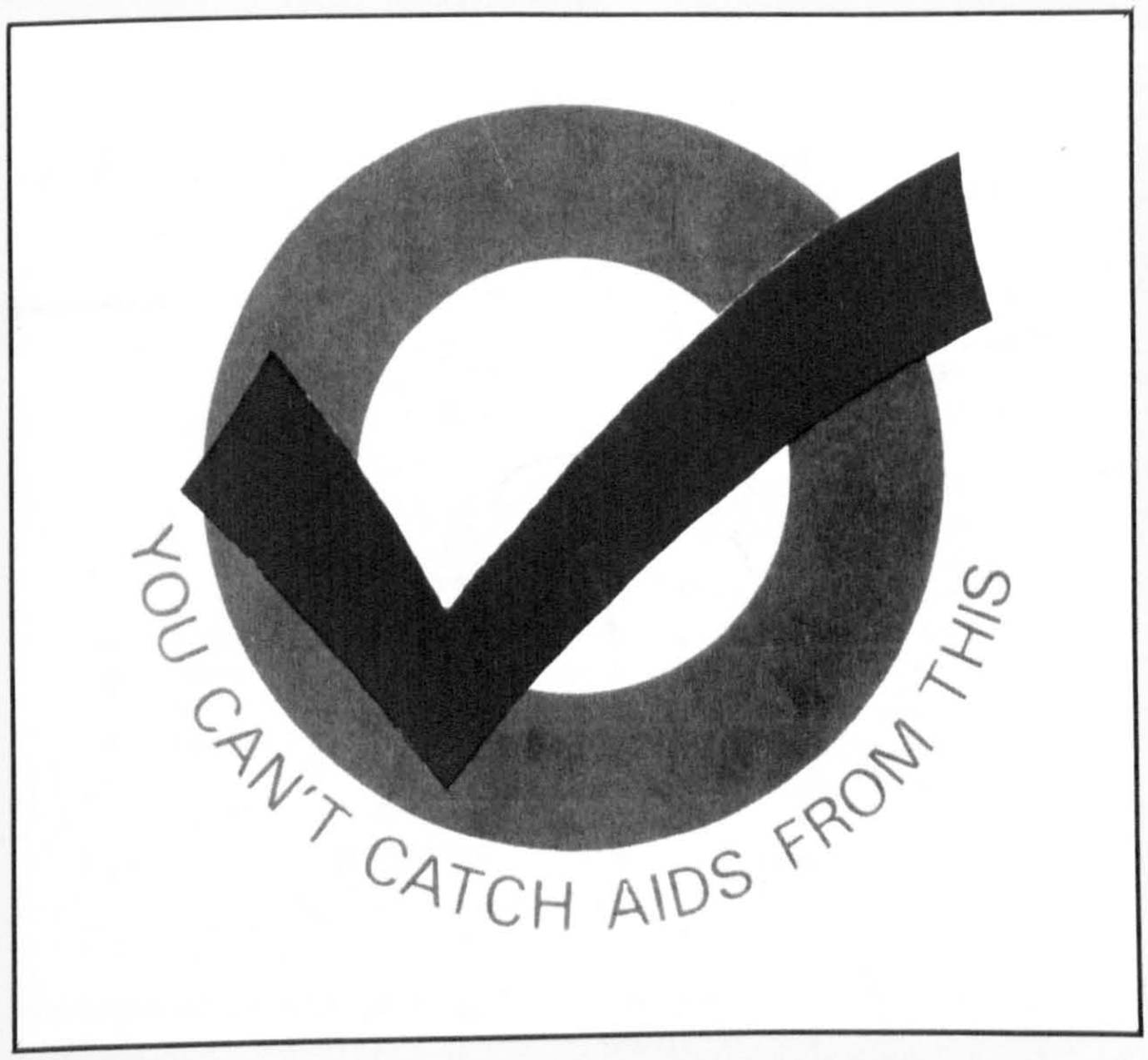
PRISON SERVICE JOURNAL

No 78 SPRING 1990



HIV/AIDS EDITION

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Contents

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Comment

What has happened to the strength of feeling so evident when AIDS hit the headlines in the early 80s in this country? In prisons at that time rumour was rife, sometimes well-founded, at other times not; some of the things said were that the bodies of those who died having contracted AIDS were cremated at higher than normal temperature; doctors were refusing to carry out post mortems for fear of coming into contact with body fluids; dentists refused to treat prison staff for fear of contamination; all homosexuals should be segregated.

The feelings aroused were ones of fear and then moral outrage leading to scapegoating. Rational discussion was difficult even to questioning the validity of what little information was available.

Any outlandish explanation for the occurrence of the syndrome was accepted and predictions of the rapid spread and escalation of the number of cases was never refuted but used to support whatever line of moral outrage was being peddled at the time.

Although those attitudes remain they are much less often expressed and the panic of those early times has gone thankfully. That has been brought about in part by a better awareness of the realities. In prisons the giving of as honest an account as was possible and a forthright picture of the situation to staff and prisoners has helped that process of education and so has the direct experience of meeting sufferers and appreciating that they are otherwise quite normal. That was especially potent when the sufferer was a member of staff as has happened on more than one occasion and where the infection was contracted outside the prison environment.

In the wake of that better understanding has come a cooler look throughout society at the need for further information and discussion. The government backed survey of life styles which was expected to give more data about the way HIV may be spread and how changes in behaviour can affect that spread has been stopped. The education campaign targetting that most vulnerable group, the under 25 year olds, has been abandoned. Money for projects highlighting issues about HIV and AIDS sufferers has dried up.

Where this lowering of the emotional temperature reflects a more rational approach it must be welcome, but if it means that less considered attention is being given to the treatment of HIV and AIDS sufferers then it is likely to be short sighted and short lived.

In prisons the segregation of prisoners who are not ill but are diagnosed as HIV infected continues despite being an unjustifiable restriction and clearly contravening the Service's statement of purpose. If that goes unchecked not only will it be unfair and possibly challengeable in the ECHR but it will erode the Service's claim to professionalism.

The Service needs to address the questions of how the spread of HIV infection can be prevented in prisons. How is the campaign for safe sex and using clean needles to be translated into prison terms?

Most prisoners are heterosexuals and see it as important to their good opinion of themselves that they stay that way. They fear the loss of virility which a long spell in prison might bring and masturbation not homosexuality is the way they cope. However there are numbers of those in prison who are homosexual outside and inside and some who adopt homosexual behaviour just for the time being in prison. Is it responsible of the Service neither to prevent sexual intimacy nor to issue condoms so that 'safe sex' can be practiced? The paradox is of course that by issuing condoms homosexual behaviour may be seen to be condoned despite being against the rules. There are good reasons for those rules for who can say whether a relationship formed in the deprived and co-ercive atmosphere of a prison is freely made and therefore by condoning homosexuality would we be encouraging the predatory activities of some prisoners. On the other hand do we not have to recognise the reality of homosexuality in prison and to issue condoms but to do so in a way which allows counselling to be available. In other words the free issue of condoms should go along with education and confidential HIV testing as part of a programme to combat AIDS and care for sufferers. I recognise to do so is inconsistent, but to go on as we are now is to be hypocritical. Furthermore we might do well to lessen the risk of those who on the outside are heterosexuals but who when inside adopt homosexual behaviour by encouraging more home leave and conjugal visits.

However the more likely way in which HIV is spread is through the use of shared needles which carry infection. To issue needles knowing they are to be used for the misuse of drugs raises objections of even greater strength than those against the provision of condoms because the misuse of drugs with clean needles remains dangerous. Nonetheless needles having been used for drug misuse are found in our prisons and so are quantities of drugs, mostly cannabis, but also substances which can be injected intravenously. If these practices do lead to people developing AIDS and dying or being infected with HIV and passing it on to those inside or on release to those outside prison and we cannot prevent such practices are we not burying our heads in the sand by refusing to offer even supplies of cleansing liquid to encourage the use of clean needles? There is no guarantee that by adopting these measures that they will succeed. However the need in the Service is for a debate in a rational manner. The danger is that we either duck the issues by moralising or ignore the issues out of complacency and the difficulty of finding a way between combating the infection and condoning rule breaking. ■

Management Models and Performance Monitoring in the Prison Department

Rick Evans has now left the Service to join the Civil Service Selection Board. We shall miss his clear thinking and practical application of theory which marked his work. This article will be familiar to those governors fortunate enough to have heard Rick address seminars on the subject of the management development of the Service but I make no apology for reproducing it because it remains a coherent account of a number of initiatives which when they were launched appeared only to be joined by a tenuous thread. This article demonstrates the strength of that thread which runs from the May Report of 1978 through 'FMI, Accountable Regimes, CI 55/84' Regime Monitoring to Fresh Start and created the springboard from which the Organisation Review was launched.

The 1980s brought radical changes to the management of the prison service of England and Wales. This paper documents some of the managerial developments, placing them in a broader context and noting elements which have contributed to successful implementation.

Like any account of organisational developments, the events noted here may present as drily mechanical. In practice, of course, each component represents a considerable amount of deliberation, managerial effort and subsequent refinement by staff at all levels of the organisation. Equally, the components of change when placed within a framework (sometimes with hindsight) seem very orderly: but, to many staff, the reality will have been a series of more or less related initiatives which have appeared in swift succession, imperfectly supported and open to widespread mistrust.

The Prison Service of England and Wales

There are more than 120 penal establishments in England and Wales ranging in function from open prisons to top security establishments and from local prisons and remand centres, which directly service the courts, to young offender institutions (the former borstals). The service is organised functionally to hold young offenders and adults, males and females separately. Until 1989, the prison population had grown to unprecedented high levels, with prisoners held on remand increasing most rapidly in number.

Since 1969, penal establishments in England and Wales have been grouped geographically into four Regions for operational and administrative purposes. There is a central Headquarters in London. The Prison Department is part of the Home Office which is also responsible for the immigration and emergency services, broadcasting, and other home affairs. Responsibility for the prison services of Scotland and Northern Ireland is held by their respective government offices.

The May Enquiry and FMI

Most accounts of the 'new reality' brought to government departments start in 1980 with Lord Rayner's programme of scrutinies and dwell on the Prime Minister's launching of Financial Management Initiative (FMI) in 1982. Since then, the importance of management skills and the ethos of value for money have become difficult but essential issues in the civil service and new approaches have been forced by downward pressure on resources, continuing programmes of 'efficiency reviews', and exploitation of information technology. The impact of the FMI has been a more efficient and effective use of resources brought about through clarity of objectives, priorities and accountabilities and by accent on skills, incentives and information for those managing the organisation.

As in other areas of the public sector, many of the developments in the prison service can be attributed directly to the impetus of the FMI. The Prison Department, however, had a John the Baptist in the person of Mr (now Lord) Justice May. When the May Committee of Enquiry was set up by the Home Secretary in 1978, the prison system was in turmoil and uncertainties about aims and philosophy, organisational difficulties, and low staff morale were the major topics in his subsequent report.[1]

Although its recommendations were stated in somewhat generalised terms, the May Report helped the Prisons Board to focus on the use of resources, the objectives of each type of penal establishment, staff disaffection, and the delivery of activities and services provided by each institution (collectively described as its 'regime'). During 1981 and 1982 many of these ideas found expression in 'accountable regimes' projects set up with the task of developing local objectives and auditing available resources. They aimed to improve management accountability, co-ordinate activities for prisoners, and apply resources appropriately with the fullest participation of the prison staff.[2] These projects were wider in scope than previous management initatives (such as Management by Objectives or MbO which had been piloted in selected sites in the mid-70's) but were allowed to evolve incrementally.

Some progress was made in making regimes more 'accountable' by better allocating prisoners to activities and by redesigning management structures, job descriptions and the institutional meeting structure. By 1984, however, these prison staff (like their colleagues elsewhere) were pre-occupied with national initatives which included a common shift system (later withdrawn), the recommendations of a new-style 'resource control' scrutiny, the unfolding of a consultative exercise about management structures,

and constraints on overtime payments. Another part of this last, the Department's budgetary control strategy, was the installation of a financial monitoring system which is described later.

Tasks And Functions

'Accountable regimes' helped to fuel the process, which the Director General led personally,[3] of defining aims and objectives. Every government department has a seminal document which marks its concerted implementation of the FMI. In the case of the Prison Department, Circular Instruction 55 of 1984 defines the management accountabilities within the service. Its main principles are:

(a) the key manager will be the prison governor who is charged with the delivery of Departmental policy and is responsible for the staff of the institution;

(b) the framework for this policy is set out as the task of prison service and a broad statment of the functions of establishments;

(c) the governor's accountability will be defined by explicit terms of reference agreed with his line manager and accounted for formally in an annual report.

Boiled down to the minimum, the task of the service is to keep prisoners in custody; present them to court as required; provide as full a life as is consistent with the facts of custody; and enable them to retain links with the community and prepare for release. This is to be done with maximum efficiency of available resources. At the time, the statement was seen by many staff and by outside observers as an uninspired and pragmatic doctrine: indeed, it set out deliberately to avoid aspirational language. One of its values in managerial terms was to cut through what had been an endless debate about the purposes of imprisonment (the sometimes conflicting issues of punishment, incapacitation, deterrence, humane containment, and rehabilitation) to focus on the precise functions to be carried out by penal establishments.

Publication of the Circular Instruction signalled the start of two years' work of translating the 22 proposed functions into specific terms for each establishment. When coupled with developments in working procedures, a statement of available resources, and an annual assignment of priorities (or targets) for the governor, the 'functions document' gradually moved towards the status of a contract between the governor and his line manager. The performance of the establishment and hence the accountability of its governor were to be appraised against this agreed manifesto.

In terms of performance criteria, the breakthrough lay in governors translating as many functional statements as possible in a quantified manner. Most commonly, regime activities for prisoners were stipulated in the form of operating hours and the number of inmates typically involved in the workshop, class or party. These figures aggregated for the week and the year, became the baselines or planned levels of delivery for the establishment. In the absence of other criteria, the activity levels assumed to be in operation under existing resources were agreed and recorded as the first regime baselines against which to measure actual performance.

In November 1988, the task and functions of the Prison Department were 'topped out' with a belated but broadly accepted statement of purpose which is being actively promoted across the service. What has elsewhere been described as an organisation's 'mission statement' runs: 'Her Majesty's prison service serves the public by keeping in custody those commited by the courts. Our duty is to look after them with humanity and to help them lead law-abiding and useful lives in custody and after release'.

Taken together, these elements comprise the basic management model which has emerged in the prison service this decade (see Appendix A).

Statement of purpose
and CI 55/1984
↓
Prison service task
↓
Establishment functions
↓
Regime baselines
↓
Establishment performance
↓
Governor's accountability

From a theoretical position, this is an unremarkable process of defining aims, objectives, work output, and performance criteria. In practice, however, it represents a fundamental development for the prison service.

Re-organisation of Establishments

To many staff, the emerging management model remains a layer of concern remote from the daily operational business of the service. Indeed, even managers have felt it a somewhat arid path to follow and have sought a 'sense of direction' which can build on clear objectives and systematic managerial information but incorporate recognisably operational principles about prison management.[4] But, from the same roots as the management model, sprang a radical re-organisation of

shift systems and management structures for staff in all establishments.. This package was launched in April 1986 with the title 'A Fresh Start'. It immediately followed several events: a protracted consultative exercise about local management structures, renewed cash limits on prison officers' overtime, an aborted negotiation about new attendance schemes, and widespread industrial action.

In a firmly directive style,[5] A Fresh Start restructured the pay of prison officers and governor grades, entirely limiting overtime payments which had been regarded for some years as demand-led and uncontrollable. It changed working practices by re-organising staff into groups with a degree of flexible rostering and by assimilating overlapping middle management grades. It revamped management systems in establishments in an attempt to assign clear roles and accountabilities, integrate specialist staff, and co-ordinate efficient prison regimes under the governors' unifying direction. It stressed value for money in the pursuit of 'efficiencies' and tied the new pay system to a timetable for reducing the working week for prison officers from 48 to 39 hours (governed by 'framework agreement' which runs from 1987 to 1992). The implications of this agreement for staffing and hence the maintenance (let alone the enhancement) of prison regimes is a continuing pre-occupation for the service.

While the more practical outworking of A Fresh Start are easy to point to, its achievements in shifting the organisational culture have been less convincing. Because of the very speed of the changes, full preparation and training of staff for new roles and outlooks was impossible: evidence of a unifying ethos or shared purpose can still prove elusive.

A major evaluation of the re-organisation at the end of 1987 therefore led to a strengthening of the managerial aspects — identification of 'best practice' in establishment procedures, continued scrutiny and consultancy by staff from the Headquarters and Regional tiers, and the formulation of agreed 'action plans' by all governors. Through 1988/89, these plans were implemented alongside the established annual targets in the governors' contracts. Managing for a shared purpose continued as a development theme in 1989/90 when the Prisons Board priorities (or superordinate annual targets) demanded a far-reaching process of agreeing corporate objectives, clarifying functional responsibilities throughout the management structure, and refining job descriptions in each establishment. The process is reminiscent (in theory, though broader in practice) of MbO and should lead eventually to task assignment and installation of specified performance indicators. It is a process which conceivably could also lead back to inflexible manpower formulations which A Fresh Start was designed to annul.

Such an examination of managerial functions all the way down from the governor's contract to the tasks of the individual prison officer will indeed be an achievement if it can be sustained. As found with earlier initatives,[2] its impact may tend to be confined to senior managers and fail to impinge with real meaning on lower ranks. This is a liability in a centralised government where change can be readily implemented by decree and implemented in what has been described as a 'programmed' fashion.[6] In this style of management, policy can be handed down more or less complete, to be pursued in a standardised format with relative speed. Unlike 'adaptive' change (which is incremental and evolutionary in style), however, it may suffer a lack of fit on the ground and be harder for staff and local management to 'own' or police with commitment. Since more adaptive initatives like 'accountable regimes' and MbO were tantalisingly slow to develop and difficult to generalise to other settings, the tendency has been increasingly to drive change through programmed policies, which begs questions about management commitment and lasting cultural change at the establishment level.

Currently, the organisation of the Department above establishment level is being reviewed. This follows logically from the re-organisation of prison establishments under A Fresh Start but is also propelled by value for money, and the possibilities of relocating staff out of London and of agency status. At the same time, the Department has been engaged in a massive rebuilding programme and has been drawn into exploring the privatisation of its remand and escort functions.

Budgets and Resource Monitoring

When he reported in 1979, May[1] found no system of financial control and budgeting which could supply the Department with reliable unit costs or provide the basis for enhanced efficiency and managerial performance. As a result, the finance division of Headquarters together with external consultants produced a financial information system which is based on existing accounting systems for Parliamentary Votes but able to break down costs and generate comparative figures.

From 1983, the prison service implemented and refined this funtional costing system by which local information about expenditure feeds a centralised computer database. Accountants were appointed early on at Headquarters and Regional tiers. Within establishments, 'cost centre' managers were identified and receive regular feedback on relevant expenditure. In relation to other sectors of government service, the establishment of a

costing system of this sort was an early achievement by the Prison Department but further work is required to align properly cost centres with the re-organised management structures of establishments and to assign appropriately to tasks the bulk of the operational expenditure which is prison officers' pay.

In line with the FMI's requirements for financial management, a degree of budgetary responsibility has been delegated to prison governors. Following trials in 1985/86 when 'shadow budgets' were assigned to governors, real allocations in cash terms have been introduced in all establishments. Governors and their staff are increasingly involved in providing Supply Estimates as part of the Department's financial cycle on the basis that successful budgets are agreed rather than imposed. The costing system provides in-year monitoring of the spending of these budgets at establishment and Regional level and prompts managers to account for variance in expenditure against planned levels. While the level of financial skills amongst staff varies widely, it is certainly the case that greater cost-conciousness has been generally achieved. On a Departmental level, the service is committed to planned efficiency savings (with only occasional belt-tightening due to unexpected costs such as prisoners held in police cells) in order to meet cash limits without resource to the earlier excesses of peremptory 'budgetary controls'.

The efficient use of that other establishment resource, manpower, is also subject to local monitoring. A Fresh Start brought adjustments to the complements of most prison establishments during 1986/87 and introduced revised methods of manpower monitoring. Where previously the accent was on the expenditure of prison officers' overtime, the Staff Planning and Reporting (SPAR) system uses the currency of work completed and time owed to staff to assess the use of manpower. Regulatory monitoring of effective hours alerts governors to patterns of leave, sickness or time owed which may be building and provides information to help interpret and plan the delivery of prison regimes.

Measurement of Regime Delivery

The development of costing and manpower monitoring systems has been accompanied by the establishment of two other major information systems in the prison service. The first of these depends upon a programme of installing in every institution a computer database which will hold and update details about its prisoners (and which will eventually be linked to a centralised inmate information system). Like other innovations (such as payroll and other financial systems), the population database exploits new technology and the decreasing resistance by staff to the use of computers. The local population database is included among key management information systems (see Appendix A) since governors need to know the characteristics and throughput of their charges for whom regimes and services must be provided.

The second system is more remarkable for the speed of progress made in its design and installation. This monitoring device for the delivery of prison regimes, called the Governor's Weekly Monitoring, is described here in some detail (see Appendix B).

Circular Instruction 55/1984 not only cut through the debate about the purposes of imprisonment in order to generate a practical approach to tasks and functions; it also permitted quantifiable performance indicators to be constructed on the foundation of agreed baselines for regimes. Up to this point, the performance of the service had been couched in terms of reconviction rates and (in the Department's statistical bulletins) in the terms of escapes, abscondings, prisoner adjudications, punishments, and levels of overcrowding. These are important but rather negative indicators of performance. Other operational services also suffer from the bluntness of such performance instruments — 'clear up' rates, for example, in the police service.[7]

The difficulty has been compounded by the absense of what are commonly called standard minimum rules — criteria which in other countries have been established administratively or through the courts and which define the least requirements of the system in terms of physical or regime facilities for those in custody.

While a statement of the prison service task has provided the starting point for ideas about performance indicators,[4,8] it was the early development of 'functions documents' at establishment level which spurred the design of the Governor's Weekly Monitoring during 1986.[9] In this system, the main regime activities to which prisoners are allocated during the week are monitored as numbers of operating hours and inmates attending. The actual hours and group sizes are recorded daily by the staff involved and, compiled weekly, are set against planned levels of provision which are derived from the governor's contract. By comparing actual and contractual levels, the governor is provided with a quantified indicator of effectiveness. Similarly, having agreed the baselines which underpin the routines of the establishment (such as kit change, bathing and exercise), the governor and his staff can be alerted to deviation in the actual levels of delivery.

The monitoring was designed by practitioners to

be brief, simple and reliable but to provide the minimum standard core for performance monitoring. Problems do occur because the complexity of a total institution operating over several days has been compressed into a relatively small number of indicators. Because the system cannot contend with detailed information about all activities nor track individual inmates through their daily occupations, a separate indication of time spent out of cell must be added. This reflection of the 'quality of life' in a closed establishment is currently undergoing field trials to determine viable methods of sampling. Some staff criticise the emphasis of the system on quantified monitoring which leaves the substantial question of the quality of regime activities as a managerial and inspectoral issue.[10] There is also continuing suspicion amongst some staff as to the purpose of performance monitoring and its relevance to the realities of their work.

Uses of Regime Measures

The prototype of the system was geared primarily to aid governors in the local management of their establishments by:

(a) alerting them to significant departures from planned levels of delivery and to trends or anomalies in the provision of regimes and services;

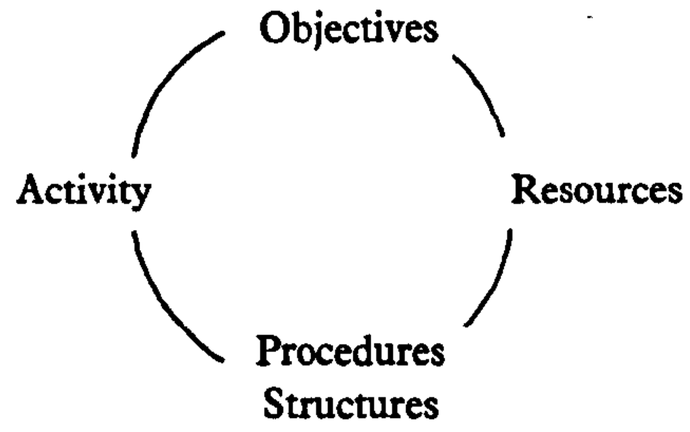
(b) allowing strategic planning and the evaluation of effectiveness, efficiency and economy by linking output to resources and working procedures;

(c) assisting management control and the reinforcement of the accountability structure through the raising of informed questions and objective setting;

(d) in turn, enabling governors to give account of their line managers for the performance of their establishments.

Monitoring of this sort can never provide complete answers; indeed, its purpose is as much to raise questions about the operation of regimes. But this was the first time that governors had been served with any systematic information relating to the effectiveness of their establishments. It armed them with objective indicators when they faced a series of scrutinies, reviews or re-organisations aimed at efficiency savings. It provided ammunition when they sought to rationalise and improve local regime procedures. At its best, therefore, the Governor's Weekly Monitoring was 'owned' by local management whose investment was reinforced through collection of more accurate data.

Such information first became available in two Regions during the cycle of agreeing annual contracts for 1987/88. Although A Fresh Start had altered the basis for the delivery of some aspects of the regime during the year, data indicated that a number of performance criteria were not being met. Some governors used the data to argue for more resources or lower baselines in the coming year. The Prisons Board, keen to maintain levels of regime activity but unable to expand resources, saw the information reflecting the extent to which efficient procedures were being employed in applying available resources to meet explicit baselines. These were classic expressions of the managerial cycle:



or the dynamics between input, productivity and output which the FMI had earlier addressed.

