Special Care Unit

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FROM PHILOSOPHY TO THERAPEUTIC REALITY
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-- THE SPECIAL CARE UNIT AND ITS CONTRIBUTION TO MENTAL HEALTH IN THE NEW SOUTH WALES CORRECTIONAL SYSTEM
BY A.V. BAILEY AND DR. D.M. SCHWARTZ
(DELIVERED IN CANBERRA, 1982)

-- SPECIAL CARE UNIT: FROM CARING PHILOSOPHY TO THERAPEUTIC REALITY
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The Special Care Unit and its contribution to mental health in the New South Wales Correctional System

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"THE MENTALLY ILL OFFENDER IN CUSTODY: WHOSE RESPONSIBILITY"

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The Observation Unit at Long Bay was the subject of strong criticism by Mr. Justice Nagle in the Report of the Royal Commission into New South Wales Prisons. The old OBS Unit accommodated a wide range of prisoners: individuals who, while not sick, were very emotionally disturbed, sometimes violent and often unpredictable in their behaviour; prisoners who were being protected from other inmates; and men who were in need of continuing psychiatric treatment. It was clear that this Unit did not represent a solution to the difficult issue of mental health care delivery.

The Corrective Services Commission, from its inception, has been very mindful of the need to replace the OBS Unit. In developing alternatives to this facility, the Commission was aware of the need to provide a series of programmes to properly meet the needs of the many types of individuals who had been housed in the Observation Unit. In addition, the members of the Commission recognised that the development of new programmes carried serious implications for training of custodial staff who would be called upon to carry out the delivery of these initiatives.

In May 1980, Mr. John Horton and Dr. David M. Schwartz visited a number of institutions in Canada, the United States, Denmark, The Netherlands, England and Scotland in order to investigate the various alternatives developed for the treatment of mental distress and illness in other correctional systems. These officers were also asked to explore the nature of custodial training and involvement in mental health care delivery at these institutions. They incorporated their observations into the programme they were developing for the Special Care Unit (one of a number of facilities designed to replace the Observation Unit) to provide an opportunity for prisoners to explore emotional needs and life adjustment problems relating to imprisonment.

This paper deals with that project, as well as the broader issue of the changing role of the prison officer as demonstrated by custodial staff involvement in the Special Care Unit. Our discussion will begin with a review of legal issues relating to the care of mentally ill offenders in custody, current options for psychiatric care and future planning for mental health care delivery in the New South Wales Correctional System.
By and large, those male prisoners exhibiting signs of mental illness are transferred to the Observation Unit at the Long Bay Complex of Prisons where they can be examined and treated by psychiatrists. (In addition, at Goulburn Training Centre, there is an arrangement with Kemore Psychiatric Hospital for a psychiatrist to attend the gaol on occasions to make available a limited diagnostic and treatment service.) The Observation Unit at Long Bay is able to hold approximately twenty prisoners, a large proportion of whom are psychiatrically ill. Until recently, medical treatment was largely restricted to scheduled visits by nurses, to administer medication and occasional visits by doctors and psychiatrists for the purpose of making assessments and providing limited treatment. In the last few months, the situation has improved with the appointment of a psychiatrist having direct responsibilities in the Unit on a full-time basis, as well several psychiatrically-trained nurses and an occupational therapist.

When a female prisoner exhibits indications of psychiatric illness, she is placed in one of the five available Observation cells available at the Mialawa Training and Detention Centre for Women. Until recently, these cells, which are attached to the prison hospital, were used as temporary accommodation for these women pending assessment by a visiting psychiatrist. However, an arrangement has now been made with the Rydalmere Psychiatric Hospital whereby the Deputy Superintendent is "on call" to the prison should the Prison Superintendent decide that a prisoner is in need of immediate psychiatric treatment, thus eliminating this prolonged wait prior to examination.

When it has been ascertained that the prisoner can be scheduled as mentally ill in terms of the Mental Health Act, he or she is moved to a medical facility. Male inmates are transferred to a specially secured ward at Morisset Psychiatric Hospital and are returned to the prison system when, and if, their condition improves to the extent that discharge from hospital is warranted; female offenders are accommodated in a specially secured ward at Rydalmere Psychiatric Hospital. (It should be noted that a new prison hospital to be opened shortly at Mulawa will contribute to improved mental health care facility at that institution.) In addition to those inmates housed at Morisset and Rydalmere, there are a number of other prisoners scattered around mental hospitals in New South Wales who are not considered to be dangerous.

C. Future planning for mental health care delivery.

Despite the ongoing improvements being made in the provision of facilities for the care of mentally ill offenders in prison, both the Minister for Corrective Services and the Minister for Health are in agreement that there is an urgent need for further positive change. This need was confirmed by the Government when the Governor, in his Opening Speech on 12th August, 1980, to the Third Session of the Forty-Sixth Parliament, stated that a special medical and psychiatric care unit, comprising a modern hospital is to be built at Malabar. The need for such accommodation for both male and female prisoners remained acute in his estimation.

As a consequence, the two departments involved prepared the necessary drawings and operational plans for the provision of a 120 bed, high security hospital complex at Malabar. This facility will incorporate four 30 room units: one of the units will accommodate prisoners who, it is anticipated, will spend most of their lives in the prison/hospital; a second unit is to house prisoners in an acute phase of psychiatric illness; a third unit is to meet the needs of prisoners who have a chronic mental illness necessitating recurrent hospitalisation; and the fourth unit will provide facilities for physically ill prisoners (e.g., convalescing after surgery, recovering from a physical illness). Unfortunately, the State's
1. An overview of the legal basis for the care of mentally ill offenders in custody.

A. Legal Issues.

The following information represents a summary of the relevant sections in both the Prisons Act, N.S.W., and the Mental Health Act of New South Wales dealing with the custody of mentally ill offenders in custody:

1. Section 7 of the Prisons Act, New South Wales, provides that the Corrective Services Commission, subject to the direction of the Minister, shall be responsible for the care, direction, control and management of prisons. This Section further provides that the Commission (or subject to the direction of the Minister) may make provisions for the training, welfare and after-care of prisoners, either alone or in conjunction with other persons or organisations.

2. Section 9 provides for the Governor of the State to appoint a medical officer for each prison, upon the recommendation of the Minister for Health and with the concurrence of the Minister for Corrective Services.

3. Section 16 provides "that every prisoner shall be supplied at public expense with such medical attendance, treatment and medicine as in the opinion of the Medical Officer is necessary for the preservation of health for the prisoner and of other prisoners and of prison officers, and may be so supplied with such medical attendance, treatment and medicine as in the opinion of the Corrective Services Commission will alleviate or remedy any congenital or chronic condition which may be a hindrance to rehabilitation."

4. Section 23(3) of the Mental Health Act of New South Wales provides that if a jury finds that a person was mentally ill at the time of the commission of the act for which he or she is being tried, the presiding judge shall order that the individual be kept in strict custody in an institution and regime that the judge deems to be appropriate until the Governor's pleasure is known, at which point the Governor may give an order regarding the individual's safe custody in a prison. Release must likewise be dealt with by the Governor.

5. Section 27 of the Mental Health Act provides that if a person whilst under sentence appears to be mentally ill, the Minister for Health, upon the issue of certificates (in the form of Schedule 3), may order the removal of a prisoner to a hospital until such time as that individual is no longer considered to be mentally ill.

B. General overview of current options for psychiatric care in the N.S.W. Correctional System

The Health Commission is responsible for staffing the Prison Medical Service. Currently there are four doctors working on a full-time basis with that service, one of whom is a psychiatrist. Other psychiatrists are retained on a sessional basis at the Long Bay Complex of Prisons and at the Mulawa Training and Detention Centre for Women.

1 Prisons Act, New South Wales, 1952, as amended.
financial situation will not permit the immediate construction of the hospital complex. In the interim, a short-term solution is being developed using, for the most part, buildings already in existence at the Long Bay Complex of Prisons that have been refurbished and altered to meet the needs of their temporary role.

