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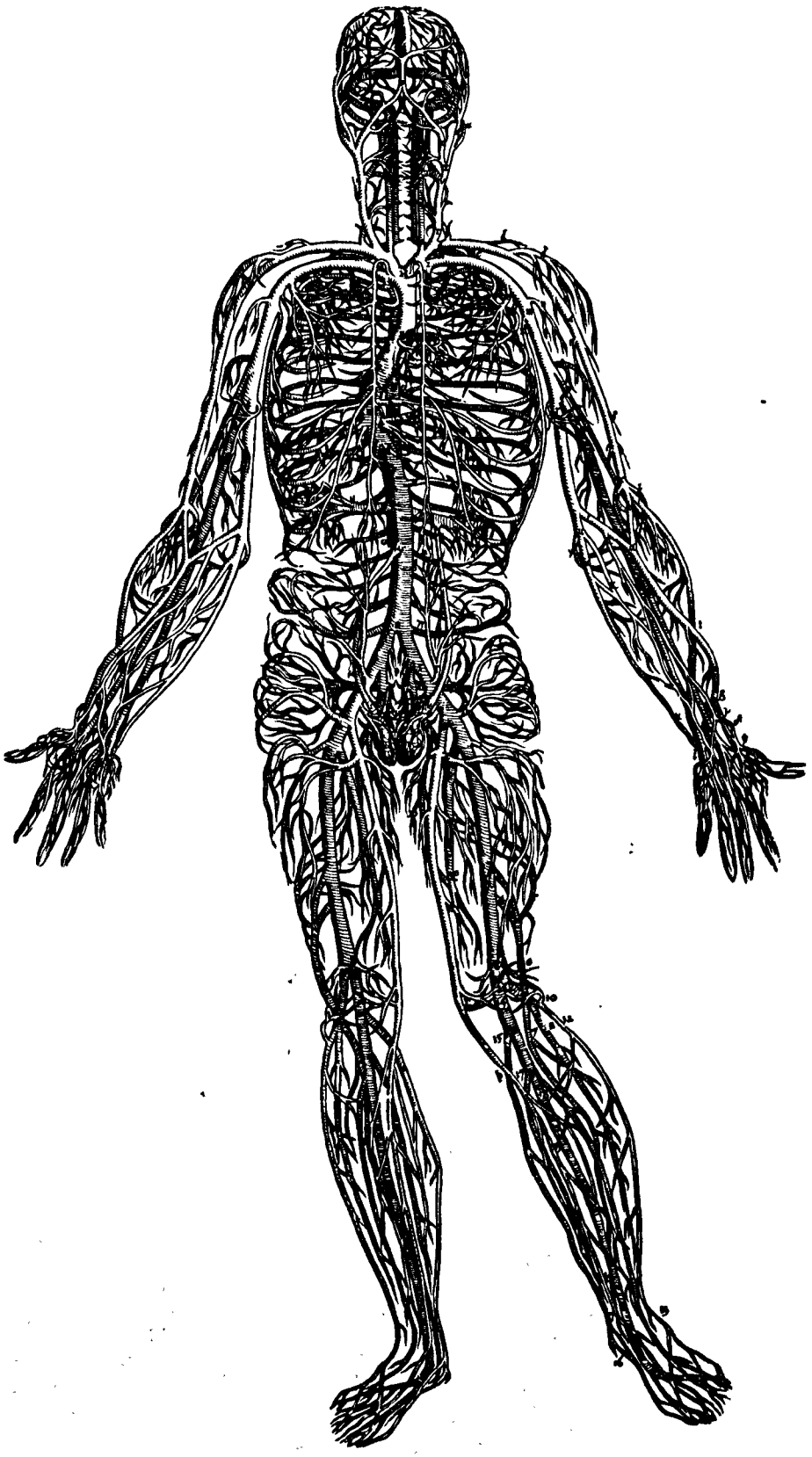

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PRISON SERVICE JOURNAL

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Comment

CPS AND THE PRISON SERVICE

Earlier this year a prisoner was prosecuted for a violent attempt to escape from an escort taking him from one prison to another. He was serving a lengthy sentence for the murder of a police officer during a bank robbery so the escort was staffed appropriately which was why the escape attempt failed. It looked like an open and shut case which should have got a sentence sufficient to deter this prisoner and others, demonstrate support for the bravery of the staff and give a clear signal to the authorities whenever in the future they considered the question of parole or other modification to the sentence. But no! To everyone's astonishment the jury returned a verdict of not guilty. The accused had launched a fanciful defence alleging all manner of extraordinary goings-on without a thread of evidence and the jury were fooled. What rubbed salt into the wounds was the press coverage which highlighted the defence allegations, naming names but without opportunity to rebut.

Such was the anger and distress of staff and their families involved that they asked that the police be called in to investigate the allegations. It didn't take long for the police to discover the emptiness of the defendant's claims but the press having had their day were less than interested.

To their credit the CPS against whom some of the anger was directed for not challenging the defence and the lack of support for witnesses, responded to the criticisms but felt they had done what they could. It had taken some persuasion for the CPS to take the case on in the first place because the prisoner was serving already a lengthy sentence and it was argued, "what was the point?" The acquittal may reinforce that view in future cases considered by the CPS. That raises the general point about cases referred to the CPS and the courts and what seems to staff to be a lack of understanding of the need for staff to be supported in doing their job which, after all, is primarily to ensure the sentence of the court is carried out.

This was a Crown Court case but an issue that has arisen in similar cases is the poor physical security of courts. One of the considerations under the heading of public interest must be whether we have got it right, in taking highly dangerous prisoners to courts which are often poorly designed to combat any serious escape attempt. Certainly there is a need for criminal offences to be seen to be dealt with by due process but is it quite out of the question to do that within the prison confines. Why shouldn't magistrates sit in the prison and judges, too? Public and press are nowadays frequent visitors to our prisons and it would take little reorganisation to allow entry to them if public and press accessibility is the issue which prevents this happening. To have courts sit openly in our prisons might lessen the reluctance to accept cases referred to them by governors and have some added value in a better understanding between courts and prisons. Or is that the problem? To understand is to challenge independence and courts jealously guard that independence and, indeed, it would be wrong if those courts became known simply as extensions of the prison system.

For courts and the CPS to shun serious criminal offences committed in prison and especially those against staff, is to send a very bleak message to the Prison Service. It does seem that increasingly the CPS is taking very seriously cases referred to it and furthermore is doing more to explain its role: the Code for Crown Prosecutors has been reviewed and re-issued recently in a clearer and more simplified form and the CPS has published also a Statement on the Treatment of Victims and Witnesses.

Much needs to be done in helping staff to understand the workings of the court and in particular the convention that prosecuting counsel do not discuss cases with witnesses or victims who may be examined in open court. The practice seems unfair and it is hard to understand or accept when defence counsel can be seen in court to collaborate closely with the defendant. The difference is underlined when the defence case is one of counter allegations against the character of the victims or witnesses. The argument for the practice is that the prosecution should avoid the suggestion that witnesses have been rehearsed or coached. How valid is that concern? There is a difference between telling a witness what to say and offering some assistance to witnesses so that they know what to expect in court and how to present themselves so as to get their evidence across as truthfully as possible. It is good news that some CP Services have agreed to offer prison officers some general guidance and training in appearing in courts.

Training for staff may be a worthwhile gain from this sad case but should we not question now some time after the new arrangements for dealing with criminal offences committed in prison whether we've got it right? Is it so unthinkable to hold open and public courts in prison for these cases? Cannot defendants be answerable for what they say on oath in court? Do judges not have some responsibility for inquiring into such allegations rather than just leaving it to the jury and the press? Would the freedom of the press be so unacceptably constrained if required to report only at the end of the case when both sides have been put? But perhaps all this is simply an inevitable consequence of our adversarial system of justice and only a move to an inquisitional system will address these points ■

OUT OF THE DIGGER

THE BARLINNIE SPECIAL UNIT AS PRISON AND ESCAPE.

Richard Sparks is a lecturer in the Department of Criminology, at Keele University, Staffordshire. This article is a shortened version of a paper of the same title presented to the Bristol Criminology Conference at Cardiff in July 1993.

The Barlinnie Special Unit (BSU) has long attracted an intensity of attention and comment, both from its advocates and its detractors, quite out of proportion to its tiny size. In its early years BSU was presented by some as a kind of penal panacea, by others simply as the 'Nutcracker Suite'. More lately it has undergone a period of comparative neglect as the Scottish Prison Service appeared uncertain over what to do with its own most celebrated creation and its notorious inhabitants.

Now, however, there are signs of a new resolve amongst senior SPS officials to 'do something' decisive both in regard to the Barlinnie Unit and its more recently created sister unit at Shotts and perhaps more generally about 'small regimes' within the Scottish long-term prison system (Scottish Prison Service, 1990). Strategically, this was evidenced when in 1992 a small team of English academics was commissioned to carry out evaluative studies of the Barlinnie and Shotts Units - the first time that they had been studied systematically by 'outsiders'. As part of that research enterprise I was fortunate enough to spend about a month in the summer of 1992 in the Special Unit observing its daily life and talking intensively with staff and prisoners. The reflections offered here are a personal and partial outcome of that experience. They in no sense represent any official Scottish Office view. The Scottish Prison Service has also undertaken to publish the full research reports in the near future. More contingently, media interest in the Unit was rekindled in January 1994, when the news broke of the death of a prisoner, Willie Ballantyne. Unlike the earlier death of Larry Winters from a drug overdose, Willie Ballantyne died from natural causes. Nonetheless the press coverage implied an association between Ballantyne's death and impending changes in the Unit's regime - an impression which comments by key Scottish Prison Service personnel did little to discourage.

It would perhaps be unwise to speculate too precisely on what the immediate future holds for the Special Unit, and I have no wish to write its obituary. However, if one chapter in its lengthy and in many ways distinguished history is about to close it does seem appropriate to recall some of those features which constituted its particularity and specialness. For the Unit's history embodies in a distilled and clear way some aspects of long-term confinement which have wider relevance. It focuses both those problems that are intractable and inherent and areas in which progress is possible. More especially, it bears implications about the scope and limits of the prospects for creating an orderly, habitable and purposive way of living in confinement which no prison system (and in particular one confronting questions about 'special handling' of 'difficult' prisoners) should ignore.

The Digger

It is scarcely possible to comprehend the rationale for a place like the Special Unit outside a developed understanding of who its inmates are and where they have previously been. Where they have mostly been before coming to the Unit is 'the digger'.

The 'digger' is the name given by prisoners in Scotland to a prison's segregation unit (in England 'the block' or 'chokey'; in America 'the hole'). Diggers may be anywhere but the digger, for Special Unit prisoners, principally means the segregation unit at Peterhead prison as most of them experienced it during the 1980s. Peterhead digger at that time held a place of special infamy and symbolic significance within the Scottish prison system, as well as in the individual prison biographies of prisoners now in the Barlinnie Special Unit. By definition, to come to the Special Unit means to have found oneself in rather extreme circumstances of conflict, antagonism, resistance - often, though not exclusively, at Peterhead. The Special Unit, from the prisoner's point of view, before it is anything else, is a route **out of the digger.**

By tradition, and indeed in practice, BSU stands at the opposite pole in the spectrum of provision for long-termers in Scottish prisons. By common consent (though subject to many competing evaluations) it is the most liberal and least punitive location - the 'last resort' which lies beyond the last resort of segregation. It is a long way geographically from Peterhead to Barlinnie as anyone who has made that weary journey knows; but psychologically it is perhaps further still. To move from one to the other is in some sense to have escaped, yet to remain in prison. To contrast the digger and the Special Unit is to sharpen our perspective on each and to grasp how each fits within the narrative of a particular prison biography. We cannot otherwise understand how BSU is constructed as an alternative model of confinement.

The implications of this are important and need to be kept clearly in view. Those who have experienced long-term segregation because they have resisted, rioted or otherwise confronted prison staff (and who remain in such conditions long enough to become BSU candidates), almost by definition have some part of themselves invested in continuing opposition. It is, after all, in the experience of having arrived at a terminal point that the 'sense of freedom' identified by Jimmy Boyle begins (1977).

It is perhaps simply this which makes such cycles of opposition so intractable, that the prisoner regards himself - his self - as under attack. But two further points can also be made. Prisoners speak of the elemental simplicity of life in the digger. Lines of battle are clear. The complexities of life in the outside world are far away. It is described at times in terms of something close to serenity. The second point is that segregation, paradoxically, of course creates solidarities. Whereas ordinary prison locations tend to be factious, competitive and ridden with cliques and jealousies, prisoners undergoing the shared deprivation of the digger can see themselves as a cadre, a caucus, a proto-political grouping. It is a sense of shared identity which can have an ecstatic effect and one which may sustain a stance of opposition long after it has come to seem irrational and self-defeating.

What was so ingenious (even if partly fortuitous) and so daring about the conception of the Special Unit was that it offered a route out of the digger in which the prisoner did not see himself as having been defeated. So many of both the controversies and successes of the Unit seem to flow from just this, namely that it seemed to embody the pragmatic recognition that in order to winkle the determined prisoner out of the digger whatever alternative he is offered has to be **different enough** from his experiences and expectations of the 'mainstream' that he would want to **choose** it.

The Special Unit - as escape

There is nowhere else quite like the digger, even if our received penological language tends to speak of the pains and deprivations of 'prison' as if these were all of a piece. The digger is of its nature rather little visited by outsiders, and its particularity as a prison environment remains largely undocumented except by some of its former denizens (Boyle, 1977; Steele, 1992). Almost from its inception there is a record of Unit prisoners experiencing powerfully mixed emotions at their partial liberation. Jimmy Boyle in *The Pain of Confinement* describes his world as having been 'turned upside down' in a way that was for him finally creative. But he speaks also of those who could not ultimately make the same transition.

Similarly for present Unit prisoners there is a sense of relief and escape at having surfaced in the Unit, but also of having

undergone a series of rather drastic and as yet unassimilated experiences. All those I spoke to drew a rather sharp distinction between their pre-unit and their present situations. In each case their experience of the mainstream is recounted in terms of conflict, mistrust and a sense of hopelessness.

By implication these prisoners are acknowledging that the Unit has 'worked' in respect of its **official** aims - its contribution towards problem-solving for the system - inasmuch as it has provided some sort of resolution in their own particular cases. But their **emphasis** perhaps lies elsewhere - in a directly personal assessment of how being in the Unit has altered their views, the course of their sentences, their relationships with their families and their orientation towards the future. The challenge for those whose earlier prison experience is mainly or largely about conflict, antagonism, solitude and the digger lies in accepting the greater complexity of a prison environment which in some ways replicates the troubling open-endedness of external normality.

I think we do well to take these perspectives seriously, for there are real dangers in not doing so. By accident or design, BSU has always had more than one kind of aim attributed to it, and which of these is taken to be most important depends on the vantage point from which it is seen. It has at times been presented officially as little more than a convenient pragmatic device, useful to the extent that it absorbs these men's potentialities for violence and disruption and hence relieves pressure elsewhere in the system. Prisoners' suspicions that key decision-makers have at times been equivocal in their attitude to the Unit fuels their besetting anxiety, namely that in reality the Unit is not part of the escape route but rather simply more prison (a 'small prison with perks' as it has been called by detractors). Their fear is that they have been shunted into a siding (albeit a relatively privileged one) and forgotten. The risk is that the commitment of prisoners in the Unit to change may be undermined by a continuing mistrust of the system's intentions towards it and them. As one put it when discussing with me a friend's prospects for forward movement and parole: 'But what if they are not planning to let him go? Have you considered that?'

... and as prison

If such pessimistic views take on general currency their implications for the individuals concerned, and for the Unit's future, are rather severe. Without the sense of progression and advance to sustain the grand personal projects ('experimenting with myself'), the unstructured time of the Unit stands in danger of reverting to being just more prison time - an undifferentiated succession of days; time to be done. In the absence of confidence in the future, prisoners may not be prepared to take the gamble of commitment to personal change. At least one appeared to have foregone such hope. This man would talk with me for hours on everything (the Olympics, politics, racing) but declined point blank to be interviewed for my research: 'Nothing personal Richard, but talking about prison bores me'.

If therefore, as some argue, it is to be regarded as a problem that people remain 'too long' in BSU and hence 'clog up' the availability of places, it should be noted that this is not a new problem. Neither, consequently, can it be attributed purely to the alleged stubbornness of some current BSU occupants in 'digging in' and refusing to move.

The recent situation, therefore, which has precipitated the present Scottish Office resolve to take decisive steps is one in which a group of men doing, as one of them put it, 'heavy, heavy, heavy porridge' find little prospect and few incentives for moving on from the Unit. The implications of this tend to preoccupy all concerned. For managers and staff this is registered as a concern about the felt lack of viable options to offer prisoners. For the prisoners themselves it takes the form of a persistent anxiety about where they might be called upon to move to, when and under what conditions. For some on both sides its singular effect lies in a growing sense of marking time, standing still even of 'stagnation' within the Unit.

The success of any special handling strategy thus depends on the degree of integration between the units themselves and the development of a coherent long-term prison policy enabling prisoners to progress towards release. In the BSU case the issues include i) the current indefiniteness of parole arrangements for lifers in Scotland and ii)

the lack of options for forward movement that are credible in the eyes of the prisoners. These in combination seem to me to represent the primary difficulties currently facing the Unit and to constitute a principal source of tension in its relation to the mainstream, especially when they appear to confirm the view from elsewhere in the system that for so long as there is no prospect of vacancies arising referrals are pointless and the value of the Unit to anyone elsewhere in the system is limited. My point is that such limits on the Unit's 'usefulness' are themselves at least in part the result of **systemic** problems and not just **Unit** problems. I discuss below (in the sections on 'obstacles to progress') the sorts of steps which need to be considered if such problems are to be obviated. This feeds some of the natural anxieties of the Unit managers that apparent unresponsiveness on the part of 'the system' places at risk the carefully nurtured cooperation of the unit prisoners. It would seem essential to the success of any 'special handling' measure (in Scotland, England, anywhere) that it incorporates some sense of direction and purpose that the individual can grasp and engage with. However, as I will go on to argue, this is more difficult to achieve where individuals do not feel that their sentences as a whole (and hence in an important sense their lives) have a feeling of forward movement. In this respect the daily level of constructive activity within the unit and uncertainties imposed by external conditions are closely connected.

Obstacles to progress

1. Marginality as an obstacle to progress: there is a perception amongst some Governors and policy makers that the unit is peripheral to the main concerns of SPS. The view of some unit prisoners in the past has been that the system has it in for them. This gives way for some to the feeling that the system has forgotten about them.

2. 'Siltage' as an obstacle to progress: meanwhile the understanding that the unit is full and perhaps likely to remain so deters assessments and makes needs analysis both for BSU and for units more generally difficult. Even in the absence of such research there is a weight of informed opinion that other candidates answering unit criteria exist, that in some cases it is known who these individuals are and that for as long as a number of prisoners remain locked-down in Peterhead or recurrently in and out of segregation elsewhere it is difficult to dispute the need for unit places.

3. Fear and loathing of the mainstream as an obstacle to progress: the powerful feelings and memories of prisoners about mainstream experiences makes it very difficult for them to contemplate returning to 'it'. It is true, of course, as managers point out that in returning they would not generally be returning to the same places. But the genuine feelings of fear and resistance to the idea of returning to the 'mainstream' as such cannot be underestimated. Staff at BSU are acutely conscious of this and by no means unsympathetic to the prisoners' dilemma. At the same time they fear for prisoners to remain over long in the unit, gain c-categories there and so forth compounds the perception of marginality and is part of what has put the Unit's future role in some jeopardy. A rationally organized system, which includes special units as an integral element must cater for options for progress towards release which the relevant prisoners can interpret as positive.

4. Indeterminacy as an obstacle to progress: the Scottish lifer system (see SHHD, 1989, ch 8) and its associated parole arrangements have historically been significantly more indeterminate than their English counterparts. This perhaps applies with particular force to BSU prisoners who have previously been very 'difficult' and who are in any case serving long life sentences. To note this is not an argument for preferential treatment for unit prisoners. Rather it should prompt reflection on the nature of the life sentence more generally. The present state of affairs encourages a structured stand off between the individual prisoner and the parole system in a way which cannot be said to serve the interests of justice or the more pragmatic interests of SPS and which, additionally, risks sacrificing the goodwill between the prisoner and the unit staff by casting SPS and the parole system in an obdurate light.

5. The 'test' as an obstacle to progress: it is unfortunate and counter-productive that the perception has arisen that the parole system requires prisoners to return to the mainstream as in some sense a 'test' of their

fitness for release. This relates on the one hand to the points about indeterminacy and conditionality made above. The necessity for a test in this form is disputed by both prisoners and staff within the unit. Such a terminology has the additional property of unnecessarily stigmatizing unit prisoners. Against this one might suggest some sort of informal 'statute of limitations' on earlier bad behaviour so that several years of trouble free cooperation within the unit be regarded positively as 'good time' rather, than as appears at present, as 'dead time'. On a more general level the issue arises of precisely what might be being tested? A number of unit staff and prisoners raise the point that a distinction can be drawn between a good **prisoner** and a good **citizen** - a differentiation which the present arrangements do not seem ideally suited to make. They argue instead that the period spent in the unit should itself be regarded as a testing one, and perhaps one especially geared toward establishing the virtues of citizenship over those of prisonization.

From prisoner to citizen

Briefly put, the distinctive internal practices of BSU receive in the main strong support from both prisoner and staff members of the community, and often in strikingly similar terms. For the most part, community members affirm that BSU, against the background of a very imperfect and cramped physical environment, indicates the benefits of sensitive and creative attention to the specifically human and social aspects of long-term imprisonment. One Unit manager comments:

Maybe by accident, we have stumbled onto something that is worth preserving and worth keeping and maybe even worth expanding. And that is a message we have to explain to other people. We have to explain it to the Parole Board, to Ministers, to the public at large.

If there is a key word which prisoners (and some staff) collectively use to summarize their prison past it is 'damage'. If on the other hand there is one word which they use to summarize their future hopes it is 'citizen'. They wish to become citizens again (or even for the first time), and in this sense of the term to be 'rehabilitated' (see McWilliams and Pease, 1990). Their argument is that the Unit is unique amongst prison regimes in their experience in cultivating the aspiration towards citizenship. And this, as Unit managers concur, provides the basis for the fragile 'consensus' between prisoners and staff on which the Unit relies.

Yet in the absence of demonstrable progress towards release and yet in the face of what prisoners feel to be an irrational requirement that their fitness as citizens be tested by moving back into the system from which they have escaped, their own sense of what citizenship is remains notional and romantic. Their visions of the far future are peopled with rural idylls, ideal communities, small-holdings in the Highlands, in one case a monastery. And on such slight foundations the consensus in favour of citizenship can easily founder and dissipate. Such, I think, is the challenge and the present danger of the Special Unit - to have created something so different and so radical, but to which there is no door clearly and unambiguously marked 'exit' ■

References

Boyle, J. (1997) **A Sense of Freedom**, Pan.
Boyle, J. (1984) **The Pain of Confinement**, Pan.
McWilliams, W. and Pease, K. (1990) 'Probation practice and an end to punishment', **Howard Journal**, 29-14-24.
Scottish Home and Health Department (1989) **Parole and Related Issues in Scotland** Cm 598 (Kincraig Report), HMSO.
Scottish Prison Service (1990) **Opportunity and Responsibility**, SPS.
Steele, J. (1992) **The Bird That Never Flew**, Sinclear-Stevenson.

CHANGING POLICIES TOWARDS VULNERABLE PRISONERS:

'THE MANAGEMENT OF VULNERABLE PRISONERS' REPORT 1989 AND THE WOOLF REPORT 1991

This is the second of two articles on the use of Prison Rule 43 in respect of vulnerable prisoners. The first article entitled, 'The Politics of Rule 43' appeared in the July Issue No 94.

A comparative study that analyses the change of official policy towards vulnerable prisoners and Rule 43 (Own Protection) during the late 1980's and early 1990's. The report discusses, compares and contrasts the Prison Service's 'Management of Vulnerable Prisoners' report of 1989 (the 'VP Report') and the 1991 report of the Woolf Inquiry into the prison disturbances of April 1990.

The VP Report embodies many of the aspects of humane containment that dictated prison policy at that time. A marked lack of interest in treatment for sex offenders, a tight rein on resources and the use of Rule 43 as a means of reasserting control over subculture are evident in the report. Its main features are the institutionalisation of encouraging vulnerable prisoners to survive on normal location by concealing the nature of their crimes; and reducing the use of Rule 43 by clarifying the statutory responsibilities of prison staff towards prisoner safety. In contrast, the Woolf Report shows more practical interest in treatment but less awareness of the implications for resources. Its main difference from the VP Report is in its strategy of creating a more tolerant subculture in order to allow vulnerable prisoners to survive on normal location. Subsequent policy since Woolf has concentrated heavily on treatment for sex offenders, the criteria for selection being based on suitability for treatment rather than vulnerability to attack. While the implications of recent policy has yet to be seen, there is a danger of overlooking other vulnerable prisoners, such as informers and prison debtors, for whom there appears to be no policy at present.

Ian Heritage is a volunteer with the 'New Bridge' an organisation which befriends prisoners. He visits prisoners at HMP Coldingley. This work is an outcome from an Advanced Diploma in Criminology he is studying with the Open University. He works as an Information Officer with a firm of surveyors.

This article is to be published also in the Journal of the Police History Society.

1.0 Introduction

Rule 43 provides a facility for the removal from association of unpopular or 'vulnerable' prisoners. These include sex offenders (which comprise approximately 70-80 per cent of prisoners on the Rule), informers, inmates who have incurred debts and socially inadequate prisoners. The rule exists as a control option and is not intended as a disciplinary measure. The use of the rule has increased sharply in recent years; the Woolf Report records that between 1983-1988, the Rule 43 population increased by 156 per cent in contrast to 17.4 per cent for the general prison population (Home Office 1991b: para.12.200). On 30 June 1991 there were 1850 prisoners on Rule 43 (Own Protection) and 962 prisoners in vulnerable prisoner units (VPU's) in British prisons (Government Statistical Service).

1.1 The Research Problem

This paper examines how official policies towards vulnerable prisoners and Rule 43 have changed in the past five years. There has been a sudden shift from humane containment to an apparent return to the ideals of treatment and rehabilitation. This return to treatment is still in its planning stages and it is still too early to tell how this new policy will be interpreted in practice. However, the recommendations of the Woolf Report and the subsequent White Paper represent a significant commitment to a policy of treatment and rehabilitation of such offenders.

1.2 Methodology

This paper will analyse recent changes in the light of two recent official statements: the 1989 'Management of Vulnerable Prisoners'

report (The 'VP Report') (Prison Service 1989) produced by a Prison Service working group; and the 'Management of Sex Offenders' section of the Woolf Report (Home Office 1991 b). The paper will also consider the period since the Woolf Report, and briefly discuss how closely subsequent policies have followed its recommendations.

The paper will assume that some provision for treatment is necessary. However, it will only discuss the conditions necessary for such programmes to operate successfully. It is not the intention to discuss individual treatment programmes in detail. Throughout this paper, 'Rule 43' will apply only to its 'Own Protection' function (for violent or disruptive prisoners) unless otherwise stated.

The two reports discussed are significant because they represent two different approaches to the same problem despite being produced within two years of each other. The VP Report is an internal document on a specific issue, produced for the benefit of prison management and not for uninformed consumption. The Woolf Report represents the public recommendations of a government inquiry into prison conditions generally after the disturbances of April 1990. The term 'official', then, is not necessarily homogeneous and such a term may embrace a wide variety of views.

1.3 Context

The context for this present paper is discussed and examined in Heritage (1993). That study looks at official policy from an historical viewpoint up to 1988 and finds that it had largely responded to the wider discourses that had shaped prison policy generally:

1) Moral Contamination up to the end of the nineteenth century;
2) Discipline and Control until after the Second World War;
3) Treatment and Rehabilitation during the early 1960's;
4) Security during the late 1960's and early 1970's;
5) Humane Containment during the 1980's.

1.3.1. Humane Containment

Humane Containment produced the climate in which the VP Report was produced. This was a period of official disillusionment, under-investment, staff disputes and overcrowding. In terms of vulnerable prisoners, the use of Rule 43 increased dramatically during this period (see section 1.0 above). The reasons for this increase were probably twofold:

1) Longer sentences for sex offenders; Bradshaw (1989) records that between 1986-1987, the average length of sentence for rape increased by 16 per cent.
2) Growing deterioration of prison conditions; increasingly intolerable living conditions, such as overcrowding, led to minority groups within the inmate community being scapegoated.

1.3.2. Equality of Treatment

Heritage (1993) identities 'Equality of Treatment' as a recurring theme around which Rule 43 policy was and is constructed. This notion, that vulnerable prisoners should be entitled to conditions and rights equal to other prisoners, has several features that are worth repeating:

1) The notion of equality can be given a different emphasis. It can imply that vulnerable prisoners are entitled to equal conditions but it can also inhibit any special treatment that groups such as sex offenders may require.
2) Conditions for vulnerable prisoners are not equal in many establishments. During the 1980's, many official commentators seemed to consider this inevitable (see, for example, HM Chief Inspector of Prisons 1981 and 1986).
3) Prison staff may see the imposition of poor conditions as a control strategy to discourage vulnerable prisoners from seeking Rule 43; some staff may themselves seek to persecute vulnerable inmates by imposing such conditions[1].

Equality of Treatment, then, was an

1. The attitudes of prison staff towards vulnerable prisoners is difficult to gauge. Priestley's survey of staff at Shepton Mallet was conducted because, 'Any systematic gathering of staff opinion has been forbidden by the Home Office,' (1980: 108). His portrayal of officers' attitudes to prisoners on Rule 43 is highly unsympathetic and even suggests that officers may collaborate in physical assaults. Although this particular portrayal is drawn from the late 1960's, Priestley's survey is confirmed by commentaries from Rule 43 inmates (see, for example, Independent 1990 and Howard League 1989). Schemes such as those at Littlehey, Grendon and Elmley show that there are also a large number of prison officers who have volunteered for such work and are highly motivated and enthusiastic.

important assumption during the 1980's, because it appealed to all interested groups. It appeared to promote both fairness and discrimination while retaining both a control facility and a means of keeping tight rein on resources. The VP Report employs several strategies in which Equality of Treatment is implicit.