Increasingly, the Governor's Weekly Monitoring has become a routinised procedure. The attractions of the prototype as a standardised system were not lost on managers above establishment level where performance measures of regime delivery were regarded as 'the missing link' in the emerging management model. In this sense, the monitoring has increasingly become a programmed or 'top down' system[6] in which definitions, amendments and format are promulgated from the centre. Its strengths remain that it was designed initially by practitioners and addressed issues of effectiveness which apply throughout the management structures at establishment level.

The FMI had as one of its objectives the development of output and performance measures in the civil service. Together with other key databases, the Governor's Weekly Monitoring now does provide performance indicators for the delivery of selected activities in the prison service. The majority of penal establishments implemented the system during 1987 and 1988, a development consolidated by the introduction of computer programs which compile the weekly data and transmit it electronically for use at Headquarters and Regional Offices. Despite reservations about the universal accuracy of the data, this development has allowed the regime monitoring to be used as the basis for a Prisons Board target for 1989/90 in which every establishment must maintain or advance a targeted level of delivery of inmate activities.

Currently work continues on the development of 'key indicators' which appropriately interconnect the data from the governor's main information systems (regimes, costing, manpower and population — See Appendix A). An extension to the Governor's Weekly Monitoring has been devised to inform the managing medical officer about the delivery of services in his domain of the establishment and performance indicators for seconded probation staff are being explored in field trials.

Developmental work of this sort is never fully completed in that management and staff will always face problems of resource deployment, efficiency and forward planning. In the case of the Governor's Weekly Monitoring system, practical work continues in order to improve the robustness of the measures and the accuracy of the data. Refinements include conversion from gross to net hours in recording prisoner activities, sampling time out of cell, and codifying routine reasons for departures from planned levels. The computer system is being rewritten to rectify some of the limitations and provide key indicators which can be abstracted from above establishment level. The format of the governor's annual report on his establishment's performance is changing to incorporate systematic information from the regime monitoring system.

The linkage of performance data of this kind to personnel appraisal has still to be fully addressed. Equally, the ability to drive systematic management methods down to and beyond the middle management tier in establishments is being tested through the process of defining functional responsibilities and performance indicators for all groups of staff. If the governor's contract and the establishment's corporate objectives can be successfully translated in this way, the prison service will have made significant headway not only in the development of machinery for accountable management but also in changing the basic culture amongst its operational staff.

Endpiece

For the prison service, several factors came together in the early 1980s to propel managerial development. Many of these coincided with and were given impetus by the framework of the government's FMI. More than anything else, the FMI provided managerial will to tackle the unresolved questions of purpose and to pursue aspects of systematic management. For a public sector organisation (albeit a centralised government department but one with considerable geographical and functional complexity), these are radical developments which have been taken forward with intent and celerity during the last decade. ■

References

1 Report of the *'Committee of Inquiry into the United Kingdom Prison Services'* (The May Report) London: HMSO, Cmnd 7673, 1979.

2 R Evans *'The Evaluation of Featherstone Prison "Accountable Regimes" Project 1981-1984'* Home Office Prison Department: DPS Report, series II, number 141, 1985.

3 CJ Train *'Management Accountability in the Prison Service'* in 'Prisons and Accountability' (eds. M Maguire et al) London: Tavistock Publications, 1985.

4 I Dunbar *'A Sense of Direction'* Home Office Prison Department, 1985.

5 R Evans and P Shapland *'Lessons from the Literature'* Prison Service Journal, July 1988, pp 23-26.

6 P Berman *'Thinking about Programmed and Adaptive Implementation: Matching Strategies to Situations'* in 'Why Policies Succeed or Fail' (eds. HM Ingram and DE Mann) Beverley Hills: Sage Publications, 1980.

7 M Hough *'Thinking about Effectiveness'* British Journal of Criminology, volume 27, number 1, pp 70-79, 1987.

8 H Goldman *'Prisons and Performance Measurement'* Home Office Research and Planning Unit: Research Bulletin number 18, 1984.

9 R Evans *'Management, Performance and Information'* Prison Service Journal, April 1987, pp 9-12.

10 C Pollitt *'Beyond the Managerial Model: The Case for Broadening Performance Assessment in Government and the Public Services'* Financial Accountability and Management, volume 2, number 3, pp 155-170, 1986.

Legal Briefing

What's the difference between a lawyer and a cod? One's wet and slippery, the other's a fish.

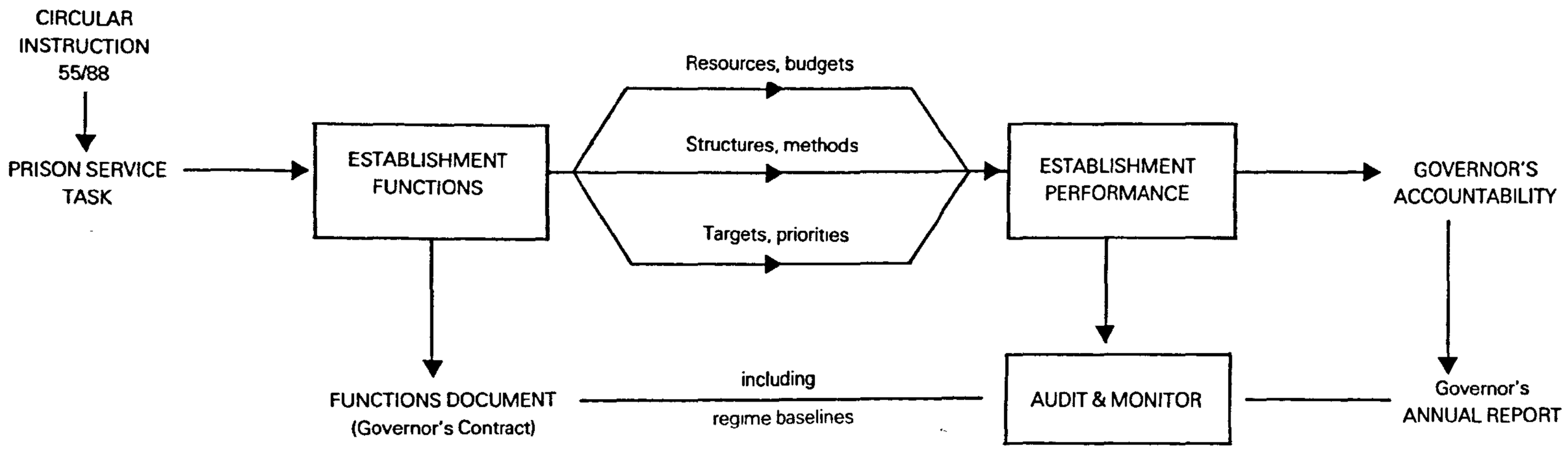
Why do psychologists use lawyers in preference to rats in their experiments?

- There are more of them
- You can get attached to rats
- There are some things rats won't do.

Enough of these jibes against people who can't defend themselves — Editor.

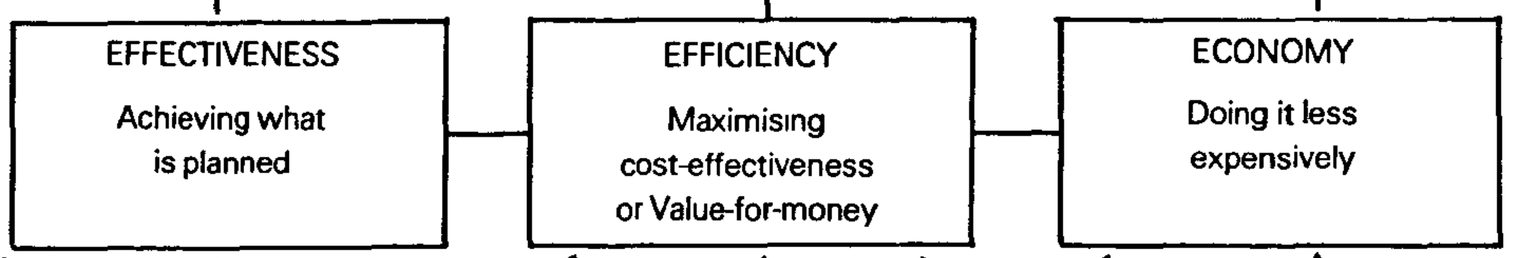
EMERGING MANAGEMENT MODELS IN THE PRISON SERVICE

[A] GOVERNOR'S ACCOUNTABILITY

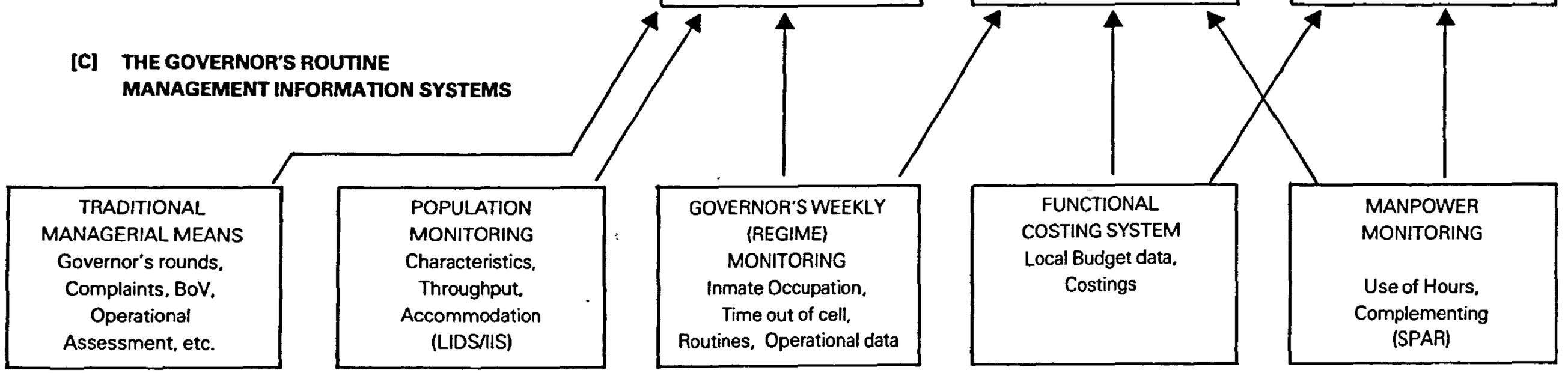


[B] PERFORMANCE MEASURES

(The '3 Es')



[C] THE GOVERNOR'S ROUTINE MANAGEMENT INFORMATION SYSTEMS



Rick Evans Midland Regional Office August 1987

Appendix A

HM ..... Week commencing ...../...../..... Week number .....

GOVERNOR'S WEEKLY MONITORING Average Daily Population ..... Highest unlocking figure ..... Number of new inmates .....

1. INMATE OCCUPATION	INMATE HOURS Actual / Planned	INMATES INVOLVED Actual / Planned	OPERATING HOURS Actual / Planned	COMMENTS
Daytime Education				
VT Courses				
CIT Courses				
Works				
PSIF Workshops				
Farm				
Gardens				
Kitchen				
Other Domestic Work				
Induction				
Other (Specify)				
All Other Occupation				

2. OTHER ACTIVITIES	INMATE HOURS Actual / Planned	COMMENTS
Physical Education		
Evening Educatuon		
Chaplaincy Actvities		

3. ROUTINES COMPLETED - Note dates & effects of any disruption

- ☐ CANTEEN
- ☐ EXERCISE
- ☐ ASSOCIATION
- ☐ BATHING
- ☐ KIT CHANGE
- ☐ INMATE MAIL
- ☐ LIBRARY
- ☐ VISITS

4. OTHER INDICATORS

Weekly Totals

LIBRARY USE	.....	
OFFICIAL VISITS	.....	
DOMESTIC VISITS	.....	
FIRST REPORT SICK	.....	Incl ..... Special Sick
PETITIONS COMPLETED	.....	
Fs256 COMPLETED	.....	Incl ..... BoV
OTHER [a]	.....	
OTHER [b]	.....	
NUMBER NOT ALLOCATED TO OCCUPATION [Section 1]		
Daily Average	.....	

5. OPERATIONAL COMMENTS - breaches in security, incidents, problems with catering, etc

6 HOURS OUT OF CELL - Daily Average (when sampled)

Weekday ☐ Weekend ☐ Location ....

An Interview with Clive Stafford-Smith

Dr David Saunders-Wilson, HM Prison Grendon

Clive Stafford-Smith came to British attention through a BBC documentary, 'Fourteen Days in May'. In this documentary Clive allowed the cameras to film him as he attempted to gain for his client, Edward Johnson, a stay of execution. He failed, and Edward was executed. Subsequently, again filmed by the BBC as a documentary called 'The Journey', Clive was able to prove that Edward was innocent of the crime for which he had been convicted and executed.

Question [David Saunders-Wilson]: Tell me about the work of the Southern Prisoner's Defense Committee.

Answer [Clive Stafford-Smith]: Well, we do two things. Firstly, we represent people sentenced to death. We are a charity because in the US there is no legal aid for people on Death Row. Secondly, we spend time suing the prison system to try and make them straighten up their act, on the principle that there's not much point in stopping someone being killed if he's going to spend the rest of his life being miserable in prison.

Q: Give me some more facts and figures about the people on Death Row.

A: There are 2,400 people waiting to die as of this day. I guess the numbers come a little more alive if you think that if we executed someone every day but Sunday for the next ten years there would still be 2,000 people waiting execution. The phenomenon is almost exclusively in the Old Confederacy — in the states of the Deep South — and clearly there is a racial element. I mean what do you expect? It wasn't long ago that black people couldn't go to the same toilet as white people. The most obvious example of this racism is that if you kill a black person you'll never get the death penalty. I cannot think of one person who has been executed for killing a black person, whereas if you kill a white person the chances of getting fried are 40 times higher than if a black had been killed.

Q: Are there particular states where the death penalty is used more frequently than other

A: Yes, Florida has 360 people on death row; Geogia 120; and Texas 310. Those are the main states.

Q: Are those states which suffer most from general prison overcrowding? Is the death penalty a bizarre way of reducing the prison population?

A: No, when you take Georgia which has the highest incarceration rates of any country in the Western world, or any area of the Western world, and you execute 13 people over a period of ten years, that is hardly going to reduce the number of people in prison. The death penalty has no effect on incarceration rates; it is just one person struck by lightening every year or so.

Q: You say one person struck by lightening every year or so, are those who are executed that arbitrarily chosen? Almost chance, or fate?

A: Pretty much. When you think that there are 30,000 murders in the US every year, and they only execute 20 people a year, and even then they don't kill the people you would expect them to kill. Edward Johnson was executed in 1987 almost on the same day as we got Marian Elvet and 'Mad Dog' Prewett off death row, and Edward, of course, didn't even commit the crime! 'Mad Dog' murdered six people.

Q: You mentioned Edward Johnson. He was your client whom we saw in the documentary 'Fourteen Days in May', and we subsequently saw your sequel to that documentary, 'The Journey', after Edward's death. What thoughts do you have about Edwards himself: what thoughts do you have about the two documentaries?

A: Well, as to Edward himself, he was just a decent person. It is hard for people in the street to believe that people in prison are just regular, and usually decent human beings. It perhaps becomes a little easier for them to comprehend that when you deal with someone like Edward, who obviously didn't commit the crime. But Edward wasn't so different from any of my other clients insofar as he was just a young black kid caught up in the wrong circumstances. Now as to the documentaries I think that they had a very positive effect on people in this country. I think a lot of people in England who would not have thought about the death penalty saw it for what it is. In the US it wasn't quite the same. They showed 'Fourteen Days in May' but only after they had butchered it to take out every reference to racism, and everything about Edward's circumstances. They refused to show 'The Journey' as they said it was too controversial.

Q: With the recent shooting of a police inspector in Manchester, and with the IRA bombings in Deal and elsewhere, there have been many commentators calling for the re-introduction of the death penalty here. How do you feel about that?

A: Well it's inevitable that when you have a problem you try and solve it by meaningless means. Those two examples you use provide clear cases of why the death penalty is a ludicrous alter-

native. In the first, much as we are sorry for the policeman who died, it is not going to do us any good to execute the person who killed him as he already killed himself. There's not much point in executing a suicide. As for the Irish, there really is no point in executing terrorists, the people they call terrorists, because they just create martyrs. If you take the example of Bobby Sands who starved himself to death there wouldn't be any point in us executing him as he wants to do it anyway, and all that that does is further the cause of the IRA. I would have thought even someone as blinkered as Mrs Thatcher would recognise that.

Q: Clive, moving away from the death penalty, I wonder if you would comment on the American penal system. The American system is often used as an example of how the British system could or should develop, surprising as that may seem. After all, American prisons are usually vastly overcrowded, have few facilities, and lack any rehabilitative ideal. What is your experience of Southern prisons? What do you think about Thomas Beasley's private penal group, Corrections Corporation of America?

A: Well David there are about 157 questions in that question! The starting point for me is who is in American prisons, and how they get there in the first place. Prison, like death row, is the privilege of the poor, simply because we spend so little money on legal aid in the US. In capital cases last year we spent on average about 50 cents an hour on defending people, and that results in an awful lot of people ending up in prison, and often on death row. One of my clients was represented by a student, because that was the only person who was prepared to defend him. His opening address to the court was 'Your Honor, can I have a moment to compose myself, as I have never been in a courtroom before'! The second problem is imprisoning people for victimless crimes. Drugs, of course in the US is the flavour of the month, and George Bush has promised to put users of drugs of any sort inside. That is just ridiculous. You're not going to solve anyone's drug problem by putting him in an American jail where there is more access to drugs than anywhere else. As for rehabilitation, that is a dirty word. It is classified as a do-gooder, liberal attitude, which is of course bad. Myself, I've never considered it wrong to be a do-gooder, which is presumably the opposite of being a do-badder! Rehabilitation is no longer valued in the US, and the idea behind sending someone to prison is merely to punish him. I think that this is counterproductive, as people end up there in the first place through lack of opportunities. If you make their lives more difficult then the chances of them committing another crime simply because they can't get a job or something are vastly increased. Surely the role of the prison, if it is to have a role, is to make society a more secure and better place. On that level the American system is going downhill very rapidly, and it didn't start too high up the hill in the first place. Privatisation — your favourite topic — is of course ludicrous. When you cut corners to cut costs the potential for abuse is enormous.

Q: Have you had any experience of dealing with private prisons yet?

A: No, not really, as it is still a very small phenomenon. There are very few private prisons in the South, and given how squalid they are I don't think they'd find too many investors.

Q: Clive, I was fascinated to hear you tell of defending a man in Georgia who did five years for having consenting oral sex with his wife! I don't think that it is too widely known in this country that this is a crime in the US. I wonder if you'd tell the story again?

A: I must say that normally I don't do anything but capital cases, but I heard about this guy who is doing five years for having consenting oral sex with his wife, and some things come a little too close to hand you know, that well I couldn't ignore it. So I represented him. In Georgia you can get up to 20 years for oral sex, as that is a criminal offence! This is my favourite bit of American Law — did you know that if you offended against the beastiality law, the necrophilia law, and the public decency law, you would still get more time inside for committing an oral sex act with your wife than doing the same with a dead animal in a public place. Anyway we finally got Jim Mosely out after he had served 19 months.

Q: 19 months for having oral sex with his wife?

A: Yes, and he had a tough time in prison, because he'd meet people on the yard who were in there for murder, and he'd be asked what he was in for. He would tell them, but of course no one would believe him, and they all thought he was there for molesting children. I managed to get him out when I asked the prosecutor to disqualify herself unless she would state on the record that she had never committed the same felony herself. She got embarrassed, probably because she hadn't, and refused to answer the question. We had a sex therapist as our star witness who showed that 85% of the Georgia population had committed this crime, and so we would really have overcrowded prisons if we enforced the statute. In the end we got the statute struck down, but there are still an

awful lot of couples in Georgia coupling with their curtains drawn.

Q: You're in this country to promote a book, 'Life on Death Row'. How did that come to be written?

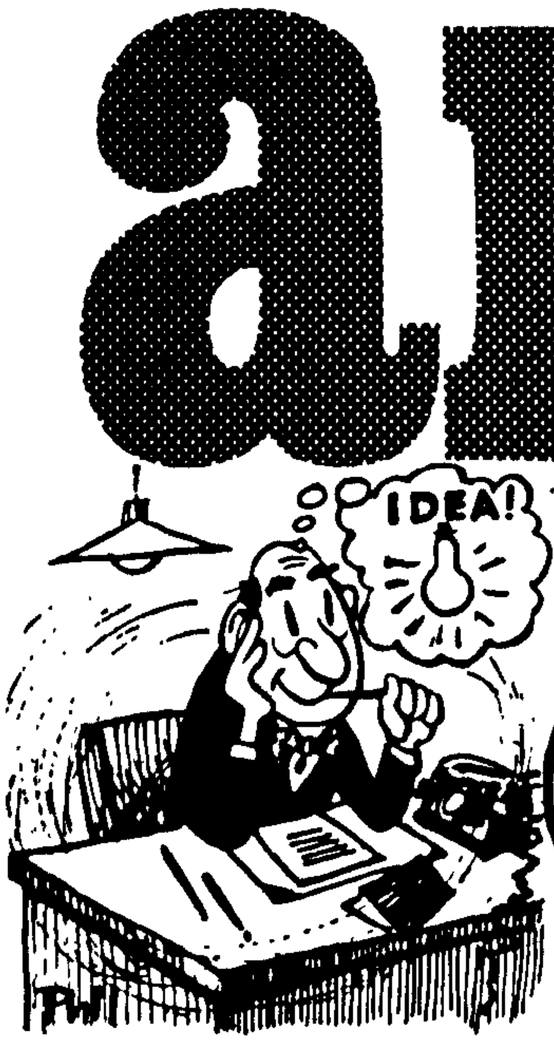
A: Well I was at a tea party in Cambridgeshire, and we were discussing the death penalty. After I had told a few stories, this journalist came up and suggested that I write a book. I told her that I didn't have the time, and asked her to do it instead, and I think Merrilyn Thomas has done a really good job.

Q: You have visited several prisons in this country. What do you think about those?

A: I think I've been indoctrinated by you, as I have to say that the ones that I've seen in Britain are very much better than the ones in the US. Here you seem to want to treat people as human beings, and allow them to pass their time productively. I'm sure that you've got your share of horrors, but compared to life in a cell in Georgia locked up for 23 hours a day, and only allowed three books — one of which has to be the Bible — conditions just don't compare. However, be warned, I think that the whole of England is headed towards the extremes which we have in the US.

Q: That's a good place to end. However, I think you should place on record that I ran a very effective campaign for you in Chapel Hill in 1979 for student body president.

A: A very effective campaign — I lost. ■



HIV/Aids in Prisons

Dr Rosemary J Wool

As Head of the Medical Services in the Prison Service, Dr Wool describes some of what has been done in the Service to inform staff and prisoners about HIV and AIDS. In considering what has happened to our knowledge in recent years, Dr Wool emphasises the need for the Service to be informed and kept up to date and explains how that is being done. What still needs to be done however is to bring about a fundamental change in attitudes.

I get perhaps more correspondence about AIDS in prisons than any other subject. Mostly it is from people who have never been inside any prisons and who therefore make assumptions about them which are totally wrong. One of these assumptions is that the spread of HIV is rife, that the Prison Service is taking no action and that as a consequence our British Society is being put at risk. If they did but know the Service was a vanguard in informing its staff and inmates about the new disease entity, starting as early as March 1984 at a time when other organisations were still only just becoming aware of the disease. From that time several joint communications have been sent out by the Director of Prison Medical Services and the Deputy Director General.

Advances in Knowledge

Since those early days tremendous advances in knowledge have been made. To name but a few, the virus has been isolated and renamed. Drugs affecting the progress of the disease have been discovered and are now being used. Epidemiological knowledge has increased. The pattern of the epidemic is changing. Whereas in 1985 in the UK the spread was most rapid among male homosexuals, during the last year the total number of people with HIV related to injecting drugs and to heterosexual contact showed a marked increase.

But for all the advances one thing has not changed and that is the way in which the infection is transmitted. It is now transmitted by sexual intercourse, by the intravenous injection of infected blood, and by mother to infant either in utero or just possibly by breast feeding.

Information to the Service

Given our knowledge of the modes of infection, avoidance of that infection is relatively simple. Getting that message over to prison staff and to prison inmates has concerned the Directorate of Prison Medical Services for the past 5 years. Recognising that concern without taking action would achieve little, so we have developed and continue to develop comprehensive education material for the Service. Guidelines for medical officers and governors are updated regularly. Links with the Department of Health are firmly established enabling the free flow of information and understanding.

Education and Training

An AIDS advisory committee to the Medical Director was set up in 1986 and remains ongoing and productive. The committee was instrumental in producing the national training package for prison staff and the national education package for inmates. Part of these were two videos which have been highly acclaimed in health education circles and now have world wide distribution.

DPMS are continuing to upgrade this education material. Courses have been developed for medical officers, and the first of these were developed in the Midland Region in October. Three more will follow in the other Regions within the next six to nine months.

Arrangements are also made for training in counselling. Initially psychologists received the training, but recently other disciplines have been included. They are trained to give advice before a blood test is taken to ensure informed consent and to give further advice and consent after blood testing.

A further extension of our training programme is a course for management teams in establishments to develop strategic thinking regarding HIV within institutions.

