggests the Placement was a significant and beneficial experience. Members of both groups perceived their activities to have been valuable and purposeful, and strongly supported its regular inclusion into the course module.

Antagonistic Co-Operation

The original concept that has lead us to the latest stage in the 'Police in Prison' Intervention Programme was initiated in 1986, as a constructive response to the dogmatically antagonistic perceptions our inmates hold towards formalised and uniformed authority.

During my first year as a lecturer at Whatton, inmates within our Education Department made it their business to ensure I received a thorough 'alternative' induction procedure into the penal environment to complement my Regime Induction into the Service. As my colleagues instructed me in the specific mechanisms of Regime control so

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the inmates introduced me to their normal value systems of normative expectations and social codification. It quickly became apparent to me that this inmate continuate of oral law and traditions was a fundamental and powerful force capable of revealing and at times neutralising Regime regulatory provision. Though this subcultural codification was less prescribed and considerably more punitive in effect, it was nevertheless similar in purpose to the official Regime in that it too sought to impose a self-serving order onto the resident population. Though the inmate had to be perpetually sensitive to Regime legislation, deviation from official norms was always met with a considered, judicial response by Discipline Staff during which the inmate was given the opportunity to fairly state his side in the dispute. To transgress subcultural normative values was an altogether more serious matter for the inmate, underscored by the very real fear that such action could release decidedly unconsidered retribution and possibly group ostracism. This latter sanction was particularly frightening because it isolated the inmate from the benefits and protection that group belonging afforded to the individual. Therefore it was vital to the inmate to continually and publicly demonstrate his credentials of acceptability to the subculture. Perhaps the most overt example of this behaviour was to be found in the vitriolic verbal rejection of the values and action of uniformed authority within and without the Institution. Though it was acceptable to award special dispensations to particularly fair-minded prison and police officers, the generic 'screws' and 'pigs' had always to be distanced and abhorred. In fact and possibly because of the age of the inmates, an individual's credibility and consequently his status within the group could be significantly enhanced if he could convincingly assure his peers that his disdain was greater and more profound even than that of his acquaintances — simply, that it paid to propagate a personal legend that identified the individual as rebellious and uncompromising in his relations with uniformed staff.

No Mans Land

As a teacher I was therefore concerned to interrupt and challenge this free flow of disinformation and prejudice through the inception of personal and social educational activities which sought to expiate these issues. However, I found myself in the invidious position of occupying a curious no-mans-land of middle ground, whilst at the same time trying to represent a third party. Because I was not perceived by the inmates to be a law-breaker, or to be involved in the combat of law enforcement, I was considered essentially unqualified through lack of experience to pursue these matters in depth. Further, within an Institution where loyalty to stereotypical cultural expectations is a pre-requisite to social identity, and identity is proudly proclaimed by the wearing of uniformed dress, the faded corduroys and check shirt of the 'professional carer' also introduced some confusion as to exactly whose side I was on.

These problems clearly indicated that a more direct and informed approach was required which would allow me to withdraw from my position as a representative and introduce personnel with acceptable credibility.

Uniformed Approach

In September 1986 I contacted Nottingham Constabulary Force Training Centre (EFTC) with the proposal that we establish an inter-agency open debate forum which would enable inmates and young Constables to enter into a democratic discourse. It was agreed to pilot two meetings composed of inmates, case work prison officers, probation officers and teachers. For these meetings we would concentrate upon the position of victims within the cycle of offending behaviour. Inmates were informed of the proposal and we received a deluge of applicants wanting to participate. To accommodate this unexpected demand, two groups were operated on each occasion. We recognized that the groups remained rather large for effective interaction, but we believed the enthusiastic response we had received would mitigate the detrimental effects on dynamics.

Both pilots demonstrated that the debate format was indeed a practical and productive medium of contact. As a result a further seven smaller meetings were held. As we expected, these meetings increased in usefulness as the number of participants was reduced (the optimum group size and composition operated toward the end of '86 seemed to be seven inmates, two Constables a prison officer and either a teacher or probation officer). Each meeting followed a similar pattern of interaction. Initially, tentatively, staff members would encourage a question and answer sharing. As the inmates became less inhibited and more secure staff would alternatively assume the roles of agent provocateur and devils advocate. Once the familiar posturing and group identities had been established, debate would ensue, often becoming urgent and animated, and lasting up to two hours. Immediately following each session all staff were orally debriefed at Whatton, and Constables later submitted a second written and oral debriefing to Force Training. Inmates were similarly debriefed during tutor periods the next day. Comments and observations were disseminated to staff and inmates during the meeting.

As I had hoped, the teacher's role was mar-

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ginalised, finally becoming one of administrative co-ordinator and occasionally chair-person. Ironically the only control problem we experienced was in persuading the participants to stop talking!

As the year drew to a close a comprehensive inter-agency analysis was conducted to assimilate our experience and the report 'A Co-operative Confrontation' (Banner 1987) was produced. Both services expressed the will to continue with the Programme:

Attending Principal Prison Officer:
Extract from Report.

'As far as our group was concerned, I thoroughly enjoyed it and consider it a very worthwhile venture to be carried on. It was interesting to note how trainees viewed themselves and how certain views and attitudes noticeably changed as the session went on. It is remarkable how the Social Services and us, all know what we think is best for our charges, and a shock to learn that they think without prompt, that the "tariff" ladder' is of no use whatsoever. I look forward to reading the written reports by inmates . . .'

Attending Police Officer (Inspector)
Extract from Report.

'Police Officer reactions to the Forums were in the main, extremely favourable. At times some frustration was evident in that many inmates would begin a session by stating with total certainty their intention to re-offend, or at least that re-offence was inevitable. Police Officers seemed to experience a sense of hopelessness in their ability to "get through to them". After each Forum, some Police Officers left with a sense of relief, thinking perhaps . . . "there" but for the grace of god . . .'

(A surprising outcome of several debates, and the focus of some discussions during Forum debriefing were the number of philosophical values and life experiences both groups had in common with each other.)

Both Agencies were now concerned to consolidate the advances made and extended our commitment to the concept of multi-disciplinary intervention.

In February 1987 it was therefore agreed to intensify both the frequency and duration of inmate/Constable contact with the implementation of a programme of Police Officer Placements. Its format was designed to reflect an amalgamation of each agency's particular needs and objectives. Force Training Centre for instance, were concerned that, at the conclusion of the placement, the Constable should:

1. know the way discipline is maintained and the restrictions placed on trainees in relation to visits, wages, training (education/physical);
2. have experienced the 'feel' of a penal institution;
3. have participated in a discussion with trainees at the establishment and as a result:
a) gained knowledge as to how young offenders view committing crime.
b) gained knowledge as to how young offenders view 'being caught';
c) identify how they see the system of court appearances, sentencing etc;
4. have experienced the hostility felt by trainees towards the Police in general but, having seen and felt it, come to terms with it; deal with it as befits him/herself; recognise it for what it is; if necessary be willing to talk it through with a trainee;
5. have an awareness that there is life after 'the arrest' and the 'final Court appearance/sentencing'.

Within the Education Department we perceived the Programme to be of great value to many aspects of our curricular activities and of particular relevance to social skills development and personal education.

Why Prison?

Though a prison sentence is foremost a punitive response to socially unacceptable behaviour, it also functions to isolate and therefore alleviate the immediate social and environmental pressures which so often conspire to engender this behaviour. Whilst serving a sentence the inmate is incidentally afforded the time to reflect upon the choices he has made and the decisions he has taken to result in such a serious judicial response. I believed our Education Department was uniquely placed to utilise this breathing space productively. By guiding the inmate toward a reasoned and objective analysis of his own particular situation, the inmate can be encouraged to accept responsibility for previous anti-social behaviour and the consequential damage this inflicts upon family and victims. This learning process (initially expiatory but centred upon negotiated strategies of behavioural and attitudinal modification) can significantly contribute to the likelihood and quality of rehabilitation. The integration of young Constables into the type of provision would, we believed, enhance and broaden the available opportunities to confront the complex issues of prejudice, stereotyping and social order. In practice the programme also offered us less overt but equally useful support. By playing the Constable into a 'doing situation' the constraining factors inherent to an open debate were diminished. Both the inmate and the Constable had a non-controversial and communal activity upon which to initiate dialogue; and it allowed all the participants to observe and interact in an informal and relaxed environment.

Placement Intervention began in March 1981. A

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typical two day Placement enabled the Constable to meet and share with inmates, Prison Officers, education and care staff and Probation Officers. Considerable care was given to preparation before each session. It was recognised that some inmates might not wish to associate with Police Officers irrespective of the opportunities this contact offered. Therefore groups or individuals not wholly supportive of the concept were encouraged to leave. (This was a surprisingly rare occurrence in practice.) Inmates were strongly supported to challenge and explore the role of the Police Officer, their purpose in the community and the application and methodology of community policing. Similarly, Constables were encouraged to examine and test inmate preconceptions, ethics and morality; and to expound upon their own values and concerns. An early decision was taken to ask Constables to wear uniform because it was felt any interaction would be more meaningful if inmates were required to confront the serge as well as the individual. (It also served to ally inmate fear that the Programme was some machiavellian C.I.D. ploy to elicit further incriminating evidence.) All participants were thoroughly debriefed following each Placement to assist in the direction of future planning.

This basic format has remained a valid and useful structure. Since '87 Probationary Constables with various degrees of experience have been employed, including Officers with as little as 11 days training. Each Officer has brought to bear his and her own special qualities with the result that to date we have experienced no adverse control or socialisation problems. In fact our research suggests that these placements are possibly the most sought-after components of Progress Monitoring Placement Schemes at Force Training, and inmates and Discipline Staff continue to thoroughly support our objectives.

Participating Inspector, FTC:
(Extract from Report — June 1988)
'. . . The aims of these attachments from the Police perspective have been to allow:
a) a greater appreciation of the problems of the disadvantaged;
b) an appreciation of the objectives and roles of other agencies;
c) the strengthening of community links within the probationer's sub-division.

I'm delighted to say that the time spent by Officers at Whatton has proved to be a major success and has significantly contributed towards their development as Police Constables.'

Participating Principal Officer, Wing Manager (14 to 17 years).
Extract from meeting:

'I see the present Police Placement Programme as a very useful and pertinent input into the regime. Police Officers are encouraged to thoroughly participate in many aspects of our work here. They are given every opportunity to gain a comprehensive insight into the Prison Service and the administration and organisation of our particular regime.

On the assumption that knowledge and experience are never wasted, I feel it can only be of benefit to them. Trainees also have the opportunity to view Police Officers in a different light, and possibly accept them as ordinary men and women simply doing a job of work.

Both groups are able to talk to each other away from the normal environmental and social pressures that disrupt their relationships . . . I would like to conclude by expressing my full and continuing support for both the Placements and Debate Forum'.

Vice Principal South Nottinghamshire College of Further Education (formerly Education Officer HMYOI Whatton).
Extract from interview:

'Changing attitudes in one of the most difficult and delicate tasks staff working with Young Offenders undertake. Attitudes towards authority are, almost invariably, negative and antagonistic.

The Police liaison work at Whatton has shown how attitudes can be changed by hard work and goodwill generated by all concerned. The willingness of the Police Officers to be questioned on controversial issues by young delinquents says a great deal for the professionalism and confidence of our young Police Officers. The ability of young offenders to move from negative and often personalised attacks upon the Police to a position of understanding of the Police's role says a great deal for their ability and willingness to accept other points of view, and understand the wider role of policing. The role of the teacher as an instigator and facilitator of this dialogue is unique in penal education.'

The Future

What then is the future for this Intervention Programme? Our most immediate concern is to strengthen the latest development to integrate inmates into FTC course activity. The 1990 pilot referred to in my opening paragraphs, has opened up tremendous areas of possibility to us. These experiences must be thoroughly examined but it is hoped that the 'Centre Placement' will in time form an integral part of the overall concept. The existing Placement Programme has recently been extended to a second YOI within Nottinghamshire Constabulary boundaries and has proved equally successful. We have also received considerable support at a national level, enabling us to share our work with our colleagues at Headquar-

ters Divisions.

Our great concern now is to develop a more centrally co-ordinated multi-agency Group, able to successfully address the present complicated restraints placed upon the programme's dissemination by Constabulary boundaries. By broader spectrum of interested organisations, including Social Services Departments. ■

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Recall

John McCarthy was Governor of HMP Wormwood Scrubs. He resigned from the Service after writing to 'The Times' deploring conditions in his prison as a 'penal dustbin.' He is now with the Richmond Fellowship managing accommodation and support for ex-offenders and the mentally ill.

I left the Prison Service over seven years ago. However I have no reason to think that conditions for either staff or inmates have improved since I left. So I will write with that assumption.

I see no reason to collude with either politicians or administrators that any good comes from the kind of imprisonment we employ. I see no reason to collude with the public in believing criminals should be punished by the conditions of the sentence. I see no reason to collude with Governors who are too often benevolent dictators and empowered by that role. The British Prison system is inarguably barbaric; barren in its philosophy, barbaric in its method and in its rationalisations. Yet that barbarism to an extent is forced on it by politicians, and to a major extent by the general public, but enacted by the Prison Service.

I therefore believe that to write — as I am asked to — to increase staff awareness of the problems that face an ex-inmate on release, is largely a time wasting exercise. I do not believe that many managers in the Prison Service today have an interest in rehabilitation and I believe that in the few instances where that belief exists, the system does not support it. Still less is there any connection between any structured, or systemised expression of that interest and the outside world. So why do I write at all? Because I am angered by the closed eyes of a system that damages the already damaged, despite being a system often managed by benevolent men and women of good faith. I particularly refer to the disturbed offender, often written off as untreatable under the name of 'psychopath' or 'personality disorder'.

Dr Gray, who opened Grendon, believed as I do that any prison, given stability of the population, could be run as a community. A therapeutic community can be defined as people of equal value (staff and residents) in community working together towards greater independence. The prison community might have a different task — peaceable co-existence might be one. Yet the lessons to be learnt from experiments of this nature are consistently ignored. It is true that prisons with a highly transient population cannot act as a community; it is true that terrorists and some others refuse to act as constructive members of the prison community; but I don't believe these are the real reasons for not trying. The management of staff in the Prison Service is too often archaic and destructive to self-respect. It ignores the fact that all staff are of equal value as people, it ignores management research into motivation, all in the cause of perpetuating a dictatorship — however benevolent. The heresy adopted by some of my erstwhile colleagues, that the Prison Service is, or should be, a kind of military organisation, requiring military discipline, is arrant nonsense and an excuse for preserving the power structure. A power structure that would be drastically changed by operating prisons on a different basis.

If Prison Officers are part of a quasi military service, how much more so are the prisoners the slaves and servants of that service. The rebellious and recalcitrant group created by the very system itself becomes the excuse for the system's continued unchanged existence. How can any real rehabilitation occur in such a society?

The concept of a community is that all people in communities should live together according to certain common principles, though the tasks of the communities will differ. In the case of a therapeutic community the task can be gaining independence. In the case of business it could be selling oil. In the case of a prison the task could be the peaceful management of the unit. The basic common thread is the need to motivate people.

Many inmates in these communities, given the right circumstances, can be motivated to consider

their past, present and future, and can be motivated to take responsibility for themselves and others. They are then in a better position to work with staff on the difficulties they, the inmates, will face when prison ends. The basic antidote to these difficulties is that ability to take responsibility for oneself — something our form of incarceration almost totally fails to work towards — and in fact destroys rather than enhances.

It is just no good asking questions about the best form of aftercare, or what problems ex prisoners face after release, until the actual process of imprisonment is changed. We are haunted by a past system of almost exclusively capital punishment being gradually replaced by taking part of a life away (i.e. the imprisonment) instead of the whole of it. Hence the systematic aridity of imprisonment irrigated with occasional benevolence.

I do not agree that the disturbed offender should not be in prison. But a sufficient part of the system needs to adapt radically to that group's needs. It does not need more doctors, nor therapists. It needs well trained ordinary staff, many of whom, given the opportunity and leadership, have the capacity for sensitivity, and the capacity for empowerment.

When the Prison Department, when most Governors manage their staff in such a way as to treat them as equal human beings; when staff are given respect, when staff feel respected in the outside world — then is the time to talk about inmates' reentry into that outside world.

The Richmond Fellowship takes an increasing number of disturbed ex-offenders from Prison, Probation and the State Hospitals. Most of these individuals bring the prison culture of staff being 'screws', of not 'grassing' others, of having to be tough, and most of all of not admitting to feelings. This protective shell has to be broken through before any work can be done, but it usually is broken, and constructive work is usually done, and increasing responsibility for oneself usually does happen, and increasing responsibility for others and the community usually does grow. If it can be done in the Fellowship, with will it can be done in the Prison Service. The traditional prison culture is the antithesis of the therapeutic community culture. A good community culture consists of the best of human values. The prison culture too often consists of the worst.

It is my belief that managers of prisons have the room given to them to innovate, to change, and to develop themselves, their staff, and hence the inmates, or at least to lessen the harm the system often does at present. The tragedy is that so few take it. I do not believe the Civil Service manages well, but neither do I believe it is a 'dead hand'. I believe it is the Governors group who have lost the soul of Elizabeth Fry, John Howard, and many others who clearly stated that some practices in our society were unacceptable, that some ways of treating human beings were degrading both for the victim and for the oppressor.

If after care is to be effective, I believe inmates have to leave prison with a sense of self respect and a sense of responsibility for themselves and others. To do this, the same qualities must be held and given to all staff. these qualities support the growth of an individual who holds the soul of the Prison Service. On a personal basis I have met many such staff but I have never found the collective prison soul that speaks and acts the truth. ■

Reviews

Villains: Crime and Community in the Inner City
by Janet Foster. Routledge, London, 1990. pp. 187.

Do you remember that joke in Private Eye where a group of hippies, sitting in a circle smoking pot, suddenly discover that they're all undercover journalists working for a Sunday newspaper? I kept thinking about that all the way through Janet Foster's study of petty crime in an unnamed area of South London. Foster, a research officer at the London School of Economics, spent several months befriending, socialising, and interviewing a group of people — male and female — in two predominantly white, working class streets which she names Gorer Lane and Stanton. Most of the action, as in Eastenders, takes place in the pub, which she calls the Grafton Arms, and where she joins the ladies darts team, to provide better cover so as to further facilitate her research. From her vantage she spies the usual round of cheque fraud, handling, and pilfering offences which fill our magistrates courts, and local newspapers. Soon she gets to know the locals so well that not only are they allowing her to tape record interviews, but are also inviting her to commit a few crimes herself!

A fascinating picture emerges of a community's attitude towards crime and criminals, and despite the fact that her sample is small, she produces enough information to challenge some received criminological orthodoxy. In particular her emphasis on the continuity of attitude and experience between generations about certain types of crime, despite significant social and economic change, is novel and arresting. Unlike much of the previous literature which would draw a distinction between juvenile and adult crime, Foster instead believes that juvenile crime is merely an 'apprenticeship' for what comes later. The major difference is that the former tends to be 'public', whilst the latter hidden

and private. She emphasises that this is not in any sense a criminal 'career', merely what people in her sample took for granted; in other words not 'crime' at all. Thus there was no impetus to give up crime as they matured as this was what they had become socialised to expect, or how to behave.

Foster spends a significant portion of her book justifying the methodology she adopted. She was right to do so, and on balance the importance of her results just about outweighs the game that she played. That she changed all the names in the book was not so much to protect the innocent as the guilty, but one can't help wondering how she herself feels about the people she duped, and into whose confidence she was taken, her ability to do so surely reflects not so much her skill at the dart board, but the openness and honesty of a group of people who were prepared to talk about everything that happened in their lives to, virtually, a complete stranger. Am I being romantic to ask did they deserve better? I can only hope that the next time Foster infiltrates a group of yuppies in a large merchant bank.

Dr D Saunders-Wilson
HMP Grendon.

'Silent Scream'
Directed by David Hayman
Starring Iain Glenn, Andy Barr and Kenneth Glenaan.
Screenplay by Bill Beech and Jane Beech

Winner of the Silver Bear Award at the 1990 Berlin Film Festival.

This year's Brighton Festival saw the first public screening of Silent Scream, a disturbing film based on the life and writings of Larry Winters, one of the first inmates accepted into the Special Unit at Barlinnie Prison.

The film grew from an idea which Bill Beech had as long ago as 1974, when he was a visiting tutor to the Special Unit and was working with Larry Winters and Jimmy Boyle. The intention had been to make a six minute film, shot inside Barlinnie, based on Larry's prison

experience and his memories of life outside. It was intended that the film should include animations based on Larry's drawings and writing, in particular his poem Silent Scream. What we saw in Brighton this summer was a brilliant but disturbing feature film, true to the original idea, but set on the last night of Larry's life when he died in his cell of an accidental drug overdose.

It is not by chance that the structure of the film is fragmented and very disorienting: it is intended to reflect the nature and the pace of the vivid images which were likely to have been induced by the quantity of contraband pills swallowed by Larry during his last trip. As the film progresses, the course of his life outside unfolds: his troubled and often violent boyhood in Glasgow, the temporary happiness he found in the Highlands, when his family lived in the gatehouse of Carbisdale Castle, and his return to a violent and alienating existence when he joined the Parachute Regiment in England. It was while he was AWOL from his regiment and trying to get back to the Highlands that he shot a barman in Soho who had refused to give him his fare from the till. His death sentence was commuted to life imprisonment because, at the time of his trial he was diagnosed as having a temporal lobe condition. For his defending counsel, this was seen as a triumph, but for Larry it meant no hope of release. His severe bouts of depression were treated by drugs to which he became addicted; he became violent towards staff and, by 1972, he had added an additional twenty years to his life sentence and had spent some considerable time in solitary in the cages of Inverness Prison. It was at this point that he was admitted to the Special Unit, where the regime encouraged inmates to express themselves in some creative fashion. Larry's poem, The Silent Scream was written during the last few years of his life, and predicted that he would only find peace in death. This being so, it was important for Larry to die at the right time: whether he achieved this is open to conjecture.

The film does not portray his life sequentially: it is a violent jumble of autobiographical scenes interspersed with the progressively more bizarre and colourful images of his trip. Whilst the officer on night duty scrutinizes the bank of surveillance screens reflecting all that is happening in the prison, Larry is behind his cell door, seemingly flipping through the channels of the TV inside his own head. It is not an easy film to watch: the Scottish accents are very strong, there is no simple storyline and the imagery is powerful and distressing. Nevertheless, it is an excellent film which is certainly worth seeing when it is released in September this year. It had a considerable effect on the invited audience of art students, prison officers and governors, magistrates and others interested in the philosophy behind the Special Unit. I stood outside the cinema at the end of the showing knowing that the film had certainly had a significant impact on me, though it was difficult to pinpoint exactly what it was. I only knew that, at the end of my own eleven-hour shift at the prison, the opportunity which presented itself in the foyer, to buy 'the T-shirt of the film of the overdose', somehow left me cold.

Marianne Miller
H.M.P. Lewes.

Should The Prison Medical Service Develop Its Role In The Treatment Of Mentally Ill Offenders

The author argues that however preferable it is to treat the mentally ill in hospital, nonetheless many do find their way into prison and therefore, proper provision should be made.

A. D. Richer, Governor V, HMP Nottingham

The Prison Service as recently as 1984, summarised its main tasks in a four point charter[1]. The Prisons' Board issued as the third point of their charter a statement that it was the intention of the Service to — *provide for prisoners as full a life as is consistent with the facts of custody, in particular making available the physical necessities of life; care for physical and mental health; advice and help with personal problems, work education, training, physical exercise and recreation; and opportunity to practice their religion.*

That care for mental health occupies such a position of prominence in this statement of aspiration is seen by many as being of considerable importance. However does this statement represent recognition by the Prisons' Board that the prison population really does need care and resources spending on its mental health care or is it simply a lip service acknowledgement that mental health is nowadays coupled with physical health in official announcements.