2.0 'The Management of Vulnerable Prisoners' Report

The 'Management of Vulnerable Prisoners' report is important in that it embodies many of the features of humane containment that determined Rule 43 policy during the 1980's. It is possible that growing unofficial pressure at this time to provide special treatment for sex offenders had influenced the outlook of the 1989 Working Group who wrote the report. Player goes as far as to suggest that this was indeed the case and the Working Group was set up, 'In an effort to catch up with such grass roots enterprise,' (Player 1992: 2). This seems very unlikely given the strategies that the VP Report finally proposes.

2.1 Discourse

The Working Group saw their brief as, 'to contain and control the growing Rule 43 problem by positive action on a number of fronts,' (para. 3.4) and the report appears to be a classicist acceptance that the seeking of protection by prisoners is a result of egoism that can be solved by discouraging the individual.

The report does this mainly through emphasising that Rule 43, 'is for the Governor's use in management, not a facility at the disposal of the prisoner,' (para. 4.1) and goes on to remind us that the term 'Rule 43 (Own Request)' is a misnomer and that Rule 43 (Own Protection) should always be used. This concern to remind staff that the Rule is a management tool for control is emphasised throughout the report. This is in contrast to earlier HM Chief Inspector of Prison reports (1981 and 1986) that tend to take as self evident the more mutually subcultural role of the Rule as an instrument of request and permission. The VP Report, then, appears to be trying to reassert the controlling powers of prison staff over the mutuality of prison subculture that had developed during the post war years:

'Officers need to be encouraged to appreciate that readily granting prisoners' requests to go on the Rule 43 (OP) amounts to allowing prisoners to dictate the running of the prison and to decide who goes where.' (para. 10.5)

2.2 Understanding of Subculture

There is little in the VP Report that actually challenges negative behaviour, merely to control it.

The report assumes that the fears of vulnerable inmates regarding attack are more perceived than real (para. 6.1) and that bullies are a small minority (para. 11.4). The first assumption, that physical violence is a comparative rarity, is probably correct[2]. This type of persecution is clearly a group rather than an individual activity and merely segregating the intimidators rather than the intimidated is no solution by itself. The report appears to have little sympathy with the anxiety that must be suffered by vulnerable prisoners on normal location who constantly fear discovery and reprisal.

The VP Report appears to pragmatically accept and accommodate the negative aspects of prison subculture as inevitable and thus also treats the existence of Rule 43 as inevitable.

2.3 Strategies

The strategies of the VP Report are based upon an earlier Adult Offender Psychology Unit report (Prison Service 1988) which had concluded, through statistical analysis, that much of the growing congestion of the use of Rule 43 was caused by inmates spending longer periods on it or failing to come off it completely. The VP Report suggests reducing use of the Rule by a number of 'strategies' and 'alternative management options'.

2. Accounts such as Bettsworth (1989), Priestly (1980), Independent (1990) and the comments of HM Chief Inspector of Prisons (1986: para 2.21) suggest that most abuse is non-violent, involving verbal abuse and tampering with food or clothes. Davies and Steadman-Allen (1989) suggest that this type of abuse allows other prisoners to scapegoat minorities, demonstrate their own comparative normality and assert their aggressive status within the prison community, without incurring disciplinary measures against themselves.

2.3.1 Concealment of Offence

A major feature of the report and the one to be completely abandoned by the later Woolf Report was the proposal to institutionalise the already widespread practice of encouraging vulnerable inmates to conceal the nature of their offences in order to go onto normal location. This has long been normal unofficial policy and is even approved by prisoners themselves (see, for example, Howard League 1989). The VP Report proposes to lend the policy official status by incorporating it into Circular Instructions and Standing Orders. This strategy incorporates two features:

1) Confidentiality; whereby counselling is offered to help vulnerable prisoners to conceal the nature of their offence. Reception areas, traditional sites of conflict for vulnerable prisoners, are to be made more private. Prison staff, police and lawyers should be advised to avoid automatically recommending Rule 43 to potentially vulnerable offenders.

2) Transfers of vulnerable prisoners to prisons where they are not known.

The policy of concealment has two worrying implications:

Firstly, it accepts and therefore perpetuates the need to segregate certain prisoners. Although the report largely ignores subculture implications, here it appears to be colluding with its more negative aspects. It places onus on the inmate to avoid persecution and in so doing, forces them to take all the risks and anxiety of possible discovery. It also appears to be trying to shift responsibility away from the Prison Service to outside professionals, such as the police, solicitors and probation officers, for what ought to be primarily a problem for prison administration.

Secondly, concealment inhibits rehabilitation. Sex offenders often suffer from inadequate socialisation and an inability to face up to the responsibility of their crimes. The Prison Reform Trust has argued strongly against this aspect of the report:

' . . . teaching sex offenders how to lie successfully about their offence runs directly counter to the principal aim of almost all work with sex offenders, which is to try to persuade offenders to admit the true nature of what they have done.' (Prison Reform Trust 1990:15)

The VP Report itself mentions the benefit of throughcare and the personal officer scheme, but the benefits of these are lost if vulnerable prisoners are to be constantly moved 'strategically' around the system to avoid detection.

2.3.2 Staff Responsibility

Prison staff are legally obliged to make adequate provision for inmate safety. The report is concerned that the 'stark, uncompromising terms' of the Circular Instructions inhibit staff who may unhesitatingly grant the protection of Rule 43 rather than risk an attack and therefore personal liability. The report recommends that staff:

' . . . need to be given some reassurance about the risk they may run of being held personally responsible if an inmate refused, or discouraged from, removal from association under Rule 43 were to be assaulted.' (para. 7.5)

The Prison Reform Trust criticises this policy and sees it as a strategy:

' . . . in which Governors can refuse them access to it (Rule 43) without incurring legal liability if prisoners are assaulted as a result.' (Prison Reform Trust 1990:14)

This is hardly a fair reading of the report. There are no recommendations in the VP Report to change the law regarding liability, merely to amend the Circular Instructions to reassure Governors that they will have Prison Service support if they are seen to *'carry out their duties conscientiously and make management decisions within the authority delegated them'* (para. 7.5).

However, the report appears to have little sympathy with the plight of vulnerable inmates. It is directed more at reassuring prison staff and defining their legal liability in the event of assault rather than laying down guidelines to ensure that such distressing situations are avoided altogether.

2.4 Staff Attitudes

At times, the VP Report presents a frank view of staff attitudes. It deplores the failure of many officers to reprimand other inmates

for verbal abuse and insults (and thereby implying consent) and recognises that, 'If officers display the same loathing and hostile feelings towards him (the prisoner) as the other prisoners whom he fears, there will be no basis for cultivating trust and confidence.' (para. 11.7; see also footnote 1). However, this recognition that staff are also subject to subculture prejudice is tempered with the view that:

'Officers generally seem to welcome such involvement and we believe that this is to be encouraged, as their acquisition of such knowledge and skills should be of benefit to all concerned.' (para. 14.26)

This assumption of willingness is essential to the report as it goes on to recommend that officers should be involved in counselling and personal officer schemes.

2.5 Resources

In line with the 1980's discourse of equality of treatment, the report is reluctant to recommend allocating extra resources for vulnerable prisoners. Unsatisfactory conditions, it says, have been due to 'lack of effort to rearrange resources appropriately', this can be resolved 'given the management will, some dedicated effort and a moderate degree of imagination,' (para. 14.1). This report is full of comments such as: 'Minimal expenditure on such facilities can enhance the quality of life of such prisoners immeasurably,' (para. 3.10). It is hard to see how the report intended to fulfil its optimistic objectives to improve education, work and cell hobbies for vulnerable inmates given these restrictions. It is notable that the report prefers counselling by prison officers to specialised treatment, presumably because this involves less expenditure.

This restriction on further resources was to make the report particularly attractive to the Conservative Government who enthusiastically accepted most of the report's recommendations because of their 'resource neutral' status (see Hansard 1989).

2.6 Treatment and Containment

Where use of Rule 43 has been considered unavoidable there appears to have been little consideration of the regimes that should exist for these inmates. Even the Woolf Report remarks that the VP Report, in describing conditions for inmates on Rule 43, uses, 'moderate language that disguises the true horror of the situation,' (Home Office 1991b: para. 12.197). The suitability of such regimes that gather sex offenders together without any form of treatment is not questioned. Indeed, although the report is sympathetic to treatment, it is a very passive endorsement. It shows more interest in counselling by prison officers although this seems to be mainly for the purpose of 'weaning' vulnerable inmates off of the rule. The report notes that there are already many such treatment initiatives in existence, but they are largely isolated and unco-ordinated. It recommends that a central repository of information on such schemes be set up. However, the report seems to show little understanding or genuine interest in such schemes. Many of the initiatives described in the report make heavy use of group therapy, but these would be quite impractical in an environment where vulnerable inmates have to conceal the nature of their offence. The recommendation that, 'an assessment of the validity and effectiveness of such counselling actions would be an appropriate subject for research in this area,' (para. 14.27) is not a forceful enough statement for establishing such programmes.

The policy of centralisation is contradicted by the recommendation that VPU's be placed under regional control (para. 12.17). A centralised policy towards VPU's (as recommended by the Prison Reform Trust 1990), would have been more effective in co-ordinating such programmes.

The report's assumption that counselling exists as a control strategy rather than treatment can be seen in its description of the scheme at Littlehey. Here, vulnerable prisoners are held together on a single wing where they receive support and counselling, but are also encouraged to use the facilities of the main prison. The report enthusiastically endorses the initiative although it notes with disappointment that only 10 inmates had returned to normal location in the first seven months of operation (para. 12.14). However, this is to misunderstand the aims of the Littlehey scheme. The report makes no mention of the treatment programme that has been operating since October 1988 (see Prison Service 1991 for a detailed description). Such a programme demands a secure and

protected environment for its success; temporary return to normal location is only a part of the programme to encourage socialisation and confidence.

Significantly, the report makes no mention at all of the sex offenders unit at Grendon prison, where such offenders benefit from specialised therapeutic treatment while integrating freely with other inmates (in contrast, the philosophy of Grendon appears to have been a major influence on the recommendations of the Woolf report). Such an approach, however, would require a more fundamental rethink of prison regimes than the VP Report is prepared to give.

2.6.1 Vulnerable Prisoner Units

At the time of the report there were three national VPU's and seven regional ones plus the wing at Littlehey. The report does not favour a policy of more VPU's except one more in a northern training prison, and fears that the Rule 43 population will increase in line with the extra number of Own Protection places and may create, 'a less arduous testing of requests for Rule 43 (OP),' (para. 12.6). This may lead to overcrowding, resulting in less individual attention given to inmates and possibly 'double Rule 43', a situation where Rule 43 prisoners, aggravated by overcrowding and poor conditions, will themselves persecute and seek to scapegoat members of their own group (para. 3.2). This is a significant (and rare) admission by the report that the increase in the use of Rule 43 may actually be a symptom of the wider problems within prisons. This is an interesting point and one worth considering.

Many of the report's recommendations on VPU's are directed towards reducing overcrowding in local prisons. Apart from recommending that one more VPU be sited in a northern training prison, it also urges training prisons generally to make more vulnerable places available. Although this recognition of the need to reduce overcrowding in local prisons is to be welcomed, the report's definition of VPU's as places to be used as a 'last resort' restricts their potential as special units for treatment and counselling.

2.7 Terminology

The report appears to be the first official document to employ the terms 'vulnerable prisoner' and 'vulnerable prisoner units', as opposed to 'Rule 43 units'. This is almost certainly in recognition of the growing awareness that 'protected location' does not necessarily mean 'removal from association'[3]. Removal from association varies in meaning between establishments; it may mean an individual confined to a segregation block under strict Rule 43, or a group of prisoners segregated from the main prison but free to associate among themselves, as in VPU's, where inmates are not officially classed as being on Rule 43, but are still labelled as such by prison subculture. In many local prisons, association is not available to any of the inmates and being kept on Rule 43 is largely academic.

The report calls for greater clarity and a set of standards for what constitutes 'segregation'. It states that inmates should only be regarded as being on Rule 43 if they are suffering a greater degree of deprivation than other prisoners.

The report, then, shifts the label 'Rule 43' away from the prisoner and back to the actual conditions under which they are kept. In this sense, the term 'vulnerable prisoner' is a useful distinction from 'Rule 43', and the two are not necessarily generic. The report, however, seems to accept that removal from association is synonymous with deprivation. Regrettable situations such as overcrowding and little inmate work can be legitimised because they also exist in the main prison.

2.8 Summary

The VP Report, then, embodies many of the features of humane containment through a discourse of reasserting control over subculture. It does this through the twin strategies of concealing the offences of vulnerable prisoners and discouraging staff from automatically granting Rule 43 on request. The restriction on resources and placing vulnerable prisoners on normal location has implications for Equality of

3. Rule 43 has always stated that removal from association should exist 'either generally or for particular purposes'. Removal from association, therefore, should only be enforced to the degree necessary. This is a feature of the rule which only appears to have been recognised by prison management in recent years. The scheme at Littlehey is a good example of this.

Treatment and explains the lack of genuine enthusiasm for developing treatment initiatives. Like many other official statements of the 1980's, the pragmatic and short term strategies of the report militate against any phasing out of Rule 43.

By emphasising the use of the Rule as a control option, denying the mutuality in deciding its use and failing to question the subculture forces that necessitate the existence of such a rule, the report effectively perpetuates the need for Rule 43.

3.0 The Woolf Report

The Woolf report devotes a significant section to vulnerable prisoners under the heading, 'The Management of Sex Offenders'. Woolf states that, although it recognises that not all prisoners on Rule 43 are sex offenders, and that not all sex offenders are on Rule 43, many of the problems are shared. Although there is a danger here of labelling all Rule 43 prisoners as sex offenders, for the purpose of making recommendations, it is a useful compromise.

The Woolf Report is significant in condemning the policy of encouraging vulnerable prisoners to conceal the nature of their offences, a major feature of the VP Report (see section 2.3.1 above). The reasons for this apparently sudden change in attitude appear to be long standing. Certainly the Strangeways riot of April 1990 itself was significant in bringing the conditions of Rule 43 suddenly to public attention. Such inmates were violently assaulted during the riot, one later dying of head injuries. This is graphically described by Woolf (paras. 3 .201 and 3 .205) . More significantly, it gained the attention of the media who concentrated heavily on this hitherto little known aspect of prison life. In this climate of opinion, a sense that 'something should be done' appears to have developed overnight.

Many of the present proposals for sex offender treatment were actually in place before the publication of the Woolf Report. A Prison Service seminar on the treatment of sex offenders was held at the Prison Service College, Newbold Revel in January/February 1991. The suggestions that came out of that are very similar to those finally put forward by the 1991 White Paper.

However, interest in treatment predates Strangeways; Player states:

'. . . rehabilitation never wholly disappeared from the agenda, but tended to fade into the middle distance during the 1970's and 1980's as other issues jostled for priority.' (1992: 5)

Throughout the 1980's there had been concern from pressure groups such as the Prison Reform Trust, NACRO and the Howard League for Penal Reform. The Woolf Report, then, is important in giving official voice to these already existing concerns rather than re-introducing the ethos of treatment. The tremendous influence of the report generally, however, has given impetus to treatment schemes and to the proposed reform of Rule 43.

3.1 Discourse

By advocating treatment and the engineering of social attitudes to accommodate the individual, Woolf takes an almost positivist stance towards the problem of vulnerable prisoners. However, this is not entirely deterministic. The report, in discussing treatment, states that sex offenders should be 'assisted' to avoided offending again. The proposition of the report is that more attractive conditions will encourage better behaviour.

3.2 Understanding of Subculture

Subculture is important to the Woolf Report because of its ethos of changing inmate attitudes to accommodate individuals rather than vice versa. Woolf devotes two paragraphs to anecdotal information about prisoners on the Rule (paras. 12.187 and 12.188) indicating an understanding of subculture implications and the plight of those inmates who are on it. This is in contrast to the less sympathetic view of the VP Report (see section 2.2 above) .

The report is sensitive to the stigmatising effect of Rule 43 and this is implicit in many of its proposals (see section 3.7 below). Like the VP Report, Woolf questions the validity of the use of such a potentially harmful label as Rule 43 when prisoners, such as those in VPU's, are on protected location but have not been removed from association (see section 2.7 above).

3.3 Concealment of Offence

One of the most striking features of the Woolf Report is the repudiation of the widespread practice of encouraging vulnerable prisoners to survive on normal location by concealing the nature of their offence. In contrast to the VP Report, Woolf states uncompromisingly:

'. . . that to encourage prisoners, in effect, to lie about their offences in order to survive on normal location, is no solution to this problem . . . we consider it is wrong for a service, whose purpose is to assist the prisoner to lead a law abiding life in custody and after release, to encourage prisoners to conceal the true nature of their offences. It should be possible for the Prison Service to deal with this problem in a more satisfactory manner.' (para 12.210)

Implicit in this statement is the recognition that responsibility for prisoner safety lies with the Prison Service; the onus should not lie with the prisoner to protect himself by concealment.

3.4 Staff Attitudes

Like the VP Report, Woolf recognises in paragraph 12.211 that staff as much as inmate attitudes are responsible for the persecution of vulnerable prisoners and will be as difficult to change. This seems to be recognised in the recommendation that one more prison similar to Grendon should be set up as a 'training ground'. This by itself is hardly enough, however, and staff attitudes will have to be changed through more widespread and repeated training.

3.5 Resources

The Woolf Report makes little mention of the cost that such improvements would entail although its implications are much more far reaching than the VP Report. This is in keeping with Woolf's status as a government inquiry rather than as a government department on a finite budget. The Woolf Report came at a time when prison reform had become a political issue and more money was potentially available.

3.6 Treatment

Woolf shows a more plausible commitment to treatment than does the VP Report. The report makes it clear that, although there is a variety of inmates on Rule 43, it sees the issue of Rule 43 as primarily a problem of sex offenders (para. 12.185). The Woolf Inquiry was obviously influenced to a large degree by the regime at Grendon and makes several references to it in connection with a subculture based on tolerance and integration.

Woolf's commitment to treatment should not be overemphasised, however. The report devotes six paragraphs to comments on treatment including a renewed call for centralisation and co-ordination of treatment schemes. Although it refers widely to interested organisations, such as the Suzy Lamplugh Trust and a proposed treatment programme by the Gracewell Clinic, there are no detailed comments on the form such programmes should take. Although the report makes many references to Grendon, this is in the context of a more tolerant subculture; whether the psychotherapeutic treatment used there is also recommended is not made clear.

Although Woolf deals with treatment in only slightly more detail than the VP Report, it is more convincing because of the commitment to providing a suitable social environment in which such schemes might flourish. The policy of housing such vulnerable prisoners in smaller, integrated units is more humane and appropriate than requiring them to take their chances in less sympathetic regimes.

Woolf recognises that the requirements of Rule 43 make vulnerable prisoners feel victimised and focuses their attention away from the victims of their own crimes:

'Those offenders need to be assisted to avoid offending again. They must be required to confront their criminal conduct.' (para. 12.215)

The Woolf Report states: 'We are not in a position to evaluate the (treatment) programmes' (para. 12.218), and obviously sees such evaluation as outside its brief. Rather, it is concerned with providing the conditions in which such schemes can flourish.

3.6.1 Special Units

Woolf is much less specific than the VP Report in recommending the type and amount of extra accommodation needed for vulnerable prisoners and in the distinction between regimes for local and training

prisons. It makes no mention of attempting to reduce overcrowding in local VPU's.

Woolf makes a specific recommendation that there should be another prison run along the lines of Grendon. There are no guidelines as to the exact purpose of this establishment, whether it should be run along therapeutic lines, as at Grendon, or merely attempt to cultivate a more tolerant subculture. The report states that such a prison, 'could make a material contribution to breaking down the culture which is so prevalent at present in relation to sex offenders, (para. 12.211) and implies that such a prison would exist primarily as a showpiece and as a training establishment for staff. Without any definite purpose other than as a showpiece, however, there may be a danger here that such an establishment would itself become isolated within the Prison Service and stigmatise its own inmates. This has already happened at Grendon which has not only become mislabelled by the media as a psychiatric prison for sex offenders, but is also mistrusted by the staff in other establishments (see, for example, Parker 1991).

A more basic approach is needed and this appears to be contained in Woolf's other recommendations to accommodate vulnerable prisoners together with ordinary inmates in small units 'within a liberal regime'. This would facilitate a closely supervised regime in which potential aggressors would be less inclined to cause trouble if a sanction existed that would remove them to a less congenial prison regime if they caused trouble.

The policy of small units is clearly a development of Woolf's wider recommendations for smaller accommodation units and community prisons.

3.7 A New Rule

The Woolf Report proposes the division of Rule 43 into two separate rules to take account of the widely differing needs of the prisoners on Rule 43 (Good Order and Discipline) and Rule 43 (Own Protection). The fundamental changes proposed by Woolf are in contrast to those of the VP Report which only suggests amendments to Circular Instructions and Standing Orders (documents normally only seen by prison staff).

Woolf's new rule for vulnerable prisoners would take account of the following points:

1. It would oblige governors to take 'reasonable steps' to protect vulnerable prisoners (not necessarily Rule 43) and would draw on 'a wide range of options and disposals which could be equally applicable to other prisoners'. Labelling and stigmatisation, then, would be reduced.

2. Removal from association would be 'only to the extent which is reasonable'.

3. The existing safeguards under Rule 43 (para. 2) for Good Order and Discipline prisoners would be made equally applicable to Own Protection inmates. Woolf proposes that Boards of Visitors should continue to authorise removal from association for Own Protection cases, thereby acting in support of the prisoner and Woolf's wider proposal that Boards of Visitors act solely as 'watchdogs' for inmate interests. The Area Manager would be responsible for all disciplinary matters.

Woolf, therefore, proposes a complete overhaul of Rule 43 which would take account of labelling and stigmatisation, a more graduated response to removal from association and a series of safeguards in the event of possible abuse.

3.8 Summary

Woolf's proposals lack the specificity of the VP Report. The recommendations for necessary accommodation are less precise and there is less concern for resources. Such preciseness was largely outside the Woolf Inquiry's brief, however, and the report is concerned with wider issues rather than exploring one issue in detail. Woolf's recommendations are long term, the fundamental aim being to alter the attitudes of prison subculture in order to allow vulnerable inmates to integrate with other prisoners in smaller, closely supervised units. A new rule, which would apply to Rule 43 (Own Protection) only, would facilitate this and minimise labelling by encouraging a range of protection options other than Rule 43. Woolf is concerned less with treatment and more with creating the conditions in which such initiatives can flourish.

4.0 Rule 43 in the 1990's

The aftermath of the Woolf Report and the revived discourse of treatment and

rehabilitation has had major implications for vulnerable prisoners. Sex offenders have always been seen as potential candidates for treatment and it is therefore not surprising that treatment initiatives should focus on this type of offender. The period since Woolf has produced two further official documents which have developed Woolf 's recommendations in this area. The first is the Directorate of Inmate Programmes discussion document *'Treatment Programmes for Sex Offenders'* (the 'TP' Report) (Prison Service 1991), which was published in July 1991 and contains the proceedings of the January 1991 seminar at Newbold Revel. The second is the very glossily produced September 1991 White Paper *'Custody, Care & Justice'* (Home Office 1991a). Both take their ideas from Woolf, although there are some subtle changes and both have implications for Rule 43.

The Woolf Report, while seeing Rule 43 as 'a regrettable necessity', obviously wished to ultimately see its demise. By trying to remove the Rule as a label by encouraging governors to consider other protective measures and by imposing removal from association only to the degree necessary, Rule 43 would gradually lose its meaning. The current proposals will house sex offenders in a few, specially designed prisons rather than Woolf's 'mini-Grendons' in each prison. The TP Report emphasises that:

'The objectives ought to be to create an environment in which those such as sex offenders are able to admit their offences and to participate in programmes to confront their offending behaviour, whilst at the same time remaining on normal location or at least having access to ordinary regime facilities. ' (Prison Service 1991: 6)

It appears, then, that the designated prisons will enjoy regimes similar to Grendon. Sampson fears that this will lead to labelling (Prison Reform Trust 1992: 9). However, there is clearly a need for compromise here. Some degree of labelling appears inevitable if certain offenders are to receive special treatment. In a controlled environment such labelling is surely academic. The Newbold Revel seminar suggested that such a controlled environment is the ideal condition for treatment; only here can an offender's attitudes be closely monitored.

If such units are to have a mixed population of inmate types there needs to be some consideration of non-vulnerable inmates. Twinn reports that despite the success of the integrated regime at Littlehey, many of the non vulnerable prisoners there resent media attention concentrating on its sex offender initiative and its reputation as a 'nonces' prison' (Prison Reform Trust 1992: 56).

The TP Report leaves some questions unanswered. The original criterion for selecting offenders for treatment was for those serving a sentence of four years minimum. Although it is now recognised that selection needs to be wider than this, it is not clear what would happen to those offenders who are unsuccessful in being chosen for treatment in one of the new units. Given that they will probably have been labelled by the selection process, would they then be sent to a protected environment?

Current policy, then, is clearly aimed at treating those considered to be treatable rather than protecting those considered vulnerable to attack.

The proposals of the policy document are enshrined in the 1991 White Paper *'Custody, Care and Justice'* (Home Office 1991 a). Notably, despite its commitment to special treatment, the White Paper still suggests that vulnerable prisoners be given, 'the same quality of opportunity as any other prisoner,' (1991a: para. 5.23). The White Paper proposes a system of Assessment Centres and Core Programme Units to accommodate a two stage programme of treatment outlined in the policy document. It accepts Woolf's recommendations that a new rule should be created for vulnerable prisoners although there are no specific details as to the form this rule will take. Paragraph 5.26 states that segregation should only be temporary until management decide how to locate the prisoner 'more appropriately'. There is no mention of VPU's, and it seems that there is still no unified policy for them.

Neither the TP Report nor the White Paper mention extra resources, and none have been allocated for the newly implemented programmes. Seen in this light, it is clear why the Home Office has now favoured having a small number of specially designated units, which largely corresponds to the existing system of VPU's rather than Woolf's more expensive option of creating

many, smaller units. Unfortunately, it will probably be less easy to integrate such large concentrations of vulnerable prisoners into the general prison population as Woolf proposed.

5.0 Discussion

Perhaps not surprisingly, the Woolf Report mirrors some of the policies of the VP Report. Woolf makes no direct critical comments concerning the VP Report and, indeed, quotes freely from it. This is unusual given Woolf's fundamental rejection of the policy of encouraging vulnerable prisoners to conceal the nature of their crimes. Woolf's recommendations. make the VP Report potentially obsolete (as ultimately happened with the publication of the 1991 White Paper) . However, it is likely that Woolf did not wish to alienate the Prison Service by openly criticising one of its recent reports. Woolf does make many strategic recommendations that are also contained within the VP Report. It questions the status of prisoners on the Rule who are on protected location but not removed from association, and it also wishes to see a reduction in the use of Rule 43 and wider use made of alternative measures. Woolf, however, wishes vulnerable prisoners to survive on normal location via a more enlightened regime rather than through secrecy.

How realistic is Woolf's proposal to create a more tolerant environment for vulnerable prisoners given the intractability of prison subculture? Certainly there are successful experiments such as Grendon and Littlehey which have broken down negative attitudes towards vulnerable prisoners, but these are isolated examples. These are carefully controlled situations where prisoners are selected for their suitability and removed at once if they do not participate in the regime. Establishments such as the VPU at Wandsworth, which have to accommodate such 'unsuitable' prisoners, may have less success in implementing such schemes. Littlehey is a modern, open prison, and it is doubtful whether a similar scheme would be practical in older prisons with less liberal subcultures. Sampson notes that the prisons chosen for such programmes: Dartmoor, Wandsworth, Albany, Full Sutton, Wakefield, etc, are also those which are traditionally punitive with histories of intolerant subcultures (Prison Reform Trust 1992:10). Woolf's 'mini Grendons' in every local prison, then, may be an over idealistic aim.

There are a number of omissions in the VP and Woolf reports. Neither make any international comparisons. The Woolf Report mentions briefly that protecting vulnerable prisoners is primarily a feature of British, American and Canadian prisons; 'With one exception, it does not exist in the European countries which were visited by the Inquiry,' (para. 12.189). A closer examination of why most countries have avoided the need for this facility might have yielded some valuable lessons for British prisons.

The issue of women on Rule 43 is also neglected. The VP Report chose not to examine female vulnerable prisoners because the number is 'extremely small' and 'we have received no indication of any particular problems arising in relation to women prisoners' (1989: para 1.7). The Woolf Report also fails to recognise this issue and does not mention it at all. Woolf's failure to discuss the problems of women prisoners generally has been identified as a major weakness of the report (see, for example, NACRO 1991). The 1991 White Paper is also silent on the issue, although the TP Report does briefly observe that the number of female sex offenders is small, but treatment initiatives at female establishments such as Styal and New Hall are being looked at (Prison Service 1991: 38)[4].

The Home Office's post-Woolf approach to vulnerable prisoners, then, is largely in terms of the treatment of sex offenders. This is less radical than it may appear. With no extra resources being allocated for the programmes, the present policies utilise the existing prison estate and carefully avoid Woolf's less resource neutral proposals for numerous, smaller units.

4. The Prison Statistics reveal that in fact there were 12 women on Rule 43 Own Protection on 30 June 1991 (Government Statistical Service), most being involved in child neglect and abuse cases. However, this small group does face problems. Brief comments in NACRO (1989) and Roberts (1989) reveal that female vulnerable prisoners are often mentally disturbed. Conditions for such women are basic. They are usually kept in segregation cells and at present there are no VPU's for them.

While such treatment programmes are to be welcomed, it should be remembered that not all vulnerable prisoners are sex offenders[5]. With the criteria for selection to treatment centres being based on suitability for treatment rather than vulnerability to attack, and with the current interest in privatisation (where treatment may be seen as a more 'marketable' feature than protecting unpopular prisoners such as informers and those who are socially inadequate) there is a danger of a group of vulnerable prisoners being overlooked[6].