24 hospital officers have recently completed the first course for health care staff developed at the request of DPMS by the English Nursing Board giving training in all aspects of nursing patients with AIDS related illnesses.

Predictions for the Future

Predictions are that the next five years will see a sharp

increase in the number of people with AIDS. I have no doubt increasing numbers will appear in the prison population. We are prepared for this, and although we have an assurance that AIDS patients who are ill with intercurrent infections will be nursed in NHS hospitals we must care for them during intervening periods when they are physically weak. A unit which will accommodate nine such patients is nearing completion in Brixton Prison. Care and support units for patients who need intermediate care are already identified in the North, Midland and South-East regions.

Generally speaking prisoners are not prisoners forever; the time comes when they are released into the community. Preparation for such release and plans for the appropriate medical and social support and treatment after release must be a priority. Voluntary organisations are of particular value in this respect, and there are plans to involve voluntary and outside agencies in order to effect a smooth and overlapping transfer between the prisons and the community.

Changing Attitudes

But having said all this I am not complacent. There is still much to do particularly in the area of changing attitudes. Maintaining medical confidentiality in this area is important and discrimination is still in evidence in some establishments. Consequently some of those whose behaviour puts them at high risk of infection are not declaring themselves, and therefore are not available for counselling and advice. Another consequence is staff complacency, and good general hygiene in all areas may be ignored.

It is most important that we as a Service maintain our commitment to education and counselling so that we do all in our power to limit the spread of this deadly disease. When we have HIV positive inmates or prisoners with AIDS in our care we must show the same degree of compassion and give the same standard of treatment that is due to any sick person regardless of the nature of their illness. ■

HIV in Prisons: Psychological Issues

Len Curran is Head of Psychological Services in the Prison Medical Service with the special responsibility for HIV/AIDS. He is also the Chairman of the AIDS Advisory Committee. Here he describes why HIV in prison is an especially acute problem and what HM Prison Service is doing in educating those in the prison community by way of advice and support.

HIV creates particular problems in prisons which need to be addressed if the control of infection, the care and support of those with HIV, the health and safety of staff and the prevention of crossover to the general population is to be achieved. The education of staff and inmates on HIV is one important element in an overall strategy that needs to be developed within prison systems. Other elements are the provision of health and safety guidelines to managers of institutions, counselling of those with HIV and those whose behaviour puts them at high risk of infection, the careful monitoring of the health both physical and psychological of those infected and the development of appropriate procedures within institutions for dealing with HIV.

The problems that are generated by HIV in penal establishments are influenced by a number of factors:

(1) **The nature of the population:** prisoners in most countries are young and therefore sexually active; they contain concentrations of IV drug users and often prostitutes — therefore a proportion will have HIV on entry into the system. Almost by definition, since they will have broken a law in order to get into prison, prisoners are 'rule breakers' and may find the restrictions of safer sex and/or safer drugs use difficult to assimilate and maintain. Many prisoners may be inadequate or mentally unstable and therefore, their behaviour inside may be unpredictable. Some will be suicidal or prone to self injury which may result in blood spillage. Others will have been convicted of violence and may be prone to violent outbursts inside prison directed at staff or inmates.

(2) **The Prison Environment:** some prisons may be overcrowded and the conditions may make them appear 'risky' in relation to HIV.

These factors combined may generate an atmosphere of fear and mistrust within institutions. Systematic education on the realities of HIV may help diffuse unrealistic fears and concerns.

Sexual behaviour: There are few studies which document the sexual behaviour of inmates in penal institutions, but it seems likely that sexual behaviour goes on in prisons and many whose sexual orientation outside is heterosexual may behave homosexually inside prison. Currently, in many countries gay men have changed their sexual behaviour and now avoid penetrative anal intercourse but this may not be true of those who engage in functional or opportunistic homosexual behaviour, because they have not assimilated the gay cultural norm regarding safer sex. Rape and prostitution inside may also be common in some systems.

Drugs use: In most penal systems, strenuous efforts are made to keep drugs out but they can and do get into prisons. Needles and equipment being harder to secrete may be a very scarce commodity and may therefore be shared by prisoners.

Policy

There is therefore the possibility of HIV transmission within the prison population and if that occurs, further transmission into the general population when inmates are released at the end of their sentence.

In response to this clear need to develop policy in the light of the best and most up to date information on HIV, the Medical Directorate appointed in 1986 a committee composed of outside and independent experts in the field and experienced prison staff, known as the AIDS Advisory Committee to provide expert advice.

Since the operation of prison depends on the co-operation of both staff and inmates, in order to contain the epidemic inside institutions, prevent crossover to the general public, and create an environment where people with HIV can receive the care and support they need: it is necessary to alter the prison culture from one which is phobic about AIDS to one which is rational about HIV. This involves education about the realities of risk and risk reduction. Both staff and prisoners need to understand clearly how the virus is transmitted and perhaps more importantly how infection is **NOT** passed on.

Education

In designing education for prisons the first step was to find out: what exactly staff and inmates knew about HIV; what precisely they feared. A survey of key staff in representative institutions was carried out by prison psychologists: staff had considerable knowledge about AIDS but they were concerned about: violence; body fluids — urine, fæces, saliva; infection by giving resuscitation; blood spillage in self-injury incidents; cuts from contaminated needles or blades in search operations. Staff were concerned not only for their own safety but also feared they might carry infection back to their families. They believed that in order to keep prisons open management might not reveal all the facts about HIV. A similar exercise was conducted with inmates. Not surprisingly, perhaps, their fears echoed those of staff.

The committee designed two national education packages — 'AIDS Inside' for prison staff and 'AIDS Inside and Out' for prisoners which directly address the concerns expressed in the research surveys. These are now in use and are being evaluated. Preliminary results show that where they are used as intended they have an impact on a number of key variables such as fear of AIDS and knowledge of HIV. Some of the evaluative research indicates that personality variables play an important part in assimilation of information regarding HIV in that those who maintain strong in-group/out-group distinctions may be less influenced by the simple provision of accurate information.

Care

Whilst it is clear that HIV creates problems in prison, it is also surely true that imprisonment presents problems to those with HIV infection. A diagnosis of HIV infection puts an individual in a situation of great uncertainty. Because of the long and variable interval between HIV infection and expression of symptoms and the variable nature of AIDS related diseases, the person with HIV doesn't know whether, when or how illness will strike. Such uncertainty leads to high and sustained levels of anxiety. Outside prison there are well established networks of support to enable people with HIV to live with the disease. Inside institutions these are not yet highly developed and are constrained by the nature of imprisonment. Moreover, HIV and AIDS have led to stigmatisation of individuals either with the disease or perceived as being at risk. Within prison systems fear and ignorance of the facts coupled with associations with sexuality and drugs use have increased the degree of stigmatisation and placed greater burdens on those infected. Finally, since HIV is largely transmitted in this country through sex and sharing of needles and syringes, people with HIV and those whose behaviour puts them at risk of infection need to make fundamental changes in the way they live. These include changes

in drugs use, sexual behaviour, contraceptive behaviour and possibly for some women, pregnancy termination. Such radical life changes are both difficult to achieve and maintain. Individuals, their families and loved ones cannot and should not be expected to make these major changes in life style without the support which comes from counselling.

The major medical advances in HIV have been in the areas of patient management and proactive intervention. It is clear that careful monitoring, both clinical and laboratory of people with HIV to enable early treatment intervention prolongs the health and quality of life of those with HIV. It is the aim of the Prison Service that prisoners with HIV should receive as good care as is available outside.

Management

All this involves medical, psychological and management issues. The Advisory Committee are now developing three specialist in-service courses:

(1) Course for managing medical officers — this covers the rationale and methodology for careful monitoring, including psychological dimensions of HIV and emphasises the importance of a multidisciplinary team approach;

(2) HIV Counselling Course — currently there are 45 prison service personnel who have undergone training in HIV counselling. It is aimed to increase this number so that prisoners will have ready access to counsellors experienced and knowledgeable about HIV. The course is to be modelled on the World Health Organisation Global Programme on AIDS preventative counselling model, adapted by the Committee for use in prisons;

(3) The Multidisciplinary Team Course — this course designed for medical and service managers in prisons both provides input on HIV/AIDS and enables managers to develop strategic thinking and planning for HIV in institutions. The courses are supported by a specifically designed prison service manual: 'HIV & AIDS: a Multidisciplinary Approach in the Prison Environment'.

Conclusion

HIV is a very big problem. In the absence of a vaccine or a cure for HIV the containment of the epidemic depends upon people making changes in their life styles to avoid infection. On the face of it this appears deceptively simple — safer sex and safer drugs use. However, anyone working in prisons knows that motivating and maintaining behaviour change is difficult to do. Education is an important part of the process but not, in itself the solution. Counselling individuals with the objective of prevention of HIV transmission and support for those who are already directly or indirectly affected by HIV is another crucial element. The proper care of those with HIV requires regular monitoring and early intervention to delay progression to disease as well as psychological support. Reaching those most vulnerable depends on creating an appropriate environment within prisons, so that those who know or feel themselves to be at risk can seek proper support and help. Looking after people with AIDS is complex and involves not only medical and support staff in the prison but also specialist resources outside.

HIV and AIDS highlights many of the challenges facing the Prison Service. If these challenges are to be effectively met it requires the mobilisation and co-ordination of management, medical and psychological services, the co-operation of discipline staff and the help of outside prison resources, both statutory and voluntary. The Prison Service in this country has shown innovation in tackling staff and inmate education. However, to date we have been fortunate in that we have had relatively few people who are ill. This is not true of other prison systems and we must therefore prepare to be equally creative and innovative in the care and support of those with HIV disease. ■

Fresh Start

'Fresh Start is the most dramatic internal change in the Prison Service since nationalisation in 1878. It offers a remarkable window of opportunity for improving the quality of staff work and the extent and quality of the regime for prisoners.

Since Fresh Start at Strangeways it has been possible virtually to double prisoners' working hours. All regime activities show a significant increase. Evening association has been introduced and now amounts to around 5000 prisoner hours per month.

Fresh Start holds the potential to transform much of the Prison Service. We need strong informed and imaginative leadership at the very top of the Service to ensure we take full advantage of the present opportunities for change.'

Brendan O'Friel, Governor, HMP Strangeways, at Perrie Lectures 1989.

Women and HIV/AIDS

Alana McCraner is the Organisor of the National AIDS Counselling Training Unit (NACTU). Alana is one of the most experienced Trainers of HIV counsellors in the UK. She is also one of the expert members of the AIDS Advisory Committee.

Explicit information and advice is given on how to minimise the risk of contracting HIV infection.

In the United Kingdom the majority of cases of HIV infection have in the main been confined to the following groups: homosexual men, bisexual men, haemophiliacs and intravenous drug-users. Although the spread of the virus into the heterosexual population in the UK has been relatively slow to date, it is important to acknowledge that it accounts for the majority of cases in many countries throughout the world.

The HIV virus carries with it many implications for the individual, including fears about future health, financial worries, future sexual practices and many more. For women the issues can be further complicated for many reasons, not least how society sees the traditional role of woman.

The relatively low incidence of heterosexual transmission in the UK has meant that to date heterosexuals have not been compelled to examine their practices and responsibilities except in groups which society can comfortably marginalise like haemophiliacs and drug-users. The virus itself, however, recognises no such categories. Heterosexual transmission is a fact and it is important that the process of transmission is fully understood.

Transmission

The human immunodeficiency virus (HIV) needs to gain entry to human cells not only to survive, but also to multiply. There are several cells in the human body that HIV is attracted to, the main group being the T-helper cells. The T-helper cells are part of the body's immune system (white blood cells). Their role is twofold: to co-ordinate the response of other immune cells to infection and to act as a direct killer cell against the bugs.

Sexual transmission from men to women

Initially it was thought that anal intercourse was necessary for transmission of the virus from men to women. However, evidence coming from countries with a high incidence of heterosexual spread shows that vaginal intercourse is the main route of transmission.

The semen of an HIV positive man can contain large amounts of the virus. If infected semen gets into his partner's body via the vagina, cervix or rectum, then the partner can become infected. The mechanics of this transmission are unclear at the present time but there is no doubt that it occurs. The vagina, cervix and rectal lining all contain cells similar to T-helper cells and this is thought to be one possible route of transmission. Damage, even microscopic, to the vagina, cervix or rectum, would give the virus access to underlying tissues and blood vessels and it is thought that this may increase the likelyhood of infection. However there is no evidence that such damage is essential for transmission to take place.

Sexual transmission from women to men

Similarly there is no doubt that women can transmit the virus to men. The cervical and vaginal secretions of an HIV infected woman will contain the virus, and through these her sexual partner can become infected. The tissue under the foreskin of a man's penis contains cells which are similar to T-helper cells and this may be one route of entry for the virus. Alternatively, the virus may gain entry through any broken tissue on the penis, but again there is no evidence that such a lesion is necessary for the virus to be transmitted.

Pregnancy

For a woman the test may first become an issue when she discovers that she is pregnant. Knowledge about transmission of the virus from the mother to the child is continually being updated. A woman who is considering becoming pregnant, or who is already pregnant should consider the following matters.

Risk to mother

In the early stages of HIV infection the majority of people will have no symptoms and indeed will be in good health. Observations suggest that most women who are healthy at the start of the pregnancy will show no signs of deteriorating health as a result of the pregnancy itself. On the other hand, a

woman who is in poor health when she becomes pregnant will be more likely to show signs of deterioration if the pregnancy is continued.

Risk to the child

According to current research the risk of infecting a child in the womb appears to depend on the amount of virus in the woman's blood. Virus levels in the blood vary at different times with different individuals. It appears to be higher at two points, the first being just after infection takes place and the second being when signs of illness appear. This does not mean that a woman who is healthy and has had the virus for a long time cannot infect her child, only that the risk is lower. Although it is thought the risk to the child is about 20 - 30 per cent, any child born to an HIV positive woman will require monitoring throughout its life. The reason for this is that the virus can be transmitted to the child but remain undetected by tests for many years.

Breast Milk

Breast milk does contain the virus and there have been a few cases where a mother has been HIV infected through blood transfusion following delivery and has passed the virus on to her child. Current advice to women who may be HIV positive is not to breast feed if there is a good supply of powdered milk available.

Pregnant women, if positive, should be aware that there is no medical intervention that can be offered except termination. Women who would not under any circumstances consider terminating their pregnancy may well decide against being tested in the first place.

Termination of pregnancy

Termination may be a consideration for a woman who is HIV positive. When considering termination the woman will require not only the known medical facts regarding her pregnancy, but she should also consider the various practical issues. For example could she cope both mentally and physically with a sick child, is there anyone who could care for the child if she develops full-blown AIDS or dies? Regardless of whether the HIV positive woman decides to terminate or continue with her pregnancy, she will require skilled long-term support.

Prevention

As there is no cure available for HIV, the medical profession has to rely on drugs which at best can only slow down the disease process. Therefore, prevention remains the only effective tool against the spread of the virus.

Prevention for intravenous drug-users

Advising an intravenous drug-user, whether male or female, not to share needles and syringes ('works') is only practical if they have easy access to an adequate supply of clean needles and syringes. In certain circumstances it is not possible to obtain clean 'works' and therefore, scrupulous cleaning of existing 'works' may be the only alternative.

Safer sexual issues for women

Often individuals will only acknowledge the need for safer sex when they feel they have already placed themselves at risk of acquiring the virus. More sensibly safer sex should be seen as a way of substantially reducing that risk in our everyday sexual lives.

It is clear that the more sexual partners we have, the greater our risk of meeting somebody who is HIV antibody positive. While this statement seems reasonable it is important to acknowledge that for many people it may be impossible or inappropriate for them to enter a long term relationship, and therefore casual sex may be the only means of sexual contact open to them. This may occur for many reasons. For example, an individual may lack the social skills necessary to become involved with another person, or they may travel extensively for work, thus prohibiting relationship bonding. Therefore, if reduction of partners is unrealistic, for whatever reason, remember that it is the quality of sexual pratice through safer sex, not the quantity, that is important.

Vaginal Intercourse: While it is safest to avoid vaginal intercourse, this may not be acceptable, and the use of a condom in conjunction with a **water** based lubricant is, therefore, essential. Condoms can and do break for many reasons, such as failure to follow manufacturers instructions, not using enough lubrication, or because of a manufacturing fault. In addition to a water-based lubricant the use of a spermicidal agent like nonoxynol-9 may offer, in the event of a breakage, additional protection through anti-viral action. It is important that a woman using condoms also uses another method of contraception simultaneously.

Anal Intercourse: The advice given above on vaginal intercourse applies equally here, but it is important to note that the failure rate for condoms is higher than for vaginal intercourse, probably as the result of greater mechanical stress.

Oral sex: The true risk of oral sex is unknown, although any risk must be reduced if ejaculation does not occur.

Sharing sex toys: Sharing of toys, for example, dildoes should be avoided.

Inserting the hand into anus (fisting): This is risky as it

often causes bleeding and is rarely done in isolation from anal sex.

Oral-anal contact (rimming): It is unlikely that HIV can be spread in this way, although other germs can be. This may be harmful to someone who is HIV positive and therefore should be avoided.

Mutual masturbation: This is a safe practice.

Body rubbing (frottage): Rubbing the penis or clitoris against skin of partner is a safe practice.

Water sports: Urinating on your partner's body, providing the skin is intact and eyes are avoided, would be safe. Urinating into a partner's body would, on the other hand, be considered unsafe.

There are many other practices that people enjoy and a general rule is that, provided there is no exchange of body fluids, the risk is probably extremely low.

But simply knowing about safer sex is not enough. Most people can accept the need for safer sexual practices but are daunted at the idea of actually 'putting it into action'. This is particularly true for many women who traditionally feel themselves to be passive in their sexual relationships, and are unable to take the initiative over, for example, suggesting the use of condoms. Similarly they may find it difficult to overcome an upbringing which may have labelled women who carry condoms as 'tarts'.

Pre-Test Counselling

The aims of pre-test counselling are:

to ensure that any decision to take the test is fully informed and based on an understanding of the personal, medical, legal and social implications that such a step carries;

to provide the necessary preparation for those who will have to face the trauma of a positive result;

to give the individual the necessary risk reduction information regardless of whether they have the test or decide against having the test.

There is no prescriptive model for pre-test counselling, and the most successful sessions are those which are tailored to fit the needs of the individual. However, there are certain areas which need to be covered. Ideally, a counsellor should be able to promise absolute confidentiality but where this is impossible a counsellor should give a frank account of any organisational restrictions that they may have to adhere to.

Assessing Risk

Although it is important to establish what the individual sees as her particular risk it is necessary for the counsellor to obtain a comprehensive history:

the sexual behaviour of the individual and, where known, the sexual behaviour of any partners;

history of injecting drug use and sharing of 'works';

history of past blood transfusions;

use of blood products for the treatment of haemophilia prior to the introduction of heat treatment;

history of invasive procedures carried out under non-sterile conditions such as cosmetic procedures or ritual scarification;

sexual partner(s) falling into any of the above categories.

It is important to remember that while an individual may appear to have minimal risk, no risk, however slight, should be dismissed out of hand.

A full explanation of the test including what a positive or negative result actually means should be given in jargon-free language.

Discussion of the possible social repercussions of taking the test, such as employment, obtaining insurance and travel is essential.

Who to tell from family doctors, dentists to friends and family must be fully explored.

Written information should be available and should be offered following pre-test counselling. This should cover transmission, safer sexual practices and so on. ■

Paying Her Way

Doesn't the College know about the market economy? The meek proposals put to the Prison Service Training Committee on charging for courses at the College suggests the Head of the College is no entrepreneur. All that was offered was better costings. A copy to Number Ten might stir the commercial spirit in Newbold Revel!

Revolution at Parkhurst

After how many years I don't know the medieval barrier between the adjudicator and accused on the table at Parkhurst has been removed. How was that achieved? — an Inspectorate Report?, Judicial enquiry?, Regional Director?, — no, just the Governor working with his staff towards decent treatment of people.

The Condom Wars — Should America's Jails/Prisons Distribute Condoms?

Allen M Hornblum serves on the Board of Trustees of the Philadelphia prison system. He was appointed by Pennsylvania Governor Robert P Casey to the Pennsylvania Commission for Crime and Delinquency: he is also a member of the Board of Directors of the Pennsylvania Prison Society, the oldest of its kind in the United States.

In June 1988, several individuals representing prison reform groups and public health organisations held a press conference to encourage members of the Board of Trustees of the Philadelphia Prison System to initiate a highly unorthodox and controversial policy — the distribution of condoms to the system's 4,000 inmates.

Prisoners' View

Though elected officials and organisational leaders attended the news conference, the media focused their cameras and notebooks on one individual, Mikal Geddes, an AIDS patient, who is reputed to be the first person to be diagnosed with the fatal disease in the city prison system. 'I know that distributing condoms will be hard and I don't know, myself, exactly how they should go about it,' Geddes said, 'but I know it needs to be done and done fast.'

Moral Issue

It is AIDS prevention, not its treatment, that has caused the greatest controversy in the nation's penal community: specifically, the dissemination of condoms to the inmate population to retard the spread of AIDS. The issue has serious moral, administrative, medical and philosophical ramifications that, sooner or later, most of America's jail and prison overseers will have to confront.

Philadelphia's attempt to tackle this dilemma may prove useful to more than one already beleaguered jail or prison administrator. The issue first arose in early February when the city's Health Commissioner, Maurice C Clifford called for the swift adoption of a comprehensive AIDS protection plan, Dr Clifford recommended such innocuous measures as AIDS education programmes, anonymous HIV testing and adequate treatment services for all AIDS patients. One recommendation was far from conventional, however: 'Prisoners should have access to condoms and disinfectant for needles.'

Penal managers were being asked by Public Health authorities to bless the dissemination of mechanisms designed for activities — sex and drugs — that had been prohibited in prisons for at least 200 years? One Board member commented 'I don't know how you can in good conscience say you are running a good correctional institution under the letter of the law and hand out condoms.' I, as well, rejected the concept proposed by Clifford, arguing that he had 'gone over the precipice' and stated that the condom proposal was like 'giving the Good Housekeeping seal of approval for sex in prisons.' For the time being, at least, the Health Commissioner's recommendations were dead in the water.

Practice Elsewhere

Several other penal systems had already implemented proactive measures to impede the spread of the deadly AIDS virus. Outside of Vermont, Mississippi and New York City, however, the correctional community was adamantly opposed to the distribution of condoms and cleaning fluid in all male institutions. A few more states distributed condoms to inmates, but only to those in conjugal visitation programmes.

New York City's programmatic response was to make condoms available to 90 avowed homosexual inmates on one wing of the Anna M. Kross Center on Riker's Island. The pilot programme began in early fall, and two months later, in November 1987, was expanded to the Kross Center's entire population. According to department officials, medical personnel, and correctional staff, the programme has operated without a hitch.

'We haven't really run into a problem,' said Captain Tony Burke, a ten year veteran at Riker's Island. Burke admitted that he was 'quite concerned at the outset'; however, it has caused 'no one to become wildly promiscuous' and has 'not changed prison policy of meeting out punishment to those caught having sexual relations'. However, Burke still felt that the system seemed to be 'condoning

sodomy' by establishing a 'Catch 22' policy whereby condoms are distributed, but sex is forbidden.

One Prison board member countered Dr. Clifford's remarks by arguing that the world outside these prison walls is the real AIDS incubator. Furthermore, he rhetorically queried, 'Heterosexuals are not allowed conjugal visits, but should homosexuals be established as a special class and afforded special sexual implements?'

The Health Commissioner replied that eight inmates had died of AIDS during the last two years and many more were expected to succumb since AIDS in Philadelphia was becoming a non-white, poor peoples' disease — a demographic profile that matched the city's prison population.

Under questioning, Dr. Clifford admitted that his department was premature in recommending inmates have access to bleach and other forms of cleaning fluid. I related that my trip to Riker's Island had elicited unanimous opposition to the distribution of bleach. As Dr. Kalkut sternly warned: 'Bleach is an alkaline solution — although it is not an acid, it would have the same consequences if it came in contact with the eye.' Captain Burke agreed: 'Bleach can easily be used as a weapon — whether it be inmate on inmate or inmate on officer.' Both men strongly advised that we reject the notion of giving out bleach in the Philadelphia jail system. As it always had been, condoms remained the central issue in question.

'Sexual Abstinence the best policy'

As the Board meeting continued, each of the wardens of the city's four prisons expressed his opinion. Three agreed that sexual abstinence was the best policy. Harry Moore of the Philadelphia Industrial Correctional Center stated it most succinctly: 'We should encourage them to abstain. I don't feel it would be good correctional management to hand out condoms.' Press Grooms of Holmesburg Prison was clearly in the minority: 'Sex does take place in prison systems. We don't condone it, but it happens. And the only way to prevent AIDS at this point is to use condoms.'

The meeting, which lasted over three hours, ended without resolution: the Board decided to weigh all the information that was presented and call the Health Commissioner in the near future if further clarification was needed. Although two Board members held opposing views, a majority of the Board was still undecided and obviously uncomfortable with the issue.

Everyone else, however, had a firm position — even inmates. One lifer wrote me a letter saying it was a bad idea and, in effect, referred to the lack of a conjugal visiting programme in Pennsylvania. Two other letters, both from women, expressed divergent viewpoints. The wife of a state prison inmate feared that a condom programme would encourage homosexuality in prison and jeopardise her marital relationship. The other letter, from a progressive political activist, proclaimed shock that the Board could be so blind in not recognising the obvious need for a condom programme as a means to slow the spread of AIDS.

