Report of Inspection of Mental Health Care Facilities and Therapeutic Communities in Canada, Denmark, The Netherlands, England and Scotland.

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Introduction.

The population of the prison system in New South Wales is extremely varied, consisting of individuals with widely differing backgrounds and an enormous range of problems, requiring a wide variety of treatment programmes. While the Department of Corrective Services has taken a number of initiatives in remediation of education skills deficits (numeracy and literacy, trades training, etc.) little has been done for those prisoners suffering from psychological illnesses of both the episodic and chronic variety.

To date, mentally-ill inmates have languished in an intermediate "no-man's land" marked out as the responsibility of the Department of Corrective Services and/or the Health Commission. Truth to tell, neither organisation has done much to generate, develop and implement treatment programmes for these inmates. Lack of initiatives in the Department of Corrective Services has been due to limited resources and expertise in the field of health care delivery, a traditionally narrow view of its contribution to the mental welfare of prisoners, and a long history of departmental deference to the wisdom and authority of the Health Commission to care for this sector of the prisoner population. In the case of the Health Commission, there seems (particularly of late) to be a concerted policy of not-so-benign neglect of the mental health needs of prisoners that, in recent months, has been nothing short of criminal. (One might cite, for example, the recent return to imprisonment of more than forty individuals designated as "G.P.'s" who were being cared for by the Health Commission as a case of this policy.) If, in fact, recent events reflect an attitude of certain highly placed bureaucrats in that organisation to relinquish responsibility for the care of convicted individuals, alternative arrangements must be explored by the Government.
Mr. Justice Nagle, the Royal Commissioner, noted the discouraging lack of treatment programmes and facilities in the Prison System. He was emphatic in recommending that the only mental health facility under control of the Department – the Observation Section (OBS) of the Central Industrial Prison in the Malabar Complex of Prisons – should be closed immediately. The facilities of the OBS are antiquated, inhumane and inadequate ("Dickensian" was the description applied by Nagle.) Moreover, there is no attempt to carry out a treatment programme there. In response to this pressing need for a proper mental health facility within the prison system, the Department of Corrective Services set up a committee to explore the range of treatment possibilities. This group ultimately arrived at the concept of the Special Care Unit.

The Special Care Unit was devised not only to meet the recommendation of Mr. Justice Nagle to close the OBS and provide a suitable treatment alternative for those prisoners who were "in psychological crisis," but also to provide a mechanism by which custodial officers could taken on increased responsibilities for the care of prisoners. It was thought that the therapeutic community concept advocated by Dr. Maxwell Jones offered the most appropriate model for such a unit in that it allowed custodial staff an equal role on a multi-disciplinary treatment team. It was hoped that prison officers, having served a period of time in the Special Care Unit, would then move back into the mainstream prison system and continue to exercise these newly acquired therapeutic skills. In short, both prisoners and prison officers would profit from placement in this experimental treatment facility.

Initially, the Special Care Unit was conceived to be a multi-disciplinary venture (medical, psychiatric, custodial, psychological), but the Health Commission, after considerable negotiation with the Corrective Services Commission, ultimately
reached the rather parochial decision that any treatment facility is, by definition, a health facility under the auspices of the Health Commission. It was felt by us that such a solution was short-sighted. Under a medical regime, custodial staff would have no part in the treatment regime, thus defeating one of the purposes for the Unit. The Corrective Services Commission decided to staff and manage the facility without on-site medical backup.

Having elected to run the therapeutic community without the active support of medical practitioners meant that we had to more carefully define the sorts of mental problems that we could properly treat. Clearly, inmates with chronic mental illness would not be suitable for such a treatment regime, inasmuch as drug intervention is often essential for them. In addition, we had doubts, based on our reading of the literature, that manipulative psychopaths would be suitable candidates for the Special Care Unit. However, this issue of who and what such a unit could best treat constituted but one of a number of outstanding questions that could only be answered by travelling abroad on a fact-finding/study mission.

The body of this report contains our systematic observation of a number of sites in Canada, Denmark, The Netherlands, England and Scotland. We chose to analyse these facilities in terms of five broad areas in order to gain information that would be crucial to the establishment of the Special Care Unit.

1. Organisation of Unit
2. Personnel: staffing, selection and training
3. Security considerations
4. Regime of Unit
5. Daily functioning of Unit.

It would be irresponsible to say that these other facilities provided us with definitive answers to the many questions we set out to investigate. However, the observations provided us with support for what previously had been a philosophical
conviction of what was possible, given the sincere dedication of custodial staff, in the area of therapeutic programming in a penal institution.

This report is organised around the body of information gathered during the trip with the aid of a rather detailed checklist (included in the next section along with a note on our method of collecting data). The various sites are grouped under three major headings:

1. Prisons which function as hospitals
2. Special hospitals
3. Therapeutic communities

--- REFER TO THE ATTACHED MATERIAL FOR DETAILS OF OUR ITINERARY AS WELL AS THE INDIVIDUALS CONTACTED DURING THE PREPARATION AND EXECUTION OF THIS TRIP INCLUDED AS APPENDICES 1 & 2 ---

Following a summary of matters discussed at non-institutional meetings held during the trip, there is a brief set of recommendations relating to observations made during the trip. To conclude the report, a set of appendices has been included to amplify and clarify information discussed in the body of the report.
For this trip, we developed a check list to explore a large number of issues, some of which incorporated material of a sensitive nature, as well as a considerable amount of qualitative data that could only be gained after a degree of rapport had been established. Because our itinerary was "rather tight", we developed a strategy for collecting the most information in shortest amount of time without appearing to "grill" our institutional hosts. Having been warned beforehand that some of these individuals might tend to "get uptight" if we came to institutions "with notebooks and pens poised", we tried to make the interviews as conversational as possible. Typically, we would introduce ourselves and explain the terms of our mission (i.e., fact-finding in order to set up the Special Care Unit) as briefly as possible. Then, Dr. Schwartz would lead the host (medical superintendent, psychiatrist, prison governor, etc.) through the various points of the check list without referring to the check list in an obvious fashion, while Mr. Horton took notes unobtrusively. With this initial information, we would then go off in separate directions: Schwartz meeting with the psychiatrists and psychologists; Horton talking to custodial and nursing staff. Attempts were also made by both of us to speak with inmates.

In the evening after each visit, we would compare notes and prepare a composite briefing on the information gathered at each site. On those occasions when we were able to return to the institution on another day, we would also prepare a set of questions for greater depth of coverage or clarification of conflicting information. Because this method involved a great deal of confidence on the part of our sources, we gave assurances that nobody would be quoted in any official report. In this manner, we collected a great deal of information in a very brief period of time. Furthermore, by dividing responsibility, we were able to compare staff/professional perceptions of an institution's functioning.
CHECK LIST OF ISSUES EXPLORED AT INSTITUTIONS VISITED.

A. ORGANISATION OF UNIT.

1. Objectives of Unit.
   a. Stated objectives.
   b. Types of individuals being treated ("target population").
   c. Generalised perception of success by personnel/custodial staff.

2. Rules and Principles by which Unit is run.
   a. Stated management principles (if any)
   b. Perception of management style by investigators Horton and Schwartz.

3. Relation of Unit to prison system to which it is connected.
   a. Physical location.
   b. Formal relationship.

4. Custodial involvement in Unit.
   a. How extensive?
   b. Perception by Horton and Schwartz of custodial effectiveness in Unit (based on conversations with them).

5. Number of individuals in Unit.
   a. Patients
   b. Staff
      (1) Custodial
      (2) Medical
      (3) Psychological
      (4) Ancillary
B. PERSONNEL: STAFFING, SELECTION AND TRAINING.

1. Staffing of Unit.
   a. Unit model adopted
   b. Service period required in Unit for staff.
      (1) Provision of a probationary period?
      (2) Specified length of service in Unit.

2. Selection of staff.
   a. Custodial component.
      (1) Vocational background.
         (a) Previous experience required.
         (b) Prior training suggested?
      (2) Method of selection (by application, secondment, draft etc.).
      (3) Selection procedure (panel, interview, etc.)
      (4) Criteria used.
   b. Medical Staff
   c. Psychological staff
   d. Ancillary staff

3. Training of staff.
   a. Objectives
   b. Length of training programme
   c. Methods used (lectures, discussion, site visits etc.).
   d. Materials used.
   e. Provision for "refresher" training?
   f. Ongoing evaluation of staff effectiveness:
C. SECURITY CONSIDERATIONS.

1. Around perimeter of Unit.
2. Within the Unit.
3. Access to Unit by "outsiders" (see "public access to Unit").
4. Generalised impression by investigators Horton and Schwartz of the "dangerousness message" given by the Unit in general.

D. REGIME OF UNIT.

1. Entry and discharge of patients.
   a. Channels of referral (self-referral, medical, custodial, etc.).
   b. Selection and acceptance of patients.
      (1) Use of formal case presentations?
      (2) Selection panel or administrative decision?
      (3) Criteria for acceptance of patients.
      (4) Length of stay in Unit specified?
         (a) Provision of formal guidelines
         (b) Average length of treatment.
   c. Discharge of patients.
      (1) Who makes the decision?
      (2) Criteria for discharge of patients.

2. Programme in Unit.
   a. Goals of programming (adjustment to imprisonment, self-knowledge, crisis intervention etc.).
   b. What range of programmes is provided?
   c. How is programme selected for the patient?
   d. Participation of prisoner in programme selection?
3. **Medical regime of Unit.**
   a. Availability of psychiatrists.
   b. Availability of psychiatric nursing staff.
   c. Use of drugs for treatment.

4. **Communication between patients and professionals.**
   a. Access to contents of reports?
   b. Use to which reports are put in decision making.
   c. Generalised perception of "openness of patient/staff interaction" as perceived by investigators Horton and Schwartz.

**E. DAILY FUNCTIONING OF UNIT.**

1. Induction procedures for patients entering the Unit (formal presentation, "buddy" system, etc.

2. **Routine of Unit.**
   a. Scheduling: structured vs. unstructured
   b. Provisions for meetings of staff.
   c. Availability of feedback options for staff and/or patients' problems.
   d. Crafts/hobbies provided.
   e. Interaction of staff and patients at meals?
   f. Input of parole officers.
   g. Provisions for clergy

3. **Public access to Unit.**
   a. How do visitors gain access (written and/or verbal application?).
   b. Who makes the decision for access?
   c. What grounds for refusal of access?
   d. Provisions made for visits by relatives and friends of patients.
   e. Ease of access to Unit by interested parties (media, citizens' committees etc.).

**F. OTHER ISSUES** (not specifically dealt with in the check list.)
III. SITE VISITS,
SECTION ONE:

Prisons which function as hospitals.

-- Regional Psychiatric Centre (Ontario)
-- Anstalten ved Herstedvester.
Section One: Prisons which function as hospitals.

Institutions Visited:

1. Regional Psychiatric Centre (Ontario)
   Kingston, CANADA

2. Anstalten ved Herstedvester,
   Herstedvester, DENMARK.

In this section, we shall review our experiences and impressions gathered at two institutions which were primarily characterised by those who worked in them as prisons, despite the fact that their primary function was as hospitals caring for prisoners who display varying degrees of mental illness. In the case of the Regional Psychiatric Centre (Ontario), the primarily custodial function may be due more to the environmental constraints of the ancient facility in which it is housed than to a conscious decision on the part of those bureaucrats who are entrusted with decisions relating to health care delivery. Perhaps all this will change when the new facility is built. Certainly, the briefing documents that were so graciously given (and sent) to us bode well for this project. However, as it now functions, this institution is little more than a containment unit for a number of prisoners, a large percentage of whom are not mentally ill (e.g., troublemakers, protection cases), staffed by a dispirited group of professionals and secured by custodial staff whose attitude to the inmates within its walls ranges from benign neglect to outright disdain. The case of Herstedvester is rather different. Prior to 1973, it served as a treatment centre for individuals on indeterminate sentences, including a large number of sex offenders who participated in a well-publicised programme of voluntary castration. Since the decision was made to do away with indeterminate sentencing, the particular function of this institution does not seem to have been defined. Unlike the Canadian facility included in this section, Herstedvester impressed us. Its physical plant was
clean and reasonably modern and the staff appeared to care for the prisoners with whom they were dealing. In addition, we had the good fortune to be briefed by a psychiatrist who does empirical research and seems genuinely excited by his work.
A. Organization of the Unit.

1. Objectives of the Unit.
   a. Stated Objectives.

   The stated objective of this Unit was summed up for us in one word: Security.

   b. Target Population.

   Any prisoner who is "troublesome" in other institutions within the province is sent to the Unit. These people were variously described as:

   - protection cases
   - "difficult" prisoners
   - troublemakers
   - sex offenders
   - psychiatric cases
   - psychotics

   We attempted to draw from various members of staff more specific criteria for their "target population", but were unable to "pin them down" to anything more definitive.

   c. Perception of success by personnel custodial staff.

   In terms of the stated objective -- security -- the staff felt that they were successful.

2. Rules/principles by which the Unit is run.

   Though we attempted, on a number of occasions, to get this information, the staff was unable (or unwilling) to supply this information. The Principal Psychologist, Mrs. Sharon Williams, felt that the Unit existed to "isolate sick people and contain them." Our perception of management style could best be summed up as "laissez faire." In other words, doctors, psychiatrists and nursing staff all seem to be "doing their own
thing." The principal psychologist voiced some concern about this issue, particularly with regard to the establishment of consistent programming for prisoners. It seems that custodial pressure has been exerted to over-rule the medical Superintendent on a number of occasions.

3. Relationship to the Prison System.

a. Physical Location.

The Regional Psychiatric Centre at Kingston is housed in a very old wing which is situated within the walls of an antiquated (130 year old) maximum security prison complex. Little has been done to update the structure of this old wing; toilet facilities consist of "honey buckets" and the cells have open grill fronts affording no privacy at all.

b. Formal relationship.

The control of the Unit rests in the hands of a medical director who is theoretically independent to administer the facility. However, it was evident that the responsibility for the Unit's functioning was in the hands of the Superintendent of the main prison; he exercised ultimate control over the Unit.

4. Custodial involvement in the Unit.

There was no custodial involvement in the functional life of the Unit. During the two days of our visit, the custodial staff did no more than open and close gates. What's more, they made it plain that they were not at all interested in what went on there. There were, however, two officers who indicated that they would like to be more involved and had volunteered to help the principal psychologist with testing for the sex offenders programme (as control subjects for the experimental design of the study), but they were most concerned that other officers not be aware of this. Perhaps the general custodial attitude was best summed up by the senior officer in charge of custodial staff who said, "The main thing in this place is to keep it clean, and that's an uphill
5. **Number of individuals in the Unit.**

a. **Patients.**

Currently there are 85 patients in the Unit. There is overcrowding due to the difficulty in discharging inmates back into the prison setting.

b. **Staff.**

(1) Custodial 26
(2) Medical 45
(3) Psychological 2 plus 2 clinical psychologists serving internships from Queen's University.
(4) Ancillary 11

In addition to these individuals, there is a social work section and a research section which are not housed in the Unit. Theoretically, they may be called upon to provide services to the Unit, but it seems that their impact on the daily functioning of the Unit is virtually nil. These staff figures are not included in the above staffing for that reason.

B. **Personnel: Staffing, Selection and Training.**

1. **Staffing of the Unit.**

a. **Unit model adopted.**

The Unit is a prison disguised as a medical facility. It is theoretically a hospital and all the inmates are considered to be "sick", but the validity of this statement is questionable when one considers the wide range of categories of inmates who are sent to, and housed in, the Unit (i.e., protection cases certainly do not seem to fit into an illness typology).

b. **Service period required in Unit for staff.**

There is no provision for a probationary period of service in the Unit, nor is there any upper limit to the length of period of service in this location.
2. Selection of staff.
   a. Custodial component.

   Custodial officers employed within the Unit have the same background as custodial officers in any other gaol in this province. They have completed basic prison officer training requirements. Selection of custodial staff is made by the personnel division. Thus, placement of officers in this Unit does not differ from that in any other gaol in the system. When pressed to provide criteria used to assess suitability, senior unit staff stressed experience with inmates, flexibility and (preferably) some nursing background. One senior officer's view was that he wanted, "someone who won't start a riot in an empty room."

   b. Other staff.

   No information was forthcoming on the issue of selection of non-custodial staff.

3. Training of staff.

   No further training was given to any member of the Unit staff following placement. There was some mention of an "induction", but this seems to be an ad hoc and somewhat haphazard process inasmuch as nobody seemed able to explain how the procedure worked and what it entailed.

4. Other Staffing Issues.

   There appeared to be considerable role confusion amongst the staff in the Unit. The senior custodial officer for the Unit occupies an office situated outside of the main prison complex in which the Unit is sited. His team of base grade officers had no senior member to whom they could appeal for advice. In the most immediate sense, security decisions are taken by the Medical Director or, during the night shift, by the nurse on duty.
These decisions are passed to custodial staff, in the form of directions by these individuals. Of course, this organisational structure leads to considerable resentment by prison officers.