The policy of Rule 43 has become fragmented. With the wider use of VPU's and more protected locations, 'Rule 43' and 'removal from association' have become misnomers in many establishments. This process mirrors the recommendations of Woolf which recommended the use of alternative management options and thus minimising the labelling of vulnerable prisoners. However, this fragmentation also prevents any unified policy for such inmates, neither Woolf nor the White Paper propose a centralised policy for VPU's.

The VP Report, Woolf Report and the 1991 White Paper have shown that the issue of vulnerable prisoners needs to be handled with sensitivity and sympathy while having regard for the management and control needs of the prison establishment. It is obvious that there is a fundamental problem here; that while a centralised policy for vulnerable prisoners is desirable, such centralisation must avoid aggravating the problems of these inmates by labelling and stigmatising them as a result. It is also necessary to produce a new coherent policy for vulnerable prisoners generally and not just sex offenders. Such a policy can best begin with a new prison rule for vulnerable prisoners ■

References

Akerstrom, M. (1986), 'Outcasts in Prison: The Cases of Informers and Sex Offenders', *Deviant Behaviour*, 7/1: 1 12.

Betsworth, M. (1989), *Marking Time: A Prison Memoir.* London: MacMillan.

Bradshaw, G. (1989), 'Living on the Rule', *Prison Report*, 8: 4.

Davies, P and Steadman-Allen, R. (1979), 'The Psychology of Rule 43', *Prison Service Journal*, 34: 7-8,14.

Government Statistical Service (1989-), *Prison Statistics for England and Wales.* London: HMSO.

Hansard (1989), *Hansard Written Answers*, 31 October 1989, cm. 115-116, London: HMSO.

Heritage, I. (1993), *The Politics of Rule 43: Official Policies Towards Vulnerable Prisoners Before the Woolf Report.*

HM Chef Inspector of Prisons (1981), *Report of Her Majesty's Chief Inspector of Prisons for England and Wales.* cmnd 8532, London: Home Office.

HM Chief Inspector of Prisons (1986), *A Review of the Segregation of Prisoners under Rule 43.* London: Home Office.

HMSO (1964), *Prison Rules.* (SI 1964 No. 388) London.

Home Office (1984), *Managing the Long Term Prison System, Report of the Control Review Committee.* London: HMSO.

Home Office (1991a), *Custody Care and Justice.* cm 1647, London: HMSO.

Home Office (1991b), *Prison Disturbances, April 1990 (Woolf Inquiry).* cm 1456, London, HMSO.

Howard League for Penal Reform (19B9), 'My Time on 'The Rule'', *Criminal Justice*, 7/1: 3-4.

Independent (The) (1990), 'My Days of Despair on Rule 43', *The Independent*, 14 September 1990:15.

McDermott, K. and King, R. (1988), 'Mind Games: Where the Action is in Prisons', *British Journal of Criminology*, 2813.

NACRO (1989), *The Quality of Life for Prisoners Segregated for their Own Protection Under Rule 43 of the Prison Rules.* (NACRO Briefing Paper) London.

NACRO (1991), *A Fresh Start for Women Prisoners: The Implications of the Woolf Report for Women.* London.

Open University (1992a), 'A Note on the Social Position of Vulnerable Prisoners', in *Open University, D803 Section A3 Course Booklet.* 16-17. Milton Keynes.

Open University (1992b), 'Sexual Offenders and Their Treatment', in *Open University, D803 Section E Course Booklet.* 26-28. Milton Keynes.

Parker, I. (1991), 'Fighting the System', *The Independent Magazine*, 27, 9 February 1991 : 22-31.

Player, E. (1992), 'Treatment for Sex Offenders, A Cautionary Note', *Prison Service Journal*, 85: 2-9.

Priestley, P. (1980), *Community of Scapegoats: The Segregation of Sex Offenders and Informers in Prison.* Oxford, Pergamon.

5. The actual composition of the general Rule 43 population is difficult to assess; such inmates are often highly secretive about the nature of their offences. A 1984 survey by HM Chief Inspector of Prisons of 50 prisoners on Rule 43 (Own Protection) in the South East and South West Regions revealed that: 60 per cent were sex offenders, 20 per cent were inadequate inmates with social problems, 10 per cent who had incurred debts in prison and 10 per cent were informers (HM Chief Inspector of Prisons 1986: para. 1.56).

6. Akerstrom's research (1986) suggests that non-sex offending vulnerable prisoners face a more intractable problem. Such inmates are despised because they have broken subculture rules and for them there is no possibility of forgiveness. In contrast, sex offenders are outsiders who have not transgressed any such rules; it is often possible for some sex offenders to gain acceptance on normal location by confronting their unpopularity (see, for example, Bettsworth 1989 and McDermott and King 1988: 66-67).

Prison Service (1988), *The Operation of Rule 43 in 1985.* (Adult Offender Psychology Unit Report), London: Home Office.
Prison Service (1989), *The Management of Vulnerable Prisoners, Report of a Prison Service Working Group.* London: HMSO.
Prison Service (1991), *Treatment Programmes for Sex Offenders in Custody.* London: Home Office.
Prison Reform Trust (1990), *Sex Offenders in Prison.* London.
Prison Reform Trust (1992), *Beyond Containment: the Penal Response to Sex Offending.* London.
Roberts, Y. (1989), 'Abandoned Inside', *New Statesmen,* 18 August 1989:17.
Sampson, A. (1989), 'Sex Offenders Campaign', *Prison Report,* 9: 5.
Tidmarsh, P. (1991), 'Working with Sex Offenders', *Prison Report,* 15: 7.

READABLES

NEWS FROM THE PSC LIBRARY

The following items have recently been added to the collection of the Prison Service College Library. They are only a small selection from our recent additions. More complete lists and our journals bulletin are sent to the training officer in each establishment every month.

'Prison law: text and materials'

by Stephen Livingstone and Tim Owen (Clarendon Press, 1993)

At long last, a comprehensive textbook has appeared looking at the law of imprisonment, and how it affects those within the prison system. It brings together and comments on all the relevant legislation, including prison rules, standing orders, some circular instructions and even the relevant European Conventions.

This book appears to fill a large gap in prison literature and should be invaluable to all those concerned with the legal framework behind the prison system in England and Wales.

'Women prisoners: a forgotten population'

edited by Beverly R. Fletcher et al. (Praeger, 1993)

An American publication, containing a number of essays on the lot of the female prisoner. Amongst the topics covered are an interesting profile of the typical American female prisoner, the incidence of drug and sexual abuse in their backgrounds and the attitudes of correctional staff towards female inmates.

'The Art of Strategy'

by R. L. Wing (Aquarian Press, 1989)

A modern translation of the Chinese classic 'The Art of War' by Sun Tzu. The original dates from around 480-221 BC but is still relevant today and so finds itself on the reading list for many management courses, including the Prison Service's own senior management programme. Each chapter begins with a brief summary followed by a literal translation from the Chinese. The original Chinese is also included.

'Body Language'

by Allen Pease (Sheldon Press, 1984)

A thorough look at non-verbal communication by the Australian expert. With amusing but clear illustrations by Peter Cox, this provides an excellent introduction to this fascinating subject.

'Managing financial resources'

by Michael Broadbent & John Cullen (Butterworth-Heinemann in association with the Institute of Management, 1993)

One of a series designed to provide the basic knowledge for any competency-based management course, this book provides an excellent introduction to financial management and management accountancy. Written in a very clear style, with illustrative diagrams and tables, this is a useful addition to the literature on a subject of increasing importance to prison service managers.

If you wish to borrow these, or any other items, from the Library, or require any further information please contact the College Librarian, Catherine Fell or her assistant, Ruth Gostin, at Love Lane (0924) 371291 ext. 273.

SNIPPETS

	TOTAL PRISON POPULATION AT 1.9.91	RATE PER 100,000 POPULATION
UK	52830	92.1
SPAIN	36562	91.8
FRANCE	48675	83.9
GERMANY	49658	78.8
IRELAND	2114	60.4
ITALY	32368	56.0
HOLLAND	6662	44.4

* New York has a murder rate 16 times higher than London

* Young Offenders (under 21) committed 45% of all serious offences in 1992

* On 30 June 1992, there were 11 people in prison for every 10,000 people in the general population and 76 people of Afro-caribbean origin in prison for every 10,000 of that group in the general population.

* The number of prisoners per prison officer has fallen from nearly four male prisoners per officer in 1971 to just under two in 1992.

VERBALS

"... attendance at a probation centre or an offending behaviour programme [are not seen by courts] as sufficiently demanding and restrictive to constitute a punishment .... needs to be .... changes .... to content of probation orders ...."

[HM Inspectorate of Probation Annual Report 1992/93].

"Challenging physical activities can provide .... opportunities .... for young offenders to confront offending behaviour and change attitudes .... It is important .... to ensure .... no question of it being misconstrued .... as a reward for offending .... young offenders should not be sent abroad."

[John Bowis, Minister in the Department of Health on 28 February 1994].

".... overcrowding .... is intrinsically wrong .... no benefit to prisoners .... no benefit to staff .... no benefit at all to the public. Overcrowded prisons are unhealthy places far more likely to turn out embittered, hardened and contaminated individuals ...."

[Brendan O'Friel, Chairman of the Prison Governors Association on 9 March 1994.]

"While, of course, the need to address serious crime must not be ignored, those responsible for setting the climate in which the majority of minor criminals are sentenced must recognise their responsibility continually to drive home the message that in the case of the majority of offences imprisonment is an immensely expensive process and that it should be reserved for those, and only those, for whom it is appropriate. It need to be reiterated repeatedly that if prison is used when it is not necessary then it is frustrating not furthering the objectives of the criminal justice system. It is an expensive way of making the criminal justice system less effective".

[Lord Woolf in the House of Lords 2 February 1994].

CRIMINAL RECORDS

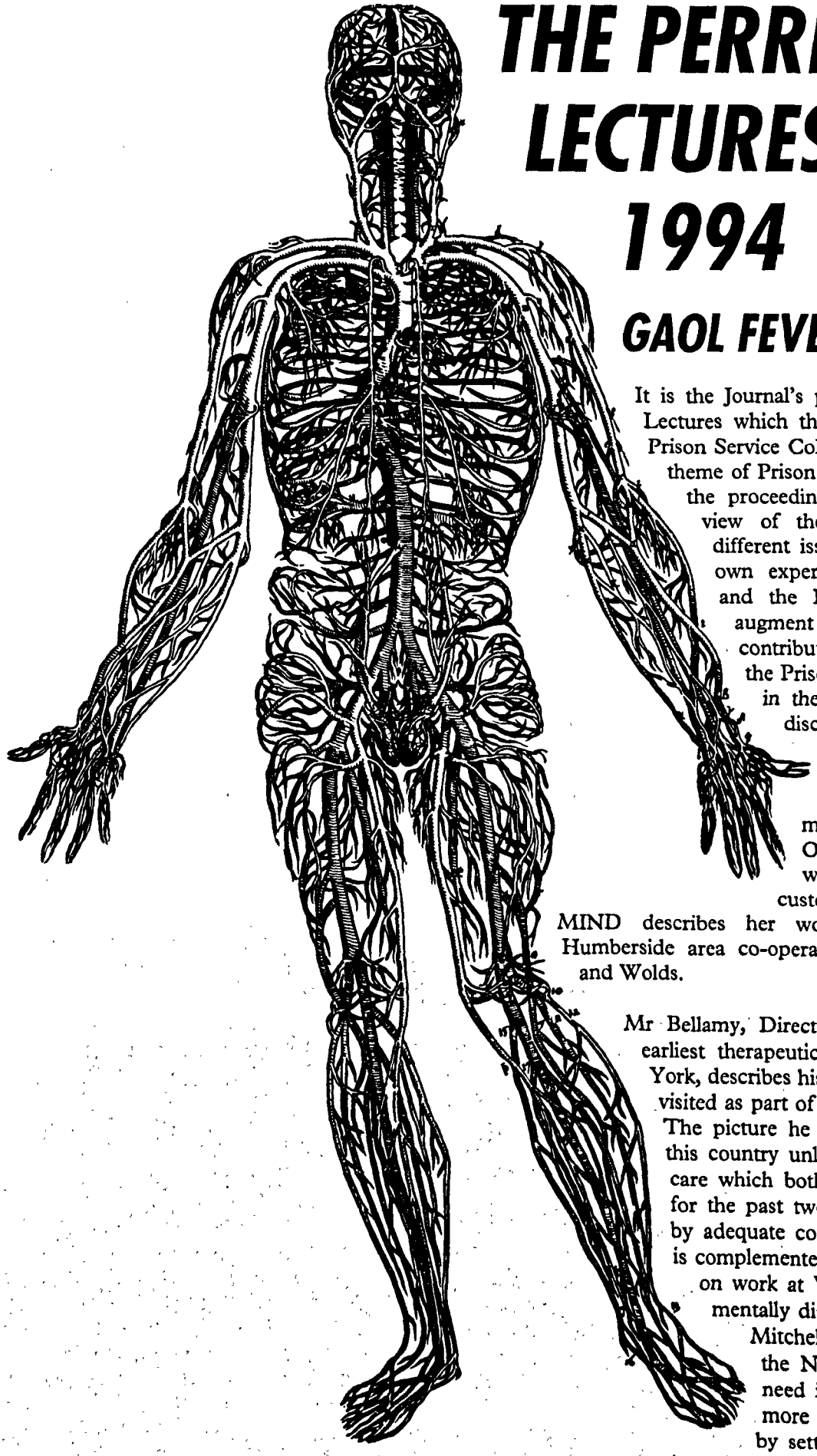
Year	Average no of males on remand	Average no of females on remand	Total
1978	5344	287	5631
1982	7103	329	7432
1986	9650	431	10081
1988	10933	507	11444
1990	9521	384	9905
1992	9707	383	10090
On 30 June 1993 Total reached			10632

TIME SPENT ON REMAND AS AT 30 JUNE 1992

Length of time on remand	No of prisoners
Up to 6 months	8160
Over 6 months up to 12 months	1190
Over 12 months up to 18 months	170
Over 18 months up to 2 years	30
Over 2 up to 3 years	10

(Hansard 15 December 1992)

EQUAL OPPORTUNITIES	No of women	% of that group
Prison Officers	1796	9
Senior Officers	144	4
Principal Officers	51	4
Governors	91	9



THE PERRIE LECTURES 1994

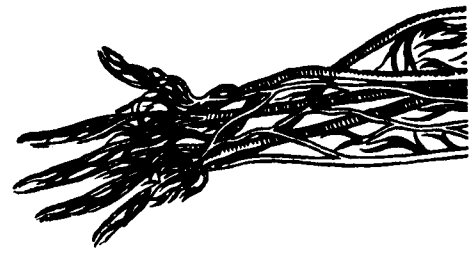
GAOL FEVER REVISITED

It is the Journal's practice to publish the Perrie Lectures which this year were delivered at the Prison Service College at Newbold Revel on the theme of Prison Medicine. Dr Bullard chaired the proceedings and has written an overview of the day, pulling together the different issues and relating them to her own experience of working in prisons and the National Health Service. To augment those lectures we sought contributions from doctors working in the Prison Service and people working in the voluntary sector. Dr Phipps discusses the Reed Report which was published in 1992 and made recommendations about the treatment of the mentally disordered offender. One of those recommendations was about diversion from custody and Catherine Staite of MIND describes her work on that theme in the Humberside area co-operating closely with Hull Prison and Wolds.

Mr Bellamy, Director of Nursing at one of the earliest therapeutic communities, the Retreat in York, describes his findings in the USA where he visited as part of a Churchill Fellowship Award. The picture he paints is an ominous one for this country unless the rhetoric of community care which both we and the USA have used for the past twenty five years is not followed by adequate community resources. That view is complemented by an article by Mary Barker on work at Winchester Prison assisting the mentally disordered with release plans. Dr Mitchell writes about a pilot project in the North East which addresses the need identified by Dr Wool to work more closely with the Health Service by setting up a contract between the prisons in the area and the local Health Service ■

THE PERRIE LECTURES 1994 GAOL FEVER REVISITED

HEALTH CARE FOR PRISONERS TODAY



Dr Henrietta Bullard, Consultant Forensic Psychiatrist, Department of Forensic Psychiatry, Fair Mile Hospital, Wallingford, Oxon, OX10 9HH.

The Perrie Lectures provide an opportunity for people from within the prison service and for academics, professionals and other agencies to meet to discuss and debate issues which affect the health and welfare of prisoners. The annual meeting, held at Newbold Revel, has become a popular annual event and this year the attendance was excellent and we were fortunate to have Professor Joe Sim and Dr Rosemary Wool to present their vision of a health care service for prisoners. We were also fortunate to have workshop leaders who are nationally known for their work and experience with the rehabilitation of offenders, the management and treatment of the terminally ill, the health care in prisons after Woolf, the special problems of prisoners from ethnic minorities and a therapeutic community for the treatment and rehabilitation of drug addiction.

Health care in prisons

The Prison Medical Service, which became the Health Care Service in 1992, has always attracted criticism; often unfairly. The role of the senior medical officer has been to provide a medical service for prisoners within the constraints of Prison Rules. The effects of custodial regimes in prisons, with their emphasis on discipline, control and security, are a constant source of friction and frustration for doctors and nurses working in prisons.

Some of the most difficult prisoners present problems of control and have long-standing medical and psychiatric difficulties. Amongst the sentenced population between 30 and 40 per cent of inmates have psychiatric disorders including a high percentage with addiction to drugs and alcohol. The psychiatric morbidity of the remand population is probably higher. While few would disagree that everyone, whether in prison or not, should have access to health care, it is not always appreciated that because of the poor health of this socially disadvantaged group, the need for health care is far in excess of that needed by the same age group of men and women in the community. A recent editorial in the British Medical Journal (BMJ) has again drawn attention to the widening inequality in health between the rich and the poor. The more deprived sections of the population have 'paid a heavy price for the official failure to take the social causes of disease seriously'. The political climate in this country has been to blame the individual or the family for most of society's ills, including criminality and poor health. It is clear that social and economic inequalities have a profound effect on the health of a population and on the level of criminality. By the time that young men are offending and being incarcerated in prison they already have health needs which far exceed those of their more fortunate contemporaries.

The provision and delivery of health care in prisons

It has been emphasised by Professor Sim that the delivery of health care is particularly difficult in an environment where the ethos is one of coercion, violence and aggression. Unfortunately, bullying and oppressive regimes are part of the culture of prisons. However, over the last few years there has been a change in the attitude of governors and discipline staff. The Inspector of Prisons, Judge Stephen Tumim, has unstintingly condemned the inhumanity shown towards prisoners and has openly deplored the degrading conditions in which some prisoners have to live. It is important for those responsible for the welfare of

prisoners to have adequate training to enable them to understand the roots of criminality and to assist prisoners to make personal choices and changes in their lives. There will always be rules and discipline in prison, but the selection of discipline staff must take account of the individual's ability to work in a structured and custodial environment and at the same time bring a humane and caring approach to their work. It is possible to change attitudes in institutions and I do agree with Judge Stephen Tumim that where people from all disciplines, including the prisoners, can work together, the personal rewards for staff and prisoners will be substantial. The development of sentence plans, treatment programmes and offending related work have done an enormous amount to improve the relationship between staff and inmates. Prison staff need to feel part of a team, capable of organising programmes of work, training and education to enhance the self-esteem of both the trainer and trainee. Discipline staff are being rewarded with knowledge and insight gained from productive work with offenders. Grendon prison provides an excellent example where inmates are treated in a civilised fashion by staff who have had the advantage of specialised training and where the use of violence and abuse is condemned.

Professor Sim draws attention to the effect of prison on prisoner's health and argues against the development of special units for the vulnerable and inadequate. He believes that segregating these groups draws attention to the individual's pathology rather than to the pathology of the institution. He makes an impassioned plea for the humanisation of prison and the abolition of a culture dominated by coercion and violence. Paradoxically, it may be that where it can be seen that the vulnerable and inadequate are being cared for, this model may be adopted by the rest of the prison. The introduction of treatment programmes in prison, particularly those designed to address various aspects of behaviour and offending, have gone a long way to encourage inmates to look at themselves as individuals and to seek out strategies to help them with deep rooted problems. At the same time, prison officers are being given the opportunity to work with other disciplines and allowed to develop their skills to help inmates deal with stress and address other aspects of maladaptive behaviour. It is also clear to me that the health of discipline officers and their families should receive a higher priority. **It is stressful working in prisons where the officers themselves can be the butt of abuse, violence and coercion. Many officers are suffering from stress and the governors and health care teams should be more involved with the health of personnel working in prisons. Everyone needs care, not just the vulnerable and inadequate.**

The purchaser/provider split

The scrutiny of the prison medical service recommended that the prison service should purchase health care from the National Health Service(NHS). As Dr Wool points out, this would go some way to challenging the criticism that prison doctors are isolated from NHS practices and standards. Four years after the publication of the scrutiny of the Prison Medical Service, there are virtually no contracts between the Health Care Service and the NHS to provide psychiatric services. NHS Trusts have shown no interest in making contracts with prisons to provide for psychiatric care for prisoners and from the prison point of view the costs would be prohibitive. Many of the mentally ill in prison need transfer to hospital for psychiatric treatment. It has always been a principle of fairness and justice that the mentally ill should be in hospital, not prison. While there is a crisis in the provision of in-patient beds for the mentally ill, there will be covert efforts to keep the mentally ill in prison. If NHS Trusts and directly managed units were to make contracts with prisons they would presumably be required to arrange for the transfer and treatment of the mentally ill in hospital or purchase this somewhere else. The difficulty in transferring the mentally ill from prison to hospital will continue until the provision of psychiatric beds is increased to a level which approaches the actual need. It would be nice to think that the Home Office might want to put extra money into the NHS by contracting with the NHS for services but as purchasers it is unlikely that they would purchase hospital care which they would argue should be paid for by the NHS. For doctors working in prisons, the difficulty in transferring mentally ill to hospital cannot be over-emphasised. It is sometimes difficult to persuade any consultant or hospital to accept responsibility for a patient and there is generally great reluctance on the part of consultants to visit the mentally ill in prison and arrange for

their transfer to hospital. Most psychiatric beds have 100 per cent occupancy and the wards are over-crowded and under-staffed. There is little incentive for medical or nursing staff in hospital to encourage the referral of mentally ill prisoners who need a high level of nursing care and supervision. There is a chronic shortage of secure beds in regional secure units and the facilities in the community for the chronically disabled and mentally disordered are lamentable. It is characteristic of this government that millions of pounds will be spent on placing vulnerable psychiatric patients on a supervision register, but no extra resources to provide care for these patients in the community.

While providing specialist medical services for prisoners in prisons may detract from the development of the services by the NHS; there is no doubt that making health care a priority in prisons improves the health of the whole institution. Prisoners who have drug and alcohol problems should expect to receive treatment and counselling from trained counsellors under medical supervision in prisons. Ideally, the health care team should work closely with other departments and disciplines; medical, psychology, occupational and other staff should meet regularly to co-ordinate the sentence and treatment plans. The needs of remand prisoners are probably greater and certainly there is more urgency to undertake assessments and provide multi-disciplinary assessments to the courts. There is also a need to bring social services into the prisons where they have a statutory duty to provide care management plans. The ultimate aim should be to plan the passage of an inmate through the prison system rather than, as at present, to react to the inmate's needs as he lurches from one crisis to the next. Crisis management is not effective in business, nor is it effective in the health care of prisoners.

Improving the image of health care in prisons

Dr Wool has a vision for the future of high quality health care for prisoners. She has encouraged the integration of health care service with the NHS and has supported doctors and nurses working in prisons by making training opportunities available. There is no doubt in my mind that promising young doctors in the prison health care service should be able to take up senior registrar training posts and that prison posts would be part of a forensic psychiatry rotational training scheme. There should also be opportunities for qualified psychiatrists to have career opportunities in the prison health care service. It should be remembered that in the 1970s a number of joint appointee consultant psychiatrists between the NHS and the Home Office were established at various prisons. On the whole these posts were not successful as consultants had difficulty in integrating into the prison culture. More thought does need to be given to the training of doctors in the prison health care service and in integrating training with that of doctors in the NHS. Doctors working in prisons need to acquire the skills to provide medical leadership within a multi-disciplinary team.

Workshops

During this year's Perrie Lectures the workshop to discuss the health care of foreign prisoners was lead by Deborah Cheney, Lecturer in Criminal Law at the University of Kent. The Director of the Prison Reform Trust, Stephen Shaw, reported to the plenary session that there are at least 2,500 foreign nationals in the prison system and that they represent a greater number than the total female prison population. Deborah Cheney identified areas of special need, including isolation, language difficulties and cultural needs including food and access to advice and information. The workshop focused on health care requirements, difficulties in tracing medical records and the reception medical examination. The workshop benefited greatly from the participation of Dr Rosemary Wool and it was agreed that translation facilities for non-English speaking prisoners should be available. It was also agreed that many prison doctors were unaware of the needs of foreign nationals.

The issue of ethnic minorities was taken up by Brian Williams who reported on the workshop lead by Eric Smellie, the Principle Race Policy Officer at the National Association for Care and Resettlement of Offenders (NACRO). Brian Williams, who is a lecturer in probation studies at the Department of Applied Social Studies at the University of Keele reported the concern felt by the members of the workshop that black people are disproportionately imprisoned and diagnosed as mentally ill. The group considered the explanation for this discrepancy and acknowledged that black people felt angry and had difficulty in

relating to white professionals. There was concern that black people were being misdiagnosed and misunderstood. The work of Roger Hood in Birmingham, Coventry and Wolverhampton does support the contention that black people are more frequently sentenced to imprisonment for the same offences than are white people. However, the evidence concerning the prevalence of mental illness in Afro-Caribbeans does lead one to the conclusion that there is a higher incidence of mental illness in both first and second generation Afro-Caribbeans. The needs for psychiatric treatment for this group should not be overlooked and particularly the provision of services. There is strong evidence that young Afro-Caribbeans are 10 times more likely that their white counterparts to require admission to a psychiatric hospital. If this need is ignored in the interests of anti-racism, this will not be doing a service to a vulnerable group.

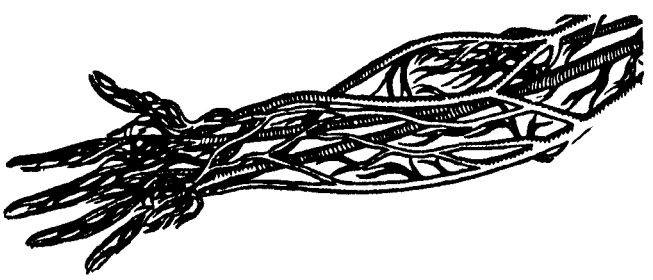
Summary

Most of us who work with prisoners recognise that the damage done to these people by poverty, social deprivation and other forms of abuse is irreversible. Professor Sim described the harrowing environment in prisons and came to the cynical conclusion that the NHS internal market would disadvantage the already disadvantaged in prison. Dr Wool supports the integration of the health care service with the NHS and does see a time when it may be possible to purchase a full medical and psychiatric service from NHS provider units. Both Professor Sim and Dr Wool recognise the importance of changing the culture in prisons and introducing the concept of care into institutions more used to discipline and control. The special needs of immigrants and ethnic minority groups were discussed in the plenary session and there were two workshops led by Barry Morse and Paul Toon to examine the work done with AIDs and HIV positive prisoners and drug abusing offenders.

When people get together at the Perrie Lectures, one is made aware of the need we all have to talk and communicate with one another ■

THE PERRIE LECTURES 1994 GAOL FEVER REVISITED

PRISON HEALTH CARE TODAY



Dr Rosemary J. Wool, MB, BS, FRC Psych, DPM, DRCOG. Director of Health Care for Prisoners.

When given the title of this programme, 'Goal Fever Revisited: Prison Health Care Today', I wondered what the implication was. Was it that the present state of prisons and their inmates, and the level of health care today equate with that of the eighteenth century? Surely not! – Or are we in fact currently repeating a scenario from history?

I should like to run briefly through the original prison scene when goal fever was rife, and then describe the current situation with regard to the health care of prisoners today. I shall then leave you to decide if the latter constitutes a case of history repeating itself.

In the eighteenth century jails were in the most appalling condition: lacking all facilities, insanitary and dirty, their communal cells dangerously overcrowded, both from the point of view of safety and of health. They were overcrowded with members of the community awaiting judgement and punishment for their illegal reaction, by design or default, to their life's situation: overcrowded with the desperate, the deserted, the despised, the destitute ...

Many were convicted under laws which have since passed out of the statute books. What a mirror to society in general these jails were, reflecting by the constituents of their own discrete population what was deemed unacceptable to the society of that day, and therefore offensive and punishable. And how satisfying to the public sense of justice was a jail full of convicts.

But there are always those in society who would temper justice with mercy, and whose consciences are troubled by the degradation of man, even guilty man. And though their voices go unheeded by the masses over many years, there comes a point when public hearing is sharpened. That point is reached when the interests of that public are at stake.

Such a point was reached in the late eighteenth century when conditions in prisons gave rise to an outbreak of typhus, goal fever. When the outbreak amongst prisoners spread to those in contact with them, affecting, irrespective of rank both judge and jailer, and in turn their contacts, families and associates, public attention was arrested by those who decried the conditions in jails, and advocated reforms.

Most notable among reformers at that time, was John Howard; and his zealous concern for prisoners together with the public's concern for their own welfare put sufficient pressure on the government of the day for them to pass an Act of Parliament which altered the administration of jails, and led to comparatively better conditions for prisoners.

Howard had, in particular, advocated the appointment of a doctor to each prison, having seen for himself on the Continent the benefit a medical presence in jails. In fact some time after his death such an appointment became a statutory requirement by Act of Parliament in 1823.

To sum up the era of goal fever, would it be too simplistic to say that the unacceptable condition of prisons manifested itself in the ill-health of the prisoners, and that the answer to the problem was seen to lie, to a large extent, with the medical profession?