The prison clergy also became involved by arranging a debate between myself and Mr Mendel, and then voting by a seven to two margin to oppose condoms in prison. Opponents of condom availability offered an amalgam of reasons including encouraging homosexuality to the presence of a gay conspiracy. Those ministers in favour of the condom proposal quite simply stated that human life was the most important consideration and we should do whatever we can to foster it.

Are there more important issues?

As we entered the hot summer months, the Board of Trustees continued to place the condom issue on the back burner, somewhat hesitant to take a stand, as well as preoccupied with more serious penal concerns such as severe overcrowding, and a recently imposed Federal Court-ordered population cap.

In late August, the Board of Trustees of the Philadelphia Prison System met to tackle the condom issue and finally decide whether to make condoms available or not. The Board voted 3-2 (with one abstention) against making condoms available.

The upshot of the 'Condoms Wars' is that hundreds of jails and prisons across America are grappling with a new and deadly epidemic whose spectre will only grow more fearsome in the coming years. Almost all correctional administrators will impose some form of inmate protection programme to harness the AIDS virus. The jury is still out, however, on whether or not access to condoms will be part of that comprehensive AIDS protection package. ■

Note

On 25 August 1988, newspapers reported that Philadelphia Mayor W Wilson Goode circumvented the Prison Board and ordered condoms distributed to inmates as part of a new AIDS prevention programme in the city's jails. Goode's programme, which started on 1 September 1988, also includes anonymous AIDS testing, counselling and treatment.

Footnote

Editor — I am grateful to the magazine 'American Jails' for permission to publish this extract which first appeared there in Autumn 1988.

Inmates with HIV — A Double Sentence

Jonathan Grimshaw is the Director of Landmark, the South London Centre for people with HIV. Jonathan is a founder member of Body Positive, the national self-help organisation for people with HIV. Jonathan is also one of the expert members of the AIDS Advisory Committee. In this article he examines what it means to someone in prison who has HIV and how important is the environment and the people around to that person's sense of well-being in that distressing situation.

'. . . since being put on normal location, I have started to notice that there are people who still don't know or understand what HIV/AIDS is about. These people have seen several videos produced by the Home Office and yet they still either can't or don't want to understand and through that I find them being ignorant towards me and withdrawn. I get blanked a lot as if they don't want to understand, want to know . . .'

Letter from an inmate with HIV to an AIDS self-help group.

The Environment

In a survey of the housing needs of people with AIDS and HIV, to be published early next year, a common plea of those surveyed is to be able to live in 'an AIDS-educated environment'. This plea is echoed in many of the letters, such as the one above, which reach HIV/AIDS self-help and service organisations from prisoners with HIV.

Many people, after receiving a positive result in the HIV antibody test, use imprisonment as a metaphor to describe how their lives change after the diagnosis. This psychological 'imprisonment' occurs primarily because behaviour based on prejudice — rejection, abuse, even physical violence — has been a common reaction to the disclosure by one person to another of an HIV or AIDS diagnosis.

Fear of Others

Such behaviour generates in someone with HIV or AIDS a fear of how others will react. Rather than risk a hostile reaction, many will conceal their HIV status, and their feelings about it, from people to whom they might normally turn for support in a crisis. But in order to maintain the concealment, emotional barriers have to be put in place which undermine and stifle close and trusting relationships.

The isolation experienced within these barriers aggravates depression and despair. Many people with HIV talk of being treated as, or feeling like, 'lepers' if they are unable to share their feelings and problems with friends or family members who are unsympathetic and unsupportive. These feelings may be intensified in the prison setting. An inmate with HIV is physically isolated from his or her usual community and removed from the support of trusted friends and family.

Loss of Control

The prison metaphor is also used to describe the loss of control over one's own life that accompanies an HIV diagnosis. The precautions needed to protect one's own health and the health of others imposes severe limitations on important aspects of personal behaviour, especially sexual behaviour. The virus reduces the capacity for self-determination. The stress associated with adapting to this loss of control can be aggravated when, through prejudicial fears of infection (using prejudice in its literal sense — forming judgements or opinions without proper information), inmates already emotionally isolated are further isolated within the prison setting by, for example, being confined to hospital wings.

If there is no medical justification for such action (and it is very difficult to think of one for an inmate with HIV who is well), it is extremely frightening for a person with HIV to find him or herself in an environment where other people — staff and inmates — control every aspect of his life, and to know that those people are taking decisions and acting on the basis of prejudice. Perhaps the closest analogy is being sentenced and imprisoned for a crime of which one is innocent and it is easy to imagine the feelings of anger and helplessness that arise in such a situation.

Enabling and Support

The importance of enabling people with HIV to participate in and contribute to the life of the community they are in is recognised by the Prison Service, but being on normal location may have its difficulties unless the prison population is

'AIDS-educated' and unless confidentiality is protected.

Inmates with HIV do not have easy access to mechanisms of social and emotional support available to those outside. Such mechanisms are important in sustaining self-esteem in the face of negative social attitudes.

People with HIV may feel enormous guilt if they suspect that, albeit unwittingly, they have infected other people, perhaps people they love. Recent mothers who discover that they have HIV must face the additional trauma that their child may be infected.

Blaming

These feelings of guilt may be intensified by attitudes such as blame. It has been a common social reaction to people with HIV that they brought the disease on themselves, that they have only themselves to blame and that ultimately, they 'deserve to die'. Without social and emotional support mechanisms to counter such attitudes, a person with HIV may come to accept such attitudes as the truth and 'internalise' them. they may themselves come to believe that they 'deserve to die' and contemplate suicide. It does not occur to those who express such attitudes to question the morality of inflicting further psychological damage on a person whose physical and mental health may already be precarious.

Sense of Loss

Because there is no way of predicting, with certainty, how quickly a person with HIV may become ill, those who have the virus must live continually with the prospect of imminent illness involving pain, disability, perhaps dementia, and ultimately death. They must come to terms with loss of health, loss of relationships, loss of security and control over their lives, loss of social acceptance and loss of self-esteem. Inmates with HIV have lost, in common with but more profoundly than other inmates, their freedom.

Denial (pretending it isn't happening), grief and depression are common and entirely natural reactions to loss. So, too, is anger. Concerns have been expressed by inmates and staff that inmates with HIV will try, deliberately and maliciously, to infect others. There is no evidence that HIV infection, in itself, causes those infected to want to harm others by spreading the infection. It would be surprising, however, if those people with HIV who feel doubly punished — by being imprisoned and isolated within the prison as a result of rejection by, or hostility from, their peers — did not succumb to the temptation to 'hit back' using HIV as a weapon.

Attempts by HIV infected inmates to inflict harm on others are less likely to occur in an 'AIDS-educated' environment where the education has provided inmates and staff with an understanding of the needs of HIV infected inmates and the appropriate response to them.

Medical Care

Prison inmates are entitled to the same standard of medical care and attention as they would receive outside the prison system. It is the Prison Medical Directorate's aim to ensure that this applies to inmates with HIV. Social and emotional support is recognised by doctors experienced in treating people with HIV as an essential part of any care programme. Part of this support is provided informally by peers and family, some is provided more formally by counsellors.

Many of the letters received by voluntary organisations from inmates with HIV complain of perfunctory or insensitive counselling and, in a few cases, no counselling at all. The delivery of appropriate counselling and medical care to inmates with HIV presents major challenges to the prison system. Difficulties may arise where the way the system operates conflicts with the way care should be delivered.

For example, it is commonly agreed by doctors that consistency in policy and continuity in care are important principles in treating people with HIV. Yet inmates with HIV may be transferred within the prison system to establishments where policy towards inmates with HIV may be implemented differently. Each time he or she is transferred, the inmate with HIV will have to negotiate a whole new set of relationships with prison staff and inmates whose attitudes to HIV may be very different from the the attitudes of staff and inmates in the previous establishment.

Much painful effort may have been expended in building up a network of formal and informal support in one establishment and this process may have to be repeated on arrival at a new establishment. Such disruption to the continuity of care and support adds to the burden of stress an inmate with HIV may have to carry. The medical care given in one establishment may vary from that in another. The HIV infected inmate may find that his experience of care — medical, social and emotional — within the prison system is one of inconsistency and lack of continuity.

Testing

Inmates who discover that they are HIV infected through being tested while in prison, and who therefore have no experience of living with HIV in the outside world, may face particular anxieties prior to release. They will be anxious about how

loved ones — boyfriends or girlfriends — will react to them. Will they want to continue the relationship on a 'safer' sexual basis? Those not in relationships may fear that no-one will want to form a close, loving relationship with them if their HIV status is known. They may have anxieties about what obstacles, in addition to having been in prison, their HIV status will pose to someone finding employment and somewhere to live.

The degree of attention given to ensuring that appropriate support for a particular inmate is arranged in the community prior to their release varies between establishments. Being unable to live, as most of us do, assuming that we have a future and time in which to set ourselves and accomplish the goals that give meaning to life, people with HIV often come to feel that the quality of life in the present is as, if not more, important as quantity of life in the future. Inmates with HIV may fear that the virus will extend their sentence to a life sentence.

Summary

It seems inevitable that sooner or later everyone in the prison system will know an inmate with HIV. It is everyone's responsibility to ensure, in the interests of the prevention of spread of HIV as well as care and support for those infected, that the prison environment is 'AIDS educated' so that whether an inmate with HIV spends some or most of his remaining life in prison, that time isn't a double punishment. ■

HIV Counselling in Prisons

Kay Nooney is the Senior Psychologist at HMP Wandsworth. She is the most experienced counsellor of people in prison with HIV. She is an advisor to the steering group concerned with the development of the special care and support unit under construction at HMP Brixton and is a member of the AIDS Advisory Committee.

Counselling is defined in useful detail and the paper outlines the problems of HIV in prison and the way in which counselling can help.

This paper will consider the following aspects of HIV counselling in prisons.

1. Definition of Counselling
2. HIV post-test counselling
   A) implications of negative test
   B) implications of positive test
3. Assessment
4. Features special to prison
   A) individual
   B) environmental
5. Nature of population
6. Advantages of prison for counselling
7. What the Counsellor will be doing

Counselling Definition

It seems important to define, in some way, what is meant by counselling.

Counselling is a word often used or misused in a variety of contexts. For the purpose of this work it is believed to contain four basic elements:

1. Empathy
2. Trust
3. Assessment
4. Strategy Development.

Empathy is a pre-cursor to the other elements if the prisoner's expectations are to be matched with those of the counsellor. The counsellor must be able to understand the perspective of the person in order to effect any influence. It follows that the prisoner would need to detect sufficient empathy in order to trust the counsellor with information which may contain details of illegal behaviour and very personal information concerning their sexuality and sexual behaviour. It is important that the relevant parts of behaviour are known in some detail in order to achieve an effective assessment of the potential problems in achieving the objectives of the counselling. It is only with an accurate appraisal that effective or relevant strategies can be introduced. It is reasonable to state that in most counselling some behaviour change is the expected outcome, though this behaviour change may also be linked to attitude or perceptual change. Counselling in this context is a relationship in which the client's perceptions and expectations can be matched with those of the counsellor.

HIV Post-test Counselling

Implications of a Negative Test

This can be a very difficult counselling objective. The inmate is probably very relieved at the result and less receptive to

any implications. It will be necessary to make understood that the test results indicate present status only and that any risk behaviour that has occurred within the preceding three months may well lead to a different result in subsequent testing. It should also be said that it is possible that the test may not detect the presence of antibodies even though the virus is present. In any instance where risk behaviour has led to the individual having sufficient uncertainty about their status to request a test, behavioural change must be implicit in the counselling. In practice it is rare that there will be sufficient motivation to continue the counselling. There are occasions, such as rape, where the behaviour change aspect of counselling will not be necessary; but in all instances the impression that some form of immunity or licence to continue high risk behaviour has been indicated by a negative test result will need to be explicitly refuted.

Implications of a Positive Test Result

At this point an individual may be in a state of great uncertainty and anxiety. The counselling should contain substantial psychological support as well as the necessary information. It will be important for the individual to be aware of the difference between being HIV positive and having AIDS. It is not yet known exactly what proportion of HIV positive people will go on to develop AIDS, though the information known indicates that it is a high proportion. It is believed, however, that lifestyle and attitude can have a strong effect on an individual's capacity to withstand disease. In this context the psychological approach of an inmate to HIV status becomes all important.

The counselling process should contain accurate information on the current knowledge of HIV, treatment and the expectation of disease. Most individuals with HIV will seek information from all the sources available to them. This behaviour emphasises the importance of a multi-disciplinary approach in order that the inmate will receive the same information from the different sources and thereby avoid confusion.

The counselling will also involve the individual in promoting responsibility for, and control of their own physical well-being. This is rather difficult in the context of prison but again emphasises the importance of a multi-disciplinary approach whereby an inmate can choose to make the most of a prison regime through the presence of options in diet, physical and mental activity and support organisations.

This aspect of HIV will form the basis of long-term counselling.

Assessment of Risk Behaviour

The immediate objectives of post-test counselling for an HIV positive result will begin with assessment of the relevant behaviour and consideration of the method needed to achieve behaviour change.

It will be important to consider the initial assessment as it is not uncommon for people to disguise the real source of their anxiety in relation to the transmission of HIV, e.g. a man may have engaged in some form of homosexual behaviour (which he has not wished to divulge) but may have originally stated a fear of transmission through contact with a prostitute. It is necessary to know the details of an individual's sexual behaviour in order to promote relevant strategies for behaviour change if change is required.

Counselling will contain not only information on safe sex in order to reduce transmission risk, but the counselling process must involve the individual in being able to make relevant choices and be aware of the particular risks to themselves as people with HIV, of other sexually-transmitted diseases. Drug taking behaviour will also be considered. Prisoners with drug-related offences may have already sacrificed many of the usual rewards of life in order to continue their addiction. Often they can be particularly resistant to behaviour change in relation to drug misuse, but there are strategies which can be employed with the most resistant groups, for example, information on needle exchange schemes and better ways to clean out 'works'.

So far the general tenets of counselling would be applicable to HIV counselling in any situation. However, there are aspects of HIV counselling in prison which are not readily translated to other environments. There has been a brief mention of the problem of promoting individual responsibility for well-being in a system in which very little individual responsibility and choice can be permitted.

There are other implicit aspects of prison which influence the nature of the counselling process. One of the most important of these is the isolation of the prison: isolation from their usual sources of support, family, spouses, lovers, friends. Many of the HIV positive prisoners may be faced with the knowledge of their HIV status on their current sentence. They may feel that the permitted access to their usual sources of support is not sufficient in which to discuss such a difficult issue. Alternatively, family and friends may have taken the opportunity of the sentence to sever connections with the prisoner.

There are also instances, especially among drug users,

where there are no consistent sources of support. Drug users may have become isolated from people other than drug users. These acquaintances may not be able to sustain the motivation to visit or offer support.

They will also be isolated (in most cases) from their main source of comfort — the drugs themselves. All prisoners will be isolated from ready access to information. They may be restricted in their knowledge of HIV and AIDS to the tabloid press. They will, however, be anxious to acquire knowledge of the latest advances in treatment. The provision of information becomes a more important aspect of counselling in prison than in other situations. Information can be better received if it is identified with an outside organisation, e.g. Body Positive.

Features Special to Prison Environment

Many prisoners have a preoccupation with health worries. This condition may be aggravated by the poor fabric of many prisons and the low levels of hygiene standards involved in slopping out. They are also unable to choose their health or psychological care. They may spend long periods without stimulation or distraction from their health concerns. They may be newly sentenced and be experiencing considerable stress. All these pressures will apply to HIV positive prisoners as well as the stress of their condition. Many of the symptoms of anxiety, weight loss, headaches, palpitations, sweating, may be mistaken for AIDS symptoms. This will add to the stress of the individual. Counselling in these instances will incorporate strategies for anxiety management.

Population

The prison population generally will contain a higher proportion of individuals who present problems to a counselling process. The population will, by definition, be characterised by rule-breaking behaviour. They may also be considerably more impulsive than the general population. It is still difficult to successfully promote behaviour change to safer sex practices among the population at large. It presents then a considerable counselling problem to promote such behaviour change in a group characterised by rule-breaking and impulsiveness.

It seems that there has been a substantial, successful effort, through intensive education, in changing the sexual practices of the homosexual community. These changes have yet to be accepted in the heterosexual population. It is also now an infrequent occurence for a prisoner to have been infected through homosexual behaviour. Most of the recent receptions with HIV will also have a drug problem

The drug-use habits the prisoners have acquired often indicate their vulnerability to pressure as well as an identification with others outside of the established community. They can be said to have inadequate coping mechanisms and the added pressure of their HIV status may make them more likely to resort to addictive behaviour. They may well have already risked illness and death through overdoses on many occasions. Those prisoners with substantial sentences may also have experienced failure at previous treatment programmes. In summary, the prison population may well contain a higher proportion of complex counselling problems.

Advantages of Counselling in Prison

There are some advantages to prison-based HIV counselling. Firstly, the prisoners will be relatively drug free enabling them to consider the possibilities and advantages of remaining drug free.

They will also have time in which to consider their future strategies. Some may represent a group which would not usually want contact with specialist intervention. The prison sentence may be a real opportunity to influence individuals not usually amenable to such contact. This seems particularly relevant in the prevention of HIV transmission.

Summary — What the Counsellor will be doing

Assessment

To find out the individual's history requires sensitivity and perseverence but is essential in order to know how to go forward. Thereafter, assessment is a continuous process throughout counselling, moving towards goals agreed between both counsellor and the individual.

Anxiety Management

This is especially important in prisons, not only to reduce stress for the individual concerned but also to prevent incidents between 'highly charged' prisoners and staff or other prisoners. There are several techniques available to achieve a level of anxiety management.

Behaviour Change

Changes in sexual behaviour will be encouraged through the provision of information on safer sex and the development of relevant strategies. Drug misuse would also be discussed in the counselling process. It may be that abstention will not be a realistic objective and in this case safer drug using behaviour will be emphasised. Unfortunately it is not possible to direct prisoners on release to maintenance programmes, as they will

not be deemed drug free and will not be eligible.

Psychosocial Support

The counsellor will be involved as part of a multi-disciplinary approach in ensuring that HIV positive prisoners receive maximum support and and contact with relevant support sources.

Relating to Outside Agencies

It is beneficial that prisoners should have contact in prison with those agencies most likely to be able to provide some help for them on release. It is also important that prisoners are able to receive information from sources other than prison on questions of health care and HIV. A counsellor will probably be a natural referral point for local drug agencies and HIV support organisations.

The isolation of prisoners from information was previously highlighted. In order to lessen this problem a counsellor may be involved in the collection and dissemination of HIV information and knowledge through news letters, bulletins and other information, which may also be provided by the outside agencies.

Crisis Intervention

HIV positive inmates are probably more vulnerable to being precipitated into crisis behaviour due to the continuing level of anxiety that their status elicits as well as the reaction of others, (staff, prisoners, family, friends) to them.

Counsellors will be likely to become involved in some form of crisis intervention (e.g. after smashing up, suicide attempts or fights).

Staff Support

There is also a role for the HIV counsellor in prison in providing support and information to all staff working with HIV inmates.

At a time when many prisoners and staff are hostile to HIV+ prisoners there may be many occasions on which a counsellor will need to act as an interface between the prisoner and the prison, (eg when an HIV+ inmate has been refused a change of library books for fear of infection).

Regime Advice

There is still some disparity between the Prison Service policy of location of HIV prisoners and the operational practice. There are also special Care Units at a planning stage and the counsellor will have a contribution to make on regimes for HIV positive inmates.

Bereavement Counselling

This is an area likely to become more important as more of the inmates with HIV become unwell. There are also likely to be more inmates suffering from AIDS related symptoms. ■

Pastoral Care of Prisoners with HIV/AIDS

Reverend Gerald Ennis, Senior Roman Catholic Chaplain to HM Prison Service

The Author relates his experience during a visit to the USA in 1987, specifically aimed at gaining information on the manner in which prisoners with AIDS and HIV infection are cared for there. He illustrates his findings both anecdotally and with statistics. He draws parallels with the situation in the United Kingdom and gives his views on how AIDS and HIV sufferers should be supported and cared for while in custody.

He rounds the article off with a check-list of points that those who come in contact with AIDS/HIV patients should be aware of.

In March/April 1987 I made an official visit to the USA to look at the way prisoners with HIV/AIDS were being cared for. I spent a week in the Federal Medical Centre in Springfield, Missouri, then a week in the Pennsylvania State System and finally a week in the New York State System. Altogether I visited about ten establishments. The Federal Medical Centre was at that time the only resource in the whole Federal System. It has a capacity for about 1100 and about 300 of them are ill, the rest being involved in running the place. The first death from AIDS occurred in 1974 and since then the records show:

	Deaths
1984	1
1985	5
1986	9
1987	19
1988	23
1989	16 (up to November — a second Unit was opened at the beginning of the year somewhere else).

Here in the UK we are supposed to be about three years behind the United States.

The Phoney War

In the prison system in England and Wales we are in a period not unlike the 'phoney war' of 1939 — nothing appears to be happening. At the time of writing in November 1989 we have 68 prisoners known to be HIV positive, and two who have been diagnosed as having AIDS. There is a serious danger of complacency resulting in high-risk activity, leading to the spread of infection. There are already some indications that there is more high-risk behaviour going on than may have at first been thought. The need is to act as though high-risk behaviour is very common, so that our efforts in education are maintained and there is as much publicity given to the dangers as possible. It is infinitely preferable for the dangers to be over-emphasised than otherwise.

The chaplaincy has made a valuable contribution to education in producing a training manual which covers more or less the whole subject as we know it at the moment. Throughout the country, groups of chaplains are meeting to improve their knowledge and skills.

Staff Training and Prisoner Education

The policy with regard to testing, diagnosis, treatment and locating of those who are HIV/AIDS needs to be known by every member of staff in every establishment. Information should be updated every year at least, and governors should ensure that *all* staff read and understand this policy. In the Department of Corrections in Pennsylvania they insist that each member of staff signs a book to say that he/she has read and understood the document.

Again it is important to keep repeating the teaching on HIV/AIDS , not simply to show the risks involved, but to show where there are no dangers from people with infection on normal location, and in everyday social contact. We have to encourage everyone to avoid creating further suffering for those infected. We do this best of all by our own example. It is not enough just to show the film 'AIDS — Inside and Out' once on reception, and hope everyone will take notice, understand and remember.

Come Across any Aliens Recently?

It is one of human nature's perversities that in spite of knowing the facts we prefer at times to ignore them and behave irrationally. Recently, a young offender was taken to a local hospital for a minor operation, but one which required a general anæsthetic. The hospital was informed that the patient was HIV positive. He was put into an open ward in the second bed. The first bed was unoccupied and the patient in the third bed was moved to the other side of the ward — so he had plenty of space! The doctor came to examine the prisoner's chest to see whether he was fit to have a general anæsthetic. Before doing so the patient was very surprised to see the doctor open a package and put on a pair of rubber gloves; he was more surprised when he opened a second packet and pulled on another pair; when yet another packet was opened and a third pair of gloves was put on he wondered whether or not he was a cosmic alien. Added to this, it was a performance witnessed by everyone in the ward because no one bothered to draw the curtains. He was told originally that his operation was scheduled for 10 am, later he was told that it would be 2 pm, and finally that he would be last in the theatre and would go in at 5 pm. A couple of nurses came to give him a pre-med injection. The needle was then, with the solemnity worthy of a high priest performing some strange liturgy, placed in a box and, at arms-length, immediately removed from the ward by the Sister. A medical conference with two doctors and several nurses took place at the far end of the ward. The patient clearly heard his own name being mentioned as being HIV, which meant that if he could hear it so could the rest of the ward. Eventually the climax to this drama came with the trolley which was to be used to transfer him to theatre. The mattress was covered in plastic sheeting, and so was the whole frame of the trolley, including the handles and legs; even the wheels had neat little covers on them. It looked as though someone had just bought it and forgotten to unwrap it. No witnesses have come forward to say what happened in the theatre — but it must have been some performance!

The patient regained consciousness ten minutes after coming out of the theatre, and was immediately put in a taxi and sent back to the Young Offender Institution. It is hard to imagine such ridiculous, unprofessional and utterly insensitive behaviour as that, but if the NHS can do that sort of thing, at least prison staff must be on guard about the signals we send out to those in custody who are

also carrying the burden of being HIV/AIDS.

Isolation

In my very limited experience, I have found that the greatest suffering is caused by being treated as an outcast, someone who is to be avoided at all costs, an untouchable. A person with AIDS knows that he will fairly shortly die and this burden is added to that of his imprisonment. Isolating him will only add to his already great suffering.

Paul came from New York and was a drug addict. He committed himself to his rehabilitation programme in prison, made good progress, and was shattered when he was told he had AIDS. Apparently he had been unwell and the prison medical staff could not obtain a blood sample for testing, because his veins were in such a bad state. He got worse and collapsed on the floor gasping for breath and was left there for several hours before being taken to an outside hospital, where they managed to get a blood sample and diagnosed AIDS. He was then transferred back to the Federal Medical Center in Springfields practically dead. They nursed him back to being well, counselled him, and when I met him I found him to be one of those people you never forget. I promised I would pray for him every day. The last I heard was about three months ago; he had been discharged from prison. He was so near death that the pain centres in his brain were affected to such a degree that he no longer had any feeling. When we had said goodbye as I was leaving Springfield, he gave me a big hug. Later that evening I was thinking how much more he was at risk in doing that than I was. I have got millions of bugs on me which don't matter to me because my immune system is not damaged — Paul's is. He was more likely to get something from me than I from him.