In many respects the Prison Service has an uncomfortable and somewhat ambiguous role in the treatment of the mentally disordered. Whilst it clearly accepts and is comfortable with an assessment role when it pertains to preparing reports to court for remand prisoners, it remains reluctant and uncomfortable, despite the presence of some treatment centres such as Grendon Prison, Parkhurst Prison's 'C' Wing and others, to actively address the problems of the mentally disordered and play a constructive role in the treatment of such prisoners whilst they are in prison. Richard Smith has described what he calls the 'changes in fashion' of Prison Service commitment to psychiatry in a series of articles[2]. Policies have fluctuated so widely particularly since the 1970s that Smith concludes with masterly understatement that — *Understandably these changes have left some prison doctors a little confused as to what exactly they are trying to do, but few see themselves as having much to do with reforming inmates*[3].

Many doctors in the Prison Service rightly point out that the provisions of the 1983 Mental Health Act ought to ensure that no mentally ill person requiring treatment is sent to prison. If they are honest they will acknowledge that the provisions of the Mental Health Act do not ensure this, and that most of the mentally abnormal in prison do not fall within the terms of the Mental Health Act and must therefore serve out their sentences in the prison system.

The Social Services Committee which conducted a review of the Prison Medical Service in 1985-1986 emphasised this view that the Mental Health Act really ought to ensure that no mentally ill person requiring hospital treatment is sent to prison and took as a basic premise of their investigations that — *It is beyond question in our view that people who are mentally ill and severely mentally impaired as defined by the Mental Health Act should be in hospital and not in prison*[4].

On face value this is an uncontentious statement. However it is clear that a number of people who are mentally ill under the terms of the Mental Health Act do remain in prison. Any consideration of mental health provision to the prison population must look beyond the statement of the Social Services Committee. If the Prison Service does not look beyond this statement then it will appear to have a more than complacent attitude to its mentally disturbed prisoners. If it simply accepts that all the mentally ill should be diverted into the NHS then of course it follows that mental health need not be a primary concern of the Prison Medical Service.

In many respects the dilemma of the Prison Medical Service is perfectly understandable. It is obviously correct for it to support the view that prisons are no place for the mentally ill, an argument that can enlist the help, if it needs any such help, of concepts such as natural justice and criminal responsibility[5]. However adopting such a line makes it difficult for the Prison Medi-

cal Service to have a coherent policy for dealing with those mentally abnormal offenders in prison who fall outside the terms of the Mental Health Act. In assessing its role it makes more sense to look at those who are actually in prison rather than having a starting point which looks at the prison population in terms of who should be in prison.

As a brief summary of the realities relating to the make-up of the prison population the assessment of Her Majesty's Chief Inspector of Prisons, His Hon. Judge Stephen Tumin, is relevant to the debate on the role that the Prison Medical Service needs to play in the future. He writes — *The old divisions of 'the bad, the sad and the mad' seem applicable to many of those held in prison hospitals because there is nowhere else to put them. Some people are 'too bad' for psychiatric units, or 'too mad' to be worth helping — or conversely, not 'bad' or 'mad' enough. There is a depressing tendency to apply labels to situations: 'he has a behavioural problem' is a common assessment. We do not doubt that many forensic psychiatric conditions are not amenable to treatment, but the patient still needs help*[6].

Judge Tumin specifically mentions sexual offenders and burnt out schizophrenics as needing help and to these could be added the ever increasing number of 'inadequates' entering prison. Often these are remanded in custody because they are homeless, or serving recurrent short sentences for relatively minor offences. Among these prisoners many might have problems with alcoholism and drug abuse. They may have personality disorders or they may be mentally handicapped in some way. Many observers believe that the increased number of inadequates entering prison is a direct consequence of the policy of closing down long-stay psychiatric hospitals and adopting a community care initiative. The full impact of this movement has yet to be assessed.

As is usually the case much is made of medical statistics in the assessment of the role that the Prison Medical Service does play and should play in dealing with and treating the mentally ill and disordered. The 1988 report of the work of the Prison Service presents what it sees as an encouraging downward trend in the number of mentally ill inmates being held in prison, who in the opinion of Medical Officers were suitable for detention in hospital under the 1983 Mental Health Act[7]. The same report also welcomes an increase in the numbers who are transferred to hospital under Sections 47 and 48 of the Mental Health Act[8]. The number of unsentenced and sentenced inmates combined, who were clearly assessed as needing hospitalisation, but were held in prison as no place could be found for them, still remained at 235 for the period 1.4.87 to 31.3.88. For the period 1.4.88 to 31.3.89 this figure was 215. This might well be regarded as a scandalous situation by those with only a casual interest in the prison and mental health systems. These figures of course only relate to those clear cut cases where there has been agreement that a prisoner is suffering from a mental illness but has not been accepted by a hospital for one reason or another. These prisoners will also have been assessed by prison medical staff and psychiatrists within the NHS who will have agreed that the mental illness in question is susceptible to treatment, a necessary condition of transfer under the 1983 Mental Act.

Statistics are also available for referrals made on behalf of sentenced prisoners under Section 47 and 48 of the Mental Health Act, which recommend a transfer to a psychiatric hospital or to a special hospital or a regional secure unit. These statistics show that the majority, although by no means all, of the referrals are accepted and result in transfer directions being issued. These figures as with those mentioned above are useful because they represent those prisoners upon which there is unambiguous agreement between the Prison Medical Service and the National Health Service. Equally clear cut are the statistics on Court Orders[9] arising from Medical Officers' reports to court although it must be said that the remarkably consistent nature of these figures as they relate to disposals reveals either a certain complacency in disposal or a very 'stable' instance of unstable people coming before the court each year. Whilst these statistics are a useful introduction to examining the role of the Prison Medical service and its attitudes towards the treatment of mental disorder in the prison population, they are only part of a much wider picture. As NACRO succinctly express their view — *There are no statistics, only estimates, of the number of people in prison needing psychiatric care or treatment who are not classified as such under mental health legislation*[10].

Richard Smith in a somewhat scathing review of published research studies reveals that the simple question of how many mentally abnormal prisoners there are in prison cannot be answered with any confidence. These studies, some of which are American, are beset with problems of definition and at best can only point to an approximation of the size of the problem. A survey by Gunn and Taylor at Brixton in 1984 has shown that 9% of the prisoners were psychotic. Washbrook conducting three surveys in 1976 at Birmingham revealed that between 8.6% to 11.6% of prisoners were in need of psychiatric help. Several studies have shown a disturbing tendency that the numbers of mentally

sub-normal and handicapped prisoners are increasing in the general prison population. When studies have attempted to discover the incidence of broader based concepts of mental illness such as personality disorders, sociopathy or psychopathy the resultant figures have increased drastically to between 60% to 75% of the population. Richard Smith's comment on studies using these vague definitions of mental illness is that there is — *undoubtedly a category where the figures are at their most meaningless: psychiatry is not very sure how to diagnose these people or manage them and the fashion seems to be increasingly for psychiatrists and especially prison psychiatrists, to leave them alone!*[11]

The Social Services Committee in 1985-86 were considerably concerned that so little accurate information was available and this may well have proved one of the deciding factors in the Home Office commissioning Professor Gunn to produce a much needed psychiatric profile of sentenced inmates. This study it is envisaged will produce over a three year period, a 'definitive' statement of the problem of the mentally disordered offender in the prison system. The Prison Service have said that the results of this study will provide a sound basis in which the Prison Department will be able to consider the development of its policies, both as regards diversion from the penal system, and for the provision of facilities within the system for the middle and long-term.

Professor Gunn's study is clearly more ambitious and more thorough than many of its predecessors, certainly its English ones. It is at the very least an acknowledgement that the Prison Medical Service needs to address itself to having a clear cut policy and an identifiable role in the treatment of mental ill whilst in prison. There has nary findings of a Home Office survey, the forerunner to Professor Gunn's research findings, has indicated that about 1,500 male prisoners are suffering from some degree of mental disorder. If at the present time the Prison Service can be said to have an official position this would be it, some 250 mentally ill prisoners which it would like to transfer under the terms of the 1983 Mental Health Act and only 3% of the population suffering from some degree of mental disorder – a figure considerably lower than any other previous study and one which, if confirmed, will almost certainly lead to considerable controversy and argument from a variety of pressure groups. It appears likely that problems of definition may prove to be crucial in the assessment of this study and perhaps this should not be a surprise because the discovery of, and treatment for, mental illness simply is not an exact science. It must also be remembered that Home Office figures reveal that over 9,000 prisoners were seen in some capacity in 1987/88. In 1988/89 this figure increased to 13,745! This figure applies only to Appointed Specialists and does not include a further 3,000 referrals to NHS Consultant Psychiatrists.

If exactness in mental health care is not always possible and remains an ideal, several safe assumptions can be made in prison. It is clear that a number of severely mentally disturbed offenders are received into prison. The most acute of these will be transferred under the Mental Health Act to special hospitals or regional secure units. Despite criticism of the lack of psychiatric training among prison doctors there is a clear role for the Medical Service in assessing prisoners remanded to prison for reports and to monitor the population for those who become mentally disorder within prison. Prelimibeen much concern expressed although less research into the effects of imprisonment in causing and exacerbating mental illness in a vulnerable prison population.

It is clear that a number of mentally ill people will slip through the Mental Health Act net and end up in prison. Some even when identified will remain in prison because a place cannot be found for them in the National Health Service either because they are unwanted or a control problem or are not thought susceptible to treatment or they may not be in a geographical region which is able to provide a bed. Amongst those who might benefit from treatment are those who will actively avoid or refuse treatment for various reasons. The very fact of being in prison and serving a court sentence or even being sent to prison by a court to be reported on, raises many ethical questions of treatment and adds a new dimension to the debate on a right to receive treatment and the right to refuse treatment.

In addition to the clearly mentally ill upon which there is broad agreement with the National Health Service, there are those prisoners upon which there is not agreement. It seems most unlikely that prison doctors and visiting psychiatrists submit all the prisoners they are concerned about for a transfer under the Mental Health Act. It would seem strange if they did so in the certain knowledge that at any one time there are clearly several hundred men who have been assessed as needing a place in a hospital who are left to languish in prison for whatever reason. This hardly provides the Medical Service with the incentive to root out the mentally ill from our prisons and arrange treatment. There seems little incentive to explore the borderline cases, also those most difficult

to assess, when it is clear that they will also be the least likely to be diverted from the prison. It is also clear that there is a certain ambivalence and confusion amongst prison medical staff as to what its role is and what it should be. There seems almost a hesitancy to grasp the nettle of accepting that it has many disturbed individuals to work with, and needs to have clearer policies and initiatives aimed at the mentally disturbed offender in prison whether or not they fall neatly into the categories laid down by the 1983 Mental Health Act. What is clear, as the Chief Inspector of Prisons points out, is that many prisoners may alternatively and correctly be termed 'patient' and the patient needs help. ■

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	1983	84/85	85/86	86/87	87/88	88/89
Number of unsentenced inmates on 31 March 1988 considered by medical officers to meet the criteria for detention in hospital under the Mental Health Act 1983	198	144	181	165	116	134
Number of sentenced inmates on 31 March 1988 considered by medical officers to meet the criteria for detention in hospital under the Mental Health Act 1983.	118	124	124	133	119	81
Total	316	268	305	298	235	215

8. Reports made under S47 and S48 of the Mental Health Act 1983 recommending transfer to psychiatric or special hospital.

	1983	84/85	85/86	86/87	87/88	88/89
Number of report submitted	140	67	151	193	206	224
Number in respect of whom transfer directions were issued	110	58	134	159	183	184

9. Court Orders arising from recommendations by medical officers.

	1983	84/85	85/86	86/87	87/88	88/89
Hospital Orders without restrictions (S37) Mental Health Act 1983.	658	811	583	517	581	489
Hospital Orders with restrictions (S37 S41) Mental Health Act 1983.	108	78	54	51	65	75
Guardianship Orders (S37) Mental Health Act 1983.	1	5	0	2	0	2
Committals direct to Hospital (S44) Mental Health Act 1983.	62	54	39	23	22	12
Probation Orders with psychiatric provision S3 Powers of Criminal Courts Act 1983.	78	52	36	38	10	8
Total	907	1000	712	631	678	586

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Grendon — The Care Of Acute Psychiatric Patients — A Pragmatic Solution

The following article is an extract from a chapter in the book, Mentally Disordered Offender in the Penal System, to be published by Heinneman in October. This represents an important initiative by the Mental Health Foundation. We are grateful for permission to print in advance of publication and the volume itself which is edited by Professor John Gunn and Dr Katia Herbst will be reviewed in a subsequent edition of the P.S.J.

M F G Selby, Governor

The problem of coping with the psychiatric offender can cause acute and painful difficulty within a prison setting. Moreover, with the closure of many mental hospitals beginning to have an effect in the wider community, a growing number of offenders with psychiatric disorders are finding themselves in trouble with the courts, and inevitably are imprisoned. The Acute Psychiatric Unit at HMP Grendon provides an example of the opportunity for the positive care of this group of offenders, and offers some optimistic indications that an appropriate regime can be established.

The theme throughout this article is the value of the pragmatic approach to solving problems. This is in relation to the philosophical attitude that if there is a problem — solve it, whilst continuing to work within the perception that the financial resources will never be adequate.

Survival In Isolation

The Advisory Committee of the Therapeutic Regime at Grendon (ACTRAG) set up on 29 March 1984 reported to the Home Secretary on 29 July 1985. Its conclusions can be summarised that Grendon had survived — remarkable in itself, because the history of the Prison Service is littered with defunct initiatives, but in surviving there had been isolation and a process of ossification. So ACTRAG, whilst encouraging the continuation of the therapeutic community method, also (amongst others) recommended that the prison hospital of 28 beds which forms an integral part of the prison complex should be converted into a Rescue Unit — the Acute Psychiatric Unit for prisoners who become mentally disturbed. This represented a return to the original first objective of its founding fathers.

Vital Link

It can and has been argued that this Acute Psychiatric Unit is not only unnecessary but also in conflict with the operation of the Mental Health Act, by retaining in the prison system those requiring immediate treatment within a penal setting. Furthermore that in providing this kind of facility, Grendon was delaying, if not preventing, the will to find the solution of the problem that this small group of gravely and sometimes grossly disturbed convicted offenders present. However, in a sense, Grendon not only is at the boundary of the notional divide between prison/punishment and special hospital/treatment but also has been described as providing the vital link bridging the two.

In a sense Grendon is not only the ideal penal establishment where this experiment could be tried but arguably the only one. The overall regime at Grendon has been one where a therapeutic community exists within a prison discipline framework. The two philosophies could be considered theoretically to be mutually antagonistic but have not only survived but prospered in dynamic tension. One reason is that Grendon has single-mindedly maintained the integrity of the pursuit of this task — which has not been easy. The second is that all staff embody in themselves both treatment and security; care and control, reconcilable in the relationship of the multi-disciplinary staff approach with the prisoners and with each other. It is therefore possible for a prisoner to state on a television programme, spontaneously, and with only slightly tongue in cheek 'We don't have grassing here, we call it therapeutic feedback'.

Climate For Change

Central to participation in therapy is a commitment to change. Referral is by Medical Officers from prisons throughout England and Wales. The culture of this community is that of helping each other, as much self determination as is practicable and observance of a strictly applied 'no violence' 'no drugs' rule.

Inmates have given as a reason for dramatic and sus-

tained improvement in behaviour and attitude, from that expressed at other establishments, that they are allowed to behave naturally and, equally significantly, prison officers respond to the opportunity to exercise the caring aspect of their personalities. The abandonment of traditional antagonisms (causing a culture shock on arrival) and the lowering of the machismo facade by both staff and inmate is beneficial in effecting therapy.

The skills acquired within the context of the therapeutic community were invaluable — at all levels — in setting up the APU and throughout its development.

Essentially it enabled prisoners during a psychotic episode the reality and the dignity of mental illness in an accepting and guiding community.

Reception Limitations

Grendon has developed over the last years, not least in accepting inmates who show a much greater propensity to violence and instability. This follows the consideration that its work should be more relevant to the needs of the prison service as a whole and to the recognition there must be a response to the wider patient need than the therapeutic community method by itself could cater for. Thus the requirement of at least average intelligence, some articulacy and psychological robustness in order to utilize the therapeutic community form of treatment of the Acute Psychiatric Unit can be seen in this setting.

Indeed had Grendon Hospital's APU not existed in its present role these men, who had been diagnosed as requiring immediate care due to the nature of their mental disorder, would have been incarcerated in various prison hospitals singly or in small groups, subject to the inevitable delay that sectioning under 47 of the Mental Health Act entails. During that period segregation and isolation caused by shortage of staff and lack of availability of proper facilities can exacerbate the condition and cause distress alike to the patient and those looking after him. So, speed of response was the first requirement, and thus within a day or two of request for a bed the transfer to Grendon can be effected. Then, during the one to three months that Section 47 takes to complete, the patient in the APU can be properly assessed and even treated. Some indeed are ready to return to normal location before that time. With regard, therefore, to the propriety of this initiative it can be that it is in the patient's interest to shorten his suffering and it is also possible to identify the long term secondary symptoms and plan a programme of alleviation if it is necessary, the patient can be transferred to a special hospital after careful assessment using an established network of psychiatric contacts developed over the years by virtue of Grendon's sound reputation. The overall effect is beneficial in that this has been a shorter time in illness and has enabled Grendon to create a centre of excellence with experienced staff, sound facilities, good liaison with outside agencies and provide adequate career planning.

Structuring The A.P.U.

When we examined the problem of setting up the Acute Psychiatric Unit, the rebuilding alterations required appeared to be both considerable and expensive. Placed centrally in the design, the operating theatre — redundant and unused for several years — presented, seemingly, insuperable obstacles to conversion without a heavy outlay of money. An even greater difficulty was that of staff attitudes — a proposed change has always the potential to bargain and, locally, there was uncertainty as to Grendon's future. Furthermore the Directorate of Prison Medical Services had proposed a future increase of qualified nurses in addition to Prison Officers with Hospital Officer training. There was thus every excuse to delay — financial, structural and staff — except that the identified need remained and was regarded as paramount. We evaluated the position and decided to go ahead and utilize the strengths that we did have. This was principally a coherent treatment philosophy based on the multi-disciplinary method successfully utilized by Grendon throughout its history, which had produced a healthy staff attitude.

In charge is a Psychiatrist who is a full time Prison Medical Officer, accountable to the Senior Medical Officer who determines the medical treatment needs of each patient, and the orchestration of the team approach. All usual psychiatric modalities are used including psychotropic medication and individual psychotherapy. Daily ward rounds at which the psychiatrist sees all patients are supplemented by weekly case conferences with all staff.

Utilization Of Skills

The inter-personal skills utilized by the Prison Hospital Officers — only six of whom have outside nursing qualifications form a significant matrix for the process of socialization, behaviour modification and acquirement of confidence in personal contact, and the business of living rather than existing. We found that the Hospital Officer training was adequate, reinforced by on-the-job and other local training. In the event there was no increase of staff numbers working in the unit and the overall staff ratio is less than one to one. At certain times

only four or five staff are actually on duty. This is remarkable bearing in mind the potential for violence in many of the patients.

The regime provides no time in enforced segregation — in fact, there is no Segregation Unit. There is limited use of the secluded unfurnished room, and the positive continuous contact of staff with patient is in contrast to a normal prison regime which, perforce, requires long periods of isolation and little opportunity for effective prisoner/staff relationships.

Regime Ethos

Within this framework, the guiding ethos of the regime is dynamic — to seek, if not a cure, certainly behaviour improvement from which a positive move elsewhere can be contemplated as part of a treatment plan. The regime is relaxed in order to provide a stress free environment where patients can develop their social and educational skills and pursue hobbies such as painting and cookery. This last — survival cookery — is considered to be significant in terms of their ability to look after themselves on discharge and is a practical expression of our concern.

Even in this environment some patients find it difficult to cope, but as many as possible are encouraged to encourage each other to participate and become members of the community. Contact with the outside world — so difficult to achieve in prisons — is energetically encouraged, the 'Drop-In Centre' has many voluntary helpers and prison visitors arrive at a variety of hours and even prisoners from the other part of the prison visit both socially and to work. The success of fostering this community spirit can be measured in the comparative absence of assaults by a group of inmates who have a history of violence against others, both staff and prisoners at previous prison establishments.

'Club — Operation'

The paradigm of the APU's success can concentrate on the use of the Operating Theatre. It was decided to regard its central position as an advantage, by converting it into a classroom that would be conducted on the lines of a club. The physical changes, however, were minimal — the operating table and instruments were moved and that was about all. The Education Department funded teacher hours and a teacher was selected — with no formal qualifications that were apparently significant, yet she had tremendous enthusiasm which infected all who came into contact with her. The result was effective co-operation with the medical staff and Hospital Officers and volunteers from outside who take part in the classes on an ad hoc basis. The task of refurbishing the room became the activity of the 'Drop-In Centre' as it became named. Informality of approach meant that the class, regarded as a club, became used by the patients who claimed ownership. The emphasis on acquirement of basic social skills — there are frequent informal 'socials' and every excuse for a party — has since been built upon, on an individual need basis.

Success.

The subsequent disposal figures indicate that the great majority return to the prison system — emphasising the APU's intended role to provide a service to the prison system by enhancing patient care through rapid response, assessment and appropriate treatment. That so few fail to respond to the regime is indicated by the small proportion who have been sent to the secure units and special hospitals. Those who are released into the community present very special problems that are both time consuming and frustrating. Hospital Officer staff are encouraged and trained to participate in more formalised shared working with the probation department, thus enabling the probation officer to concentrate on the disposal of his men who present such special difficulties. Certainly those participants who are inadequate with a history of reactive violence, sexual offences and those who require regular medication present almost insuperable resettlement problems.

The Move

Recently Grendon's method has been put under a severe test. On 19 December 1989 we were required to empty the whole prison before Christmas and did so within two days. The patients of the Acute Psychiatric Unit were moved in a group to a discrete part of A Wing in Wormwood Scrubs and in April to the hospital in Parkhurst. Throughout it has remained a separate unit looked after by its own Grendon staff. This has been successful and it seems likely will be able to return as a unit in being, so to provide an essential element of continuity for the future. The significant aspects of this move undertaken with great disquiet but in the event admirably well behaved was essentially their trust in the Grendon staff. The relationship founded on this trust has been sufficient to sustain this immature fragile community. The strength of being part of Grendon has been enough to care for these patients through the buffeting of adverse circumstances which, overall, it can be agreed has shown admirable resillience.

Pace Of Development

Clearly, the problem of the

mentally ill offender patient is likely to increase, certainly in numbers, and the Grendon proposal to develop an ad hoc solution could — and has been — described as a first aid patch which prevents a long term solution being attempted, as no longer necessary. To some extent this could be correct but too many mentally ill offenders in unsuitable penal conditions, awaiting delayed appropriate referral, damaging others and themselves, demonstrate that delay would be intolerable. The laggardly pace of development of the Regional Secure Units recommended by the Butler Report of 1975 is only too persuasive an argument for action. Now the uneven pace of the development of the community based alternatives provides further support for the rightness of Grendon's attitude.

The blight of the mentally ill offender simply cannot be wished out of existence, at a deeper level Grendon's success provides a significant example for the future. It is that it is possible to bridge the gaps caused by bureaucratic division which have little congruence with patient need. The division of placement between prisons, special hospitals, regional secure units, can have haphazard relation to what is necessary to seek appropriate patient treatment. Grendon demonstrates that putting the patient needs first, within a seemingly rigid prison structure, can achieve a significant change in the practice of care of the mentally ill offender. ■

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Monsters, Beasts and Animals

An account of the introduction and formation of HMP Grendon's Sex Offender Treatment Programme.

Jim Gomersall is currently on the waiting list for promotion to Principal Officer and presently employed as Wing Manager of D Wing HMP Wellingborough formerly G Wing HMP Grendon

The number of people convicted of sex-related offences has steadily increased over the last five years. The problems faced by the Prison authorities in dealing with this group of prisoners is immense, although the development of Vulnerable Prisoner Units has gone some way both in providing these inmates with protection from other prisoners, and an atmosphere in which their offending behaviour can be tackled. However, much of the work that is being done is in the hands of 'professionals' — doctors, psychologists, teachers and probation officers — and there has been a general reluctance by prison staff to become too closely involved with this type of offender. Nonetheless the development of Grendon's sex offender programme has shown that prison staff have an important contribution to make in the provision of a positive regime for people who are often too quickly labelled, or at best ignored.