It would be good to be able to say that thereafter ill-health in prisons was not a serious problem: that the medical service safeguarded the good health of prisoners. Certainly, responsibility for the good health of prisoners was handed over to the prison doctor; but of course, he did not practise medicine in isolation.

Although conditions and regimes improved, they were still, oftentimes, prejudicial to health; for what advice the doctor gave, for example, on diet (Millbank), or on the imposition of excessive hard labour (treadmill), was either virtually unheeded, or ranked so far behind matters of security, control or political expediency in the order of priority that it remained of no effect. Therefore, the medical service in prison was confined to the treatment of ill-health, with the prison doctor working under the additional stress of a prison environment, which unavoidably constrained his clinical practice.

On that note I want, now, to move forward from the past to prison health care today. However, before today we must pass through yesterday: and for my purpose here our 'yesterday' is the state of prisons prior to 1990: before the Manchester riots and the Woolf Report, both of which had such a dramatic effect on the prison service.

Up to then, a case could be made for the scenario of the eighteenth century being repeated. Conditions in many prisons still rated, when set against current social conditions, as appalling and disgraceful. Many were overcrowded, to a dangerous degree, hence the Manchester riots: over-crowded, as in the past, with constituents who reflected current society – the unprincipled, the undisciplined, the violent, the drugged, the deviant, the inadequate, and the mentally ill for whom there was no place in society.

Then, too, in the last decade, as in former times, the health and welfare of prisoners became an issue. The reformists targeted the mentally ill, being particularly vocal about the unacceptably high number of suicides in prison: and unfairly, it has to be said, ignoring all prior factors contributing to the tragedy, placed the blame on the prison doctor who, of necessity, came last in the line of those who had to do with the deceased.

Again, also, as in the time of goal fever, the fear of contracting infection from prisoners gripped their custodians as the AIDS/HIV issue arose. Until its aetiology was made clear, its presence in a prison brought near-panic to those in contact with diseased inmates.

The government, too, through the Home Office, brought many changes to the administration of the prison system; and on a practical level began to make provision for

some new prisons while at the same time beginning to up-grade old buildings to a more acceptable condition.

They also turned their attention to prison medical services. This came about through one of the Thatcher government Value for Money Efficiency Scrutinies in 1990. Actioning the recommendations of the Scrutiny since then has taken place simultaneously with reforms to the prison service in general. Also contemporary with all of these reforms has been the reform of the National Health Service, and during the last year, the effects of the recommendations in the Government White Paper, *The Health of the Nation - A Strategy for Health in England* (HMSO 1992).

As a consequence of these, the 1990's has seen a complete transformation of the prison medical service; and they have given me the opportunity, since becoming Director of the Prison Medical Service in 1990, to put into effect some of my personal ambitions for the service: not least to raise the standard in every respect to the level of that provided to patients by the National Health Service.

I want, now, to give a picture of health care for prisoners today: how far along the road of improvement we have gone to date, with some brief explanations on how the transformation has been, and in many cases still is being, made.

Firstly the Prison Medical Service has been relaunched as the Health Care Service for Prisoners, signalling a fresh approach: a move away from the treatment of ill-health to a commitment to provide a full health care service, not only including treatment but also health promotion, illness prevention and rehabilitation. The new name also indicates the emphasis now being put on the prisoner-patient, and a new approach of giving him/her a greater responsibility for his/her own health.

In line with National Health Service policy to place more emphasis on health promotion, we are too working out co-ordinated health programmes, and at present have pilot projects going on in five prisons to test the best ways to carry this forward.

In this, we are also moving in line with the Government White Paper, *The Health of the Nation*, in which prisons are recognised as pivotal in public health terms. In cooperation with the World Health Organisation we are developing the concept of Health Promoting Prisons. This pilot scheme is involving the close cooperation of caterers, physical education officers, education staff, staff running pre-release courses, personnel officers and health care staff.

Health Care Centres in many establishments other than the five selected have taken the initiative to explore and develop for themselves ways of promoting good health. They, too, are devising schemes to involve their colleagues from other disciplines within the establishments, and of course the prisoners, too.

At the same time as we are establishing a multi-disciplinary approach to health care within prisons, we are also working through the process of introducing medical services from without the prison service. In one respect we were already using these, for almost half of all prison doctors are GPs who work part-time in prisons; and thousands of treatments and consultations are already obtained annually from visiting specialists in the National Health Service (NHS).

It was, however, one of the central recommendations of the Scrutiny that the Prison Service should become a purchaser of health care services through contracts with the NHS or other providers. We have, therefore, been drawing up a model contract for primary care services to use with the NHS and other providers. My ultimate aim is to staff our Health Care Centres in establishments with a team of health professionals such as now exists in NHS health centres in the community, so that our patients in prisons have access to the same range of services as has the general public.

We are also negotiating with the NHS for whole packages of services, and since the NHS is not in a position, at present, to meet all our needs, we have prioritised in two specific areas of health. A contract has been signed to provide a full specialist mental health service for a cluster of prisons in the North East; and one for contracting in a genito-urinary medicine service for a number of the London prisons.

This contracting in should go a long way to silencing the criticism that prison doctors are too isolated from NHS practices and standards: a criticism with some justification. Contracting in services will also demonstrate the clinical independence of the health care services, which has at times been called into question.

Some presently employed doctors have seen our new role as purchasers of medical services, rather than providers, as a

threat to their employment; but I believe there is a crucial place for a core of full-time doctors in establishments to provide leadership and to take overall responsibility for clinical and other health services, and to represent the prisoner's health rights on the governor's management team. To this end they must be highly trained in all aspects of prison health and health management.

For this reason we already have in place an on-going programme of in-service and external training. This includes an induction course and later development courses for new entrant medical officers, and similar courses of induction and development in management. Other training programmes include a diploma course in addictive behaviour; courses in clinical aspects of HIV/AIDS; provision for external courses in psychiatric care; seminars in health and safety; and seminars for medical and senior nursing staff in the context of management meetings. Furthermore I have very recently appointed a Head of Professional Development who will, amongst other things, develop and implement a training strategy which will lead to an accredited specialist service.

Of equal importance to the doctors in the Directorate's drive for an improved health care service for prisoners is the group of health care officers engaged in the nursing care of the patients. Clearly, a whole new policy was required to address the problem of nursing being undertaken in the main by prison officers with a maximum of six months in-house training, thereafter being called hospital officers.

We therefore formulated, in consultation with appropriate colleagues, a new nursing policy. In our newly-named Nursing Service for Prisoners we aim to reach a nursing manpower skill mix where 75 per cent of all nursing staff have a statutory qualification. Of these, two thirds will be civilian nurses and one third health care officers with a qualification. The remaining 25 per cent will be health care officers with a basic National Vocational Qualification (NVQ) training in nursing.

To this end we are providing training opportunities for health care staff, which include secondment for first level nurse training (RGN or RMN); enrolled nurse conversion courses; and induction courses in security and control for nursing grades. We have also funded English National Board courses in nursing care for a range of mental health, alcohol and drug dependency, and HIV/AIDS related illnesses. There is, too, the opportunity for health care officers with no professional nursing qualification to obtain their NVQ in nursing.

In addition to the range of nationally recognised courses, health care centres are being encouraged to explore opportunities for more localised training; and several have established links with local colleges of nursing.

As with the doctors, so with nurses, I am determined to see a level of qualification and professionalism as good as that in the NHS.

This aim to equate in quality with the NHS in the medical services we provide for our prisoner patients has also prompted us to review our pharmaceutical service: an area, incidentally, in which the Scrutiny also called for improvements.

We are working on the restructuring of the service, and pharmacists, as a significant member of the Health Care Centre team, are becoming more actively involved in procedures for the administration of medication to inmates. In many establishments, now, pharmaceutically acceptable systems are in operation for the administration of 'in possession' medication. Prisons formularies are fast becoming the norm; and all main pharmacies are now computerised.

In restructuring health care within establishments, we in the Directorate have not held ourselves exempt from reform, and have cast an equally critical eye over our own organisation and administration, with the result that necessary changes have been made. This demonstrates our commitment to constantly assess, in all areas without exemption, the needs of the service.

The Yorkshire prisons, in liaison with Yorkshire Health Authority, are undertaking a complete needs analysis of the health care needs of their prison population. The needs of the population will also become clearer as we receive the results of health surveys which are being undertaken this year by independent workers, and the results of research into the psychiatric profile of the remand population being undertaken by Professor Gunn and his colleagues.

Of course, to speak of the needs of the population, and the needs of an establishment is but to speak of the needs of our patients. It is so easy to speak in abstract terms; yet we have made it our mission in the Directorate never to lose sight of the fact that ours is a Health Care Service for

Prisoners.

I want, therefore, to return to the patients themselves for the latter part of the time here; and explain what we are doing for prisoners with special needs, in particular those with mental health problems, those with drug dependency and substance abuse problems, and those with, or at risk of, infectious diseases, notably HIV, Hepatitis B and tuberculosis.

With regard to mentally disordered offenders, a study by Professor John Gunn et al, of the Institute of Psychiatry, which was published in October 1991, revealed that an estimated 38.8 per cent (ie, 14,718) of the total sentenced population, suffered some form of psychiatric disorder.

A further study, this time of mentally disordered remand prisoners, by Dr Adrian Grounds et al of the Institute of Criminology in Cambridge, issued in July 1991, found that remands in custody of the mentally disordered were too often carried out not because of the nature of their offences, but because of their need for social and psychiatric help. They were being remanded primarily for the purpose of psychiatric assessment: 'an inefficient, ineffective and inhumane way of securing psychiatric assessment and treatment', to quote Dr Grounds.

In 1990 a joint committee of members from the Department of Health and the Home Office, under the chairmanship of Dr John Reed, was set up to review the health and social services available to mentally disordered prisoners. Subsequently, recommendations were made in a final report in November 1992. As a result, we are now working to develop a strategy for early identification and transfer of mentally disordered offenders to outside psychiatric facilities, and where that is not appropriate or achievable, for the provision of equivalent care within the prison service. Significant improvements in the number of mentally ill patients transferred to hospitals within the terms of the Mental Health Act 1983 have occurred in the last three years.

In February 1993 a new psychiatric unit was opened in Brixton prison; and is being staffed partly by a NHS psychiatric team.

Increasing cooperation between sectors within an establishment, and between the Prison Service and outside agencies is leading to some improvement in the care and treatment of disordered offenders, for example, longer out-of-cell hours, and visits by voluntary agencies such as the Samaritans. But nothing can compensate for the correct placing of patients diagnosed as in need of treatment in purposely resourced and appropriately staffed hospitals.

The second group of patients with special needs to which I would draw your attention contains those for whom drug dependency or misuse is a major problem. Dr Gunn, in his report referred to earlier, estimated that 19.6 per cent (i.e. 7,500) of the sentenced population had such a problem. Numbers amongst the remand population are thought likely to be higher.

To address the needs of this group we issued guidelines in April 1991 to help establishments tackle the problem. This was followed by a resource manual, *Caring for Drug Users*, which was produced by a multi-disciplinary group of experts both from the Prison Service and outside agencies. It stresses the need for a multi-disciplinary approach, and contains information on drugs and the impact of HIV, together with in-formation about community-based services, counselling, and treatment options.

To give further help to drug misusers, most prisons have established links with district Health Authority Drug Advisory Committees, and have appropriate voluntary groups visiting prisoners. Some have also developed specific throughcare programmes for drug abusers.

In many respects work with this group of prisoners overlaps work with HIV/AIDS infected prisoners, many of whom come from the drug scene. With this third group of prisoners with special needs, the HIV/AIDS infected, we have developed a three-fold strategy: to prevent the spread of infection; to protect the health of staff and inmates; and to provide care and support for those infected.

A manual *AIDS and HIV Infection: a Multi-disciplinary Approach* was produced and issued in 1991 to everyone in the Prison Service involved with the care and support of prisoners with HIV. It stresses the importance of education and counselling; and both these aspects have been taken forward successfully by the multi-disciplinary approach. All establishments now have trained HIV counsellors and trained support officers. Outside agencies have also contributed to the success.

A wide ranging review of the HIV/AIDS policy has recently been undertaken by my AIDS Advisory Committee, and this review is currently

under consideration by the Prison Board. At the same time we are up-dating the strategy for the management of drug misusers.

It is particularly with the groups with special needs that we recognise the importance of continuity of treatment; and we are encouraging establishments to form links with appropriate agencies and voluntary bodies so that prisoners have continued treatment, care and support when they leave prison.

This cooperation of many disciplines both within and without the prison walls brings me to my final point: a concern for all our prisoner patients, not just those with special needs. Within the prison the health component impinges on every aspect of prison life – it is a core function of a prison, and the responsibility of every member of the establishment, not least the prisoner himself.

Beyond the prison walls, we now recognise, are other medical and caring services whose expertise will enhance our own health care service for prisoners. We are looking forward to our NHS colleagues working with us in prisons.

Out in the community are many agencies and individuals who can give help and support to our prisoner patients on release from prison. We take heed to the thrust of the Government White Paper, *The Health of the Nation*, when it speaks of alliances between health services and the community; and we shall be doing all we can to foster links between our Health Care Service for Prisoners and the community.

We in the Health Care Service for Prisoners, I hope I have shown you, are fast leaving behind the isolation and backwardness which marked the old Prison Medical Service. Now we are in the vanguard of health care reforms, seeking to incorporate into our Service, all that is best practice in the NHS, and taking the initiative ourselves to develop new ideas and practices in some instances.

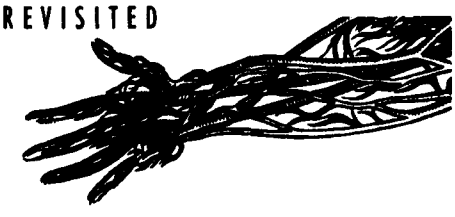
We have health care staff with a rising level of training and professionalism, who are imbued with our new caring ethos, and committed to according to their patients the same right to courtesy and consideration that patients in the community have.

Goal fever revisited? ..... Certainly clinical practice and health care regimes are still, as yet, subject to the constraints of the prison system, its buildings, its custodial regimes, and its limited facilities and resources for health care, just as they were when the first doctors were appointed to prisons; but there the comparison ends.

Despite these constraints and despite the fact that we serve a population presenting us with some of the most intractable of health problems, we are aiming with confidence and determination to give all our patients access to a level of service equal to the best available in the community.

Health care for prisoners today has already improved beyond all recognition from yesterday; and tomorrow it will be even better ■

THE PERRIE LECTURES 1994 GAOL FEVER REVISITED



PRISON MEDICINE & SOCIAL JUSTICE

Joe Sim
Professor of Criminology
Institute of Crime, Justice and Welfare Studies
School of Social Science
Liverpool John Moores University

In an editorial in the *British Medical Journal* in December 1993, Professor Ronald Laporte, Head of the Department of Epidemiology at the University of Pittsburgh commented that "we know considerably more about the global numbers of eagles, sperm whales and bison than we know about the number and distribution of people who are unemployed, sick or hungry in our societies" (*The Guardian*, 31 December 1993). Professor Laporte might also have added the category of prisoners' health and ill-health to his list because despite a long history of controversy and concern around

prison health care and its delivery the medical needs of sick prisoners and indeed their number and distribution still remain relatively unexplored. This is why I welcome the theme of this year's Perrie lectures. In my view the question of health care for prisoners today is one of the most important issues confronting the contemporary prison system.

In this lecture I want to address the issue by exploring three inter-related themes. First, what have been the important influences on the historical development of medical care in prisons? Second, what changes have occurred since 1992 and will these changes resolve the series of criticisms that have been levelled at the old Prison Medical Service (PMS)? Finally, what kind of care should be available to the confined in our society? This last question raises a series of philosophical **and** political questions which in my view go to the heart not only of the health debate but the prison debate in general.

Historical Context

In 1990 my book *Medical Power in Prisons* was published (Sim, 1990). This book was the first criticial account of the origins, development and consolidation of the PMS between 1774 and 1989. One of my concerns in the book was to move beyond the evolutionary view that had dominated previous histories of the PMS. This view with its emphasis on the benevolent march of scientific progress had underpinned both official and academic accounts of prison medicine. As my research developed it became clear that there was an alternative history to the PMS which was not about enlightened progression. Rather many prison medical workers had operated from a position which perceived prisoners as being less eligible for medical care. It followed therefore that medical provision as with every other aspect of prison regimes, was set at a level **lower** than the care and attention received by the so-called law-abiding beyond the prison gates. This was no historical accident but was the result of a series of complex processes in which prison medical personnel were active agents in constructing the parameters for health care inside.

At the same time the historical evidence also pointed to the role of medical personnel in the management and regulation of prisoners and their concern with caring for the order of the prison rather than ordering care for the prisoner. As I noted women prisoners were particularly affected by this managerial drive. In writing this revisionist history I was **not** denying the care and attention that individual doctors and nurses demonstrated (and continue to demonstrate) towards the sick in prison. But these benevolent concerns, in my view, had to be set against another deeply embedded and highly influential set of discourses with their emphasis on discipline and control which not only had been ignored in official histories but which often had a dire and detrimental impact on the confined. To take one example that had remained unexplored prior to my research. In the 1880s and 1890s there was, as now, a deep concern about deaths in custody and the relationship between these deaths and the discipline of the prison regime. This relationship was explored in *The Lancet* and the *British Medical Journal* at the time. Prison doctors were heavily involved in this debate but not simply in relation to their role as neutral dispensers of medical care. Rather they had their own views about the level of penal discipline which was necessary for the maintenance of order both inside and outside the walls of the penitentiary. In March 1895, R.F. Quinton, the M.O. at Wandsworth outlined his position when he argued that he:

'yielded to none in the desire to shield the prisoner from the consequences of his own misconduct or it may be misfortune; but as the Home Secretary pointed out in the circular to which your correspondent alluded, it must be remembered that prisons are places of penal discipline, not places where prisoners may retire to recruit their health with a view to fitting them for hard work on their discharge'

(cited in Sim, op. cit., 51-2)

Two weeks later Dr. Thornton, another medical officer, was even more forthright:

It is not always remembered by writers that the inmates of a prison are largely made up of the scum of our population ready for any disturbance if the government is lax, and lax prison management is not a kindness nor is it safe (Ibid).

The idea that prisoners generally were less eligible and that some in particular were sources of potential disorder continued to be cental to the discourses that underpinned

prison medicine into the twentieth century. The development of psychotropic drugs in the 1950s and 1960s only reinforced the role and commitment of many medical personnel to the management of order. As one wrote in 1962:

During the year an increasing use has been made of the psychotropic drugs. Largactil has been used mainly due to personal experience of it and as a standard to compare the effects of others... It has been found useful in controlling prisoners who were always at odds with authority... The climate situation and inaccessibility for visits are further causes of resentment against authority.....(Prisoners) can be given further help from Largactil before they resort to acts of indiscipline to relieve their feelings (Ibid, 90).

Between 1962 and the establishment of the Gwynn Inquiry and 1992 when the *Health for All Conference* declared the cessation of the PMS and the establishment of the Health Care Service for Prisoners, the concern about and criticisms of the Service became intensified as a range of different individuals and groups highlighted a series of issues abut the role and place of medicine in prison.

As Adam Sampson has pointed out, between 1986 and 1992 alone there were a succession of reports of "unquestionable authority" which raised serious questions about the work of the PMS: the reports by the Royal College of Physicians and the Social Services Committee of the House of Commons; the Woolf Report; Gunn, Madden and Swinton's analysis of psychiatric provision for the mentally disordered; almost all of the reports from the Chief Inspector of Prisons and repeated verdicts returned in coroners' courts. (Sampson, 1992, 3). Others could be added to this list: the work of pressure groups like *Inquest* and *Women in Prison* who have pointed to the questions of suicides and deaths in custody particularly in relation to lack of care verdicts and the specific problems confined women have experienced with prison medicine in relation to both care **and** control (cited in Sim, op cit); Ward's analysis of the operation of Section 47 of the Mental Health Act in relation to the disproportionate number of ethnic minority prisoners transferred to hospital (cited in Grounds, 1990/1); Deborah Cheney's recent research on the lack of health care provision for immigration prisoners (Cheney, 1993); and Wandsworth Community Health Council's report on its local prison which highlighted a series of complaints from prisoners including the long wait for optical and dental services, the treatment of possible HIV positive prisoners by segregation, sick prisoners having to stand for long periods waiting to see the MO and poor provision for personal hygiene. (Wandsworth Community Health Council, 1992, 5).

I do not want to dwell on this history but I do want to repeat one important point that Adrian Grounds made in his 1990 Perrie Lecture, namely that the "themes which dominate contemporary discussions are not new in origin" but that these debates "have deeper and more pervasive historical roots" (Grounds, op. cit, 31). I would also add that there is a strong tendency to deny this history which in doing so not only denies the complexities behind the development of medical care in prison but also opens up the serious likelihood that those who plan and provide medical care inside will fail to learn the lessons of history and that the mistakes of the past will be repeated and reproduced.

It is with these points in mind that I now turn to the most recent developments in health care provision for prisoners.

The Health Care Service for Prisoners

As I noted above, the *Health for All Conference* in 1992 saw the inauguration of the Health Care Service for Prisoners. As many of you will be aware this development came on the back of the recommendations made by the Government Efficiency Unit's scrutiny of the PMS. Despite the limited terms of reference of the scrutiny team, the efficiency review has been welcomed by many commentators as heralding a new beginning for medicine inside. It also has far-reaching implications for the way that medical care is to be organised including: the rationalisation of existing health care services; the contracting in of specialist and other services; the development of co-ordinated health promotion programmes; and the establishment and maintenance of effective programmes for prisoners with special needs. (Home Office, 1992, 5.)

However laudable some of these aims might be, for example, the new emphasis on health promotion, I want to suggest that in practice the proposed changes will not alleviate the problems of health care for prisoners and indeed, through the

introduction of contracting in, may exacerbate them.

In order to sustain this argument I want to focus on the question of the prevention of illness and disease. One of the key elements in illness prevention is the promotion of a healthy diet, appropriate exercise and a healthy and safe environment. The problem is, as a number of commentators have argued, prisons are not healthy places either physically or psychologically but in practice undermine the goals of a healthy lifestyle. Indeed, given the arguments that I made earlier, I would maintain that prisons cannot by definition be healthy places because of the continuing emphasis on making life difficult and uncomfortable for prisoners. In the current febrile law and order climate how can prison regimes including health care services be positively maintained and match services outside the walls against a background which is emphasising "austerity" in these same regimes?

Take the issue of diet and food preparation. In the case of the latter this is often done in kitchens which as the Association of Members of Boards of Visitors has pointed out suffer from "chronic, deep-seated cockroach infestations because basic design faults allow easy access... [they are] cockroach motorways". In addition, the use of hot cabinets on wings, the transportation of food to the wings, the handling practices adopted in, and the staffing of, prison kitchens all raise serious questions about the place of diet in the promotion of prison health (Association of Members of Boards of Visitors, 1992, 3-4). In his most recent publication , the Chief Inspector of Prisons noted that it was disappointing to have to report that:

In 1992/93 as in previous years prisoners rarely had anything complimentary to say about their meals. The complaints remain much the same: poor quality; small portions; poor presentation; lack of variety; poor hygiene standards; inadequate servery facilities producing less than hot food; and meal-times compressed to suit the convenience of staff. Although we found some complaints were exaggerated the vast majority had some foundation. (Home Office, 1993a, 14.)

Many here will be familiar with this argument but the point I want to make is that those absolutely key elements which are necessary for the health of prisoners are still being undercut by the continuing emphasis on punishment and regulation. How can a prisoner have a healthy lifestyle if basic commodities such as food and exercise provision are restricted? Those who defend the new health care system maintain that the situation is improving but I would suggest that close examination of official reports reveals a different picture. These reports indicate how low prisoners remain on the ladder of expenditure in terms of food and exercise provision. In the financial year ending in March 1993, expenditure on catering in prisons was £39million or 3.5 per cent of the Total Establishments' Operating Costs. For physical education the corresponding figure was £16.5million or 1.5 per cent of operating costs. Altogether therefore five per cent of the operating costs of prisons in 1992/3 was attributed to catering and physical education. At the same time £10.9million or nearly one per cent of operating costs was spent on prison dogs. The total amount allocated to prisoner care was £171million or 15.1 per cent of the total. On the other hand the money allocated to prisoner control was £463million or 41 per cent of the total and to administration and other costs £230million or 20.4 per cent of the total. (Home Office, 1993b, 3.)

My own research with Phil Scraton and Paula Skidmore into food provision in Peterhead Prison in the late 1980's produced an even starker picture. In 1987 the Scottish Office spent 81 pence on each prisoner per day. Peterhead catering staff were also allowed a discretionary payment to buy extras to season and garnish food. In 1986 they were allowed to spend 34 pence per prisoner per week, or just under five pence a day. (Scraton, Sim and Skidmore, 1991, 53.) I do not want to get embroiled in the financial statistics of the Home Office which in their presentation seem to become more complicated with each passing year. I do want to make the point, however, that even if one was to accept the parameters of the new health care system inside – which I do not – it is important to realise that this system is being confronted by a culture of power still based on the principles of less eligibility which undermines any move towards a more humane or benevolent delivery of health provision. The perception of prisoners as less eligible still cuts through the politics and culture of the prison system in this country and remains a potent force in the delivery of prison regimes, whatever the stated intentions of those who staff the new

health care service might be.

At the same time, the impact of the prison on the psychological health of the confined adds another dimension to the debate about health provision. The research with my colleagues in Peterhead revealed that many prisoners perceived the prison as a dangerous place. This had a hugely detrimental impact on their psychological well-being. (Scraton, Sim and Skidmore, op. cit., Ch.3). This issue will not be new to many here. However the point is that male prisons in particular are not **naturally** dangerous places. Rather they are dominated by a culture of masculinity which encourages solving problems through coercion, violence and aggression. Both staff and prisoners are caught up in this masculinist web which in turn generates stress, tension and illness. The number of assaults, the number of prisoners held in vulnerable prisoner units and the question of bullying have all been highlighted in the recent report by the Chief Inspector of Prisons as having a detrimental impact on individual prisoners. For Judge Tumim the solution to these problems lies in the closer involvement of staff with prisoners.

I believe that this solution is too idealistic. Undoubtedly there are individual members of staff who do exemplary work in defusing violent confrontations inside and curtailing the influence of predatory prisoners and prison officers. Against this, however, is the lack of support that these officers receive from within their own ranks, the stress and tension which this in turn generates and the recurring emphasis on coercive strategies to maintain order inside which only intensifies this stress and tension and generates further psychological problems for them. What I am suggesting, therefore, is that it is the culture of masculinity and the power networks that flow from it that need to be problematised and deconstructed if some kind of psychological health is to be generated for staff and prisoners. Concentrating on difficult or dangerous or weak or so-called inadequate prisoners merely individualises the problem and reduces the complex issues around psychological ill-health to one of individual pathology.

This point I believe can also be applied to the question of physical health provision inside the new service. There is a great danger, in my view, in following a policy which seeks to over-emphasise the individual's responsibility for his or her own health. This policy which resonates with the present government's obsession with individual and market-tested solutions to every social issue places the onus firmly on the shoulders of the individual prisoner. Undoubtedly many of those who come into prison have a range of health problems associated with alcohol and/or drug abuse. But the answer to this problem does not lie in simply focusing on this one area of the individual's behaviour. As the survey published by the Prison Reform Trust in 1991 indicated, prisoners also suffer from lack of employment opportunities, housing and welfare provision. (Prison Reform Trust, 1991). Research on women in the criminal justice system has also revealed these problems as well as the particular problems that women experience outside of prison in terms of domestic violence, sexual abuse and sexual harassment. (Carlen et al, 1985).

What I am suggesting therefore is that there are a series of structural questions which also need to be highlighted and which also raise questions of responsibility, but this time state responsibility for provision in a range of welfare and therapeutic areas. To talk simply or solely in terms of individual responsibility shifts the focus of attention away from the structural and denies the impact that the lack of wider social provision has on individual lives. It tends to scapegoat and pathologise the individual for failures in the system. So while smoking should be discouraged among prisoners (and in the wider society) the complex reasons **why** individuals smoke need also to be addressed. Current policies concentrate on the how question of individual prevention rather than on the why question of social context. Women, for example, may smoke in order to relieve the stress and tension generated by their structural location in our society, by the fear of actual or threatened violence or by the feminization of poverty which has occurred in the last two decades. By concentrating on the individual smoker the complex web of social processes that lead to this social action are neglected and marginalised.

I am not denying the importance of constructing a social order within prison in which responsibility is a central element in the individual's life. The Barlinnie Special Unit has provided a brilliant example of how this can operate. But responsibility cuts both ways, attempting to encourage prisoners to be responsible without a visible increase in the commitment, scope and level of responsibility of the state to its citizens and a

concomitant increase in democratic accountability will result in failure. It will lack legitimacy in the eyes of the confined.

Contracting In

I want now to turn to the question of contracting in. This strategy has been developed out of the recommendation of the Scrutiny Report that the Prison Service should become a purchaser of health care services through contracts with the NHS or other providers. The Report also argued that the principles and practices of contracting in should be extended to the purchase of packages of services as distinct from the services of individuals (Home Office, 1992, 4).

Four years ago in his Perrie Lecture Adrian Grounds raised a series of concerns about contracting in which emanated from the initial Scrutiny Report. These included: the fact that the report failed to explore the feasibility of its central proposals; the failure to address a number of administrative questions; the simplification of the relationship between treatment and clinical responsibility; the lack of any independent external monitoring of medical care in prison and finally the commodification of welfare and medical care in which both can be bought and sold on the market. (Grounds, op cit, 38-9). Four years on I would argue that not only are these criticisms still important and valid but that the experience of the National Health Service during this time has only added to my conviction that contracting in is not a viable option for prisoners or indeed that free market principles are appropriate for the delivery of health care in general. There are a number of reasons why I take this position.