In one County in Pennsylvania where there is a high proportion of HIV drug users and homosexuals, the prison authorities compulsorily test offenders. One man so tested was found to be HIV positive, and because there was no place in any part of the prison where he could be kept apart he was put on Death Row! He was quite well at the time.

I met one man who had a personality difficulty and preferred his own company. He told me that he had joined a group for counselling, and during a session, sitting next to the counsellor, he was told by this man that he felt uncomfortable sitting next to him. 'I feel it is better to say this outright rather than just fidget,' said the counsellor. The prisoner thanked him and moved across the circle to the other side I said to him, 'Ed, I would like you to know that I feel perfectly comfortable sitting here on your bed sitting next to you, and talking with you and shaking hands.' Ed said, 'That's great, Father, thanks very much, that helps.' When I was about to leave him I asked if he would like a blessing from me. He said he would. He knelt on the cell floor and I placed my hands on his head and prayed aloud for about half a minute, in no hurry to take my hands off his head; then I blessed him. As I took his hands to help him to his feet again he was in tears. I could be wrong, but I strongly suspect that, from the look in his eyes, they were tears of gratitude.

The most damaging and hurtful experience for prisoners who are HIV/AIDS comes from being treated as an outcast.

Don't Let Me Die In This Place

Imprisonment becomes relatively insignificant compared with the life threatening condition of AIDS. However, as illnesses come and go and death gets nearer, the great anxiety is 'Will I die here in prison?' It is the most important thing in the world to them to be released before they die. 'I don't care even if I have to die on the steps outside, but I don't want to die in this place.' I would hope that we will never allow this to happen in the UK. When a prisoner is acutely ill he may need to be treated in an outside hospital, but if he should die he is still not a free man until his release has been signed. Whatever punishment is due to him as a result of his crime, when death threatens mercy must over ide the demands of justice. There will be difficulties and fine judgements required about the likelyhood of recovery, and perhaps it will not be possible in every case to release prisoners in time, but if formalities are dealt with early enough, quick decisions at times of crisis have a better chance of success.

How do we help the Staff?

I met some wonderful people in the Federal Medical Center and in particular those working in the AIDS Unit. Again and again I heard the prisoners say 'They really do care for you here'. Many of them had been responsible for nursing the patients through from ventilators to being well again, and able to walk about in relative good health. One man had been on a ventilator three times, and I understand that this was quite exceptional. Inevitably, there was a great deal of stress upon staff, and when I asked the nurses whether the Superintendent ever came round to give a word of encouragement I was told 'No, the only support we get is what we give to each other. It would be nice if someone would take the trouble to say "atta girl" '. I was happy to hear that

the chaplains were a great support, and the patients themselves were full of praise for everyone.

The nurses and correctional staff got very close to the patients and there was great sadness when a patient died. It was at times like this that the need for support for staff was greatest. Hopefully the time will come when there will be a programme to meet this need, and support in the form of counselling will be part of the caring process for staff. We need to be aware of this before it happens. Counselling may sound a rather pompous word, but what is needed is someone who is simply prepared to give the staff the time they need, to be a listener, and to understand empathetically and compassionately. In other words, to be the friend who is prepared to be leaned on during the difficult times. Senior management, especially the Governor, has an important role to play. The care that staff are able to give their patients and other prisoners will be in proportion to the care which they receive from the Governor and others in senior positions. Hopefully, we will only hear that an ex-prisoner has died outside, but there will be staff needs when this happens. All chaplains will have some experience in helping people through necessary grieving, so they will need to be alert. It is a mistake, however, to think that it is exclusively the chaplain's job to do this. It is the task of everyone to care for each other, and I hope that, through the arrival of HIV/AIDS in our midst, we will all learn to be more sensitive to our neighbour. Not very long ago I heard that one officer who had volunteered to join the staff of a new therapeutic unit for Young Offenders was spoken to by another officer, who said, 'I thought you would have had more sense than to volunteer for that job.' The foundation for a caring and concerned person is strength not weakness.

Don't tell your ten best friends

In fact do not tell anyone unless he or she needs to know. Confidentiality about HIV/AIDS is the responsibility of all staff, not just the medical staff. They say there are no secrets in prisons, and this may well be true. However, there is going to be quite a problem if the only place where a person with HIV/AIDS has to be located is in the prison hospital. At the moment there are so few known carriers of the virus that our hospitals can cope, and prisoners generally prefer to be located in the hospital rather than on the landings. This may be for no other reason than that they do not wish to have to suffer abuse from fellow prisoners. We have probably all seen the training films, both for staff and inmates, and the position is very clear that there is no danger to anyone in mixing normally with a person who is HIV/AIDS.

An additional threat is that location in hospital can lead to a false sense of security. There will always be some HIV positive inmates that we do not know about who will be on the landings, and high risk behaviour is what it says — risky. One chaplain, known to be well-informed on this subject, was suddenly set upon by an angry officer who said, as though it was the chaplain's fault, 'They've put a man on my landing who has AIDS'. The chaplain's response was worthy of being quote of the month: 'Why, have you been having sex with him?' This made the officer even angrier and he stormed out, but ten minutes later, to his great credit, he came back and apologised to the chaplain.

The aim in the Prison Department on HIV/AIDS should be to reassure every member of staff that its policy presents no threat whatever to staff, nor to other prisoners, so long as certain behaviour is avoided. Only in this way will it be possible for us to cope with the future.

A check-list . . .

It might be helpful to highlight a few things that we need to be aware of:

1. There is no need for people to be isolated unless for their own privacy.
2. Staff must not make judgements about other peoples' lifestyle.
3. Get close to the patient — it is healing for both parties.
4. Do not be afraid to touch.
5. We may not be able to cure people with AIDS, but we can all be healers.
6. Be open to the emotional, spiritual, social and psychological needs of the patients: Be available
   to listen,
   to talk,
   to pray,
   to laugh and cry,
   to talk about death if ***they*** want to, and
   to respond to any need with sensitivity.
7. If I have a heavy chest cold it could be fatal for a person with AIDS.

What is AIDS?

A call to compassion . . . ■

Aids in Prison — The Edinburgh Experience

The following six articles describe the multi-disciplinary approach pioneered in Scotland by HM Prison, Edinburgh to the problem of managing prisoners with HIV/AIDS. The Group has recently been awarded a Butler Trust Certificate for their work.

AIDS in Prison — The Custody and Care Dilemma

Michael Duffy, Deputy Governor (Chairman AIDS Management Group)

During the 1980s Edinburgh earned itself the unenviable title 'AIDS Capital of Europe'. Inevitably there was a spill-over into the prison and through 1988 the number of known HIV positive inmates was rising remorselessly. As the numbers increased so did anxieties internally amongst inmates and staff. It was a new problem for prison management and the community. The uncertainties surrounding this problem gave rise to wild speculation in the media and amongst pressure groups about the true number of HIV positive inmates and about the extent of remedial adjustment required to the prison regime if the problem was to be tackled effectively. The articles which follow trace this background and map out the approach of the management at Edinburgh Prison to this problem.

The Multi-Disciplinary Approch

Stuart Monteith in another article in this edition describes the creation and composition of the AIDS Management Group — an approach to the problem which has yielded considerable rewards. Like many successful ideas it has at its core a simple philosophy: a multi-faceted problem requires a multidisciplinary approach. Indeed the variety of contributions for this issue underlines the value of such a perspective. Stuart details the background to the HIV/AIDS problem here in Edinburgh and describes the major initiatives taken here.

Communications and Liaison

Our part-time Medical Officer, Dr Jolliffe, who is also a GP in Edinburgh, describes his early realisation of the likely impact of HIV/AIDS on the prison. As the numbers of inmates affected increased, so inevitably did his contact with external health service agencies. In its early stages the source of information about the disease and its management were largely medical. It is not surprising therefore that as the full ramifications of a high HIV/AIDS population unfolded it was the medical side who first realised that this was not solely a medical problem. Dr Jolliffe gives detail of his clinical experience gained and also, importantly, describes the communication network established with other medical services in the community.

Training and Counselling

One of the wider problems identified as the spread of infection increased was the impact on staff and inmates. This had been a major issue with the Scottish Prison Officers' Association locally and nationally for some time. Our local branch was prepared to take part in the AIDS Management Group and indeed have played a full role since. In his article Michael Clark, who in the early stages was trained as an 'AIDS Counsellor Trainer',

describes how discipline staff now share the responsibility for training inmates, other staff, one-to-one counselling, and running an AIDS Support Group.

Care and Aftercare

The final article details the contribution of our Social Work Unit. We have identified the need for continuing care and for the co-ordination required between ourselves and the many varied statutory and voluntary organisations dealing with HIV/AIDS. This field has been developed by Social Workers who have also used their particular expertise in the counselling of inmates and the training of other staff in these skills.

Good Practice

As a summary we have identified from our experiene ten points of good practice in the management of HIV/AIDS in our prison setting. These are offered below as guidelines only and we recognise that our experience may not be transferable. They must be regarded as being provisional because as a new phase of the problem unfolds so our approach evolves.

Ten Points of Good Practice

(1) Blood tests should be available for inmates on request.
(2) Blood tests should be preceded and followed by appropriate counselling.
(3) Strict medical confidentiality must be observed.
(4) Information on HIV/AIDS inmates needs to be recorded systematically to aid forecasting.
(5) There should be regular health checks for all inmates identified as being HIV+.
(6) Counselling on a continuing basis should be available for all of those inmates identified as being HIV+.
(7) Arrangements should be made for proper community support on release.
(8) Adequate information and training should be provided for all staff and inmates.
(9) There should be a policy of non-segregation within all prison regimes.
(10) Those establishments with an HIV/AIDS problem should set up a multi-disciplinary local management group to co-ordinate all aspects of the problem.

For the above points to go into place however there is a major commitment which must be entered into: the aim should be to provide a standard of medical and other services at least equal to those available were the inmate at liberty. We made this commitment, realising the challenge, but our experience to date encourages us that it can be achieved in the prison setting. ■

HIV/AIDS — The Prison Medical Officer's Perspective

Dr David Jolliffe, Part-time Medical Officer

When I first came into contact with those who were HIV positive, comments such as 'I've got the virus, I'll need a special diet', or 'I've got the virus, I need to preserve my body, I can't work any more' were quite common. Prisoners who were very frightened by this disease tried to intimidate the staff. Three years later, we have seen over 100 prisoners infected with the virus and a great deal has changed. It is difficult now to remember that our first attempts to set up a multidisciplinary group were rebuffed as not being necessary. In the early days, some colleagues suggested that HIV testing should not be carried out within the prison setting and that this was a disease to be left to the 'experts'. I suspect that some people reading this article will be in a simillar situation to that in which we found ourselves in 1986, so I think it might be useful to share some of our experiences of the last three years.

Tackling the Problem

My first knowledge of HIV/AIDS came from talks with medical colleagues dealing with the outbreak of the disease amongst the hæmophiliac population. However, we soon became aware that in Edinburgh a large number of intravenous drug users were also likely to be infected. This meant that we were going to encounter for the first time a large number of young people who were going to be ill. Hitherto, we had seen a few prisoners who were seriously ill, but they tended to be amongst the middle-aged section of the population. It was clear that HIV infection and AIDS was to provide a major

challenge for our prison. As I mentioned, some colleagues expressed the views that we should not test individuals unless we were trained as counsellors, and advocated referring all patients to the local hospital. This was not a practical proposition and it also became clear that prisoners were looking to us for advice about the disease. They were anxious and needed encouragement to talk about their worries. In the halls, there was considerable discussion about the disease and prisoners learned that signs of advancing disease could include weight-loss, night sweats and the presence of lymphglands all over the body. In order to encourage the positive approach, we decided that we should carry out testing whenever it was appropriate. We developed protocols for both pre- and post-test counselling and always tried to ensure that a test was not carried out if we could not be sure of telling the prisoner the result. It also became clear that we needed to try to help those who were positive and who were anxious about possible progression of the disease. As time has gone on, these prisoners have become more knowledgeable about the disease and we have learned from them, as well as trying to monitor the progression of their disease. We decided to offer them regular medical check-ups every three to six months, depending on how quickly the disease had advanced. This system was very valuable and through this, not only have we increased our knowledge, but we have been able to show that we are trying to adopt a caring attitude. We have found the T4 test, which monitors the progression of the disease, is valuable. This test is a useful indicator of the progression of the disease; but now that new treatment such as AZT is becoming more widely used, the test is a useful guide as to when such treatments might be commenced. Confirmation of the accuracy of this test has been given further impetus recently by reports coming from the Royal Free Hospital in London. Anticipatory care such as this has shown that we have built relationships with these patients and that we are determined to give our prisoners a level of care at least as good as they receive in the community. More recently, we have also had local Consultants visiting the prison. This has increased our links with the community.

Nursing

As in any prison, the Nursing Officers are the front-line people and it is to them, in the first instance, that prisoners frequently turn for advice and counselling. It was thought that with a new disease such as this, special training was required for the Nursing Officers. We therefore arranged a series of talks which covered medical aspects of the disease, pre- and post-test counselling and, whenever possible, updates as to how the disease rate of progression has changed. In addition, we have encouraged staff to attend courses whenever possible and this autumn, each member of the staff spent one week at the local ID hospital in the AIDS Unit. This again has demonstrated to the prisoners our commitment to increase our knowledge and skills and develop a right attitude to dealing with this illness. It is only through measures such as this that we can fully understand the likely epidemic that is going to develop in this City in the very near future and prepare ourselves for it. Without a doubt, education of our staff and especially the Nursing Officers is a major pre-requisite for any policy.

A Multi-Disciplinary Approach

It is difficult now to imagine that a suggestion of a multi-disciplinary group would be dismissed. Nevertheless, this is what happened when it was first suggested by the Medical Officers in 1987. The developing multi-disciplinary group within the prison has drawn us much more closely into contact with discipline staff, the Governors and other agencies, such as the Social Workers. This has been most helpful and very important in a disease which is not solely a medical problem. It has enabled us to support the disciplinary staff, to allay anxieties and also to point out dangers of other illnesses such as Hepatitis B. I believe that Medical Officers have a major educative role in a multi-disciplinary group such as this and that they also have a real place in the planning of regimes for those who are suffering advanced disease. The advent of HIV infection and AIDS has dramatically changed the role and work of the Medical Officer. Whatever happens in the future, life will never be the same again. We have developed close relations with some of our prisoners and, as we mentioned before, are seeing patients who are quite ill, which is a new feature of Prison Medical work. Nevertheless, this is a most stimulating field to be involved with and I personally find the work extremely satisfying. To begin with, I was afraid, through lack of knowledge and inability to cope with the workload, but I can reassure anyone in a similar situation that one can learn to cope with the demands of the work and that the appropriate means are at hand to learn how to deal with this terrible illness. ■

The Prison Officer as an AIDS Trainer and Counsellor

Michael Clark, Senior Officer, HMP Edinburgh

One of the first areas to be addressed with regard to HIV/AIDS in prison is that of staff education. Fear and ignorance in relation to the virus can be catastrophic, therefore staff must be given all the available facts and information. These will give them the confidence and the reassurance that they work in a safe environment. Also, equally importantly, they will realise that those in their charge who have the virus may be treated the same as any other inmate.

The way we decided to go about our task of training was to plan a designated 'AIDS Month'. During our month, in this case June 1989, we held staff education groups, normally attended by 16-20 staff, from all disciplines. These were obligatory and the sessions ran approximately one to one-and-a-quarter hours. The contents were as follows:

A. INTRODUCTION
20 minutes
1. Why the talks were necessary.
2. How the virus is spread.
3. High risk groups.

B. HOME OFFICE VIDEO
'AIDS Inside'
22 minutes.

C. LOCAL POLICY DEVELOPMENT Explanation
10 minutes.

D. QUESTION AND ANSWER SESSION
20 minutes.

In addition to these sessions, lock up meetings were arranged for all staff at which guest speakers from the community, including experts in the field of HIV/AIDS, addressed staff on this particular issue. A newsletter was produced explaining policies for the future, and containing relevant information regarding AIDS. It is intended to continue this method of communication to keep staff up to date. A leaflet has also been produced which staff are advised to carry on them at work. This leaflet identifies different situations which arise in their daily work which may give rise to fears, for example: being bitten, spat upon, contents of pots being thrown at them. Opposite each situation is advice on what action should be taken.

All these initiatives have given us a staff who are aware of the facts, confident in their ability to deal with HIV carriers and reassured that they know that the problem of HIV/AIDS is being addressed in a constructive manner. They know also that questions of their safety are uppermost in all local policy decisions.

Counselling

We recognise that inmates who ask to be tested for HIV require pre- and post-test counselling. It is felt that Nurse Officers are the most appropriate personnel for this task as they are the first contact an inmate has if he is requesting a test. Several Nurse Officers have attended courses on HIV/AIDS and counselling. Once this was established, we soon realised that inmates with the virus displayed a wide range of problems and needs which had to be addressed. Many of these were in the domestic and individual counselling areas. Given our high numbers of these inmates, continued use of outside agencies was impractical so it became necessary for us to develop the appropriate skills internally. We therefore had to take on board all the services that were available on the outside when dealing with AIDS and we identified the most urgent of these as counselling. Our strategy was to send two staff on a course for training AIDS counsellors and have them train volunteer staff on return to the establishment.

Staff responded enthusiastically to this initiative and the first course saw a group of ten volunteers, made up of two Social Workers, one Nurse Officer and seven discipline staff, completing the training. It is intended to repeat this training shortly so that as the numbers of inmates who are HIV positive increases, and as some of these start to show signs of illness we will have sufficient trained counsellors amongst our staff to meet likely demand.

Our counselling training was carried out by a Senior discipline officer, a Social Worker and a teacher from our education department. Once again this showed the effectiveness of our multi-disciplinary approach to dealing with the problem. The response from staff to the education of inmates, and to the training for one-to-one counselling has shown that the interpersonal skills possessed by prison staff can, with coaching, be developed to a very high level. Equally our experience has indicated the willingness of staff, when given the opprtunity, to adapt and take on the new skills required to meet the anticipated AIDS epidemic. ■

The Contribution of the Prison Social Work Unit

Donald R Millar, Principal Social Worker

The extent of the HIV/AIDS problem in Edinburgh, with twice the rate of known HIV infection of any other regional health authority in the United Kingdom, and the early detection of the extent of infection amongst the City's intravenous drug-using population, has resulted in the development of links between the major statutory bodies with an interest in the problem. In particular, Lothian Health Board and Lothian Regional Council have developed a series of links at strategic middle management and practioner levels. The Prison has benefited from the availability of knowledge and information in the City when developing its own response to HIV and AIDS. The Governor attends the Regional AIDS Group, at which the major services consider the strategies to be adopted across the City. A Lothian AIDS Forum provides an opportunity for representatives of a wide range of statutory and voluntary agencies providing services for drug users and their relatives, including the Prison, to exchange views and information. The various specialists represented on the Prison HIV/AIDS Management Group have links into their own employing body for the gathering of information from colleagues working in other settings in the City and for training purposes.

The Prison Social Work Unit

Prison Social Work services in Scotland are provided by Regional Council Social Work Department staff seconded to the Prison Service for the purpose. As a member of the Prison HIV/AIDS Management Group, the Principal Social Worker is able to provide up-to-date information on the range of services for HIV positive men and their relatives. The scene is rapidly changing as money and resources are directed towards prevention of the spread of the HIV virus by the statutory health and as social work bodies and self-help groups spring up to meet the needs of HIV positive people, AIDS sufferers and their relatives. All of these services seem to want to visit men in prison and the HIV/AIDS Management Group must consider the appropriateness of the service offered. The Prison Social Work Unit has provided a locus for co-ordination of an HIV/AIDS Counselling Service and input into the training of prison staff from a variety of disciplines to act as counsellors. Local information and training material has been supplied to supplement the material contained in the Scottish Health Education Group's training package. Edinburgh Prison is now in a position to provide a one-to-one counselling service for prisoners who wish such a contact throughout their sentence. This service is seen as following on from the pre- and post-test counselling provided by the Prison Medical Officer and the Nurse Officers and complementary to the education programme. It is available to assist men to come to terms with the implications of their HIV positive status for themselves, their life-style and that of their partners and their offspring. Prison Social Workers provide support and advice for counsellors and a library of information on HIV and AIDS. Another initiative involved the setting up of a support group for HIV positive inmates staffed by prison officers and social workers.

Scottish AIDS Monitor

The Prison HIV/AIDS Management Group has reached an agreement with Scottish AIDS Monitor, an Edinburgh-based organisation similar to the Terence Higgins Trust, for them to provide 'buddies' for prisoners who want this particular service. Prison buddies are carefully selected and trained volunteers who have knowledge of problems with HIV and AIDS. They offer, on a one-to-one basis, practical and emotional support. This befriending service is seen as being particularly appropriate for prisoners who are approaching release, thereby allowing the contact to continue in the community if desired. Prison Social Workers make the link between prisoner and Scottish AIDS Monitor.

Aftercare

The Prison Social Work Unit is now considering the links that are required between the support that an HIV prisoner can receive in the Prison and the services he will require in the community. If the man is being released to stay in Edinburgh, there is an increasing number of services available to him to assist, whatever the state of his health. The task of the Prison Social Worker lies in discussing with him his needs and, when he wishes it, making contact with the appropriate services in the

community. Lothian Regional Council is developing a range of accommodation resources. However the Prison serves South-East Scotand and men come from all over the country. Prison Social Workers have already had to liaise with housing departments and other agencies in different parts of England and Wales, who have encountered the particular needs of an HIV/AIDS ex-prisoner. Away from the City, specialised services for HIV positive people may be non-existent and statutory services lacking in knowledge. Everywhere the HIV positive person can be subjected to hostility and stigmatisation. Lothian Regional Council has recognised the need for co-ordination and follow-up and has proposed the appointment of a Drugs/AIDS worker for the prison, to co-ordinate after-care.

Prison Social Workers have used their particular skills to assist prisoners who have reacted to the outcome of their HIV test. In discussion, they have assisted men to decide how and when to tell their partners and joint interviews with the Prison Social Worker have been used for this purpose. The Prison Social Workers liaise closely with their colleagues in the social work team based in the Infectious Diseases Unit at the City Hospital. Joint work has been carried out when the partner is known to the Hospital and the man is currently in prison. Issues over the care of children are dealt with by social workers in the local area offices and again involve close liaison between prison and community-based staff.

Those intravenous drug users who are known to be HIV positive generally show little inclination to stop injecting. Currently in Edinburgh, there is an absence of heroin and prescribed medicines and painkillers are the favoured substance of abuse. Crimes are still being committed to provide the cash to supply their addiction and the Scottish Prison Service can expect to be caring for an increasing number of young men facing debilitating illnesses and early death. Prison staff will be faced with human dilemmas and areas of care they have seldom had to tackle before. Social Workers with their knowledge of loss and bereavement have a significant contribution to make to the quality of care in the prison setting. ■

It's People We're Talking About!

Catherine Phillips

To bring into focus the needs of prisoners in what can become either a dry medical debate or one morally charged, Catherine Phillips, a prison education and development worker for a voluntary organisation, SAM in Scotland and two prisoners on this side of the border were asked to comment on the issues. Catherine Phillips describes the vital co-operation which is going on between the Scottish Prison Service and Scottish AIDS Monitor, a voluntary organisation in what has become known as the prison buddy network.

The letters from the prisoners speak for themselves.

THE PRISON BUDDY NETWORK: A Community response to meet the challenge of HIV/AIDS in the Scottish Prison System

'Prisons provide an opportunity to inform and educate large numbers of persons who may have engaged, or may be likely to engage, in HIV high-risk behaviours.

Many of these persons are unlikely to have received such education in the general community.'

World Health Organisation: consultative document on prevention and control of AIDS in Prisons, 1987.

In 1988, Scottish AIDS Monitor mounted a joint initiative with the Scottish Prison Service; this initiative was in response to the ever-increasing concern over HIV/AIDS in Scottish Prisons. Together we saw a tremendous need and potential for services in the HIV/AIDS field in Prisons; services for both staff and inmates. The focus of SAM's prison initiative has been education, training and support services.

On July 22, 1988, Lord James Douglas Hamilton, Minister for Home Affairs and the Environment said:

'The Government recognises the difficulties that sometimes arise in prisons through concern over HIV infection and AIDS. I therefore very much welcome this new initiative by staff at Saughton Prison and Scottish AIDS Monitor, who will work together to give guidance and counselling to prisoners on these issues. Training in such counselling is already being given to prison nursing staff and this new initiative will provide

further impetus to our efforts in this field. Like Scottish AIDS Monitor, we see this approach as the way forward in tackling HIV and AIDS in prisons.'

Education through Participation

SAM provides HIV/AIDS education through participation with staff in prisoner groups, i.e. pre-release group, remand education groups and drug dependency groups. We also provide written material with follow-up resources for inmates once they are released. Training consists of working with prison staff on HIV/AIDS education and issues, plus providing support to staff who are dealing with this extremely emotive issue.

Free Needles and Condoms?

The focus of SAM's education is on explaining transmission routes, harm reduction techniques and discussing openly fears and concerns. We discuss real issues, giving real answers and the best information possible to assist inmates in and out of prison. We talk extensively about taking care of yourself, using clean 'works' and practising safer sex. Scottish AIDS Monitor does not advocate the distribution of needles and condoms in prison due to the impossible nature of this procedure. Logistically, it is very unrealistic to imagine that this would cure the increasing HIV/AIDS epidemic among prisoners.