Included in this current development project is a small psychiatric unit managed by a psychiatrist and staffed with psychiatrically trained nurses and an occupational therapist. Some of the staff are already working in the Observation Unit, but they will be transferred to the new facility when it opens. However, other qualified personnel will be needed to conduct the programme of this Unit. In addition, it is anticipated that a limited number of custodial officers will be rostered for duty in the psychiatric unit. The stated purpose of this small institution will be:

- to observe prisoners who are considered to be psychiatrically disturbed.
- to treat prisoners who have been diagnosed as having a psychiatric illness.
- to retain other prisoners who need to be in the psychiatric unit.

In summary, we have attempted to sketch out our legal responsibility for the care of disturbed inmates and relate this to our current initiatives/options for psychiatric care, as well as future plans in that area. Let us next turn to a discussion of those individuals who bear the major responsibility for mental health care delivery in New South Wales prisons: the prison officers.

II. Custodial involvement and the changing role of the prison officer in the New South Wales Correctional System.

In recent years, there has been increasing debate about the role of prison officers and the quality of work that they are required to perform in a modern correctional system. In New South Wales this discussion was fueled to no small degree by the Report of the Royal Commission into N.S.W. Prisons, carried out by Mr. Justice Nagle. However, it would be unfair to overlook the ongoing concerns of prison officers themselves about their work roles which certainly predates Nagle's remarks. While the Royal Commissioner concentrated on the inhumane conduct of officers and the callous attitude of management in the System to treatment of prisoners in New South Wales, he did not seem to take into account the predicament of prison officers who were expected to perform a difficult and stressful job for which they received little or no training and enjoyed very low prestige in the eyes of society. This predicament was often brought to the attention of the second author when he was involved in prison officer training between 1977-1980. Many of these men and women in correctional work were seeking an identity as professionals, but had no idea of how to improve the sort of jobs they were being required to do. In addition to the abovementioned factors of societal criticism and personal dissatisfaction of prison officers, another source of pressure made itself felt: management accountability for the considerable financial investment in custodial wages. Simply stated, this last issue may be translated as follows: If the State is paying so much money to prison officers, it can surely expect them to do more than open and close gates and stand guard on towers. In brief, all of these criticisms seem to be nudging prison officers to take a much more active role in areas of human relations and prisoner management.

In its ongoing review of the training progression requirements for
custodial officers, the Corrective Services Commission has recognized the urgent need to focus attention in the area of human relations and has commissioned a number of modular training courses in this area from qualified psychologists.

These training segments have been revised a number of times in accordance with the experiences of those psychologists engaged in teaching them. It is anticipated that this special emphasis on human behaviour and associated problems will increasingly create an atmosphere in prisons conducive to the health and mental well-being of prisoners and staff alike. However, it must be appreciated that the process is a slow one.

The Special Care Unit was conceived as a therapeutic community in which prison officers were the therapeutic agents. They would be responsible for the day-to-day programming of the Unit in consultation with other professionals, such as psychologists, probation and parole officers, medical staff, clergy, etc. The emphasis of "other professionals" was an important one because we wanted officers in this unit to feel that they were to perform a job that was professional in every sense of the word. That is, they would be carrying out services whose value they could see and which would be requested by others in the System. As the start of this project we recognized that our greatest difficulty would be to convince prison officers of how severely hampered they were by the narrow role definition they had held for so long and how truly effective they could become with a minimum amount of initial training to take up the role of therapeutic agents in a therapeutic community.

In summary, it was noted that the role of the custodial officer has come under increasing criticism, not the least of which has been from the officers themselves. While everyone seems to be in agreement that change must take place, particularly in the area of mental health care delivery, few suggestions have been offered as to how custodial staff might redefine their work role. As was suggested, much of the criticism may be traced to a very narrow definition of the custodial role on the part of both prison officials and officers. Coupled with this was the very real ignorance on the part of officers about how to handle individuals with personality problems ranging from mild attention-seeking behaviour to psychotic episodes. In response to this situation, the Department of Corrective Services set up a task force to investigate the means by which mental health care could be more effectively and humanely delivered by prison officers. Out of these deliberations came the concept of the Special Care Unit. Prior to a discussion of the philosophy of the therapeutic Community and the ways in which the Special Care Unit has sought to embody the principles of that philosophy, we shall describe the early history of the project.

III. Special Care Unit: Planning, staffing and training for the project.

A. Royal Commission criticism of the Observation Unit.

The Observation Unit in the Central Industrial Prison at Long Bay was the subject of strong criticism by Mr. Justice Nagle in his report on the New South Wales Prison System. Nagle criticized that facility for a number of reasons. First, the facility itself was antiquated and, in his words, "Dickensian." He believed it to be unsuitable for the humane containment of prisoners. Second, he criticized prison authorities for placing untrained prison officers in that unit to supervise prisoners who were in need of specialized psychiatric care. It was his feeling (as well as that of many of the officers who have worked in that area) that custodial staff were not equipped to deal with the often disturbing and provocative behaviour of Mentally-ill prisoners and could not be expected to satisfactorily care for
Of these individuals without specialised training. In addition, he commented on lack of resident medical staff in the Observation Unit. At the time of Mr. John Horton's visit to the Correctional Services Commission in 1980, medical personnel visited the wing regularly to dispense medication and examine inmates; in the case of emergency, which often occurred, professional staff had to be summoned from another prison in the Complex. It was clear that standards of care in this Unit fell far below those to be found in non penal institutions. Yet another criticism levelled by Mr. Justice Eagle at the Observation Unit was the indiscriminate use of force by prison officers to deal with widely differing categories of prisoners. At any one time, the OBS could be found to contain the following sorts of individuals:

1. Medically certified prisoners awaiting transfer to Norwest Hospital.
2. Prisoners in the process of being certified.
3. Emotionally disturbed inmates who, while not medically certifiable, required on-going psychiatric care due to their unpredictable behaviour.
4. Inmates who had recently received life sentences and were under observation as potential suicides.
5. Prisoners whose acts of violence/aggression had caused them to become unmanageable in normal prison discipline for the time being.
6. Prisoners who needed to be protected from the sexual and/or aggressive actions of other prisoners.

In short, there were too many different types of individuals to be catered for by an untrained staff with no on-site medical back-up staff.

Positive changes have taken place in the Observation Unit in recent times. There is now a psychiatrist in charge of the facility, psychiatrically trained nurses on duty in the wing and an occupational therapist in resident. This is an attempt to take care of the mental health of the inmates who are being placed in the facility. The dilemma facing the Correctional Services Commission was the need to develop a variety of programs to meet the needs of those prisoners who were being housed in the Observation Unit without any medical justification (i.e., categories 4 to 6 above). To that end, Mr. John Horton and Dr. David Schwartz, recently appointed Superintendent and Senior Psychologist of the Special Care Unit, were sent on a fact-finding mission to see how other countries dealt with these sorts of prisoners.

1. Fact-finding mission to Canada, USA, Denmark, The Netherlands, England and Scotland.

Horton and Schwartz visited a large number of facilities and interviewed many individuals on that trip (see Appendix I for a list of facilities visited and individuals contacted). They were concerned with programmes available in other countries for the treatment of prisoners exhibiting a broad range of mental/emotional disturbance, as well as the contribution that custodial staff made to the care and treatment of these individuals and the training that these officers received to carry out such responsibilities. Prior to their trip overseas, it was the conviction of both these officers that custodial staff could perform a more meaningful role in caring for disturbed inmates. However, they were concerned that an appropriate model be identified and developed for the Australian situation to serve the needs described above.

In their report to the Correctional Services Commission, Schwartz and Horton categorised the facilities they had visited as follows:

1. Prisons which function as hospitals
2. Special hospitals
3. Therapeutic communities
It was this third category that seemed to hold the greatest degree of promise for the type of institution that was to become the Special Care Unit, due in no small degree to the high degree of participation afforded custodial staff in the management of those institutions and the positive emotional environment observed and experienced by Schwartz and Norton and confirmed in conversations with staff and prisoners alike.