First, it has been pointed out that contracting in is not a new phenomenon. Almost half of all prison doctors are GPs who work part-time in prisons while each year tens of thousands of treatments and consultations are carried out by visiting specialists. While the Director of Health Care is therefore quite correct to point out that there has always been contracting for prison medical services, it could be argued that such contracting was and is part of the problem **not** part of the solution to health care inside. Visiting specialists and part-time medical officers worked in prisons at precisely the time when the various criticisms of the PMS that I outlined earlier were at their most intense. Contracting therefore has been and still remains problematic because it fails to confront the culture of less eligibility, the prisoner as malingerer, difficult or a nuisance. The Scottish prison system provides another example, there has never been a separate PMS in Scotland, medical treatment has been carried out by specialists coming in from the outside. And yet, many of the criticisms which have been raised about medical treatment in Scottish prisons parallel the criticisms in England and Wales. Contracting in therefore does not have a good track record historically.

The second problem with contracting in is that it means that the purchaser model which underpins it switches the main determinant of health outcomes from "need to demand". This in turn is likely to fragment health care provision and "undermine the notion of a unified service". Strategic assessment of need will be secondary to a set of aggregate health outcomes determined by the "many purchasing decisions" that are made. (Holiday, 1992, 78-9). It could be argued that what prisoners require is a coherent strategy which is more responsive to need rather than one in which need is subservient to demand.

Third, as Ian Holiday has noted, the drive towards increased choice and autonomy is likely to result in decreased equality and social justice. Efficiency is produced by competition rather than by attempts at strategic planning (Ibid, 79-80). Again I would maintain that it is precisely the lack of strategic planning and the consequent failure to deliver medical or social justice to prisoners that has been at the root of the problem in the PMS. Therefore to push forward with plans for even greater individual choice will only intensify this problem.

Fourth, the idea of choice in the new market driven NHS is based on the notion of free floating individuals operating equally in the open market. But clearly there is a contradiction here, prisoners do not have a choice[1]. Medical care and treatment will still be based on choices made for them by health care specialists. It is difficult to see in the various documents that have been produced where choice and autonomy will

1. I am grateful to my colleague Gillian Hall for pointing this out to me.

be developed for prisoners. The answer is that they are not there because prison in general is based on denying autonomy and choice which are subservient to the demands of the institution.

Finally, I would maintain that what has happened in the NHS is not a good advertisement for restructuring medical care along free market lines. As Will Hutton has pointed out what has happened is the emergence of a two tier system in a social situation in which Britain spends less as a proportion of its GDP on health than it did in the mid-1970s. Purchasers and providers are competing for a slice of a health cake that is becoming smaller in a market that is becoming increasingly dominated by administrators and accountants and where information is increasingly controlled by reference to financial or contractual confidentiality (Hutton, 1994, 15). In that context dramatic decisions are being made about cost; which diseases cost more to treat, who has an esoteric or a difficult illness, who is curable and who is incurable? Look at three reports that have appeared in the last nine months. In June 1993 it was reported that trustees of the Government's Independent Living Fund had decided to stop giving financial support to terminally ill people. Under this change people would not be eligible for money if they were receiving disability allowances under the special rules for those considered at risk of dying within six months. People with Aids were likely to be amongst those hardest hit. (*The Guardian* 15 June 1993). In September the report of the National Confidential Enquiry Into Perioperative Deaths 1991/1992 was published. The report blamed a shortage of facilities, unsupervised surgery by junior doctors and a lack of research for causing postoperative deaths. It identified four problems: lack of an operating theatre reserved for emergencies; inadequate intensive care facilities which left some operations for old and sick people little chance of success; emergency operations at night on old and sick patients by unsupervised doctors in training grades; and poor standards in the appointment of locum doctors. Seven thousand consultants were invited to take part in the investigation "but 24% declined to do so, often because they could not find the case notes or other medical records" (*The Guardian* 8 September 1993). And finally in March 1994 the question of the limits to free health care for people with long-term illnesses was discussed in the House of Commons. In particular, MPs pointed to the possibility that if doctors deemed a patient ready for discharge and the social services arranged further care then the individual would face a means test and could have to pay (*The Guardian* 10 March 1994).

Is this the kind of model that is seriously being suggested for medical care in prisons in this country even if funding remains with the Home Office rather than with the Department of Health? There is a real danger in my view that prison medical workers will be forced to make decisions which, like the issue around passing prisoners fit for punishment, will compromise their ethical position. What we might see emerging is not a two tier health system but a four tier system comprising of the ordinary respectable sick, the respectable but expensive sick, sick prisoners and finally those prisoners whose treatment might be costly. I think therefore it is idealistic to talk about market driven medical care as the answer to the crisis in prison medicine and naive to think that particular groups in the prison population – women, HIV prisoners, sex offenders and the mentally damaged – will not suffer as a result of this switch from need to demand.

What is to be Done?

I want to conclude by making three points which I think are central to the way forward for prison health in particular and the prison system in general. First, there needs to be a huge reduction in the prison population in this country with a concomitant increase in different and alternative centres outside of prison for the treatment of alcoholism, drug dependency, mental disability and individuals with HIV. Separate facilities should be made available for women in these categories. Prisons should therefore become places of last resort, not the first stop on what often proves to be a grim institutional journey for these groups.

I am aware that this point has been consistently made for a number of years by a range of different individuals and groups within and without prisons. I am also aware that the power to introduce these policies does not lie in the hands of those who work in health care in prisons. However, I would argue that the principles underpinning the new health care system in prison take as given the idea that prison is the appropriate place to deal with these groups. One of the

strategies identified by the current Director is "the setting up and maintenance of effective programmes for prisoners with special needs". (Home Office, 1992, 35). I do not agree with this. As the Howard League has pointed out "there should not be special treatment centres for drug addicts or alcoholics inside prisons as this would only encourage their being sent to prison" (Howard League for Penal Reform, 1990, 2).

Second, and allied to this, there needs to be a complete redistribution of resources within the prison system and in the criminal justice system in general. The £7 billion that are now being spent on law and order are proving largely ineffectual in dealing with the problems of crime and disorder. It is therefore not a question of putting more resources into the criminal justice system or of privatising parts to save money or even of efficiency savings. The strategy should be to question how resources are spent in the context of needs, not in the context of efficiency or savings or political expediency. Does our society really need another six prisons when, as Adam Sampson has noted, the new programme for sex offenders announced on 7 June 1991 will not receive any increase in resources? The programme will have to be staffed and funded out of existing resources which as Sampson notes may make it "doomed before it has begun" (Sampson, 1994, 198-201).

Third, and perhaps more controversially for a number of people here, I would argue that the idea that medicine in its present form can provide the answer to a range of physical and psychological problems needs to be reconsidered. I have already indicated that a substantial improvement in the physical environment is a key component in the generation of individual health. A range of sociological studies have made this point.

It is a point as I have said that can also be applied to prisons. Concentrating simply on the individual's responsibility for his or her health denies the impact of the wider social environment and reinforces individual rather than collective responses to social issues.

I would argue that this point can be extended to the question of psychiatric health as well. Psychiatric discourse both within and without prisons has been highly successful in creating an intellectual, political and policy platform for itself as the discipline most likely to offer solutions to crime and deviance. And yet as Jill Peay has pointed out, even in the area where psychiatry might appear to have an edge – that is in dealing with the mentally disordered offender – there is confusion within the profession for example around the definition of psychopathy, how long treatment will take, whether treatment will work or whether on completion it has worked. As she notes "there are inherent limits to treatment. The whole area remains a quagmire, underlining how little is known about treating 'criminality' **per se**" (Peay, 1994, 1148). The most recent report by the Chief Inspector of Prisons also points to the continuing problems within the existing system: psychiatric reports and care of psychiatric patients still often rest with prison medical officers who have no special training in psychiatry; gravely ill patients being kept for several weeks when they should have been in a psychiatric hospital; relatively low staffing levels compared to the NHS; "and a shortage of staff with appropriate therapeutic skills, a situation compounded by not being able to treat the more florid disorders" (Home Office 1993a, 45). As Don Grubin has wryly observed, the situation is unlikely to get any easier:

> *When it comes to resources the mentally disordered offender must compete with hip replacements, famine in Africa and the railways. In the present economic and political climate success is most likely to be achieved if it can be demonstrated that failure to do anything will cost more than what is being recommended. (Grubin, 1993, VI)*

Quite clearly there is a question of resources here in relation to these offenders but again I would argue that if there is a major increase in resources it is **how** these resources are spent that is the key question. More psychiatry is not necessarily the answer. As Pat Carlen has pointed out, the overt intervention of psychiatry into the lives of offending women has often exacerbated their problems through medicalization. Surely she maintains:

> *It is not in the public interest for mentally and emotionally disturbed women to be sentenced to penal regimes which send them out less able to cope than before they were imprisoned? ... Mentally and emotionally damaged women should by and large* **not** *be in prison and when, because of the seriousness of their crime, they have to be locked up they should be held in an entirely different type of*

establishment to those in which women are currently imprisoned. (Carlen, 1990, 29-30 emphasis in the original).

Psychiatry's defence has often rested on the claim to protect us from the dangerous offender. But even here there are problems because quite clearly while there are individuals in prisons and state mental hospitals who do pose a threat to particular groups in our society, are these the only dangerous individuals? What about the 'normal' man who routinely uses domestic violence or the white racist who routinely attacks Asian people or the building site manager or factory owner who deliberately ignores health and safety regulations which leads to death and destruction? The many women who are violently abused, the Asians who are racially attacked and the two hundred thousand people who die each year on a world wide basis through 'accidents' at work might all have something to say about the definitions of dangerousness which psychiatry and we as a society operate from.

In taking this position I am not being totally nihilistic. There have been some excellent programmes developed in the last two decades which have attempted to change offending behaviour. These have ranged from the Barlinnie Special Unit through to Grendon Underwood and onto Parkhust 'C' Wing. All of these institutions have employed and continue to employ individuals trained in psychiatry and psychology and have generated programmes for offenders which have had a huge impact on their personal psyches. The recent Guardian report on Bob Johnson's work in Parkhust is a good example of this tradition (*The Guardian* 5 March 1994). What distinguishes these programmes is the attempt to deal with the individual as a whole human being; that punishment and discipline are subservient to empowerment and support; and that offending behaviour is understood as part of a continuum rather than in terms of the old positivist distinction between normality and abnormality with its particular and simplistic distinction between dangerous and non-dangerous offenders.

I do not want to idealise these institutions nor underestimate the problems and stress generated for those who work in them, problems which often come from those within the prison service who see such institutions as an 'easy' option. But I do want to say, in conclusion, that these institutions may offer a kind of blueprint for future penal arrangements for those who need to be confined. That confinement needs to take place within a political context in which prisons as places of punishment are decentred and become places of last resort; places which have a series of social, educational and psychotherapeutic programmes which are **not** separated from similar programmes in the wider community; and places which are staffed by individuals who are not regarded as strange and deviant by their colleagues but who are democratically accountable for their actions.

In this situation we may finally attain some kind of medical justice for the confined and perhaps social justice for all citizens in our society irrespective of their status as free or unfree individuals ■

References
Association of Members of Boards of Visitors (1992) 'Prison Kitchens' in **AMBOV**, 47, October, 3-4
Carlen, P. et al (1985) **Criminal Women**, Cambridge, Polity
Carlen, P. (1990) **Alternatives to Women's Imprisonment**, Buckingham, Open University Press
Cheney, D. (1993) **Into the Dark Tunnel**, London, Prison Reform Trust
Grounds, A. (1990/1) 'The Mentally Disordered in Prison' in **Prison Service Journal**, 81, Winter, 29-40
Grubin, D. (1993) 'Editorial: Services for Mentally Disordered Offenders' in **Criminal Behaviour and Mental Health**, 3, III-VI
The Guardian 15 June 1993
The Guardian 8 September 1993
The Guardian 31 December 1993
The Guardian 5 March 1994
The Guardian 10 March 1994
Holiday, I. (1992) **The NHS Transformed**, Manchester : Baseline Books
Home Office (1992) **Prison Health**, 4, July. London : Home Office
Home Office (1993a) **Report of Her Majesty's Chief Inspector Of Prisons**, April 1992 - March 1993, London, HMSO
Home Office (1993b) **H.M. Prison Service Annual Report and Accounts**, April 1992 -March 1993, Vol. 2, London, HMSO
Howard League for Penal Prison (1990) **Medical Reform Service**, London, Howard League for Penal Reform
Hutton, W. (1994) 'Equality is the Casualty of an Unhealthy Market' in **The Guardian** 10 January, 1994
Peay, J. (1994) 'Mentally Disordered Offenders' in Maguire, M., Morgan, R., and Reiner, R.(eds) **The Oxford Handbook of Criminology**, Oxford, Clarendon Press, 1119-1160
Prison Reform Trust (1991) **The Identikit Prisoner**, London, Prison Reform Trust
Sampson, A. (1992) 'Crisis in the Prison Medical Service' in **Physicians for Human Rights (UK) Medicine within Prison Report of the Conference**, 3-4
Sampson, A. (1994) 'The Future of Sex Offenders in Prison' in Player, E., and Jenkins, M., (eds) **Prisons After Woolf**, London, Routledge
Scraton, P., Sim, J., and Skidmore, P. (1991) **Prisons Under Protest** Buckingham, Open University Press
Sim, J. (1990) **Medical Power in Prisons**, Buckingham, Open University Press
Wandsworth Community Health Council (1992) **Health Care of Prisoners in H.M. Prison Wandsworth** London, Wandsworth Community Health Council

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THE FACILITIES AVAILABLE FOR OFFENDERS REQUIRING PSYCHIATRIC CARE IN THE USA

"... closed psychiatric hospitals being reopened as jails ... with prisoners having been previously patients in the hospital ..."

Neil Bellamy,
Winston Churchill Fellow 1993, Director of Nursing, The Retreat Hospital, York.

There is considerable concern among many health care professionals with regard to the growing number of mentally ill people caught up in the penal system who require more appropriate and effective care. For example, there are many patients in our Special Hospitals who are waiting to move into Regional Secure Units (RSU's) but who, due to the lack of facilities, remain on long waiting lists.

My Fellowship has enabled me to visit Washington, Philadelphia, New York and Boston, where I was able to examine the effectiveness of the psychiatric care offered to offenders in these cities. Of particular interest were the alternatives open to sentencing authorities, and in particular, the role of institutional and community psychiatric services.

A common theme over the last few decades has been the declining role of large mental hospitals in long term care. In the USA this process has been going on for over 25 years. Most professionals within health care would agree that Community Care is preferable to large mental hospitals. In the USA available beds have reduced from 559,000 to 110,000. It is the opinion of most health care people whom I met that the provisions made available within the community have not been sufficient to support those discharged from hospitals which were closing or reducing beds.

In all the cities I visited, hostels for the homeless have more than doubled, with a high percentage of people using them having a related mental illness. The hostels cater for only a small proportion of the homeless and many more are sleeping on the streets, many of who again have a history of mental illness. There is an ever-increasing number of ex-patients and newly mentally ill people finding their way into the prison system through either drugs or alcohol related crime. Staff in the prison system confirm that these increases coincide with the de-institutional programme.

One of the most worrying consequences of this lack of strategy is the way in which closed psychiatric hospitals are themselves being re-opened as prisons.

Washington

The Substance Abuse and Mental Health Services Administration offices are just outside Washington and their purpose is to strengthen the Nation's delivery system for prevention and treatment for addictive and mental disorders.

The numbers of Americans with a mental illness is estimated at 52 million, an estimated 21 million are chemically dependent and over 37 million American citizens receive no medical care, due to having no medical cover.

Due to the contracting of psychiatric hospital beds there has been a considerable rise in the mentally ill in the jails (short term) and prisons (long term). There are also examples of closed psychiatric hospitals being reopened as jails and/or prisons, with prisoners having previously been patients in the hospital, which is now their jail.

Ninety per cent of drug users in prison have a mental health problem.

Philadelphia

Greaterford Prison is a maximum security prison for people serving life sentences for murder, arson or rape.

The prison has 4000 inmates. Of these, 600 are at present receiving some

form of psychiatric help. There are at present 77 prisoners who are diagnosed as having Aids and 75 per cent of the prisoners are illiterate. Fifteen per cent of the prison population were receiving some form of psychiatric care, but there were no trained psychiatric nursing staff working in the hospital wing. The only appropriate trained staff were one part time psychiatrist and a full time psychologist.

Facilities are not designed to cater for this large number. For the more acutely ill, there is the possibility of transfer to the prison's psychiatric hospital which has only 19 beds. The remaining prisoners receive support from the hospital staff who see prisoners in their cells.

The conditions inside the prison were poor, and when I was taken round one of the prison wings I was struck by the small size of the cells and the unwholesome smells.

There was a workshop for prisoners to do woodwork, art and craft and looking at some of the work on show, it was clear that some of the prisoners were very talented. There is certainly a shortage of appropriately qualified staff in all disciplines. The impression that I received was that trained mental nurses would be welcomed, to work alongside general nurses. The problem appears to be lack of money.

One of the biggest problems within the prison was the high percentage of prisoners who were drug dependant, and the fact that prison officers, seeking financial gain or under duress of blackmail, would supply drugs to the prisoners.

Putting these problems into context, Dr Sador told me that two psychiatric hospitals had closed in 1987, Cresson Hospital and The Retreat (ironic!). Both have recently reopened but as prisons, clearly showing that the de-institution-alisation of psychiatric hospitals has failed, and that the development of community mental health centres has not been sufficient.

New York

Sing Sing Correctional Facility

Sing Sing is situated up the Hudson River and about 30 miles outside of New York and was one of the very early prisons to be built, and is probably the only prison in the world where a train service runs directly through the prison.

The prison was built by prisoners who claimed the granite from the land, and the scenes in the films where prisoners are digging for stone are taken from the building of Sing Sing, many films have been shot at Sing Sing.

Sing Sing is a security level maximum A prison (similar to Greaterford).

Sing Sing has a population of 2276 prisoners, of whom approximately 1300 are deemed to have a mental illness.

Compared to some of the other prison mental health units I visited this was reasonably well staffed.

The Staff consisted of the Unit Chief, 2.4 wte psychiatrists, four psychologists, two recreational workers, 5.4 wte Registered Nurses and two admin clerks. Working alongside these staff are the prison officers. Again no trained psychiatric nurses were employed.

The Mental Health Unit had facilities for 22 prisoners. The Unit comprised a 16 bed dormitory and six single secure observation beds for the more acutely disturbed.

There is also an intermediate Care Programme Unit for 60 prisoners; this serves seriously and persistently mentally ill prisoners who cannot be maintained in the general prison population.

Very careful screening is essential, as many prisoners will fake illness to go into the hospital unit. There could be a number of reasons for this; it may be quieter than their prison wing, they may be under threat from another inmate or they would like to get at an inmate already in the hospital unit.

The majority of prisoners in Sing Sing are black and Hispanic; whites count for a small percentage, and many cannot read or write.

Montefiore Mental Health Programme at Rikers Island

Rikers island is situated in the borough of Queens, New York, and is the largest municipal jail in the world, with a population of 14,000. At its height, when CRACK first became available, Rikers island saw an increase of up to 18,000.

Everyday 10,000 prisoners will go through the courts in New York and 110,000 prisoners will go through Rikers Island Detention Centre every year, with an average length of detention of eight to nine months.

Montefiore hospital has 450 beds designated for health care, and in addition a communicable disease unit providing a

further 140 beds. The hospital is therefore a substantial facility with a correspondingly large number of staff.

A comprehensive range of services are staffed by more than 160 professionals and support personnel that work closely with medical staff and the Department of Correction to identify and provide co-ordinated care to patients with psychiatric illness and substance abuse disorders.

It was a matter of surprise that there were no psychiatric nursing staff working in the hospital. Dennis Shoen had been asking for appropriately qualified nursing staff for some time, but, as in so many similar facilities, funding had been a major obstacle.

Twenty six per cent of new admissions are referred for mental health evaluation. Each of the 10 facilities has mental health clinics that provide evaluations as well as treatment for the inmates. Patients evaluated as depressed or psychotic are assigned to mental observation units where they receive individual and group therapies from a multi-disciplinary staff consisting of social workers, psychologists and psychiatrists.

Two thirds of all persons entering the New York City Department of Correction and approximately 90 per cent of mental health patients report a history of illicit drug use.

The hospital is serving increasing numbers of HIV positive persons in all its facilities. HIV/AIDS is a serious problem with an estimated 16 per cent (Male) and 24 per cent (Female) seropositive status.

The numbers of successful suicides has significantly decreased since the early 1980's from more than 12 per year to fewer than three per year. This decline is directly related to Montefiore's presence.

As part of the methadone detoxification programme, Montefiore has introduced a KEEP (Key Extended Entry Process) programme in order to offer limited methadone maintenance for certain inmates and has significantly reduced needle use during the crucial period following discharge from prison.

Dennis Shoen, Assistant Director, pointed out that the closure of psychiatric hospitals has led to an escalation in the number of mentally ill and homeless people in Rikers island and on the streets of New York.

Looking at the wider social issues, there has got to be an improvement in the community education programmes and school systems, particularly in the poor areas. This is necessary if children are to be educated at a sufficiently early age to keep away from crime and drugs. The scale of the problem can be understood when it is realised that 25 per cent of black Americans have been involved in crime, and that in Harlem and the Bronx, the figure is even higher.

There is also a desperate need to provide more psychiatric community centres, hostels, and day care which have programmes for those with dual diagnosis of drugs abuse and psychiatric illness.

Boston

Suffolk County House of Correction

The Suffolk County House of Correction contracts to Correctional Healthcare Solutions, a private company, to provide a full range of mental health services to the prison population. The contract is renewable every three years.

Suffolk County House of Correction is a purpose built facility designed to house 850 prisoners. It has now a population of 1380 including almost 70 women, with many prisoners doubling up. There has been no additional building. Single cell occupation is very limited.

Statistics show that 59 per cent of prisoners are black, 20.9 per cent are white, 19.1 per cent are hispanic and 0.67 per cent are Asian. The age ranges are highest in the Male 30-39 year old group and the Women 20-29 year old group.

Thirty eight per cent of crimes are drug/alcohol related, 17 per cent are property crime, 22 per cent are personal assault, 88 per cent are sex crimes and 22 per cent others.

Of the 1380 prisoners, 37 per cent have previous convictions.

The mental health care programme includes one full time Psychologist, three full time mental health clinicians, and 10 hours a week of psychiatrist coverage. As in some of the other facilities visited, no Registered Mental Nurses are employed, but Registered General Nurses are. The psychology staff provides mental health screening for staff and training to prison officers.

It was drawn to my attention, that there is an increased number of mentally ill people finding their way into the prison system. It was pointed out that many of

those convicted had committed only petty offences but due to a lack of community support networks, day care or partial hospitals had found themselves in prison.

In all the cities that I visited, the increase in Hostel accommodation was noticeable, in Washington, the old Department of Correction building is a hostel for the homeless (700 beds), in New York, the old Bellevue Hospital is a homeless hostel of around 1000 beds and in Boston there is a very efficient homeless organisation, where buses will collect the homeless each night and take them to an old prison now a hostel on Long Island. There they receive a meal and a change of clothing and are returned to the streets of Boston the following morning.

It is estimated that 80 per cent of all the homeless will have a mental illness, in addition, 80 per cent will have either a drug or alcohol problem.

Recommendations

The key lessons to be learnt from the experience of the United States are:

1. The strategy for Community Care must be reviewed, especially with regard to the major cities.

2. The range of services required by mentally ill people must be identified. This range should include the in-patient facilities needed to back-up social and health support in the community.

3. The strategy must clearly indicate how the range of needs will be met and realistically show where there will be areas of unmet need.

4. There must be clear lines of responsibility for the implementation of the strategy.

5. On the assumption that there will still be prisoners with psychiatric problems, there is a need to provide professional support. Non-clinical prison staff must also receive formal training to identify potential psychiatric problems.

6. Evidence from the United States shows the real need to train police officers in how to deal with people who show signs of psychiatric illness. This is especially so in the major cities.

It is my opinion that if we continue with our present policies in this country we could develop a system of care replicating many of the negative features observed during my visit. There is no doubt that the mentally ill deserve better ■

PRISONS PARTNERSHIPS

DIVERSION FROM CUSTODY FOR MENTALLY DISORDERED OFFENDERS

Catherine Staite - Director North Humberside MIND, Member - Board of Visitors, HMP Hull

The problem of Diversion from Custody for mentally disordered offenders has achieved some prominence in recent years. The joint Home Office and Department of Health circular 66/90 highlighted the duties of all agencies in the criminal justice system and health and social welfare agencies to meet the needs of this group. The committee chaired by Dr John Reed added weight to this message in its report in 1992.

The climate of change has been further enhanced by the availability of funding, such as the Mental Illness Specific Grant, and additional funding from the Department of Health and Home Office, for improvements and enhancements to health and social services to facilitate diversion from custody. However, this has lead to a rather

piecemeal approach to diversion from custody.

Diversion schemes vary enormously. Some schemes concentrate on assessment by psychiatrists or community psychiatric nurses at Magistrates Court, to facilitate diversion from custody, especially to hospital.

Other schemes operate by bringing together representatives of the various agencies after the first court appearance by the mentally disordered offender. This 'panel' discuss the best outcome for the client and agree a multi-agency package of care, including community care services and a health care programme where appropriate.

Information about care available is presented to the Magistrates Court to facilitate a decision in favour of remand on bail or a non-custodial sentence.

In North Humberside, a Diversion Project has been developed by a multi-agency steering group chaired by the Director of North Humberside MIND. The Steering Group manages, via a small management sub-group, a Project Team, comprising a probation officer, an approved social worker and two community psychiatric nurses. The team members assess persons in police custody, and assist with diversion from the police station. They also assess prisoners at Court, in co-operation with a rota of psychiatrists. When mentally disordered offenders are identified the team will arrange a package of care, including for example, psychiatric outpatient care, appropriate housing and bail support. The Project has recently been evaluated by the Centre for Systems Studies at the University of Hull. The evaluation showed an 85% success rate in diverting mentally disordered offenders from custody. The re-offending rate was only 12% in the first year of operation.

In addition to being the only Diversion Project in which MIND is the lead agency, the North Humberside Diversion Project is distinguished by the close working relationship between itself and the local prison, HMP Hull. This is particularly noteworthy because prisons are usually outside the network of arrangements which enable agencies in the community to co-operate to provide mental health care.

The Police and Social Services are organised and managed locally and are accountable to the local authority. The Probation Service, Health Commissioners and Health Provider.

Trusts are managed by boards of local people and their focus is on the responsibilities which lie within their own boundaries.

The Prison Service is very different from other agencies operating within the area it serves. It is a national agency. Development and change within the Prison Service is decided in London as part of a National Strategy. This can lead to the exclusion of prisons from local partnerships and working arrangements.

The isolation of prisons has been exacerbated in the past by the self-sufficiency of the Prison Service. There was, until recently, little need to have much contact with the outside world. It is as if in our midst, prisoners and people who work in the prison service are exiles in their own country.

The barriers which created that exile situation are gradually being broken down. Privatisations and market testing of prisons, contracting out of parts of the work of prisons, devolution of purchasing budgets to individual establishments, have all contributed to a gradual erosion of the fortress-like isolation of the prison service. While there are many who would argue that these changes are morally or economically indefensible, it is not the purpose of this article to make judgements but to sketch the picture, as it is, not as it perhaps should be. A broad understanding of the process and progress of change within the prison system will inform consideration of opportunities for further development and change which may be of benefit to mentally disordered offenders.

As part of this larger pattern of change, changes have also taken place in the prison medical service, and in the way in which the prison provides for the health and social care needs of its inmates.

Devolution of health care budgets may enable the prison to create a mixed economy of care where some aspects of health care for mentally disordered offenders continue to be provided by prison medical and nursing staff, while other needs are met by services purchased elsewhere.

Although health commissioning by prisons is not yet widespread, it provides an opportunity for the prison to become stake-holders in the purchasing of local services and increases the chances of a better service for mentally disordered offenders in prisons. Joint commissioning also helps to emphasise that prisoners are not 'elsewhere' or in exile,

they are here, and along with the rest of the population require good quality and comprehensive services to meet their individual needs. If the prison contributes to the cost of providing a forensic psychiatrist in the community, it will be entitled to demand the same standard of care for its mentally disordered inmates as they would have had had they been in the community, or in a mental hospital.

Diversion from custody systems, if they were in effective operation throughout the country, would dramatically reduce the number of mentally disordered offenders remanded or sentenced to custody. However, there is always likely to be a small residual prison population of mentally disordered offenders, for a number of reasons. Therefore the prison will have to continue to make some provision to meet their needs, even as their numbers decline. A substantial reduction in the number of mentally disordered offenders in the prison should make it easier for the prison to meet the needs of those remaining.

Where efforts to divert mentally disordered offenders have failed or are not appropriate the prison becomes responsible for the care of prisoners who have less serious problems. Transfer to hospital will not be necessary or appropriate but such prisoners nevertheless have special needs. Vulnerable prisoner units may be able to provide an adequate level of care and support for mentally ill prisoners or those with learning disabilities. However, places may not always be available and the mentally disordered offender may therefore not fit in with the rest of the unit population and be as isolated and threatened as they would have been in a normal location within the prison system. When in the community, such individuals may be able to access a range of caring and support services including contact with a CPN, a key worker, out-patient visits to a psychiatrist, attendance at a day centre run by social services or a voluntary organisation such as North Humberside MIND.

In the prison these services are not available. The only statutory social care agency which operates within the prison is Probation. Due to the high ratio of prisoners to probation officers, the probation service within the prison may have a very limited role. It cannot be all things to all inmates although it is often expected to undertake a wide variety of work such as responsibility for prisoners' welfare and working with prisoners to confront offending behaviour. The prison probation service, with its existing establishment, cannot provide a comprehensive social support service for mentally disordered offenders.

It could be argued that prison officers should contribute to the provision of services to meet the welfare and social care needs of prisoners. Some prison officers do attempt to fill this role, for example in establishments and units which have a personal officer system. However, it is difficult to combine a caring role with a custodial function. There are also many other demands on a prison officer's time.

In some prisons, voluntary organisations such as the Samaritans, MIND, various drug agencies, and prison visitors make a valuable additional input to the social care available. However, the availability of such services varies from prison to prison and is often dependant on inadequate and insecure funding.