History

In 1987 60 prisoners on Rule 43 (own protection) were moved to HMP Grendon from various prisons in the South West Region. They were housed on G Wing, and the former Young Offender inhabitants were either re-located internally or transferred to other Young Offender establishments. Initially the staff for this 'Rule 43 Wing' were provided by HMP Albany, who did an excellent job in establishing, and then maintaining a regime based on labour, education and limited association. Although the two staff groups (Grendon and Albany) mixed well together, neither was allowed to work in the other's regime, and G Wing's population was strictly segregated from the rest of Grendon.

The months passed and, inevitably, Albany's officers were gradually recalled to their parent establishment, being replaced on a voluntary basis by Grendon staff. Naturally the day came when G Wing was being run by Grendon staff, with the unit now operating as a VPU. This situation was to last for a further 12 months, with the staff developing the skills necessary to create a 'safe environment' for this type of prisoner, and in forging good team spirit. However it was soon obvious that G Wing was a 'thorn in Grendon's side'. The unit was not treatment-orientated, and its inmates were not allowed to mix with Grendon prisoners, which inevitably impinged on the running and cost-effectiveness of the whole of Grendon's regime. Thus there were many reasons to re-assess G Wing's direction when I joined the unit in late 1988.

Beginnings

In November 1988 the staff were informed that the function of the wing would be changing in the near future. Crudely, it was intended to bring G Wing

into line with the rest of the prison but that the treatment programme offered would be unlike any other in the establishment. The new unit would specialise in the treatment of sex offenders and stabilised psychiatric cases referred by the Senior Medical Officer from Grendon's Acute Psychiatric Unit. Coincidentally at around the same period the staff were offered the chance of taking part in an experiment in casework and welfare using the Shared Working Scheme (SWIP). Initial misgivings quickly gave way to acceptance and enthusiasm for this new challenge.

There followed several hectic weeks of internal and some external staff training in casework and methods of practice available to workers in the field of sex abuse and its treatment. During this period the wing population had to be reduced, mainly by natural wastage, from 60 to 40 — a more workable number for the programme envisaged. The inmates were kept informed of the latest developments and given the choice of staying for the treatment programme or leaving if they had strong reservations. Initially few chose to go, though some had a change of heart as the regime began to change.

It is known that education is an integral part of most courses of treatment of sex offenders and with this in mind a daily routine for basic education, cookery, sex education, life skills and social skills was formulated by Mike Lambe, Grendon's Education Officer and his staff. To facilitate this, the number of wing tutors was increased to complement the resident tutor.

So began the first phase of the conversion. The second phase involved a total integration of the, by now, ex R.43 inmates into the regular Grendon routine including mixed visits and exercise. Interestingly, this took some time as, despite a number of sex offenders being present on other wings, G Wing inmates were looked on as being the lowest in the pecking order and care had to be exercised until the Rule 43 image had faded.

Treading Water

Phase three, the full-time treatment concept, necessitated a resident therapist on the unit. Unfortunately due to unforeseen and unpreventable circumstances, this did not happen in the stated time span and consequently both staff and inmate morale and motivation began to ebb. Staff were encouraged to start their own small projects as a stop-gap until more direction came. One of these, a joint experiment with Milton Keynes NSPCC, dealing with a group of child abusers using the resources and techniques of both is still under way today and it is hoped to publish the results of this later in the year.

Good News, Bad News And Worse!

Towards the latter part of 1989, information was received to the effect that the whole prison needed re-wiring and all wings would be moved to the Assessment Unit on a rotational basis to enable this work to be carried out. On the positive side, this meant that Dr Jack Wright was freed from his duties on the Assessment Unit and he kindly offered to become G Wing's therapist. The future looked promising.

Within weeks and before Dr Wright could take up his new post, a surveyor's report found Grendon's electrical system to be in a far worse state than had been originally anticipated. During the week before Christmas we were directed to close the prison within 48 hours!

Two days later most of the staff and inmates were squeezed into one wing in the Mount and, fortunately, were made to feel welcome by the incumbent staff despite the intrusion. Long days, coach travel and very cramped working conditions are not conducive to the effective running of a treatment unit but still the programme ticked over, just, thanks to the efforts of staff. The process was soon to be repeated. Staff, inmates and equipment moved to the present domicile — four wings of HMP Wellingborough, at the end of January this year. Again we have been made to feel at home by the resident staff despite the upheavals.

Since moving here, the type of programme that had originally been envisaged so long ago is now being offered. There are five very different offence or problem-related groups, community meetings, individual counselling, work training and an excellent education programme in operation within an emergent therapeutic community.

In the near future the mainstay of the treatment plan formulated by Dr Wright will come into effect. This centres around Psycho-educational Therapy and will be delivered by the Education Department in due course.

Getting Things Going — Some Observations

Several issues are important for the effective management of a unit dealing with such emotive subject matter. Training is of paramount importance and within the usual constraints of time, money and availability of courses must receive the most attention. Workers cannot be expected to operate without information about this complex subject. The adoption of the Shared Working system has proved to be very valuable as it has led to a better understanding between

officer and inmate. This provides the 'foot in the door' that is so necessary to establish the degree of trust that is required. Teamwork is possibly the key word for successful management. It is vital that each of the disciplines involved (and for us this includes: unified grades, Medical Officer, education staff, Probation and Social Services and the NSPCC) feel that they are part of a team with a common objective. Splinter groups create tension, promote poor communication and foster ill-feeling, rapidly eroding the chances of success. To illustrate the point, each of the four Grendon wings here has been allocated a number of Wellingborough officers for external duties. However instead of allowing the staff to be split, the external duties are shared equally between the two sections, and as a result several Wellingborough officers are now actively involved in Shared Working and group work. Specialist grades are not a pre-requisite for success. In fact the majority of our staff are Discipline Officers who came here from other establishments, the training school or from other units of Grendon. It is essential that all staff coming into this type of work should have a high degree of self-awareness and should be given the option to leave if they subsequently feel unsuited to the task.

The Future

There will be a need to expand similar sex offender treatment programmes on a national level if Rule 43 prisoners are to be absorbed into the main prison system, and the pressure from all quarters is sustained to try to modify behaviour on a voluntary basis to some degree prior to release.

With this in mind, centralised co-ordination of such programmes must be a priority. No-one seems to know what is happening in other prisons with units involved in this type of work. Some are run as ours, some by probation, some by Psychologists, some by Education staff etc. We sometimes meet by chance at outside conferences and training courses but other than this most information comes from third parties working in outside agencies!

Only when we pool our own ideas, knowledge and skills from within the prison system can we hope to share and work fully with other agencies and produce a package that follows through discharge and into the outside community.

Finally

I am indebted to the staff of D Wing. Without their drive, enthusiasm and sheer professionalism, this article could not have been contemplated. ■

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a. 'The Sun' on the conviction of a group of paedophiles in June 1989.
b. I am indebted to Dr D Saunders-Wilson, who read many drafts of this article.

A Review of Recent Literature Evaluating Treatments for Sex Offenders in Prisons and Comparable Institutional Settings

In recent years there has been growing emphasis placed on treatment of sex offenders during their prison sentences. This article attempts to review the evaluative literature on treatments, and points out the inherent difficulties in the formulation of programmes for offenders.

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A basic problem in evaluating sex offender treatments is the need for reliable recidivism data against which to judge the effectiveness of the treatment. This is difficult to establish for any offence — but for sex offences there is the additional problem of gross underreporting by victims, (for example the British Crime Survey 1988 gives a figure of 21% for reporting of sexual offences by victims). The most recent Home Office statistics showed a reconviction rate of around 5% for sex offenders when followed up for a period of two years after discharge from a prison sentence. In the absence of better reporting, a long follow-up period is necessary in order to be reasonably certain that any reoffending is picked up and enters the appropriate statistics.

As the Howard League (1985) recently noted, a primary problem for sex offenders in prisons is the attitude of other inmates (and possibly of staff also). There is a strong incentive for sex offenders to attempt to conceal the nature of the crime for which they were imprisoned. It is also inherently difficult in a prison regime to achieve the levels of confidentiality, (and confidence in that confidential-

ity), necessary for the open group discussions, counselling and behaviour therapy used in many treatment programmes. Security considerations will also affect the feasibility of such programmes.

A considerable number of psychotherapeutic and behavioural methods have been developed and used over the years for the treatment of sex offenders in institutions and prisons. The methods of treatment fall into three broad categories — psychotherapy, behaviour modification and social-skills training.

The psychotherapeutic approach tries to change the offender's behaviour by providing him with relevant insights into the motivation for his offences. It often takes the form of counselling or supported discussion, such as is found in the 'therapeutic community' at Grendon. Family therapy involving the offender's immediate family in the discussions, may also be used when appropriate. Psychotherapy may be especially relevant when there is no obvious sexual context to the offence, that is, when sexual gratification is not a primary motive for the offence.

When there is a sexual context, it is often considered more appropriate to use behavioural techniques to attempt to change the offender's behaviour. To achieve this it employs a variety of methods (for example, interview, questionnaire and physiological measurement etc) to establish the type of fantasies indulged in by the offender, and then employs a variety of techniques such as aversive therapy in order to redirect, or at least control, the particular deviant sexual drive.

Social skills training will involve attempting to teach the offender interpersonal skills so that he can avoid the circumstances which led him to offend, e.g. by providing anger-control training, relaxation training, sex-education and assertiveness training. Job-finding skills, and other more common rehabilitative training may also be involved.

However, most treatment programmes tend to employ all three broad types in a rather heterogenous 'blunderbuss' manner, with the exact components of programmes being tailored to particular groups or individuals. This tailoring is usually based on clinical judgement and creates difficulties for evaluation. As several methods of treatment are used together, it is difficult, if not impossible, to evaluate any single technique. Instead research can only try to show whether a generalised treatment can be effective.

There are also chemical and surgical interventions available for the treatment of sex offenders but, in general, they are not considered appropriate in the British prison system. These methods represent containment of offenders considered uncontrollable. In the absence of opportunities to offend in a prison setting they could be considered superfluous treatments.

Institutional Factors

The confines of a prison are far from ideal for the purposes of altering a person's sexual behaviour, largely because of the absence of contact with others in a normal social setting, which makes it difficult to put into practice the social skills training intended to normalise relationships with others, especially with the opposite sex. Moreover, changes in motivation and behaviour that have been achieved in a prison context may not be generalisable to real-life situations, where the offender is suddenly confronted with a full range of opportunities for reoffending. Finally, the rigid timescale of prison sentences does not lend itself to effective treatment — the treatment may end before the sentence, or vice versa, and both circumstances may cause problems.

More attention is now being paid to establishing the institutional framework that allows treatment programmes to operate most effectively in prison environments. For example, Darnell (1989) argues that in order to treat sex offenders in prisons, the environment needs to be conducive to treatment, by housing treatment groups separately for their own protection and to provide peer support, to have multi-disciplinary treatment teams and to ensure careful follow-up and support when released from prison.

Cowburn (unpublished) has conducted descriptive research on prison based treatment programmes. His work is still ongoing, but at a recent NACRO conference he presented some of his interim conclusions as to the features of a prison regime which are conducive to treatment programmes. These requirements can be summarised as follows:

a. Institutional commitment: work with sex offenders has to be important to the establishment because the necessary programmes and regime cannot really be created and sustained in a typical regime.
b. Continuity of work within prisons: most treatment programmes result from individual initiatives and many of them lapse when the person responsible leaves or is transferred elsewhere. There is thus a need for continuity.
c. Throughcare is particularly important for sex offenders — for example it is important to identify elements of behaviour that are better dealt with in prison and those best treated in the community, and then ensuring there is continuity with

community-based treatment after release.

d. A unified multi-disciplinary approach: it is important that treatment should be broad based. Ideally it should make use of the Special Hospitals' concept of having individual treatment plans administered by multi-disciplinary teams.

There are only a handful of studies which have tried to evaluate systematically the effectiveness of treatments. In a wide ranging review of the pre-1980s literature, Furby et al (1989) provided a basis for a review of such research, but their work now requires updating. They suggest that the most common problems with evaluating treatment fall into the following three categories, selective sampling, the targetting of the offenders to be treated and provision of adequate recidivism data.

Problems of Evaluation

Most treatment programmes require subjects to be well motivated or, at the least, to acknowledge that their behaviour is abnormal and wish to change it. In this sense, most samples of treated sex offenders are biased, since many are motivated to change their behaviour.

Thus, the ideal study is one that is able to compare groups of treated and untreated offenders who are equally well motivated. Such studies are very rare indeed and most comparisons, including the majority of those reviewed below, have been made between treated motivated groups and untreated unmotivated groups.

Furby et al (1989) identified some five studies based in prisons or mental hospitals which involved comparisons of treated and untreated groups. In four of these five studies, the sex offence recidivism rate for the treated offenders was higher than for the untreated offenders. In the remaining study, Sturgeon and Taylor (1980), the difference was not significant, but because they differed in ways other than whether they received treatment or not, they refrained from concluding that treatment was ineffective.

Groth (1983) constructed a treatment programme in Somers Correctional Institution in Connecticut, consisting of psychotherapy, social skills training, sex education and general counselling, but not including any behaviour modification components. The follow-up period ranged from zero to four years, and showed that six out of 72 treated offenders had been reconvicted of a sexual offence (8%) compared with nineteen of 122 untreated offenders (16%). However, the comparability of the two groups is dubious, as their characteristics are not described.

Another important American study is the Sex Offenders Treatment and Evaluation Project of California (Marques et al 1989). Although a voluntary programme for imprisoned sex offenders, it has an effective comparison group of offenders willing to undergo treatment. Pairs of offenders were selected with one of the pair then being denied treatment. Treatment was based on psychotherapy and counselling, with behaviour modification techniques given on an individually tailored, or prescriptive, basis, as were anger-, anxiety- and depression-management. As this study only began in 1985, and with subjects to be followed-up for five years, only preliminary results are as yet available. These are as yet inconclusive; of the 40 treated offenders only one has been arrested for a sex offence since release, and likewise for the untreated control group of 49 offenders. Of a matched sample of 42 non-volunteers, i.e. those who had not wanted treatment, none were rearrested for sex offences during the same time period.

The only comparable British study in recent years is that of Perkins (1987). He compared the reconviction rate of 13 sex offenders receiving treatment in HMP Birmingham with another 13 who wanted treatment but for various reasons were unable to attend the programme. Some offenders subsequently received treatment in the community and were also followed up. The treatment methods used were individually tailored to the offenders, but included orgasmic reconditioning, social skills training, and counselling as well as other methods. Offenders more than four years at liberty were followed up, and roughly equal percentages of the 10 treated and 12 untreated offenders requesting treatment were reconvicted of sex offences.

Probably the most important long term follow-up study of recent years is that of the Massachussets Treatment Centre program by Carter and his colleagues (1988). This program is obliged by state law to accept any sex offenders allocated to it, on the grounds of being 'sexually dangerous', the only restriction being on the basis of availability of places. The treatment program consists of individual, family and group psychotherapy, with prescriptive availability of aversive, satiation and covert sensitation therapies. These therapies are administered until the offender is deemed to be no longer sexually dangerous, so the period of treatment may be any length, but must last for a minimum of two years. The researchers used charges for sexual offences, rather than arrests or convictions, as their follow-up criterion, and they found: 24.8% of 129 child molesters were charged over a five year follow up (rising to 32.5% at 25 years, although this time period is not equal for all offenders), and 24.3% of 111 rapists over five years (29.7% over 25 years with

the same qualifier). Although no comparison group of untreated offenders is available, the authors suggested comparing their figures with those of similar studies (e.g. Marshall and Barbaree (see below) who found a rate of reoffending of around 40% for untreated, non-incestual, child molesters over a variable time span, and up to 60% over four years).

Marshall and Barbaree's (1988) study however considered only child molesters, and in an outpatient program. It attempted to normalise some of the treatment components by utilising them in more natural settings than the usual clinic laboratory. Thus, although electrical aversive conditioning was performed in the lab, masturbatory satiation was performed by the offenders at home, and they also carried smelling salts at all times, to administer as an aversive stimulus when in deviantly arousing situations in public. Social skills training, similar to that in most other studies, was also given, as well as sex eduction, anger control and relaxation training. The participants also were volunteers, and were required to fulfil the clinicians' assessment of their desire to change, i.e. a certain amount of preselection occurred.

However, many more offenders filled the entry criteria for the program than could eventually complete it, so a natural group of offenders willing to change, but unable to complete the program for reasons beyond their own control, was formed. This group of 58 untreated offenders showed a recidivism rate (based on information not only from convictions, but also from care agencies and unofficial police records) of 34.5% over the follow-up period, compared to 13.2% for the 68 treated offenders over a similar period. Over a uniform four or more years follow up (with the sample of offenders somewhat decreased) the figures for untreated and treated offenders respectively were 60% and 25%. This study also showed incest offenders to be consistently less recidivist than child molesters.

Treatment Targetting and Offender Profiling:

The vast majority of existing studies do not distinguish between types of sex offenders when presenting their recidivism results. Given the considerable evidence that recidivism rates are different for different types of sex offender (for example Frisbie and Dondis 1965, Mohr, Turner and Jerry 1964, Sturgeon and Taylor 1980) this is a serious shortcoming and means that evaluation of treatment becomes problematic. Gibbens, Way and Soothill (1977) suggest that a small number of sex offenders, perhaps paedophiles and aggresive rapists, may be particularly recidivist. The Prison Reform Trust, in a recent report on the use of imprisonment for sex offenders, cite evidence from the USA, where it was found that 53 sex offenders had been responsible for almost 26,000 offences, which they had admitted to only after being offered an amnesty. Some had offended for 15 years before their first arrest. This suggests that effective targetting of offenders for treatment might produce good results even if only a small number of offenders were treated.

Consequently, in recent years there has been greater emphasis on trying to profile sex offenders, by studying their criminal histories, their motivations, the behavioural antecedents of their offences (drugs, drink problems, marital problems etc), their personality characteristics etc in order to provide individually tailored treatment regimes.

Thus for example Burgess et al (1986) and Prentky et al (1988) have explored the development of motivational types or classifications — eg compensatory, displaced aggression, sadistic, impulsive/opportunistic etc.

Research in Progress:

The Institute of Psychiatry is currently conducting several pieces of research along these lines. For example, Drs Grubin and Kennedy (research in progress) are carrying out a study of the characteristics of both sex offender and non sex offender prison populations in order to develop a more useful classification of sexual offenders which can be used for assessing treatment needs and treatment effects. Dr Grubin has also began a study of how rape offenders come to commit their offences, paying particular attention to their background, character, attitudes and motivations.

Dr Gillian Mezey is studying the characteristics, criminal histories and recidivism records of special hospital and lifer sex offender populations in order to see whether treatment can be more accurately targetted (some results may be available towards the end of 1990).

The Home Office Police Requirements Support Unit (in cooperation with the Directorate of Psychological Services) is also undertaking a pilot study of serial sex offenders in special hospital and prison settings with the aim of developing offender typologies which can be used to help the police in the investigation of serial offending.

Interviews and records will be used to gather information about their histories, personalities, social circumstances and lifestyles at time of the offence etc. and to look for patterns.

However, there are considerable limitations to the immediate usefulness of such offender typologies. Undestandably they tend to reflect the opinions and

theoretical standpoint of the particular clinicians and researchers who produce them, which makes them difficult for others to replicate and leads to poor inter-rater reliability. Thus there is a need for typologies which are not only specific enough for treatment targetting, but are also standardised and replicable enough for evaluative purposes.

Summary:

There are very few evaluations of the effectiveness of prison based treatment programmes for sex offenders. There is no firm evidence that any particular type, or combination of types, of treatment effectively reduces recidivism. However, this may reflect the methodological inadequacies of the studies as much as the inherent difficulties in being able to treat sex offenders. Most programmes include a variety of treatment techniques so that it is virtually impossible to determine whether one form of treatment is more effective than another.

As most treatment programmes require their subjects to be well motivated, few studies have been able to find a satisfactory control group. This has made it difficult to relate changes in behaviour to treatment rather than to individual differences in motivation for treatment between subjects.

There is ample evidence that recidivism rates are different for different types of sex offender, but few studies distinguish sufficiently between them in order to judge whether treatments are differentially effective.

The underreporting by victims of sex offences means that recidivism rates for sex offenders are frequently unreliable and provide an inadequate basis against which to judge the effectiveness of treatment. It also means that follow-up periods need to be unusually extended so that reoffending is more likely to be detected.

It follows that progress in treatment evaluation depends upon the development of better sampling techniques, more detailed and more reliable 'baseline' reconviction data for sex offenders of all kinds and more detailed and replicable (standard) offender typologies.

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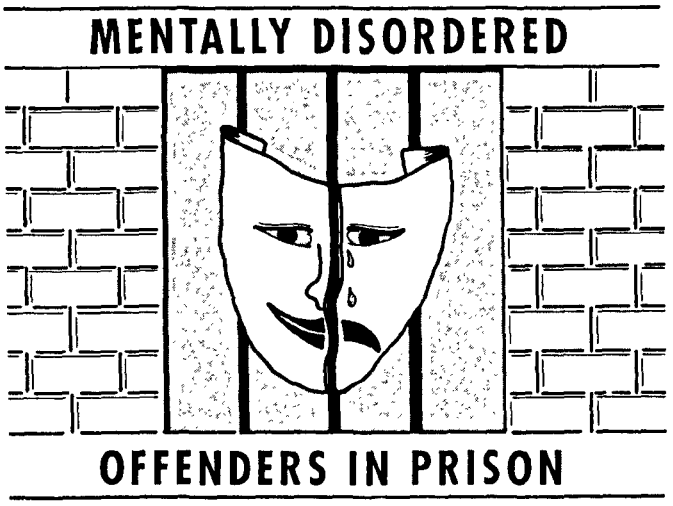


PERRIE LECTURE

The Mentally Disordered in Prison

'. . . we need a wide range of services particularly for those who are disabled by long term mental illness.'

Adrian Grounds, University Lecturer in Forensic Psychiatry, Institute of Criminology, University of Cambridge

Providing for mentally disordered people who commit minor offences is a problem. Psychiatric and social services do not want them because they are offenders and criminal justice agencies do not want them because they are mentally disordered. Nevertheless, many enter the prison system. My purpose is to sketch out an analysis of this state of affairs. First, some historical background will be outlined, secondly the current use and effectiveness of Mental Health Act powers will be examined, and thirdly some future prospects will be considered, particularly in the light of the proposed reforms of the National Health Service and the recent scrutiny of the Prison Medical Service (Department of Health 1989; Home Office 1990a).

Historical Background

One of the achievements of the 19th Century was the establishment of special institutions for 'criminal lunatics', separating insane prisoners from others (Walker and McCabe 1973). Despite the agreement that this was a desirable policy aim, from the start there were difficulties in implementing it. In the early 1800's a new wing for criminal lunatics was opened at the Bethlem Hospital, London, which took some of the most dangerous cases, but other insane prisoners were to be found in county asylums, private licenced madhouses and in local jails. The county asylums at that time had similar problems to those experienced in local hospitals today and places were scarce. Walker and McCabe (1973) note that the Inspectors of Prisons in 1835 reported that the surgeon at Newgate had 'complained of insane prisoners being placed in the infirmary until he was tired of saying more about it' (p.20).

During the 1850's as new, liberal ideas about treatment led to the abandonment of mechanical restraints in asylums, criminal lunatics were unwanted patients in these hospitals. The attitudes of some local asylum doctors towards the admission of offender patients in the late 19th century were not dissimilar to those of today. The report of the Criminal Lunacy Commission (1882) records in its minutes of evidence numerous interviews with asylum superintendents, of whom Dr Charles Medlicot, Superintendent of the Somersetshire County Lunatic Asylum in

Wells was typical. On 18 March, 1881, when questioned by the Commission, he justified his belief that criminal lunatics with homicidal tendencies should have no place in an asylum that aspired to function as a hospital:

'...we do not have the proper means of supervision, we do not have proper accommodation for them. We do not know in fact what to do with those cases; anxiety and responsibility is endless with a class like that, and the restraint that ought to be exercised in their cases is utterly incompatible with the liberty that we wish to give to others where we know that there is a possibility of restoration to reason' (para 1246).