The two institutions that provoked the most interest were H.M. Prison Grendon, Grendon Underwood and the Barlinnie Special Unit in Glasgow. Though these two facilities differed in a number of respects (Grendon holds no more than twenty-five prisoners in a wing; Barlinnie houses a maximum of eight men), both prisons work on the principle that the inmate community can exert a powerful and positive influence on the re-socialisation of prisoners in tandem with custodial officers. In both institutions, custodial staff are supplemented by various other professionals (medical officers, psychiatrists, occupational therapists, art therapists, psychologists, etc.), but the burden of responsibility for maintaining the integrity of the “programme” was carried by the prison officers in those institutions.

Five important insights were gained at these two therapeutic communities. The first point has already been touched upon; custodial officers could accept the responsibility for carrying out a treatment programme and experience personal growth through this expanded work role. In conversations with staff at both gaols, Schwartz and Norton learned that staff morale was high, officers felt greater job satisfaction than had previously been the case at more traditional institutions and, following from that previous point, believed they were making a genuine and positive impact upon the lives of the prisoners with whom they were working.

The second insight related to the personal cost paid by those officers for opportunity to achieve such a positive work experience. Other prison officers at adjacent penal institutions displayed antipathy towards these men. It seemed that therapeutic communities that function in prison settings were viewed by “rank and file” prison officers as a challenge to their notion of what should be happening in prisons in general and, by extension, as work that proper custodial staff should not be performing. It was obvious that the Special Care Unit would have to be staffed by volunteers, as had been the case at both Grendon and Barlinnie, in light of the antagonism which this type of prison management seemed to provoke.

The third insight related to the sort of training carried out by officers in preparation for working in these two settings. Because both programmes had been in operation for a number of years — Grendon opened in 1962 and Barlinnie in 1973 — those few members of the original staff could not recall what training had actually taken place prior to the opening of the institutions, save for the fact that they had visited psychiatric institutions, observed group therapy, read about and practiced counselling techniques and discussed issues relating to abnormal psychology and psychological development. Both groups of officers felt that experience in a therapeutic community would be the best sort of preparation for carrying out such a programme. Herein lay the important insight for staff training. Whatever the content of the training programme, it must be experiential in nature, simulating the sorts of group therapeutic techniques that would ultimately be carried out in the Special Care Unit.

The fourth insight related to the issues of structure and philosophy of the Special Care Unit. At Grendon, the day was organised around therapeutic groups and community meetings. Given the number of inmates (twenty-five prisoners in each self-contained wing at this institution), a structured programme was carried out to accomplish maximum contact in
small group therapy (eight or nine inmates in each of three therapy groups) and, following upon that, feedback to the entire unit at a large community meeting. By contrast, Barlinnie, containing only eight prisoners, had no structured programme. Therapy was focused on self-expression through the medium of art and poetry, as well as community meetings. Grendon's larger inmate population required a more structured programme, whereas Barlinnie's smaller numbers allowed a more flexible regime to operate. Yet another difference in the two units accounted for different operating philosophies. Grendon's programme was concerned with inmates nearing the end of sentence, while Barlinnie held long-term prisoners, some of whom had spent eight years in the unit. Thus, Barlinnie could afford to operate at a more leisurely pace, while Grendon's therapeutic impact had to make itself felt within a specific period of time.

Though the structured programme of the Special Care Unit took its cue from that of Grendon, the basic philosophy of inmate participation and personal goals was best expressed at Barlinnie. The aim of that unit is the development of model citizens, not model prisoners, and this is achieved by providing an environment in which the inmate is able to deal with issues of responsibility (to himself as well as the community) and freedom. In a sense, the Barlinnie Special Unit allows the inmate to begin rehearsing the role of a responsible citizen prior to his release.

The final insight gained by Horton and Schwartz related to the sort of "client population" that could best be helped by the programme being formulated. Initially it was thought that the Special Care Unit might cater for the whole range of mental disturbances, but the advice given was to be cautious against such an indiscriminate approach on the grounds that resources would be spread too thin to make any impact at all. This fact, coupled with the thorny issue of legal responsibility for the care of severely mentally ill inmates being entrusted to another government department led Horton and Schwartz to define suitable candidates for the Unit in terms of those inmates in "crises" (though not psychiatrically ill), as well as those individually due for parole whose need to understand how prison experience has diminished their ability to function successfully upon release.

C. Staff selection.

Upon their return to Australia, Schwartz and Horton set into motion the process of recruiting officers for the Special Care Unit. In the early planning stage of the project it had been decided that very few of the staff would be permanently appointed to the Unit (i.e., five Principal Prison Officers, the Assistant Superintendent, Superintendent and Senior Psychologist). All other staff would be seconded to the institution for an initial probationary period of six months, renewable for an additional period of twelve months if the officer was suitable in carrying out the duties required and desired to remain attached to the Unit. The rationale behind the decision to staff the facility with seconded officers rather than permanently appointed ones related to the desire of the Corrective Services Commission to use the Special Care Unit as a training facility in which officers could experience an expanded work role and subsequently return to the main prison system with the benefits of this training. The description for these twenty-four seconded positions read as follows:

"The Special Care Unit is an experimental therapeutic community run by a team of custodial, psychological and other professional staff. It will operate in an informal, non-traditional manner, which will be characterised by a high level of democracy, where frank and open discussion will be encouraged, and where there will be a maximum involvement in the decision making process."
Officers employed in the Unit must be understanding, accepting and empathetic. Selected officers will be stable and mature in temperament, well informed about modern psychological practices and have demonstrated an interest in the Department on a career. They will also have the ability to function in a multi-disciplinary group.

Experience obtained from working in the Special Care Unit will prove valuable to officers when they return to the "main stream" of the prison community.

Because of the special demands placed on officers who work in the Special Care Unit, it is not anticipated that overtime will be worked. 2

Apathy to the project was much higher than expected. The advertisement was circulated four times and three sets of interviews were held to obtain the initial complement of prison officers. The interview itself was non-traditional. Applicants were first given a series of psychological tests:

1. a semantic differential designed to measure the degree to which applicants could discriminate among a number of categories of people,
2. Survey of Interpersonal Values, used to tap helping orientation of the applicant, and
3. Fire-B, an instrument designed to assess the configuration of the applicant’s fundamental interpersonal relations orientation: need to give and receive affection and desire to control (lead) or be controlled (described as not wishing to be accountable to those in charge, nor have those in supervisory positions make decisions for them).

Applicants were then given individual interviews during which they were told about the aims of the Unit and questioned about their reactions to this. Following this, the applicant was presented with a number of hypothetical prison situations (e.g., a depressed prisoner, a manipulative prisoner and a physically assultive prisoner each of whom behaviour requires the officer to respond in some unspecified fashion) and asked what action he or she would take. In this part of the interview the applicant’s flexibility, interpersonal concern and ability to act in a non-traditional fashion was being assessed. Finally, three videotaped vignettes were shown to applicants with the following introduction:

"Imagine that each of these individuals has come into your office to seek your help. What you will see is the client’s opening statement of his problem or difficulty. What we would like you (the applicant) to study is your first response to the client. Keep in mind that your purpose in making this response is to initiate the therapeutic or helping relationship."

The characters in the vignettes were a distraught Black father who realises that he and his son have a serious conflict of values, an angry young parolee who has been "busted" for smoking marijuana and required to see a counsellor, and a pathetic young husband who has lost his job and is seriously considering suicide. The applicant’s responses were graded in terms of the ability to make a positive counselling response (personal, non-judgmental, caring, etc.). These vignettes proved most difficult for the candidates, but were a valuable indication of the abilities of applicants to perform in the Special Care Unit programme. Approximately forty-five prison officers were interviewed for the seconded positions -- twenty-one men and three women were selected.