Prison chaplains also provide pastoral care within prisons. Many are part-time and may be limited in their effectiveness by the lack of anyone to whom to refer the sort of problems that they are not able to solve.

It could be argued that the service should be expanded to fill this gap, but this would re-enforce the tendency to see the problem as one which could be solved by one agency alone. Such a solution would also lead to the prison being seen as an acceptable destination for mentally disordered offenders.

Should the prison provide such services and mirror the range of care and support services provided in the community?

This is a real dilemma for the Prison Service. Prisons seem already to operate as emergency substitutes for bail hostels, mental hospitals and de-toxification units.

Would, therefore, the provision of a wider range of social care services for mentally disordered offenders within the prison exacerbate an existing tendency to use the prisons as a dumping ground? If the prison could provide an acceptable substitute for care in the community, would it be swamped by a sudden influx of inmates who would previously have been diverted in order to receive those services in the community?

This does not solve the problems of those who do end up in prison and who still need health and social care maintenance.

One way in which the prison can resolve this dilemma is to become involved, as HMP Hull has done, with all the local

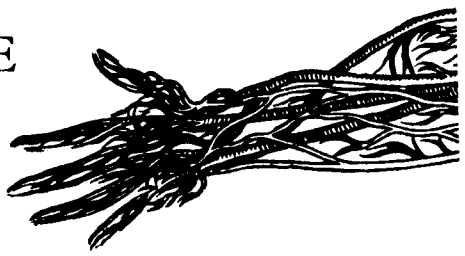
agencies in solving local problems relating to mentally disordered offenders.

Joint commissioning with health and social services of some additional responsive services should help the prison to meet the individual needs of prisoners who cannot be diverted for any reason without creating a system of care which would encourage sentencers and others to feel that prison is a good way of accessing services for this group ■

The writer is co-author of a new book, together with Neill Martin (Senior Probation Officer), Michael Bingham (Police Inspector) and Rannoch Daly (Governor, HMP Hull). **'A Practical Guide to Diversion from Custody for Mentally Disordered Offender'** Longmans 1994.

COMMUNITY CARE FOR MENTALLY DISORDERED OFFENDERS

THE EXPERIENCE OF THE WESSEX PROJECT



Mary Barker
Project Researcher and a Research Fellow in the Department of Law at the University of Bristol.
and
Barbara Swyer
Project Manager

Diverting persistent criminals from prison is not one of my hobby-horses. I believe that bad people must be punished and have happily signed up with the Howard League - Michael's that is. Nevertheless, standing on the centre at 12.00 hrs watching the prisoners pass by with their meals I invariably see the familiar faces of men who are clearly disordered. They deserve our help. Defining the mentally disordered offender is a minefield - I would not put the percentage as high as some - but it is beyond dispute that we lock up a good number of such men who are not a threat to life and limb and who are not going to rob a bank. They will steal the milk or the odd bottle of wine. They cannot cope in our society unaided. Finding an effective alternative to gaol is in everyone's interest. That is what the Wessex Project is all about. Hence, at Winchester we were pleased to offer our full co-operation. I am delighted that prison officers, as well as doctors, are working with the team. It is a project worthy of our support.

Michael Pascoe, Governor HMP Winchester

Bob is a persistent minor offender. He suffers recurrent mental health problems, exacerbated by drug-taking and occasional alcohol abuse. His behaviour follows a pattern - committing relatively minor offences, being remanded in custody and offending again within days of release. He has been received into prison five times in the past year.

Criteria for sectioning under the Mental Health Act 1983 exclude Bob. He is not usually ill enough. On only one occasion has his remand in custody resulted in him being transferred to hospital. More usually he is offered a voluntary place in hospital which invariably breaks down. He leaves, returns home and the familiar cycle begins again; except that his offending becomes more aggressive and threatening with each turn of the wheel.

Breaking the cycle: the Wessex Project

Bob is one of a number causing growing concern amongst criminal justice

agencies, health and social services - stuck, as he is, in the 'revolving door' between the inappropriate environment of the criminal justice system, and inaccessible services in the community. Estimates of the numbers of mentally disordered offenders amongst the prison population vary, but the Institute of Psychiatry's finding that 30 percent of sentenced prisoners show signs of mental disorder (Gunn et.al., 1990) indicates that there may be many more offenders in Bob's situation. The Wessex Project, which began life as the Wessex Mentally Disordered Offenders Scheme, was set up to ensure comprehensive assessment of those like Bob and to help them to access appropriate community services on their release from prison.

The project was initiated by a group of senior managers from a number of agencies in the Hampshire area. It grew out of a concern to improve general health care for prisoners in the area, though it quickly became apparent that the major health issue was the number of prisoners manifesting mental disorders. The group's response was to establish a team of seconded personnel from health and social services and the probation service, led by a project manager and evaluated by a researcher from Bristol University. Following a model that is becoming increasingly common for such initiatives, the project is funded by both charitable funding, in this case the Mental Health Foundation, and by the statutory agencies. It's lifespan is intended to be three years.

The aim of the project is to establish an inter-agency network of referral from within prisons holding Hampshire prisoners, and to co-ordinate care and services for the mentally disordered to be taken up on their release. In effect, the project acts as the link between the prison and community services.

Identifying and assessing mentally disordered offenders

The initial focus of the project has been Hampshire's sentenced male prison population, and has been based in Winchester Prison. Partly as an attempt to identify as many of the potential client group as possible, and partly so as to gain an impression of the extent of mental disorder amongst Hampshire's sentenced male prison population, the project has carried out a programme of mental health screening in Winchester Prison. For the past year, every newly sentenced prisoner coming into the prison has been interviewed with a view to establishing whether the prisoner has any current or past mental health problem, the nature of that problem and any previous psychiatric involvement. If prisoners give any cause for concern, they are interviewed again within two weeks of their reception, this time at greater length.

Project workers apply the definition of mental disorder as determined by the Mental Health Act 1983, and hence are looking for signs of mental illness, personality disorders and mental impairment. They assess but do not diagnose. Close to 800 prisoners were interviewed during the recently completed screening period, about 13 percent of whom warranted some sort of follow-up by the project team. This figure excludes those whose primary problem appears to concern drugs or alcohol. This latter group are referred to the prison probation service who may be able to offer, or in turn refer them on to, appropriate services. The majority of the 13 percent who have received further attention have been the mentally ill depressive illnesses and schizophrenia being the predominant diagnoses. Smaller numbers of prisoners were found to have personality disorders, learning disabilities or were sexual offenders with no underlying mental disorder.

Winchester Prison has a relatively large hospital and is fortunate in having medical staff with training in psychiatry. Consequently, the prison hospital has become central to the project's operation, and a good working relationship has developed such that medical officers will either offer a diagnosis or arrange for a medical examination of prisoners referred to them.

In the near future, the project will begin a period of mental health screening of prisoners newly remanded into Winchester. One of the project's aims is to produce a mental health profile of all types of Hampshire prisoner, including those in young offenders institutions and in women's prisons.

A basis for collaboration with other agencies working in the prison has gradually taken shape and the network of referral has spread wider than the prison hospital. Regular contributions by the project to training sessions for prison officers has helped spread the word about what the Wessex Project is trying to achieve. The project has established a presence in the

prison such that prison officers are beginning to refer prisoners about whom they have concerns, and will involve project staff in decisions.

Community care for mentally disordered offenders

To describe the project's work within the prison is to present only half the picture. The real aim of the project is to increase access to care for mentally disordered offenders by improving liaison between the prison and community services, so that prisoners can be released into networks of care and services. It is hoped that by supporting the ex-prisoner in the community, the chances of his re-entering the criminal justice system can be reduced. This support is being arranged through community care using, in particular, the Department of Health's Care Programme Approach and Social Services care management. Both initiatives provide continuing care for people with mental health problems living in, or returning to the community. This provision is now being extended to prisoners. The case of Robert explains how the system can work.

Case history: Robert

When he was put in contact with the project, Robert had just begun a 21 month sentence in Winchester Prison and had recently been diagnosed as a paranoid schizophrenic. His conviction was for unlawful sexual intercourse and causing actual bodily harm, both offences involving his step-daughter. Two psychiatric reports had been written, one connecting his offences to his mental health problem, the other refuting such a connection. However, the medical officer at the prison agreed to keep Robert in Winchester in order to monitor his mental health. When first seen by the project, Robert was depressed and anxious about the possibilities for returning home once released.

After consultation with Robert, the prison medical officer and others prison staff involved in his care, the project team organised a care programme meeting. The priorities at this stage were to secure an address to which Robert could be released, to arrange support and medical services for his release and to ascertain from social services the likelihood of Robert being allowed to return home. Present at this first meeting were the consultant psychiatrist, the probation through-care officer, the children's social worker, a member of the Wessex Project team and the client. The upshot of this meeting was that Robert's medication and accommodation were arranged for the period immediately after his release. It was made clear to him that there was no immediate prospect of him returning home.

Just after Robert's release on licence, a second care programme meeting was held. The same services were represented as at the first meeting though some personnel had changed. Robert's full programme of support and care was formalised at this meeting. His probation officer was nominated key worker, giving him overall responsibility for ensuring that the care programme was delivered as agreed, and providing Robert with a named person to go to in times of crisis. The consultant psychiatrist and his team committed themselves to providing Robert's medication and monitoring his mental illness. Local child protection services agreed to conduct a risk assessment in relation to Robert's eventual return home.

At present, Robert is being maintained successfully in the community. His psychiatric condition is under control, he is settled in his own bedsit and is enjoying twice weekly access to his children. He awaits the outcome of the risk assessment.

Robert's case highlights the need to be proactive in providing services for mentally disordered offenders, and demonstrates the value of becoming involved well before the offender is released or discharged. Decisions about release can be informed and the support system set up ready for the offender's release. A co-ordinated approach may mean the difference between a successful return to the community and a break-down resulting in reinvolvement in the criminal justice system. However, a planned release into community care does demand some reorganisation of services and cannot be achieved without co-operation from the prison service, in particular the prison medical service. The project has been fortunate in Winchester in finding medical officers and staff responsive to ideals of continued care for offenders beyond the bounds of the prison walls.

There is no question that Robert has received a level of services and structured support unlikely in another context. Achieving a 'successful' return to the

community in cases such as Robert's may simply mean stabilising the ex-offender's mental health and living conditions. The value of the care programme approach is that this can be set in a structure, where all agencies share responsibility for monitoring and maintaining his mental health and social care. As with any group of mental health service users, the problem for those working with mentally disordered ex-offenders is to make arrangements for care flexible enough to respond to the crises which may occur, without allowing the individual's situation to deteriorate.

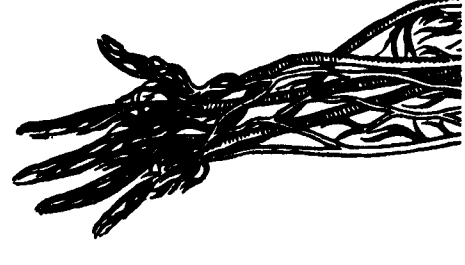
The substance of what is offered to mentally disordered offenders through care planning and the care programme approach is clearly not new. No doubt there have been, and are, many examples of good practice in working with such offenders. The difference is that the new structures allow professionals to move from good practice into best practice - from providing services in isolation to providing a carefully woven net of care.

The work done with Robert illustrates the need for a catalyst such as that provided by the Wessex Project. Until community cafe is commonly available and organised for released prisoners, the initiative is unlikely to be taken by criminal justice professionals except those with enough confidence and experience to risk working in what are, at present, uncharted waters.

Progress and the future for the Wessex Project

The initiative has another two years to run, but success in the first year of operation has given the team confidence that real work can be done to improve the care of mentally disordered offenders in the community. The governor of Winchester Prison and his staff have welcomed and thoroughly support what the project is trying to achieve. Professionals both inside and outside the prison express relief that now they can get help in arranging services for mentally disordered offenders about whom they have concerns. The research accompanying the project is documenting both its achievements and its failures. On this basis, it will be possible to report on the feasibility of community care for mentally disordered offenders ■

THE DURHAM PSYCHIATRIC PILOT



"... a comprehensive service bought in under contract from the National Health Service."

Dr R. G. M. Mitchell, Director of Health Care, HM Prison Old Elvet, Durham, DH1 3HU.

In the aftermath of the scrutiny report and those of Gunn Woolf and Tumim into various and varied aspects of the old Prison Medical Service, consideration was given to a number of ways by which the perceived deficiencies in service for the mentally disordered offender might be addressed. The Durham Pilot was conceived as one approach to redressing the deficiency by seeking to provide a comprehensive service bought in under contract from the National Health Service.

There are three Prison establishments within Durham City limits, HMP Durham, HMP Frankland and HMRC Low Newton, each different and differing from the others. It was decided to try to provide psychiatric services for all three prisons under the one contract despite their different needs.

HMP Durham is a large Victorian local which also contains a small high security wing for female prisoners and additionally serves as the in-patient facility for a number of satellite prisons. For the past

three years, Durham has been and will, for the next two years, be undergoing a major refurbishment with a variable CNA as individual wings close and reopen. This has meant that it is always at or near capacity and has meant that there is a constant need to move prisoners onwards to other establishments, in order to have space for the endless and unpredictable input from the Courts.

HMRC Low Newton accommodates young male as well as young and adult female prisoners on remand. It has small in-patient facilities for each sex but lacks full-time nursing cover.

HMP Frankland is a dispersal prison with accommodation for 430 inmates, with a fully staffed in-patient facility which can cope with physically disabled prisoners. Frankland also is the base for the NE area Forensic Psychology unit.

Initially, discussions were conducted with the Newcastle Area health Authority by the Governor, the Senior Medical Officer and a member of the PMS headquarters staff; however it quickly became apparent that the absence of secure accommodation in Newcastle would severely limit the proposed providers' ability to meet the developing service specification with the result that South Tees Community and Health Service was invited to join the discussions. From this point the discussions increased in frequency as the prison side refined its estimates of requirements and the provider consortium began to calculate its manpower needs to service them. Budgetary limitations soon made it apparent that a fully comprehensive seamless service was impossible on the grounds of cost and that it was necessary to reduce the level of provision initially incorporated. Chemical substance abuse was an area thought to be capable of being better managed outside the contract while the cost of tertiary referrals was better controlled by the Health Care Service staff. Eventually after nearly three years, and innumerable changes of negotiating personnel, agreement was finally reached in early 1993 on the service specification and costings and the service was introduced on 5 May 1993, some three weeks before the contract was officially signed.

Both the provider units had acquired 'Trust' status by this time and each supplied consultant forensic and general psychiatrists supported by senior registrars and community psychiatric nurses. In addition Newcastle provided a consultant adolescent forensic psychiatrist to work in Low Newton and clinical psychologists to work in cooperation with the forensic psychology staff from Frankland at all three prisons. A senior community psychiatric nurse was appointed to co-ordinate the activity of the several different members of staff, to arrange the allocation of referrals, to locate beds for patients being transferred to NHS hospitals and to facilitate such transfers. The co-ordinator also monitors the work done, collates the statistics, serves as the link between the Health Care staff and the Mental Health Team, acting as the trouble-shooter, and finally chairs the weekly clinical meetings and the monthly joint departmental meetings.

Broadly, the work referred to the Mental Health Team falls into three areas:

a) Prisoners who are identified as showing past or present evidence of mental disturbance and who therefore need assessment with or without ongoing treatment. This forms the bulk of patient referrals.

b) Prisoners who threaten or indulge in self-harming activity or attempt suicide.

c) Prisoners who require an assessment and psychiatric report for court purposes, F75, sentence planning, parole board, etc.

Referrals to the Mental Health Team are mainly made by the prison medical officers, as a result of the screening of new receptions. Prisoners on the wings can be referred by discipline or health care staff when their behaviour is seen to change, indeed anyone coming into contact with prisoners is encouraged to refer an inmate for assessment and/or treatment if they have any concern for his or her mental wellbeing. Increasingly the Courts are requesting psychiatric assessments of their clients, these together with the statutory reports for sentence planning, F75s, etc, constitute a considerable part of the workload of the Mental Health Team. Referral can be made directly to whichever member of the Team is seen to be most appropriate, for example, community psychiatric nurse, psychologist, etc.

Psychiatric assessments are to full NHS standards which causes some delay and concern, no longer does the prison medical officer send a brief voluntary note to a Court on a prisoner's state of mind, as

we have done in the past, psychiatric reports are only sent when requested and then only after full documentation has been obtained. At Durham, we felt that on occasion this may deprive the courts of valuable information.

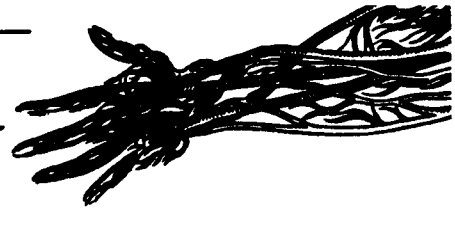
Treatment is on an out-patient basis although where necessary 'at risk' patients can be admitted to the Health Care Centre under care of the duty medical officer, with the psychiatrist available for further consultation or advice. Formal in-patient care necessitates transfer to an NHS facility using the appropriate section of the Mental Health Act. Transfer to a bed not directly controlled by members of the Mental Health team is, on occasion, managed without a tertiary referral and the associated additional expense. However, we still frequently and frustratingly make such referrals only to find the patient is refused on the grounds of being too much of a risk for the intended facility.

In addition to the care of mentally disordered prisoners there are training initiatives for the staff of the purchasers as well as the providers. Research into the mental health of the prisoner population is also being pursued. Members of the Mental Health Team have become involved in the Multidisciplinary Suicide Awareness Team as well as other areas of prison life and activity.

Staff at each of the prisons have expressed satisfaction with the enhanced service provided by the 'Pilot' and it is clearly proving to be quantitatively successful. Within the next month we expect to commission an external and independent appraisal of the project which will examine the qualitative benefits to both prisoners and prisons, evaluating the cost benefits in order to justify the continuation of the Pilot Project beyond the initial three years. I can say without fear of contradiction that the medical, health care staff and the senior management at each prison will almost, without exception, be most reluctant to see the Pilot Project terminated for financial reasons ■

THE REED REPORT

MENTALLY DISORDERED OFFENDERS



Dr A. J. Phipps, MBBS DRCOG, MRCGP is Head of Health Care at HMP Frankland and is currently in the 2nd year of a part-time MBA degree with Sunderland Business School.

In my experience, prison staff rapidly identify inmates whose behaviour is in any way abnormal. On the landings, officers are able to observe the way an inmate functions in the routine of daily life, and from talking to him, will be able to gain some impression of how he 'ticks'. Inability to follow the daily routine (collecting meals, keeping rooms clean and in some degree of order) or difficulties in communication (bizarre talk, paranoia, shouting to himself at night) alert staff that an inmate has problems. Similarly, education staff work closely with inmates and quickly assess verbal and written communication. They may find that abnormalities of thought and fantasy are exposed in conversation, in writing and in art.

Inmates with some of the above problems will be referred for a psychiatric opinion. They may be found to be suffering from a mental disorder, a legal term defined in the Mental Health Act 1983 as 'mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind'.

When an inmate is diagnosed as having a mental disorder, for example, schizophrenia, the prison doctor and psychiatrist decide whether he can be transferred to a psychiatric hospital or must continue to be treated in prison. The former is the preferred outcome in most cases, but the overall demand for psychiatric beds is such that it is often difficult to achieve this. In addition, there are mentally disordered

offenders coming through the courts who need diversion for treatment in a psychiatric hospital rather than entry into the prison system.

These difficulties in transferring individuals from prison to hospital have been known for some time and the needs of mentally disordered offenders in general have been reviewed a number of times recently. The Glancy working party in 1974[1] suggested the provision of 1000 secure hospital places, whilst the Butler Committee in 1975[2] recommended the provision of 2000 places in secure hospital units of lesser security than Special Hospitals. These recommendations led to the medium (Regional) secure unit programme which had provided 600 beds by late 1992[3]. It is obvious that the number of beds achieved falls far short of the targets of both Glancy and Butler.

In 1990 a further review was set up under the chairmanship of Dr John Reed. The final report of the Reed review[3], published in November 1992, examined the Health and Social Services for mentally disordered offenders and others requiring similar services.

The five guiding principles that it identified are that patients should be cared for:

- with regard to the quality of care and proper attention to the needs of individuals;
- as far as possible, in the community, rather than in institutional settings;
- under conditions of no greater security than is justified by the degree of danger they present to themselves or to others;
- in such a way as to maximise rehabilitation and their chances of sustaining an independent life;
- as near as possible to their own home or families if they have them.

Reports were gathered from groups looking at service provision in the community, hospitals and prisons. Other groups were concerned with finance, staffing and training, research and academic development. The report made 276 recommendations to be applied to services in England. It emphasised multi-agency working using multi-professional teams linking for example, police, courts, probation, prison and NHS.

I will concentrate on those recommendations relevant to prison experience:

Assessment/diversion arrangements

There should be nationwide provision of properly resourced court assessment and diversion schemes. The latter are arrangements whereby a psychiatrist, community psychiatric nurse or approved social worker assess defendants suspected of being mentally disordered and advise the court on custodial alternatives. In 1992 Blumenthal and Wessely[4] did a national survey and found 48 establishment schemes with 34 under development. By October 1993 there were over 60 schemes established in England[5].

Medium secure provision

Medium secure hospital beds in NHS units, suitable for patients who are too difficult or dangerous for local hospitals but who do not require the higher security available at special hospitals, should be increased from 600 to 1500 nationally. A significant increase in the capital budget for medium secure provision was made by the government for 1992/93 for the building of new units and the report recommends that adequate resources should be provided in subsequent years to move towards the target.

Staffing

Consultant forensic psychiatrists should be increased from 70 (1992 figure) to over 150. If medium secure beds are increased as above, then over 2000 NHS nursing posts will be needed for these services. In addition, the resulting planned increase in community and medium secure unit work would create a need for more NHS clinical psychologists, more probation officers and more education staff.

The report also makes a number of recommendations in terms of medical and nursing training. It suggests that forensic issues are covered in medical student psychiatric training and that there are forensic training opportunities available after qualification. There are recommendations covering forensic training for community psychiatric nurses, more flexible training in forensic nursing and the enrolment of prison

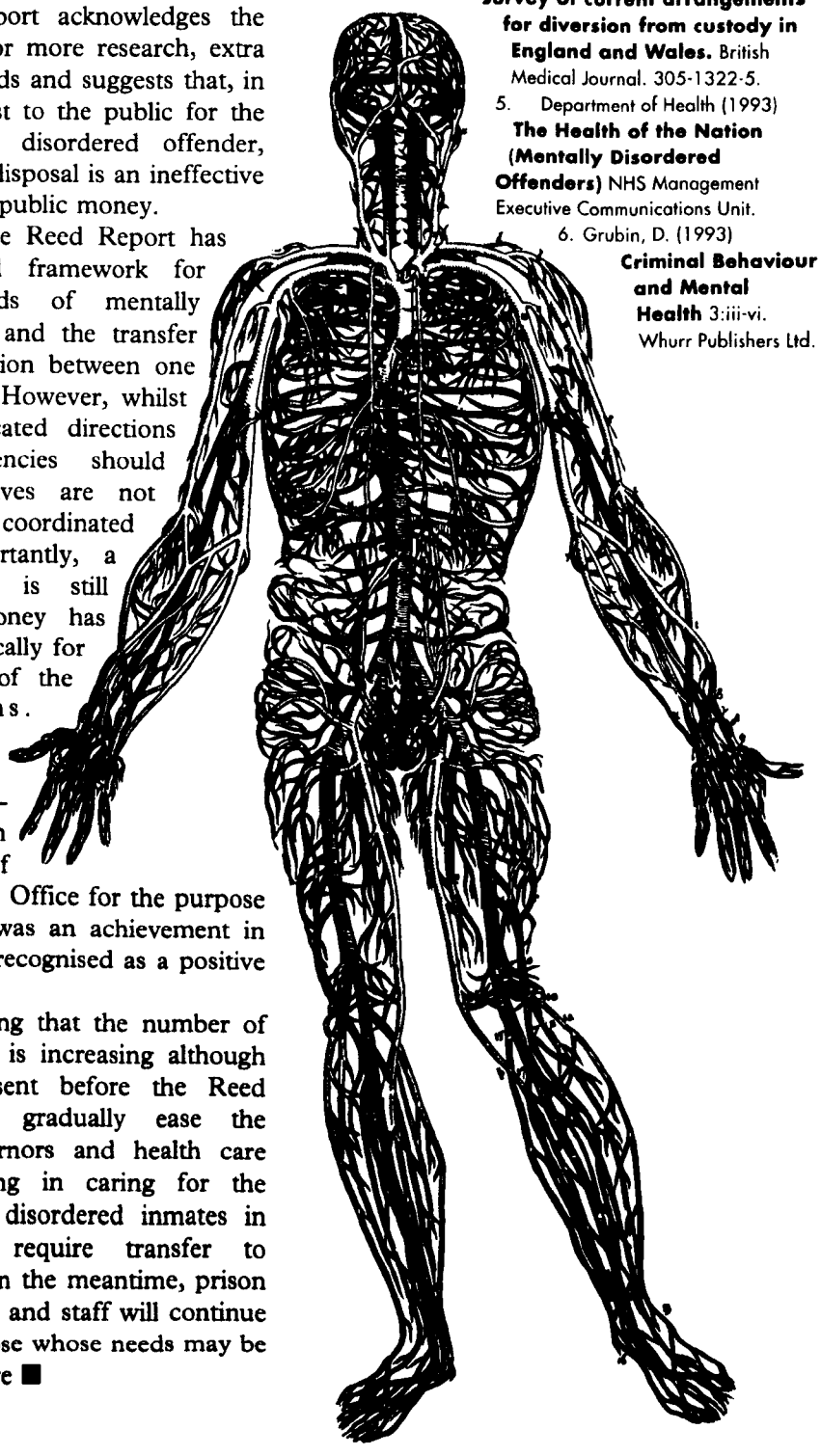
nurses on specialised English National Board (ENB) courses.

Financial resources

The report argues that financial arrangements should encourage community, rather than institutional care, of no greater security than is required, in order to follow Reed's guiding principles. The Reed Report has not costed most of its recommendations so the amount of money needed to finance the whole package of recommendations is unspecified. The report acknowledges the need for resources for more research, extra staff and training needs and suggests that, in terms of life-time cost to the public for the care of a mentally disordered offender, inappropriate prison disposal is an ineffective and inefficient use of public money.

I think that the Reed Report has established a useful framework for managing the needs of mentally disordered offenders and the transfer of care and cooperation between one agency and another. However, whilst the report has indicated directions that particular agencies should follow, these initiatives are not being managed or coordinated overall. More importantly, a ministerial response is still awaited and no money has been allocated specifically for the implementation of the recommendations. Grubin[6] has suggested however, that establishing communications between the Department of Health and the Home Office for the purpose of the Reed review was an achievement in itself, and should be recognised as a positive development.

It is encouraging that the number of medium secure beds is increasing although this trend was present before the Reed Report. This may gradually ease the problems that Governors and health care staff are experiencing in caring for the backlog of mentally disordered inmates in our prisons who require transfer to psychiatric hospital. In the meantime, prison health centre facilities and staff will continue to be stretched by those whose needs may be better served elsewhere ■



References

1. Department of Health and Social Security (1974) ' **Revised Report of the Working Party on Security in NHS Hospitals (Glancy Report).** HMSO, London.
2. Home Office, Department of Health and Social Security (1975) **Report of the Committee on Mentally Abnormal Offenders (Butler Report).** Cm 6244. HMSO, London.
3. Department of Health, Home Office (1992) **Review of Health and Social Services for Mentally Disordered Offenders and others requiring similar services (Reed Report).** Cm 2088. HMSO, London.
4. Blumenthal, S. and Wessely, S. (1992) **National survey of current arrangements for diversion from custody in England and Wales.** British Medical Journal. 305-1322-5.
5. Department of Health (1993) **The Health of the Nation (Mentally Disordered Offenders)** NHS Management Executive Communications Unit.
6. Grubin, D. (1993) **Criminal Behaviour and Mental Health** 3:iii-vi. Whurr Publishers Ltd.

Interview

HOLLY WELSH INTERVIEWS BRIAN LANDERS, DIRECTOR OF FINANCE (May 1994)

Holly Welsh: *Could you tell us a little bit about yourself – before you joined the Prison Service?*

Brian Landers: Yes. I've had a very interesting career with lots of career moves. I spent six years in insurance, two years in family planning, worked in manufacturing, worked in retail for a long time, especially with Sainsbury's, and I've worked overseas a lot. My last job was with Habitat which was to help turn round Habitat in the UK. They were going in the red – and then once we'd done that I took over responsibility for some of the international operations and my last job was managing director of Habitat Spain. Actually I was responsible for all Habitat's operations outside the UK and France. I'm married. I've got a son aged eight and a daughter aged six weeks. I live in Ealing and my wife is finance director of an NHS trust.

HW: *How did you come to be in this particular job?*

BL: I was head hunted. I was looking for a job back in the UK and I was looking for a job in the public sector – not specifically in prisons but this come up. I'd worked with Price Waterhouse before and it all come together.

HW: *Why did you want to go into the public sector?*

BL: Two reasons I think. I've always been interested in working in the public sector and I did politics at university specifically because I wanted to go into the public sector and then changed my mind when I found out something about it. I just felt that I wanted to do something a little bit more useful than flogging widgets. And the other side is because there's lots of things going on in the public sector. Most of the turn around situations in the private sector are not exactly petering out, but things like Habitat – we've turned it round and it's now very successful again – it's just a question of adding stores. And there's lots to do in the public sector.

HW: *What did you think the Service thought it was buying in you?*

BL: I think it thought it was buying two things: one was just a fresh perspective and the second was the experience I've had. The actual experience in financial systems and financial control and IT control. I think it was the perspective and the culture as much as the actual knowledge. You really ought to ask Derek that.

HW: *What have you found most difficult?*

BL: It's certainly taken me longer to adjust than I expected. The most difficult thing is the culture. It's not that my preconceptions were proved wrong but I hadn't realised how different the culture was – the strength of the differences in the culture.