'. . .I should think also to refer to one most important point as showing the function of a county asylum. The order for reception of a pauper patient refers to his detention but it also specifies that he is to be detained under "care and treatment" . . . Those words, I think, point to the arrangements to be made for the care and keeping of a patient when he is in a county asylum; as distinguished from those to be made for the reception of a criminal. I think those words are most important because they raise the whole tone of treatment respecting the lunatic (para 1249).

'. . . I do not think [a criminal lunatic] should be in the same institute. I feel strongly on this point, because I have found difficulties in working an institution like a hospital with this criminal element brought into it' (para 1250).

So argued an asylum doctor over a century ago. Some familiar themes can be recognised. There is reference to lack of appropriate security, anxiety about risk to others, and lack of treatability is used as an argument to justify exclusion from hospital.

From the mid-19th century onwards prisons were carrying out three functions in relation to the mentally disordered which continue to the present day (Walker and McCabe 1973). First there was an effort to achieve transfers of some insane inmates to asylum, using available legal powers. Secondly care and treatment was provided for those who had mental disorders but not of a severity to warrant transfer to hospital. Thirdly prison doctors carried out diagnostic work for criminal courts in relation to the mental state of the accused.

Pressure of numbers led to the introduction of legislation enabling the transfer to asylums of sentenced prisoners, and the first specific legal powers for this purpose were enacted in 1816, with other statutes following later in the century. The mentally disordered who did not warrant transfer to an asylum caused continuing problems and periodically during the 19th and early 20th centuries there were crises within the prisons because of large numbers of mentally disordered prisoners for whom there was not hospital provision. According to Walker and McCabe (1973):

'The transformation of prisoners into patients has never done more than relieve the jails of the obviously disordered. They have always had to cope with the residual problem of the prisoner whose degree of disorder, though marked enough to interfere with discipline and communication, is not sufficient to satisfy the psychiatric criteria of the day.' (p. 38).

As in the present day, concern about prisoners who required special care and surveillance led to some prison establishments becoming designated to specialise in the care of certain kinds of mentally disordered inmate. For example following the report of the Gladstone Committee of 1894-1895, Parkhurst became a prison for weak minded men and ten years later became an officially approved criminal lunatic asylum, using a specially adapted wing, for a temporary period of time until Rampton Hospital opened in 1912. Contemporary opinions that prison hospital wings should be designated as hospitals for the purpose of detention and treatment under the Mental Health Act are not new.

The role of prison doctors in the pre-trial diagnosis of defendants had become established by the end of the 1880's. By this time London courts had developed the practice of remanding in custody prisoners whose mental state required assessment and observation, and this became increasingly popular despite the fact that the Prison Commissioners initially disapproved of the practice and regarded it as indicating a failure by magistrates to commit the people concerned to asylums. There are similar concerns now about the failure of the courts to remand the mentally disordered to hospital instead of to prison custody for assessment (Home Office 1990b).

The asylums were subjected not only to external criticism from prisons, but they also had to meet internal demands to justify their functions and cost effectiveness. One of the lesser known chapters of Broadmoor's history involved a scrutiny which took place in 1876, 12 years after the institution opened. A Committee of Inquiry chaired by Sir William Hayter was convened because of concern about the expense of maintaining the Asylum, and the Committee was required to report: *'. . . on the existing state of that establishment, both in respect of its cost as a lunatic asylum, and of the expenditure required to put the building into proper condition, and maintain it; to consider whether any arrangement could be made by which the expense of maintaining such an establishment could be reduced, by retaining the existing buildings and site, or any alteration thereof, or by the present site and removal elsewhere, or otherwise; and to submit... an approximate estimate of the probable*

cost of any alteration that may appear to be advisable; together with a general report on the whole subject' (Broadmoor Criminal Lunatic Asylum Commission 1877, p.2).

Eventually Sir William Hayter's report concluded that the costs of Broadmoor were satisfactory and removal to another locality would involve 'greatly increased expenditure without any adequate result and no economy in its working would be attained' (op.cit. p.23). There were however two dissenting members of the Committee who took a different view. One argued, '... that it would be wise for Government to sell Broadmoor even should they do so at a great sacrifice. The site would of course sell at a very large profit...and should such a course be adopted there is much to be said in favour of not replacing it but instead adding lunatic wards to convict prisons (op.cit. p. 26).

The second dissenting member, Dr F J Mouat, reached a similar conclusion but argued on penological and clinical grounds for an integration between the prison and medical systems: '...It then becomes a question whether it is not right in principle, and would be successful in practice to consider lunacy associated with crime as an integral branch of the general prison administration of the country, and not as a special branch of insanity needing exceptional treatment in separate institutions.

'. . . I believe the principle of the best means of treating those who were termed criminal lunatics to be of greater importance than a mere saving of money. This, it seems to me, can be most humanely, economically, and completely accomplished by dealing with their safe custody and management as a branch of the general prison administration of the county, and by addition of lunatic wards to carefully selected prisons' (op.cit. pp 34 & 36).

The purpose of this initial excursion into some by-ways of history is to illustrate that the themes which dominate contemporary discussions are not recent in origin. Debates about controlling public sector costs; the relative merits of providing medical care for the mentally disordered inside or outside the prison system; suitability of local facilities and issues of treatability; these are not new problems brought about by the advent of community care, but have deeper and more pervasive historical roots.

Current Provisions

Against this background current practice in relation to mentally disordered prisoners and their transfer from prison into NHS psychiatric care will be examined. First some of the main legal and service provisions will be summarised and then their use and effectiveness will be considered.

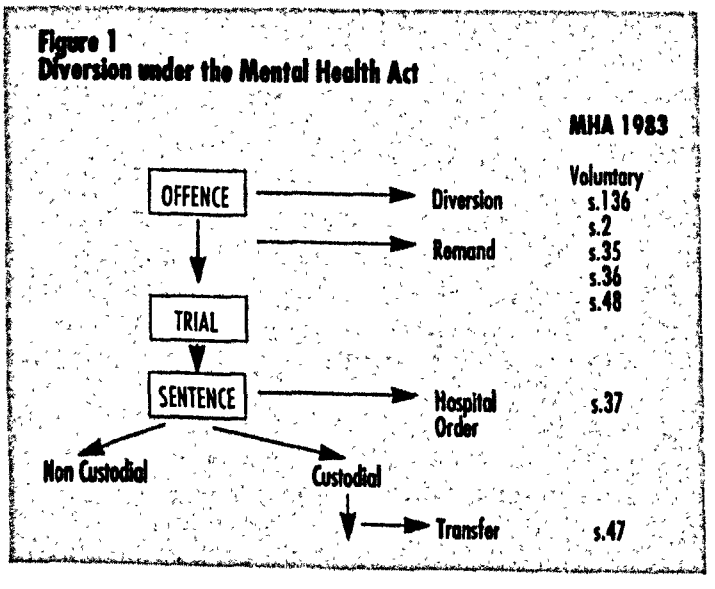
Legal Avenues

As indicated in figure 1, there is no shortage of legal avenues for transferring mentally disordered offenders or defendants into medical care and powers are available at all stages of the criminal justice process. For example, the police have powers to take a mentally disordered person in a public place to a place of safety such as a hospital under s.136 of the Mental Health Act 1983. Alternatively, a psychiatric assessment may be sought with a view to voluntary admission to a hospital or compulsory admission under civil powers. If a mentally disordered person is charged, courts have the power to remand to hospital for assessment (under s.35) or for treatment (s.36) as an alternative to remanding in custody. Remanded mentally ill prisoners who need urgent transfer to psychiatric hospital for treatment may be moved under s.48 of the Mental Health Act. At sentencing stage a hospital order (s.37) may be made as an alternative to a prison sentence. Finally, sentenced prisoners, who become mentally disordered and who require treatment in hospital can be transferred under s.47 of the Mental Health Act.

NHS Hospital Provision

The framework of hospital provision currently available is indicated in figure 2 and broadly this provides three levels of security. The maximum security hospitals together provide about 1800 beds for detained patients requiring treatment in condi-

Figure 1
Diversion under the Mental Health Act

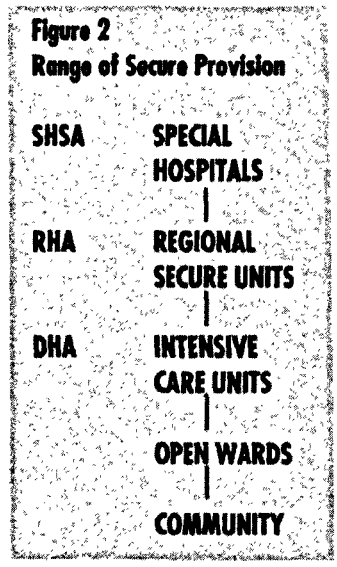


tions of maximum security. Regional Secure Units (RSU's), which have developed in the last 15 years in response to the recommendations of the interim report of the Butler Committee (Home Office, Department of Health and Social Security 1974), provide a medium level of security. These units currently have a total of about 650 beds, a level which falls far short of the 2000 initially recommended by the Butler report. RSU's tend to have strict admission criteria only taking patients who require this level of security and who will need admission for no longer than 18 month or so.

District health authorities have about 63,000 adult mental illness beds in local psychiatric hospitals and units. Here there is a very patchy availability of locked ward accommodation. In 1986 there were about 900 such beds, ie approximately 5 per district health authority and 800 beds in mental handicap hospitals. Some districts have no local locked ward provision. In my own Regional Health Authority, East Anglia, which serves 2 million people, there are currently only 4 such beds in one of the eight health districts. The number of locked beds at local level in mental handicapped hospitals has fallen from about 13,000, 15 years ago to about 2000 now (Reed, 1991).

This is a current snapshot of hospital provision, but it needs to be seen in a broader context of change. There has been a major and continuing shift in the pattern of general psychiatric services with a move away from the use of large institutional settings and towards the development of community based facilities. From the 1930's onwards models of psychiatric practice moved closer to those of general medicine, methods of treatment became more successful and aftercare services expanded. Since the 1950's the number of beds in psychiatric hospitals in England and Wales has fallen by more than half.

Figure 2
Range of Secure Provision



Perimeter walls and railings and bars at windows were taken down, wards were unlocked and hospitals became geared to short term admissions. There were many merits in these changes. But the optimism of the 1960's gave way to questioning about the extent to which all the functions of the traditional mental hospital could be replicated in the community. Where available, new services could provide shelter and support but the functions of control and custody were less likely to be provided and patients requiring them could be excluded (Bennett and Morris 1983).

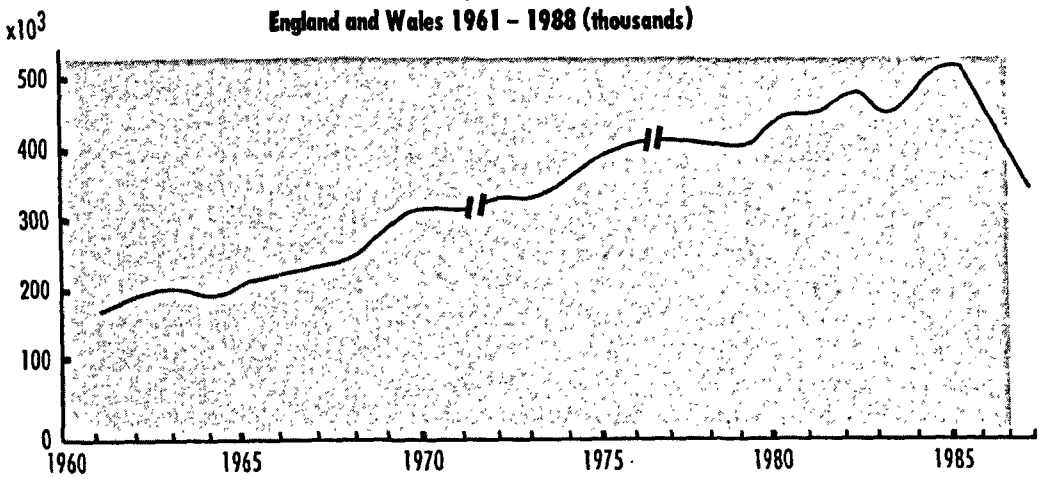
There is now a more general recognition that we need a mixed range of services, particularly for those who are disabled by long term mental illness.

There are two other general points to make about this change. First, although psychiatry has become increasingly community orientated, the structure of mental health legislation has remained hospital orientated, consisting essentially of a series of powers to detain in hospital. There is an increasing disjunction between the locus of legal provision and there is a need to consider for the future the possibilities of community based legal powers. Secondly, there has been a change in the nature of the social criticism of psychiatry. No longer are psychiatrists criticised in the media for the exercise of too much authority and the imposition of custody. Concern now is much more likely to be based on a perceived failure of psychiatry to meet public expectations of containment and social control.

These broad changes in the pattern of psychiatric services have had important consequences. Bowden (1975) examined hospital provision in one regional health authority in the south of England and demonstrated a relationship between the number of available beds and the likelihood of patients being admitted under the Mental Health Act on court orders. A large hospital with a locked ward took proportionally more such patients than a large hospital without a locked ward and admissions were also related to the total number of beds in the hospital. Thus a reduction in overall beds and the loss of locked ward provision led to fewer admissions of mentally disordered offenders under the Mental Health Act. Bowden quoted Douglas Bennett's warning against the wholesale acceptance of an open door policy in mental hospitals, which could result in the rejection of undesirable patients so that staff with the most skill and training could concentrate on treating the least disabled.

Bowden's findings are consistent with the picture that emerges from available official statistics. Figure three shows the total number of people convicted of indictable offences between 1961 and 1988. Overall, the number has approximately doubled over the time period. This population is approximately equivalent to that from

Figure 3
Persons Found Guilty of Indictable Offences
England and Wales 1961 - 1988 (thousands)



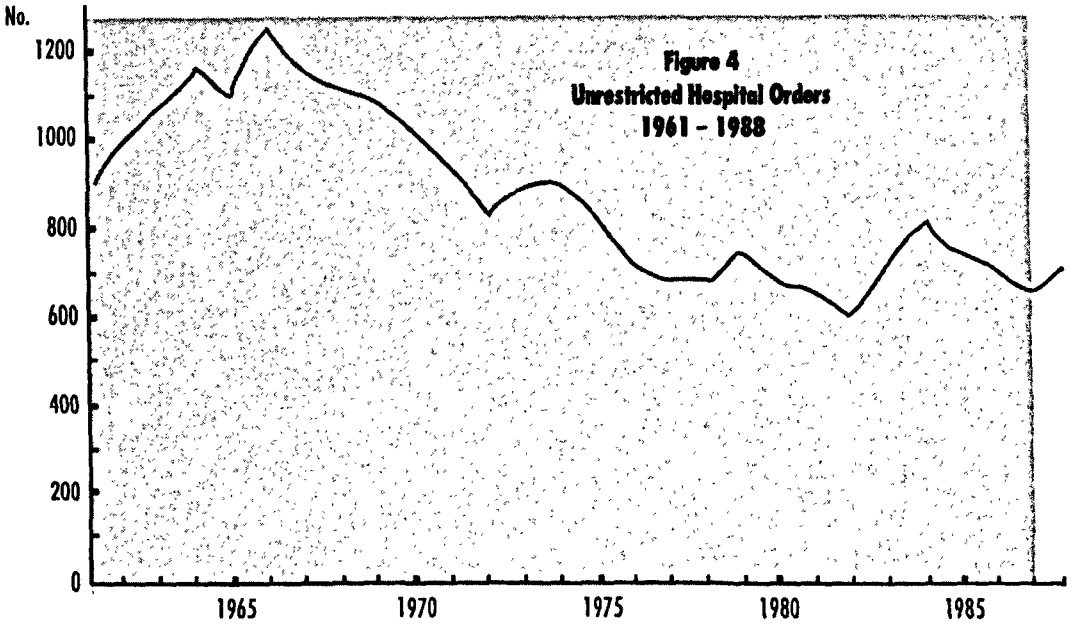


Figure 4
Unrestricted Hospital Orders
1961 - 1988

which those sentenced by hospital orders are drawn. However, the pattern of use of hospital orders has gone in the opposite direction (figure 4). Between the early 1960's and the early 1970's the proportion of those convicted of indictable offences who were sentenced by means of hospital orders fell by 40% (Robertson, 1984). The main group contributing to this decline was the mentally handicapped.

In order to examine current practice in detail I will move backwards rather than forwards through the criminal justice process, first focussing on the mentally disordered in the sentenced prison population, secondly, looking at those on remand and thirdly looking at the possibilities of diversion at an early stage with a view to avoiding the use of prison custody.

Sentenced Prisoners

Professor John Gunn and colleagues at the Institute of Psychiatry have carried out a Home Office funded study of the prevalence of psychiatric disorder in a representative sample of the sentenced prison population.

Publication of the report is currently awaited, but if advance newspaper reports are to be believed it may be that 2% of sentenced men and 1% of sentenced women suffer from psychotic illnesses. Those with diagnoses of alcohol or drug abuse form by far the largest group, approximately 20% of sentenced men and 30% of sentenced women. The implications of such findings for service provision are not yet clear, but it is conceivable that the results will indicate a need for more NHS beds, particularly providing long term medium security

(Gunn 1990).

The Mental Health Act has specific powers to enable sentenced prisoners who require treatment for mental disorder to be transferred to hospital under s.47 of the Act. (previously s.72 of the 1959 Mental Health Act). In some respects the pattern of use of this power has been similar to the pattern for hospital orders. Figure 5 shows the gradual increase in the average total sentenced prison population between 1960 and 1989 from approximately 25,000 to approximately 38,000. In contrast the number of transfers to hospitals of sentenced prisoners declined sharply until the mid-1970's after which there was some recovery (figure 6). It is probable that the provision is under used.

However, there is also evidence that these transfer powers can be used in undesirable ways. When I worked at Broadmoor Hospital a few years ago there was much concern about transferred sentence prisoners being admitted at a late stage of sentence. An examination of the cohort of cases (N-380) admitted to Broadmoor between 1960 and 1983 under the 1959 Mental Health Act showed a remarkable change over that time period. Table 1 shows the proportion of sentence served at the time of transfer to Broadmoor. Between the early 1960's and the early 1980's the proportion of patients being transferred during the last half of sentence steadily increased. In the early

Figure 5
Average Population in Prison Custody
1960 - 1989

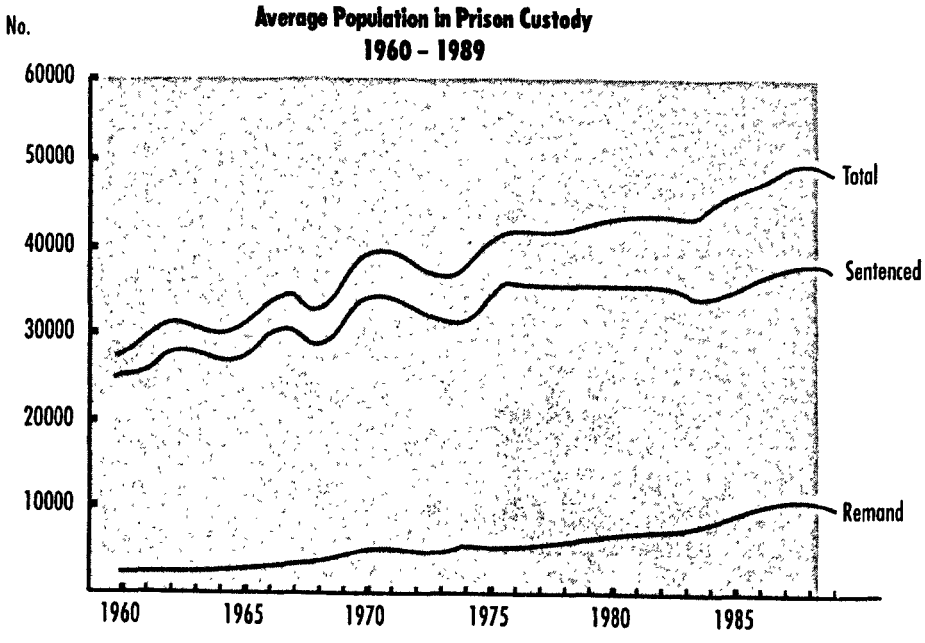
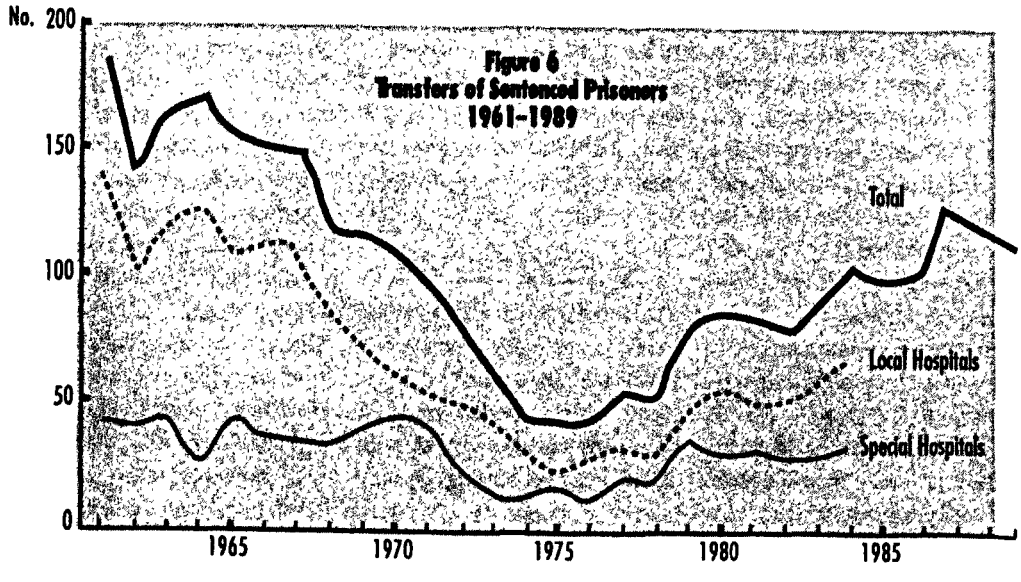


Figure 6
Transfers of Sentenced Prisoners
1961-1989



years admission tended to occur at the initial stage of sentence but in the late 1970's and early 1980's it occurred at a late stage. During the last decade a third of the prisoners serving fixed sentences were transferred within a month of EDR (earliest date of release) and a third of these were admitted during the last week of sentence. Detention beyond the expiry of sentence became the norm. Various factors contributed to this change, the most important of which was the use of a waiting list for these admissions introduced because of the hospital's overcrowding (Grounds 1991)

The purpose of this legislation is to enable psychiatric treatment during sentence, not to keep people in preventive detention beyond sentence, but there are insufficient legal safeguards to prevent the Mental Health Act being used in this way. What this means to the individual concerned can easily be imagined. The first patient I saw on admission to Broadmoor was a man who had been transferred from prison two weeks before his EDR at the end of a 4½ year sentence. The medical recommendations for transfer had been signed over a year before. Efforts to arrange local psychiatric aftercare had failed because of fear of the patient in the local psychiatric services. On admission to Broadmoor he recounted how that morning he had been told at the prison to pack because he was going on a 'day trip'. He assumed he was to be transferred to a prison nearer his home area prior to release. Only when the van was passing through Reading did it dawn on him for the first time that he was going to Broadmoor. He was still an inpatient four years later. This is an area of mental health law which requires reform (Grounds 1990).

Table 1
Transfers of Mentally Disordered Prisoners to Broadmoor Hospital 1961-83: Timing of Admission

Year of admission	Proportion of total sentence (to LDR) served at time of admission to Broadmoor		
	0-25%	26-50%	over 50%
1961-65 (n=97)	35%	43%	22%
1966-70 (n=93)	34%	33%	32%
1971-75 (n=46)	17%	30%	52%
1976-83 (n=37)	3%	22%	76%

chi^2=41.8
df=8
p<0.001

Remand Prisoners

There has not been a study of a representative sample of the remand prison population to determine rates of psychiatric disorder, but it is likely that mental disorder is much more common amongst prisoners on remand than in the sentenced population. Taylor and Gunn (1984) examined a sample of men remanded to Brixton and found that 6% suffered from schizophrenia and a further 3% from other forms of psychosis. The rate for schizophrenia was about 15 times higher than would have been expected in the general population.