2 New South Wales Department of Corrective Services Vacancy Notices. In addition, the positions were advertised in Public Service Board notices and in Sydney newspapers and, as a consequence, two more officers were recruited.
The inclusion of females on staff was a major breakthrough. Although neither Broadmoor nor Borallon had female prison officers on staff, both jails had females in their programmes as art/occupational therapists, medical officers or psychologists, and officers questioned at those institutions, as well as many of the others visited, believed the various environments benefited appreciably because of the presence of women. In addition, all prison officers questioned did not believe that the women were in any personal danger, nor was prison security being compromised by their presence. Mr. R. Donnec, then chairman of the Prison Officers’ Vocational Branch, Division of the Public Service Association of N.S.W., agreed to the mixed staffing of the Special Care Unit on an experimental basis. In addition to the three seconded females, a woman was appointed Principal Prison Officer, another advance inasmuch as she would be supervising males as well as females.

D. Training Programme: Intent and Content

A copy of the Initial Induction Programme is appended to this paper (see Appendix 2) for reference. The programme was drawn up by the second author of this paper in consultation with John Horton. The aims and specific goals are stated in that document. Beyond these stated objectives, it was hoped that in the course of the training programme the following would occur:

1. Custodial staff would seriously question their traditionally passive role and begin to exercise independent modes of decision making.
2. Staff would recognise how the traditional custodial role limits their options to care for individuals in crisis.
3. Officers would understand how they could be therapeutic agents without compromising their need to maintain security.
4. Staff would become a community and begin to develop a joint approach to problems of management.

This last point needs to be expanded upon. During the month of training, the staff developed a very high level of community. This was due in no small part to the fact that training sessions were held in the modern educational facilities of a large teaching hospital in the Western suburbs of Sydney (Westmead Hospital) and meals were eaten there in the staff cafeteria. Being absent from the traditional prison setting and also being away from former custodial colleagues, the staff was able to establish new relationships in a supportive environment.

The content of the programme needs some explanation. Much of the first week was concerned with the development of group cohesiveness. To that end, structured topics were set for discussion in small groups which, in turn, would report to the large group of participants. At the time, staff were unaware of the fact that this mode of functioning was to be the model for the Special Care Unit programme (small therapy groups and large community meetings). Past experiences with prison officer training indicated that exercises involving self-disclosure were very difficult to run. However, such exercises were called for, particularly with regard to the clarification of personal goals. It was decided that this task be run in the following fashion:

Each participant anonymously filled out a sheet of paper completing each of the following statements--

a. Hopes I wish to achieve by working in the Unit
b. My fears about working in the Special Care Unit

d. These pieces of paper were then placed in two boxes (Hopes, Fears) and mixed up, after which each participant was asked to draw one paper from
each box. In the small groups, participants discussed the responses they had drawn and prepared a summary report for the plenary session. On large sheets of paper, each group's reports were summarized and these were discussed.

In this fashion, self-disclosure was achieved very early in the training programme and a considerable amount of affect was expressed by the participants because of the realization that so many of them held the same sorts of hopes and fears. The other important highlight in the first week was the discussion of "What is a therapeutic community?" The groups were required to define three concepts: therapy, community and therapeutic community. "Therapy" presented the greatest difficulty due to the insistence of participants that "it is something we, the officers, do to them, the prisoners." Though originally scheduled for 2½ hours, the discussion occupied more than 6 hours, at which time the realization occurred that therapy was a process involving mutual growth. These moments of insight contributed immeasurably to the growth of community among the participants.

A cursory glance at the programme will reveal that there were only a few sessions in which course members were passive participants (e.g., abnormal personality, transactional analysis concepts, behaviour modification, psychiatry: what & how?, the "whole person" concept). Perhaps as a function of the experiential and participative nature of this training, even these sections of the course were characterized by a very high degree of discussion and questioning of material presented.

The institutional placements were carried out at three psychiatric hospitals (Parrawatta Psychiatric Centre, Rydalmere Hospital, Gledswood Hospital) over a period of two days, rather than four. The additional two days were occupied with counselling exercises and role plays that were videotaped and analyzed for non-verbal imagery as well as verbal messages.

The purpose of these psychiatric site visits was to de-sensitize officers to the "acting out" of mental patients, as well as allow them to observe group therapy. In the end, course participants felt more comfortable with the issue of psychiatric illness and dealt openly with their apprehension in relation to personal contact with individuals exhibiting emotional disturbance.

In summary, planning for the Special Care Unit proceeded from criticisms contained in the Report of the Royal Commission into H.S.W. Prisons, as well as a concern on the part of the Corrective Services Commission, John Horton and David Schwartz that prison officers were capable of performing a much more active role in the care and management of prisoners than had hitherto been the case. Justification for these philosophical convictions was found by Schwartz and Horton overseas, particularly at H.M. Prison Grendon and the Barlinnie Special Unit. Two therapeutic communities operating in prison settings where custodial staff were responsible for the treatment programmes. On the basis of insights gained from these fact-finding missions, staff were selected and a training programme was devised.

IV. The Special Care Unit: Therapeutic community as treatment model

A. Philosophy of the therapeutic community

A number of authors have discussed the concept of the therapeutic community. They are essentially in agreement that the concept defines a style of management and a philosophy of caring representing an attempt to reduce formality and humanize relationships, share input in the decision-making process by means of group discussion and consensus-taking, provide maximum communication throughout the therapy setting and reduce to a minimum the hierarchical system commonly found in institutions and social organizations.

In their study of Grendon Prison, Gunn and his co-workers (1978) provided the following quotation from Dr. Gray, the first Governor of that establishment:
"The treatment philosophy towards which Greenson aims is that of the therapeutic community, that is, a system in which all the individuals of the institution -- staff, patients and relations -- are mobilized in the interests of treatment. Treatment takes place in small groups and in larger community meetings of thirty or forty people living in the same wing. Therapy taken place by the elucidating and working through of personal relationships.

"Side by side with this involvement of patients in each other's treatment an endeavour is made... to get patients to participate in the organisation of their own activities and in making important decisions about each other.

"The activities into which patients at Greenson are encouraged are likely to be more rehabilitative than the customary institutionalised dependency... A population who are grossly disturbed in their capacity for personal relationships... benefit from a situation which maximises the possibility of such relationships. Since disturbed individuals are notoriously prone to distorted ideas of reality it is hoped that frequent meeting with other patients may constitute an opportunity for genuine reality confrontation.

"The essence of the system is to help patients to mature by giving them a high degree of responsibility (as in) an atmosphere less authoritarian than usual..."

"Care is taken that decisions on the running of the institution shall, as far as possible, be democratically arrived at by all grades of staff and patients, rather than by a flint of the Medical Superintendent." (p.77)

Elly Jansem (1980) founder and director of The Richmond Fellowship, an international organisation fostering the growth and support of therapeutic communities, has described them as follows:

"Drawing on the disciplines of social psychiatry and group psychoanalysis, as well as on fundamental humanitarian ideals, the therapeutic community is based on a number of principles, some of which present paradoxes which are part of either the charm or the exasperation of the work, depending on one's point of view.

What are the usual components of the therapeutic community?
---agreement to join after the fullest possible exploration of the issues
---for an agreed purpose which is shared by the other members
---the purpose being to obtain help with psychological difficulties
---within a structure specially designed to illuminate personal problems, by involving people directly in community living and encouraging face-to-face encounter
---with the aim of eventually leaving the community
---in order to live as a viable member of society.

The features which enable a community to fulfil its therapeutic aims have defied close definition; however, some consensus has evolved on the governing principles. Robert E. Rapoport (in his book, Community as Doctor, London: Tavistock Publications, 1960) formulated a set of beliefs which he felt tended to unify all forms of the therapeutic community (with reference to the hospital setting):
---the total social organisation in which the patient is involved and not only the relationship with the doctor - is seen as affecting the therapeutic outcome
---the social organisation is not regarded as a routinized background to treatment, but as a vital force, useful for creating a milieu that will maximize therapeutic effects
the core element in such an institutional context is the provision of opportunities for patients to take an active part in the affairs of the institution ("democratization").

all relationships within the hospital are regarded as potentially therapeutic.

the "emotional climate" of the institution is accorded significance, and warmth and receptivity are in general regarded as helpful

--a high value is placed on communication for its morale-building and therapeutic effect on staff as well as patients."

(p.24).