C. Security Considerations.

The perimeter of the Unit has no additional security because of its placement within a maximum security gaol. Entry to the Unit is via a locked double "air-lock" arrangement of doors. Once inside the living area of the Unit, one has the uneasy "feel" of a maximum security unit which is "on edge", in a volatile state. There appeared to be some reluctance and embarrassment about showing us around this area. Comments on our tour around this area included a number of the following:

- "Don't walk down that corridor because the guy in 5 cell is liable to toss his honey bucket at you."
- "Don't wake up the man in the 'Chinese cell' because he's liable to spit at you."

As we have previously noted, the cells date from ca. 1850. The regime in our view is worse than that in operation in the O.B.S. Section at Long Bay Complex. Stripped cells appeared to be the norm and closed circuit television cameras are focused into each cell. Three (3) prisoners are given the "run of the wing" each night to cope with "problems" that might arise with other inmates. Needless to say, such an arrangement would be questionable in a regular prison regime; the spectre of inmate-inmate victimisation was very palpable, particularly when one considered that a number of the prisoners in the Unit were psychologically unstable and/or defenceless.

Officer morale and standards of dress were apparently at a low ebb. Obviously work interest and job satisfaction are lacking. In part, this must be due to the lack of custodial involvement in the functional running of the Unit. The Principal Psychologist supplied corroborative detail to support our perception.
of officer malaise: instances of sick leave among officers is frequent in the Unit.

D. Regime of the Unit.

1. Entry and Discharge of Patients.

Inmates are referred to the Unit by the doctor of the prison in which they are currently housed. They are then seen by a psychiatrist and, if suitable, are admitted to the Unit. That, at least, is the theory of admission; in practice, it is obvious, given the wide range of inmate categories in the Unit, that the superintendent of the Kingston Penitentiary determines admissions.

Discharges from the Unit theoretically take place when the inmate is cleared by the psychiatrist for return to his gaol of classification. In practice, everyone to whom we spoke mentioned considerable difficulty in discharging inmates and the resultant overcrowding problems.

2. Programmes in the Unit.

Programmes seem to be provided by a few members of staff who have retained an interest include:

- an intensive (17 hours per week for 4 months) sex offenders treatment programme.
- transactional analysis
- self help/living skills programme.

As you can see, the programmes are psychological in orientation and are run by the two psychologists (both with doctorates) on staff as well as 2 university students (clinical interns) from nearby Queen's University. The psychiatric and nursing staff were, for the most part, dismissive, condescending and patronising when discussing these programmes.

3. Medical Regime of the Unit.

Full-time psychiatrists and psychiatric nursing staff are part of the staff complement for the Unit. The use of drugs
for treatment is determined by the psychiatrist in the case of each inmate. Although no specific information was given, our perception of drug usage for treatment is that it is considerable.

4. **Communication between patients and professionals.**

There is no access to reports by inmates under any circumstances. It was not possible to obtain information about the use to which reports are put in decision-making. In spite of asking the question a number of times in a number of different ways, a direct answer was never forthcoming. Our perception of the "openness of patient/staff interaction" can best be summed up in one word: Closed.

E. **Daily functioning of Unit:**

1. **Induction Procedure.**

There is no formal induction procedure for the Unit. There are formal written rules which are enforced within the Unit, but we were told that these rules are precisely the same as in any gaol (i.e., "straight from the book").

2. **Routine of Unit.**

The routine of the Unit is much the same as any other closed gaol. Work is provided for some inmates in internal workshops in such areas as: Spray painting and furniture repair, including staining, varnishing and upholstery. The works officer impresses as a dedicated man with a desire to help the prisoners in some vaguely rehabilitative fashion in spite of the very limited facilities at his disposal. Other inmates (i.e., those not in the shop) are involved in psychological programmes (described above), but the majority sit around, read books available from a somewhat limited library in the Unit, or sleep. At the time of our visit a rather innovative programme was in the process of being established: the installation of an internal radio
station to be manned by inmates. In addition, a well-equipped gymnasium was available for use by residents.

There are no provisions for meetings of staff, nor was there any formal structure whereby inmates and staff could meet. No informal interaction occurs between inmates and staff due to the physical separation of staff and living facilities in the building. Also, there seems to be an unwritten rule that "most of the inmates are violent and untrustworthy, particularly in their own living quarters" (a message, incidentally, that is reinforced by the open bar arrangements of the cells). Therefore, staff see inmates on a one-to-one basis, typically. Because of the fact that the Unit is situated within the confines of the main gaol, its routine is tied to that of the larger surrounding institution. Therefore, the Unit closes from 11.00 am to 1.00 pm each day and all inmates are locked in their cells for lunch. During the summer months, there is a provision for an 11.00 pm lock-in at which time the inmates may use the outside exercise yard and gymnasium (incidentally, the exercise yard is not available for use by inmates because of a shortage of custodial staff to supervise activities in that location). Lock-in during the winter months occurs at 4.45 pm. In addition, films are shown in the gymnasium on weekends and public holidays.

3. Public Access to the Unit.

There is virtually no public access to the Unit. Representatives of the media or other interested parties can seek permission from the Regional Director to visit the facility, but we were assured that this would occur very rarely. In fact, no staff member to whom we spoke could recall a visit of this type.

Visitors to prisoners must be registered on an approved list; they are allowed in the normal visiting facilities in the main prison. We were advised that they would be allowed to
visit in the Unit "in exceptional circumstances, by very special arrangement." Again, no staff could recall such an extraordinary occurrence.

F. Other Issues.

1. It may appear that we have been unduly critical of the Regional Psychiatric Centre at Kingston. However, this critical stance must be understood in the context of our itinerary. Our previous stop had been to the Regional Psychiatric Centre at Abbotsford. Naturally, we drew comparisons between these two Canadian institutions. Upon reflection, we feel that the contrast between Kingston and Abbotsford (which appeared in so many ways to be such a positive experience for us) may be related to two different reasons:

- a complete lack of interest, innovativeness, managerial expertise and willingness to make decisions at the local level.
- the difficult and antiquated surroundings in which the Unit is forced to operate.

2. In complete contrast to the attitudes of local management were those of the Senior Administration at the Ontario Regional Headquarters. In particular, mention must be made of Ross Duff, Regional Manager, Security. Whilst acknowledging the difficulties inherent in operating old establishments, the difficulty in obtaining the necessary finance to build a new psychiatric unit and the planning delays, Mr. Duff retained an enthusiasm and hope for the future that was not evident in his subordinates at the institutional level. He was also much more open in his discussions of those difficulties and very prepared to provide information to us and the Corrective Services Commission of New South Wales. To that end, he has sent us a complete set of briefing materials and specifications for the new psychiatric unit.
Mr. Duff also arranged for us to visit the Ontario Correctional Staff College. This visit will be discussed elsewhere in this report (Section VI),
A. Organisation of the Unit.

1. Objectives of the Unit.
   a. Stated objectives.

   The objectives of the institution have not been defined since 1973. It is perceived as an institution for mentally disturbed inmates.

   -- REFER TO THE ATTACHED MATERIAL ENTITLED "HERSTEDVESTER 1978/79" (DANISH ORIGINAL AND ENGLISH TRANSLATION) INCLUDED AS APPENDIX 3 --

   b. Target population.

   Those inmates with behavioural problems were said to be the target population at this institution. Many are psychopathic or borderline psychopathic/neurotics (80%) but there are a number of psychotics (15-20%) as well. A large number of these men have alcohol-associated problems. Drug addicts are not accepted, unless there are exceptional circumstances. 10%-15% are dangerous offenders who have repeated convictions and are serving indeterminate sentences -- mainly sex offenders and some pyromaniacs.

   c. Perception of success by personnel/custodial staff.

   Staff believe that they are successful in relieving the pressure on the main prison system, although they noted an increasing incidence of violence within the institution during the last two (2) years.

   The programme of voluntary castration for sex offenders, for which Herstedvester was best known in criminological circles, was discussed. Between 1929 - 1959, 900 males were castrated, 738 of whom were criminal sex offenders. It was
stated that recidivism rates among this 'special' group of men was only 1%-2%, as opposed to 30%-50% for other categories. Though this programme of surgical castration was suspended in 1972, an alternative treatment consisting of "chemical castration" is presently in the early stages. This treatment consists of the administration of a chemical that blocks the effects of endogenous male hormones (androgens), resulting in a lowering of sex drive. Though dosage levels required for this outcome are still in the process of being determined and there still seems to be some concern about the acceptance of such a programme by legal authorities, the chemical treatment of sex offenders seems far more humane than the surgical procedure previously carried out at Herstedvester because the chemically induced impotence is reversible when the administration of the drug is stopped. Dr. Jørgen Ortmann, the psychiatrist involved in this programme, suggested that this treatment seems to be the only alternative for treatment of sex offenders inasmuch as aversion therapy (the other treatment often used for these offenders) and surgical castration are inhumane.

2. Rules/Principles by which the Unit is run.

A formal hierarchy exists within the prison, but there is considerable openness between staff and the institution was said to function on a democratic basis. Our perception of management style was one of an egalitarian community.

Meetings of the professional staff are held daily, chaired by the senior psychiatrist. Each officer is required to report on inmates within his unit, followed by an unstructured discussion. In addition, there is a weekly meeting at which the following topics may be discussed:

- Releases: inmates may be released after they have served between 1/2 and 2/3 of their sentence.
- Weekend Leave: available to all inmates as a privilege every third weekend after 1/4 of their sentence.
Returns to other prisons: in this case, a determination is made of whether the inmate is suitable or unsuitable for return to another institution.

3. Relationship to the prison system.
   a. Physical location.
      This is a separate, self-contained institution.
   b. Formal Relationship.
      This institution is considered a prison, rather than a hospital, and is an integral part of the Danish penal system.

4. Custodial involvement in the Unit.
   The custodial staff are fully involved in the operation and programming of the institution. We were advised that this involvement is much greater than in any other Danish penal institution. The psychiatrist (Dr. Ortmann) stated that information and opinions of custodial staff are highly valued because of the close contact that these individuals have with inmates.

5. Numbers of individuals in the Unit.
   a. Patients.
      The Unit has a capacity of 140 beds. However, one section is closed due to lack of funds for maintenance and provision of staff. Currently the institution holds 117 inmates.
   b. Staff
      (1) Custodial 149
      (2) Medical 11 (5 psychiatrists, 2 doctors, 4 nurses)
      (3) Psychological 7
      (4) Ancillary 5 teachers, 1 interpreter (part-time), 28 admin. staff
B. Personnel: staffing, selection and training.

1. Staffing of the Unit.
   a. Unit model adopted.

   The institution is considered to be a prison. A great deal of emphasis was placed by all staff on the fact that it is a prison and prison rules must be obeyed. The institution is run by a custodial superintendent, on a daily routine basis, who is legally empowered as the head of the institution. However, the Medical Superintendent, Dr. Marianne Schiøler, is, in reality, the ultimate authority within the institution. Therefore one might make a case that this is a hospital disguised as a prison.

   b. Service period required in unit for staff.

   No provision exists for a probationary period. Staff generally serve for at least two (2) years, but there is no upper limit to the service period and some staff have worked in the Unit for more than six (6) years.

2. Selection of staff.
   a. Custodial component.

   Custodial staff have completed an initial training period of 5½ months and a secondary training course of 2½ months. In addition, they have had 2 years of experience as prison officers. Selection is by interview which is held in response to formal application by the prison officer who seeks selection. All custodial staff are paid an allowance of 10% of salary for work at Herstedvester.

   The morale of the staff was generally high, but it was clear from talking to junior staff that the strain of working in such close contact with inmates takes its toll. Indeed, it was suggested that junior staff typically leave for other institutions after two years because of the strain.
It is worthwhile to note that female custodial staff are regularly employed at Herstedvester without any difficulty. In fact, male staff seemed surprised that we should question the utilisation of female staff in custodial roles in a male prison.

b. Other staff.

Selection is on the same basis as for psychiatric hospitals in Denmark. There is some interchange between the two systems. Research is currently being undertaken in Denmark which suggests that psychiatric and penal systems share a considerable portion of their clientele -- nearly 70% of psychiatric admissions are on record as committing criminal offences, according to Dr. Ortmann.

3. Training of staff.

Additional training is confined to custodial staff. Prison Officers selected to work in the institution are given three (3) months of psychiatric training in a psychiatric hospital. In addition, "in-house" training is being given by psychologists and psychiatrists to custodial staff. These sessions of two (2) hours per day in a one (1) week block are extremely popular. Staff attend these sessions during normal paid working time.

C. Security considerations.

Herstedvester is surrounded by a high masonry wall and the perimeter is monitored by closed circuit television cameras from which images are transmitted to a 9 screen array located in a central control room that is, in turn, situated in the Administration Building.
Internally, security is fairly standard with manually locked doors fitted for wings, grill gates to corridors and solid doors for cells. Custodial staff indicated that their most serious security problems are the result of drugs brought into the institution from outside.

Electric shavers are used at Herstedvester because razors are not allowed, for obvious reasons.

Each of the buildings at Herstedvester has an alarm button which, when activated, sets off a flashing red light on a map of the institution that is located in the control room of the Administration Building. This map and its lights are duplicated in all other locations, enabling each officer to see where the problem exists. Additionally, each unit officer carries a radio which is monitored by the staff in the Administration Building.

With the exception of the Isolation Unit (which consists of a number of bare cells with restraining devices secured to cots that are, in turn, secured to the floor), the "feel" of the institution was positive although some inmates indicated that they felt stigmatized (labelled as "crazy") by being at Herstedvester.

Visiting arrangements reflect the concern of staff with regard to smuggling in of contraband drugs. Inmates on visits may be required to change into visiting clothes. By the same token, visitors may have their bags searched and be given a body search. The visits take place in a private room, out of sight and hearing of staff and are available to inmates for one (1) hour per day. When questioned about the likelihood of sexual contact during these visits, staff indicated that it was officially forbidden, but probably occurred.

Telephone calls are allowed by inmates. There is no limit to the number of calls allowed, but they must be approved at the daily staff meeting. Generally, one call per week is allowed. However, this arrangement applies only to outgoing calls; incoming calls are not a part of this scheme. Also,
calls from prisoners are randomly monitored.

There is no limit on the number of letters an inmate may send or receive. There is no censorship, although the police or a court may direct that a particular inmate's mail be read. As a general rule, inmates show the letter and accompanying envelope to their wing officer; if the letter is outgoing, it is sealed in the presence of the officer.

When staff were queried about prisoners' needs and grievance committees, they stated that such organisations no longer functioned at Herstedvester, although they seem to exist in all other Danish prisons.

D. Regime of the Unit.

1. Entry and Discharge of Patients.

This institution receives 100-150 new inmates per annum. Between 1933-1973, Herstedvester was an institution that dealt solely with criminal psychopaths who were serving indeterminate sentences. These people were sent there for treatment, rather than punishment. In the wake of the political decision to abandon this special function, Herstedvester differs very little from other Danish penal institutions, save in two respects:

- the courts may direct inmates to an institution that deals with criminal psychopaths. Though Herstedvester is not named, it is the only location in the Danish penal system which has facilities to cater for such individuals.

- "difficult" prisoners may be referred here from other prisons.

There is, however, no structured referral procedure. Prisoners may be simply classified to Herstedvester because the facility is regarded as a prison; in some cases this option is exercised because this gaol is viewed as the "last resort", an option to be taken when all else has seemed to fail.

There are no formal provisions to return inmates to other institutions. In those cases when return seems indicated,
the decision is made following case discussion at the daily meeting. When a prisoner is received, he typically comes to stay until released. The average length of time spent at Herstedvester is 7-8 years, but one inmate has been resident there for 27 years.

2. Programmes in the Unit.

There are no well-defined programmes at this institution, although there was a general consensus among staff that better defined programmes and more staff would enable the institution to have greater impact on the prison system generally. Dr. Ortmann said, "I personally believe that there is little that can be achieved by treatment, except for sex offenders, other than to provide humane treatment." He went on to add that the effectiveness of most psychological treatment was dependent upon the expertise possessed by prison officers in the area of management. Indeed, he stressed the need for additional training for prison officers and the appointment of more female officers to the institution.

The therapeutic benefits of pre-release leave into the community is recognized. Prisoners are allowed to leave the institution on escorted leave with an officer or psychologist. Non-escorted weekend leave is also used extensively. In the event that an inmate returns late from leave or fails to return for a day or so, he is automatically given two (2) additional weeks' sentence and no further leave for three (3) months. Of course, this is the case only if no further crimes have been committed whilst on leave: criminal acts would require judicial procedure. If the prisoner repeatedly abuses the leave privilege, total loss of leave may result.

Prisoners are encouraged to decorate their own cells. Indeed, one entire wing is self-managed by prisoners who are nearing the completion of their sentences. In this Unit, the 10-12 inmates maintain their own garden, cook their own food and formulate the rules for their community, including the
determination of which outsiders will be allowed to enter the Wing itself. Staff do not enter without permission or invitation.