The practice of remanding mentally disordered people to prison causes great concern (Coid 1988a; 1988b). At present, colleagues in the Institute of Criminology and the Institute of Psychiatry are involved in a Home Office funded research project in which we are following up samples of mentally disordered men and women remanded to Brixton, Holloway and Risley. The process and outcome of referrals to the Health Service are being examined together with the decisions of the sentencing courts. It is hoped that the results of the study will help elucidate the problem of inappropriate remands and the difficulties in securing psychiatric care in the Health Service.

One issue that must be critically examined is the practice of remanding in custody for psychiatric reports and it has to be questioned, as indeed the Prison Commissioners did in the 19th Century, whether the practice is justifiable in principle, particularly for individuals charged with trivial offences. In 1984 new powers were introduced to avoid remands in prison custody. The remand to hospital provisions of the 1983 Mental Health Act became available, because, in the words of the Minister in the House of Commons, 'the Government did not wish the courts to have to send sick people to prison' (Hansard, Written Answer 23 October 1984). To what extent has this intention been achieved?

At first sight there appears to have been an impressive increase in the use of these new provisions (figure 7). The top line on the figure shows the number of remands for assessment under s.35 which amounted to 304 in 1989. Similarly there has been a rise in the number of unsentenced prisoners transferred to hospital for urgent treatment (s.48). However, when compared with remands in prison custody for medical reports the number remanded to hospital remains very small (figure 8). Although there has been a decline , reports on those remanded in custody are still in the order of 6000 annually

(Ward 1990).

The remand to hospital provisions have not worked as an alternative to custody. Indeed in many cases a remand to hospital is only recommended after an initial period in prison custody. In its evidence to the House of Commons Social Services Committee on the Prison Medical Service (1986), the Prison Medical Association argued that the remand to hospital provisions should not be used until the person had had a prior period of assessment in the safe setting of the remand prison, an opinion which directly undermined the intention of the powers (Minute of Evidence, p.32).

Figure 7
Unsentenced Defendants Transferred to Hospital
1961-1988

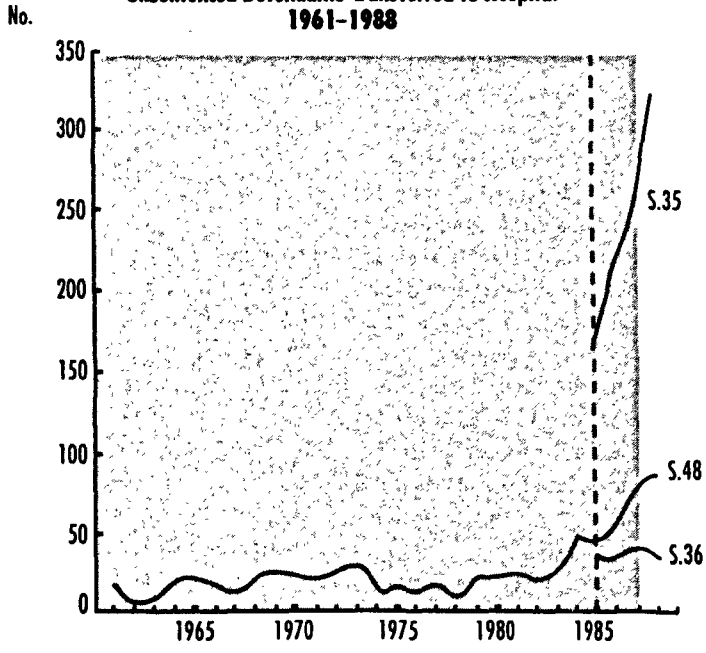
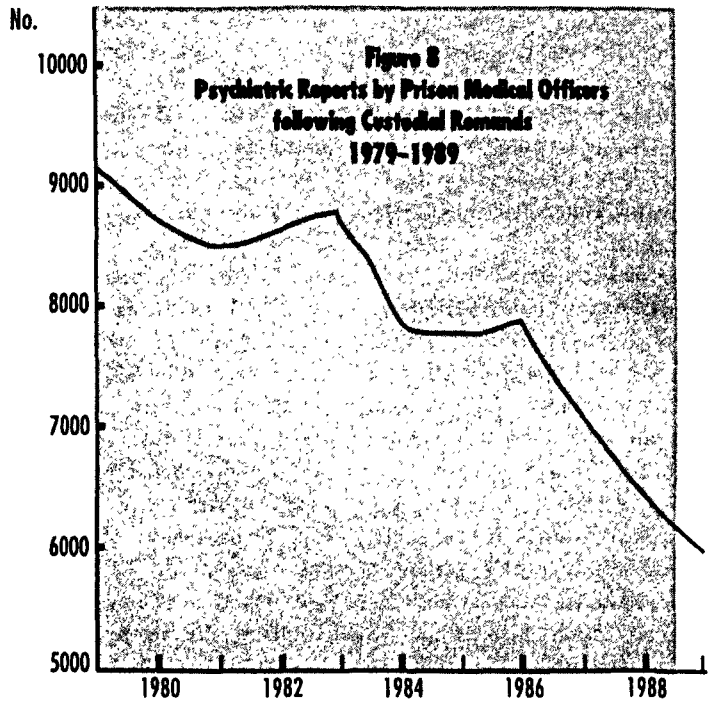


Figure 8
Psychiatric Reports by Prison Medical Officers following Custodial Remands
1979-1989



Future Possibilities

What further steps might be taken to reduce the number of mentally disordered people in the prison population?

First it is necessary to set policy objectives that are realistic and that are matched by the means to achieve them. The broad policy aim of securing the diversion of the mentally disordered in prison has a long history of failure and will not be achieved solely by means of further exhortation and encouragement expressed in the recent Home Office circular on mentally disordered offenders (Home Office 1990b).

Incentives to remand in custody rather than to hospital for psychiatric assessment remain; the former is easier for courts, cheaper for health authorities and may also suit the interests of prison doctors. If the policy of diversion is to succeed, radical steps may have to be considered to reverse these incentives, for example, curtailing the powers of courts to remand in custody for medical reports and developing mechanisms to ensure that financial responsibilities of health authorities do not cease on entry to prison.There also needs to be consensus about the categories of mentally disordered people who should be diverted from prison and about what will be done to meet the needs of those who are not diverted.

Monitoring and investigation of the experience of people from ethnic minorities is particularly important. Recent statistics from the Home Office Research and Statistics Department (Ward 1990) indicate that 23% of the 252 sentenced prisoners transferred to hospital under s47 of the Mental Health Act in 1987 and 1989 were from ethnic minorities compared with a proportion of 14-15% in the general prison population. Afro-Caribbean men are also over represented amongst patients detained under Part 3 of the Mental Health Act in locked wards and secure hospitals (Cope 1990). Further critical enquiry and research in this area is required, together with ethnic monitoring in statistics measuring the use of health services.

Service Needs

In the hospital sector two particular gaps in the range of provision ought to be filled. First there is a need for long term medium secure beds and secondly, high quality locked ward provision at local level (O'Grady 1990). There will always be boundary disputes between hospital units with different levels of security and there is a necessary tension between the referral pressure to move patients who are difficult to manage to greater levels of security and the gate keeping pressure to keep out those who do not require the level of security in question and to ensure that the environment of care is the least restrictive alternative. However, these tensions become severe when there are major lacunae in the range of facilities (figure 9), and ill people fall through the holes in the safety net.

In the local psychiatric services it is necessary to recognise the cycles that lead to exclusion of 'difficult to manage' and unpopular patients. When there is no provision referrals will cease but this should not lead to the conclusion that there is no case of need. The cycles need to be broken by acting on the need services and by ensuring staff experience and training.

In the community desirable developments include bail and residential hostels specialising in the care of mentally disordered offenders. Attention to the training and support of staff in such facilities is also required.

Liaison With Criminal Justice Agencies

Successful diversion at an early stage in the criminal justice process will partly depend on the extent to which psychiatric services are able to provide a quick service to the police and local courts when mental disorder is recognised in a suspect or defendant (Joseph and Potter 1990). Liaison and joint planning arrangements at local level should be established between psychiatric services and local criminal justice agencies and such arrangements should primarily involve general psychiatrists rather than forensic psychiatrists.

Forensic psychiatry services tend to deal with the minority of patients who have committed grave offences and who require treatment in conditions of maximum security. Most mental disordered offenders have committed minor offences and do not require the facilities of regional secure units or special hospitals. In any event the speciality of forensic psychiatry is numerically too small to serve all local criminal justice agencies and it is unlikely that the regional services on their own can meet the psychiatric needs of the prison population, despite the suggestion by the Chief Inspector of Prisons in his 1989 report that " . . . regular routine involvement of Forensic Psychiatrists with all inmates should be the norm" (Home Office 1990c, para. 4.39). Currently in England and Wales there are about 60 consultant forensic psychiatrists working from about 20 hospital bases. In some areas (Wales for example) prisons are distant from these centres and the sheer number of prison establishments makes the above recommendation unrealistic. If the other criminal justice agencies are to be added to the list, it has to be recalled that there are approximately 580 magistrates courts and 1200 probation officers in England and Wales together with about 8000 police stations in Britain as a whole. There are formidable problems of scale. Forensic psychiatrists may give a lead but cannot provide a uniform ser-

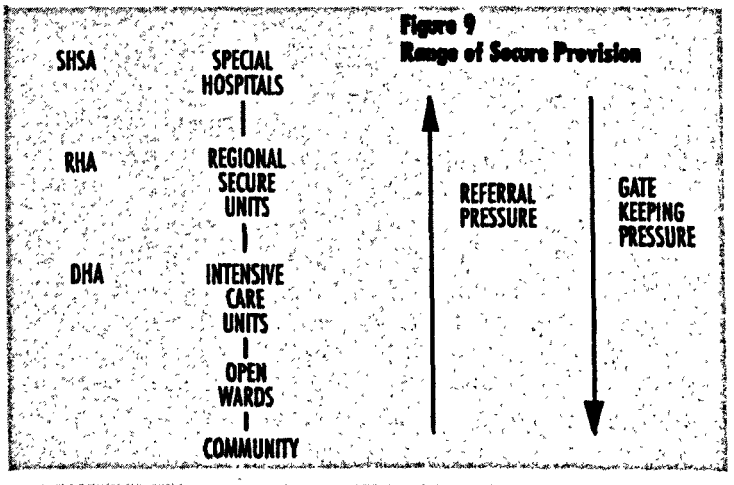


Figure 9
Range of Secure Provision

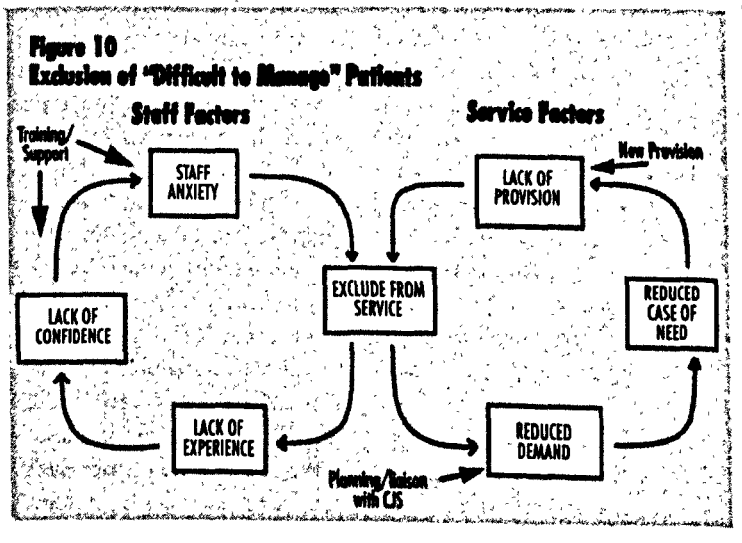


Figure 10
Exclusion of "Difficult to Manage" Patients

vice to all local agencies.

General psychiatric services already have established joint planning teams and liaison with other health and social agencies including general practitioners, social services, housing departments and other medical specialities (figure 11). Psychiatric services provide a same day referral service for GP's and others referring urgent cases. Similar structures need to be established with local criminal justice agencies with appropriate liason and joint planning, so that problems and areas of need can be defined and better services developed.

may have a disadvantageous effect on services for stigmatised, unpopular groups such as mentally disordered offenders. In a recent interview (Smith 1990) the Chief Executive of the National Health Service Management Executive illustrated this approach with reference to long waiting lists:

"I made it a priority because the public does . . . above all . . . they criticise the time they wait for the first outpatient consultation and the long waits for operations. That's what the public is telling us and we must respond" (p.857).

Primary care should be obtained from GP's and hospital officers should be replaced by nurses.

These recommendations raise a number of questions, quite apart from the anxiety they may cause to prison doctors and hospital officers. (On this particular point King and McDermott in the Perrie lectures last year, made the prophetic comment that "the most important task for the Prison Service is to make up its mind whether its staff should be regarded as the problem or the solution to the problem" (King 1989, p.12).

The scrutiny report fails

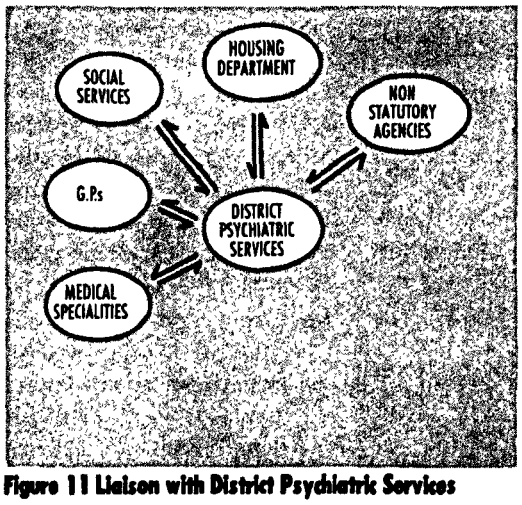


Figure 11 Liaison with District Psychiatric Services

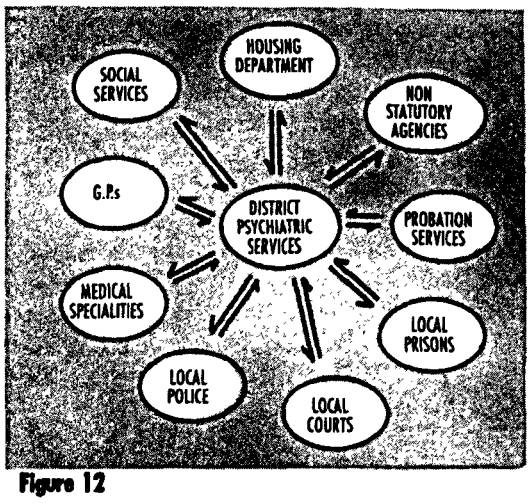


Figure 12

Reforms Of The Health Service And The Prison Medical Service

There are two clouds on the horizon of this idealistic scene. The first is the current reform of the National Health Service and the second is the scrutiny of the Prison Medical Service (Department of Health 1989; Home Office 1990a).

Under the National Health Service reforms regional secure units face an uncertain future, particularly if they have to enter into contracts with individual purchasing district health authorities to provide inpatient services. The principle that priorities in the allocation of scarce resources should be responsive to the concerns of the public has general merit, but

In addition, the message about resources was blunt. ". . . a management framework . . . Management should deliver a more uniformly efficient service that is more responsive to the needs of the patient, and that does not depend on any particular level of resource" (p.857).

The second recent development is the scrutiny of the Prison Medical Service Home Office (1990a). Consistent with the approach that has become pervasive throughout the public sector, the scrutiny recommends a separation between the purchaser and provider of services. The function of the Prison Medical Service should be the purchase of clinical services through contracts with health authorities, family practioner committees and others.

properly to explore the feasibility of its central proposals. Bodies such as regional and district health authorities, the National Association of Health authorities and trusts, health service managers and their representatives, do not appear in the list of those consulted by the scrutiny team. This is extraordinary in a report with a central recommendation that contracts should be made with them. Secondly, despite terms of reference which include making proposals to increase the value for money, the report does not have costings for buying in specialist medical services. Experiences of contracting out medical services in the United States suggests that purchasing services from the private sector can lead to an increase in overall

costs (Ryan and Ward 1989). Thirdly, a number of administrative questions are not addressed. Is there the willingness and the manpower in the Health Service to take on this work? How would contracts fit with the principle of districts being responsible for their local populations. My nearest local prison, Bedford, takes receptions from a wide geographical area which includes at least eight district health authorities within four different regional health authorities. Are contracts to be established with all or only with a local service. If the latter option is chosen, will that authority cross charge for patients whose home areas are in other districts? The idea of money following the patient means in practice billing the health authority following the doctor's visit. Fourthly, there is the need to consider the implications for clinical practice. Providing a psychiatric service is not just a matter of individual reports and prescriptions. Treatment and clinical responsibility are not so easily packaged. For example, if a prisoner with schizophrenia is to be treated according to the standards which might apply in the health service, this will involve not just medication but attention to the person's entire environment of social relationships, occupational activities and day care, with the aim of helping the individual maintain the best possible level of functioning and independence. Treatment involves manipulating the environment. To what extent will this be possible within the prison context? If standards have to be compromised to an unacceptable degree, who will wish to do the work?

Feasibility studies are required to examine these issues and it is questionable whether the target date due to establishing contracts by April 1992 is reasonable.

Finally, the scrutiny report does not recommend any independent, external monitoring of medical care in prisons. this would have been a proper response to the team's concern about the 'lowest esteem' (para 1.6) with which the service is regarded and to the concern of the Chief Inspector of Prisons who made many criticisms of prison doctors in his annual report for 1989 (Home Office 1990c). It would also have been a proper response to public anxiety about legal cases such as that of *Knight V The Home Office* (Law report, the Independent 24/1/90). Knight was a 21 year old mentally disordered man who hung himself in Brixton in 1982. The judgement in his case concluded that standards of medical care in prison could not be expected to match those in a psychiatric hospital. Organisations with the appropriate expertise such as the Mental Health Act Commission and the Hospital Advisory Service should have their remits extended to include prisons. Perhaps, however, there is concern about the resource implications that would follow if such bodies reported unacceptable standards, falling below, for example those advised in the Department of Health's Code of Practice for the Mental Health Act (Department of Health and Welsh Office 1990).

There is a last, more general, point to make. We should guard against medical care and welfare being reduced to commodities that can be bought and sold. The concept of welfare is more complex and important. Michael Ignatieff's book 'The Needs of Strangers' develops this theme: *"My responsibilities towards them are mediated through a vast division of labour. In my name a social worker climbs the stairs to their room and makes sure they are as warm and as clean as they can be persuaded to be. When they get too old to go out, a volunteer will bring them a hot meal, make up their beds, and if the volunteer is a compassionate person, listen to their whispering streams of memories. When they can't go on, an ambulance will take them to hospital, and when they die, a nurse will be there to listen to the ebbing of their breath. It is this solidarity among strangers, this transformation through the division of labour, of needs into rights and rights into care that gives us whatever fragile basis we have for saying that we live in a moral community".*

(Ignatieff 1984 p.10)

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Prisons and Special Hospitals: Custodial Care

" . . . out of their rooms all day, including the evening and have to ask permission to stay in their rooms!"

Miss Joy Kinsley, OBE. Head of Personnel and Director of Home Office Liaison Special Hospitals Service Authority, formerly Governor of HMP Brixton and HMP Holloway.

For many years I have had a deep and abiding interest in mentally disordered offenders. For me, therefore, the change from the Prisons to the Special Hospitals was a natural one. It seemed to bring so much of my experience both inside and outside the Prison Service together. It has been said that the Special Hospitals stand at the junction between the Criminal Justice System, the Prison Service and the National Health Service. Like the Prisons, the 'Specials' work at the outer limits of human behaviour.

Broadmoor was the first hospital to be built in 1863, followed by Rampton in 1910. Moss Side was acquired after the First World War and Park Lane was built as a modern secure hospital in 1974. It is reminiscent of Prison Department buildings of that decade. They were generally managed by the Home Office until the years after the Second World War, when their control passed to the Department of Health in the interests of ensuring progressive psychiatric treatment.

Under the National Health Service Act 1977, Section 4, the Secretary of State for Health was charged with the duty: *'to provide and maintain establishments (in the Act referred to as Special Hospitals) for persons subject to detention under the Mental Health Act 1959 (subsequently MHA 1983) who, in his opinion, require treatment under conditions of Special Security on account of their dangerous, violent or criminal propensities'*

A departmental Special Hospitals Service Board carried out the functions of the Secretary of State under the Act.

Special Hospitals Service Authority

During the eighties it became increasingly clear that there were difficulties in this system and that the Special Hospitals needed to move nearer to the norms and standards of the NHS. There were those who thought (and still do) that nothing less than total integration would do. However that stance does not give sufficient consideration to the special security needs of the hospitals and is not sufficiently sensitive to the role of the Home Secretary. The majority of patients are there by order of the courts, many of them on Restriction Orders, and they cannot be released without the approval of the Home Secretary. This duality is at the heart of the 'specialness'. Nevertheless it was clear that modern methods of hospital management must be made available to the service and on 1 October last year the Special Hospitals Service Authority came into being.

The SHSA can really be described as the first of the new style Health Authorities formed under the Government's new legislation and described in the White Paper 'Working for Patients'. It has a Chairman, who is a former business manager, four non-executive members, a

Chief Executive, who was a former District General Manager and Heads of Medical Services, Nursing and Finance. As Head of Personnel I work directly to the Chief Executive. Each Hospital is managed by a Unit General Manager, supported by a management team which reflects the centre to a larger extent. The impact of the new arrangements is to bring NHS General Management styles and initiatives to the Special Hospital Service. It is perhaps worth stating the Government's aims for the Service which we are mandated to carry out and have to account for.

* To ensure the continuing safety of the public.
* To ensure the provision of appropriate treatment for patients.
* To ensure a good quality of life for patients and staff.
* To develop the hospitals as centres of excellence for the training of staff of all disciplines in forensic and other branches of psychiatry, psychiatric care and treatment.
* To develop closer links with the NHS local and regional psychiatric services.
* To promote research into fields which are related to forensic psychiatry.

Although the Special Hospitals all worked directly to the Department of Health, they were really quite independent. The SHSA has to achieve consistency, progress and common standards whilst at the same time ensuring that responsibilities for the operations and delivery of service is at local level. Like many prisons, the Special Hospitals have been around a long time and have seen many changes and fashions. They are places of solid traditions, suspicious of change — sometimes with justification. Often generations from the same family have worked in the hospitals. New ways do not always come easily and the new Authority has a lot to achieve in a short time.

Managing Change

The first and fundamental change for the staff was the loss of Civil Service Status. As employees of the Department of Health they had been Civil Servants, although the nurses pay and conditions of service were and still are decided by the Nurses and Midwives General Whitley Council. For historical reasons dating back to the Home Office days, most of the nurses, ancillary and occupations staff belong to the Prison Officers Association. Having successfully achieved the change of status, we are now faced with having to work through inevitable changes to a whole range of policies and agreements.

It has to be said, many of the changes are long overdue. In the Civil Service most agreements are negotiated centrally and local issues militate to the centre for resolution all too easily. The style in the NHS, which we have adopted is that only issues which affect all the hospitals will be dealt with centrally, all other matters should be dealt with and resolved locally. To this end Directors of Personnel have been appointed in each of the Hospitals. This is a much more considerable change than at first appears and does mean that the hospitals can manage their personnel affairs with a large degree of autonomy.

Like prison officers, hospital staff are conscious of the security responsibilities placed upon them. The 'protection of the public' is a very real thing to them. This has to be reconciled with the modern and progressive methods of treatment. It is difficult enough for the nurses in our hospitals to achieve this balance, but since joining the SHSA I have become even more conscious of the very difficult task the Prison Service requires of its hospital staff. Any governor must be conscious of the conflicts and balance between treatment and containment, but being continually at the 'sharp end' of the conflict must be exceptionally difficult.