It was the endeavour of Schwartz and Morton to emulate those principles as much as possible. At the completion of the training programme, staff seemed ready to work with inmates along the lines described above. While actively seeking to promote an atmosphere of informality in the Unit, officers, after considerable debate, decided to retain their uniform in the Special Care Unit in the belief that the oft-stated antithesis to "the actor in the uniform" must be overcome realistically. Inmates would have to confront their own ideological concerns about this outward symbol and learn to relate to the individuals within the uniform. It was also hoped that this learning experience would be generalised to officers outside of the Special Care Unit.

Another decision taken during training was the adoption of a series of rules, dealing with life in the community, that were to be followed in addition to standard prison rules and regulations (see Appendix 3).

B. Translating the philosophy of a therapeutic community into action

1. Criteria for admissions and discharges. Information regarding these issues was detailed in Department of Corrective Services Circular Number 81/19, issued on 2 June, 1981 (see Appendix 4). The problems involved in detailing the complex issues of admission criteria, program philosophy, admission procedures and discharge procedures were formidable. The information had to be directed to the widest possible lay audience in a form that was both direct and meaningful. In addition, the guidelines needed to be stated in such a way as to allow for maximum flexibility. During the year that has intervened since the publication of this document staff in the Special Care Unit have had an opportunity to assess the value of this circular in terms of the sorts of referrals that have come to the Unit for admission. All in all, the document must be considered a success inasmuch as a large number of those individuals proposed for the Unit have been appropriate, but problems continue to be associated with this task of "defining the Special Care Unit" and the "target client" to both staff and inmates.

At least four types of difficulties have been associated with referrals sent to the Unit by Corrective Services staff:

a. A number of staff in positions of authority have recommended inmates to the programme without informing the prisoner that he has been referred. More often than not, the individual has come to the interview with a great deal of anger and hostility, totally disinterested in discussing potential admission and very distrustful of the interviewing team. These instances of staff paternalism have caused considerable distress for inmates concerned.

b. On a number of occasions, custodial staff have referred individuals for the Unit whose behaviour is indicative of severe mental illness. When this fact has been pointed out, the staff in question typically shrug their shoulders and say "If you can't help someone who is sick, what do you do?" This attitude can best be characterised as one of inappropriate expectations.

However, assuming that the motives of referring staff are sincere,
we feel the concept of the Unit has been misunderstood because it has sensitized staff to the issue of mental disturbance.

c. In a number of cases, staff have referred prisoners to the Unit in an effort to "rescue" those individuals from a hopeless prison situation. Several examples come to mind of this sort of "rescue" operation:
   (1) the retarded prisoner who has constant problems relating to staff and inmates and wants the heart of their practical jokes.
   (2) the prisoner with a long history of suicide gestures, coupled with a considerable amount of self-destructive attention-seeking, that becomes particularly apparent when the "rescuing" officer is on leave.
   In each of these cases, the referring officer has an inappropriate expectation of what this programme could accomplish for the prisoner in question. In effect, the "rescue" seems to be asking the Special Care Unit to take over the rescuing role from the officer.

d. On a number of occasions, psychologists and probation/parole officers have referred cases to the Unit out of desperation, due to the lack of programme options, similar to the Special Care Unit, that would provide a humane "time out" from the typical prison system. One example of this was a referral from a psychologist for a prisoner weighing 160 kilograms who, it was hoped, would come into the Unit to lose weight and increase his self-esteem. Another instance was the young offender who had been brutally raped and, it was suggested by the p/p officer, needed a "nice place to calm down and get his head together."

To a greater or lesser extent, all of the individuals referred in the four kinds of situations need "some place to go to" but the Special Care Unit is not indicated in these instances. The prisoners in each case have not defined a personal issue for "work." It is in this notion of self-help that is central to the group therapy programme in the Unit. In most of these inappropriate referrals, the prisoner has not set out goals for himself that he hopes to achieve during his stay.

The difficulty of defining the programme of the Special Care Unit to inmates revolves around two issues, one of which we have touched on in reference to the "self help" issue. When a prisoner is interviewed for entry, he is required to stipulate his goals for his therapy. In addition, he is required to set a time limit within which he will attempt to meet these goals. It is these two points that seem to be most difficult for inmates to comprehend.

2. Admission procedures: Officer and inmate participation.

The admission procedure for inmates is carried out in two stages:
   a. Initial screening session conducted by Special Care Unit psychologist and prison officer
   b. Entry assessment of candidate by a panel of officers and inmates held in the Special Care Unit.

This two phase process has been found to be necessary to enable candidates to clarify their motives and goals, as well as allow community members (officers and inmates) an opportunity to participate in the admission process.

During the initial screening interview, a number of purposes are accomplished. Initially the inmate's reason(s) for coming into the Special Care Unit is reviewed in a discussion of either his application for interview or the referral that has been submitted on his behalf. (It should be noted that referrals may come from any number of sources: psychologists, probation/parole officers, clergy, prison officers, solicitors, judges, the Ombudsman's office, etc.) This discussion inevitably involves a
description of the Unit programme, as well as a number of misconceptions about the facility generally held among members of the inmate population. Explaining the prisoner's need to enter the Unit is often a difficult process. In a large number of cases, the inmate is unsure about what he could do in the programme other than "get my head together." Obviously this sort of response is unacceptable as the basis of a therapeutic contract for the simple reason that there is no opportunity to evaluate when such a global and undifferentiated objective has been met. This process of negotiating the therapeutic contract is of central importance inasmuch as most of the applicants have been unaware that the Unit programme involves contracted self-help. Psychological intervention in the prison system is often perceived as supportive in nature, a means of talking about a crisis and resolving tension. However, therapeutic contracts are rarely entered into at Long Bay (where the Special Care Unit and most of our prospective clients are located) due to the transient nature of the population there and the enormous difficulty of carrying out meaningful psychological intervention in a maximum security setting. Thus, a large task of the interview involves the explanation of the contract as a public statement of goals and objectives that can be evaluated during the course of the therapeutic intervention. Often the inmate is asked to more carefully define his goals and objectives with the help of psychologists in his particular goal, after which another interview is arranged.

This process of negotiation and refinement of goals has been a very successful means of separating genuine candidates from those who wish to enter the Unit solely to benefit from its benign environment, increased telephone contact with family and friends and generous visiting arrangements (contact visits all day during the weekend, for example). It is understandable that inmates would like to take advantage of such features of the programme; likewise, it must be accepted that manipulation is a "way of life" for many of the men we deal with. During the initial screening interview, every effort is made to deal honestly with the inmate. If it is felt that he is not being entirely frank and honest about his reasons for wishing to enter the Unit, he is told so and invited to restate his needs or terminate the interview at that time with the option of requesting another interview at any time.

The question might now be asked about how this sort of process applies to individuals in crisis. Can such individuals enter into such protracted negotiations? The answer is that few of our candidates are experiencing acute crisis at the time of interview. In those cases where the need was urgent, the candidate was immediately brought to the Special Care Unit for an entry assessment, during which the therapeutic goals were discussed. More often than not, the "crisis" that most of our prisoners describe is related to their personal inadequacies (e.g., highly aggressive tendencies, inability to relate to others, low self-esteem etc.). In this sense the issue is one of "life crisis." Experience has demonstrated that those individuals who are sincere about dealing with such personal problems readily enter into this initial negotiation process of one or more interviews and seem to derive benefit from discussing these matters with the interviewing team.

Having spoken of the function of this initial interview from the point of view of the inmate, the benefits gained by the interviewing officer must also be noted. As previously stated, this interview is carried out by one of the Unit officers and the psychologist. When the programme began more than a year ago, the psychologist was involved in only about a third of the interviews, the balance were done by two officers who would return to the Unit after the interview and report their impressions as well as the content of their discussion. However, officers felt they needed more guidance in interviewing, believing they were not sufficiently skilled in negotiating a contract with the candidate. The decision was then taken to include the
psychologist on every interview, after which he would review what had been done with the "officé on the team (i.e., jail residence, contract negotiation, confrontation of obvious manipulation, supportive counselling, etc.). In the early stages of this scheme, the custodial officer deferred entirely to the psychologist, but with practice and some prompting, the officers have begun to take a more active part in the initial screening interview.