Group therapy and workshop options are available at the institution. The groups are run by the medical superintendent and, sometimes, a psychologist. A full range of work is available in such areas as:

- carpentry/joinery
- bookbinding
- laundry
- tailoring
- leatherwork

All inmates are required to work. Any who do not work do not get paid. However, provision is made for a psychiatrist to recommend a "sick" inmate for a "pension." The wages from work are paid weekly and may be spent in the canteen.

In addition, educational programmes and a library are provided.

3. Medical Regime of the Unit.

Full-time psychiatrists are available, as are nurses, though not necessarily psychiatric nurses. Pharmacological intervention is carried out with psychotics, but the general philosophy of the institution seems to favour the avoidance of drugs, particularly addictive drugs. In fact, staff insisted that fewer drugs, per head of population, are used at Herstedvester than at other Danish penal institutions. Drugs are ordered by the doctor and dispensed by the nurse to the prison officer who, in turn, issues the drug to the inmate. It is of interest to note that the officer is liable to prosecution if medication is given to an inmate against his will.

Other problems discussed in relation to medical regime included:
- transfer of actively psychotic patients to regional psychiatric hospitals is very difficult to achieve; even in those cases when this is accomplished, they are often returned to prison within a few days. Clearly the "instant cure" is more expedient than medical...
psychotic inmates are often remanded there prior to sentencing after which they may be sent to psychiatric hospitals

- manipulative psychopaths who disrupt the running of the institution pose the usual difficulties

Alas, no real solutions were offered to these vexing problems which are probably as common in New South Wales as they are in Denmark.

4. **Communication between patients and professionals.**

All staff have access to all reports, but concern was expressed about notes/reports leaving the institution. Communication was said to be good with inmates, particularly at the prison officer level. There is no formal access by inmates to reports which are used at staff meetings to discuss such issues as release, leave, etc. Also, some staff admitted to maintaining "private" notes on individuals to which there is no access by staff in other institutions.

E. **Daily functioning of the Unit.**

1. **Induction procedure.**

No formal induction procedure exists, but all inmates are received into a reception wing and informed formally of the requirements of the institution by a prison officer; informally by another inmate. Some inmates may be received directly into the Isolation Unit and, after a few days (maximum stay: two weeks) be placed into an appropriate ward.

2. **Routine of Unit.**

As stated above, provision exists for daily staff meetings which are attended by custodial staff representatives. Decisions made at these meetings are communicated by prison officer to the inmates. Any inmate may request an interview with the superintendent if he has a grievance either by making a verbal request through his wing officer or by written application. Any inmate may request to be interviewed at his leave of absence.
forwarded to "head office."

A football oval is available within the secured perimeter of the institution. Staff engage in all forms of sport and activities with inmates. An auditorium is used for weight training and other exercises after working hours. A film is shown every two (2) weeks and outside bands visit the institution occasionally. Staff and inmates take their meals separately.

A number of professionals from outside the institution visit prisoners. Parole officers are welcome, but in the view of some staff they are not seen at Herstedvester frequently enough. There is a full-time chaplain on the staff (who is a trained psychologist), but other clergy are welcomed as visitors or as requested by particular inmates.

3. **Public access to the Unit.**

Anybody is welcome to visit Herstedvester, with the exception of some former inmates. Visiting procedure requires the prisoner to place the names of his visitors on a list that is then vetted for approval by staff at the daily meeting. We were informed that this is now a formality and all lists are generally approved, with the sole proviso that the inmate must supply the name and address of the proposed visitor. In the event that a visitor is denied access to a prisoner, the facts of the decision are explained to the inmate by his wing officer. If there is further disagreement, the superintendent is empowered to make the final decision. As previously noted, visits are for one (1) hour per day and are conducted in absolute privacy.

The media and local citizens are encouraged to visit, but the staff indicated that this opportunity is seldom exercised.
F. Other Issues.

The perception of crime in Denmark by both custodial and psychiatric staff is as follows:

- the "crime rate" is rising rapidly

- approximately 7,200 convicted persons should be in custody, but present conditions in penal institutions allow for a capacity of only 3,300. Considerable numbers of units of cell accommodation are presently "shut down" as an economy measure.

- the prisoner population at Herstedvester seems to be "hardening" and becoming more difficult to manage with strategies currently in practice.
IV. SITE VISITS,
SECTION TWO:

Special Hospitals.

-- Broadmoor Hospital
-- Moss Side Hospital
-- Park Lane Hospital
-- Regional Psychiatric Centre (Pacific)
Institutions Visited:

1. Broadmoor Hospital
   Crowthorne, Berkshire, ENGLAND.

2. Moss Side Hospital
   Maghull, Liverpool, ENGLAND.

3. Park Lane Hospital
   Maghull, Liverpool, ENGLAND.

4. Regional Psychiatric Centre (Pacific)
   Abbotsford, British Columbia, CANADA.

The Special Hospital System (in England) represents a type of solution to the problems that have recently occurred in New South Wales between the Health Commission and the Department of Corrective Services. In such a system, firm guidelines are provided for the care of prisoners who have serious mental illness, as well as those individuals adjudged to be "not guilty" who are serving indeterminate sentences "at the pleasure of the governor." We have included two papers that explain the structure of this system in England.

--- REFER TO THE ATTACHED MATERIAL ENTITLED "THE ENGLISH SPECIAL HOSPITAL SYSTEM" AND "CUSTODY AND RELEASE OF DANGEROUS OFFENDERS" INCLUDED AS APPENDICES 4 & 5 ---

As the reader may note, such a system also allows for the transfer of inmates who are certifiably insane. We believe that the introduction of such a system in New South Wales would provide for a facility that would specifically cater for imprisoned individuals, both male and female, within the confines of a secured establishment. Until such time as such a facility is established, the haphazard and inhumane treatment of mental illness will continue to be in the hands of individuals who are less than enthusiastic about the full and caring responsibility of convicts. Clearly, this was the broader issue alluded to by Mr. Justice Nagle when he recommended the
closure of the Observation Section at Long Bay.

We believe that the Special Hospital System, were it to be set up in New South Wales, could also take over the functions of a psychiatric assessment unit for court referrals. The model for such a unit would be the Pieter Baan Centrum.

We have included in this section the Regional Psychiatric Centre (Pacific) because of its functional resemblance to the English establishments. The primary difference between it and the English Special Hospital lies in the use of custodial staff in the Canadian institution for maintaining security. This seems preferable to the arrangement in England where nursing officers perform the dual role of custody and treatment, resulting in some potential conflict of goals. Because the Canadian facility presents the more potentially useful model for New South Wales, we have presented information from that site in considerable detail. Information from the three English sites will be presented in a briefer and more impressionistic manner.

At the present time, the English Special Hospital System is under considerable fire from the press because of the recent release of several individuals (from Broadmoor and Rampton) who have re-offended. As a consequence, a great deal of pressure has been brought to bear on the authorities in control of these institutions to be far more conservative in the exercise of criteria for releasing individuals from custody. As if this political situation did not present enough difficulty for these institutions, yet another obstacle is preventing the Special Hospitals from discharging individuals to regular psychiatric hospitals: the militant nursing union which refuses to accept responsibility for the charge of mentally ill ex-offenders. Thus, the Special Hospitals are caught "between the rock and the hard place," unable to easily discharge people into the community or to alternative facilities. At the same time, the courts continue to commit cases
to the Special Hospital System. It seems certain that this impossible situation cannot continue for much longer. Not even the completion of the Park Lane Hospital, due to open to full capacity in 1984-85 will appreciably alleviate the problem of over-population. Because of the turmoil resulting from these pressures, Rampton Hospital was eliminated from our itinerary.

On the basis of telephone contacts, it was evident that the authorities running the institution were very anxious about having to host an official visit. Therefore, we decided to see both Moss Side and Park Lane Hospitals in the time now made available, though we had initially planned to see only one of these sites.
A. Activities of visit.

1. Interview with Dr. P.G. McGrath, who related the history of the institution, the proposed re-development programme, description of facilities, etc.

2. Tour of Reception and Adolescent Units.

3. Meeting with D.A. Black, Consultant Psychologist

4. Lunch with the senior medical staff

5. Attendance at a case conference, chaired by Dr. D. Tidmarsh.

B. Issues raised during the visit.

1. Broadmoor is a vast complex of buildings dating, for the most part, from 1863. The following is indicative of the size of the institution:

   - 400+ psychiatric nurses
   - 9 psychologists
   - 9 social workers
   - a large number of doctors, psychiatrists, and consultants
   - workshop managers (with therapeutic training)

   811 patients (692 males and 119 females)

In a breakdown of cases sent to Broadmoor, Dr. McGrath said that 90% of patients were sentenced there and 10% were from the prisons: 75% of individuals were actively psychotic, 25% suffered from personality disorders. The majority of individuals had committed homicides (45%).

-- REFER TO TWO ATTACHED PAPERS ENTITLED "BROADMOOR INS AND OUTS: 1960-1977" AND "A FIVE-YEAR FOLLOW-UP STUDY OF MALE PATIENTS DISCHARGED FROM BROADMOOR HOSPITAL" FOR ADDITIONAL INFORMATION, INCLUDED AS APPENDICES 6 & 7 --

2. The problem of releasing individuals detained at Broadmoor was discussed throughout the day. This institution is feeling considerable pressure because of the recent release of a violent rapist who subsequently re-offended, murdering his victim in the course of the offence. What was remarkable
about this discharge was that it was ordered by the Deputy Director of the Hospital without the benefit of a psychological assessment. Clearly, such an assessment was in order since a previous psychological report (done in 1976) stated that the prognosis for this man's safe release into the community was not good.

3. Following from the issue raised in point 2, it seemed that the psychiatrists do not treat the psychological staff in a collegial manner, in spite of the fact that several of the staff psychologists have done very respectable research at Broadmoor Hospital. We were left with the impression that considerable professional resources were "going to waste". At the present time, with Dr. McGrath's retirement imminent, the psychological staff are lobbying for a change in the management structure of the institution demanding greater participation.

4. We felt privileged to be able to sit in on a case conference, but were more than a bit concerned with the events that transpired: due to the heavy bias in favor of psychiatry at the conference, members of staff seemed overly anxious to "label" an individual without having sufficiently researched the man's case or listened to the facts that the patient was openly disclosing. As a function of this experience, we were more convinced than ever before that a multi-disciplinary staffing model must be achieved for the Special Care Unit. What's more, we feel that considerable thought and attention should be given to the staff organisation of the new Hospital Facility before the Government turns this facility over to the Health Commission. As stated in the recommendations, we feel that such an institution should become a Special Hospital, possibly governed by individuals from both the Health Commission and Corrective Services.
MOSS SIDE HOSPITAL - MAGHULL, LIVERPOOL, ENGLAND.

A. Activities of visit.

1. Meeting with various heads of departments (Social work, industries, psychology, nursing and administration of hospital) at which the programmes of the institution were outlined by Dr. M.P. Neill and her staff.

2. Tour around workshops, classroom and living facilities on the part of the complex near Park Lane Hospital.

3. Lunch with heads of departments.

4. Tour of women's wings and other male living units.

5. John Horton tours administration and security facilities. David Schwartz meets with psychologists from Moss Side and Park Lane Hospitals.

6. Final meeting with Dr. Neill, Sheila Scott (social work) and J. Eric Postles (Administrator for both Moss Side and Park Lane).

B. Issues raised during the visit.

1. At present, Moss Side Hospital has a large complement of intellectually sub-normal patients as well as individuals with average intelligence. However, there is a fear among the staff of the hospital that this institution will handle only sub-normals after Park Lane Hospital is fully operational. Thus, Moss Side would cater for the same sort of individuals in the north of England that Hampton Hospital serves in the lower part of the country. Staff would not be happy to see this development because they believe it is beneficial to staff to have the opportunity to work with both normal and sub-normal patients.

2. Moss Side is apparently losing members of its staff to Park Lane as that new facility becomes fully operational. This has generated some bad feelings.

3. We were very impressed with the various workshops at the institution as well as the security arrangements present in each location. Of particular interest is the use of assessment procedures structured as craft activities that were used for the
4. Educational facilities and instructional programmes were of interest. Though the man in charge of these facilities is employed by the local council, he is a full-time member of the Moss Side staff.

5. Once again we had the impression that psychologists felt isolated from the rest of professional staff. However, to counteract this, they have organised a regular series of staff seminars on a broad range of topics. Their plight is not nearly as serious as seen at Broadmoor Hospital.

6. Because of the nature of the population at Moss Side Hospital, a set of guidelines have been printed for the handling of violent patients. We feel that this material is of interest and have included it in the Appendices.

--- REFER TO THE ATTACHED DOCUMENT ENTITLED "MOSS SIDE HOSPITAL: GUIDELINES FOR THE MANAGEMENT OF VIOLENT PATIENTS" INCLUDED AS APPENDIX 8 ---
A. Activities of Visit

1. Tour of facilities (old living units, gymnasium, etc.)

2. Meeting with Dr. Malcolm MacCulloch (Medical Director), and two senior nursing officers about plans for the institution when it is completed, as well as procedures currently in operation.

3. Lunch with Dr. MacCulloch, Mr. J. Eric Postles and the other senior staff.

4. A visit to the two units scheduled to be opened in late June.

B. Issues raised during the visit.

1. We were most impressed by the new units that we were allowed to see (even before a number of members of staff). While some chances have been taken in the design of the living units (each of which has a private toilet), the attempt to provide an environment that is both aesthetically pleasing and humane is highly commendable. We told the Senior Nursing Officer Norman Pearce that we would like a "progress report" in twelve to eighteen months to see what problems have been discovered in these housing units.

-- REFER TO THE ATTACHED DOCUMENT ENTITLED "PARK LANE HOSPITAL - PHASE I PREVIEW" INCLUDED AS APPENDIX 9--

2. The senior staff were very helpful in sharing information with us on the following procedures:

- incident reporting relating to unusual events of patient's behaviour
- seclusion procedures when a patient is exhibiting irresponsible or disturbing behaviour or behaviour that may harm the patient or others
- admission procedure
- patient's temporary absence for treatment procedure
- sick noticing procedure
- dying in hospital procedure
- recording procedure for goods received from visitors and relatives
- accidents to staff, patients or visitors (procedure)
- procedure for taking specimens of blood
- induction of new staff into ward environment
- various security procedures (movement of patients, spot checks, personal search of patients, missing tools/equipment, search operations,
3. The Medical Director seems intent on operating a very open hospital with much more staff participation in the management of wings than we saw in the other special hospitals. It is perhaps indicative of change that the nurses in this institution did not wear standard uniforms; they wore civilian clothing.

4. In order to maintain professionalism and a "fresh" approach, Dr. MacCulloc has established professional contacts with major hospital and university facilities in the region. It is his intention to avoid "staff staleness" by continually giving them contact with professional personnel who are not connected with the Special Hospital System.

5. The psychologists at this institution do not feel as alienated here as was the case at Broadmoor. The Medical Director has stated in the Policy Station (on file at Long Bay, along with the Policy Statement for Moss Side and the Joint Policy Statement for the two hospitals) that he has no objection to turning over the running of a wing to psychologists. Given the context of this system, that is, indeed, a radical departure from tradition.
A. Organisation of the Unit.

The Unit was opened in May 1972, following the tabling in Parliament of a report entitled "The General Programme for the Development of Psychiatric Services in Federal Correctional Services in Canada", more generally referred to as "The Chalke Report". The Unit is administered by Dr. C. Roy, a psychiatrist.

This report led to the creation of Regional Psychiatric Centres throughout Canada. Initially there was a considerable amount of criticism and opposition to setting up these units. Generally this criticism following the argument that prisons as a reform or rehabilitative measure had failed and considerable pressure was applied to gain acceptance for the "Just Desserts Model" of sentencing.

1. Objectives of the Unit.
   a. Stated objectives.

   The rendering of professional health care to Federal inmates (all inmates sentenced to 2 years or more), approximately 10,000 in number, primarily from British Columbia. The Unit is accredited as a hospital and serves as a teaching Unit for the University of British Columbia.

   b. Target population.

   The present population of the Unit consists of the following groups:

   25% Mentally Ill - "Psychotic"
   10% Sex Offenders
   65% "Behavioural Problems"
c. Perception of success by personnel/custodial staff.

The staff of the Unit 'believe' that they are successful in terms of their stated objectives. However, 48% of inmates who have served periods in the Unit are subsequently re-admitted for further periods.

One thing we noted however, was the attitudes of custodial staff. From discussion with the custodial staff, it is apparent that the regime of the Unit is in some way, and to some degree, responsible for more positive custodial attitudes. No attempts have been made to measure these changes.

2. Rules/Principles by which the Unit is run.

Although no formal principles of management style were stated, it was obvious to us that the Unit reflects the personality of the Director, Dr. C. Roy. He tends to push the staff in the direction which he wants to go, by persuasion, discussion and consensus seeking, rather than by direction. In our perception his style is that of a "Benevolent Dictator". It is apparent from discussion that if persuasion fails, then he is prepared to use direction. He is, however, well thought of and, in general liked by staff from all groups and at all levels.