The 'through-put' of patients is small. These really are long-stay hospitals and in this respect can only be compared to the most long-term of Prison establishments. Even the dispersal prisons have a quicker change over than the Special Hospitals — and by a long way! The need for a balanced and humane regime is therefore very important. The integration of male and female staff is probably less advanced at the moment than in the Prison Service, but there is already some integration of male and female patients. It is part of an attempt to normalise life as far as is practicable. Both these initiatives are proving successful and will be further developed.

One of the most difficult of our tasks is the requirement to amalgamate Moss Side and Park Lane Hospitals which are on adjacent sites. These are two institutions with differing traditions and separate staffs. Moss Side is an old hospital which tended to specialise in the treatment of the mentally handicapped. It is like many hospitals of its type and has similar rather paternalistic traditions. Park Lane is a modern hospital with a prison wall round it, which tended to deal with acute mental illness and psychopathy. There is a central administration block in what was once a Nurses home. There are many good reasons to run the two units as one and the SHSA duly appointed one Unit General Manager and the process was begun. Following consultation with staff and patients the new hospital has been called Ashworth. Recent redevelopment plans have been published for consul-

tation. We are trying to create a modern and viable unit which can truly become a centre of forensic psychiatric excellence. The visions are there, but the staff are understandably ambivalent about such fundamental change.

The SHSA, therefore, now manages three hospitals. Ashworth, Broadmoor and Rampton. We employ 3,200 staff, doctors, nurses, remedial professions of ancillary staff. One pleasing factor I have found is that Occupational Health Services are developed on each site. This is an area that I found myself unable to develop in the Prison Service.

Our Patients

The SHSA cares for about 1400 male and 300 female patients — all of whom are either mentally ill or mentally impaired or psychopathic. An important factor, not always appreciated, is that their underlying clinical condition must be susceptible to treatment and rehabilitation to the same degree as that of patients with similar conditions cared for within the NHS. This important point can be the cause of misunderstanding between prison and hospital staff over potential admissions. The difference between our patients and those in general psychiatric hospitals is, of course, that they have all been assessed at some time as displaying 'dangerous, violent or criminal propensities' to the extent that they are a risk to the public safety or that of other patients. The criterion used by the admission panels is that of 'presenting grave or immediate dangers'. These factors are the justification for the enhanced security which goes beyond that of any other hospital in the NHS. In 1988 62% of our patients were suffering from Mental Illness, 25% were handicapped and 4% were severely mentally handicapped. There has been a reduction in the number of mentally handicapped patients and in the number of psychopaths admitted in recent years. The SHSA intends to review the treatment of psychopaths in the light of the most recent knowledge.

The ever present need for security has tended to dominate the public's view of the hospitals and this together with the 'notoriety' factor has sometimes made it difficult to keep up with modern concepts of psychiatric care and treatment. As far as prisons are concerned it seems to me that there has never been any doubt that their primary objective is to keep in custody those people sent to them by the courts. After that there can and must be a variety of humane objectives, but the main function of the prison service must be to carry out the sentence of the court. With the Special Hospitals, it is more difficult. Our patients are often highly dangerous and the ones the public least wants to see escape, but the treatment objective presses far more closely upon the security consideration than it does in prisons.

The majority of the doctors are of consultant status and there is always medical cover during the evening hours and on-call arrangements during the night. The main body of the staff are nurses of varying grades. Their 'treatment expectation' is of course higher than in the prison service, but they have to come to terms with the overall security situation.

Regime

I suppose the most striking difference is that of the patient's day as opposed to the prisoner's day. They are — unless there is reason to the contrary — out of their rooms all day, including the evening and have to ask permission to stay in their rooms!

Obviously there are staffing implications, but the absence of unnecessary 'lock-ups' is quite striking. Daytime activities cover a range of 'work shop' and daytime centres, education and various treatment programmes. Each patient should have a patient care plan agreed by the clinical management team to whose unit he or she belongs. Smaller numbers, smaller units, more time out of rooms, more staff available of all grades, adds up to the difference between a secure hospital and a prison.

Most of the patients are discharged to the community indirectly, ie: they are likely to go to a Regional Secure Unit or to a Psychiatric hospital before release into the community at large. The same problems are encountered as with lifers. 'Not in my back yard' can be the attitude, but it is particularly essential to keep the movement of patients through the hospitals, so that those who have responded to treatment and no longer need our conditions of security can pass on and room is created for new admissions.

There are many more psychologists in the Special Hospitals undertaking a wide variety of clinical work. As there seemed to be far fewer of them in Prison Service as I left it, I do find this a contrast. The Social Workers have much in common with probation officers in the dispersal prisons and life centres, but do undertake considerable travelling in order to meet the families of patients and keep in touch with local social work agencies.

The average number of referrals for a special hospital place over the last five years has been 184, most patients are admitted from the courts. 68% are under Home Office restriction. Most of these will have spent significant amounts of time in prison. There are also numbers of transfers of sentenced prisoners for treatment. The difficulty the staff then have is encouraging

patients to accept the environment and behavioural standards of a secure hospital as opposed to a prison hospital. It is still unusual for a patient to be admitted during the remand period. Although this is an attractive option theory, there are practical difficulties.

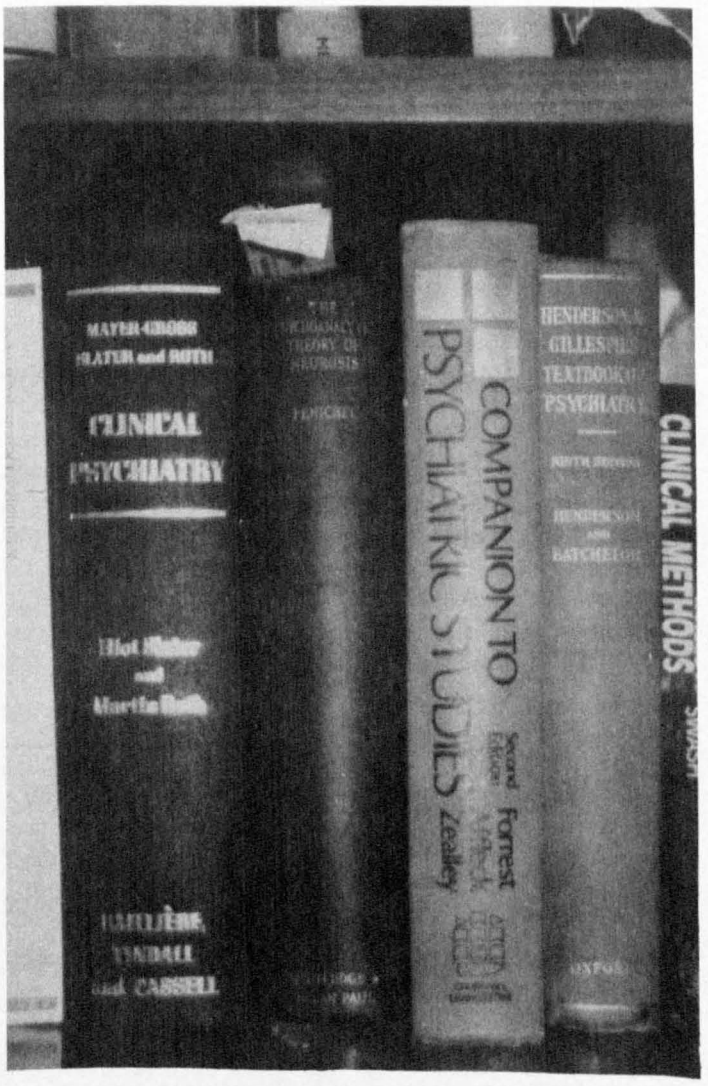
The total revenue available to the SHSA is £76.55 million, whilst our capital allocation is £12.13 million. It may be of more interest to look at the following cost comparisons:

* Average cost per patient per week:Special Hospitals £826
* Cost per patient per week:typical district general hospital £1,265
* Average cost per patient per week:London postgraduate teaching hospital £775
* Cost per week:typical central London hotel £560.

Security

Physical security as it is known to the Prison Service is a mixed bag. All the hospitals cover very large sites. Ashworth North (Park Lane) has a capped prison wall, but unlike most prisons of that level of security, the wards are all single storey. Thus although there is space, you can't see over the wall. I find it curiously claustrophobic. On the other hand Ashworth South (Moss Side) is an old hospital with little perimeter security to a large extent, Ashworth South must have firm internal controls. Rampton is a mixture of central wards and villas, all set in grounds with a fence that could at best be described as a Category C. Broadmoor, which is being redeveloped and refurbished on site has a high old fashioned brick wall.

I considered myself privileged as a Governor to have served in the establishments that I did and particularly to have governed two London prisons, Holloway and Brixton. It has been enormously interesting and worthwhile to have been in at the birth of the new Health Authority. Although the Special Hospitals and the Prison Service have differing aims, methods and standards, there are many areas in which closer co-operation in the care of mentally disordered offenders and perhaps staff training could be mutually beneficial. ■



A Pilot Prison Treatment Group For Sex Offenders at HM Prison Norwich

Effective treatment for sex offenders is possible in the prison system and there is a real need for this work.

In 1989, sex offenders at HMP Norwich were involved in a pilot treatment group. This article is a discussion of the group. It explains why and how it was set up, the theoretical underpinnings of it, and the advantages and diadvantages of running such a group.

Colin Jones, Probation Officer at HMP Norwich, and Julia Lewis, Forensic Clinical Psychologist at the Norvic Clinic in Norwich.

Norwich prison has a large number of sex offenders representing 13% of the total population of the Prison. It is an increasing population. The idea of a treatment group grew from the concern of three prison staff members early in 1989 who thought that little was being offered, in terms of treatment, to sex offenders during their imprisonment. Moreover, it was felt that the experience of serving a prison sentence without receiving treatment might further reinforce the styles of thinking and the behaviour characteristic of sex offenders. This could lead to an increase in the chance of re-offending once the sentence was served.

The three staff members had individual and group work experience of working with sex offenders. One member was the Prison Hospital's Health Care Manager; one a Prison Probation Officer and the third a Clinical Psychologist attached to a Regional Forensic Unit. There were two males and one female member.

Following discussion it was felt that a pilot group was needed:

1. To explore the possibility of group work with sex offenders in a prison setting.
2. To explore the possibility of multi-disciplinary working.
3. To explore particular therapeutic approaches to working with sex offenders.

In all, it took four months from conception to the group starting.

It was felt important to have three staff members. This would ensure an appropriate level of co-worker support and continuity of the group (ie, to allow for staff holidays, sickness, etc). A gender mix of staff members would enable issues of sexist behaviour and language to be addressed: it also offered the group members the opportunity to direct comments and questions to either sex, and it allowed staff members to check out gender issues with each other.

Theoretical Underpinnings of the Group

Assumptions based on research (Salter, 1988) and on experience were made about the sex offending behaviour of the group members and were used throughout the running of the group. These included:

* That the behaviour was deliberate, addictive and formed part of a cycle of behaviour; it was not spontaneous.
* That the offender would seek to say the offence was a 'one off' but that in reality it represented only the 'tip of the iceberg'.
* That the offender would seek to place the blame on others (especially the victim).
* That the offender would deny all or part of the offence.
* That the role of fantasy and masturbation was central in the offender's life as an end in itself, as a disinhibitor to action, and as a means of rehearsing offences.

Finkelhor's Four Preconditions Model of Sex Offending

Finkelhor's model (1979) requires that four preconditions must be met before an offence can take place.

The offender must:

1. Have the motive to offend.
2. Overcome his or her own inhibitions.
3. Overcome the external inhibitions.
4. Overcome the victim's resistance.

The combined framework was used in the group. It sought to make understandable the offending behaviour and offered opportunities to interrupt the behaviour pattern and thus, it was hoped, to impose some control.

Cognitive Distortions

According to Beck (1976), a cognitive distortion is 'a statement one makes to oneself which contains distorted information about the reality of the situation'. For example, an offender who sexually abuses children may say that 'she seduced me', 'it's an education for the

child', 'it causes no harm' and so on. Cognitively distorting the offence allows the offender to overcome his or her own inhibitions (precondition two), and allows the offender to minimize and justify the offence, thus making the unacceptable behaviour 'acceptable'. Cognitive distortions appear to be an important factor in maintaining the offending behaviour. Put simply, if the offender thought that there was nothing wrong with his behaviour, he would see no reason to stop it.

Format

As the group was to have a short-life, its format was purposely narrow. By challenging the cognitive distortions of the offender, it was seeking to shift the offender from a passive account of the offence to an active one. This would allow the offender to accept the responsibility for it and therefore enable him to consider the harmful effects it had had on the victim. The group was a closed group, consisting of 12 sessions of approximately one hours duration. The meetings took place in the Probation Interview Room.

Groundwork

Following discussions with the Prison Governor, the concept of the group was accepted and the planning went ahead. A group of this nature not only needed the support of the Governor but also, that of the Prison Officers. It is well known that sex offenders are not as acceptable to Prison Officers as other types of offenders and the opinion is often that sex offenders in relation to other offenders receive too much attention. Therefore, a group of this nature could easily have been jeopardized. To help overcome that, from the outset Prison Officers were kept informed about what was proposed, why it was proposed, and who would be involved. Their feedback was welcomed. It was emphasised throughout that the treatment of sex offenders was not simply for the sex offenders per se, but that its most important function was to prevent future incidents of sexual abuse.

Selection Criteria

No elaborate selection criteria were used. Basically, the group members were sex offenders, who had admitted their offences (to whatever degree), who had expressed an interest in the group and who were available at the time of day that the group had planned to meet.

At the first meeting of the group, there were seven members: three were on remand and four were convicted. They had committed a wide range of sex offences, including incest, rape and indecent assault.

The Group Programme

A contract had been drawn up by the staff members which emphasised the confidential nature of the group. The first and second sessions were spent systematically working through the contract. This gave group members the chance to ask questions which enabled them to decide if they wanted to stay in the group. One member decided to opt out at this stage. These first two sessions were crucial in establishing rapport and gaining trust.

In the third session, it was felt important to make the group members aware of what assumptions were made regarding their offending behaviour. For example, that they would say the offence was spontaneous, that it was a 'one-off', etc. Also during this session the notion of control rather than cure was introduced. The aim of the group was to help its members discover ways of controlling their offending behaviour.

In the fourth session the concept of denial was introduced. During the following six sessions each member gave a detailed account of the indexed offence: how it came about, what happened, what the victim did and what followed from it. Throughout the accounts any distorted thinking was challenged: initially, this was by the staff members but later by the offenders themselves. The last two sessions were spent discussing the group sessions overall and treatment for sex offenders in general.

Following each session the staff group met to de-brief and plan the next session. This was found to be an extremely important part of the process. It demonstrated the obvious benefits of reviewing progress and ensured that the group's objectives were being attained. More importantly, perhaps, it enabled the staff to make sure their own feelings were dealt with.

Summary of the Pilot Group

Did the Pilot Group help to answer the three questions initially set?

1. Exploring the possibility of group work with sex offenders in a prison setting.

It had been thought that there would be problems arising from prisoner movement: motivation of both the offenders and officers ensured that this was not so. It highlighted the importance of thorough groundwork and the gaining of support of the whole institution.

From the outset, it had been emphasised to the remand prisoners that inclusion in the group would not have any effect upon sentencing. It was envisaged that those awaiting Court apperarances would be highly motivated prior to the appear-

ance but not afterwards. However, this was not the case. Disruption was caused by Court appearances and some time during sessions immediately following the appearances was necessarily taken up with talking about them. The group did not experience 'shipping-out' problems and, again, this highlighted the importance of having the support and commitment of the Governor and of the various departments concerned.

2. Exploring the possibility of multi-disciplinary working

It was felt that the multi-disciplinary cross gender make-up of the staff was beneficial to the running of the group. In essence it meant that there were three perspectives in the group and this made it easier to deal with the different issues that arose. It also offered colleague support and allowed a much sharper focus of attention to be maintained.

3. Exploring particular therapeutic approaches to working with sex offenders.

The therapeutic approaches centred on assumption making (Salter, 1988) and Finkelhor's four preconditions model (1979) focussing, in particular, on cognitive distortions (Beck 1976).

It was felt that this approach allowed both the staff members and offenders to make sense of the sex offending behaviour.

It was essentially an optimistic way of working with sex offenders. A non-hostile confrontational method of challenging cognitive distortions was adopted, which allowed the offender to feel safe and thus enabled the process to continue. It was non-accusatory and it was felt that this allowed the offender to move from a passive to an active perspective of the offence.

Review

It had been recognised from the outset that the pilot group would be limited and the decision had been to concentrate on one area of sex offending within a closed group. A rolling group was felt desirable in order to address a wider range of issues: victim awareness; issues of power and male/female sexuality: the role of fantasy and how to control it; more work on previous offences to build up cycles of behaviour. It would allow group members to join when they are available and to stay for as long as was felt necessary within an ever-changing population.

The selection criteria were generally satisfactory except for the convicted/remand mix, which was found to be disruptive. Having a range of offence types and levels of denial was thought to be helpful especially in encouraging inmate participation, in terms of their challenging one another.

Given the inconclusive nature of the meetings it was agreed that a longer time would enable the sessions to close within both the natural length of issue discussion and length of concentration. It was also recognised that the frequency of sessions was not enough because of the deep seated nature of the behaviour, but within the obvious resource constraints a once-a-week frequency is considered a minimum.

It was felt important to retain the gender mix of staff members. Often the group members would address particular questions to the female member which would have been difficult for a male member to reply to.

It was felt to be important to have a minimum of two therapists and a maximum of ten officers.

It would have been useful to include prison officers in the group and indeed some expressed this wish. Issues of confidentiality would, of course, be crucial here.

Tape recordings of sessions would also have been useful: they could have been kept as a record of the sessions and used to challenge such things as cognitive distortions.

Conclusion

The experience led the staff members to believe that it was possible to undertake effective group work with sex offenders in the prison system. Furthermore the pilot group served to highlight the absolute need for such work to be undertaken. The theoretical framework adopted was felt to be effective and helpful and although no objective evaluation of the pilot group was undertaken feedback from group members would suggest that they were taking on more of the responsibility for their offences. One group member, who initially strongly denied aspects of his offence, poignantly said in the very last meeting: 'It's all about excuses, excuses, excuses.'

Arguably such an awareness is the first important step towards preventing the future sexual abuse of adults and children.

Postscript

An ongoing group programme is now running at the prison, based on the results of the pilot group. ■

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Institution: Role Power Authority

This article is the text of a lecture given by the author to a recent conference of Prison doctors. The authors own analysis of role, power and authority in prisons owes much to the ideas and language of the GRUBB Institute who have been influential in shaping the leadership styles of a number of Governors of successive generation.

Bill Abbott, Governor of HMP Pentonville

For those of you who may be under the illusion that I arrive here because the organisers sought me out as someone with expertise in the area of institutions let me disillusion you — to some degree the truth says something about how institutions work. I was sat next to Dr Penton at a South East Conference lunch and she spoke of the difficulty of finding speakers for this conference — I naively volunteered and to my surprise I was booked there and then with freedom to choose a subject. Looking at the programme as a whole with its concentration on management I believe what I have to say has some relevance and may offer you new tools or concepts with which to approach the subject. My expertise is drawn from active reflection on experience in what was once termed a 'total institution' by Goffman writing in the 1960's namely a prison. I have also been influenced in understanding the experience by work done on human group behaviour at The Grubb Institute in London as part of Senior Command Studies.

Having referred to Goffman's concept of a 'total institution' — one in which the behaviour and action of the inmates are completely controlled by the organisation — he uses prison/prisoner, army/soldier, monastery/monk, patient/hospital. I want to challenge the concept. I am not convinced that there is such a thing as a total institution. The word institution has emotive connotation — it suggest a large brick building forbidding as its image and austere in its practices. I am not sure that such images are of any real help in understanding institutions. The problem is one of definition and the concept of institution which I want to offer you is that of a structured system or process structured that has a defined aim and in which individuals relate in role to other individuals. This definition does allow us to define an institution in much wider terms than we may previously have considered — the family becomes an institution: The shopping precinct becomes an institution; the school becomes an institution. The list can be continued and this conference itself takes on the process of being an institution — it has a stated aim, there are organisers, there are speakers, there are students, there are cleaners, kitchen staff, waiters, etc.

I want to suggest that the key to an understanding of the institutional process is the concept of working with the stated AIM of the institution and with the role that people take up in an institution. The concepts of AIM (defined as what is actually happening) and of ROLE are the tools to understanding and influencing the changes taking place within an institution.

Given my definition of an institution as a structured process which individuals relate in role to others relationships become very important. As individuals we do not see things in the abstract but rather we see relationships between things. An institution is not simply hierarchical in structure but rather presents as a random patterning of relationships between individuals. There are unwritten rules, there are strong forces of tradition. There is a strong tendency to want to resist any change in the way things are done. The culture which evolves will have a powerful effect regardless of the stated aim of the institution. The culture can resist change in favour of survival and continuity. Because we are subject to inertia we will not give up our grumbles. For Trade Unions grumbling has become a way of life. For the prison service Fresh Start offered a direct challenge to these historical random patterned relationships strengthened by years of tradition.

One of the tasks I set newly promoted members to the governor grade is to study who drinks coffee with whom and where in the institution. The study will provide an understanding of where influence groups are in the prison. The second task is to ask the governor grade how he or she intends to gain access to the more influential groups. At a simplistic level he or she could offer to buy the coffee or up the market brand to Nescafe 37. The task does reveal the complex pattern of relationships that exist in an institution and does reveal that relationships between people are at the heart of the institution. It is the complex pattern of relationships that makes change difficult to achieve and it is the same pattern of relationships that can divert an institution from its set task. A headquarters can issue what ever policy it wants but there is need for control of the patterned relationships if there is to be delivery of the policy.

There is a sense in which the scenario I have just presented suggests that the important skill in an institution is that of manipulation and that that is all there is to it. It is rather like the new recruit asking the question 'How do I get on here?' Answer

— crawl. Second question 'How do I do that?' Answer — skilfully.

Let me attempt to offer you skilful options to helping develop a healthy positive institution. Fresh Start made two significant advances:

1. It defined the top team management concept and developed new structural roles.
2. The Prisons Board set out a statement of purpose for the Service — the statement in my terms is an AIM, a description of what the Service as a whole is doing. The statement is not a missionary statement but rather a statement of prison service activity. My own belief is that each institution should develop a statement or aim of its own. To some extent the work on the Contract, on Priority 5 is work on an aim.

In developing a statement of aim you will, given that you are examining what you are doing, come to understand the institution better. One example I can give is when Parker pens looked at what they were doing they learned that they were not making pens but making gifts. That learning changed the marketing strategy and the profits. In the South East Region this year we have held a Head of Inmate Activity Conference — our purpose was to state that we in South East Region were concerned with the quality of regime: we have held five training courses for top teams again stating our concern at the quality of management and the importance we attach to Priority 5 which is a concept of working with aim. We have also held two 'institution assessments' and in both we have shown how failure to set up proper role structures can prevent the institution developing proper regimes and ethos under Fresh Start. In one, inmate activities was done by the Head of Custody thus subordinating activity to custody in that it had no independent role in the top team: in the other the evidence suggested the governor had not taken up the appropriate role in relation to functional heads and thus no roles were fully effective.

Let me deal with the concept of role. Fresh Start has I believe widened the Medical Officer role, he/she is now both doctor and manager within the defined role. There may well be resistance to the manager role both on the part of the doctor and on the part of those who should be managed. It may be seen by them to be in their interest in terms of tradition and survival to resist the development of the managerial role. There is in addition to the managerial role towards subordinates a managerial role within the policy group and in my view the institution will suffer if that role is not taken up. If the manager/doctor role is not fully developed the full input to the institution of a highly trained, widely experienced person will not be made.

It is not possible to learn a role simply from books or from attending conferences. You probably learn most about role from analysing your experience. You may come to understand the role you fulfil by working with your own feelings about the role. If you feel you are only in the doctor/patient role you will not be managing anything very well. As I will argue shortly I am not certain that the doctor/patient concept is descriptive of role at all but rather of aim.