The second stage of the admission procedure involves an entry assessment of candidates by a panel consisting of three inmates residents and three officers, one of whom had been on the initial screening interview. It is this officer's job to introduce the candidate to the panel and, if necessary, aid the prisoner in clarifying his goals and objectives for entering the programme. Because of his position in the management structure of the Unit, it is the psychologist's presence would hinder open discussion of the candidate's merits by both prisoners and officers. In addition, there seemed to be little reason to duplicate the original interviewing team at this assessment. The ten new officers for this assessment are selected from the daily roster by the psychologist; the inmate members are elected by the entire community as part of the Assessment Panel which also deals with the important self-assessment process (discussed in a later section of this paper).

It is relevant at this point to highlight this participation of inmates on this panel and relate it to the programme. The greatest barrier to therapeutic progress in any prison setting is the "prisoner code" which Conn et al. (1978) describe in the following manner:

"These traditions are irreconcilable with participation in a therapeutic community, which requires people to examine themselves and to change in the light of what they experience in the community. The values of the sub-culture demand the opposite approach: they depend on rigid stereotyping, and a gulf between prisoners and staff, and on an inflexible code of conduct." (p.77)

During the early days of the Unit, entry of candidates to the Unit was determined entirely by staff. Inmates were informed after candidates had been discussed and accepted. As prisoners began to identify more and more with the goal and the Special Care Unit, they sought a greater voice in the selection of future residents. At this stage, they asked to be informed of potential candidates. Informal discussions were held and the perceptions of residents figured in the final decision process. The final stage in this progression was the formalisation of prisoner participation on an elected panel. This represents a "giant step forward" because previous prisoner input was informal and "off the record," whereas the election of an assessment panel (which soon became common knowledge among the rest of the prisoner population) represented a formal "break" with the prisoner code which implies the following: no inmate may sit in judgment of another prisoner, particularly in company with prison officers. Surprisingly, this participation of inmates has met with little comment from prisoners who have been interviewed; it is seen as part of Unit programme strategy.

The presence of the inmate/officer assessment panel serves a dual function for prisoners being interviewed:

1. It is indicative of the participatory nature of prison officers and inmates in Unit management. Because equal numbers of inmates and prison officers are present, neither group has the advantage of numbers and both groups have an equal voice in discussing the merits of each candidate's case.

2. The candidate makes concerning his work in the Unit (the therapeutic contract) is a public one, stated before
Following the entry assessment, candidates are asked to leave the group while his case is discussed, after which he is called back to learn the decision. To date, only two inmates have been refused admission and one other candidate was asked to return to his cell and clarify his objectives during the course of meetings with the Unit psychologist in the ensuing month, after which he was re-assessed. In the case of the two refusals, the candidates were given honest feedback about the panel's decision. Both of these individuals reported being impressed with the openness of the process in spite of their disappointment at not being accepted. In those cases where the prisoner has been accepted into the programme, a date is arranged for the prisoner's transfer to the Unit and an informal orientation discussion about Unit rules and operating procedures is held.

3. Therapeutic programme: Small and large group therapy.

As has been implied previously, therapy in the Special Care Unit consists of many elements, including relationships with prisoners and officers, the resolution of interpersonal crises in the Unit and coming to terms with situations arising outside of the prison (breakup of relationships, deaths, family problems, etc.). Each of these experiences provides a potential for learning. The function of both small and large therapy groups is to give the prisoner an opportunity to discuss these learning experiences and evaluate them in the light of feedback from peers and officers. The two types of therapy groups are meant to have different functions.

The small therapy group meets daily in the morning for one and a half hours. At present there are two groups meeting simultaneously in the Unit, consisting of 7-10 members and facilitated by one or two prison officers. In addition, the Unit psychologist visits each group on alternating days to maintain contact with issues being discussed by inmates, as well as aiding officers who are serving as group facilitators. Following the meeting, the psychologist meets with the facilitators of both groups to discuss the content of the meetings, offer suggestions about the subsequent course of therapy, explain particular cases, describe and elucidate group dynamics from his perspective, as well as give feedback to the officer-facilitator he has just observed. This last function is central to the psychologist's training role in the Unit; the other information discussed relates to the psychologist's function in the therapeutic programming of the Special Care Unit.

During the small group therapy meeting, the focus is on intrapersonal issues; inner concerns and problems that have been identified by prisoners (as part of their therapeutic contract) as needing attention. In the words of a Unit resident, "these are the sort of things that kept me from being happy on the outside." Such issues as low self-esteem, inappropriate aggressive tendencies, poor communication skills and lack of assertiveness are typical examples of topics dealt with in the small group. Each prisoner is expected to speak openly about himself; the group, in turn, functions as a "social mirror" providing the speaker with honest and realistic feedback. This is very necessary since many inmates maintain very distorted and unrealistic images of themselves and their social reality. Of course, everyone benefits from this interchange; the inmate gains a more accurate sense of self, the other prisoners in the group are called upon to break through the boundaries of self-preoccupation (an all-too-prevalent issue with the most of the prisoners we have so far encountered) and place themselves in a "helping role", and the officer is in a position to experience prisoners as individuals who are dealing with fairly universal life issues. In thinking about the effects of therapy on officers, one is once again reminded
of the breakthrough during the induction training period: Therapy is something we all do for each other – it is about mutual growth.

Having described the process of what goes on during small group therapy, it would be important to contrast this with traditional counselling relationships and place these "one-to-one" in the context of the Unit programme. In the Special Care Unit, every effort is made to inform the inmate that there are no confidences held in secret. All information may be used for therapy, but there is a clear understanding that the prisoner will be prepared in advance for any discussion relating to highly personal material. This constraint on "one-to-one" counselling relationships relates to the public nature of therapy taking place in the Special Care Unit. The majority of prisoners in the programme have very disturbed and/or inadequate relationships with others, both in and out of prison. The insistence on public disclosure and self-revelation serves to focus these relationship problems for inmates. No less important is the fact that this orientation of the programme to public process avoids the pitfalls sometimes experienced by counsellors, such as the manipulation of the therapist to accept a particular account of the client's relations with others. In a sense, this focus on the group-as-therapist is a logical extension of the public accountability that was begun at the initial screening interviews and highlighted at the entry assessment. Thus everyone is felt to have a contribution to make to the personal growth of each member in the community.

Yet another problem encountered in traditional counselling situations (and far more serious one in the long term) is that of the client's dependency on the therapist. All therapeutic contacts are finite; they must come to an end at some point. All too often, the client particularises his personal growth to this relationship with the therapist and suffers a setback at the termination of therapy. In an effort to avoid the debilitating effects of such dependencies, we have endeavoured to limit such contacts to the focusing of work by the inmate that will ultimately be carried out in the small group. Rita Nicholson (1982), one of the officers in the Unit, has eloquently stated this process in the following extract from a position paper about her counselling work:

"We are dealing with individuals. Some inmates can unravel their tangles by remaining detached and analytical. Some allow their emotions to cloud the issues. Many are afraid of introspection lest they destroy their own self-esteem, or lose the respect of others. Yet others (mostly those with repressed guilt and low self-concept) will reveal themselves only to someone they have learned to trust and can accept as — in psychological jargon — "a significant other". Fortunately, those who make the heaviest demands also give the greatest payoffs.

"The 'loners' feel more able to test themselves out in a one-to-one relationship, before confiding in a group of people with whom they may frequently not even identify.

"For those taking a long time to open up in a group situation it may be more expedient to first establish a one-to-one relationship, progressing to a triad, and then to group. This can be achieved in a team spirit, without professional rivalry or empire building."

To date, this practice has proved most successful. The psychologist is personally involved only at the point of the triadic contact, but the inmate is aware that his progress up to that point has been monitored by the psychologist in consultation with "the significant other." These triadic counselling sessions represent the rare instance when work is carried on by the psychologist in the privacy of his office. At all other times, meetings with inmates are held in the public spaces of the Unit, symbolically

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reinforcing the public process of work being carried out.