Community Agencies

However, the core of what we do is to ensure that inmates with HIV+, ARC or AIDS receive support services while inside and when released. This is done through the Prison Buddy Network. We recognise that people who are imprisoned are still part of the community at large, although they may be temporarily removed. Inmates come from the community and will eventually return to that same community; therefore, it is pertinent that they work with community agencies on issues that will influence their eventual return. This is where utilisation of the Prison Buddy Network can come in.

The concept of Buddies came about as a direct result of the AIDS epidemic in San Francisco. The basic concept of buddying is not new, though. It has been around for years, through befriending / lay counselling schemes used by community mental health programmes and community hospice programmes in cancer. The basic tenets of buddying are the utilisation of both these schemes, subsequently, providing a stable commonsense support approach to assist individuals in dealing with the many issues that surround HIV/AIDS.

Setting up the Network

What is new is the use of buddies in the prison environment. It has been difficult to gauge what effect buddies will have on inmates, as access for volunteers working with HIV/AIDS in prisons has been fairly small worldwide. Fortunately, the Scottish Prison Service has been very co-operative in allowing SAM access to inmates and also allowing us to set up buddy meetings between inmates and volunteers.

We have initially targetted three east coast prisons, Saughton, Glenochil and Cornton Vale Womens' Institution for our Prison Buddy Network, We chose these prisons for two reasons: proximity and uniqueness. Saughton is located in Edinburgh and is home to 35 known HIV+ men. It also does a tremendous remand turn-over for those living in the City of Edinburgh. Glenochil is located in the Central Region of Scotland and takes in long term inmates from all over Scotland. Cornton Vale, also in Central Region, is the only womens' prison in Scotland.

Although the project is in the infant stage we have been able to place five buddies successfully in our targetted prisons. Generally our referals come from prison officers, medical staff or prison social workers. We also receive requests directly from inmates. We can foresee this initiative expanding into other area prisons. We have already had requests from social workers to link up inmates upon release with buddies in the community.

Open Communications

The key to community involvement in prisons has been our willingness to co-operate with the Scottish Prison Service and to communicate openly with them. We do not, however, compromise our confidentiality within the buddy relationship, as this is paramount in maintaining an effective supportive service. All volunteers receive regular supervision, support and information to ensure they are kept up-to-date with changing medical views and get feedback for the many emotive issues that they may encounter within the buddy relationship.

With approximately 5,000 inmates in Scottish prisons and some 70 recognised HIV+ cases, we see the role of the Buddy Network as supplementary to counselling services that the prison service will be providing. Having a community organisation like Scottish AIDS Monitor is an added perk that will benefit both staff and inmates. The benefits are twofold. This type of support service allows inmates to ventilate their uncertainties, fears, questions within a neutral zone, a zone outwith the prison

environment but as a person who is part of the community as a whole. As a community agency we are always updating our resource information, therefore we are able to provide the most up-to-date information and services to prison staff and inmates.

In the light of the ever-increasing demand for resources, ideas, supports in the field of HIV/AIDS, we see the role of SAM being consultative. There are too many unknown and challenging areas of this most dreadful disease to fool ourselves into believing that we have got all the answers. However, we as a voluntary agency, come to the arena with a wealth of information which has come from our years of providing services to the community in education and support. The Scottish Prison Service has recognised this experience and is utilising it.

In a world of AIDS it makes sense that all organisations, statutory and voluntary, work together to help one another. HIV/AIDS is a multi-faceted issue that needs to have input from different sources in order to keep it in perspective, for the individuals involved, who need our support and assistance.

PRISONERS COMMENT

Two letters from prisoners in the prison system in England. One with a diagnosis of HIV+ and the other not, but both letters illustrate the need and potential of a Buddy Network this side of the border.

When I was first told I had HIV positive in July 1988 my first reaction was to cry. I did not know much about the disease apart from what I had heard from people who knew no more than I did. I was very hurt and angry in myself — I kept on saying why me? But there was no answer.

I never thought I would contract the disease. I knew I was a high risk with being a homosexual and I was always so careful and I kept on thinking who gave this disease to me. I kept on thinking I am going to die of AIDS and that I was in prison and that made things so much worse. I would say to myself please God don't let me become ill in prison and die, let me out to have a little happiness with my friends.

My worst fear was the rejection I might and would get from friends and family. I have not had contact with my mother and family for six and a half years. But I wrote to them and told them and they said I had made my bed so now lie on it. I never told my close friends for eight months, I was too scared of what they would say. But when I told them they were upset but I think it brought us closer together in some ways.

While being in prison I have been kept in the Hospital wing. The Hospital staff are very caring people but when I go out of the Hospital to another part of the prison the disciplinary staff on the units don't come near me and won't even talk to me. I am not allowed into the visiting hall so I have my visits in the Hospital. The confidentiality is not all that good in prison otherwise I would not be turned away from by disciplinary staff who don't really know me and work in a different part of the prison. Disciplinary staff don't need to know that I am HIV Positive. Most of them think that the disease is going to jump out of my body into theirs, which is quite stupid. A lot of the prison inmates outside the Hospital always shout abuse at me about having AIDS and not to come near them etc. And it really hurts me inside to just hear what they say and to know that those people could be so mean and callous to someone who is already suffering.

I have been on the drug AZT for seven months now as I lost a lot of weight and became quite ill. When the doctor told me I was going on ATZ I thought I had AIDS and that I was going to die and I cried for a day and a half. I am much better now and quite healthy. I had quite a lot of support from the Hospital staff and doctors. But I still have to walk around with a wall around myself because I am so scared that if I let my barrier drop then I am quite vulnerable to people who don't really care and could hurt me with their words or rejection.

In my opinion more people should be educated on HIV and AIDS and should know all the risks involved because some of those people who don't understand can be cruel with words and their rejection could do more damage to the HIV patient than the disease itself in the long term.

A Serving Prisoner
(Name withheld — Editor)

When I first heard about AIDS my first impression was: 'it serves those gays right'. I mean after all the hype from the papers about how people were meant to catch it, . . . what was I meant to think?

That's how my thoughts stayed for quite a while until I got my sentence and was put in custody, I was placed on the hospital unit as I had diabetes.

When I got my job as a cleaner, I was told straight away of another inmate who was HIV positive, all I thought was how can they put me with this inmate who has a killer illness. When I first saw him, I was very tense and in a way completely rejected him, I didn't want him to touch me or anything as he made me very paranoid. I found myself watching and studying him like he was a creature. After a while I broke my silence by making a brief conversation with him, when that finished I walked back to my cell thinking 'There's nothing wrong with

this inmate'. After a few weeks, my conversations had come on quite a bit with this inmate, so I asked him if he had AIDS? He replied quite openly by saying 'yes'. From that day onwards, he got the utmost respect from me for being so straight-forward about it. We talked for quite a while about what HIV was and how it couldn't be passed on by contact as I was once told. I was told the ways it could be caught and how it affected his life with others in here. I didn't really care what people thought of me being close friends with an inmate who had HIV but when people used to make jokes about him, it used to hurt me inside and I found myself being very protective over him.

At the moment, me and this inmate have a very close friendship and there isn't anything I wouldn't do with him that I would do with an uninfected person.

I, myself don't have HIV and am not gay in any way. All I'm trying to say is that people with the infection are just plain unlucky and I'm trying my best to help the only way possible in here . . . by giving him the same respect and friendship I'd give anyone else. ■

A Serving Prisoner
(Name withheld — Editor)

The Role of the Voluntary Drug Agencies in Prison

Dr Betsy Ettore

A positive view is taken of the opportunity offered in prison of educating those who misuse drugs and alerting them to the risks run of contracting HIV. The voluntary sector can help the Prison Service both inside and in providing supportive networks for prisoners on release. However a successful partnership between a prison and a voluntary agency requires thought and preparation. This article offers useful guidance on how to set up such a partnership. Betsy Ettore is the manager of the Drugs Unit and Prison Liaison Group at the Terrence Higgins Trust.

Reduction of the spread of HIV/AIDS among drug misusers in prison must be a key area of concern for both the prison service and the specialist, voluntary drugs and HIV/AIDS agencies. Given that a fair number of drug users are incarcerated during their drug using career, the prison environment provides an excellent opening to educate drug misusers about safer practices as well as to inform them of the established network of both statutory and voluntary helping agencies and professional workers on their release.

Today 43% (145) of the 323 specialist services dealing with people with problems related to drug use in England are voluntary agencies. The majority (67%) of these voluntary agencies are advice and counselling services with specific HIV/AIDS service components. Within this current framework of drugs services, increasing attention has been paid to the needs of drug users who are in prison or on parole. New areas of prison work consistent with the need for a multidisciplinary approach in the HIV/AIDS and drugs misuse field are being developed specifically by voluntary agencies. Education, counselling, staff and volunteer training, and throughcare support, appear to be primary areas of concern for these agencies.

In **'AIDS and Drug Misuse, Part 1'**, the Advisory Council on the Misuse of Drugs (ACMD, 1988) recommended that the Prison Service should make full use of voluntary agencies as providers of confidential advice on risk reduction and greater opportunities for access by these agencies will need to be improved. While extending this recognition, the second report of the ACMD, **'AIDS and Drug Misuse, Part 2'**, (ACMD, 1989) noted that prisons can be said to be major institutions in the care and management of drug users. With further reference to ex-drug users in prisons, the report says:

'. . . because of this large population who have misused drugs, they will contain a higher proportion of seropositive individuals than in the wider population . . . within the prison system there exists the potential for rapid spread of HIV infection among inmates. Depending as it does on co-ordination between the Prison Medical Service and the Probation Service, with outside agencies playing a part in the counselling and support of inmates, it mirrors in many ways the pattern we are recommending for the care of drug misusers with HIV-disease in the outside community.' (p.64)

The main aim of this paper is

to look briefly at the role of the voluntary drug and HIV/AIDS specialist agencies, their potential impact on service delivery in prisons, and policies needed for effective intervention. The key theme, providing the basis for the following discussions, is that voluntary agencies have the potential to be 'facilitators of HIV/AIDS awareness' in the prison system.

The Role of Voluntary Drugs and HIV/AIDS Specialist Agencies

Generally, the voluntary sector is unique in its ability to provide a diversity of provision as well as an innovative response to the various levels of service provision. In the HIV/AIDS and drugs use area, voluntary agencies are increasingly recognised and valued, as they can be seen to establish vital, complementary roles with statutory agencies. Closer links with the prison service provide a unique opportunity to demonstrate further 'complementarity' and specifically to help stop the spread of HIV within penal establishments

In recent years, the main roles of voluntary drug agencies in the treatment and rehabilitation field have been clearly identified as the 'specialist role'; the 'assessment and onward referral role' and the 'innovative and campaigning role' (Ettore, 1987). With the impact of HIV/AIDS on injecting drug use, it could be argued that these agencies have needed to expand specifically their specialist role. Simply by providing a service designed for problem drug users, workers in these agencies have recognised that an understanding of the link between injecting drug use and HIV/AIDS has resulted in an increasing emphasis on risk reduction and harm minimisation strategies of care. Minimising HIV risk behaviour is the goal of these strategies. Within the prison context, an awareness of these strategies and this goal needs to be generated and maintained. Given that awareness, voluntary agencies have the potential to make an important contribution in this process.

What can Voluntary Agencies do?

Since HIV/AIDS is not an area in which we can afford to wait and follow public opinion, all these agencies, establishments and professionals working in the field must provide leadership now. Within this context and with special reference to prisons, outside agencies such as the voluntary ones, should have a key function in the provision of HIV/AIDS education and counselling as well as general support of prisoners concerned about injecting drug use.

Already some voluntary agencies in dialogue with the prison service are working closely with local prisons to provide a clear perspective on risk reduction and health maintaining behaviour. Voluntary agencies can provide a post release 'package' for prisoners who have had problems with drugs and help them to get in touch with specialist agencies that may be helpful to them on their release. Whether or not they need accomodation, counselling, health care and general support, throughcare for drug misusers can be seen to be an issue which needs to be tackled effectively. Outside voluntary agencies are in a prime position to take on this issue.

Local voluntary agencies with appropriate resources and staff support should be able to liase closely with prison officers, psychologists, medical officers, governors and other relevant professionals in providing HIV/AIDS awareness groups for inmates. At present, some agencies are running support groups for HIV+ inmates, while providing individual counselling when this is needed.

Policies for voluntary sector work in prisons

Given the sensitive nature of HIV/AIDS in the prison system, it is of vital importance that any input from outside agencies is monitored carefully. Thus far, the discussions in this paper have highlighted the unique role and potential contributions of voluntary drugs and HIV/AIDS specialist agencies in prisons.

Objectively you need a 'check list' or a series of guidelines to help you and your colleagues to ascertain what is an appropriate link with a voluntary agency and what is not. The following topics should provide a basis for further discussions on guidelines.

1. Accountability

Before inviting any voluntary agency into your prison, you need to assess what the accountability structure is within that specific organisation. In other words, you need to know not only that these voluntary workers are being properly resourced and supported but also you need to have someone in authority within the organisational structure to turn to, if anything goes wrong. This is not to suggest that prison staff should have anxieties concerning letting these 'outsiders' in the prison. On the contrary, all involved (both inside workers and outside workers) will feel more confident in the service delivery when the roles and responsibilities are clear. In this context, all workers from voluntary agencies working in prisons should have at least one 'inside worker' to whom they are responsible. This should be

negotiated between the appropriate co–ordinator/manager in a voluntary agency, the particular outside worker and the respective inside worker concerned. Additionally, prison staff should require all staff from voluntary agencies whether paid or unpaid to have some training and supervision in order to work properly in the closed context of the prison.

2. Training and Experience

In order to ensure the highest order of professionl practice in prisons, it would be useful for the prison staff to design a simple questionnaire for use with all potential outside workers from voluntary agencies, wanting to provide a service with inmates and/or staff. For example, what type of drugs and HIV/AIDS training have these outside workers had? How long have they been working in their particular agency and in this particular field? Have they had previous experience of working in prisons? In what capacity? Which Prison? What type of face-to-face advice and/or counselling work have they ex-erienced? What training courses have they participated in as trainers and/or as those in training?

Positive answers to these questions need to be made if what is provided is to be seen as of the high standard required by the prison service and indeed the inmates themselves. This does not imply that prisons should be turning down voluntary agency work. Rather, answers to these questions will allow both the voluntary workers involved and the prison staff to set up basic requirements for the specific tasks at hand. There needs to be an exchange of expertise on both sides in order for access to be fully achieved.

3. Links between local 'inside' workers and 'outside' prison workers

In order for an input from voluntary agencies to be effective on local levels, all prison workers (both inside and outside the prison) need to build up a cohesive communication network. In the drugs field, the District Drug Advisory Committees have existed to secure links between local drugs workers, to provide a forum for communication and to establish local policies in the field. Prison workers in the field of drugs and HIV/AIDS would most probably benefit from a similar local set up.

For example, as more work from outside drugs and HIV/AIDS agencies is established in local prisons, there will be an increasing need to set up similar working parties, working groups, committees, forums, etc. It is essential that local prison officers are represented on these committees. Exchange of information as well as professional support should be one of the main functions of these groups. If organised and well motivated, these groups could carry out small scale studies of drug misusers in local prisons in order to ascertain a measure of prevalence and to gain an understanding of the scale of need. Of course, one should be vigilant in the area of confidentiality and ethical considerations would need to be discussed fully. Nevertheless, anonymous data sheets could be distributed to inmates, given the unknown number of people with a history of drugs use in prisons.

4. Maintaining access

While prisons are closed institutions, it is important that access for voluntary agencies specialising in drugs and HIV/AIDS remains open. This does not mean to imply that these voluntary agencies and their workers should enter prisons without careful negotiation with respective prison staff. It suggests that the prison service should make full use of these agencies in carrying out their important work. Along with access, voluntary agencies need to know that their work is valued in the prison setting. Regular meetings about their work could be set up between these workers, prison staff and some inmates affected by the service provided. In this way, ongoing evaluation is maintained, while access is being strengthened and ensured.

While the above discussions are exploratory, they have allowed us, in the context of drug use and HIV/AIDS, to look closely at the involvement of specialist voluntary agencies in prisons. There is a need to understand this involvement within the prison context in order to build up a framework for models of good practice. While we may need more work in this area from voluntary agencies, we most certainly need work of a high standard. ■

References

Advisory Council on the Misuse of Drugs (1988) *'AIDS and Drug Misuse Part 1'*, London, HMSO.

Advisory Council on the Misuse of Drugs (1989) *'AIDS and Drug Misuse Part 2'*, London, HMSO.

Ettore, B. (1987) 'A Study of Voluntary Drug Agencies: Their roles in the treatment and rehabilitation field', *British Journal of Addiction*, 82, 681-689.

Prison Management of HIV/AIDS — The Edinburgh Experience

Stuart Monteith, Governor V (Management Support)

Background

Edinburgh Prison currently accommodates 550 prisoners which equates with its design capacity. Its primary role as a long-term training establishment accounts for two-thirds of the total population, and these prisoners are mainly from the Central Belt of Scotland. The remaining one-third comprises adult untried prisoners and short-term convicted prisoners (serving sentences of 18 months and under) drawn from the local catchment area of Lothian, Borders and Southern Fife.

Historically the drug-taking population of the City of Edinburgh has had a preference for intravenous injection coupled with the social aspect of sharing needles. These preferences led to a high HIV infectivity rate, especially in the years 1983 to 1986', before key risk behaviour was identified and information disseminated to these people. This intravenous drug-taking population formed an increasingly significant proportion of the prison population, especially with the untried and short-term convicted element. Statistics produced by Lothian Health Board in 1987-88 showed that at least 60% of Edinburgh's intravenous drug-taking population was infected with the HIV virus and it was predicted that by 1991 AIDS would become the major cause of death in the adult male population of Edinburgh between the ages of 15 and 41.

One consequence for Edinburgh prison through 1987 and into 1988 was that the known sero-positive population grew at an alarming rate and now averages 35 prisoners. This posed major management problems chiefly:

(i) fear by staff and prisoners, often orchestrated by the media, regarding the possibility of becoming infected;

(ii) calls for segregation of those identified sero-positive prisoners and compulsory blood-testing of all prisoners;

(iii) demands for needles and condoms to be issued to prisoners, and;

(iv) local public alarm regarding the prison being a bridgehead for the transmission of the HIV virus out into the heterosexual population.

Management Response

Against this background and in recognition of the multi-faceted implication for the core functional areas of the prison, the Governor decided in October 1988 that a multi-disciplinary HIV/AIDS Management Group should be set up. This group was headed by the Deputy Governor and was tasked with responsibility for the planning, development, implementation, co-ordination and monitoring of the establishment's policy and strategies relating HIV/AIDS. The Group consists of a Governor V (Management Support), Senior Psychologist, Principal Social Worker, Staff Training Officer, and the two main Trade Union representatives from SPOA Local Branch and NUCPS.

From its inception the Group identified a number of key policy issues:

(i) education/training packages for staff, prisoners and their respective families;

(ii) preservation of medical confidentiality;

(iii) provision of voluntary screening, testing and counselling facilities;

(iv) full integration of all prisoners, whether sero-posotive or otherwise, unless deemed medically inappropriate; and

(v) provision of services for sero-positive prisoners equivalent to those available in the community.

It was recognised initially that there was a need for research into the background perceptions held by staff and prisoners regarding HIV/AIDS in prisons and to explore knowledge, attitudes and behaviour in this area. This was considered vitally important in providing realistic strategies and responses. The research was carried out by the Scottish Health Education Group through the University of Strathclyde Advertising Research Unit in January/February 1989 and a wide range of prisoner and staff groups were identified and interviewed on an entirely voluntary and confidential basis. Given the particular problem of intravenous drug use, sample groups of known prisoners within this category were also interviewed. The major fact which was identified by this research was that both prisoners and staff had a general awareness of the main methods of transmission of the HIV virus but their chief concerns centred around the possible areas of social transmission. Prisoners were concerned particularly regarding transmission by sharing communal facilities especially cells, toilet and washing facilities, crockery and cutlery and by general standards of health and hygiene. Staff concerns

centred around the escorting of prisoners, assaults, fight situations, dealing with armed and/or violent prisoners, attempted suicides and resuscitation of prisoners.

The Management Group additionally recognised from the beginning that HIV/AIDS was a public health as well as a prison management issue. It was therefore considered most important to forge a close liaison and working relationship with the relevant statutory and voluntary agencies within the Edinburgh and Lothian area. This would assist the prison management in the development of relevant and co-ordinated strategies, including the utilisation of community services where appropriate. It would also develop mutual understanding and provide up-to-date information, knowledge and new developments regarding HIV/AIDS. To this end, the Governor became a member of the Lothian Regional AIDS Group, which plans and co-ordinates the community strategies between the voluntary agencies.

Treatment, Care and Counselling of Sero-positive Prisoners

All admissions, including those known to be in the 'high-risk' group, are advised of the availability of voluntary screening and testing, including the actual procedures involved. This facility is also available to the long-term prison population. Those prisoners who request testing receive pre-test counselling carried out by the Medical Officer and nursing staff, all of whom are trained to SEN standards and have attended courses on HIV/AIDS counselling.

In those cases where the test proves negative, post-test counselling is available and further tests carried out if the prisoner remains concerned and may be in a 'high-risk' group.

In those cases where the test proves positive, a full counselling programme is initiated including the Medical Officer and a member of a trained multi-disciplinary team (which includes nursing, discipline and social work staff). These prisoners are kept in mainstream prison circulation as long as their medical condition permits and hospitalisation is not considered necessary. Confidentiality regarding those prisoners who have been identified as sero-positive is considered vitally important and a purely medical matter. It has been the Edinburgh experience, however, that a number of sero-positive prisoners, who have fully come to terms with their situation, have freely elected to share this information with staff and their fellow prisoners.

A prisoner support group for sero-positive prisoners has recently been established and is co-ordinated by trained discipline and social work staff.

Given our knowledge of infectivity rate and patterns amongst the Edinburgh sero-positive population, it can reasonably be expected that a considerable number will become ill from now onwards. A Care and Support Unit has been approved for the prison with 22 beds to cater for these men. The concept of this unit includes a medical facility to deal with acute opportunistic illnesses characteristic of the HIV virus and also a unit to look after those in the remission phase. The Unit will be staffed on a 24 hour basis with appropriate levels of medical, nursing and counselling staff. It is envisaged that occupational therapy style activities will be available as appropriate, and suitable visiting arrangements made for families.

Since August 1989, the prison has benefited from a fortnightly clinic held within the prison hospital for the sero-positive population by the Senior Consultant in HIV/AIDS at the Edinburgh City Hospital. This has reduced the need to escort these prisoners for outside hospital appointments and helps to protect confidentiality. It has also led to a close working rapport between medical and nursing staff from both settings and has ensured a high level of care for sero-positive prisoners.

In order to provide throughcare counselling and support facilities for those sero-positive prisoners approaching their liberation date, Scottish AIDS Monitor have provided a team of 'buddy' counsellors who have received training within the prison setting. This voluntary organisation also contributes a session to the Pre-Release Course for long-term prisoners on the community supports that are available.

Education and Training

Education programmes on HIV/AIDS for all untried and convicted admissions take place on a fortnightly basis as part of the Hall induction procedures. They are conducted by a trained pool of six discipline officers who have received suitable training on HIV/AIDS Material and each session lasts one hour. The format of the programmes covers basic facts on HIV/AIDS, methods of transmission, ways the virus cannot be transmitted in prison, health and hygiene issues, personal responsibility and the testing, screening and counselling facilities available.

The programme for short-term prisoners (convicted and untried) also involves an input from the Scottish AIDS Monitor prison liaison officer regarding their role and the statutory and voluntary supports available within the community. The programme for long-term prisoners includes an

input on testing/screening/ counselling facilities given by a member of the nursing staff. All talks are visually supported by the use of the Home Office video 'AIDS Inside and Out'. To date, over 1000 prisoners have attended the education programme which has been running since April 1989.

These programmes are further supported by posters and information leaflets produced by the AIDS Management Group in conjunction with the Scottish Health Education Group. All prisoners receive a pamphlet upon initial admission and posters are circulated in all residential, work and visits areas. These posters and leaflets were produced as a direct response to the findings of the initial research survey and they address particularly the areas of concern surrounding 'social transmission'. They were therefore designed to give the facts about HIV/AIDS, allay possible fears and misconceptions, encourage personal responsibility and adoption of good health and hygiene practices.

Drama has also been used as a medium to address issues regarding HIV/AIDS and in August 1989 the Geese Theatre Company from Birmingham attended the prison for two days. They performed two plays entitled 'the Plague Game' and 'Are you Being Positive?' as well as mounting a drama workshop with the prisoners' Drama Group.

An ongoing programme of staff education and training has been introduced since the beginning of 1989. A series of monthly meetings for all staff (discipline and non-discipline grades) have been held inviting a range of specialist speakers to address particular issues within the HIV/AIDS and drug-related fields. All sessions were videod for future staff training purposes and post-talk discussion was conducted through the use of seminar groups. Additionally, all staff including discipline and non-discipline grades (total 390) have attended education programmes in small groups conducted by the Governor V and Local Branch SPOA representative from the AIDS Management group. These programmes were of one hour's duration and included elements on public health issues relating to HIV/AIDS, local management and its philosophy, assessment of risk factors to staff in everyday situations and precautionary methods to be adopted as appropriate, basic facts on HIV/AIDS and differences between the two, proven methods of transmission, ways the HIV virus cannot be passed, concentrating on concerns regarding possible areas of 'social transmission' and available medical and support counselling. These programmes are supported by the Home Office video 'AIDS Inside' which deals with the elements of prison life where staff may be concerned.