What does a role mean and what does taking up a role mean? The traditional concepts confuse it by seeing role as a position in a hierarchy. In that sense role is best described as a status. It can mean a job description which is a list of things to be done. Different people of course have different expectations about people who hold a particular position. A role is also a part played by an actor — all these suggested that a role is something defined for us, at most there is an allowance for a difference of style but not of substance. I suggest none of these prescriptions of role do justice to our actual experience of the roles we take up. No one can do a job by following a job description: decisions have to be taken and cannot be prescribed: Decisions cannot be based on people's expectations. There is a need to feel in order to respond to a role. The concepts I have outlined are static and do not allow for change in context which is always occurring. The script keeps changing. The father/child relationship changes as the father and the child both grow older. It is this development/experience factor that relates role and person. The role is made and fashioned by the person taking up the role in the organisation. An actor will acknowledge the need to be in tune with the character he plays. In understanding role we need to be aware however intuitively of some regulating principle within ourselves that allows us to manage the situation we are in. Role as a regulating principle goes further than the previous more static concepts and I suggest it is more true to our experience.

Everyone who joins a group comes into a position with particular expectations but neither the position nor the expectation define the role or say how it should be managed. What allows us to take up a role is the identifying of the aim of the system and the taking of ownership of the aim. If we acknowledge the aim we can take up the role choosing action and behaviour that will achieve the aim from that position. We need to take all the influences past and present into account. A role is never static. A model could be the yachtsman who is continually tacking to meet the wind.

In this concept role is an idea in the mind through which we manage ourselves in relation to the system of which we are members in order to fulfil the aim of the system. We accept accountability ourselves — I am my authority. I have the technology. In diagram terms.

The cube is three dimensional within its relationship are system: role: person.

In taking on a role we take on the authority within the role. We need to distinguish here between power and authority. They are not the same though both are needed and both need to match each other.

Power is a quality given to persons or groups.

Px — personal power: own skill: know how: personality.

Pi — instrumental power — power of what I control.

Pp — projected power — given by other people.

Po — official power — because of my title: influence gives privileges I can use.

Authority is not a quality of persons but is attached to role and seeks to further the aim of the system. Each one has authority in their role. To take that authority it needs matching with power — that requires use of skills, of instrumental resources, others must have confidence in me. Use of official power.

While power can be exercised without authority, authority cannot be exercised without power. Where power is dominant people will seek to control others. Where authority is dominant it is concerned with managing the process to free others to take up their authority and take up their role. Roles are effective when power relationships are controlled. It is this concept which my newly promoted governor grade must work with having analysed an informal power structure.

What of your situation in prisons at present? You occupy a traditional role — a member of the triumvirate appointed by the Prison Act 1952 — each prison shall have a governor, medical officer and chaplain and such other officers as may be necessary. There is a danger that tradition may weigh you down, a tradition that reflects the role in terms of a doctor/patient relationship. However in the health service as a whole greater emphasis is being placed on management of that relationship. What I am suggesting is that in coping with change in the Prison Service and in the health field in general practice the need is to work with the concepts of aim and of role. In doing this I am left wondering if the doctor/patient concept is a concept best dealt with in terms of aim — the aim of the institution is to improve or maintain the health of the patient. To achieve the aim the doctor needs to take up the role of doctor and use his or her authority within the system. The doctor manages himself drawing on skills, knowledge, on patient's trust, on back-up within the system. The patient also needs to take up the role of patient and to use his authority to allow an identification with the aim. In certain cases an examination of the aim — of what is actually happening may reveal that the aim of the institution is not being met, a new aim has taken over.

In working with your role as a medical officer in the Prison Service you need to identify with the aim of the Service as stated in the statement of purpose, you need to occupy a managerial role within the organisation. You bring with you your own personality which will allow you to make something of the role, to shape and develop it but to do that successfully you need to identify with an aim. It may help to look at the aim of the medical services or hospital in the prison.

Certainly there is a need for the governor to take up his role to enable you to take up yours. In working with role it is often helpful to set out your feelings about the role and about the aim of the institution. Working with the process of itself will help the understanding. ■

The Dealer and the Enterprise Culture

The author describes the risk and rewards of international drug trafficking.

P. A Thomas (Senior Lecturer in Law), Cardiff Law School.

David Young is a rich commodities dealer who travels the world. In three years he visited Amsterdam sixty times and has made business trips to Pakistan, India, Thailand, Turkey, Nigeria, Kenya, Sweden, Brazil, Venezuela and Columbia. In 1989 he went to Morocco on eight occasions. Currently he is not working. I met him in Spain, in Puerto de Santa Maria II: a prison near Cadiz. David Young is a professional drugs smuggler.

Young was arrested by the Spanish police in Algeciras on returning from Morocco. He had two kilos of hashish strapped with brown tape to his side. The police were waiting as he stepped off the ferry. He was set up by his Arab supplier. Either the Moroccan was given a half kilo by the police for the tip off or he owed a favour. David Young became the 'favour'.

The cost of the hashish in Ceuta was cheaper than usual: £150 a kilo. His 'lump' was to be sold in Dublin for £7,000 to a regular dealer. Young's job is buying and transporting. He holds the drugs for no more than an hour in Ireland. A taxi from the airport to his buyer's house and the deal is

done. He called it 'a business. I wouldn't hand over £7,000 worth of hash to a stranger. I catch up with him in a couple of days for the cash.' The street value of the drug is £5,000 a kilo.

I met him the day after his trial. He, like 40% of the prison population, had been remanded in custody. His case had been heard relatively quickly: six months. It is not unusual for cases to take two years before coming for trial. His case took five minutes, the interpreter was unintelligible, his lawyer spoke no English, the British consulate was not represented. The judicial sentence in Spain may be delayed for several weeks but the tariff for two kilos is four to ten years. It was his first offence in Spain and there were no aggravating circumstances such as the involvement of minors. The Dean of the Cadiz University Law School, Professor Juan Terradillos, told me that he could expect a prison sentence of four years of which he would serve two years if he behaved and undertook prison work.

Young, a tall, slim and piratically handsome thirty-year-old has smuggled drugs for ten years. He is a confirmed dope smoker who does a little cocaine from time to time. His home now is Ireland though he has the accent and verbal confidence of Notting Hill where he lived until he was 18. In his village he is thought to be a very successful international photographer but his real business is moving drugs.

He called himself 'a jet-setting nomad' who enjoyed his work. He claims hashish is his main line of import partly because he uses it and partly because the sentences for heroin deter him. He has brought into Heathrow as much as 50 kilos in a suitcase. He normally takes the 'green line' through customs as a game of psychology. When the hairs on his neck stand up he gets a buzz as he 'gets one over the system'. He described it as a game but not one of chance. He studies the habits of tourists and considers how to dress and behave. The cardinal rule is not to stand out from the crowd. He does 'what the sheep do'. For example, cocaine users avoid the sun because of its bad effects. His comment was 'what kosher tourist comes back from Spain looking like a ghost?' He tops up his tan for a couple of days to match the best of the Costa del Solites as they wobble through customs.

Moving Drugs

My large, legal briefcase was much admired. He reckoned it could carry £25,000 worth of hidden 'oil' if properly pressed and double stitched. It will never look the same to me again! On occasions he straps dope to his body and dons a cut down wet suit. This is to reduce its odour and contour the package to the shape of his body.

He talked of the use of vehicles to transport large amounts. Doubled skinned trucks with hidden compartments packed with drugs are commonplace. His favourite technique is to gut the car battery, fill it with drugs and then insert a tiny motor bike battery. This is hooked to terminals and the original battery is covered with the dirt and grease which graces all working batteries. After all, it is a well known fact that batteries are full of liquid acid and could not possibly be a drugs cache!

He is a frequent traveller to countries of interest to customs officials. I felt that ultimately they would catch up with David Young through computers and the airline passenger manifest. But smugglers have ways of responding to new technology. He likes to fly from Malaga in the summer. The hot weather suits him and also brings in the tourists. Malaga airport is chaotic in the tourist season with charter flights and travellers sandwiched on top of each other. It is commonplace for return tickets to be sold on by British tourists. Certain 'English' bars in places such as Fuengirola have notice boards advertising tickets. Young agrees to buy a ticket from 'X'. They meet at the airport and 'X' presents his ticket and passport to the clerk. He is given a boarding pass and sells it for £50. Young flies to London under the name of 'X' thereby reducing the possibility of official scrutiny. He travels but never gives notice of his return.

Young possesses six passports. The Swiss and American ones are forgeries. He bought them in London for £1,500 each. His parents are Irish so he has two passports in his real name, Irish and British. He also borrowed a birth certificate from an Irish farmer for £200. 'he'll never leave his farm and he was glad of the money' was the explanation. This produced a second Irish passport. He obtained a duplicate birth certificate of a man his age who is permanently hospitalised in England. This gave him his second British passport. He also has 'a stack of British Visitor Passports. The more the merrier'. With this selection of travel documents he was able to move around the world.

Prison Life

His association with drugs continues inside prison. When I offered him cigarettes he produced hashish from his pocket. He preferred to smoke his own brand! He is in the non-Spanish module with 200 inmates. They are almost all there for smuggling. He thought they represented a total of sixty tons of drugs! First time couriers prone to make simple mistakes, mix with professionals and learn how it should really be done. Many nations are represented in those cells. There is even an East German who was taking drugs to

East Berlin. The enterprise culture is catching up fast.

Certain drugs are freely available inside. The guards are tolerant of dope as 'it keeps the prisoners quiet but they go ape over heroin'. Of the 1,000 prisoners in Puerto de Santa Maria one third are believed to be HIV positive. The senior prison doctor, Dr. Ojo, told me that his studies indicate that 80% of the heroin addicts carry the virus. Last year a prisoner was killed in a fight over heroin in the Spanish module. Young had never been in there and, in a serious tone, told me it was 'a hell hole'. The drug problem outside prison is horrifying with an estimated 5,000 addicts in the province of Cadiz.

Young has a positive attitude to prison. He intends learning good Spanish so that he will be a more efficient smuggler on his release. His access to money makes for an easy life inside. There is illicit, home-made apple wine available and although 'its not Mouton Cadet it helps you sleep'. His cell, shared with two others, has its own toilet and the sun is unlimited. He spends much of the day on the patio, smoking, chatting and generally relaxing. He knows the inside of British prisons and he was clear where he would prefer to be, 'outside but failing that then in this nick.'

He displayed a disarming fatalism towards his sentence. 'Every job has its pitfalls. Prison is my pitfall. I could be in Amsterdam on Monday and Tangiers on Saturday. What a life. Better than being behind a desk'. The irony of being behind bars escaped him. There was even a suggestion of job satisfaction although it was the enormous profit motive that kept him trafficking. He thought it was job which logically must come to an end. 'One day governments will wake up and tax dope. Then my business goes down the tubes and I take early retirement.' ■

Grendon Evacuated — The Winchester Experience

A number of establishments were affected by the evacuation of prisoners from HMP Grendon in December 1989. HMP Winchester held twenty-nine Grendon prisoners for some seven weeks and the author describes how the needs of the group were met.

M. Hughes, Hewell-Grange

The speed with which Grendon was evacuated allowed very little time for the staff and management at Winchester to prepare adequately for the arrival of 29 prisoners who had not experienced the regime of a local prison for some time. Therefore, the reception of these men on 20 December 1989 presented an unusual challenge.

Anxious Times

The anxiety experienced by these prisoners as a result of being transferred to Winchester was certainly matched by the apprehension of those staff having to receive them. For the prisoners, many questions remained unanswered: How would they be received at Winchester? How long would they be there? Would they be able to return to Grendon? Would they be dispersed throughout the prison system or would they be able to stay together as a group and enjoy the support of each other? For the staff, too, much uncertainty existed: How would these prisoners respond to being transferred to a Local prison at such short notice? How best could this rather large group of prisoners be absorbed into the regime of a Local, considering that only hours earlier they had been part of the supportive, therapeutic environment of Grendon?

It was not possible to provide them with the sort of regime they were accustomed to at Grendon and, indeed, to do so would have provoked a reaction from those prisoners already in custody in Winchester who were used to a rather more limited type of regime. For this reason, they were originally dispersed between the two convicted wings in an attempt to integrate them into the day to day life of the prison.

'Nonces or Nutters'?

Unfortunately, this attempt at integration proved unsuccessful. Much myth and rumour exists within the Prison Service, both amongst staff and prisoners, concerning the type of prisoner held in custody at Grendon and the sort of activities which take place there. The general feeling among prisoners is that those who are in custody in Grendon are either 'nonces' or 'nutters', and it was these types of prejudices which created problems for the Grendon men from those already at Winchester.

Within 48 hours of their arrival, it became apparent that some of the Grendon prisoners were

being intimidated by other members of the population. One or two altercations occurred, both on the wings and on the exercise yard, and it was feared that the situation may gradually escalate out of control. For this reason, it was decided to relocate all the Grendon prisoners together, as a group, on a different wing, thus segregating them from the rest of the prison. However, the problem the Governor was now faced with was how to create a humane and purposeful regime for this group of segregated prisoners with the limited resources available to him. The management team at Winchester was very conscious that any constructive progress which had been made with these prisoners at Grendon should not now be undone through no fault of either the prisoners concerned or the staff at Winchester, but purely due to lack of resources.

Supportive Segregation

In order to limit any possible damaging effects caused by their segregation, a separate regime was designed for the Grendon prisoners, using the services of two officers on detached duty from Grendon. Under the supervision of the Wing Group Manager, these two officers took responsibility for the day to day welfare of the prisoners and operated a regime for them which resembled as closely as possible that which they were used to at Grendon. This 'regime within a regime' included the regular group meetings and counselling which they found supportive. It was very noticeable that following the introduction of the new regime on 1 January, the behaviour and attitudes of the Grendon prisoners became much more settled and relations with staff improved greatly. This shows the extent to which they find strength and support from the kind of regime Grendon has to offer and how difficult it sometimes is for them to adjust once again to life in other establishments in the prison system. Their insecurity on losing the support obviously contributed greatly to the sometimes antagonistic behaviour of some of these prisoners prior to 1 January.

Reselection

Probably the most anxious time for the Grendon men came at the end of January when decisions were being made as to who amongst them would be transferred to the new therapeutic community being set up at Wellingborough. Many of them feared that the seriousness of their offences would rule out any possibility of them being part of such a transfer due to Wellingborough's lower security category. It was an extremely frustrating time for both prisoners and staff as the decision-making process took some time to complete. During the waiting time staff were unable to answer adequately the many questions posed by them, simply through lack of information.

26 of the original 29 Grendon prisoners were transferred to Wellingborough on 8 February. The other three had moved to other prisons a few days before. An entry in the Governor's Journal for that day reads: 'The Grendon prisoners left for Wellingborough — a successful stay'. Overall, their stay had been a success. Winchester staff had demonstrated a great deal of flexibility and professionalism by adjusting the regime sufficiently to accommodate the Grendon prisoners and so enabling them to cope more effectively with their enforced change of circumstances. Despite the early tensions that had existed between the Grendon prisoners and certain elements amongst the rest of the prison population, their stay remained fairly well trouble-free. These views were shared by the elected chairman of the 'Grendon-in-Winchester Community' who, in a letter to the Governor, expressed his gratitude for the professional manner in which his group had been dealt with and the assistance which had been given in enabling them to cope positively with their transfer to Winchester.

A Job Well Done

Whilst appreciating their reluctance to do so on the grounds of modesty, the staff at Winchester would be fully justified in congratulating themselves for a job well done in co-operation with the Grendon staff and management. The learning for the prisoners involved was considerable and is further evidence of the effectiveness of Grendon's approach towards behavioural change. ■

Prisons As Self-Expressions

'. . . prisons pay . . . prisoners are converted from workers to products, from humans to things . . .with private prisons we build an enormous growth factor . . .'

Professor Nils Christie, Oslo

There are two dominant views on the number of prisoners in society.

The one perceives the prison population as a simple reflection of crime figures. If crime increases, then the prison population increases. With reduced crime the numbers go down. In this perspective prison figures become a major indicator of the crime situation in a country.

But it is also possible to apply a completely different perspective. In that perspective the number of prisoners in a country is not seen as a necessity, created by crime. Instead it is seen as a result of a magnitude of forces and counterforces, all open for choice. With this perspective prison figures are also open for evaluations. Prison figures are not seen as determined by crime. We determine. In this perspective the use of prison is seen as other cultural phenomena. This implies that use of prison has to be evaluated, as all cultural phenomena. This is my major position in the thoughts I want to share with you.

But first some figures.

And let us start at home — at home for you. The first two tables will be a selection from the Council of Europe, their last Prison Information Bulletin of June 1988. As you can see from *Table 1*, the United Kingdom has close to 56,000 prisoners, and close to 100 per 100,000 inhabitants. Scotland has more than England and Wales; Northern Ireland is at the top. The Republic of Ireland has only 56 per 100,000. A peculiar feature of U.K. is that the prison population here is much younger than in most European countries. 25% of prisoners in U.K. are 21 years or less, while only 5% of prisoners in Norway and Sweden are that young.

In Table 2 I have moved to some of the other European countries. The first finding is that none of them reaches your level. And I want to add: You are, with one exception, unbeatable in Western Europe when we look into the total material from the Council of Europe. The one exception is Luxembourg with 382 prisoners and a detention rate of 103. A year back Turkey was the champion in putting people behind walls, but they have calmed down to 90 now.

The second observation from this Table is the great variation between European nations. And variations difficult to explain. The Netherlands has moved up recently, but is still the country in Europe most hesitant to apply this ultimate form of physical force. Little Iceland has moved ahead, and passed the multicultural, highly complex, densely populated and urbanized Netherlands. The only real competition you can find in Western Europe is from Austria, with 96 prisoners per 100,000.

Table 1
Prison figures in the U.K.

	Total	Per 100,000
England and Wales	48,348	97
Scotland	5,427	106
Northern Ireland	1,954	125
U.K.	55,729	98

Table 2
Prison figures in selected European countries, 1988

	Per 100,000
The Netherlands	36
Iceland	41
Norway	47
Sweden	61
Denmark	69
Fed. Rep. Germany	86
France	92
Finland	93
Austria	96

Table 3
Prison figures in U.S.S.R., Poland and U.S.A. 1976 and 1989

	Per 100,000 1976	1989
U.S.S.R.	660	214
Poland	300	170
U.S.A.	230	407

But let us leave Western Europe, as in *Table 3*. Here I have complicated the picture with an historical dimension. In 1979 a former prosecutor in the USSR estimated their prison figures to be 660 per 100,000. This was in a presentation that year to the American Society of Criminology. At the same time the Polish prison figures were about 300 per 100,000 inhabitants. USA had 230 per

100,000. In other words: 6.6, 2.6 and 2.3 as many as in the United Kingdom today.

Let us then move up to 1989. The picture is dramatically changed — to the better in Europe, for those of us who favour few people behind bars, but in the opposite direction in the USA. The USSR figures are not official, prison statistics are still a secret in that country. The figure 214 is based on sources I prefer not to reveal, but I feel relatively certain.

The Polish figures are based on estimates from colleagues in that country, and I have every reason to believe they are accurate. The figures from the USA are from The National Council on Crime and Delinquency, elaborated on by Marianne Hakansson in the Journal for the Swedish Council for Crime Prevention — Apropos 1989. If the figures are right, then the USSR has reduced the prison figures to one third in a ten year period, while the USA has doubled the numbers. In the biggest state of all, California, the figures are now up to what they were in the USSR ten years back. The forecast for 1993 in California is 800 per 100,000 inhabitants. Canada has 111 prisoners per 100,000.

Some lessons from these figures:

There are no reasons to believe that crime in Austria is three times as high as in the Netherlands. Or that Norway has more crime than the Netherlands. And then that there is a dramatic change of positions between the USSR and the USA. It seems close to obvious that all this is not a reflection of crime, but of broad structural and cultural phenomena within the various countries.

If crime does not explain prison figures, we have to look at other variables. I will look into four major ones.

1. Social conflicts
2. The integrative function of crime control
3. Prisons pay
4. Major features of the legal arrangements

Social conflicts are strongly reflected in the figures already displayed. Northern Ireland is at the top in Europe. It is not by chance. Finland is at the top in Scandinavia. I have in an early study pointed to the great amount of conflict in Finland's external and internal history. The USSR was at the top in Eastern Europe, probably for some of the same reasons. The decrease during the last years — in the USSR and in Poland — is even more interesting. The conflict aspect might also be useful in explaining the growth in U.S. figures. The U.S. has long since passed Poland. Pepinsky (1985) claims that not less than one quarter of the male black population between 20 and 30 years is in prison in the U.S. just now. I found it unbelievable and have, to the best of my possibilities, tried to control his calculations, and find nothing wrong. In the prisons of California 65% are black, Mexican or Indian.

The integrative functions of certain types of crime control are also clear. There are so many dangers in life. There have always been. Our personal control is limited. So is also state control. Cancer might hit. Radioactivity. War. So much is incomprehensible. But a small selection of acts are seemingly easy to understand and have also other characteristics which make them ideally suited for state action. Acts designated crimes are **not** manipulations at the stock market but robberies in the street, **not** expressing family control through beating wives but beating unknown in the dark street, **not** smuggling liquor to Islamic countries — such acts are jokingly commented on in the Western press — but smuggling of cannabis back into Europe, **not** large scale export of outdated medicine to Asia or Africa but selling morphine in the streets of Oslo.

Crimes ideal for state actions are those carried out by Powerless groups in the periphery (young, poor, mentally confused) People with appearance that blocks identifications (hippies, punks, skid rows, gipsies, foreign workers, immigrants) — People performing acts generally disapproved of, and with only limited similarity to deviant acts carried out elsewhere.

Around suitable acts carried out by suitable actors and directed against suitable victims can be stirred up moral panics. Mass media apply — and cash in heavy profit — on the concept 'crime wave'. I am old enough to have experienced several of them. Waves of car theft, of vandalism, of drug use, of youth violence. After some time the wave is seen as normality. But in the heat of the panic imprisonment of the category of culprits is pushed up, and then tends to remain at the high level for a long time.

The panics around drugs represent the most typical case in Europe today. Drugs are real problems. Don't interpret me as a drug freak, I prefer that we all get high from walking in the mountains rather than smoking marihuana. Drugs are problems, but at the same time completely unimportant compared to the major killers, which are alcohol and tobacco. But drugs, certain drugs, criminalized drugs, are perfectly suited as State enemies for all the reasons I have given above. One president after another has used the war against drugs to unite the not so United States of America. And European politicians are using drugs in much the same way. It is impossible not to be in favour of stern measures against drugs. It is as impossible as not being against sin. The drug arena is perfectly suited for a competition among politicians for being the champion in the olympic game

against the evil. Lots of votes, nothing to lose — only some from the category of basic losers in prison. The war against drugs helps insiders in society to become more integrated, at the usual cost of increased alienation among traditional outsiders.

A third factor contributing to high prison figures is the simple fact that **prisons pay.**

For centuries we had slaves. It was rather profitable. The workhouses of last century were not that successful; they could not compete. But this century has seen successes. Stalin's work-camps and Hitler's concentration camps fulfilled several tasks. They went out of fashion, but what are we up to just now? I would call it a renewal of the idea of the useful prisoner. In two ways. First in countries where the work moral is low. Here the lower class produces more in strictly controlled surroundings, as e.g. in prison. Some years ago I visited a model prison in an Eastern European country. From the top floor there were factories as far as the eye could see. Factories inside the wall and belonging to the prison. According to the vice-director of the prison administration in the country, this prison runs with considerable profit.

And then, at the other end of the continuum, the United States, and with spiritual children in France and West-Germany: the idea of **the private prison.** This is in reality **not** a continuation of the old idea of galley slaves and workhouses. The profit does not come from the work of the slave or prisoner, but from the work of handling them.

Prisoners are thus converted from workers to products, from humans to things. The old historical model is the poor-house. Auctions were often arranged. Those who had the lowest bid got the offer — the care of the poor. With private prisons we build an enormous growth-factor into the system. It is remarkable that the new private entrepreneurs do not recognize their heritage.