The problem of self-disclosure in small groups was initially very difficult to overcome. As stated previously, self-examination and self-disclosure are antithetical to the prisoner code. In the prison system, such activities are considered to represent weakness, an admission on the part of the prisoner involved in such activity that "something is wrong with him." To complicate this difficulty by placing a prison officer in the role of therapy group facilitator might seem to be foolhardy, but we knew that one of the most important lessons to be learned by residents of the Special Care Unit was that of relating to prison officers on a personal basis. To achieve this end of building a meaningful personal contact that would ultimately allow officers to facilitate therapy, inmates were brought into the unit very slowly during the first weeks of operation. In this period personal relationships were established among inmates and officers. Once this was accomplished, a group discussion period was established that was essentially unfocussed. No effort was made to facilitate this interchange in any formal manner. When there were eight inmates in residence during week two we broke up into two groups with one officer sitting in on each group along with the resident psychologist and another psychologist. From that time, officers were always present to co-facilitate group therapy with a psychologist and the practice was not questioned. Every new inmate is now socialised by the "old hands" into dealing with the custodial presence in the unit and working through issues of trusting officers (in spite of previous negative experiences, sometimes involving officers now attached to the unit) as part of the initial "work" of his residency.

Recently, there has been some discussion among staff and residents about bringing "outsiders" (non-residents) into the small therapy group. To date, the psychologist and a number of staff and inmates have opposed this move, viewing this as an erosion of the purpose of this group. An alternative proposal has been made that special small groups be convened for inmate volunteers and outsiders (family of residents, friends, etc.). This latest development in small groups has yet to take place.

There are a number of large therapy group options, including the following:

1. Community meeting
2. Crisis meetings
3. Communication/debating group
4. Jobs group

The most important of these groups is the community meeting. Initially, the community met every weekday, but as of 12 October a vote was taken to hold these meetings only on Mondays, Wednesday and Friday, beginning at 12.30 with no fixed time for conclusion. Inmates are required to attend for at least the first hour, all available officers are strongly requested to attend as well.

The community meeting, from the inception of the Unit was described as the venue for discussion of the following:

1. Problems relating to housekeeping issues, as well as allocation of work assignments,
2. Needs of community (e.g., replacement of sporting equipment, furniture in need of repair),
3. Rules relating to the management of inmate privileges, such as amount of time allowed for telephone calls, conduct of contact visits, areas to be used for visits, etc.,
4. Resolution of interpersonal conflicts among members of the community,
5. Requests for variations in community rules (extra telephone calls, additional visits, missing therapy groups, etc.),
6. Issues dealt with during small group therapy,
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7. Sanctions to be imposed for failure to meet "standards" of community (i.e., breaking rules)
8. Procedures for carrying out Unit programme (self-assessments, induction of new inmates, etc.).
9. Election of various Unit officers (Chairperson, Secretary, members of Assessment panel, members of Inddy Corporite),
10. Orientation of visitors to Special Care Unit

The focus of the community meeting is on interpersonal issues, in contrast to the small group therapy sessions where attention is concentrated on intrapersonal material. From a therapeutic perspective, these large community groups are concerned with working through issues involving relationships among members of the entire community. Not surprisingly, these interactions have proved to be the most negative expressed in the Special Care Unit.

An analysis of the underlying reasons for the conflicts witnessed at these meetings seems to indicate two major themes:

1. An inability to come to terms with the central notion of "community": a state of affairs in which everyone feels a sense of responsibility to self and others, as well as meaningful personal involvement with one another.
2. A misunderstanding among inmates about the management of our therapeutic community that might best be described as revolving around the difference between a democracy versus participatory decision-making and problem-solving.

From a psychological point of view, the difficulties that have grown out of the second of these themes certainly relate to those personality deficits that account for problems in the first area. An attempt will be made to briefly explain these two sources of conflict.

One of the clearest definitions about "community" comes from Dr. Howell Jones (1953), one of the most influential spokesmen for the therapeutic community movement:

"Our aim is to achieve a communal responsibility in relation to patients or staff. This distribution of responsibility while frequently increasing the tensions leads to a far more realistic attitude towards treatment... The cultural pressure of the Unit community is directed towards his acceptance of a more useful social role, which may then appear desirable because of his growing identification with the group." (p. 159-160).

During the community meetings, situations have often arisen in which an inmate wishes to fulfill his needs without regard to the key issue of communal responsibility. For example, in the early history of the Special Care Unit, telephone privileges were made for liberal use of telephones. At that time, there were only a handful of prisoners in the Unit, no consideration was given to length of 'phone calls. As the number of prisoners increased, more and more friction developed over the amount of time certain inmates were using this facility. Countless hours were spent in meetings to settle this problem; to date, no solution has been achieved because the prisoners do not seem to grasp the concept of "community" as an embodiment of "the social contract", a living arrangement in which the individual is given the opportunity to fulfill his needs, but doing this in such a way as to not interfere with another inmate's ability to fulfill his needs as well.

It has been stated elsewhere in this paper that one of the goals of the therapeutic community is to give its inmates a less distorted perception of reality. Clearly, the example of the problems arising over use of telephone privileges typifies such a distortion: in this case, an uncaring and unrealistic desire to fulfill one's needs at all costs. It should not be
surprising to us that prisoners in the Special Care Unit would have deficits in this area. The criminal careers of men, if not all, of these individuals has been the result of an inability to come to terms with the values of a particular social order. Staff have made numerous attempts to model responsible action at the community meetings in an effort to sensitize the inmates to the requirements of a more socially appropriate style of doing things. It is these efforts that have given rise to the extreme negative effect witnessed at these sessions.

In a clinical sense, the negative interactions between inmates and staff may be seen viewed as resistance, a phase in the therapeutic process when the client attempts to disrupt the progress of the therapy. Often, resistance takes the form of negative transference, a situation in which the client transfers to the therapist negative feelings he had not resolved in the past. In this case, our prisoners are "acting out" the unresolved attitudes they have had to various authority figures in their pasts. This experience has been difficult for the staff to understand.

The other source of difficulty experienced during community meetings arises from a basic misunderstanding about the management of this therapeutic community. Though numerous efforts have been made to explain the Special Care Unit in terms of participatory decision-making and problem solving, the prisoners have consistently chosen to construe this to mean "democracy." Dr. M. Sainsbury (1980), in discussing the issue of permissiveness, responsibility and authority in a therapeutic community has focused on this problem:

"The concept of permissiveness has been touched upon, and the point made that one is as permissive as a patient's mental state will allow. There is a tendency to overlook the implications of this and to develop a laissez-faire attitude with respect to individual patient requirements and management. The general therapeutic community umbrella, with in-built group therapy sessions, is hidden under, patriarch-like, by some staff as if this milieu will completely protect suicidal patients or those grossly disturbed by delusional thoughts. It helps, but it is not enough for these patients." (p.17).

"Two points will be made (regarding responsibility for authority and participation of patients and junior staff in government). One is that a team leader can have authority without being authoritarian, and the other is that one does not run a therapeutic community to create anarchy, or to produce a democracy, or any other political system. One is merely giving patients and junior staff the opportunity to make their relevant contributions according to their capabilities and training, thus effecting the unhealthy social situation brought about by the application of the 'authority-submission' formula. One gives them the opportunity to contribute and to develop their personalities, preventing the insidious onset of a state of institutionalisation in staff and patients alike." (p.18).

Because much of the content of community meetings has been concerned with the discussion of rules and guidelines for behaviour and at any one time has involved all levels of the Special Care Unit management (Superintendent, Psychologist, Principal Prison Officers, and prison officers), inmates have chosen to believe this implied they had an equal voice in management decisions. Conflict arose from this very basic misunderstanding whenever an attempt was made by staff members to set limits to inappropriate demands by inmates or staff reminded prisoners that their current desires conflicted with therapeutic policy of the Unit (e.g., missing therapy group to have a visit). It was suggested earlier in this section that this problem of 'misinterpreting' the management style of the Unit relates to the distortion of reality on the part of inmates to suit their current needs. Support for this hypothesis comes from the characteristic response of the prisoners when staff attempted to suggest responsible communal solutions: they inevitably raised the issue
of "screws versus crime", called for a vote and overruled staff since at
any one time there are more inmates than residents present at a meeting.