Staff leaflets on HIV/AIDS have also been produced in conjunction with the Scottish Health Education Group to support the main education programme and staff are kept fully informed on all developments on HIV/AIDS within the prison by a Staff newsletter.

The AIDS management Group have recognised that AIDS is a fairly unique illness in that, with continuous surveillance, it is possible to make good forecasts regarding disease progression. Individual and central compilation of data, on a systematic basis, on sero-positive prisoners is therefore considered essential in order to aid forecasting and predict future trends. This will also allow for accurate forward planning.

Future Developments

In addition to the developments within the Care and Support facility, the AIDS Management Group is now addressing the provision of suitable education/information packages for both staffs' and prisoners' families. It is envisaged that the staff programme will include the provision of a library facility with relevant video/literature material. This will be supported by talks held within the Officers' Club by members of the AIDS Management Group and education counsellors from the Lothian Health Board.

The membership of the AIDS Management Group will need to alter as the disease progresses. With the opening of the Care and Support Unit the Chaplains will develop their role and the Education Officer will be involved in the provision of daytime activity. ■

Health and Medical Matters

68 prisoners were known to be HIV antibody positive on 31 March 1990 and one had AIDS. This brings the total number of prisoners reported to be HIV positive since March 1985 to 286 and the total number to have AIDS to 12.

329 prisoners were considered by Medical Officers to meet the criteria for detention in hospital under the Mental Health Act 1983 as on 30 September 1989.

A Prisoner's Tale — Up On The Fives

'Up On The Fives' is a short story. It catches the flavour of an older British prison accurately. But more importantly it deals, amongst other things, with a matter well in the forefront of the Service's pre-occupations — suicide. It is by the way of a cautionary tale — or so it may be read. There are more ways of providing insights into the human problems that prisons face than academic studies, learned articles and official instructions. This bit of fiction sheds oblique light on a grim subject which should be exercising many minds — and none the worse for that.

The day had started badly. Prison Officer Bob Ramsdale had been late for work. It had seemed a good idea at the time to squeeze a few precious extra hours in Spain by taking a night flight back. He had been generous to himself with the duty-free, which had led to the row with Ellen. The kids were tired and fractious so no-one got any sleep until they got home. The result was that at 7.30 the next morning Bob was still putting his uniform on as he was trying to start the car — which had decided to sulk after being neglected in the garage for two weeks.

Principal Prison Officer Mr Graham (unaffectionately nicknamed 'The Wounded Pigeon' by his staff because of his habit of yelling 'Get off my bloody wing' to staff and inmates alike) seemed to have been born angry. On good days he only yelled in the morning, so that by the afternoon he was too tired to be anything but sarcastic. 'Pigeon' immediately realised that Bob was hung-over and put extra energy and volume into the standard telling-off. Bob let the tirade wash over him and thought back to his first days at Grimsden Prison. Pigeon had told him he had been a Prison Officer for 30 years and Bob (in a misguided attempt to flatter him) had said this was longer than he'd been born.

'Longer than you've been born, longer than you've been born! Don't ***know*** you're born, you lot. Fairyland this is, bloody Fantasy Island. When I joined this job, nick was nick — you knew where you were — none of your 'social problems' and 'victims of society' then and no do-gooders trying to make you feel guilty for doing your job. The beggars got caught and expected it to be hard in here and we didn't let them down; none of this "I'll be your friend' bleeding-heart sob stuff . . .'

The wing Probation Officer had once tried to discuss the finer points of penological theory with Pigeon but he seemed to lose heart the second time Pigeon 'accidentally' locked him in the bath house. This morning the words had been different but the tune was the same. Bob had stood in front of Pigeon's desk as the words rained down. Like an inattentive churchgoer he waited for the familiar last line which would be the signal to shuffle out. It came.

'Now you disgraceful waste of a good uniform — get off my bloody wing!!!'

Bob had worked at HMP Grimsden for two years. Some prisons had elegant, genteel names like Hamden Grange and Courtly Park — names which reflected the fact that they were old stately homes sold off cheap in lieu of death duties. Grimsden had no pretensions. It was solid, black and unmistakeably a prison. Bob had left Pigeon's office that morning to find that he was detailed 'Yard duties'. This meant he was destined to spend the day picking up unsavoury packages that were thrown from cells that did not have their own toilets. At least the fresh air might help to clear his head. The first person Bob saw as he turned away from the detail was Edwards, the inmate tea-boy (he was at least 50).

'Morning Mr Ramsden, back from your holidays then?' said the inmate brightly.

'No I'm still there.' Bob had snapped back and immediately he regretted his words — not because he was particularly fond of Edwards, but it never did to fall out with the tea-boy. You never knew what might find its way into your tea. It was now 7 pm. Bob had spent a rich, full day in the grounds. At least his headache was gone. Pigeon was still on duty. He didn't like long days any more than anyone else and he was feeling mean. Bob went in for his evening detail duty.

'5s landing, please, Mr Ramsdale' smiled Pigeon. Bob knew he was still being punished. The 5s was the highest landing and Pigeon knew the height made Bob dizzy. It was also a difficult place from which to sneak off for a cup of tea. All the landings at Grimsden were the same. Two parallel lines joined at each end and looking into a central well. The space across each landing was strung with wire mesh to prevent inmates throwing themselves (and staff) over. At the far end of the 5s someone had wedged a five foot table-tennis table into a five foot two inches space. The inmates had consequently devised a curious scoring system whereby ten points were deducted every time the ball went over the railing onto the mesh — 'Ping-pong, ping-pong — plop' followed by a scramble and more of the same.

At the other end of the landing 20 or so inmates sat in front of a TV set. 'Officer Rediffusion — best officer in this place' Pigeon had said, and it was certainly true that the telly seemed to have a hypnotic effect on the inmates. A few weeks previously an officer had brought a TV remote-control box in and had spent most of the evening flicking between channels undetected by inmates. Eventually someone had banged the telly and it blew up but Bob had been more interested in the large number of inmates who had continued to look at the screen apparently unsurprised that an old Western should be interrupted by Gardener's World and a man discussing Estruscan pottery. Bob spoke briefly to a few inmates who'd been at Grimsden for a long time, and then settled down

to watch the telly himself. He automatically counted heads. There were a lot of new faces. That was the worst of being away. People came and went as though it didn't matter whether you were there or not — as of course it didn't.

'Mr Ramsdale!!!' The name exploded beneath him. Pigeon obviously had eyes in the top of his head as well as the back. 'Still here Mr Graham' Bob called back and moved off down the landing. Dave Egan, another officer, met him half-way down. 'He's in a right old mood tonight' said Dave. 'He's just found out Woods' got parole and he hates him!' Bob laughed and carried on down the landing. In a minute he'd go and see Woods and have a crafty fag.

As he walked down the landing Bob glanced at the names on the cell cards looking for new ones. Most of them he knew; Jones, Gorman, Singh, Sanderson — Sanderson, number 15, that was a new one. The room was surprisingly cold and dark — even for a Grimsden cell — and at first Bob didn't see the figure on the bed. The man didn't look up as the door opened. Bob saw he was reading a letter. The room was quite bare with none of the usual page three wallpaper which were found on most of the prison walls.

'Hello son, I'm Mr Ramsdale. You must have arrived while I've been on holiday.' The man still did not look up and Bob was annoyed that his friendly gesture was being ignored. 'What's up with you then?' The figure drew its legs up and Bob saw it was a young lad, perhaps 21 or 22. He was very pale and Bob saw to his embarrassment that he was crying. Bob felt awkward and uncomfortable. He had intruded on a private grief and he knew from experience that most men preferred to be left alone at these times. But this lad looked so young. The boy looked straight at him for a long moment. Bob hesitated and then offered the boy a cigarette. 'Want to talk?' The boy sat up. 'Thank you, but I don't smoke'

Bob's feeling that the lad had never been in prison before was confirmed. No old inmate would ever refuse a free fag — it could always be traded for something else. Bob looked quickly up and down the landing. Officer Rediffusion was still earning his keep and there was no sign of Pigeon. He went back to Sanderson's cell and sat down. He was struck again at how cold the room was. Two weeks in the sun had made him soft. The boy was sitting in his shirt sleeves and didn't seem to notice the cold. Bob looked at him again. He was small and round-shouldered and looked rather pathetic and vulnerable in the striped prison shirt which was too big for him. His hair was black and greasy and the dark rings under his eyes stood out against the pale face. Bob lit his own cigarette.

'Row with your girlfriend?' The boy answered by handing him the letter. The paper was thin, of poor quality and the handwriting was large and round like a child's.

'Dear Michael,
Just a note to say your mam's been took bad. The doctor says it's heart trouble. He says it could have come any time and its probably nothing to do with your business. Mam's in the Royal but she says to tell you not to worry. She says to tell you we love you and there's always a room at home. Must close now as mam worries if I'm late getting to the hospital.
Love Dad.'

Bob was conscious again of an unpleasant, embarrassed feeling. He felt he was spying on a very personal matter. He did his best to cheer the boy up. 'Well he's just letting you know what's happening. It's probably nothing at all. She'll be okay.' As Bob spoke he knew he didn't sound very convincing. The boy was crying again but he began to talk through the tears. 'It *is* my fault. They just won't say so. She was alright before. Dad's not well either — it's all because of me.' His voice cracked and he wiped his nose and his eyes on his hand like a child. 'All me dad kept saying was "What did we do wrong?" it was nothing to do with them, it was ***me***.'

He looked up at Bob and explained, 'They always gave me everything I wanted. If I needed football boots I got the best. Even when dad got made redundant I got whatever I asked for. They didn't even tell me he wasn't working for ages. I found out from the woman next door. Me dad had been going out at the same time every morning with his sandwiches and sitting in the library. They all have jobs where I live and mam was ashamed . . .' He tailed off and looked down at the floor. Bob lit another fag. He could still hear the telly and the gentle 'ping-pong-plop' from the end of the landing.

'What happened then? How come you got into trouble?' The boy started up as though he'd forgotten Bob was there. 'I wanted this motorbike. Me mam wasn't happy. She thought it was dangerous. Dad said he'd help me buy it but I'd have to get a job. I hadn't worked since I left school — mam always saw me right. Anyway, Dad got me a job in the corner shop helping Mr Patel. He'd known dad for ages and he put me on the till. It was boring and I worked out that it was going to take me six months to earn the deposit and even with dad helping I'd have to work in some crummy job to keep up the HP.' Bob found himself in agreement. He was stiff with cold and wished Sanderson would hurry up and get to the point. 'So I got to thinking about what would happen if I took the money out of the till. Mr Patel

didn't trust banks and he used to keep loads of cash in the drawer. There was some trouble with skinheads who sprayed 'Paki go home' all over the front of the shop and once they came in and nicked a load of fags before Mr Patel could get the police. I could say they'd come again and taken the money. I could even say I'd tried to fight them — they might even give me a medal.'

It was meant to be funny but Bob could see the boy wasn't smiling. 'It was just a laugh at first but the more I thought about it the easier I saw it would be. Patel trusted me. He was always telling me what "fine people" my parents were and how well they'd brought me up. Patel hadn't noticed I'd been helping myself to chocolates all the time I'd been there. I started watching his routine. He went to the bank on Tuesdays to bank last week's takings so there was plenty of money in the till on Mondays when I worked late and he went to the Cash-and-Carry. Sometimes there was a thousand quid in there. I could take it while he was out, hide it somewhere, knock over a few cans and say the skinheads had done it. When the fuss died down I'd tell dad I'd won some money and then get the bike.'

Bob looked at his watch. He was cold and bored with the boy's tale. He'd heard countless variations on this story. Usual self-pitying stuff. If the boy didn't hurry up Pigeon would be yelling again. He got up, fully intending to go but the lad carried on, not noticing Bob's move towards the door. 'It was a good plan. I set a date. I even waited for the skinheads to start hanging round again.'

'Then Mr Patel came in unexpectedly and caught you with your hand in the till and here you are,' interrupted Bob impatiently. The boy looked at him quizzically. 'No,' he said, 'it was the old man.' Bob sat down again. He was going to have to hear the end of this apparently. He lit another fag. 'What old man?' he said, more out of resigned politeness than interest.

'It all went like I planned. I waited 'til he'd gone out on the Monday. I could even hear the skinheads kicking a can around in the road. There was a woman looking at birthday cards. I thought 'Good — she'll be able to say the gang were hanging about.' As soon as the woman had gone I went in the till and stuffed the notes in my pocket. I'd seen there were a lot during the day and now they were mine. I threw some coins around and knocked some piles of tins over to make it look like a fight — that's why I didn't hear the old man —'

'Who was he, a customer?' Bob showed interest for the first time. 'No, he came from upstairs. I didn't even know he was there. He had a stick and started yelling at me in that foriegn talk. He saw I had the money and got between me and the door. I was just shouting 'Move you old beggar' but he wouldn't and just kept shaking the stick at me. I had to push him in the end to get out — I was panicking. I heard him fall and I think he banged his head on the counter.' He stopped abruptly. The last speech had come out in a rush and the boy was flushed and breathless. Red spots stood out against his otherwise pale features.

'What happened then — to the old bloke?' said Bob. The boy was staring at the floor. 'I wanted to get out — to run away — but when he fell down I looked back. He was bleeding. I kept thinking "this wasn't in the plan so it's not my fault." The man didn't move. He had one of those little round white hats on and there was blood on it. I just looked at him for a bit then I came back in the shop and rang 999. I don't know what I told them but the police came and an ambulance and they took the man away. Mr Patel was there and he kept saying "Mick, Mick what happened?" I saw the look on his face when he understood. That was the worst. Then I was here.'

The sudden finish took Bob by surprise. 'Was the man alright?'

'He died. At the court they said he had an "eggshell skull" and that I hadn't been responsible.' The boy sneered the last two words. 'Anyhow, the Judge said I wasn't guilty of intent and that he'd take into account my previous good conduct.' There was a pause. 'The old man was Mr Patel's dad. He was in bed. He must have come down when he heard the noise.'

The boy drew his legs up to his chin and Bob realised with relief that he'd finished. He was stiff with cold. Bob stubbed out his cigarette. As he got up he looked again at the huddled figure on the bed. This one was sorry, he thought, and wouldn't be in trouble again. It was always the same. The ones you wanted to try and help didn't need it and the ones who knew it all and you didn't want to be bothered with always came back.

'Mr Ramsdale!!!!'

This was the second time tonight Pigeon had shouted for him. Bob looked at his watch. Hell's teeth it was 8.15! Without looking at the boy again he left the cell, locking the door behind him. 'Yes Mr Graham?'

'Your numbers please Mr Ramsdale if you've got the time.' On the other side of the landing Dave Egan was chivvying the TV viewers back to their cells. Bob began the routine testing of the doors and counting heads through the glass panels. '27, 28, 29 . . .'

'Where the hell have you been all night?' said Dave as they met at the end of the landing. 'Talking to one of the new lads.' said Bob. 'Careful, you'll be giving them fags and calling them "son" next' said Dave. '30 on my side.' Bob reddened and rubbed his cold hands. He felt frozen to the

bone but Dave was in shirt sleeves. It was going to take him ages to acclimatise after Spain.

Mr Graham was sitting at his desk in the office. All the staff were in there, coats on, ready to be off. 'If you could give me your numbers Mr Ramsdale, perhaps we could all go home.'

'59' said Bob and went to sign the book. Pigeon's hairy hand slapped down on the page. 'How many Mr Ramsdale?'

'59' said Bob, checking the biro figures on his hand to make sure. He was aware of low-pitched mutterings behind him. Until the lock-up figures were right, no-one could go home.

'Go up and check again.' Mr Graham spoke very slowly and distinctly as though to an idiot. 'I'll come with you' said Dave Egan, 'I might have made a mistake on my side — it should be 58 altogether.'

This time Bob counted the left and Dave the right.

'28 this side' said Dave. 'No there's 29 over there, 30 over here' said Bob. He went over and checked for himself. 'Have you moved the lad in number 15 for something?' said Bob. 'There isn't anyone in 15' Dave replied.

Bob opened the door to cell 15. There was a smell of cigarette smoke and a pile of ash and fag ends on the floor but the boy was gone and the mattress bare. 'Well someone must have moved him,' said Bob 'he was here earlier on.' Dave glanced into the cell. 'I suppose that's Pigeon's idea of a joke.' Bob didn't understand the comment but ignored it in his rush to get back to the office.

The staff were now glowering and Bob felt angry and fed up. 'Who's taken the lad in 15 out — it's 58 now but it was definitely 59.' Mr Graham had his cap and coat on ready to go.

'No-one's been in 15 since that lad topped himself last week' said Graham.

'Well there's been someone in it tonight,' said Bob 'a miserable looking kid called Sanderson told me his life story.' The murmurings in the room suddenly stopped. Bob saw Graham sit down, the colour drained from his face. Bob felt suddenly very tired and embarrassed. Everybody was looking at him. Now what had he done. 'That lad in 15, bit gawky-looking. Some beggar's shifted him. What's everyone looking at?' Mr Graham was looking directly at Bob. There was an unusual expression on his face which frightened Bob. Graham seemed to collect himself.

'Right you lot go home.' Bob knew the instruction wasn't meant for him and sat down. The staff shuffled out. They were quiet and Bob knew it had something to do with him. When they'd gone Mr Graham was silent for a few minutes. Bob was uncomfortable. He sensed that this was something worse than a telling-off. Mr Graham took off his hat and pulled an inmate's record out of a drawer. He pulled out a photograph. 'That the lad in 15?' Bob saw the greasy hair and bony features and nodded.

'Michael Sanderson hanged himself 10 days ago in cell 15. He tied a bedsheet round the bars. Didn't find him 'til next morning. He left a note about an old bloke he'd done in. Said he couldn't take the guilt.'

Bob felt his stomach lurch. There was a rushing in his ears. It was a joke. He looked at Graham. It wasn't a joke. 'But I was talking to him Mr Graham, he was sitting there real as you . . .' With a shock Bob remembered the pale features and the cold room.

At that moment Edwards the tea-boy came in with two cups. He wasn't happy at being got out of bed to provide an after-hours service. He handed Bob a cup. Bob drunk deeply — and immediately choked. The tea had salt in it instead of sugar. 'Sorry Mr Ramsdale, my mistake' said Edwards. Bob grinned. Tommorow he would have to make his peace with Edwards . . . ■

Letters

PRISON SERVICE BIOGRAPHIES

Dear Sir,

A few years ago a Prison Service College initative to institute an annual memorial lecture to commemorate the life and work of Sir Lionel Fox led to the establishment of a project to commission short biographical essays about notable Prison Service personalities. I was asked to edit the series and various present and former members of the Service invited to contribute an essay on the personality of their choice. The essays so far received concern the following — Edmund du Cane (G.Hart), Alexander Paterson (T.Hayes & G.Penn), Elsie Hooker (J.Kelley) and Lionel Fox (K.Neale). But there is a wealth of other past Prison Service worthies, among them such as Llewellin, Rich, Mellanby, Bradley and Vidler that merit inclusion. The long term intention is to publish these essays in volumes of about twelve in each so there is a long way to go.

It is important to the pride and traditions of the Prison Service that its important and interesting figures of the past should be remembered and their work valued. The Prison Service Biographies seems to be an appropriate and useful way of encouraging that. This letter, therefore, is to invite contributions without which the project cannot be brought to fruition.

Contributors will find the work of researching their subject and writing the essays interesting and have the satisfaction of participating in a project which is dedicated to recognising the value of the Prison Service and the crucial importance of the people who carry out its tasks. The subjects of the essays do not have to be major figures — it is just as important to record the life and work of any past member of the Service who served with distinction and made a significant contribu-

tion to its work whatever the level or area of activity.

Those interested may obtain details of the scope and nature of essays and the terms on which they may be undertaken by application to John Staples, Head of Prison Service College or to me Ken Neale, care of the College.

Ken Neale
c/o Prison Service College,
Newbold Revel, Rugby,
Warwickshire CV23 0TN

A SENSE OF DIRECTION

Dear Sir,
Ian Dunbar's 'A Sense of Direction' and its sequel 'A Sense of Direction: a Service Response' by Professor Jepson are echoed in the Prison Department's staff notice 'Briefing No.6.' It seems that Prison Officers will soon be asked to implement the ideas that they contain on the landings. They talk of the relationship between Prison Officers and prisoners as being the strongest contribution to security and control, even to being a criterion for promotion. They talk of involving prison staff in decision processes, allowing them to learn by their mistakes rather than being censured for them. A new policy to replace the defunct 'rehabilitation ethic' aimed at meaningful tasks and activities that will assist with control, giving proper weight to prisoners' preparation for release and in turn giving greater job interest to Prison Officers. This is not the Prison Department that I know.

The route that the Prison Department now wish to take contains much of what the Prison Officer would suggest. At last they have found the subjects that need to be dealt with, but there are some difficulties with the new suggestions. I wrote in 1983: 'What is needed is a new lead, a new direction'. The Prison Department is now providing a lead that could be supported by the whole Service. But it will not even get off the ground, or should I say, onto the ground floor, without the right approach to implementation. And it is a matter of 'image'. In developing a Pre-Release Course at Channings Wood Prison I found that its acceptability had as much to do with how it was 'sold' as its actual content.

On joining the Prison Service in 1973 I was forced to accept the view of my colleagues that our work was meaningless: our task was rehabilitation, and that task was unachievable. We are the Apathy Army — we are now so well entrenched in our disillusionment. The staff tea room is more rehabilitative than workshops are for prisoners, and it is more fruitful, and necessary, to watch that the boss does not catch you for a scapegoat when things go wrong, for if you do nothing then you improve your chances of not being caught making a mistake.

Yes I know it is not true for everyone, but with regard to the rehabilitation of prisoners it is pretty much so. The implementation of any treatment or training policy will therefore be a formidable task; it can be helped if the Prison Officer feels involved. The Prison Officer has something to say, and the new ideas will get stuck without him. But the plea goes the other way too. We will stay stuck if we do not support the way forward; not wholehearted acceptance perhaps, but we move together or neither of us will move at all.

From an exposure to psychology, sociology, criminology, social skills training, systems behaviour and analysis, I have come to respect the contribution of the academics. But at some stage we have to reconcile their views, and the views of the Prison Board, with that of shop-floor experience. The imposition of a ready-made treatment and training policy for prisoners is a mistake. A developing, learning environment is required: we have a long way to go before we can say we know what we are doing in that area. I have been looking at the use of the gymnasium as a Leisure Pursuits Centre, the Library as an information centre. There is much potential in these ideas, but how best to use them is a matter of learning not imposition. And how do we measure their effectiveness? My fear is that a method that seems to have merit will be cast aside because it is non-measureable. Do we know what we are doing? Do we know how to teach 'leading law-abiding lives'? Do we know how to measure that? Are the opportunities we can provide the right ones? Is the 'Chance to Change' the right Chance? Does anyone know how to implement the rehabilitation techniques? And then measure those techniques? The way forward must be a learning. experience and the prison officer already has years of this.

The prison officer requires that a policy of treatment and training of prisoners be an objective that is achievable. His experience demands that the policy must be in terms which are practical and realistic. Prison Rule No.1. was viewed as an objective which is not achievable, the Mission Statement of the Prison Service is no more so. It cannot be a matter of what certain people would like to see happen. Even if it is a proper aim to have, whatever the level of achievability, if the perception of it is that it is not achievable, then it is unacceptable.

Another suggestion has been put in tentative form as 'A Chance to Change'. the prisoner will respond: 'You're not changing me!' so it's unacceptable. And the Prison Officer will ask: 'What Chance?' so it is perceived as unrealistic. The idea is right, it's the words that are wrong. And it is the words that will be interpreted as the unachievable. During my time at Leicester Prison, and from the many detached duties I did from there, the criteria for any new initative was always the same: it must be seen to be believable and it must have practical application. Prison Officers will agree with the words of Priestley and McGuire: '. . . existing evidence suggests that no form of treatment of offenders — whether it be punishment aimed at deterring them or therapy aimed at curing them — has ever proved itself effective in reducing rates of crime'.

It is not the method — by punishment or training — that requires further argument, but the objective rehabilitation. While rehabilitation is seen as unachievable we need an alternative, and one that is restricted to realism and practicality, and developed as we learn. Resettlement in the Community is a practical exercise that all prisoners engage in, some sooner, some later, and realistic objectives can be set in relation to this. It is not a matter of seeking a solution to criminality but of handling practicalities that exist. It is a matter of providing opportunities, trying to improve those opportunities, and learning how to encourage the better use of the provisions. Preparation for Release encompasses any and all attitudes to criminality, but is restricted to practicality and what is achievable at the present point of learning. It can be all things to all people; indeed it must be.

'Her Majesty's Prison Service serves the public by keeping in custody those commited by the courts. Our duty is to look after them with humanity and . . .' to provide opportunities to assist with satisfactory resettement in the community after release. What satisfactory resettlement means will require a paper of its own. Its most important element is flexi-

bility — to meet the needs of the individual, and his demands; and to meet the requirement for change as learning develops. It is not an objective to be achieved, but a search — an objective to be found, which can differ for each prisoner and be guided by the individual views of each prison officer.