3. Relationship to the prison system.

(a) Physical location.

Regional Psychiatric Centre (Pacific) is located at the end of a cul-de-sac which also contains the Matsqui Medium Security Prison. It is, however, physically quite separate from this institution. It is administered and staffed separately, although some limited, informal contact takes place between both groups of staff. The contact is limited at the custodial level because of the differing attitudes of staff in each.
The Regional Psychiatric Centre was not purpose-built. The Centre was previously used as a female institution and had lain empty for four (4) years before being re-opened in its present form.

b. Formal relationship.

The Unit is primarily a provincial or state unit, although it has been called upon to deal with offenders from other provinces. The Director reports to senior administrators within the province, or through them to Federal Officers in Ottawa.

4. Custodial involvement in Unit.

The custodial involvement in the Unit is mainly that of traditional prison officers; that is, they are not directly involved in programing and provide the security for the Unit. However, it became apparent as we moved around the living units that the custodial personnel have good rapport with inmates and are sympathetic and in some cases, empathetic to inmates' problems.

5. Number of individuals in the Unit.

a. Patients

The Unit has a capacity of 138 beds. It is a policy of the unit to maintain 10 - 15% of the beds vacant as a contingency plan. On the day of our visit the Unit contained 113 inmates.

b. Staff.

(1) Custodial 71
(2) Medical 94 (6 psychiatrists, 88 nurses)
(3) Psychological 5
(4) Ancillary 15
B. Personnel - Staffing, Selection and Training.

1. Staffing of Unit.

   a. Unit model adopted.

      The Unit is run as a medical facility and is, in fact, an accredited hospital; inmates are sent there because they are 'sick'. There is considerable use of such terms as patients, rooms and wards in lieu of inmates, cells and wings. It was noted, however, that some custodial staff lapsed into the more familiar custodial terms on some occasions.

      The Unit operates as a teaching facility for overseas Correctional Psychiatrists.

   b. Service period required in Unit for staff.

      There is no provision for a probationary period of service within the Unit, nor is any upper limit applied to length of service within the Unit. Indeed it was noted that some staff in almost all groups had worked there since the Unit had opened.

2. Selection of Staff.

   a. Custodial component.

      The previous background of the custodial staff was indicated to be the same as that of any other officer in any other prison. He would have completed his normal entry and progression courses and his refresher course. It is mandatory for all officers to complete forty (40) hours of refresher training per annum.

      Officers are selected by a panel selection interview after submission of a written application. Posting to the Unit is much sought after and a number of officers to whom we spoke had dropped one or two ranking levels in order to obtain placement there. The Unit Director's view was that suitable custodial staff were vital to the effective running of the Unit. The qualities which were sought, he indicated, were similar to those required to function in a medium, or open, security institution.
Personality (positive and open)
Leadership ability
Credibility (with their peer group and in the community).

b. Other Staff.

From lengthy discussions with the Unit Director, it is apparent that he endeavours to attract the staff he considers to be most suitable from other similar institutions. He indicated that those qualities he desired in his custodial staff were equally important in other staff within the Unit. He placed considerable emphasis on the need to publish frequently the results of individual research projects carried out by staff. In addition, he spoke of encouraging staff to continue professional work outside of their work in the Unit.

3. Training of all staff.

Additional training has been primarily confined to custodial staff. The initial intake of staff was given some weeks of lectures and discussions in the following:

- the purpose of the Unit.
- the types of inmates for which it would cater.
- the background of types of inmates.
- recognition of types of mental illness, unusual behaviour, etc.

This "training" is reinforced by staff meetings held every two (2) weeks. It seems that these meetings also provided a means by which the Director could continually assess the interest and involvement of the custodial staff in the work of the Unit. A device has been adopted in the Unit to encourage custodial interest in daily changes observed in patients' appearance and behaviour, that consists of a log which is kept in the muster room. A scan of the log revealed that it is used frequently by the officers.
c. Security Considerations.

The security of the Unit is totally in the hands of the custodial staff of the Federal Penitentiary Service. The level of security around the perimeter of the Unit was described as "ultra-maximum." The perimeter exterior and an internal "no man's land" is constantly scanned by a number of closed circuit television cameras. Images from these locations rotate sequentially every ten seconds. There is provision to "fix" any single camera onto a second screen in the event of problems. Taping facilities are provided to produce a visual record of any incident. In addition, there is another camera fixed high above the Unit which can be adjusted for size of field observed. This camera was trained on the external entrance during our visit, but the officers demonstrated how it is controlled from the control room (focus and changes in the observed field of vision); images from this camera appeared on a third monitor in the control room. Internally, the level of security was described as medium. However, the following features must be noted:

1. All external doorways and internal doorways in the Administration Building and Admissions Unit (Nova Ward) are hydraulically controlled and oversighted by closed circuit television monitors.

2. Each ward, room or work area contains an alarm button, monitored by central control.

3. Each member of staff carries a personal alarm which is monitored by central control.

4. The cell and room doors are hydraulically opened by an officer isolated in a mini-control unit in each ward/wing. Cell and room doors can be manually closed by staff or inmates.

5. Corridor grill doors are controlled, both as to opening and closing, by an officer in the wing/ward control unit.

6. All parcels are X-rayed before being opened and patients' mail is both opened and read.

The Director placed great emphasis on what he termed "dynamic security", consisting of personal knowledge by staff on the inmate/patient. He expressed a personal dislike of the use of "razor wire" on the gaol perimeter saying that he would prefer that an escapee be shot, rather than torn and scarred.
on the wire. There are a number of points during the day when an inmate's location is checked and all patients are accounted for. This "count" takes place eight (8) times a day, during which all inmates are required to "stand to."

Control of keys and weapons within the Unit was excellent. Three (3) separate keyboards are maintained. Of the two (2) boards within the Central Security Zone, one (1) must always be intact. The third set of keys is located on the perimeter at the main gate. Keys are issued only on the production of an identity tag which is placed on the board in lieu of the keys. Weapons were maintained in a central perimeter armory, with the exception of two (2) revolvers and batons which are on issue to Central Control Staff. Officers on duty in the Unit and not stationed in the Central Control area may not carry any weapons, in accordance with the policy of the Director.

It was interesting to note the recent acquisition by the Canadian Service of Australian "saflock" handcuffs which are used for prisoners' escorts in conjunction with a light 5-chamber .38 calibre Smith & Wesson revolver and leg-chains.

In spite of the very detailed security measures, both around and within the Unit, there was no impression given to us of the "dangerous message." The "feel" of the Institution was comfortable, even in the living units. We particularly noted the number of women freely moving about the institution and subsequently found that over 60% of non-custodial staff are female, although the inmate population is totally male.

Allied with the issue of security is the usage of illicit alcohol in the form of "home brew." We inquired about this problem area, but were informed that the incidence of "brews" is virtually nil because of a very simple solution: all sugar and sugar concentrate items are not issued to inmates in bulk. Tea and coffee is served sweetened or unsweetened and cordials are likewise available in mixed form.
Officer morale and standards of work and dress (a most reliable behavioural indicator of the quality of custodial standard) was described and observed to be high. Clearly, these outcomes are the positive result of eight years' good management of the Unit. The following information was given as a brief resume of "disturbances":

- one suicide
- one escape
- one murder
- numerous hostage-takings (which seem to be a feature of the Canadian system).

"riots" were referred to by some officers, but the Director said that these incidents were usually disturbances involving fewer than twenty patients. As Dr. Roy said "I'm from Calcutta, so I think of ten thousand people demonstrating violently as a riot. Anything less than that is a disturbance."

incidents of physical aggression have been infrequent; raised hand gestures are not tolerated by the Director, whereas verbal aggression is encouraged as part of the therapeutic process.

D. Regime of the Unit.

1. Entry and discharge of patients.

Inmates are referred to the Unit by the Director of the prison in which he is currently housed or by other members of staff, including members of the National Parole Service, via the prison doctor or consultant psychiatrist at that institution. The decision to accept or reject a particular inmate is the responsibility of the Director, although Dr. Roy indicated that he uses a "team approach" to make the determination. Discharges are determined in the same manner, with Dr. Roy as the individual who is ultimately responsible for the decision.

The average length of stay in the Unit is 160 days, with the majority of inmates/patients remaining for less than six months. Some are cleared after thirty days, while some men have been in the Unit for some years, however. As previously stated, the rate of re-admission is 48%. 
2. **Programmes in the Unit.**

Programming at Abbotsford is of a purely medical/psychiatric nature and was said to have a single objective: to return the inmate/patient to his gaol of classification in a more healthy state than he enjoyed prior to admission. Staff were very keen to point out that there was no experimentation carried out at the Unit and that the inmate/patient was there on a purely voluntary basis. Thus, he could return to the institution from which he was received at any time.

3. **Medical Regime of the Unit.**

Full-time psychiatrists and psychiatric nurses are part of the Unit's staff. Drugs are used and the type and level of drug dosage is determined by each individual psychiatrist. The Unit has an excellent drug accounting record system, providing the Director and other medical staff the following information:

- level of drug usage in a particular ward/wing
- number and type of drugs issued to a particular patient.
- breakdown of drugs being prescribed by particular doctors.
- a costing for each drug on a continuous basis.

All this is very up-to-date, being available on a daily print-out. It seems that such information is used for a variety of purposes, the least of which is cost accountability. According to Dr. Roy, the "team" of the Unit is free to query treatment prescribed by colleagues during staff meetings. In addition, the information on the printout may serve to alert a doctor that he is habitually using a particular drug or possibly over-prescribing for a patient.

4. **Communication between Patients and Professionals.**

There is no absolute right of patients/inmates to be given access to reports which are written about them. However, each staff member has the personal freedom to discuss such matters with inmates and/or allow them to read reports if the staff agree to such a procedure. Reports are generally used only as a basis
for transfer from the Unit to other institutions. Our perception was that patient/staff interaction was reasonably free and open.

E. Daily functioning of Unit.

1. Induction procedure.

A formal admission/induction procedure is carried out over a number of days. Each patient/inmate is interviewed, assessed and tested within an admission unit (Nova Ward) and his placement within the Institution is determined. Patients/inmates are given a booklet to read during their time in the admission wing/ward which they sign and return to staff when they leave for formal placement. In addition, he is supplied with a set of "Directions and Regulations".

--- REFER TO THE ATTACHED MATERIAL ENTITLED "REGIONAL PSYCHIATRIC CENTRE (PACIFIC): NOVA WARD INDUCTION BOOKLET" AND "THE REGIONAL PSYCHIATRIC CENTRE (PAC.): DIRECTIONS AND REGULATIONS" INCLUDED AS APPENDICES 10 & 11 ---

2. Routine of Unit.

The routine of the Unit appeared to be relatively unstructured. Inmate/patients were seen in the living units, at school, in the library, in group sessions, working in the canteen/dining room. Crafts and hobbies are available and decoration of one's personal cell is permitted, although the cell layout must conform to one of three alternatives. A stereo/music room is provided. Staff and inmates dine in adjacent dining rooms, but the food provided is the same for both groups. A well-equipped gymnasium is also available. In addition to all of these amenities, a chapel is provided for the use of both staff and inmates and both groups are encouraged to worship together. Visiting clergy officiate at services.

The normal day extends from 7.00 am to 11.00 pm, although it is possible for inmates to remain in the television/
recreation room (in a locked-in situation) until 2.00 or 3.00 am. on weekends. During the night, should an inmate need to use the toilet facility, he presses a call button and communicates his desire to officer in the wing control room who then releases the lock on the man's door. When the man returns to his room, he pulls his door shut and the locking mechanism is activated.

3. Public Access to the Unit.

Inmates/patients must place the names of visitors on their visiting lists for approval. In addition, provision is made for inmate/patients to send their visitors visiting forms which detail the arrangements for such contacts at Abbotsford. The decision to allow or refuse access by particular visitors is made by a social worker or the chief psychologist. In addition, arrangements may be made by a social worker for a volunteer to visit an inmate/patient who is not being visited by family or friends. Ex-inmates, particularly sex offenders, are encouraged to return to the institution as visitors after discharge. All visits are contact visits and take place in the visiting lounge. In addition, each inmate/patient is allowed two 'phone calls per month as a means of maintaining outside contact.

Community access is provided freely to the Unit. There is an active Citizens' Committee that comes to the Unit frequently. Requests by media representatives to see the facility are traditionally approved and the media are periodically invited to come to the Unit.

F. Other issues.

1. Dr. Roy, the Unit Director, indicated that he believed that 25% of all inmates within the prison system require some psychiatric treatment, 10% in a hospital situation such as Abbotsford provides.
2. Concern was expressed for the inmate who responds to the treatment available at Abbotsford. By breaking down the prison culture of the inmate, he becomes very vulnerable within the system. His "coping mechanisms" are removed and he becomes very susceptible to pressure from his peer group. In negative terms, it was suggested that the inmate/patient is faced with two rather unsavoury alternatives:

- reversion to former attitudes/actions.
- not surviving in the general prison.

Dr. Roy felt that an an individual under treatment should not be left so defenceless after his experience in the Unit. Instead, treatment outcome should take the form of self-knowledge rather than deeper personality change. However, he admitted that this is a considerable problem in any intervention strategy.

--- REFER TO THE ATTACHED MATERIAL ENTITLED "R.P.C.; REGIONAL PSYCHIATRIC CENTRE, ABBOTSFORD, BRITISH COLUMBIA" INCLUDED AS APPENDIX 12 ---
V. SITE VISITS,
SECTION THREE:

-- Dr. Henri van der Hoeven Kliniek
   (and Pieter Baan Centrum).
-- H.M. Prison, Grendon.
-- Barlinnie Special Unit.
Site Visits, Section Three: Therapeutic communities.

Institutions Visited:

1. Dr. Henri van der Hoeven Kliniek (and the Pieter Baan Centrum)
   Utrecht, THE NETHERLANDS.

2. H.M. Prison, Grendon,
   Aylesbury, Buckinghamshire, ENGLAND.

3. Special Unit, H.M. Prison Barlinnie,
   Glasgow, SCOTLAND.

These three institutions were the "peak experiences" of our trip. We were naturally interested in the physical resources, as well as the staffing requirements, that each of these therapeutic communities utilised. It would be difficult for us to draw any firm conclusions about the sort of physical plant that is needed to set up such a programme on the basis of these three sites because of the enormous number of differences between them. The van der Hoeven Kliniek is a new, purpose-built facility in which every imaginable institutional need has been planned for and provided. Grendon, on the other hand, is basically a prison with a large amount of "public space" (group rooms, meeting rooms, etc.) which is used for the therapeutic programme. To compare the Dutch and English units would be like comparing a first-class hotel of international standing with a guest house. If, to continue in this vein of comparisons, we were then to place Barlinnie's physical plant on this rating scale, we would have to say that it rates as a shabby youth hostel in comparison with other units. However, it is begging the obvious to say that four walls do not relate to the success or failure of a programme, no matter how opulent or spartan they are. In each case, the wealth of these three programmes was embodied in the resident staff.

Because we had committed ourselves to the idea that the Special Care Unit would be organised along the lines of a therapeutic community, run, in large part, by custodial staff,
we were anxious to view several examples of this species in situ. Naturally, we were particularly interested in the role given to custodial staff and the training programme that was provided for them prior to the start of their service in the institution. In two of these sites (Grendon and Barlinnie), we found some of the answers we were looking for in the area of custodial involvement. In the Dutch institution, on the other hand, there was no custodial involvement, but much to be learned about the meshing together of the skills and talents of many different kinds of professionals.

From the start of our planning for the Special Care Unit, we had envisaged a multi-disciplinary approach to staffing. However, our initial efforts in that direction had been stymied by the Health Commission of New South Wales which entertained the parochial viewpoint that any treatment facility must, by definition, be run by the Health Commission. We felt that such a "narrow focus" would only serve to close off treatment options for the Unit we had planned. In particular, the adoption of the Health Commission's model would have precluded prison officers (and other professionals, such as clergy and parole officers for example) from getting involved in therapy. We were delighted to find custodial staff doing the sort of work we had believed, as a matter of personal philosophy, was possible at Grendon and Barlinnie. (Because the Dutch institution is privately run, there are no custodial officers employed).

Moreover, officers in those units reported that they were experiencing more job satisfaction than had previously been the case when they were working in more traditional settings and performing the more conventional duties of prison officers.

Another important issue that we were able to explore was the extent to which programmes should be structured in a therapeutic community. Each of the three settings offered an alternative answer. The most structured programme was to
be found at the van der Hoeven Kliniek where every day's activity is carefully detailed on a daily program card. Grendon's routine is geared around the daily schedule of group therapy meetings, but a lot of the day is still left open for the inmate to spend according to his own plans.