The fourth factor influencing prison figures is more complicated to handle. I have called it **'major features of the legal arrangements.'** This formulation is clumsy, but so is also the reality. If I had made it more streamlined, I might have lost a basic dilemma. I could have called it either: Features of the institution of crime control or Features of the institution of justice.

But here we have to move carefully. An institution of crime control is not necessarily equal to one of justice. The formulation 'An institution of crime control' has a built-in goal: to reduce crime. It is a utility-orientated institution. Through the term crime control we have in a way accepted that crime can or ought to be controlled through the application of pain, that crime control is the purpose of punishment. Prisons as treatment or training, prisons to deter others, or security measures, are all ideas based on utility-thinking.

Utility is a child of our time. Could it be otherwise with punishment? Punishment is intended delivery of pain. Could we inflict pain on other people if it was not directly useful in the fight against crime?

Maybe we could not. Maybe a de-emphasis on use-functions would reduce the seemingly 'obvious' need for pain delivery. I think so. But that is not my major point here and now. Instead, my point is that a reduction of utility-thinking around punishment opens the way for alternative paradigms. I have three in mind.

First some reflections on the **function of rituals:** let us compare sorrow and anger.

A death has occurred. If it was a person close to us, most among us prefer some help to cope with the situation. One such help is the type of organization of grief carried out in the funeral.

But what a waste of opportunities, seen from a rational, utilitarian point of view. What an anachronism, compared to how penal courts take care of situations of **anger.**

In a health-orientated utilitarian society, funerals ought to be given some rational purpose. They ought to be used for the prolongation of other people's health. The Ministry of Health ought to distribute an assortment of suitable banners to hang on the walls of the crematoria. For example: 'If he had not smoked, we had not been here now'. Or 'Pubs are danger-spots'.

They do not do it. They know, as we all know, that grief is an act without purpose.

But in this perspective we might be able to perceive present-day's courts as lost opportunities for coping with anger. They **might** have provided a frame. Anger is of no smaller concern than grief, with no smaller need for finding an expression. Courts might have provided the framework for ritualized expression of this anger. But with modern courts we are instead back to utilitarian state pedagogical purposes. And we are in a situation badly suited for the victim. Grief is a **personal matter.** One cannot grieve by proxy. But that is the fate of the victim in court where the prosecutor carried his case. Grief is also an emotional matter. Again the dry character of court proceedings is badly shaped to take care of anger.

But if courts were seen as arenas for ritual expression of anger, how should they then decide on the level of punishment? What sort of punishment, loss of honour, money, time, limb or life would be the right one?

If there is no relationship between crime level and imprisonment level, if we feel free to think along other lines than utility, then we are also free to concentrate on the pure moral considerations involved. Here come the absolute theories of punishment.

There are two major variants of such penal

theories. The one has a basic similarity to the utilitarian theories on one very important point. It is a theory founded on strong, non-disputable authorities. Utility theories have the State as their foundation. Most of the non-utility theories have scripts from God, prophets or other authorities. The conception is one where the truth exists somewhere out there, given by absolute authority, and the task for the Scholar is only to translate the truth into modern language. The theoretician is only the spokesman for God, exactly as the modern one is for the State.

An alternative to a conception of law as something existing, ready-made from God or eventually nature, is one **where justice does not exist, but is created!** This alternative is one where justice does not consist of ready-made principles to be excavated through methods applied within law or within social sciences, but as principles formulated in the process of finding them. It is a concept where the truth does not exist except in the moment of creation. It is a conception of each human being as a moral agent, each and everyone as a prophet!

This then opens questions of how to find out. It opens questions as to which form of social organization is best suited for creating standards for justice and standard for pain — if pain at all is to be considered. Some would think lawyers were particularly useful in such a process. Some would on the contrary think that ordinary people uncontaminated by legal artifacts would be the best. I belong to the last group. And have in a paper called 'Conflicts as property' (Christie 1978) said why. Here I will only add: **social researchers are not any better suited than lawyers.** Particularly: public opinion surveys on the general sense of justice are of no use whatsover. They do not go deep enough, and are in our time mostly pale reflections of stereotypes created by mass-media. Questionnaires are not answered under the burden of responsibility. Acts are the tests of opinions. Concrete acts. It is through ordinary people's responsible participation in concrete cases of decisions on the use of pain that we get insights into their principles of justice. It is when they personally have to decide on the use of pain, and preferably have to carry out the decision themselves — it is only then we get to know the basic views emerging from the process of participation.

Such an approach would also be in constant need of systematic surveillance. But not only of the auditing type or the legalistic one. Free from utility-thinking we would be confronted with a need for an evaluation of the penal approach as a **cultural phenomenon.**

Again, this can be done out of several positions. One is from the point of the emperor. Hitler himself decided on questions of art, particularly in painting and music. Cultural expressions were important to him. They expressed the state, and had to be decided by the state, which meant by him. Franco, Mussolini and Stalin had similar inclinations.

An alternative view is to look at cultural phenomena as representing everyone, including myself. The National Theatre in Oslo represents me as a Norwegian. So do Henrik Ibsen and Edvard Grieg. But so does also the fact that we executed 25 prisoners after the Second World War. The killing of Quisling is a part of me. So is also the magnitude of our prison population. And I am disgusted by that part. But I am of course also — belonging to the western industrialized culture — represented by what happens in the U.S.A. It is in a way a part of me that cultural relatives find it acceptable to do such a thing to so many fellow citizens.

It is not unavoidable to have a national theatre, or money for painters. Arguments for it can only be based on values. It is right to have it; terribly expensive, but right. The same is ultimately the case with penal measures. It does not feel right to cut fingers as punishment. Not any longer. We felt it O.K. up to 1815. To me it does not feel right to have 2,000 people in prison either. Nothing drastic would happen if we slowly reduced it to 500. We are free to decide on the pain level we find acceptable. There are no guidelines, except in values.

Those of us working close to the penal system, have particular responsibilities. But not as experts. As a criminologist I feel more and more that I function in a role very similar to a book-reviewer or art critic.

Rulers, and in democratic states politicians, do all the time attempt to give the impression that theirs are rational tasks in a field where utility-thinking is of obvious importance. Our counter-idea as cultural workers — or members of the intelligentsia as they would say in Eastern Europe — is to puncture this myth and bring the whole operation back to the cultural arena. The delivery of pain, to whom, and for what, contains an endless row of deep moral questions. If there are experts here, they are the philosophers. They are also often experts in saying that the problems are so complex that we cannot act. We must think. Maybe that is not the worst alternative where the other option is to deliver pain. ■

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Copies of this talk and others given at the Lincoln Conference can be obtained from Bishop's House, Eastgate, Lincoln LN2 1QQ.

Scene From Here

The author discusses the problem of mentally disordered prisoners and suggests a way in which the problem could be tackled

Paul Bowden MPhil, MRCP, FRCPsych. Consultant Forensic Psychiatrist Bethlem Royal and Maudsley Hospitals and to the Home Office

It is taken for granted by the present writer that there are some people in prison because of the failings of a variety of individuals and organisations: the police who neglect the provisions of the place of safety order, section 136 Mental Health Act 1983; the courts who use remands for a variety of covert reasons, both benevolent and punitive; hospital psychiatric staff who, either from prejudiced attitudes, laziness, or a dislike of objecting and objectionable patients choose the easy option. What is not accepted is that there is any evidence of a trend whereby increasing numbers of mentally disordered persons who should be hospital inpatients are to be found in prison. That there is a casual, reciprocal relationship between the numbers in asylums and prisons is ill-informed and unimaginative, or an example of scaremongering.

Some express the opinion that all mentally ill prisoners should be removed to hospital. This righteous view ignores the facts that some do not want to receive treatment and they are not detainable under the Mental Health Act: in others it is wholly inappropriate that the criminal label should take precedence over the mentally ill one; in yet others there is no discernable association between illness and criminal behaviour.

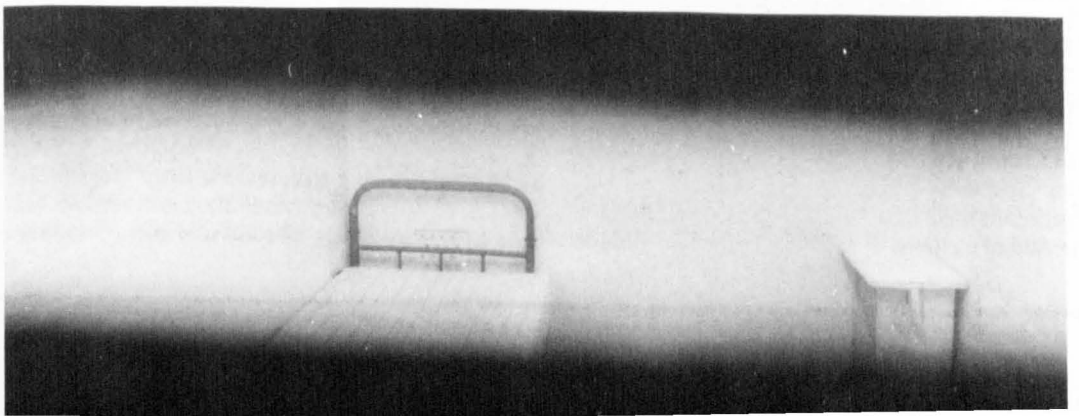
In some circumstances prisons and hospitals are very different institutions; in others they are almost indistinguishable. We do have hospitals in England where security is effectively the paramount consideration. What we need are areas in prisons where treatment of the mentally ill has a similar priority.

Take as an example the management of serious suicidal behaviour. One strategem is to double-up which means that another prisoner (willingly or unwillingly?) acts both to police the situation and as a therapist. A recent innovation has been to block windows so there is no anchorage for a home-made rope. It also means that there is little ventilation in the cell and no egress for the faeces parcels whose jettisoning made life a little less unbearable. Blocking windows and the proposal to insert CCTV cameras in strip-cells (euphemistically called special medical rooms) reflect the Home Office response to behaviour caused by profound emotional distress.

A second example concerns prisoners with acute psychoses. Without their consent treatment can be given only in circumstances of grave necessity. Such a practice is wholly unacceptable outside prisons and a major purpose of the 1983 Mental Health Act was to provide a framework for treating detained patients. The Act does not apply to prisons where common law prevails. It is also true that acute psychoses are not effectively treated in prisons because without adequate monitoring of vital signs such as blood pressure and level of consciousness psychotic prisoners cannot be tranquillised to the point of sedation.

In the absence of sufficient staff to do escorts and bed watches and given the delays in arranging NHS transfer and other factors there will always be mentally ill people in prison. They must be catered for properly. The Home Office disguise for its parsimony relies on a flood gates metaphor: if the mentally ill people in prison are acknowledged and facilities are provided for them courts will sentence unfortunates to prison for treatment. Behind this thinking is the belief that the Department of Health, which can select those to whom it dispenses the benefit of the welfare state, will increasingly renege on its reponsibility to provide care. Another argument is that in the absence of adequate community care the prisons will be used to keep our streets nuisance-free in an elaborate public hygiene exercise. There is no evidence that either process is operative and a more persuasive argument is that introducing humane treatment and care is an anathema in a system dedicated to punishment.

Why not make a start at, say, a large remand prison? A small ward could be opened which does not depend on cellular accommodation and which could be designated as a hospital within the National Health Service Acts. The work would then come under the guidance of the Mental Health Act Commission which would provide the staff and prisoners with the support they need. ■



Letters

RE: PERSONAL OFFICER SCHEME

Dear Sir,

I wish to express some disquieting thoughts about a development in prison regime, which I feel now needs reconsideration. This is because of the post riot aftermath and the continuing unresolved difficulties with Framework.

At the outset I must stress this is *personal* disquiet and does not reflect the views of anyone else at Thorn Cross. My anxiety is, however, shared by my own Senior Probation Officer and if tested publically would reflect the unspoken views of many others however, as I feel there are moral implications in the issue.

Over the last five years I have been actively involved with the *Personal Officer Scheme* (it is Welfare Care on the cheap).

1. In theory, it is a fine concept. However, in practice the trainees' care, worries, concerns and throughcare preparation is achieved in a systematic and achieved manner *only* if:

a. The Officer is not on leave, especially at a crucial period in the trainee's period of custody.
b. The Officer is not on nights, especially at a crucial period in the trainee's period of custody.
c. The Officer is not on sick leave, especially at a crucial period in the trainee's period of custody.
d. The Officer is not on Training Courses, especially at a crucial period in the trainee's period of custody.
e. The Officer is not on Detached Duty, especially at a crucial period in the trainee's period of custody.
f. The Officer is not on Control & Restraint Training especially at a crucial period in the trainee's period of custody.

In the natural course of life a-d would happen anyway and in theory the case load is picked up by his partner; now the reality of detached duty and more C & R courses raises other issues.

2. The operational need for consistent regular C & R courses is now quite obvious and pushes into focus the dilemma for the Prison Officer in his role of having to police, contain control and protect, and his responsibility to be the replacement for the Probation Officer in the establishment. Now with cutbacks, probation visits from the Home Officer are not as frequent.

Officers undergoing C & R training are required to adopt a different mental stance in order to be personally and corporately effective.

3. On their return from the course, they are then required to pick up their 'Probation Officer' role as Personal Officers. Since the riots this is not an option that prison staff find easy to reconcile with what is required from them in their primary role. They become distanced from their clients and some do not wish to act in this capacity. This is an honest realistic response.

4. So far I have not yet mentioned staff shortages, TOIL, framework problems which then require the Prison Officer to complete normal everyday routines, and until these are completed 'Casework' is 'dropped'.

5. Nor does it deal with the inmate who does not, will not, confide in a uniformed member of staff or the Prison Officer who was recruited, not primarily for his skills as a social worker, but a Prison Officer, and is unable to function effectively as the former.

6. The above scenario leaves the inmate (as ever) at the end of the list. In the Personal Officer concept, the Senior Probation Officer is only there as a *resource* and not to do casework.

7. The 'Shared Working System' is the effective way of achieving care and throughcare in prisons as well as DYNAMIC security. The inmate is then the responsibility of the integrated attention of both Probation Officer and Prison Officer. Both contribute different skills in managing the inmate through his sentence.

8. Because I, as a practitioner, who deals with Officers, inmates and Probation Officers both locally, but in my training capacity meet with a wide spectrum of both, feel that the Personal Officer scheme now provides a chasm into which the inmate falls because of the points I have outlined, I really feel that perhaps there is now a lack of realism or honesty in our perception of this development in the role of the Prison Officer and we should not be afraid to address it.

9. On many occasions the Prison Service has become frozen in time and progress — routines can stand this, but the inmates cannot.

10. Establishments with Personal Officer schemes have not been complemented to take into account the time that casework demands. It is not possible to adequately look after trainees with ad hoc, irregular time snatched and clawed back from routines.

11. I do not think that there needs to be a review of what the Prison Officer is and be honest in what a Prison Officer, not Probation Officer, can achieve as the total case worker.

12. Perhaps the merits of shared working should be examined and if it is a better deal for inmates, despite the expense, this be adopted as the model of best practice we want.

K Dawson (Mrs)
Governor V

REHABILITATION

Dear Sir

I read with interest the letter from David Law in the Spring 90 edition of the Journal. The views expressed reflected the current attitudes of many staff in prisons, often being positive about developing roles, but also seeing the years of experience of using prison as a 'treatment' to rehabilitate offenders as ineffective. The 'treatment' concept was clearly implicit in Rule 1, but I think the present mission statement can accommodate more realistic concepts. However the need to rehabilitate is still seen as central to this statement.

It is impossible for any system or any individual to rehabilitate an offender. This was clearly expressed in prisoners contributions to a Radio 4 debate broadcast from Leyhill Prison, earlier this year. Prisoners claimed that prison could not rehabilitate, only the individual could do that for themselves. This, I think, clarifies the role of not only the prison, but all other agencies in the criminal justice system. This must be to help give an understanding of offending behaviour, and to try to motivate the individual to choose a more socially acceptable lifestyle.

To achieve this there must be greater understanding between different departments of a prison. Training, experience and varying personalities ensure that a wide range of expertise and skills are available in establishments but unfortunately traditions built up often mean that these are used in isolation, rather than as part of a planned approach to sentences. To achieve the aim of motivating prisoners to 'lead law abiding lives' requires the best of skills and abilities on a planned way, with a multi-disciplinary approach.

Fairly early in sentence work on offending behaviour must be undertaken. All too often prisoners are allowed to complete a sentence hiding behind social factors as the sole cause of their offending. The fact that there are alternative strategies and

ways of coping with prbblems must be looked at. The aim of such work is to try to get 'ownership' of offences by those who commit them. For example, the prisoner who claims that a theft occurred only because a fuel bill was unpaid and disconnection would mean hardship for children must be helped to understand that the theft was a choice, with other ways of coping with this situation not chosen. As such it was the prisoners responsibility for that choice.

Social factors which contribute to offending need to be identified and addressed during sentence. These may be alcohol and other drug counselling and education, basic education, relationships and so on. To do so must involve the working together of all disciplines in a prison, and if the conditional release for many prisoners envisaged in the White Paper is implemented, communication about process and progress with the supervising probation officer is also essential. This can be done as experience from some YOI's show.

Towards the end of sentence the various strands of work with a prisoner can be brought together in a pre-release course. This will supplement work already done and also involve employment and interview techniques, budgeting, debt and use of leisure into inputs.

The object of this work is to give coping methods and show the choices available. If the individual then chooses to re-offend, it is a choice made with better knowledge of alternative.

This type of working could maximise the expertise and interests of all staff. All too frequently there is an assumption that 'specialists' must be involved. This is demonstrably untrue. In prisons in Avon we have officers running groups for offending behaviour, including sex offenders, jointly with other staff, leading development in the work with HIV/AIDS with both staff and prisoners, the development of work with problem drinkers and liaising with other agencies such as NACRO, Apex Trust, and DSS. This work is very professionally done and those officers involved find the work rewarding. There are, of course, numerous examples of prison officers staffing pre-release and social skills courses.

To develop in this way means that attitudes must change, not only by uniformed staff, but by all working in prisons and clearly there are implications for management and resourcing . There is a way forward which would show the mission statement has meaning, would give job satisfaction and would be a contribution from the Prison Service to the overall aim of the criminal justice system to reduce offending.

F Haynes
Senior Probation Officer

Answer to Comment

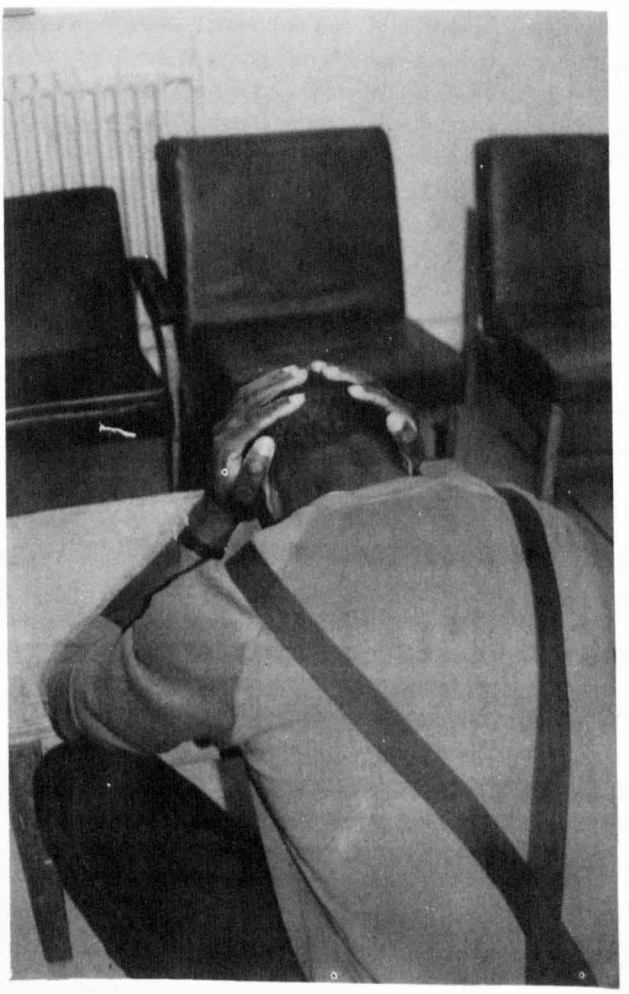
Dear Editor,

In your editorial comment (Prison Service Journal 1990 Summer Issue) you ask 'How can we give them (prisoners) a stake in maintaining order?'.

I think that we know the answer to this question and with a bit of imagination the solutions are relatively easy to apply.

Firstly, we must never forget that prisoners are people. If we want to know how they might respond in any circumstances we can assess our own likely response.

Secondly, there are some excellent examples around of prisoners having a stake in maintaining order. Take Grendon for instance: they have succeeded in getting prisoners to recognise that the regime offers them the prospect of self knowledge, and self determination. Most people can identify what is valuable and good for them and will work to preserve it. This holds true for all establishments which can offer real opportunities for prisoners to do something they value. It could be a useful desirable learning experience such as an Open University or a Bricklayers Course. It could also be an opportunity to earn money such as on P.R.E.S. or working out schemes. It might even be the chance to re-learn social skills or understand more about self motivation and behaviour. On a ladder of things which prisoners value these would be the top rungs.



The middle rungs of the ladder would consist of things such as access to family and friends. Evening and weekend visits, generous home leave, access to telephones, the ability to personalise one's living area and clothing, a liberal policy towards possessions and privileges and above all, choice; as much choice as possible.

The lowest rungs of the ladder will consist of vital elements such as good food and clothing, good access to sanitary and bedding arrangements, a good environment (the value of gardens and greenery in human life is too often overlooked.)

None of these things guarantee that prisoners will have a stake in maintaining order, but it is obvious to anyone that an ugly, bleak prison where family visits are difficult, which has many restrictions, little choice, and offers no positive experience is the worst possible scenario from a control standpoint.

David Waplington
HM Prison Service College, Aberford Road, Wakefield, West Yorkshire WF1 4DE

Lookout

Not so long ago I was the manager in charge of a unit for acutely ill, psychiatric prisoners. As part of my induction I asked some naive questions of the psychiatrist who was responsible for the unit. Why did we have so many prisoners — most of whom were black — who were psychiatrically ill, and a waiting list approaching 50? I remember his reply : 'Oh hardly any of these are psychiatrically ill — they're simply management problems that the system can't cope with. "Psychiatrically ill" is just a label that gets them out of the hair of some hard pressed governor, and into here'. It didn't take too long for his words to come true. A few days later one inmate (again black) arrived via a body-belt, and five staff. They left, and the body-belt was removed. The 'inmate' became a 'patient', and that simple change of label allowed the patient to walk freely around, take exercise, use the library, have normal visits and intermingle happily with staff and other patients alike.

However it is rare to find the application of the label 'mentally ill' bringing with it any benefits. It was the Russians, pre-Glasnost, who specialised in labelling people as mentally ill, and removing them to institutions. It was a neat way of getting rid of dissidents, whilst at the same time appearing to 'treat' them. It was also a very powerful way of expressing an orthodoxy: you are mentally ill because you do not support the government, and the government is 'sane'. In the old USSR this meant that those, like Andrei Sakharov, who made claims for democracy, or freedom of speech outside of Marxist-Leninist ideology were immediately at the mercy of a state psychiatrist with a career to build.

Are things really any better here? The prison has for a very long time been the prime site for state-sponsored psychiatry. The Prison Medical Service, founded in 1774, has over 100 full-time medical officers, the vast majority of whom are recognised under Section 28 of the 1959 Mental Health Act as having 'special experience in the diagnosis and/or treatment of mental disorders.' As a consequence they have a great deal of power, both in the preparation and writing of reports to courts etc, and in the authorization/use of psychotropic drugs. The psychiatrist's aim, although rarely stated, is to assess, classify, control, transform, and finally to recycle. Nobody minds too much if this is done to a crazy bag-lady who quotes the Bible and shoplifts in Marks and Spencers. But what if it was a sexually mature 12 year old girl who wasn't getting on too well at home, and whose mother couldn't cope any longer? Far fetched? Before you recommend another prisoner to see 'the Doctor' I suggest you read Sue Read's 'Only for a Fortnight: My Life in a Locked Ward'. ■

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