David Law B.A.
Prison Officer, HM Prison Channings Wood

The Journal welcomes correspondence. Please address your letters to: The Editor, Prison Service College, Newbold Revel, Rugby, Warwickshire, CV23 0TN.

Training

Physical Education and the New Entrant Prison Officer

How can we encourage staff to take seriously personal fitness? One mistake we have made is to pretend that what physical exercise is about is a test of endurance and strength of character. This is the mentality which invented games such as 'British Bulldog' in which the one left standing at the end is the winner, a Victorian version of 'Rollerball'. Have we moved on? Well we've been through a phase of physical prowess for its own sake which spawned the Mr Universe who was so muscle-bound he couldn't run for a bus let alone an alarm bell, but I think now at the College we are moving nearer to what is the proper role for fitness in a wider programme of healthy living. The job of prison officer demands that staff should be physically fit to protect themselves in the event of violence, to help colleagues when the alarm bell rings and have a feeling of wellbeing to cope with the stresses and strains of prison life and avoid the debilitating effect of too much stress.

The Central Council for Physical Education has stated in a recent report that far too many officers are unfit and out of condition. The problem is not just confined to officers of course, you only have to look around your own establishment to realise that, but it did indicate to us the need to evaluate what new entrant prison officer training is trying to achieve in its physical education sessions.

The PE Instructors of both new entrant training centres, together with representatives from PE Branch, and I met to try and decide the aims and objectives of PE and begin work on the formulation of a new programme. We wanted something which was consistent with the Service's promotion of the benefits of a healthy lifestyle. It had to be something which took account of a prison officer's working situation and had to extend to those situations where little or no equipment was available. Most importantly we wanted to make physical education consistent with the rest of the course by training not for what happened at the college, but training for what happened when staff left the college. In other words, we were concerned to do better than simply getting staff fit during the course, in the knowledge that they would become progressively less fit when they left us.

I was also ambitious for our PE staff to be excited about the new programme. As one of them pointed out to me — physical education is a true specialism and not control and restraint. In his view a modern revitalised PE programme was important to the PE staff's sense of professionalism.

After many meetings we have set out some new aims and objectives for a physical education programme on the new entrant prison officer course. The objectives are as follows:

1. To instruct students how to improve their physical fitness and to provide opportunities to do so.
2. To broaden students' knowledge of sports, games and exercise techniques.
3. To develop awareness of the benefits of keeping fit and encourage students to maintain and improve physical fitness.

What we intend is to show new officers that sport can be fun. We want them to have the necessary knowledge to utilise time, space and colleagues for a healthy sports activity. However, we recognise that a lot of emphasis must be placed on sports which can be taken up by individuals such as swimming or running. We also want to give people information about their physical fitness in a way that will motivate them to try to keep fit when they leave the training centre. We want to tell them how exercise can help in losing weight, how it can help in stamina as well as strength, in normal wellbeing as well as fitness. Many of these things can be effectively monitored by officers themselves and we hope to encourage them to do so. After all when they leave us it is only they who will set standards.

For all these reasons the physical education may vary depending upon available facilities, for instance in Wakefield it is possible to attend the local swimming baths, whereas at Newbold Revel it is not, but the message remains the same, exercise is beneficial, exercise can be fun.

Of course it will be very difficult to find out if our new programme is achieving its aim, but recently a complete new entrant prison officer course has been fitness tested and, as part of an experiment designed to assess staff fitness, there is to be a full follow up. The first follow up will be after twelve months with a further follow up after a much longer period. This ought to give us some information about whether our new physical education programme has had any impact. It cannot be a comparative evaluation because there has been no monitoring in the past, but it is likely to be very helpful to us.

Focussing upon the purpose of our physical education programme made us conscious that the message of health through exercise cannot be given in isolation. We realise that it was important to us to support it with a campaign to promote healthy eating and we were fortunate that one of our Contract Caterers responded enthusiastically to supporting the course through the menus provided for course members in the dining room.

The change in our physical education programme has also meant that we cannot be ambivalent about smoking and alcohol. When you visit a new entrant prison officer training centre there will be posters and leaflets about the dangers posed to health by alcohol and smoking abuse.

Time alone will tell whether our changed programme has had any impact, but we believe that there are very great benefits involved, not just for our organisation but most importantly for individual members of the staff themselves. Indeed our healthy eating campaign has already proved to be very popular with our 'customers'.

We are sure that this is a simple and familiar message which we are sending but it is indicative of the fact that the College wants to be in the forefront when it comes to the best practice and benefits for staff. ■

Scene from here

Trading With The Enemy — A View of Sexual Perversion

Working in the prison service could be described as Trading With The Enemy — doing a deal with the prisoner on behalf of society: keeping him in, because he's in the wrong.

But the two programmes Adam Phillips, Principal Child Psychotherapist at Charing Cross Hospital in London, and I have made for BBC Radio 3, take and I think establish the line that everybody is 'Trading With The Enemy': the enemy in the threat of other people, and the enemy in ourselves, in the threat of the possibilities contained in our sexuality. And the personal does affect the social.

What is Perversion?

Prisoners for sexual perversion just epitomise the struggle: they're at the extreme end of a continuum everybody is on. We spoke to Robert Stoller, psychoanalyst and Professor of Psychiatry at the University of California, Los Angeles. 'Perverse mechanisms are ubiquitous,' he says, 'on a continuum you get to a point where the implication is that whatever is going on inside that person's head is well along the continuum. If a man gets turned on by a woman's underwear in a store and is not turned on by a woman, or if he's turned on by a woman it's because she's wearing the underwear, then I say you are further along the continuum and you're into perversion.' But Stoller, whose books include 'Perversion: The Erotic Form of Hatred', 'Sexual Excitement', and 'Observing the Erotic Imagination', is reluctant to define 'perversion'. 'I don't think that homosexuality is an abnormality because I don't believe there's any such thing as homosexuality. I think there are homosexualities — probably as many as there are people whose preference is a person of the same sex . . . I do believe all homosexualities are abnormal: but I wouldn't dare say that unless you give me time to say I think all the heterosexualities are abnormal. I find myself much more comfortable starting out by saying everybody is abnormal now let's see what kind of abnormality is it, and the greater question I think has to do with the harm that's done in society. I think way out at the far end we know pretty well what's harm: a man who murders a woman and

masturbates into her steaming entrails has harmed somebody and has harmed society at large.'

The writer Susan Sontag puts the possibilities of the sexual continuum like this: 'Sexuality is an extreme experience, it's one that most people don't experience at an extreme level: it's an addictive experience which can feel as if it gives you some altered state of consciousness if only briefly. We know that people can go further and further into sexual experience and perhaps not come out. One can die of it, I don't mean die of it because you get a sexually communicated disease.' I would add one is dying of it if one is imprisoned for a sexual offence: one no longer has a life. But perhaps this is because, ironically, one has only found isolating sexual experiences exciting.

Pornography — a kind of wish fulfilment

Take pornography: widely thought to be perverse — both as a component of perverse fantasy life and as a stimulus to acting out perverse fantasies. Leo Bersani, Professor of French at the University of California at Berkley, observes that pornography presents in a shocking and explicit way some of the truths about sexuality we prefer not to recognise: 'pornography shows the inequality that always risks entering into any kind of relationship — and most painfully and most visibly and most sort of felt by the whole being in an intimate, physical relationship.

Pornography represents without any of the anxieties a kind of wish fulfilment of inequality, power and a certain violence. And it's usually men over women and it's interesting also that in a lot of gay pornography that's repeated: those who take the tops and those who take the bottoms: it repeats the heterosexual thing which suggests how important it is to represent in pornography those inequalities.' In pornography the picture on the page or video can't answer you back: the person or people are strangers you use as sex objects: there is no risk of emotional intimacy. as Robert Stoller says 'Voyeurism is the looking at strangers or you convert them to strangers. It might be a neighbour but you convert them to strangers. Exhibitionism is done to strangers. You can't be an exhibitionist and get turned on doing it to your wife!' It's a violation of privacy: 'you can't invade someone who has already given it freely.' Stoller says even 'Playboy' is perverse even though 'hundreds of millions' of males look at it. There's still a hostility. It's still a wanting to get back at somebody and harm them. And if you don't feel you are harming I would guess one of the reasons that you've got to have a new girl on the centrefold every month is because it gets boring: she gets familiar.' And he believes familiarity is counter-erotic to a large number of people. 'I believe the perverse person needs, in order to have full pleasurable erotic excitement, needs that special, probably coming from childhood, element of hostility, of restoring the power by revenging and humiliating.'

Fear of the Opposite Sex

But what power is being restored, and why is it exciting? There's a clue, according to Dr Nicholas Temple, Psychoanalyst and Consultant Psychiatrist at King's College and the Tavistock Clinic in London: if we realise that perversions contain fear, even though the fear may appear to be masked by violence and the desire to dominate: 'One of the most common patterns one sees in a perversion is a tremendous fear of the opposite sex, because of internal fears related to difficulties in early childhood which will in a way condition the ways an individual can respond to the other person.

'It may be that the only way a person with a fetishistic perversion can relate to a woman is by only relating to part of her or a part that represents her. It might be a shoe or a handkerchief or a part of clothing: as if the whole sexual person is too alarming and difficult to deal with.' Temple thinks of this way of relating to say, a woman, as a solution to a problem involving fear. 'It may be the only solution that that person can find and it may hold that person together psychologically.'

Dr Robin Skynner, family therapist and former Chairman of the Institute of Family Therapy in London, believes the self needs and finds protection from an early non-mutual relationship — where a parent or some person was trusted and the child discovered it was exploited or abused: it was giving something and not getting something equal back: it was a breakdown of reciprocity: hardly surprising when parents may be, as Adam Phillips points out, depressed or preoccupied, and therefore unavailable to the child. And there may be good reasons their feelings. Nicholas Temple acknowledges this sort of subtle trauma, as well as the kind that comes with physical and sexual abuse, where the disregard for the child as a person is much more obvious. The bad experience can then be sexualised: a humiliating, isolating and painful experience can be turned into an exciting and triumphant one. 'A patient I once treated who had a masochistic perversion first developed it in his childhood relationships when he was beaten by his mother: when that experience wasn't so much painful as very humiliating to him, that when he began to become sexually excited as a result of the beating he experienced himself triumphing over his mother as if he was saying to her "you are humiliating me but actually I'm going to turn it into something sexually exciting and enjoyable."'

'Why is male sexuality basically sadistic?'

So the sexualisation is a kind of furtive victory over a powerful and humiliating person. A pattern Nicholas Temple has seen with young rapists where the rape was full of sadistic and cruel fantasies about what was going to be done to the victim. 'Frequently I noticed this [rape] would occur following an experience of a young man being perhaps very humiliated by failure in work or by actual sexual failure in his life. So it was as if he would then go and find a victim and get rid of it, making the victim suffer. As Phillip Adams points out the perversion is 'bound up with an attitude to vulnerability and powerlessness so that in any relationship it's as though there is always an echo from the past, that there's a kind of misrecognition going on: that the rapist sees the person that he rapes as really somebody from the past: they cease to be a person in their own right.' And I think we all do this some of the time in our relationships, and particularly our sexual relationships with others: if we thought more about this it might help answer the feminist Andrea Dworkin's question 'Why is male sexuality basically sadistic even if it isn't knives and torture sadistic? Why is it so controlling and domineering? Why is it possessive in the sense of actually owning the person? Why does womens' masochism bring men so much pleasure?' And it might help us to think more about the question 'Why do we find pleasure in pain and power?'

Robert Stoller has another clue: he found that four of eight consensual sado-masochistic couples he spoke to who wished to be pierced, cut or otherwise involved in physical pain discovered (to his surprise and theirs), that as small children they had been subjected to immense medical physical pain for illnesses they'd had: 'Many times a day they had to passively submit — nothing consensual about it — to horrifying pain and they remembered consciously transforming the pain, over days or weeks, using various mechanisms, trance states, rubbing parts of the body and so on, into pleasure.' Dr Michael Eigen, a psychiatrist and author of 'The Psychotic Core', suggests that in sado-masochistic relationships of all degrees the couple enacts a combination of 'I am the shitty one versus I am the great one . . .' But this is a rigid and inflexible way of solving the problem of pain or humiliation: as sexual experiences are acted out in adult life they become sex as a refusal to know someone rather than as a way of knowing them. Moreover, the excitement generated by the perverse fantasy or act can make a person feel alive, and keep them going. As Nicholas Temple says 'The perverse behaviour is quite often compulsive and driven in order to enable the person to survive what I otherwise think might be a sense of profound depression or psychosis. The perverse person is crippled in his or her capacity to enter into a vulnerable link with another person.'

Sexual Perversion is Part of Nature

But how does society deal with this? Nicholas Temple believes that in order to avoid facing the sadness and emptiness of perversions, and to avoid acknowledging that as children our vulnerable neediness has been damaged to some degree, we create a spectacle of excitement out of perversion: we are curious and appalled: look at the tabloid press, the way 'nonces' are treated in gaols, the fascination and glamour engendered by transsexual operations, attitudes to pornography. He believes we should 'examine the defensive use of our feelings. This [sexual perversion] is part of our nature and we can't say that somebody who suffers with a sexual perversion is profoundly different: they may have a profound disturbance but they are components which are in all of us.' And as Adam Phillips points out: 'in wars, racism and in legal punishments we are more than capable of treating other people in ways we would otherwise think of as perverse': the God feeling versus the shit feeling. Just which enemy are we trading with? ■

Reconviction Rates

53% of male and 34% of female prisoners discharged in 1985 were reconvicted within two years. 64% of young male and 44% of young female prisoners discharged in 1985 were reconvicted within two years. 81% of 15-16 year old males (on sentence) were reconvicted within two years.

From Home Office Criminal Statistics

Lookout

'The ism of L.A. of O'

In his work as education officer at Holloway, Richard Brown has found that far from needing training in social skills, women in prison bring those skills with them in abundance but at a price paid for in evading addressing the true source of their deviance, abuse in early years. If that is so, how far is it also true of men?

When I first stumbled, afraid of prisons and terrified of females, into the Victorian halls of Holloway there was just emerging, from the bright young graduate newly in charge of education, a device known, rather grandiosely, as The Holloway Survival Kit. This was my first introduction to prison education curriculum planning. The theory, utterly untested as far as I could tell, was that virtually all Holloway women knew nothing about surviving in society, they were, I gathered, constitutionally incapable of finding work, locating a suitable residence, filing proper applications to the benefit office and tending their own health. All we needed to do was to teach them how to remedy these sad deficiencies and criminality would be solved at a stroke. (I parody somewhat but it is not wildly far from the mild hysteria generated by the Survival Kit at that time). Meetings were called at County Hall, erudite papers commissioned. From the textile sweatshops we dragged the doubting denizens to receive the potent medicines from our box of social tricks

Horror Movies on Health

It fell to my lot, amongst a burdensome lot of lots, to teach them about contraception, of which my experience was tantamount to zero, and to arrange a series of horror movies on health. One of these, purporting to put women off smoking, dramatically increased the consumption of tobacco by pumping up anxiety to insupportable proportions. Lurid, accelerated pictures of sweet pink lung tissue turning into incinerated tar served only to boost the profits of the grateful tobacco barons.

Another offering rejoiced in the tantalising title 'Better Dead'. This cinematic masterpiece was aimed at intravenous drug abusers. The idea, realised by vivid technicolour close-ups of a post-mortem, was to prove to addicts that the indignities of addiction continue after death. Shots of users fixing unashamedly whilst engaging in the witty repartee customary with those on heroin were intercut with the ghoulish surgeon's ministrations. It's the only film I've ever shown with my eyes shut all the way through. Even then I desparately wanted to vomit. For a time it seemed as though this chunk of the survival kit was working; the women sat agog on the edges of their seats groaning with unsuppressed emotion. As they exited I learned the true cause of their excitement. 'Thanks, Rich, thanks for the bleeding wind-up'. 'You'll be showing porn movies to he 43's next' were but two of a dozen telling comments.

I would not seek to deny for one moment that basic social skills are worth teaching, nor would I want in any way to undermine practical courses and vocational training, but it is clear, is it not?, that lack of social skills is not the primary cause of crime. Plenty of citizens lack social skills without turning to burglary or violence. The answer has to be more complicated.

Why don't we ask why?

The odd thing is that our criminal 'justice' system seems largely indifferent to causes. Criminologists do their researches and form convincing theories but in the courts the emphasis rarely seems to be on the question 'why *this* person?' This, I suspect, comes about because there is, in fact, a largely unspoken theory underpinning our judicial system. The theory holds, with fetching naivety, the simple hypothesis that all criminals are evil. Like the diagnostic gems favoured by psychiatrists this four letter word not only serves to eliminate the need for further explanation it also has the shining advantage of possessing a built-in cure; if all criminals are evil then what they clearly require is punishment. Under this philosophy, education, other than a heavy, judgemental moral version, is irrelevant. Punishment, by some unexplained arcane process, cancels out the misdemeanour thus achieving retribution and reform in one simple operation.

In my experience the only circumstances where something akin to punishment can be administered without damage is where a reliable atmosphere of love has been established. Some parents can use punishment as a controlling device without much risk. But retribution taken coldly leads either to further rebellion or to psychological breakdown; it is no solution and neither, in my estimation, is the 'evil' theory of crime viable.

So, if we reject the simplistic physical approach of the Holloway survival kit and dispense just as summarily with the 'evil' account we are still bound, if we are to make education relevant to

needs, to enquire 'why this person?' and so I continue to pursue the question making, I hasten to add, no claims for originality. I start by identifying one factor which is not quite universal among criminals but which is very, very common.

Admittedly my experience is entirely with women but I have talked with colleagues, read relevant literature and seen appropriate documentaries and I think it fair to say that most people who become serious or habitual criminals come from social backgrounds which are lacking in, to put it at its mildest, stability. All children need a totally reliable ambience of love if they are to develop properly; most of our students have not just lacked love, they have been abused.

This, though, will not of itself do as a sufficient cause, for many people survive unloving childhoods without resorting to crime. But 'nurture' is not the only element in personal development. We all come into the world equipped with different levels of skill, sensitivity, creativity, intelligence. It is tempting to slip into classical theories that criminals are somehow deficient in natural abilities and some, it has to be admitted, seem to be so. But my experience is that the prison population distribution is very much bi-modal; and I would venture to suggest that there are more who are ***above*** average ability than there are below. Most are not ***less*** intelligent, ***less*** sensitive than the societal norm but more so. It is often, I suggest, the combination of high ability and social deprivation which can lead individuals from the creative to the destructive. I have no hard evidence for this thesis but the testimony of many teachers bears it out. Newcomers to prison teaching are almost reliably amazed at the hidden potential of many of their students.

Drifting into Crime

If it is true that many prisoners have drifted into crime because they have

(a) below average or above average potential, and

(b) histories of social deprivation,

then the consequences of our curriculum are considerable. Further, venturing into dangerous territory, it might be concluded there is an exciting hint that if only we can make education more relevant then it might turn out to be the most potent agent of habilitation of all.

(I use the unfashionable word 'habilitation' because the prefix 're' implies a previous state of 'grace' which frequently has never existed.)

If there are any criminologists in the audience they are probably muttering wearily 'nothing works'; all treatment programmes have been shown to have zero effect on recidivism. There are two ripostes to this dangerous and despairing creed. The first is that not everything has been tried. Education, for example, has never, as far as I can see, been given a solid chance to work its peculiar brand of healing magic. Secondly, any criminological study which looks only at recedivism rates is using a measure of efficacy which is far too crude. Penal institutions are generally filled with younger people. There are several possible accounts of the age imbalance but one very plausible one is that crime is essentially a juvenile activity. Children have inappropriate emotional responses, they want instant gratification, they ignore the longer term consequences of actions, they duck problems rather than face them. Much of crime is like this and many criminals seem to be immature. And it is not difficult to see why they might be immature; they have, as I suggested earlier, mostly come from social circumstances which precluded proper psychological development. Some argue that prisoners seem to be immature because the institution makes them so. There is, of course, a disempowering effect of total regime but my belief, based in part on keeping in touch with released prisoners, is that the immaturity is not just a temporary product of incarceration.

Growing out of Crime

My suggestion, then, is that prisons are full of younger people because eventually, later than others, most criminals grow up. Now, if this is the case then I would further suggest that the only effective measure of habilitative inputs is a record of the last age of offending. Any study on the effect of habilitative programmes should look not just at one input but should track people through the system. One or a dozen returns to custody have, I plead, no great significance. What matters is how much help the prisoner received during the delinquent period. The prediction, of course, is that, statistically speaking prisoners who have been helped considerably will retire from crime earlier than those who are subjected to mindless punishment. Any study would have to be very wide-ranging and long term and it is perhaps impracticable but, until it is carried out it far too easy to conclude that 'nothing works'.

In a few moments I will conclude by specifying the ways in which education might offer valuable habilitative input but I just want to preface this contribution with a brief homily on education in general.

We educationalists are, for the most part, poor at self-promotion. The current malaise in education is partly due to the fact that we have not fought loud and hard enough for recognition. And remedying this is part of the point of producing a coherent scheme of aims and objectives. If we can speak with confidence and offer potential positive

outcomes we will gain a new respect. We suffer from the difficulty clearly, that we have little technical language with which to impress the authorities. When we do make use of a mystical term ('dyslexia' springs to mind) just to see the effect it has. Suddenly we are whizz-kids with lovely labels, (a problem labelled is a problem shelved), but we do not need to invent a spurious, mystifying language; we can claim with good authority that we know prisoners best and that we have sound ideas, together with a potential test of efficacy, as to what best to do. (Incidentally, a claim that we know prisoners best can readily be advanced on the grounds that we are what I call 'client neutral' we rarely have to write future-determining reports nor do we have to make crucial diagnoses, nor, happily, do we generally have to mete out punishments. In the continuum which links the 'us' of prisoners to 'them' of the uniformed staff, teachers come, I suggest, precisely in the middle. This often makes life professionally uncomfortable but it provides us with a picture of the inmates which nobody else possesses).

And so, to conclude, I suggest three major areas in which education can plead for its efficacy. Although I have argued against technical language I ***can*** offer an 'ism' which is bound to impress someone. It is a device for remembering the three areas which I have identified. Before explaining the significance of my 'ism' I should just perhaps register the point that if my claim for bi-modality is correct, if we have generally a student population polarised between the bright and the not so bright, then we perhaps have to consider different ***levels*** of approach but the three target areas highlighted by my mnemonic device are common to both categories.

Insight

The 'i' stands for 'insight'. If it accepted that most of our students have emerged from childhood battered, fostered, abused, deflected into community homes, then we can teach, very directly, very courageously, about the effects of improper development. People tend to take their history for granted, it is the thing with which they are most familiar. I have known women in Holloway who genuinely believed that sex with the stepfather is the norm. For many women, battering and abandonment are also often taken to be facts of nature. Through showing otherwise we can give students insight into their own predicament and via this lead them to self-directed change.

We are, of course, not therapists nor should we stray into this arena, but easily the most effective form of therapy is that devised and directed by the individual. Personal change is always a threatening process, our theories of the world, and our consequent identities, cannot be radically altered without stress. One way, adopted by many, is to ascribe such change to an external agency, sometimes a guru, more often, a god; but self-change without loss of respect is practicable if the person can say 'I changed because I wanted to change'. Unlike therapists, teachers are not making theories and proposing strategies, we are providing people with the information and the skills to work things out for themselves.

Self Worth

The 's' of my 'ism' stands for 'self-worth'. One of the personal discoveries which astonished me most when I started at Holloway was that there are people who do not like themselves. Naively, I had believed that anyone who did not like themselves would either change or commit suicide. But there, in those classes, were people who woke up every day detesting what they were. Education, uniquely, can provide people with rich opportunities for achievement and thereby for an improvement in self-evaluation. And in this category we have the perfect argument for a broadly-based curriculum. It doesn't matter if the individual chooses to learn china-restoration or a new computer language; what matters is self-enhancement and an improvement in prestige.

Maturation

Finally the 'm' stands for the process alluded to earlier; 'maturation'. We can teach about personal development, we can use history, literature, the humanities in general to bring about a vast broadening of perspectives. Students will grow much more rapidly than they would have done locked futilely in their cells. The effort may not pay off immediately, after all adoloescents have to venture into the world to make their crass mistakes, but eventually the work will have its locus and a person who might have struggled for maturity until mid-thirties might come to an adequate personal peace at twenty-eight. Those 'purchased' years of non-criminality will be precious to the individual and, dare I suggest?, cost effective for the community.

Many of you will be shuddering at the prospect of education as habilitation. Education is a 'good' in its own right. Exactly so, but we cannot, in the world where cash is monarch, expect others to take a philosophical view of our endeavours. But further, if there is any substance in my arguments will we not be letting our students down if we take a lordly stance? Should we not be trying everything we can to make our classes relevant? It is, in my view, too cosy just to claim that our students are, as it were, spiritually free. Yes, perhaps there

are some who coldly choose to live as criminals and who view imprisonment as an unfortunate consequence of their elected path but how often is this formula trotted out purely as a cover for internal pain? To be arrested, tried, locked up, branded, is a negative experience for anyone however tough they seem to be on the bustling surface. Maybe we educationalists have a duty to do what the prison system strangely almost never does; to attack a little more directly the facts of criminality. Some believe in a liberal tradition, which I much respect, that this would be insulting. I used to hold that view myself but I not longer do so. I believe that most of our students are searching for explanations and, at a deep level, looking for a way to change. If we design our programmes accordingly I believe that far from alienating our students we will gain their deep respect. ■