At Barlinnie, on the other hand, we found what appeared to be a complete absence of structure. After a considerable amount of conversation with prisoners, however, we became aware of the fact that what appeared to be a lack of programme, was, in reality a function of our different (and much faster) perception of time. Every day seems to represent another opportunity for each man to self-actualise and get more in touch with himself. As such, the goals for each inmate are idiosyncratic and personal. The residents of the Special Unit are serving sentences of longer duration than the individuals in either of the other two institutions and can enjoy the luxury of being in an environment where "becoming" is more important that "doing" (i.e., involvement in group work at Grendon; working in a shop at the van der Hoeven Kliniek). While we found no answers to the question of structure in programming, we were grateful to be given the opportunity to observe the alternatives.

Lastly, the observation of these institutions made us realize there is a philosophical dilemma inherent in any therapeutic programme that is designed to enable an inmate to alter his perceptions of himself and take an active part in dealing with those problems that brought him to gaol. To release him back into the "jungle environment" after having stripped him of his time-honoured defences (those behavioural patterns that served him so well in his peer group and the prison setting) seems immoral. There are two alternatives: release to parole or, at the least, to an open setting that will allow him an opportunity to
exercise some of the personal autonomy and social responsibility that he has begun to achieve in the therapeutic setting. Grendon and the van der Hoeven Kliniek have both attempted to come to terms with this issue. It is unfortunate that only Barlinnie, the institution in which there would be the greatest justification for release to parole, is not able to follow through with the logical last step in its programme.
Our original itinerary allowed us to see only the Dr. Henri van der Hoeven Kliniek. However, in order to better understand the process of assessment which logically ends with discharge from the Kliniek, we decided to alter the itinerary to include the Pieter Baan Centrum where individuals are assessed prior to trial. On the basis of this assessment procedure, a determination is made as to where the individual might be sentenced for treatment. One of the treatment alternatives is the van der Hoeven Kliniek. The system is explained in the attached paper.

--- A COPY OF THE DOCUMENT ENTITLED "DETENTION AT THE GOVERNMENT'S PLEASURE: TREATMENT OF CRIMINAL PSYCHOPATHS IN THE NETHERLANDS" IS INCLUDED AS APPENDIX 13 ---

Pieter Baan Centrum, Utrecht, The Netherlands.

1. Objectives of the Unit.

The Centrum is constituted as an assessment centre to provide an objective determination of an offender's level of responsibility only in the most severe cases of criminal behaviour. This process occurs prior to trial. The Unit deals with a mixed population of individuals who are charged with serious offences, such as murder, manslaughter, rape, violent assault, etc. Though most of the remands are male, 3 to 4 women are processed every year.

2. Rules/principles by which the Unit is run.

The Unit emphasises a team approach to investigation and decision-making. In our perception it seemed to incorporate a variety of disciplines.
3. Relationship to the prison system.

The Centrum has no physical or formal attachment to the Dutch Prison System. It exists purely to provide an unbiased external evaluation to the courts. All information, which may be of value to both the inmate and/or his legal counsel, as well as the prosecution, is provided in the final report at the end of the assessment process. This report may also include information concerning unreported or undetected crimes which has been obtained during the assessment.

4. Number of individuals in the Unit.

The Unit has a capacity of 36 beds, but at the time of our visit, only 24 of these beds were in use (because one wing is temporarily closed due to lack of funds and staff). There are 20 staff members on the treatment/assessment team assigned to each group of eight (8) inmates (14 group leaders, 2 social workers, 1½ psychiatry positions, 1½ psychological positions, 1 legal representative).

5. Entry and discharge of remands.

Each potential client of the Centrum is interviewed in prison by members of staff and a group decision is made to admit/reject the individual.

Each inmate may decline to attend the Centrum or, after arrival, may drop out of the assessment programme at any time. However, he/she is given the opportunity to take legal advice prior to arriving at a decision either to not go into the programme or drop out after having entered.

As alluded to in a previous section, an individual's undetected or unreported crimes may become part of this assessment to the court. At the point in the process when such information becomes known to the assessment team, the offender is given two procedural options:
allow the information to be included in the report and continue in the programme of assessment

elect not to allow this information to be included in the report, resulting in the automatic termination of the assessment process, at which point the Centrum submits a report to the court stating that assessment was voluntarily terminated.

Because of the fact that a "TBR" sentence is highly desirable (and such a sentence can only be gained upon favourable recommendation of the Centrum staff team to the court), there is considerable payoff for staying in the assessment programme, even at the expense of admitting the previously undetected offences. The staff indicated that "treatment sentences" could only be effective if the offender was totally candid during both the assessment and treatment phases of the process. Otherwise, the entire exercise is empty and useless. In addition, staff indicated that the judges often queried them as to why the assessment was prematurely terminated, inasmuch as the official report of this event does not include this information, and this information is given to the judge "off the record." Lest the reader be left with the impression that this process sounds very punitive and authoritarian, it should be added that the offender knows all about this option to terminate prior to entry into the Centrum.

6. Regime of the Unit.

During the first week of admission, each staff member meets with the inmate. At the completion of this orientation process, during which staff get to know the individual and he/she gets to meet the staff and learn the objectives of the assessment process, the staff meet as a group to plan the programme which will be carried out during the following six (6) weeks.
Such programmes include the following:

- full medical examination
- neurological investigation
- psychological report
- social history which is analogous to our pre-sentence report in which interviews are conducted with family, friends, previous employers and the inmate.
- psychiatric report.

Each member of the five member assessment team (medical doctor, psychologist, psychiatrist, parole/social work officer, a probation/parole officer from offender's home area and a legal adviser who operates as an advisor) provides an individual report for the final assessment meeting setting the following:

- degree of responsibility for the criminal acts for which he/she is standing trial
- determination of the inmate's dangerousness to self and/or society
- advice to the court regarding sentence

These reports are considered at the final meeting at the end of the seventh week of assessment and a covering report is then drafted. This report may contain a consensus decision or a majority and minority viewpoint (in cases where consensus could not be reached).

7. Communication between patients and professionals.

The final report is explained to the inmate. In some cases, the inmate is allowed to read the actual report. However, there are situations in which this policy of complete openness is not followed such as:

- reports containing confidential information from spouse or other close family members who might be subjected to retaliation from the inmate for disclosing such material
- when the inmate was psychotic or otherwise unfit to deal with the material in a reasonably objective fashion.
While the staff of the Pieter Baan Centrum do not appear as witnesses for either defence or prosecution, they may give evidence to the court as expert witnesses.

At the completion of the assessment process, inmates are returned to the remand gaol to await the completion of the judicial procedure.

8. **Security Considerations.**

All external and internal entrances are monitored by closed circuit television cameras and these images are projected onto monitors in the central control unit of the Centrum. There are no bars on windows, but all apertures are covered with bullet-proof glass or thick, unbreakable plastic. In appearance, the building looks like a large office block from the street. Only when one is at the entrance does one get a sense of security systems controlling access. Internal security is identical with that employed at the van der Hoeven Kliniek reported on in the next section.
As stated in the introduction to the Dutch sites visited, this is a treatment facility to which an individual may be sent by the courts after assessment has been made at the Pieter Baan Centrum. The Kliniek itself is a private institution that receives funding from the Dutch Government on a contract basis for individuals of both sexes being treated under provisions of the "TBR" sentence.

-- REFER TO ATTACHED DOCUMENTS ENTITLED "THE DR. HENRI VAN DER HOEVEN KLINIEK BACKGROUND AND TREATMENT CREDO" AND "THE DR. VAN DER HOEVEN CLINIC, UTRECHT, THE NETHERLANDS: THE NEW BUILDING AND THE IDEAS WHICH UNDERLIE IT" ATTACHED AS APPENDICES 14 & 15--

A. Organisation of the Unit.

1. Objectives of the Unit.

   a. Stated objectives.

   The Kliniek's objective is to treat mental illness and prevent further criminality. Amplification of this statement is included in the applicable attachments. The central principle involved is the re-socialisation of the offender.

   b. Target population.

   Inmates at the Kliniek are defined as individuals of average intelligence who are assessed as emotionally disturbed and convicted of aggressive offences, including murder, manslaughter and sex offences. The age range for treatment is 17-45 years, though the most representative group under treatment is generally between 20-25 years old.
c. Perception of success by personnel/custodial staff.

The success of this clinical approach is, as yet, unknown. The Director, Mr. J.R. Niemantsverdriet, stated that a research project designed to assess effectiveness of the facility's first twenty-five years of existence was undertaken in 1975 and is nearing completion. A small pilot research study was carried out in 1971, however, and is attached to this report.

-- REFER TO RESEARCH STUDY ENTITLED "TREATMENT RESULTS AT THE DR. HENRI VAN DER HOEVEN CLINIC, UTRECHT, THE NETHERLANDS", ATTACHED AS APPENDIX 16 --

2. Rules/principles by which the Unit is run.

The Director, a criminologist and lawyer by training, stated that the central principle by which the Kliniek was run was, "A community sharing the risks together." From our perception, it is certainly a very democratic management style in which the decision-making is shared. The Director is viewed as a facilitator who can aid the organisation in achieving consensus. This institution was noteworthy inasmuch as it was the only site that we visited where the directorial responsibility was not placed in the hands of a custodial superintendent or a medical director (typically a psychiatrist). We felt that note should be made of this fact inasmuch as it was the original desire of those connected with the initial planning of the Special Care Unit that directorial responsibility should logically be handled in this fashion. Unfortunately, the Health Commission of New South Wales chose to press their far more parochial point of view that a treatment facility must
necessarily be headed by a medically trained individual.

3. **Relationship to the Prison System.**

   As the reader may note from the various attachments, the van der Hoeven Kliniek is not part of the Dutch Prison System. Instead, it represents an alternative to a custodial sentence. As such, it is neither physically nor formally attached to a prison.

4. **Custodial involvement in the Unit.**

   There are no custodial staff employed at the Kliniek.

5. **Number of individuals in the Unit.**

   a. **Patients.**

      Currently there are 70 patients residing there.

   b. **Staff.**

      There are 150 members of staff (110 full-time and 40 part-time personnel). No breakdown of staff was available for us. However, it should be noted that the facility operates on the principle that various roles are blurred (e.g., a trained psychologist may be involved in the full-time running of an industrial training unit and a medical officer could be in charge of a residential unit). Thus, the sort of staff breakdown provide for other institutions would not be meaningful, in the same sense, in providing staffing information for the van der Hoeven Kliniek.

B. **Personnel: Staffing, Selection and Training.**

   1. **Staffing of the Unit.**

      a. **Unit model adopted.**

         This institution may be best described as a "therapeutic community" along the lines set out by Maxwell Jones. A wide variety of staff are employed. Though their formal qualifications are taken into account, the professionals (such as social workers, psychologists, criminologists, etc.) are treated no differently than trades people who are involved...
in running trades training shops. In fact, some of these professionally credentialed staff members are involved in work that is far removed from their traditionally defined areas of expertise. This blurring of roles is an intrinsic aspect of the team approach adopted by the Kliniek. Each member of the team is considered to be potentially interchangeable with another team associate, whether he/she be a psychologist, sociologist, criminologist, or social worker. The virtue of such a model is the extraordinary amount of "cross-fertilisation" of knowledge and expertise that is possible. Because re-socialisation is the central aim, every attempt is made to model the Kliniek on the outside world.

b. Service period required in the unit for staff.

There does not seem to be a probationary period or upper limit of service requirement involved for individuals working in this institution.

2. Selection of Staff.
   a. Custodial Component.

      Not applicable to this institution.

   b. Other staff.

      No information was specifically gathered in this area, but it was our impression that each applicant who interested in working at the Kliniek is evaluated in terms of role flexibility and the maximal payoff gained from his/her services to the facility.

3. Training of staff.

   All new staff are given a one (1) week induction to the Unit. During this time, new staff familiarise themselves with the facility, attend all meetings, and, in general, observe the life of the Kliniek. After the start of their work in the institution, new members of the team attend training seminars for one hour per week, each of which may deal with a particular topic.
time to time, in-service courses are provided in such areas as report preparation and interviewing techniques. As stated previously, the object of the training is to break away from traditionally defined roles.

C. Security Considerations.

Closed circuit television cameras monitor the perimeter and all internal "public spaces." The images are projected on a bank of monitors in a central control room. All doors are controlled from this monitoring area. People wishing to pass through various sections of the building must press a buzzer, causing a signal light to flash in the control centre. The individuals on duty (who, incidentally, are the only custodial personnel on site, occupying a role analogous to that of any building security staff) activates the television monitor in that location to identify the individual and evaluate the request for entry. If approved, the door is released. All "public spaces" (visiting rooms, workshops, stores, etc.) have windows that allow observation from the corridors. Each inmate is provided with a key to his/her own room, but staff of each living unit retain a master key to the rooms of their section. Inmates wear their own clothes and are paid a social service allowance in cash. Each group must provide for their own daily needs (i.e. buy their own food, furniture, cleaning materials, newspapers, etc.) Each living unit cooks its own meals. Twice a day, the institution shop opens for purchases; the prices reflect those found in the outside community. Also, laundry facilities are provided in each living unit.

There are no "head counts" made during the day; the only check is carried out at 10.00 pm. While most of the sentence of an individual is served within the Kliniek, the latter part may involve day release to work, clubs, school, or family, in the
outside community. In the event that an inmate does not return at night, his absence is noted and the police are notified that he is "out", but no escape charges are brought against him. In fact, there is a provision to "legalise" the escape if the inmate does not commit another crime, is able to find employment and successfully survives "on the outside". This feature does not seem so extraordinary when one considers the focus of treatment as re-socialisation for a successful life in the community. Because each individual is placed in the Kliniek on an indeterminate sentence which is considered to end only when the staff believe an inmate would be able to survive in society, the staff may make this decision after the fact of the inmate's failure to return and demonstration of survival in a legitimate life-style.

Security is generally very tight, but unobtrusive. There is no "dangerousness message" inside the institution. Indeed, the environment gives one a very comfortable feeling. Externally, the van der Hoeven Kliniek looks like a low-rise city office block.

D. Regime of the Unit.

1. Entry and Discharge of Patients.

Each year, approximately one hundred (100) individuals are received directly from the courts. The Minister of Justice is required to decide whether a person is sent to a traditional prison or a treatment centre such as this one. In addition, twenty to thirty (20-30) individuals are referred from prisons by a psychologist or psychiatrist. In these cases, there is a formal case presentation and the decision to accept or reject is made by a selection panel.

The length of stay in the unit is indeterminate. This aspect of sentencing is currently under government review and may ultimately be fixed at 5 to 6 years in the future.
Currently, the range of residence is one to eight years, although the majority of inmates are released after three (3) years at the Kliniek. Provision is made for formal review of each case by the courts every two (2) years. The Minister of Justice retains the right to release an inmate at any time in the sentence, but we were assured that he usually acts on the advice of the staff of the institution.

2. Programmes in the Unit.

Because the goal of treatment is re-socialisation, a wide range of work and activities is provided, covering areas of basic education, trade courses, social/survival skills and works release experience. Course provision includes the following:

- cooking
- metalwork
- carpentry
- sewing
- gardening
- shopkeeping
- school (internal and external courses)
- works release
- day release to family, shopping trips, community clubs, etc.

Inmates are housed in a living group of 6 - 8 members and 4 staff members. The emphasis is on the inmate's self development. As such, any number of techniques are used to advance the aims of the programme, such as

- psychotherapeutic sessions
- creative games
- art classes and art therapy
- photography
- psychodrama
- theatre
- video/sound interviews (for self observation of one's social presentation).

Each living group meets weekly. After six (6) weeks, an inmate is assisted by the group to determine his/her choices for future programming. This session is viewed as a formal "contract" which may be referred back to in the future. After this formal commitment, an inmate may be seen daily, if necessary, to evaluate progress and set new goals.
The Director stressed the fact that any issue discussed in the living units becomes "public" (group) property. No communication is privileged, with the exception of private discussions held by an inmate with the chaplain (a part-time member of staff) who serves in a pastoral role.

3. Medical Regime of the Unit.

Availability of psychiatrists is very limited. In fact, there is no formal allocation in staffing for psychiatrists or psychiatric nurses. General nurses are part of the clinical team, but the use of drug intervention is very limited.

4. Communication between patients and professionals.

Communication between staff members and inmates appeared to be very open. Most matters are ventilated at group or community meetings. As an example, the Director outlined the steps of a grievance procedure for inmates which are as follows:

1. discussion with living group
2. discussion with clinic council
3. convene a special committee of the clinic council
4. write to the appropriate governmental authority.

In the case of the first and second options, inmates are in the majority, while there are elected inmate members in the third option who are eligible to sit on special committees. In all three instances, all voting parties (inmate and staff) are considered to be equal.

E. Daily functioning of the Unit.

1. Induction procedure.

There is a "buddy system" in operation at the present time wherein orientation responsibility is carried by an inmate and a member of staff. In addition, each new inmate is supplied with an orientation handbook. The Director graciously supplied us with a copy of this booklet; it is currently in the process of being translated for us by a Dutch-speaking prison officer.
2. **Routine of Unit.**

The routine of the Kliniek is very structured. Inmates are required to be in certain locations at a particular time, according to the demands of their programme. This schedule is formalised to the extent that the inmate is given a card each day with the daily activities noted. This card is used for punching a time-clock every time the inmate leaves a place of work to attend other activities, such as hobby crafts, psychodrama, etc.