HW: *Can you give me a couple of specifics?*

BL: Things take much longer here because you've got to consult a lot more people. On things like procurement there are a lot of regulations that you don't have in the private sector so you can't make quick decisions. There's much more of a consensus building approach which is very positive – that side of it's very positive. The actual way of working – the way of working on paper I find distinctive – I find it a real pain at times.

HW: *Does that mean you've had to change your time-scales?*

BL: Well either I've got to change them or the people I work with have got to change theirs and I hope it'll end up somewhere in the middle. I've certainly got to change my way of working – I mean I'm committing much more to paper than I ever have done but I still find that people who are working with me are probably committing less to paper than they used to.

HW: *You're under Treasury controls now that it's public money. Are there any freedoms that you get now that you did not have in a more commercial setting?*

BL: No, I don't think so.

HW: *It's all bad news?*

BL: Well it's not necessarily bad news – I mean at the end of the day it is the tax payers' money and we're spending an enormous amount of the tax payers' money and there ought to be those rules of propriety. They're very frustrating at times – especially the rules on procurement – but on the other hand you understand why they're there.

You know at the end of the day at Habitat if you'd gone bust it would have been some shareholders losing money. If you make a mess of things here then it's my tax and your tax.

HW: *One of the things that establishments are probably getting excited about – it could be the right word – is the devolvement of budgets, but there's also concern about whether the Finance EO or the HOMS is actually equipped to deal with devolvement and there's talk that accountants will have to be employed and that kind of thing. Can you see that happening or are we going to develop our own internal expertise and is that desirable?*

BL: That is a really difficult question and it's something that my views are changing on. I had understood before I came here that because there are so few accountants in the Prison Service there were significant weaknesses in financial management. I have to say in the establishments I've been to I haven't found that and I've been surprised at the quality of the HOMS that I've come across. Maybe I haven't visited typical establishments, but I think I probably have. There is certainly a need for more accountancy expertise and there's a need for more formalised financial training right throughout the organisation and it's not a problem just in establishments – it's a problem at headquarters as well. Whether bringing in accountants – especially private sector accountants – is the right answer I've got some doubts about. I think the Government is not very good at using accountancy expertise and it's not very good at developing its own accountancy expertise.

HW: *But you've come in with commercial expertise which is greatly valued, but you don't think that would be true further down the organisation?*

BL: I think there's a difference between saying that you can bring in commercial expertise to add to the organisation and saying that certain posts in the organisation have to be filled by people with commercial expertise. If you look, for example, at David Miller at S and T who's got a commercial background, I think his input has been very, very important and very useful, and there are some HOMS around with commercial backgrounds. If we look at the private sector, Blakenhurst has effectively got a head of finance with a commercial background and he's got a lot of strengths that some of our people haven't got, but the idea that every HOMS should have some sort of commercial accountancy training is quite wrong.

HW: *If we are going to employ better qualified people that would cost us, wouldn't it?*

BL: Yes, it would.

HW: So you wouldn't envisage actually granting money for that?

BL: Yes well wait a minute, that raises another question which is the whole philosophy – it does seem to me there's a certain amount of lip service to budget devolution because people talk about budget devolution and then say I want to be granted money for this or granted money for that. I mean budget devolution means exactly that – it means devolution of authority. If individual governors feel that their establishment is of a sufficient size and complexity to need accountancy expertise or any other expertise then they ought to be free to buy it. They would only do it if they thought it generated efficiencies and savings so by definition they don't need any extra grant. If you take the two extremes we've got in terms of budget – Belmarsh and East Sutton Park – it would be very difficult to see how you could justify an accountant at East Sutton Park under any consideration at all, but at Belmarsh there's £20 million – well that's a big business – there are publicly quoted companies on that sort of cost base.

HW: *Just to change tack a bit ...*

BL: Can we come back to budgetary devolution at some stage – it's something that I've got quite strong views about.

HW: *Okay, the Prison Service is demand led. Is there a point at which you think that you would go back to the Treasury and say we need some funds for central contingencies – for example is there a point where the prison population would get so high that we could actually say that we can't afford to provide the service on the allocation?*

BL: It doesn't really work like that – I mean that is what PES negotiation is about every year – we say this is the population forecast – this the money we're going to need to provide the places. This is why we need Fazakerley and Bridgend – this is why we need two extra house blocks and so on – the whole funding process is basically around cost per place and the number of places is one of the variables.

HW: *But there's been a very sharp increase in the prison population.*

BL: Yes, there has, but there's been a lot of new house blocks as well. Police cells is another issue, yes. There are all sorts of what are hopefully temporary operational problems that we ought to be able to sort out but if for some unexpected reason the population zooms up ...

HW: *We just have to absorb that, do you think?*

BL: In as much as we can absorb it within our current state that's fine; if we have to go into police cells then in the past we've gone to the Treasury and asked for more money, but it's not

automatic. The theory is that if the population is in line with the forecast more or less we ought to be able to deal with it within the budgets that are based on this forecast. That's fine in theory and it ought to be fine in practice.

HW: *We're trying to plan more now and the one year budgets and the PES system as it stands don't actually help us plan for longer periods of time. Can you see that establishments could get budgets for the next three years, say, the next four years?*

BL: Yes, the PES budget processes surprises me for being so long – I mean I am now arguing about the money that we will get from April 1995 and the three years thereafter which is quite a long way out, so the PES process isn't a barrier to long range planning at all – I mean the long range planning ought to be in the PES. What has been the barrier is that we've not done the local planning that far out and even where we've done the local planning we haven't put any financial numbers to it and haven't then built that strategic planning process and linked it into the budget process and that obviously has to happen. I mean establishments need an indicative figure of what they're going to spend and what they're going to receive over the next three years, and that's got to be part of the planning process. But the facts of political life are that you cannot guarantee that Dartmoor in 1997 will receive £x.

HW: *Have you got any idea when governors will be able to start purchasing things themselves like training or works services?*

BL: I would hope, at risk of seeming to give you the party line – I happen to believe that the party line is right – the way to approach those issues is for the service providers like the college and so on to decide how they would charge for their services and what the implications overall are of untying. I would expect to see a fair degree of untying from 1995/96, but it's something that you've got to manage. I mean if we suddenly say everybody doesn't have to use the college and they all decide not to then we're going to be in a mess. But in the long run governors have got to be free to do those sort of things. Can I explain why I think we're tied into devolution, because it seems to me that there's a perception that devolution of authority is some sort of trendy theory that people mouth without necessarily believing in it, and there's a certain amount of cynicism around about what it's really going to mean in practice. It does seem to me that in any business that there are two ways of running it: you can run it in a way that a retail company would run where everything is decided at centre, and you can do that with all stores because all the stores are basically the same – when I was at Sainsbury's if we made a decision about something then we knew that every store could follow it and those economies would flow straight through. At the other extreme there are the totally diversified companies where the actual operations are so different that you can't do that, and that's what we're in, and we're doing devolution not because there's an alternative or because that's the current theory, we're doing devolution because that's the only way it will work and it really has to be effective. At the end of the day the only people that are going to generate the quality that we want at the price we want are the local governors. So it's not a question of saying how much devolution are we going to do or when, it's a question of saying how are we going to make it effective and I think the principle's already there – or it ought to be there – that's the way we're going.

HW: *You mentioned with the college for example that if everybody decided not to use them that wouldn't be on ...*

BL: That wouldn't be on in the short term. I mean if everybody decided not to use them then there are only two options – they change their offer so that people do want to use them or we close it, and you can't close a college just like that so that's not a practical short term option. I would hope that the longer term option was that they'd be used – I mean I've no reason to believe that they wouldn't be used. But the only way to make sure that it is wanted is for governors to have the budgets and buy it at the end of the day.

HW: *But they would also do what I believe PSIF did a few years ago and actually turn themselves into a service for governors rather than say this is what we've got on offer.*

BL: I don't know enough about the college to fall in the trap of saying that's not what they're doing but it's what they ought to do. If you're right that they're not doing that ...

HW: *I think they are certainly trying to do that now. How do you judge the performance of an establishment from your point of view? I mean you must have some view of some establishments that you think are weaker than others?*

BL: Yes.

HW: *Is that from the figure sheets – is it in conjunction with looking at others – you know talking to other directorates?*

BL: Oh, you mean at this stage – I mean at the stage I'm at, being fairly new, it's largely anecdotal but I guess the KPI – I'm not close enough to know how the KPI targets were set to know whether performance against target is the best way of judging establishments, but it ought to be, and certainly I would always look at the KPI's before I go and visit an establishment.

HW: *How many establishments have you been around?*

BL: Fourteen or so up until mid-May.

HW: *Have you got a rolling plan to keep plodding round them?*

BL: Yes.

HW: *There's still a belief within the Service that if you overspend you get a bigger budget next year and vice versa. Is there any way we can stop that?*

BL: Absolutely. We've got a project under Walter Mowbray looking at exactly that. The way to do it is to see the budget as the last stage in the strategic planning process so that the budget is the financial representation of the plan and isn't just a pot of gold that falls out of the sky – last year's pot plus a bit or less a bit.

HW: *So you're costing all the way along?*

BL: Yes, not in a lot of detail but certainly you should produce a plan and then say what it will cost rather than saying here's what we got last year what do we do with it. Because once you've got that that then enables you to argue about the components and say you know, you want to do this extra but do you really need it, is it the priority for this establishment – is it the priority for this area – and if you do need to do it is there something else down here that you're planning to do that you can drop out, and you've got to get into that sort of debate. I think there is a place for more mechanistic approaches like the Wessex Matrex but at the end of the day it's going to come down to judgment and discussion about particular plans, and that's how it ought to be.

HW: *There's a feeling in the whole of the public sector that the Tories have put money as the only thing that matters and that quality and other things are only given lip service. Do you think this is a necessary truth in that we are dealing with public money and that's the bottom line?*

BL: No, I don't.

HW: *What about the Sainsbury's connection, I mean I was in the Health Service before, when Griffiths was doing his report. I mean is Sainsbury's a model of how an organisation should be? I just find it interesting that you did your spell there.*

BL: Yes. I am worried about the belief that seems to exist in parts of the public sector that there are models out there that we can just copy. There's no way you can run the Prison Service the way we ran Sainsbury's – I mean they're just totally different beasts. There are certain things you can look at – Philippa Drew, Richard Tilt and I had a meeting with some of the directors from Sainsbury's to talk about their capital investment proposals – how they actually decide to spend capital, and that was really informative and useful, but at the end of the day there is no comparison at all between running a Sainsbury's store and running a prison. They are chalk and cheese.

HW: *But you went to Sainsbury's on that particular issue?*

BL: Yes.

HW: *Why was that?*

BL: Because they've got an enormous capital investment programme and they're very good at managing it. We've been talking to the DSS about IT strategy, but when I first started at Sainsbury's I went round and I talked to London Transport and all sorts of places to get ideas, and some you apply and some you don't, and there are lots of ideas around.

HW: *What about the Planning function at HQ?*

BL: The Planning Unit's role is fundamental, but it's got to be much more than just a co-ordination and consolidation and collation which is probably what it was until Richard Tilt arrived. I think Richard's done a fabulous job in actually getting the Planning Unit to do two quite difficult things. One is a sort of lead role – of saying where are we going in the longer term – how do we compare with prison services in the States or Australia or Scotland and where do we want to go overall – what are the major issues that are coming up – and trying to think strategically and imaginatively on that level. The other level that we haven't really got into yet is co-ordinating the individual establishments' strategic plans and make sure that they all fit together. And there's a danger that we will optimistically assume that the establishments' strategic plans when you add up will come to the national one, and they won't. It's a process and the Planning Unit has got to get hold of that process and really drive it and not be driven by it. If it works and I believe it will work with the people that are coming in now – I think it's going to be tremendous.

HW: *A slightly different tack here. There's a pay and grading review going on; traditionally reorganisations of public sector have resulted in a little bit of what Beveridge call stuffing Doctor's mouths with gold or at least sweeteners. I understand that the plan is that this particular review will be at zero cost.*

BL: I'm not sure that's been formally decided. It seems to me that it's got to pay for itself.

HW: *But that could be in the longer term rather than the short term?*

BL: The whole Service has got to operate within the constraints of the Treasury in terms of expenditure and that is about a real reduction in the current cost per place.

HW: *But there's things like redundancy or early retirement costs.*

BL: That's going to have to come out of PES and that's a major constraint. I hadn't thought of it in zero cost terms but if you put it like that – I mean I don't think the Treasury are going to come along with a pot of gold and say ...

HW: *Not even if we said this is going to save us in the future?*

BL: I can't think of any examples of when they've done that. If you can find any I'll be interested.

HW: Because there are quite a lot of groups of workers who certainly at the last reorganisation felt that they missed out – they are thinking that this is going to be their time.

BL: Yes, I guess you're right. But there isn't a pot of gold there that you can sprinkle over whatever we come up with, and there shouldn't need to be.

HW: *How do you think your time in this job will be rated by a future prospective employee/employer – assuming that you're not going to pick up your gold watch from this particular post?*

BL: It all depends on the results, doesn't it. I mean if I achieve what I want to achieve I think it'll carry me forward.

HW: *What was the view of your ex-colleagues about you taking this on?*

BL: I think (a) they thought it was typical of me and (b) they thought that they wouldn't have done it. I didn't meet anybody who said 'I wish I'd done it'.

HW: *What about the people that you've been working with. Obviously without going into specifics, I mean have you been surprised by the calibre of the people within the job or do you feel that because people have spent their whole careers possibly in the Prison Service that that's limited them. Do you think that they would benefit from periods out which have been done by a very small handful of senior management?*

BL: That's a difficult one to answer. I think the Prison Service would benefit by having more people in it who have had outside experience, whether that's people who've moved into the Prison Service part way through their career or whether it's people who are seconded out for a couple of months – I have no doubt about that. I've certainly been impressed by the sort of culture – the atmosphere in the place. It's a much friendlier place to work than most places I've worked – there's much less back biting. Maybe it's just that I haven't come across it but certainly the people I've been working with are far less political in the sense of empire building. And intellectually they are a much higher standard than you'd get in the private sector, and there's a dedication. I do find the generalist philosophy extremely frustrating.

HW: *Can you elaborate more?*

BL: The idea that if you're in a certain rank you should be able to do just about any job in that rank.

HW: *That's the old Army thing.*

BL: Yes, it is – where you sort of auto-migrate through lots of jobs for the good of your career irrespective of whether you know anything at all or can contribute to that job; and I think that the people I've got working for me have done an incredibly good job considering their total lack of training in some cases for their posts. I mean they really have – I think they've done as well as the generalist culture would allow them to do. But it's still not a culture that I'm really happy with. And it's a funny sort of place, the Prison Service, because at the one end you've got that generalist structure, but in other parts of the Service you've got restricted practices about who can do what that almost seem the opposite pole. And somehow we've got to find a means that actually does recognise the competences that you need in particular jobs and that doesn't stifle people. I think that's probably the biggest challenge we've got.

HW: *Have you got a sort of five year plan?*

BL: For the job?

HW: *Yes.*

BL: There are a number of things I want to get done that mainly revolve around devolution and giving people the tools to do their job.

HW: *So what do you hope to hand over to your successor?*

BL: I hope to hand over an organisation that financially is sound and where the financial planning can be relied upon and where the standard of financial management is excellent. I mean it's not my job to change the direction that the Service goes.

HW: *Thank you* ■

Letters

A SOCIETY FIT FOR RE-OFFENDING?

Dear Sir

I have off and on in my service career been asked how I would effect the training needs of re-offenders, bearing in mind that we often see the same old faces re-offending which, although the inmates sometimes treat as a home coming 'Can I have my old job back', does nothing for the professional honour of the trainer. I, like many others, participated in the staff suggestion scheme back in December 1991 and received a speedy reply in March 1994, but lots have changed since then but not the problems.

The perspective forwarded under the Criminal Justice Act 1991 early release is tackled by the conditions of good behaviour, ie, pre-requisite of early release that there are Probation Accommodation Grants Scheme (PAGS) under C6 Division to support voluntary organisations which suggest something of a Half Way House for return to society.

Although this is an admired situation, in reality we fail dismally as the constant stream of old faces prove. As we have a high re-offend rate for ex-custodial prisoners the problem should be tackled at source, our current practice is to confine prisoners within secure establishments, then release them back into society via our pre-release system into an over burdened support system under the Probation Office on general release conditions. There are many reasons why ex-inmates re-offend and there are no doubt statistics to say why, but it is the professionals who are engaged in re-training the inmates to give them a better chance of not re-offending upon release. This is divided between being looked after in custody with its areas of support and their contact points as opposed to problems that throw up difficulties when being released back into society at large.

Inner City areas with its high unemployment and low social standards of living is a social problem in local and central government areas of responsibility, but ex-inmates re-offending by taking the easy option after trying to cope unsuccessfully, being re-sentenced become ours once again.

To address this situation a new perspective is needed, one that backs up the Prison Service trainers, enabling them to continue the rehabilitation process with a direct input for the prisoners' needs, ie, a Half Way House rather than the adopted attitude of 'In, trained, out, next please'.

A Half Way House is the follow up from being re-trained or re-educated, but instead of being put back in society, persistent re-offenders should be given the chance to understand the needs of general society themselves and for the re-offender to find a niche within this.

The Pre-Release Employment Service (PRES) introduced in 1953 was set up for preparing prisoners for release into society and is run on a hostel basis, but there are only six hostels providing 107 places nationally with the bulk of placements being taken up by life sentenced prisoners. Even if they were all available, there would be only one place per 448 prisoners nationally.

If each large prison establishment were to operate a PRES type of building for a small number of re-offenders needing support, the cost involved would be relatively low as opposed to future placements within secure establishments, plus this would go some way to breaking the chain of second, third or even fourth generation criminals.

A suggested manning of this type of set up would be for service personnel with a proven track record of understanding the needs of society and industry, as well as the needs of the persistent re-offender, people with experience of life as well as professional qualifications taking priority over purely academic qualifications.

Once this problem is addressed then we will have a better chance at retraining re-offenders for release into society and hopefully reduce some of the burden on the taxpayer, although there are probably statistics which prove otherwise, it is something all trainers within the Prison Service see all too commonly, but there again it was Gladstone, I think, who said there are three types of lies, 'lies, damnable lies and statistics'.

Brian Salmon,
Farm Manager,
HMP Belmarsh

Letters

Prison Service Journal – Article CULTURAL CHANGE AND THE PRISON SERVICE 'A Case for Staff Involvement'.

Dear Sir,

An article I submitted for publication in the Journal appeared in print in the March 1994 issue No. 92.

I was amazed and disappointed that the article had been censored to an extent whereby I believe the balance of the argument was shifted.

I recognise that all submissions are subject to editorial review but believe this amounted to censorship.

Two main areas of the article were completely omitted.

I included what I considered to be a constructive argument of staff resisting change, particularly at the inception of Fresh Start. Although very much resisted by staff at the time; I argued that few would return to pre-fresh start days. The basis was to demonstrate that fresh start was, in hindsight and some reservations, a good idea but was badly handled. All that section was removed.

Secondly, the case for differentiating between communication, consultation and negotiation was also omitted.

I believe that the deliberate omission of parts of my article were not in line with the 'Guideline's for Authors'. I was not consulted about changes to the substance of my article. That is clearly a breach of the Journal's own criteria.

In the same issue were lengthier articles, one of which was a reprint from some years ago. I can, therefore, surmise that space was not a factor when my contribution was 'edited'.

It would appear that the majority of the Journal's contributors are managers or outside professionals with an interest in penal policy matters. It does little to encourage academic contributions from staff such as myself, particularly when the censors pen becomes active.

This was my first article to appear in the Prison Service Journal. I would hope to submit others but only if the Journal's own guidelines are adhered to.

I look forward to your reply.

R. M. Lewis,
Officer Instructor, HMP Usk, Maryport Street, Usk, Gwent.

PS: I would have no objections to this letter being published, provided it was not 'edited'.

Editor

'I am sorry you were disappointed that your article was edited. It is not the intention when editing to alter the thrust of what is being said and I don't believe that was done in this case, however, it would have been better to have discussed the alterations with you prior to publication. I hope you will not be put off from further contributions.'

VERBALS

"It is wrong to require judges to sentence all categories of murderer in the same way, regardless of the particular circumstances of the case before them."
[Lord Lane Chairing the Committee on the Penalty for Homicide]

"The fact that a judge must always warn the jury that a victims evidence alone may be unreliable discourages victims from coming forward. Such a warning is outdated and demeaning to women, particularly in rape cases." [Michael Howard, Home Secretary]

" ... Ministers should give a lead in convincing the public of the value of community service rather than talking-up the use of prison for so many who do not need to be there."
[Anne Mace, Chair of the Association of Chief Officers of Probation]

"Most burglaries are anonymous crimes with the house empty or victims unaware of the burglary. Violent or threatening confrontation between burglar and victim occurred in 3% of cases in 1991: about half the confrontations involved strangers. Burglaries involving gratuitous damage (such as soiling or graffiti) were extremely rare."
[Bristol Crime Survey published in Criminal Justice Digest No 75 HMSO]

A STRATEGY FOR THE PRISON SERVICE

Clive Welsh is governor at Headquarters on the Pay and Grading Review. Tony Wood is Governor of HMP Camphill.

This article is a summary of the Strategic Management Project report by members of the Prison Service College programme for Senior Management.

Introduction

Having examined strategic management theory in previous SMP modules, the group analysed the internal and external environment of the prison service in order to shape our selection of an overall strategy for the service. The main techniques employed were SWOT and PEST analyses, linked to Mintzberg's model of Strategy Formulation (see Diagram 1). The strategic choice was made from a current theoretical model.

The outcomes of the analysis were unexpected. If our analysis is correct, there are some important lessons for the Service, some of which are set out in this article.

Strategic management is the process of aligning the internal capability of an organisation with the external demands of its environment: it is an essential process if human, financial and material resources are to be utilised optimally.

The internal organisation of HM Prison Service has developed upon hitherto unchallenged assumptions that no viable alternative structure can be considered, or could be appropriate. It is proper, following a significant change in the external environment, to examine whether this assumption is leading to inefficiencies, which are costing the business money – reducing its profits, or increasing its costs.

Interest groups which affect the operation of the Prison Service include managers, employees, suppliers, customers (including the courts and lawyers), consumers (including prisoners), competitors (including other public services), pressure groups, the media, government and society at large. It is clear that their expectations vary considerably, and are often in conflict.

What, then, can strategic management in the Prison Service hope to achieve?

We contend that strategic management is essential to the future success, if not to the survival, of the business. Articulating the Purpose, Vision, Goals and Values – defining the aims and objectives – provides the philosophical framework for the business. Strategic plans, at Service level and establishment level, must structure the processes of organisational development so that they can incorporate, dynamically and intelligently, perpetual change into fundamental operational and organisational processes necessary to achieve the outcomes by which the success or failure of the business will be judged.

Consistency of management approach over time has not been a characteristic of our business: strategic management provides the fundamental framework which will facilitate that. There is only one realistic option, and a failure to engage in the process of strategic management will increase the instability of the organisation, reduce its capacity to deliver services efficiently, effectively and economically, and result in seriously sub-optimal performance at all levels.

Decisions about the future are based on assumptions: they are affected by the values of the individual and the organisation: and evaluation of consequences should prevent undesirable outcomes arising from the strategic management process. Environmental analysis is essential to structuring plans. The Chief Executive, or other organisational head, must consider the

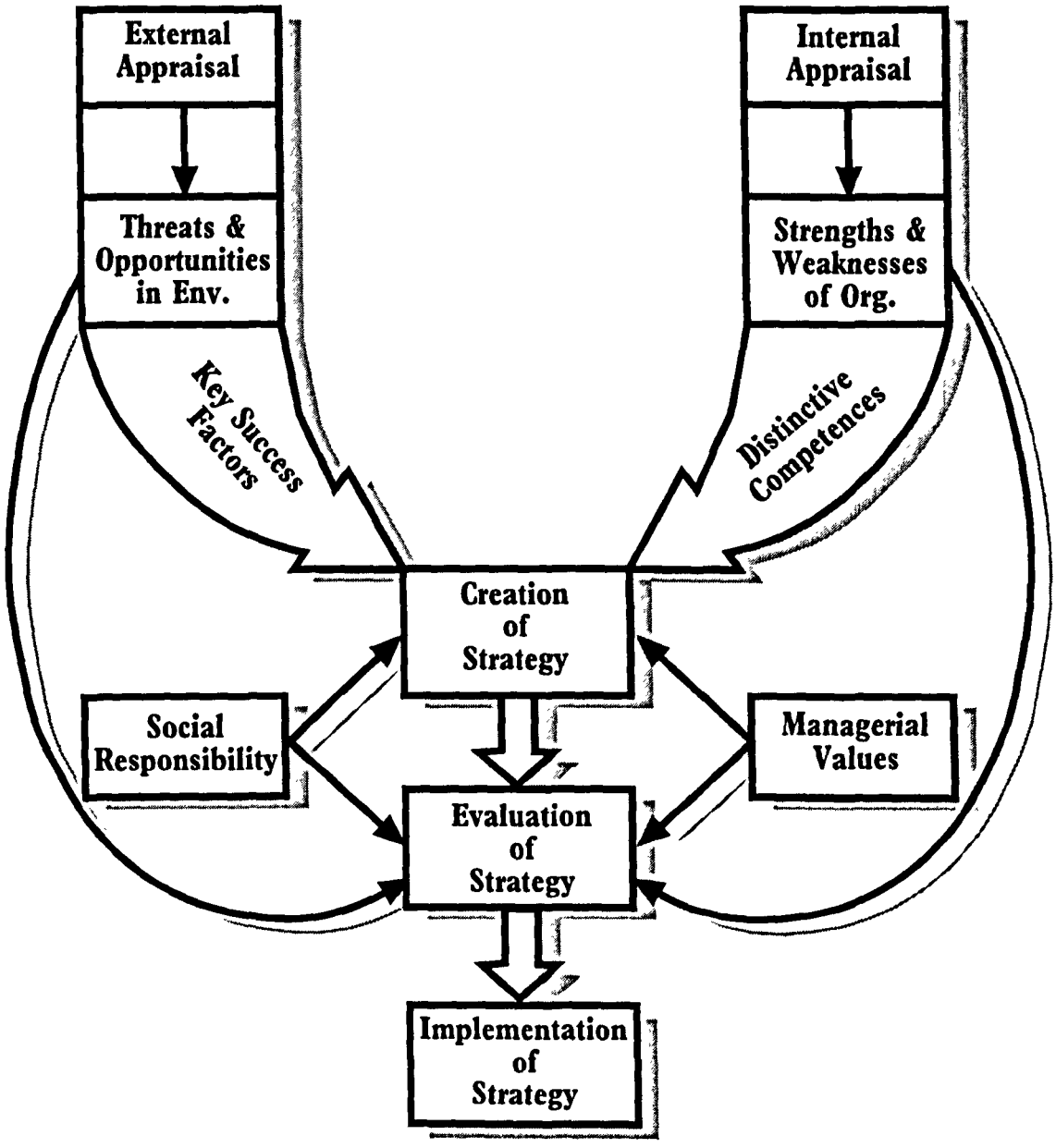


Diagram 1: Deliberate Model of Strategy Formulation

influence of the external environment: government, law, other Criminal Justice Agencies, competitors and the market opportunities, the economic environment, significant groups, the media, competing demands for scarce resources: and how the organisation can achieve its goals whilst managing the external environment and coping with the expectations of the principal stakeholders.

In order to realise the business strategy, there must be internal structural alignment, including selection processes which ensure that those who are preferred are those who have the competences to deliver the business and corporate plans – the steps by which strategy is accomplished.

But it would be incorrect to assume that strategy, once determined, is a static entity to the achievement of which all planning and activities should be subservient. The external environment will change, and therefore strategic management should be sufficiently flexible to accommodate change. But agreement by key players – and others whose influence may become increasingly significant – should minimise the probability that the strategy will have to be changed fundamentally.

The strategic management process is about the **future**: thus information management is critical to the success of the enterprise, for information provides the basis of projections about future activities. As a

result suppliers, customers and those organisations with an allied interest can begin aligning their own strategic plans to cope with such projected changes. Thus sub-unit planning within and without the organisation rests upon the strategic plans not just of the parent organisation, but also of the other stakeholders. As defined by Ansoff[1], who recognised that the business environment is rarely stable, but often turbulent, diagnosis and evaluation are key processes of strategic management: continual adaptation to provide the optimal internal/external interface is required.

This sounds as though it is as much a reactive as a proactive process, and in part it must so be. But management should be seeking to **manipulate,** if not to **direct,** the changes in the environment, and to minimise the need to adapt to circumstances which are unforeseen. The processes of information gathering and analysis, strategic planning, resources allocation, outcome evaluation and adaptation should facilitate incremental development of the strategic plans – not result in shifts which dislocate the activities of contributors and result in seriously sub-optimal performance.

External Analysis

Our environment is ever changing, and constantly shapes and reshapes our strategy as we respond to our political and economic surroundings. In diagram 2, the influences identified change in importance and strength as the environment changes. The influences also interact and change each other as well as the Prison Service. We conducted a PEST (political/economic/social/technological) analysis.

Political Influences and Pressures

We have a pro-active Home Secretary and a Government which wishes to see a movement towards punishment and austere regimes. It has a belief that 'prison works'. The Government influence is strongest in that it decides overall policy in the criminal justice system, controls funds and through that, the Prison Service ability to manage and cope. Through the Criminal Justice Act, it influences the size of the inmate population. All the evidence points to a continued rise in the prison population, in the medium term at least: the latest projection indicates a population of 55,000 at the turn of the century. The weakness in Government influence is that it operates on a five year political cycle and suffers from short term investment policies and planning horizons.

Social/Culture Influences

We live in an area of increased fear of crime. There is hardship in the community and the perception that prison is luxurious. This leads to more pressure for criminals to be punished and for more focus to be placed on the needs and plight of the victim. The media influence is strong and currently supports the Government's drive towards punishment. The Woolf agenda is still alive, supported by the Prison Service and lobby groups but is itself under pressure. The influence of the prisoners themselves must not be ignored. Any change which is anticipated needs to include them and needs to be properly explained and understood.