To date, the therapeutic intent of the community meeting has not been
successful for the reasons outlined above. All attempts to deal
meaningfully with interpersonal tensions have met with little success. The
conflicts generated have not been turned into learning experiences. Future
growth of the Special Care Unit must be concentrated in this crucial area.

The second type of large group therapy is the crisis meeting, a
specially convened community meeting that may be called by any member
of the community. In the past, crisis meetings have been called to deal with
suspected violations of community rules (drug/alcohol use, improper conduct
during a visit, violence among members), as well as discussions relating
to lack of participation, perceived victimization of prisoners by staff,
etc. Reservations relating to the regular community meetings apply to these
gatherings. Efforts made in the area of problem-solving have been largely
eclipsed by the negative emotions displayed by a large segment of inmates
to responsible staff and, on occasion, inmates who had the temerity to
express a minority point of view (i.e., that of a staff member).

The communication/debating group meets once a week and is run by a
volunteer who coaches debating groups in other prisons in Sydney. The positive
value of this man's contribution to the programme of the Special Care Unit
is impossible to estimate. Because of the great communication deficits of
most of our inmates, this group has proved to be an extremely valuable
educational adjunct to the programme. It has served to highlight the
contribution of other professionals to our work and hardened thinking among
staff that more structured activity should be required from inmates
(educational courses, hobby-crafts, etc.) as a work commitment. This will
constitute another area for future development.

The final group-therapy outlet is the work group. This is conducted
by one of the officers of the Unit as the need arises and is designed to
assist inmates due for release in exploring attitudes to work issues, the
current job market, financial requirements for someone leaving prison,
interviewing style, personal presentation, etc. As part of this activity,
imates are escorted out of the Unit by two officers for one or more job
interviews, after which the prisoner's feelings and attitudes concerning
"the outside", his success on the interview(s) and his emotions concerning
releases are explored. These trips have been a positive feature of the
programme.

4. Self-assessment as therapy. One of the most important elements of
the Special Care Unit programme is the self-assessment which every inmate
in the Unit is required to carry out. The inmate is given an information
sheet containing the sort of material to be included in his self-assessment
soon after his arrival in the Unit (see Appendix 5 for a copy of this
information sheet). The areas dealt with in this exercise are:

--self-concept: personal self as the inmate is now aware of, social self
as the inmate's accuracy in understanding how he is being
perceived by others and the ideal self as the sort of
individual the inmate would like to become in the future.

--involvement in Unit: an estimate of his participation in groups, with staff
and in helping other inmates who are experiencing some
programme: sort of personal difficulty.

--programme after leaving skills and post-release opportunities with emphasis on
placement and skills/educational programme from a realistic
Unit. viewpoint.

--accuracy in understanding why he came into the Unit.

This exercise is typically first carried out eight weeks after the
The Special Care Unit, from the early planning phases of the project, has been designed to serve a staff-development function in addition to its therapeutic status for prisoners. Throughout previous sections of this report, various aspects of prison officer training have been touched upon. We shall therefore only underscore a number of points that have been made in other contexts. Broadly speaking, staff development in the Special Care Unit takes place in two areas:

1. Skills development
2. Personal development

The category of skills development relates directly to the interdisciplinary nature of the Unit. In no other institution of the New South Wales Correctional System is there such a close working relationship between a psychologist and the custodial staff. The role of the Unit psychologist encompasses a number of functions. Principally he is responsible for the integrity of the therapeutic programme of the institution (management of therapy groups and counselling contacts maintained by officers from time to time). Since so many aspects of policy relate to the therapy taking place in the Unit, he is also in constant consultation with the Superintendent. Finally, this officer is responsible for training custodial staff to carry out therapeutic objectives. To that end, the psychologist has a major training function. (Parenthetically, it should be noted that the psychologist rarely performs the traditional therapist's role; the community is the therapist and all "helping responsibility" must be focussed throughout the entire community.)

Skills development of officers is carried out within a framework of role modelling and close supervision by the psychologist. The first skill to be dealt with is the interviewing of prisoners for entry into the Unit. In this case, an officer accompanies the psychologist to the interview. An attempt is made to define roles and strategies explicitly in the early stages of this training. Thus, the psychologist might probe for the inmate's motivation about entering the Unit and the officer might be responsible for informing the candidate about the therapeutic programme. Following the interview, the psychologist discusses his interviewing tactics and elicits from the accompanying staff member possible alternatives that might have been pursued in the interactions with the prisoner.

Learning the role of small therapy group facilitator is the most complex task for custodial staff to master in the Unit. In this regard, one of the officers in the Unit has drafted an orientation programme for the introduction of new officers to the work of group facilitation that demonstrates the use of role modelling, as well as peer training, for this task. (see Appendix seven). The greatest hurdle involved in this particular job is convincing officers to feel comfortable in a professional role. Having accomplished this, officers have experienced little difficulty in carrying out the individual responsibilities of the group facilitator (active listening, involving all members of group, activating issues pertinent to the group members, appropriate questioning, feedback techniques, etc.)

Carrying out counselling relationships has been yet another area of skills development. In this area, inmates typically seek out particular officers. This having been accomplished, the officer and the psychologist develop certain objectives for the counselling relationship, taking care to point the work that is accomplished to the ultimate goals of the therapy group. In these cases, the dynamics of the inmate's case are discussed with the officer and strategies are arrived at for work to be done in the "one-to-one" interaction. At various points in this work, the officer and inmate become involved in intensive counselling sessions with the psychologist, after which two staff members discuss the dynamics of the session and the skills utilised.
Participation of officers in panels with inmates provides another opportunity for professional development. This is particularly the case when officers sit on the assessment panel inasmuch as the staff member is in a position to observe the inmates on the panel, the prisoner being assessed and the psychologist. After the assessment sessions the psychologist meets with the two staff members and outlines both implicit and explicit issues that have arisen from the session, in addition to giving officers feedback about their participation on the panel.

Personal development of the prison officers in the Special Care Unit is also viewed as important to the staff development function. There are two avenues for this important process to take place: staff meetings and the prison officers' therapy group. In staff meetings, every opportunity is given for the officer to communicate his concerns about the work taking place in the institution as well as his/her relationships with other Unit officers. In a sense, this meeting, analogous to the large community meeting, gives staff a chance to participate in the management of the Unit, examining and articulating issues of programme direction and policy implementation. Above all, honesty in communication is stressed at these meetings.

The prison officers' therapy group represents the newest feature of the Unit programme. It is analogous to the daily small therapy group, but at the moment is held only once a week. During these sessions, facilitated by the Unit psychologist, officers are encouraged to discuss personal issues relating to job satisfaction, personal happiness, employment aspirations and family problems, for example. The only restriction placed on this discussion is that Unit matters are not dealt with; the principal focus is personal growth and the development among therapy participants of mutual respect and caring. However, this therapy group also serves a training function. Following the formal end of the session, a de-briefing is held in which the participants discuss specific techniques used by the psychologist during therapy. These therapy groups, though initially requested by some officers out of concern for what they perceived as deteriorating interpersonal relationships among members of staff, hold great promise for both morale among staff and professional development of the Special Care Unit officers.

Finally, consideration must be given to one of the central aims of this project: the "seeding" of the New South Wales Correctional System with prison officers' equipped and experienced to perform a complex role in the management of prisoners. In addition, these officers will be better equipped to understand difficulties facing those charged with the running of other penal institutions.

In summary, the Special Care Unit, in addition to its therapeutic function for inmates, was designed to offer staff the opportunity to develop a number of skills (interviewing, group facilitation, counselling). Provisions for the personal growth of custodial staff are no less important for the developmental functions of the Unit programme.
REFERENCES