Staff meet together on a daily basis from 9.00 to 10.00 am at which time feedback is provided on organisational matters. Pertinent information is carried back by staff to inmates at subsequent group meetings. Once a month, a meeting of the full community is held.

"A number of leisure-time facilities are provided for at the Kliniek, including a fully equipped gymnasium and an indoor swimming pool.

As noted previously, a chaplain is available on a part-time basis.

3. **Public Access to the Unit.**

No friend or relative of an inmate is admitted to the Kliniek unless known to staff. When an inmate is admitted to the institution, he/she provides a list of visitors to the staff. Each individual on the list is visited by a social worker from the Kliniek before being allowed to become an official visitor.

Family members and other relatives/close friends are sometimes invited to the institution to participate in the programmes. For this purpose, five (5) self-contained apartments are available to provide accommodation for these visitors to live in along with the inmate who moves out of the living unit during this period of time. Additionally, provision is made for the inmate to travel away from the institution with family members to go on outings. As the reader will notice, every effort is
made to normalise the living circumstances of the inmate in order to make future adjustment upon release as painless as possible. It goes without saying that sexual relations during visits, including those with homosexual lovers, are not against the rules.

There is some hesitation over former inmates of the van der Hoeven Kliniek being allowed to return to visit staff because of the fear that they might use the clinical staff as a prop, rather than testing their self-sufficiency.

The media, local citizens, staff and patients meet as required to ventilate particular issues as the need arises. Incidentally, media coverage in Holland seems to be far more responsible than that enjoyed in New South Wales.

F. Other issues.

1. The reader may gather that this institution as well as the Pieter Baan Centrum, are co-educational. When the staff of both locations were questioned about problems with this arrangement, they said that very little difficulty has been encountered. In addition, there is a high proportion of female-to-male staff at both facilities. Again, the presence of women in an institution that caters predominately for male offenders, some of whom are under treatment for violent sex offences, is accepted as a commonplace situation. In fact, surprise was expressed that women are not employed in male penal institutions (and vice versa) of New South Wales.

2. The openness of access to the van der Hoeven Kliniek has given rise to a serious contraband problem which staff indicate is impossible to completely control without resorting to the adoption of a very repressive regime. However, steps are taken to control this problem by the use of peer pressure in the living group with the implicit message that drug traffic imperils the treatment programme of both the individual who is
A. Organisation of the Unit.

1. Objectives of the Unit.

   a. Stated Objectives.

   It was stated by Dr. Jillett, the Medical Superintendent/Governor, and Dr. B.J. Barrett, Clinical Director, that the objectives of the institution were:

   - To investigate and to treat offenders suffering from disorders which call for a psychiatric approach.
   - To investigate the mental condition of offenders, the nature of whose offences suggest mental disorder.
   - To explore the problem of the psychopath and to provide treatment or management to which he might respond.

   Clearly, the treatment is directed toward building self-motivation of the inmate in a therapeutic community setting.

   --- REFER TO ATTACHMENT CITING "BUTLER REPORT REFERENCES TO GRENDON" FOR ADDITIONAL MATERIAL AND INCLUDED AS APPENDIX 17 ---

   b. Target population.

   The population of Grendon is totally composed of individuals convicted of violent crime. Dr. Jillett added that the following criteria apply:

   - no psychotics are included in the programme
   - no referrals from the court are taken since judges are often uninformed as to the suitability of the facility for certain individuals
   - inmate must be of average (or better than average) intelligence and possess the ability to deal with emotions and past offences in a verbal manner.

   --- REFER TO THE THREE DOCUMENTS ATTACHED THAT DEAL WITH CRITERIA FOR TREATMENT AT GRENDON AND INCLUDED AS APPENDICES 18, 19 & 20.---

   c. Perception of success by personnel/custodial staff

   We were able to discuss this issue with three different categories of individuals: prison officers, inmates, and medical staff.
and one of the psychiatrists who is Clinical Director, Dr. Barrett. Custodial staff who were interviewed indicated a belief in the success of the work carried on at Grendon, but could not specify the "success" in any sort of objective terms. Perhaps the more crucial measure of staff effectiveness was their "gut-level" feeling that their work at Grendon was very satisfying. The inmates that we spoke to were far less guarded in their estimate of the programme: they felt that 70% of people who had the opportunity to come to Grendon did not return to gaol. Dr. Barrett stated that 30 - 40% of prisoners would not return.

2. Rules/Principles by which the Unit is run.

Grendon has a formal hierarchical structure such as is found in other penal institutions. It was, however, stated that Grendon was run on a very democratic style of management. From observations that we made during our attendance at various meetings (small group, wing and staff meetings), it would seem that such a claim is warranted. Within each wing community, three (3) inmates are elected to serve as representatives on staff-inmate wing committees and their votes are considered to have equal weight with custodial representatives. In the event of a case conference, the inmate in question is always informed of the matters discussed and may be present at the actual discussion. Wing committees may make recommendations to the Governor who is the only individual empowered to make any final decisions regarding the functioning of the gaol. We were assured by all parties that a wing committee's recommendation is rarely over-ruled in this manner. It should be emphasized that in all interpersonal contacts at Grendon inmates and officers address one another using Christian names. At no time did we feel that this intimacy was artificial.

--- A TYPICAL WING CONSTITUTION IS ATTACHED AS APPENDIX 21 ---

3. Relationship to the prison system.

The institution is located near H.M. Springhill, an open prison and the two prisons share an officers' mess.
Grendon is an autonomous institution within the British Prison Service and is controlled by the British Home Office.

4. Custodial involvement in the Unit.

The custodial staff are generally very involved. They serve as team leaders in group counselling sessions and formal wing/community meetings. When queried about working conditions, these staff members, to a man, said "It was a pleasure to come to work." It seems, however, that the regime does not suit all custodial staff at the institution. There are a group of more traditionally-oriented officers (referred to by some Grendon personnel as "excused convicts") who have chosen to opt out of the therapeutic work of the prison and work in areas where contact with prisoners and other staff is at a minimum (e.g., prison hospital, the assessment centre, gate posts, etc.).

5. Numbers of individuals in the Unit.

a. Prisoners

There are currently 165 inmates at Grendon.

b. Staff

(1) Custodial 140 positions (current strength: 100).

(2) Medical 9 (6 doctors with psychiatric training, 3 nurses)

(3) Psychological 6 (5 psychologists plus a testing officer)

(4) Ancillary 6 welfare officers from probation service

In addition to the above, the institution is served by:

- visiting medical consultants
- social work students
- office/support staff

In discussing the issue of staffing, Dr. Jillett stated that although the inmate-staff ratio was approximately 1:1, he believed that the ratio should ideally be closer to 2:1 for effective treatment.
B. Personnel: Staffing, Selection and Training.

1. Staffing of the Unit.
   a. Unit model adopted.

   The model which Grendon was to most closely approximate was that of a "multi-disciplinary therapeutic community", according to Dr. Barrett, the Clinical Director. It was emphasized that it was not to be seen as a "medical" facility; the inmates are not regarded as "sick" or "mentally ill." Grendon differed in some respects from the other two therapeutic communities (van der Hoeven Kliniek and Barlinnie Special Unit), due, no doubt to the size of inmate population and the lack of modern amenities (such as seen at the Dutch location). There seemed to be more "private communication" between staff members at Grendon than at either the Scottish or Dutch facilities. However, this may be due to the need to more carefully co-ordinate and structure treatment for so many inmates.

   b. Service period required in the Unit for staff

   There is no formal provision for a probationary period of service at Grendon. However, officers are closely watched by senior custodial staff and can be removed from the institution following a written report. There is no specified maximum length of service within the institution.

2. Selection of staff.
   a. Custodial component.

   The background of custodial staff at Grendon is similar to that of staff in other British Prison Service institutions. Additional in-service training of two (2) weeks in group work is required before placement at Grendon. Placement to Grendon may take place in two ways:

   (1) by draft from the Officers' Training School
   (2) by application and selection by a board consisting of the governor, a senior custodial officer and a member of the Head Office personnel section.
Selected officers are said to possess the following qualities:

- intelligence
- empathy
- be sympathetic to problems of others
- highly developed verbal skills
- show leadership ability

Our observation would suggest that the Officers' Training School selection is equal to that of the Selection Board.

b. Other staff.

No information was gathered in this area.

3. Training of Staff.

As noted above, a special course in group work is required for placement at Grendon in addition to basic prison officers' training. In addition, ongoing "in-house" training is provided through group discussions that are held following each group therapy session, during which time the clinically trained team leader highlights various dynamics of the previous session and may make suggestions as to how certain situations could best be handled. Also, weekly sensitivity meetings are held in order to clear the air and ventilate any problems that might have arisen during the week. Aside from serving a healthy "safety valve" function, these sessions are also used to illustrate dynamics for the custodial group involved.

C. Security Considerations.

The perimeter of the prison is surveyed by closed circuit television and monitored at the main gate. There are no tower posts at Grendon. Internal security consists of manually operated grill gates within corridors and solid doors giving entry to wings. Internal security is as based, to a large extent, on the "know your inmate" principle, as well as the considerable amount of community responsibility and trust. The institution has had two (2) escapes in its history. Grendon has a comfortable "feel" giving no environmental message of "dangerousness" such as is typically found in maximum security areas.
D. Regime of the Unit.

1. Entry and discharge of prisoners

Inmates are recommended for Grendon by a prison medical officer (typically a psychiatrist). A preliminary cull of these recommendations is made by the Governor at Grendon; the balance are referred to an Institutional Assessment Committee. Prisoners are generally kept at Grendon for the last 12-16 months of their sentence and then released to parole. Life sentence inmates spend approximately three (3) years at the institution and are then transferred to an open prison facility. An inmate may request to be removed from Grendon at any time. By the same token, the community in which an inmate is resident may ask that the prisoner be removed. However, both of these types of requests must pass through "correct channels" to the staff whose responsibility it is to reject or recommend such a transfer to the governor. The governor always retains the right to transfer.

2. Programmes in the Unit.

Daily group meetings and community meetings are held six (6) days of the week. These sessions may take the form of discussion, psycho-drama, transactional analysis or "family groups" (wherein the prisoner's family may be invited into the group to aid in the inmate's therapy). Each inmate is required to discuss his background, his offences, his attitudes and feelings within group and community meetings. The community, in return, assists the inmate in identifying problems and setting goals. Once these issues have been dealt with in a cursory sense, a form of "contract" is arrived at by the inmate with the community. This agreement, which may be a very informal sort of verbal statement or a written and highly specific set of goals, is reviewed by the community periodically.

-- REFER TO ATTACHMENTS DEALING WITH "AIMS AND METHODS OF TREATMENT ON 'A' WING" AND "NOTE ON TREATMENT IN 'B' WING" AS APPENDICES 22 & 23 --
3. Medical regime of the Unit.

Psychiatrists are available on the staff at Grendon. However, there is no psychiatric nursing assistance. General nursing is supplied by nurse officers. It is the official policy of the institution that drugs will not be used as part of the treatment because such intervention hinders the inmate's functioning and "blocks his perception of his own feelings," according to one of the group leaders.

4. Communication between inmates and professionals.

Communication was stated to be very honest and open by staff. Our observations confirmed this claim. Inmates are generally present at case conferences and decisions are discussed with inmates. Reports are used at Grendon for purposes of parole and for transfer to other institutions. As stated previously, inmates and staff refer to one another using Christian names. It is interesting to note that verbal aggression is permitted between staff and inmates, but no physical violence is allowed at Grendon between any individuals.

E. Daily functioning of the Unit.

1. Induction procedure.

A formal induction and assessment unit operates at Grendon. During the first week of his arrival, the new inmate is tested and a determination is made regarding his acceptance and appropriate placement. Drs. Jillett and Barrett indicated that the Assessment Unit is not functioning at its full level because of cut-backs in funding. However, it was our perception that few of the tests carried out in even the presently limited assessment seem to be used in the actual programme at Grendon. This impression was confirmed by the psychologists. Once the inmate is placed in a wing -- the basic community or living unit at Grendon containing approximately 25 inmates -- an orientation takes place that is determined by the community itself.
2. **Routine of Unit.**

The scheduling of the Unit is very structured in terms of daily meetings, briefings, de-briefings, etc. Group and wing meetings take place daily and inmates are provided with progress reports from staff and peers. Each inmate is formally assessed by the Assessment Committee of the community every one to three months.

No attempt is made to structure an inmate's free time. A wide variety of crafts, hobbies, games and sport are available and facilities include a gymnasium.

There is no formal interaction of staff and inmates at meals, although this was observed to take place on an informal basis. Aside from custodial staff, probation officers and clergy are also present at Grendon. Probation officers perform a welfare role within the institution and one of these individuals is allocated to each wing community. Members of the clergy are employed within the gaol. Depending on the personality of the minister and his acceptance in the wing, he may be called on to perform a role in the community (e.g., B Wing's Assessment Committee includes a clergyman who performs a very detailed role).

3. **Public access to the Unit.**

Visitors to inmates are given access on the same basis as at any other institution within the British Prison Service. A list of visitors is submitted for Home Office approval. Visits are of the open or contact type. Family members are also encouraged to attend group meetings within the institution. Another unique feature of Grendon's social life is the "wing party", a reception with food (paid for by the prisoners on the wing) at which officers and their spouses/friends, as well as families are invited to attend. These parties were said to be a very positive social experience for all in attendance.
F. Other issues.

1. Those wings at Grendon that have dormitory accommodation, have devised a unique means of utilising that space for therapeutic purposes. Particularly noteworthy is the programme developed in "B" Wing where the community may vote to have an inmate moved to the dormitory in the event that the man is seen by the group to be withdrawing from social interaction, getting "uptight", etc. At the same time, various other individuals also are elected to move out of their rooms to the dormitory to act as "social therapists." When the individual is judged to have passed through this difficult period, the group can vote to allow him to return to his own room. We considered this a rather unique means by which the community is able to become involved in psychological crisis management without having to resort to use of drugs. At the same time, there seemed to be psychological growth benefits for the "social therapists" that might be described in terms of empathy, social responsibility, compassion, etc.

2. It should be noted that women moved freely about the wings of Grendon and their presence was seen to be beneficial by the staff. The fact that these women are performing non-custodial roles is more a reflection of the British Prison System's hiring practices than an indication of the danger involved in allowing women to work with males in a male prison.
A. Organisation of Unit.

1. Objectives of the Unit.

a. Stated Objectives.

The aim of the Unit is to develop model citizens, not model prisoners, 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 Unit allows the inmate to begin rehearsing the role of a responsible citizen prior to his release.

b. Target population.

The Unit was set up for the "treatment" of prisoners with propensities to, or a history of, violence towards staff. It was also viewed as a facility for selected long-term inmates.

c. Perception of success by personnel/custodial staff.

The personnel who are currently working in the Special Unit (as well as one member of staff no longer stationed in the Unit) believe that the Special Unit is very successful.

--- REFER TO THE ATTACHED MATERIAL ENTITLED "BARLINNIE INFORMATION BOOKLET" AND "SPECIAL UNIT: BARLINNIE" INCLUDED AS APPENDICES 24 & 25 ---

2. Rules/principles by which Unit is run.

The Special Unit is managed by the community. Decisions are made by staff and inmates in a democratic manner at community meetings. The Unit Governor (Mr. Alex Thomson) retains the power of veto, but we were assured by staff and inmates that this veto is rarely exercised.
3. **Relationship to the Prison System.**

The Unit is physically located inside H.M. Prison Barlinnie, a reception and classification prison for the city of Glasgow. The population of that facility varies, but generally holds 1,000 inmates. The Special Unit has its own Governor and is considered to be a separate administrative unit, answerable directly to the Controller of Administration for the Scottish Prison Service, Home and Health Department, whose office is located in Edinburgh (Mr. Richard C. Allan). Because of the unusual geographic location of the Unit within the main institution, some conflict has arisen at the main gate which gives access to both gaols. Visitors to the Unit have voiced irritation over what they perceive to be less than professional treatment at the hands of the staff from the main prison who operate that post. This issue has yet to be resolved. We attended a special community meeting at which the Governor of the main gaol, Mr. Andrew Gallagher, and his chief officer were in attendance during which the problem was very frankly aired. Assurances were given that the issue would be investigated and settled by Mr. Gallagher.

4. **Custodial involvement in the Unit.**

The custodial staff are totally involved in the running of the Unit. Our perception of their effectiveness varies, depending on the individual involved. Because of the small numbers of people located in the Unit, we were able to spend time with every inmate and officer resident there, as well as Mr. Alec Thomson, the Unit Governor. It would appear that the Unit is presently uncertain of "where it is going." It was unfortunate that we had to leave Glasgow for Sydney the day before the community meeting was held to discuss the topic: "The Special Unit as an experiment is dead." We have no doubt that the quality of the discussion would have given us some insight into the truth value of that statement. (This issue will be referred to in greater detail in section F.)
5. Number of individuals in the Unit.
   a. Inmates.