Economic Influences

There is pressure on public spending. We are in a world recession, have high unemployment and have an ageing population. We are in competition for funds with other public bodies. There is little political and public belief in our need to spend money in the way we do, due to perceptions of luxurious regimes and inefficiencies. With the growth in the prison population, it will be expected that we shall achieve 'more for less'.

With commitment to the Woolf agenda, we will need to ensure the growth of purposeful activities for inmates, with more time out of cells being used constructively. We will need to devote more resources to the confrontation of offending behaviour. We will need to achieve this with less money and reduce the cost per prisoner place.

Privatisation, contracting-out and market testing are threats which are there to spur us towards the achievements of standards and the reduction in costs, as well contributing directly to the reduction in costs.

1. Ansoff, H. I.: Strategic Management in a Historical Perspective: International Review of Strategic Management, 2, 1: 1991. ed Hussey, D. E.

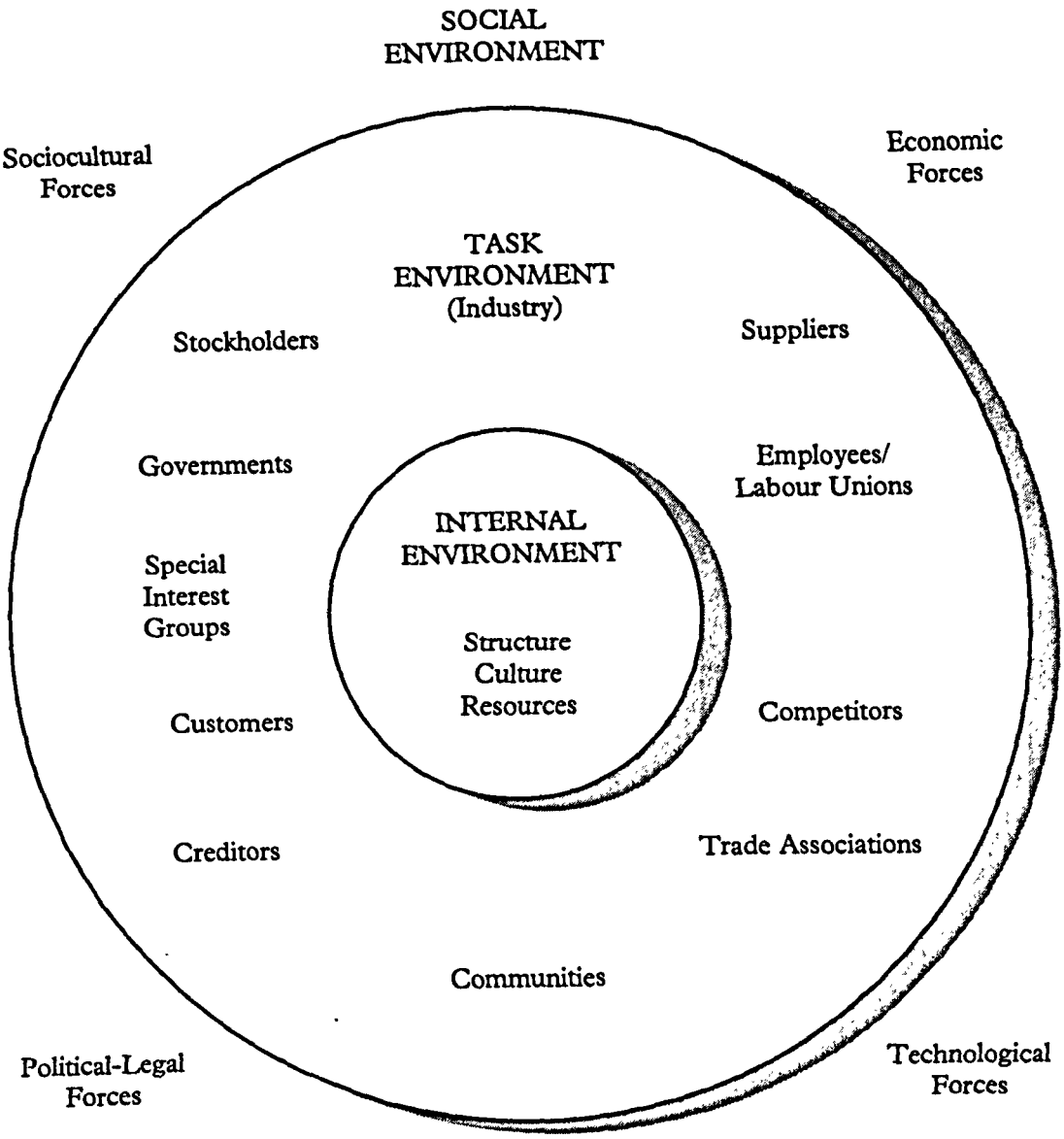


Diagram 2: Environmental Variables

Technological Change

Good management information systems are important, and are now becoming available as are good communication systems. Building technology is greatly improved. Although we will always suffer from old buildings in the stock, it should become easier and quicker to produce more suitable buildings in the future. There are now better possibilities for control with areas of technology being developed in personal alarm systems, drug testing, video links, building design and tagging.

INTERNAL ANALYSIS

This is the process of examining the business that we are in, identifying its strengths and weaknesses. We further identify the values and social responsibilities that underpin both the organisation and those who work within it.

Weaknesses

- **Personal and business Agendas:** to much historical baggage. A lack of focus on customer (and consumer) needs.
- **Lack, and fear, of innovation:** fear of failure. Previous experience of innovation has failed through poor research, planning and delivery.
- **Inertia:** the feeling of helplessness because of outside and inside pressures (political, cultural and economic). This inertia is not helped by the absence of a Performance Culture.
- **Bureaucratic Structure:** the Civil Service's centralism stifles individual

entrepreneurial initiative, demanding identical responses from establishments which are distinct and unique.

- **Headquarters Culture:** this builds on Civil Service centralism and is best described as headquarters over-managing. Strategic direction tends to be lost amongst the detail of prescriptive instructions.
- **Information:** the service is swamped with information. Too much information is demanded, and too much is provided. The important is mixed with the trivial.
- **Market Ability:** we do not identify our products and we do not have a strategy (plan) for marketing these products either nationally or locally.
- **Strategic Change Management:** change is viewed with suspicion and fear, as something which happens to us, not something we engineer or manage.

Strengths

- **People Industry:** we are good at managing all sorts of people.
- **Operational Management:** we manage crisis quickly, efficiently and responsibly.
- **Spirit of Togetherness:** despite industrial difficulties staff work together effectively.
- **Caring Service:** we care about our Staff and inmates, setting high standards which we recognise demands continuous improvement.
- **Experienced Workforce:** we have a national tradition over many years without fragmentation.

Values and Social Responsibilities

We expect individual and corporate respect for ourselves, those in our care and for those associated with our business. We see people as individuals. Everyone is encouraged to grow and develop as an individual within the organisation, at their own pace. We have a sense of social responsibility to care for the weak and the disadvantaged.

As a service, we see our role and place in society to be providing an orderly and protecting environment, which promotes personal development.

GENERATION OF STRATEGIC ALTERNATIVES

Having considered the external and internal environmental audits it is necessary to generate strategic alternatives from which a selection may be taken to shape the future of the service.

From the work of Hunger and Wheelen[2] and Johnson and Scholes[3], Jon Beaver of De Mountfort University, has synthesised a grid of strategic development strategies. The model contains three levels, each level containing three options and thus provides a grid producing a possible 27 separate strategic options (See Fig. 1).

There are no natural links between the various Generic Strategies, Direction and Method, but it can be seen that some Generic Strategies more readily lend themselves to some Direction and Method options than others. The Generic Strategies can be described thus:

- **Cost Leadership:** In selecting this strategy the company or corporation seeks to remain or become the most cost effective provider of a particular range of goods and services in the market place.

- **Differentiation:** The adoption of this strategy seeks to discover within an organisation's business a unique element which can be used to built up customer loyalty within a competitive market and thus be able to survive higher unit costs without loss of revenue.

- **Focus:** This strategy focuses the company's activity on one specific market niche. The advantages to this strategy are similar, although differently achieved, to that of Differentiation.

Sub-Generic Strategies – Direction

- **Stability:** This strategy may be adopted because the company is facing a situation of

2. Hunger, I. and L. Wheelen 'Strategic Management' 1993 Addison Wesley Publishing Co. Incorporated.
3. Johnson, G. and K. Scholes 'Exploring Corporate Strategy' 1993 Prentice Hall International (UK) Ltd.

Fig. 1: Development Strategies

GENERIC STRATEGIES	DIRECTION	METHOD
Cost Leadership	Stability	Internal/organic
Differentiation	Growth	Acquisition
Focus	Retrenchment	Joint Alliances

modest or no growth, or key forces in the environment are in the process of great change where it is impossible to predict the relative positions of threats and opportunities.

- **Growth:** The adoption of the Growth direction, indicates an organisation's willingness to expand, to integrate, or to diversify their business. This is a popular aggressive market strategy which is by far the most widely pursued corporate strategy in both national and international markets. The UK Prison Service, unlike commercial corporations, may not favour a growth strategy, but may nevertheless by the circumstances indicated in the external audit, be forced into its adoption.

- **Retrenchment:** Retrenchment indicates that the organisation urgently needs a strategy for turn around or divestment of elements other than its core business. Its adoption is usually accompanied by across the board cuts in both size and costs, followed by a period of consolidation prior to the adoption of a different strategy in the future.

Sub-Generic Strategies – Method

Method is essentially about how the Generic Strategy and the Direction are to be implemented. As can be seen from the grid, there are again three viable alternatives. They can be described as follows:

- **Internal Organic:** This method requires the formal rearrangement of people's role and relations within an organisation, often referred to as adjustments within the chain of command and quite frequently shown in new and reorganised organisational charts. Decisions will also be taken as to whether the company should be managed with many rules and controls and highly prescriptive centre or with much looser controls relying more heavily on the integral skills of the managers in the system.

- **Acquisition:** Pursuing a method of acquisition includes buying other companies and acquiring both skills, stock or plant. Acquisitions can be pursued in either a friendly or hostile mode, both of which have advantages for a company which particularly wishes to approach a development strategy based on a growth direction

- **Joint Alliances:** Joint Alliances indicate both ventures and long term business conducted in concert with another company or corporation. This has most of the advantages attributable to Acquisition without necessarily the initial costs incurred in purchase.

One common theme involved in the method of all three of these options, that is Internal or Organic reorganisation, Acquisition and Joint Alliances, is the development of synergy whereby it is held that the combined efforts of one or more divisions or companies can produce a greater benefit to the whole than would be the case were the divisions or companies acting independently – the so called 2+2=5 concept.

STRATEGIC EVALUATION AND SELECTION

The members of SMP1, working in small groups, sought the best strategic option for the future development of the Prison Service at organisational level, not at establishment level. To do this, each of the generic strategies, strategic directions and strategic methods was considered to discover the most appropriate combination. Each of the 27 possible combinations was evaluated against three 10-point rating scales; these

provided a measure of the possibility, probability and desirability of each strategic option.

Generic Strategy

It was concluded that cost leadership had a high validity because the Prison Service was now in the position where it had to compete more effectively for resources against other Government departments and agencies, in an environment where the money available was steadily reducing.

Differentiation was an unlikely option because any 'added value' created would be likely to be at the expense of increased costs. Because the Prison Service needed to provide for all facets of imprisonment, focus on specific markets – for example long-term prisoners or sex offenders – did not appear to be appropriate.

Strategic Direction

Stability was quickly dismissed as unrealistic because of the requirement to deliver a higher level of service to an increasing number of prisoners against a background of diminishing resources. Therefore, growth was quickly identified as our future situation, even though it was not one which we welcomed.

Retrenchment did not seem to be a possibility, because of the political and logistical need to keep in Government control many aspects of the Prison Service business which might, at first sight, appear to be non-core business, such as Category A escorts. Equally, the costs of retrenchment would be substantial; for example concentrating only on prisoners requiring full secure conditions would result in the loss of economies, including economies of scale in services such as transfers.

Strategic Method

The internal/organic method has produced change, but was felt unlikely to be effective in meeting the demands currently being placed upon the Prison Service. Acquisition was not considered to be a realistic option: the Prison Service has been in a monopoly position and there seemed few competitors to consider taking over and a limited range of subsidiary skills to buy in at the strategic, national level, though at establishment level, particularly for non-core business, this may still be a possibility.

The final option considered was joint alliances, a method which has been increasingly used over the last few years. Examples already include running establishments, escorting prisoners and the provision of education, healthcare, catering and probation services.

STRATEGIC SELECTION

Much to the surprise of the group, we were unanimous in agreeing that there was only one option that was likely to succeed. This was:

- **strategy** – cost leadership (because of the need to reduce costs),
- **direction** – growth (because of the rapidly increasing population),
- **method** – joint alliances (as the most effective way of importing relevant skills and encouraging the public sector to compete).

Whilst the Service, as a whole, has no direct competitors in its market, the competition for public expenditure resources has never been greater. Our purchaser (the Government on behalf of society) therefore requires the increasingly effective use of resources: the public sector equivalent of cost leadership.

From a professional standpoint, the Service may not welcome an increasing population, but there is no evidence (either at home or abroad) to suggest that it will not continue to rise in the foreseeable future. Put simply, population capping is not a realistic option.

It was concluded that the internal/organic development of the service, on its own, would not be able to deliver the strategy. Whilst improvements in the directly-managed system are required, this was more likely to be encouraged by the development of joint alliances with other organisations. The buying-in of specific skills, whilst useful, cannot have the same impact as utilising the skills of other organisations. The use of Probation Officers and LEA teachers has been part of this process for many years, and increasingly links are being developed with other organisations. This process is further

enhanced by contracting out elements of the core and non-core business, both to reduce costs and as a spur to the directly-managed parts of the Service.

At sub-organisational level

The group then considered whether or not this strategic option should be applied at establishment and Headquarters division level. The conclusion was that whereas this would normally be the case, there could be legitimate exceptions. For example, it might be more cost effective to concentrate a particular service in one establishment, rather than spread it throughout a number. Similarly, not all establishments are in, or are likely to be in, a growth situation and in a few, there may be much more scope for joint alliances, either because of the establishments' geographical isolation or because such opportunities had already been taken.

STRATEGY IMPLEMENTATION

The implementation of organisational strategy is the process by which strategic policy is activated through the development of appropriate systems, budgets and procedures. The overall process may involve significant changes within the culture, structure and management of the entire organisation. Course members split up into groups to identify key issues.

The selection of this strategy means that any managerial proposal should be tested against it in order to ensure an acceptable level of fit. It was considered important that the task of implementation should hold in tension the competitive advantage of cost efficiency with the development of a quality and service culture. The shared results of the group assessment were as follows.

Cost leadership implies the need for:

- incentives to generate income which can help to resource meaningful development of regimes and programmes.
- better and more flexible use of the estate which requires a radical re-appraisal of prisoner categorisation, community prison, sentence planning, and movement of prisoners.
- greater devolution of resources to establishments which should be accompanied by greater flexibility in determining the use of resources to build and maintain appropriate systems and structures pertaining to regime development.
- meeting but not exceeding the specification, thus avoiding unnecessary costs: Corporate and Business Plans should reflect the goals, objectives and values of the Service and managers need to be held accountable for the delivery and quality of agreed specifications.
- reduce costs including more economies of scale so that savings and efficiencies are maximised.

Growth implies the need for:

- optimising the use of the available estate, building new units, converting unsuitable accommodation and reclaiming cell space currently used for other purposes.
- a re-appraisal of population management with a built in contingency element within the strategy. Population management must move from crisis management to a planned and efficient use of space and prisoner movement.
- computer scheduling of cell vacancies (as in hotels). Valuable unused cell space is created at any one time through Home Leave; hospitalisation; court appearances and accumulated/inter-prison visits. A cultural shift away from individual prisoner cell ownership could allow a more effective use of available space.
- re-definition of CNA/overcrowding to establish parameters which permit the most flexible and economic use of the estate.
- better liaison with courts and other countries; proper and appropriate liaison between the various operational Criminal Justice Departments should be seen as an essential element in the custody and control of prisoners. The creation of waiting lists for the allocation of places for sentences to be served at weekends (or for offenders not requiring immediate imprisonment) is not unknown in other countries. It was suggested, cautiously, that a feasibility study be undertaken of liaison with European prison systems to extend the available estate, particularly given that geographical distances and journey times involved may be shorter and/or cheaper than within the UK.

Joint Alliances: The aim of joint alliances is the enrichment/enhancement of existing skills and resources through shared

expertise. This implies the need for:

- private building and management of prisons.
- contracting out the non-core business and parts of the core business; wherever a more cost-effective option can be found contract out, for example, catering, maintenance. Keep the distinction between core and non-core business under review.
- shared provision of services (purchaser/provider); explore options for shared service provision with other organisations handling similar and/or overlapping populations, for example Special Hospitals and the Probation Service. Actively pursue both purchaser and provider role in areas such as training; establish the Prison Service as market (and marketable) leader in relevant areas of expertise.
- joint enterprises, sponsorship; explore all possibilities for joint internal/external schemes, for example sponsorship and industrial training schemes. Capitalise more on support from voluntary agencies contributing to regimes.
- a redefinition (at corporate level) of our place in the Criminal Justice system. Explore alternative, mutually advantageous, relationships with Probation, Police, Mental Health Agencies, Training and Educational Institutions.

ACTION ON ATTITUDES

To be successful in implementation, the strategy needs to be owned and supported by the majority of staff. We thought it essential that the strategy is endorsed and publicly supported by senior management.

The strategy has been chosen to achieve the key Success Factors of:

- Enabling the service to handle more prisoners.
- Working more efficiently.

Highlighting these factors as top priority goals is likely to meet with resistance from many employees at all levels. The new focus on a cost-effective, business-like approach may appear to be incompatible with the existing non-profit, quality service culture. An important stage in implementation is that of identifying and predicting stakeholders' attitudes and actions. Ways to minimise resistance and to strengthen support are necessary so that staff are working **with** the strategy.

The culture is unlikely to be changed easily; major organisational change is required. Senior management will need to utilise all available mechanisms. The review of HQ, devolution and the Pay, Grading and Performance Review offers the opportunity to effect a major cultural shift through new working structures and relationships and in improving the service's focus on customer related service delivery and improving performance in relation to the Purpose, Vision, Goals and Values.

CONCLUSIONS AND RECOMMENDATIONS

The process of applying the techniques of strategic analysis to the prison service as a whole produced surprising, and initially uncomfortable, results which bore little relation to the participants' initial perceptions.

Each of us had, over the past year, developed our strategic thinking, but had done so in a fairly parochial context: that of our business unit. The impact of the project was achieved by placing ourselves in the position of the Board, looking at the Prison Service as a whole, in its wider environment. Only then did the picture make sense and were we able to jettison our deeply held "professional" beliefs and be able to embrace the wider strategy.

The outcome was the selection of a strategy which was closer to the policies being implemented by the Prison's Board than had been anticipated. The policies being implemented which most clearly relate to the elements of the strategy are:

Cost Leadership - H.Q. and Pay, Grading and Performance Reviews; devolution of resource management; efficient working practices and civilianisation; emphasis on VFM, effectiveness and service delivery, underpinned by the service's PVGV which focuses the efforts.

Growth - planning new accommodation and cell reclamation; improved tactical and estate management; contingency

planning for unexpected surges in the prison population.

Joint Alliance - developing shared provision of services and the use of the voluntary sector and other expertise; contracting-out and market testing both as a direct means of reducing costs, and as a spur to the directly managed prisons to improve efficiency and service delivery. These policies recognise that the service itself may not possess all the expertise needed, or may not be the cheapest way of delivering a given level of service.

It was felt that there were signs that this (possibly unconscious) strategy needed to be further developed, and some suggestions have been made. These include harnessing technology in support of the strategy and such difficult issues as re-examining the concepts of CNA and overcrowding, meeting but not exceeding the specification of service provision, and defining the service's role in the context of the wider Criminal Justice system.

Many of the elements of the strategy are being implemented, though the strategy in relation to growth still has the feel of being imposed, even at corporate level. A clearer statement of the overall strategy and the embracing thereof is likely to free managers from a victim role and thereby enable them to work in support of the Service's strategic direction.

There are two elements of current policy which it was felt require particular strengthening in strategic management terms:

- the Strategic Planning system is being applied within individual business units (establishments and HQ divisions/ Service groups) without a clear perception of the overall strategic context as it applies to the service as a whole. Strategic plans are likely to widen and focus managers' perspectives. Again, too many managers see themselves as purely in a victim relationship with the market-testing and contracting-out processes.

- the population management developments continue to be seen as an unhelpful diversion from the main business of the service: this too needs to be placed in an appropriate strategic management context. Whilst there are signs of the growth elements of the strategy being developed, they are resented because the strategy has not actually been articulated or embraced. Our professional judgement needs to be directed to offering opportunities to those imprisoned rather than wasting energy on bemoaning the rising population: we need to manage the process rather than behave as its victims.

A third element, namely market-testing and contracting out, is also somewhat under-played. The policy features in Corporate Plans, but is not highlighted in the main strategies for the service which were published in April 1994. Whether or not these policies have been forced upon the Service by the Government, they have a place in the strategy for improving efficiency and, despite their sensitivity, need to be articulated and seen as such, rather than as an unfortunate "bolt-on" to internal/organic changes. We believe that the Service should be open about this objective.

What is necessary for this to be possible is for the overall strategy to be better articulated and presented as a strategic direction rather than as a series of individual policies and initiatives. The members of SMPl are not in a position to know to what extent the emerging strategy has actually been adopted or embraced by the Board, but it was felt that some messages emanating from the Board had not always given that impression. It is, of course, conceivable that the Board itself would benefit from going through a similar process of strategic evaluation.

Following this articulation, it will be easier for all managers to examine their proposed policies and strategies to see whether they fit the Service's strategy. This can be done by testing the proposal against four questions:

- Does it meet or influence the customer specification?
- Does it enhance cost leadership?
- Does it support growth in capacity?
- Does it enhance or support the use of joint Alliances?

The difficulty in selling this message is not underestimated. The vast majority of

the group initially felt that they wished the service to be wholly directly managed, following the traditions of the public service, and that the population should be reduced or capped. However, going through the process led to the conclusion that these wishes are irrelevant to the social-political and economic environment in which we operate. In a sense these wishes were as relevant to the overall strategic context as those of a company seeking protectionist barriers to competition whilst at the same time wishing to limit its production to a level which is insufficient to meet the demands of its customers.

It is unlikely that negative attitudes towards potential career disturbance (or redundancy), or towards the appropriateness of private prisons, will ever be eradicated. But if the role of these changes in the delivery of services to the public is more clearly understood, their negative impact may be ameliorated.

CONCLUSION

The need for governor and HQ division/service group managers to understand and embrace the overall strategic direction of the service appears to be clear. Three complementary means of achieving this are recommended.

1. The previously described need for the Board to articulate the overall strategy, and the place of initiatives within that strategy;

2. enabling senior managers to go through the strategic analysis as we did: as already indicated, this is a different exercise to that of strategic planning for business units because it involves undertaking the process from the viewpoint of the Board. We noted that many managers had responded well to a more narrowly focussed exercise on the 'Managing for a Shared Purpose' programme in 1987-1988. A similar programme, or the inclusion of this process in courses for senior managers would be beneficial. Given the enriching and liberating impact of the project upon us, we see advantages in other senior managers working through the process of analysis and strategy selection for the service as a whole. If these outcomes can be repeated, we believe that other senior managers will be able to embrace, refine and deliver the agenda indicated. If all managers test their proposals against the strategy we will ensure a greater coherence of approach across the service.

3. The use of senior managers to vocalise support for the overall strategy on behalf of the Board. The members of SMP1 decided to write up the work and presented it formally to the Director General and other members of the Prisons Board in June 1994. They have also volunteered to act as champions in this regard, whilst wishing to retain their critical perspective in relation to some details of the implementation of the strategy.

The experience of SMP1 suggests that these recommendations could assist the Service, and particularly its senior managers, in embracing the strategy and enabling it to respond positively, rather than as victims, to the managerial challenges that it poses for us all.

We hope that our work will play a part in the wider appreciation of the problems we face in delivering the performance the Service needs to meet its Purpose, Vision, Goals and Values ■

Footnote

The authors thank the other members of SMP1 for their work on the main report: John Alldridge, Mike Longfield, Martin McHugh, Nigel Newcomen, Chris Scott, Adrian Smith, Peter Taylor, Dave Waplington and Terry Ward. The full text of the project is available from Clive Welsh or the PSC Library.

PRISONERS' FAMILIES AND THE PRISON SERVICE AFTER THE WOOLF REPORT

Scene from here

Under this title the Journal invites someone who is not a member of the Service but who knows us well to contribute a reflection on some aspect of our work.

Jill Mathews works for the National Association for the Care and Resettlement of Offenders.

In 1990 the Prison Service told the Woolf Inquiry that prisoners' families were important. 'The family can provide both the incentive and the pressure to change ... their presence around the offender can be a source of support, encouragement and discipline.' The improvement of family ties, it was said, must be a priority for the Prison Service, for humanitarian as well as practical reasons. Prisoners' families, their needs and concerns, were being put firmly on the agenda for the first time.

To the Prison Service's credit the following four years have been ones of innovation and positive change on prisoners' families issues. There is now a Family Ties section at Headquarters, responsible for policy. That it exists at all is an achievement, reflecting the greater importance attached to prisoners' families, and it has made a huge contribution in its first three years; liaising with support groups, successfully promoting the expansion of visitors' centres, and producing standards for visits.

One of the most significant changes affecting prisoners' families has been the introduction, in April 1994, of a second assisted visit per month for families on Income Support. Groups such as Prisoners Families and Friends Service and Prisoners Wives and Families Society believe that this is fundamental to attaining a fairer deal for families. According to Sue Roberts, Director of PFFS: 'Since 1990, all prisoners have been entitled to a minimum of two visits a month, yet without the second assisted visit, many families could not afford to take advantage of this. We are delighted about the introduction of the second assisted visit; a reform we had been campaigning for more than 20 years.'

Another good news story is the assistance the Prison Service has provided to prisoners' families support groups. This year it contributed funds to the Federation of Prisoners Families Support Groups (FPFSG) – an umbrella organisation which acts as a voice for families and to several individual support groups.

In September 1991, the Home Office Consultative Group on Family Ties was launched, bringing together organisations such as NACRO, the Federation of Prisoners' Families Support Groups, SCF, the probation service and prison service. This group brings the prison service into direct contact with organisations working in the family ties area, enabling it to find out what families' needs and priorities are and what families think of changes in policy and practice. Members of the Consultative Group were recently asked for their views (and those of the prisoners' families they represent) on changes in the private cash system and how these might affect prisoners' families. Canvassing the opinions of prisoners' families and taking them into account before policy changes are initiated is sensible, humane and a major step forward for the prison service.

However, prisoners' families are not routinely consulted, or even taken into account, over many key changes in Prison Service policy and practice that affect them. One Prison Service initiative which bypasses families yet has a potentially adverse effect on them is the search for a system of incentives and sanctions. The 1994-97 Prison Service Corporate Plan states:

'The prison system will be organised, as far as possible, to provide differential regimes based on a properly structured system of facilities and incentives. As the prisoner progresses through the system, good behaviour and performance should be reflected in additional facilities and privileges. But facilities over and above the minimum need to be earned and can be withdrawn.'

The press release attached to the Corporate Plan points to Feltham as an example of how incentives might work.

'A points system ... gives inmates the chance to earn their way to privilege by not misbehaving ... those misbehaving can spend more time in cell and lose involvement in family activities.'

Prisoners' families feel strongly that incentives and sanctions should not be applied to family ties which imprisonment renders tenuous enough and difficult to maintain at the best of times. Contacts between prisoners, their parents, children and partners should not be seen as a privilege, they are important in their own right. A humane Prison Service should seek every opportunity to extend them beyond minimum entitlements whatever the behaviour of the person in prison. It is also worth noting that the Feltham points scheme has been heavily criticised recently by the Chief Inspector of Prisons. He found

'There was no single system operating throughout the establishment ... The rules were not consistent across the units, which confused inmates. The system gave power to individual officers to deduct points without reference to managers and, possibly as a result, there was a lack of consistency in its application ... inmates often felt they had been dealt with arbitrarily and unfairly. The monitoring of the loss of points was confused and varied between units.'

At present, only the Wolds private prison allows families to visit on every day of the year. All other prisons are closed to visitors on Christmas Day and Boxing Day and most are also closed on Good Friday. Last year, the Federation of Prisons' Families Support Groups raised this issue with the Prison Service, suggesting that prisons, like hospitals, allow Christmas and Boxing Day visits. One of the arguments put forward against this was that it would raise prisoners' expectations and cause undue pressure to be put on families to visit. Another was that it be unfair to prisoners who had no one to visit them. Similar points have been raised about town visits, home leave, prisoners' access to phones, and a number of other reforms. It might well, in some cases be true that prisoners put pressure on family members, but it is not up to the Prison Service to pre-empt the problems of prisoners' families and attempt to solve them before they even occur. Families' individual arrangements, the possible stresses their relatives may inflict on them, unfair or otherwise, are not the business of the Service. It is not its job to attempt to create an artificial society, where everyone is equal and people treat each other fairly and unselfishly, however nice that might be. Rather, it should be working to facilitate and enable the maximum amount of opportunities for family contact and allow families to negotiate whether or not and when to take advantage of them.

In the past, the Prison Service has shown itself able to respond flexibly to new areas of importance and concern. During the 1980's, Race Relations Liaison Officers and management teams were established at each prison to tackle racial discrimination and give proper consideration to race issues. A concern about increasing numbers of suicides led to the appointment of suicide prevention officers and creation of suicide awareness teams at every establishment. As yet however, there is nobody working in prisons with specific responsibility for prisoners' families. There needs to be a family ties officer with responsibility for services to prisoners' families at each prison, backed up by a family ties team at management level, to fill this gap, and help put into practice the positive policies which have been developed since the publication of the Woolf report ■

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