   At the time of our visit, there were seven (7) inmates in the Unit. However, another prisoner had been accepted for admission just prior to our arrival and was scheduled to move in the week after our departure. The maximum capacity of the Unit is eight (8) inmates.

   b. Staff.

   (1) Custodial 18
   (2) Medical 2 (one consultant doctor from the main gaol and a consultant psychiatrist who visits the Unit regularly)
   (3) Psychological 1 (one consultant who visits regularly)
   (4) Ancillary 2 (one consultant occupational therapist and a full-time art therapist)

As the reader may note, the art therapist Ms. Joyce Laing is a major presence in the Unit. Aside from being an artist, she has had analytic training and has proven to be an extraordinarily valuable individual in the therapeutic work of the Unit. Her success may be measured, in part, by the fact that six of the seven Unit residents are involved in some sort of artistic endeavour. Prior to coming to Barlinnie, none of these men would have essayed the act of artistic creation. Additionally, the week after our departure the Second Arts Festival, organised by Joyce Laing and the members of the community was being held in the Unit to be followed by a travelling exhibition of art from the Unit that would be seen around Scotland.

B. Personnel: Staffing, selection and training.

   1. Staffing of the Unit.

   a. Unit model adopted.

   The Unit is a "therapeutic community" emphasizing social responsibility and social change.
Because of the difficult inmates housed in the Unit, staffing ratios are high (2.25:1). In fact, when the Unit was originally set up, these staff-inmate ratios were higher, but the custodial staff petitioned to have staffing figures lowered because there were too many officers competing for the chance to work with too few inmates in a very small building.

b. Service period required in Unit for staff.

There is no formal probationary period in the Unit and no specified maximum length of service. Continuity of staff is seen to be very important to the smooth functioning of the Unit. In spite of this, the Unit staff has had 52 different members from the time of the opening of the facility in February 1973 until February 1980. The Unit also has had six (6) governors. During this same period, sixteen (16) inmates have been admitted to the Unit, seven (7) of whom are still there.

2. Selection of staff.

a. Custodial component.

Staffing is on the basis of normal custodial background, but at least two (2) of the staff must have nursing training. All staff members are volunteers. In an effort to give officers a sense of "what the Unit is about," all prospective applicants are invited to spend one (1) week in the Unit before applying for permanent placement on the staff. Volunteers are interviewed for selection by a panel consisting of:

- The Governor
- Chief Officer
- Consultant Psychiatrist
- Consultant Psychologist

b. Other staff.

The only point worth noting is that the position of Governor is an appointed position. Clearly the mortality rate for this post has something to do with the wisdom exercised in
the past when selecting the individual to fill this post.

3. Training of staff.

Initially, the training of the staff consisted of visits to various institutions that are defined as "treatment" facilities, including H.M. Prison Grendon and two of the special hospitals, Carstairs and Broadmoor. These visits were of two weeks duration. In addition, instruction was given in group work and understanding of "deviant" personalities. At the present time, induction for new officers is not nearly as thorough: trips to Grendon and Broadmoor seem to have been eliminated. However, according to a former officer in the Unit, Mr. Ken Murray, much of that original preparation was carried out with the implicit notion that the Special Unit would be more akin a psychiatrically orientated treatment centre than a therapeutic community, such as described by Maxwell Jones.

C. Security Considerations.

The Special Unit is in the centre of a major maximum security prison. Additional security is provided by closed circuit television cameras which are mounted to monitor the perimeter of the Unit and relay images to the control room at the main gate of the prison which is oversighted by officers from the main prison. Internally, the Unit has only basic security. A grill separating the cell areas from the main section of the Unit is closed at night. Inmates cook their own meals, have access to metal cutlery and tools for carrying out hobbycrafts, wear their own clothes and handle money.

No area in the Unit, including the officers' staff/muster room, is "off limits" to any inmate. Christian names are used for all staff-inmate exchanges (including those with the Governor).

In short, internal security is based purely on the personal relationships between staff and inmates and may be summed up...
D. Regime of the Unit.

1. Entry and discharge of prisoners.

Entry is recommended by the governor of the prison in which the prisoner under consideration is currently being housed. The nomination is discussed by the community and the inmate is accepted or rejected. If the vote is for acceptance, an interviewing committee consisting of the Unit Governor, the Consultant Psychiatrist, and two (2) members of the Unit staff go to the inmate candidate's prison to speak with the staff there, as well as the inmate, in order to ascertain the man's suitability. If this group agrees to the inmate's acceptance, he is escorted to the Unit by Special Unit staff. Discharges occur in the reverse manner with Unit staff preceding the inmate to the receiving prison to explain any special problems to staff there. It should be noted that this escort procedure is "under fire" from staff in the main prison system who believe that escorts from the Unit should occur in the normal impersonal fashion with staff from the receiving gaol coming to pick up new receptions.

2. Programmes in the Unit.

There are no formal programmes in the Special Unit, other than art therapy, community meetings, reception of visitors and escorted paroles, a form of day leave in which the prisoner leaves the Unit in the company of an officer (seen as a means of aiding a prisoner to adjust to the outside world's pressures in the company of a trusted acquaintance). Each inmate is free to structure his own day. Some informal "contracts" may be negotiated between the community and individual inmates, depending on each member's particular needs. A basic rule is that no physical violence will occur to anybody and drug use will be minimised.
3. **Medical regime of the Unit.**

A consultant psychiatrist attends the Unit as required. There are no psychiatric nurses on duty, although at least two (2) of the officers on the staff are trained as general nurses. The use of drugs in treatment is minimal. Even when drugs are prescribed by the psychiatrist, officers typically encourage inmates to reduce dosage or give up the drugs, if at all possible.

4. **Communication between inmates and professionals.**

Communication was seen to be very open at a personal level. On a number of occasions during community meetings, officers and inmates challenged one another about the issue of honest communication in day-to-day functioning of the Unit. At a more formal level, communication of inmates did not appear to be as open as at Grendon (i.e., inmates did not seem as ready to discuss personal issues of background, family, offence, etc. at the Special Unit as at Grendon). Also, though departmental reports on individuals as well as the Unit are discussed with inmates and the community, there appears to be no formal access to these documents. Again, we were left with the feeling that in this area, Grendon enjoyed a slightly better situation.

E. **Daily functioning of the Unit.**

1. **Induction procedure.**

The community has devised a system of induction for both new inmates and staff. It is called the "4 Group System", consisting of the new community member and experienced staff and inmates. Meetings are structured to inform an individual about the Unit philosophy. They also may be used for individuals who have difficulty in coping with the larger group.

-- REFER TO THE ATTACHED PAPER ENTITLED "BARLINNIE SPECIAL UNIT - "4 GROUP'SYSTEM" INCLUDED AS APPENDIX 26 --
2. **Routine of Unit.**

The routine of the Unit is generally unstructured. Although there are provisions for formal community meetings, any member of the community may call a meeting at any time to discuss a particular problem or issue. (Additional information regarding routine and programme option is set out in the "Barlinnie Information Booklet" included as Appendix 24.)

3. **Public access to the Unit.**

Any person may gain admittance to the Unit by making written application to the Governor of the Unit. It was very apparent during our stay at the Unit that outside involvement is greatly encouraged. We discovered from participating in the community meetings that two (2) issues were the source of some contention:

1. the need to obtain approval from Head Office to admit members of the media (a rule that is applicable to all prisons in Scotland).

2. the need to obtain approval from Head Office for escorted paroles (applicable only to the Special Unit).

Certainly, the Unit receives a vast amount of media coverage ranging from sensational and irresponsible reportage in the "yellow" press to more reasoned statements in the quality newspapers. In the case of attacks by the former, the Unit cannot make statements, but must sit back and wait for a typically bland defence to appear from the Home and Health Department.

Visits to inmates by friends and relatives are unrestricted. They can take place all day every day of the week. After an inmate has settled into the community, these visits may take place in the inmate's cell. This liberal arrangement has occasionally given rise to some problems of contraband; these have been handled in a very mature and responsible manner by the community. However, the visiting arrangements have also
been played up in the sensational media with the accusation that the Special Unit is a place where killers have access to booze, drugs and sex. Little can be done to combat such bad press.

F. Other issues.

There seems to be a problem of where to send an inmate when he is ready to leave the Special Unit. A couple of men have gone directly to parole, but the Prisons Department seems to prefer to discharge inmates to parole from more "typical" institutions. Thus, a man who has learned to act responsibly and stop playing "prison games" is forced back into the very environment he has sought to overcome. Clearly there are some enormous philosophical problems to be dealt with here.

2. There was considerable concern voiced among the residents of the Special Unit, as well as some of the Officers, that other special units have not been set up throughout Great Britain, in spite of the fact that the success of the Special Unit is so evident to all who come in contact with it. In part, the problem seems to relate to the Home and Health Department's lack of interest in publicising the achievements of the Unit for fear that some incident will occur there that will cast doubt on their bureaucratic credibility. (In fact, two incidents have taken place there -- one death by drug overdose and one knife attack on an inmate by another inmate -- but the community has dealt with both incidents in a reasonable fashion.) Unfortunately, the achievements of the Special Unit are unknown to the general public (e.g., the positive advances made by the men who have been there and are now out in the community, the intellectual/artistic advances of the men in the Unit, etc.). Even more startling is the fact that the Home and Health Department has not attempted to scientifically evaluate the effectiveness of the Unit. In the past, the
community (staff and inmates) have called upon the "powers that be" to commission such an evaluative study, but Head Office has not "come to the party." As early as 1974, the Department of Sociology at the University of Salford was approached by the community to explore this issue, but they were ultimately refused access to the Special Unit for this study. However, certain problems were explored in a working paper prepared by D. Webster for discussion with the community.

-- ATTACHED IS A COPY OF THAT DOCUMENT ENTITLED "THE SPECIAL UNIT: SOME CENTRAL ISSUES" INCLUDED AS APPENDIX 27 --

3. It was earlier stated that a debate was scheduled to take place the day after our departure from Glasgow which was to focus on the statement: "The Special Unit as an experiment is dead." The pessimism of that topic relates to the current crisis at the Unit precipitated by the removal of Ken Murray from the Unit to another gaol and the imminent departure of Jimmy Boyle from the Unit, thus depriving the community of its two "wise elders," their connections with the history of the Unit and its early struggles. Deprived of informal leadership from both custodial and inmate ranks, the community is now engaged in the painful process of fending direction for itself and, it is hoped, renewing its commitment. This process is difficult for an organisation to deal with at the best of times, but for the Special Unit it is complicated by decisions taken by the Scottish Prison Service in the wake of the prisoner's suicide in late 1977 which resulted in a tightening up and codification of rules/practices in early 1978 and, still more recently, in the appointment of a Governor who believes in taking a firmer directorial control of the Unit.

-- ATTACHED ARE A COPY OF THESE RULES CONTAINED IN A DOCUMENT ENTITLED "SECRETARY OF STATE'S INSTRUCTIONS ON THE OPERATION OF THE SPECIAL UNIT AT BARLINNIE PRISON (21st February, 1978)" INCLUDED AS APPENDIX 28 --

While it may be comforting to bureaucrats to call for a more tightly structured organisation, statutory definitions might
security and less "experimentation", all of these measures seem to be antithetical to the therapeutic method that has been so successful to date in the Special Unit. Perhaps New South Wales can profit from these problems should the venture be replicated on the shores of Botany Bay. A fact sheet about the Scottish Prison Service is included in the Appendix to give the reader a sense of the context in which the Barlinnie Special Unit operates.

-- PLEASE REFER TO ATTACHED MATERIAL ENTITLED "FACT SHEET 18: THE SCOTTISH PENAL SYSTEM" INCLUDED AS APPENDIX 29"--
Summary of Non-Institutional Meetings.

At several points during the trip, we took the opportunity to meet with other individuals working in the field of corrections in order to discuss the concept of the Special Care Unit with particular reference to the following issues:

1. Therapeutic communities
2. Training programmes for custodial staff, particularly in the area of counselling skills, etc.
3. Security arrangements for treatment facilities
4. Visiting arrangements
5. Staffing needs for "special programmes" (therapeutic communities, drug rehab., etc.)

In addition, we spent a great deal of time talking about the New South Wales Department of Corrective Services (as well as handing out documents prepared for distribution concerning the Department and the new training scheme for prison officers). What follows is a very brief summary of matters discussed during these meetings.

1. Professor Duncan Chappell and Dr. William E. Lucas
Department of Criminology, Simon Fraser University, Burnaby, British Columbia, Canada.
20 May 1980

At this meeting, aside from describing the concept of the Special Care Unit, the issue of Health Commission participation was discussed. Dr. Lucas expressed scepticism that such a Unit could be run adequately with custodial staff, feeling that a psychiatrist should be in charge and the staffing be handled by the Health Commission. Professor Chappell was more optimistic about the success of the concept, but stressed that staff could not be placed in such a community unless they were interested in doing that sort of work. Dr. Lucas remarked on our enthusiasm and agreed to take a "wait and see" attitude.
2. Mr. Ross Duff, Regional Manager of Security
Regional Headquarters (Ontario)
Correctional Service of Canada
Ministry of the Solicitor General of Canada
Kingston, Ontario, Canada
22 May 1980

We discussed the security needs of a secured psychiatric facility and Mr. Duff agreed to give us a set of the briefing documents for the proposed Regional Psychiatric Centre (Ontario) and, in addition, most generously consented to mail them to us. (These volumes are now at Long Bay and are available for anyone who is interested in seeing them.). In addition to security matters, we discussed the need for training custodial staff in roles that involved greater participation with inmates. In response to this discussion, Mr. Duff arranged for us to meet with the Director of the Correctional Staff College (Ontario) and his Regional Training and Development Officer.

3. Mr. M.E. Millar, Director
Mr. C.W. Burton, Regional Training and Development Officer.
Correctional Staff College (Ontario)
Correctional Service of Canada
Ministry of the Solicitor General of Canada
Kingston, Ontario, Canada
22 May 1980

The main topic of discussion was training of custodial staff. Mr. Millar was most interested to receive a copy of Mr. A.V. Bailey's paper about the new programme of training for prison officers in New South Wales. We took an extensive tour around the facilities of the Staff College and were quite impressed with the facilities (a very well-equipped audiovisual laboratory with video taping and editing facilities, a full-scale firing range, large library, living facilities, cafeteria, etc.). Both men spoke of their success in running simulation exercises for custodial staff (hostage taking, gaol riots, escapes, communication problems within an institution due to poor staffing and lack of preparedness, etc.). Some consideration should be given to sending our Staff Development officers to see this
setting up simulation exercises. Messrs. Millar and Burton also agreed to send us material (which is also on deposit at Long Bay).

4. Federal Bureau of Prisons
United States Department of Justice
Washington, D.C., U.S.A.
23 May 1980

a. Mr. George Diffenbaucher,
Executive Assistant to Mr. J.D. Williams
Correctional Programs Division.

Mr. Diffenbaucher has had considerable experience in running therapeutic communities for treatment of drug addicts. He suggested that such communities have often fallen apart because they were perceived as democratically run when, in fact, the true model for such organisations is one of participatory management. We discussed staff training and he advocated the use of sensitivity training for staff. He stressed the crucial matter of inmate induction into the community and suggested that the best solution was the use of welcoming committees composed of pre-selected inmates. If a therapeutic community is successful, according to him, one will be able to train prisoners as "linkers" (lay therapists) and they, in turn, would train other inmates to run groups. The issue of definable objectives was also mentioned; Mr. Diffenbaucher advocates the use of contracts which he sees as a measure of the inmate's involvement.

b. Dr. Robert Powitzky, Chief Psychologist
and members of his staff

Dr. Powitzky spoke of the mixed success of therapeutic communities in the Federal Prison System and felt that there was a need to properly evaluate what is being done. He stressed the need to obtain interested staff, but seemed to feel that communities for prisoners with psychological problems would be difficult to run.
c. Mr. Garland Jeffers and Mr. Thomas Walker
Training Program Development

Both men are ex-prison officers who have been working in training for some time. They were most excited by our plans for the Special Care Unit, feeling that since both of us were involved in selection, our chances for the success were very high. They offered us assistance in the project by sending us material developed by the Federal Bureau of Prisons for training prison officers in counselling skills. These men did not share Dr. Powitzky's scepticism about the success of the venture. Mr. Jeffers then arranged a meeting for us with Ms. Nancy Sabanosh.

d. Ms. Nancy E. Sabanosh, Publications Writer-Editor
   National Institute of Corrections.

The principal accomplishment of this meeting was the establishment of a liaison for our Department with the extensive document retrieval system of the Federal Bureau of Prisons. The National Institute of Corrections is involved in the commissioning and publishing of problem-based studies in the area of corrections. We discussed a variety of programmes for which we were interested in receiving documentation including:

- Therapeutic communities
- Prison industries
- Training programmes for custodial staff
- Visiting arrangements for prisoners
- Young offenders' programmes
- Alternatives to imprisonment
  (community service orders, etc.)
- Pre-release programmes.

(We have already received a great deal of material which is also at Long Bay.)
Dr. West spent a considerable time in discussion of the need for a detailed and independent evaluation of the Special Care Unit. For him, the situation of developing "innovative" programmes in penal institutions has had little impact in the field of criminology because procedures were not sufficiently documented to allow for replication. In addition, these programmes were rarely evaluated to ascertain if the claims made for them were demonstrably valid. He felt that any programme that humanised prisons was a positive step, but it must be evaluated to be credible as a contribution to penology. On Saturday, Dr. Schwartz spoke briefly to Professor Nigel Walker who expressed interest in the Special Care Unit as well as the information that was gained from this trip.

6. Scottish Prison Service
   Home and Health Department of Scotland
   9 June 1980

   a. Mr. Richard C. Allan
      Controller of Administration.

Focus of interest for us was a discussion of the administrative problems connected with the running of the Barlinnie Special Unit and the great deal of time demands made upon Mr. Allan by the Unit. He stated that there was no intention to close the Unit, but there is also no intention of replicating it at this time. Mr. Allan was interested to hear of our situation with violent offenders in New South Wales and informed us of the Scottish system. From information provided, the size of their system and the number of individuals in the gaols seems to be very comparable to that of New South Wales.
b. Mr. Allistair Thomson
Controller of Personnel and Services.

Mr. Thomson joined us in Mr. Allan's office and John Horton discussed the issue of a prison officer exchange programme between Scotland and New South Wales, as per instructions given to Mr. Horton prior to his departure from Australia. It was envisaged that officers (2) would be seconded to New South Wales to work in the Special Care Unit (or some other special programme) for a period of three to six months, during which time a couple of officers from our Department would go to Scotland and gain first-hand knowledge of the Barlinnie Special Unit. Both Mr. Thomson and Mr. Allan thought that such a plan was feasible, but said that the Scottish authorities might not be able to send individuals to Australia because of lack of funding. They felt that, in principle, there was no problem with having two Australian prison officers seconded to Scotland. At the conclusion of the meeting, Messrs. Allan and Thomson agreed to consider the information about transfers left for them by Mr. Horton and see to it that their department sent the Corrective Services Commission of New South Wales a reply.

7. Mr. Philip Barry, Chairman, Parole Board of Scotland
9 June 1980

Mr. Allan arranged for us to have a brief discussion with Mr. Barry. He was most interested to hear about the situation of parole in New South Wales. At present, there is considerable difficulty in granting parole in Scotland because of the very stringent criteria. Mr. Barry regretted this and hoped for a change soon. He expressed an interest in our new Parole Act and asked if he might receive a copy of it when it is proclaimed. He invited us to attend the next sitting of the Parole Board of Scotland, but unfortunately, that
was not due to take place until after our departure for Australia.

8. Mr. Ken Murray, Principal Nurse Officer
H.M. Prison Low Moss
11 June, 1980

We spoke at great length of the problems of maintaining the momentum of special programmes, such as the Barlinnie Special Unit. He made a large number of suggestions about ways to avoid the problems that beset the Barlinnie Unit. In addition, he spoke positively of his experiences during his visit in New South Wales as a guest of the Law Reform Society and was most interested to hear about the continuing interest being shown in setting up a Barlinnie-type of programme, but he cautioned against an exact replication, feeling that conditions here might call for variations to the Scheme now in practice in Scotland.

The meetings with representatives from Radical Alternatives to Prisons (R.A.P.) and Dr. Oliver Briscoe did not take place. In the case of the latter, telephone calls were never returned. In the case of the former, the organisation seems to be beset with the problems of most volunteer-staffed organisations (nobody to answer telephones, lack of reliable staff, etc.). Upon arriving at our hotel we found a letter from R.A.P. stating possible times for meetings. However, we were never able to find anyone at their office who could arrange a meeting for one of these nominated times. John Horton returned from Cambridge to London expressly for the purpose of setting up this appointment, but contact was not established. In addition, time commitments did not allow us to contact Mrs. Sarah McCabe at the Centre for Penological Research at the University of Oxford as originally stated in the proposal for travel.
RECOMMENDATIONS.

1. Females should be employed in the Special Care Unit inasmuch as foreign authorities have indicated their positive influence on the environment and little in the way of risk in male prisons.

2. Psychotics and manipulative psychopaths have no place in the Special Care Unit (or in other therapeutic communities) because they tend to create destructive dynamics among staff and inmates.

3. A multi-disciplinary approach must be taken to staffing of Special Care Unit or any special unit to allow for a variety of experimental programme options and role sharing among staff of the Unit.

4. Staff-inmate ratios in the Special Care Unit (and other special units run along the lines of therapeutic communities) should be at least one-to-one on a 24 hour basis, but all staffing need not be drawn from custodial ranks to achieve such beneficial ratios (i.e., probation and parole officers, psychologists, clergy, etc.)

5. Continuity of staffing in the Special Care Unit is imperative for ongoing programmes and routine of the community; it is further suggested that some sort of contract be entered into with custodial staff in the Unit to preclude industrial action.

6. The backing of the Corrective Services Commission must be given for the Special Care Unit to implement "experimental" programmes without the restrictions imposed by current rules and regulations (e.g., visits, telephone contacts, mail, clothing, etc.).

7. Access of family and friends of the inmate is a necessary element of therapy that should be encouraged and facilitated in the programming of the Special Care Unit.

8. Consideration should be given to encouraging the return of ex-offenders to the Special Care Unit inasmuch as a number of therapeutic communities abroad have found these individuals to be useful as therapeutic agents.
9. All efforts must be made to make the Special Care Unit open and accessible to the general public (any interested parties and the media), subject to the discretion of the Superintendent of the Unit. Non-departmental requests for access must be evaluated on grounds of safety of staff working there, security of the institution and the privacy of inmates.

10. Escorted parole of inmates from the Special Care Unit must be a part of the programme options, at the approval of the Superintendent of the Unit.

11. Drug therapy must be considered only as a last resort in the Special Care Unit.

12. No physical violence of any sort can be tolerated in the Special Care Unit, but verbal statements of any sort will be allowed.

13. Continued placement of an inmate in the Special Care Unit must be voluntary, in order that treatment not be seen to be coercive; procedures to allow inmates to leave of their own accord or to be compelled to leave by the community must be a part of the Unit's regime.

14. Discharge from the Special Care Unit should be either to liberty, parole or to open environments.

15. Follow-up of ex-inmates from the Special Care Unit (and any sort of special unit) is an essential adjunct to the programmes of that institution.

16. An evaluative study examining the functioning of the Unit, the role relationships among staff and inmates, and the ability of the Special Care Unit to meet its objectives should be commissioned from some independent body such as the Bureau of Crime Statistics and Research (currently evaluating "Day in Gaol" programme, bail law changes, offences in public places law, etc.) to insure accountability to the Commission (as a valid innovation in programming), the Government and taxpayers.

17. A secure prison need not look like a traditional gaol and may, in fact, look no different than a high rise office block in the city.
18. Electronic technology should be utilised to a greater extent as an adjunct to security practices in the Unit and all other N.S.W. institutions in order that custodial manpower may be concentrated where it is most needed: one-to-one contact with inmates.

19. Replication of the Barlinnie Special Unit in New South Wales must be given every priority.

20. A Special Hospital System should be set up in New South Wales to provide a facility for mentally ill offenders.

21. An assessment unit for court-referred psychiatric evaluations should be included in a special hospital system.
LIST OF APPENDICES

APPENDIX

1. Itinerary of trip
2. List of individuals contacted during the planning and execution of the trip.
4. The English Special Hospital System --- Dr. P.G. McGrath
5. Custody and release of dangerous offenders.
7. A five-year follow-up study of male patients discharged from Broadmoor Hospital --- D.A. Black
8. Moss Side Hospital: Guidelines for management of violent patients.
9. Park Lane Hospital - Phase I Preview
11. Regional Psychiatric Centre (PAC): Directions and regulations --- Dr. C. Roy.
14. The Dr. Henri van der Hoeven Kliniek: Background and treatment credo --- P.A.M. Hendricks
15. The Dr. Henri van der Hoeven Clinic, Utrecht, The Netherlands: The new building and the ideas which underlie it --- A.M. Roosenburg, Director.
16. Treatment results at the Dr. Henri van der Hoeven Clinic, Utrecht, The Netherlands --- J.J. Jessen & A.M. Roosenburg
17. Butler report references to Grendon --- B.J. Barrett
18. Criteria for treatment at Grendon --- B.J. Barrett
APPENDIX.

20. The group of people we treat at Grendon are those with personality disorders — B.J. Barrett.


22. Aims and methods of treatment on 'A' wing

23. Notes on treatment in 'B' wing

24. Barlinnie information booklet

25. Special Unit: Barlinnie — Scottish Information Office.

26. Barlinnie Special Unit - '4 group' system

27. The Special Unit: Some central issues — D. Webster.

28. Secretary of State's instructions on the operation of the Special Unit at Barlinnie Prison (21st February, 1978)

29. Fact Sheet 18: The Scottish penal system — Scottish Information Office.
APPENDIX 1:

Itinerary.

1. Mon. 19/5
   Depart Sydney - Arrive Vancouver, B.C.

2. Tues. 20/5 a.m.
   Regional Psychiatric Centre (Pacific)
   Abbotsford, B.C.
   p.m. ... late aft. departure for:
   Meeting: Prof. Duncan Chappell and
   Dr. V.E. Lucas at Dept. of Criminology,
   Simon Fraser University.

3. Wed. 21/5 a.m.
   ... drive to Kingston, Ontario and present credentials
   at Regional Headquarters.
   Regional Psychiatric Centre (Ontario)
   Kingston, Ontario.

4. Thurs 22/5 a.m.
   ... drive to Toronto and early eve. departure
   for Washington, D.C.
   p.m. Meetings: 1. Ross Duff (Regional Manager of Security)
         2. M.E. Miller and C.A. Burton,
            Correctional Staff College (Ontario)
         3. Garland Jeffers and Thomas Walker
            (Training Programs Division)
         4. Nancy E. Sabanosh (Publications Writer-Editor,
            National Institute of Corrections).

5. Fri. 23/5 a.m.
   Meetings: Federal Bureau of Prisons,
   U.S. Department of Justice.
   1. George Diffenbaucher (Exec.Asst. to J.D. Williams)
   2. Robert Povitzky (Chief Psychologist) and staff
      members.
   p.m. 3. Garland Jeffers and Thomas Walker
         (Training Programs Division)
      4. Nancy E. Sabanosh (Publications Writer-Editor,
         National Institute of Corrections).
      ... early evening flight to Europe.

6. Sat. 24/5 a.m.
   p.m. ... late aft. arrival in Copenhagen, Denmark.

7. Sun. 25/5
   Rest Day

8. Mon. 26/5
   Prepare material from Canadian sites and U.S. meetings
   Anstalten ved Herstedvester, Herstedvester, Denmark.
   p.m. ... early evening flight to Amsterdam, Netherlands

9. Tues. 27/5 a.m.
   Dr. H. van der Hoeven Kliniek, Utrecht, The Netherlands
   p.m. Pieter Baan Centrum, Utrecht, The Netherlands.
   ... late aft. departure for London, England.

10. Wed. 28/5 a.m.
    ... pick up car and drive to Cambridge
    p.m. Meeting: Dr. D.J. West, Institute of Criminology,
          University of Cambridge.

11. Thurs. 29/5 a.m.
    ... J.H. returns to London to arrange meeting with
    R.A.P. and with Dr. O. Briscoe, while D.M.S.
    stays in Cambridge.
B. Australian contacts:

His Honour Judge D.G. Stewart,  
Chambers, Queen's Square, Sydney.

Mr. Gordon Hawkins, Associate Professor of Criminology and  
Assistant Director, Institute of Criminology,  
Sydney University Law School, Sydney.

Mr. Tom Kelly, Barrister-at-Law, Sydney

Mr. Col Bevan, Assistant Director (Training), Australian  
Institute of Criminology, Canberra, A.C.T.

Dr. Jeff Sutton, Director, Bureau of Crime Statistics and  
Research, Sydney

Mr. A.R. Green, Bureau of Crime Statistics and Research, Sydney

Dr. Charles Cullen, Penal Reform Council, Marrickville Community  
Health Centre, Sydney.

Dr. Norman L. Thompson, Senior Lecturer, School of Behavioural  
Sciences, Macquarie University, Nth. Ryde, Sydney.
**HERSTEDVESTER I 1978/79**

(nogle fakta og tal)

1. Anstalten ved Herstedvester fungerer som psykiatrisk institution for kriminalforsorgen. Opgaven er at modtage, observere og behandle indsatte, der har behov for psykiatrisk bistand.

2. Anstaltens kapacitet er 106 + 23 på specialafdelinger (syge- og isolationsafdeling). Desuden er der en pension lige udenfor hovedanstalten (Holsbjergvej 15) med plads til 17 bevægere.


4. Anstaltens personale består især af: 3 psykiatriske overlæger, 2 yngre lager, 3 psykologer, 1 oversygeplejerske, 3 sygeplejersker, 6 forsørgsmedarbejdere, 4 lægere, 1 deltidsanstalt grønlandsk folk, ca. 24 værkmeister samt ca. 125 vagtmestre og fængselsbetjente, hvoraf 3 har tjent på pension. Administrationspersonalet (herunder sekretærerne for lager, psykologer og forsørgsmedarbejdere) udgøres af i alt 26 hel- og deltidsanstatte.

5. I 1978 blev 135 personer indsat i anstalten; heraf var de 44 varetagtsarrestanter, hvoraf 15 i løbet af 1978 fik dom. Af de i alt 106 domfødte indsat i 1978 var 1 dømt til fængsel på livstid, 2 forbøende, 2 direktortilbageforfølge på vilkår efter prøveudskrivning fra forvaring, 5 dømt efter den grønlandiske kriminallov og 1 idømt § 68-foranfaldning. De resterende 95 var idømt tidsbestemt fængsel. Straffeløngden ses nedenfor:

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6. Indsættelseskriminaliteten for de 106 domfødte fordeler sig således:

- Mændrab og forsøg herpå 11
- Voldsofbrydelser 8
- Røveri 15
- Sædelighedskriminalitet 9
- Brandstiftelse 3
- Ejendomskriminalitet 44
- Ejendomskriminalitet + lov om euforiserende stoffer 9
- Straffelovens § 191 4
- Direkte tilbageført 2
- Forårsaloj alone 1
Der er benyttet følgende inddeling:

Vold omfatter legemsbeskadigelse, ulovlig tværmønstring og frihedsbemvelse.

Roveri omfatter opløbsforbrydelser, der bar vigtig forbundet mod vold eller trøjler overfor

Sedovighedskriminalitet omfatter opløbsmele af straffelovens kapitel 
r

Ejendomskriminalitet omfatter opløbsmele af dokumenter og private 
lad i forvaltning af andre formål.

Personer, der er dømt for kriminalitet, skal tage udfordringer for 


Vold eller trøjler om vold

Selvbedødelighedskriminalitet omfatter opløbsmele af straffelovens 

Blandingskriminalitet omfatter opløbsmele af straffelovens bestemmelser 

Personer, der er dømt for kriminalitet, skal tage udfordringer for 


9. Af de ialt 110 indsatte er der 5 udlændinge, fordelt således:

   Fra Polen           3
   " Israel            1
   " Sverige           1

10. Der er pr. 15. november 1979 14 grønlandske indsatte,
    2 er dømt efter dansk straffelov - 9 er dømt efter grønlandske
    straffelov - 3 er varetægtsarrestanter.

11. Der er pr. 19. november 1979 17 (= 18,7 %) af de indsatte, der er
    psykotiske.

12. Udgangssommer i de 3 første kvartaler af 1979:

| Forsinkelse uden ny kriminalitet | 24 |
| Forsinkelse med ny kriminalitet | o  |
| Udeblivelse uden ny kriminalitet | 15 |
| Udeblivelse med ny kriminalitet | o  |
| Ny kriminalitet uden udeblivelse/forsinkelse | 3  |

Dette er i samme tidssrum været i alt 537 udgangstilladelser.

13. Undvigelser og bortgange i de 3 første kvartaler af 1979:

| Undvigelser | 7 |
| Forsøg på undvigelser | 5 |
| Bortgange | o |
| Forsøg på bortgange | o |

14. Vedr. beskæftigelsen:

De indsatte har arbejdsppligt.

Anstalten har i alt en kapacitet på 125 arbejdspladser, fordelt med
ca. 65 pladser på værksteder (trykkeri, smedkøk, montage, celle-
arbejde), ca. 35 pladser ved bygningsvæsen, rengøring samt ca. 25
pladser ved skole, terapi og bibliotek.

Med det nuværende beløb på ca. 106 indsatte er ca. 1/3 arbejdsmæs-
sigt beskæftigt på værksteder, ca. 1/3 ved økonomimrådet og ca.
1/3 ikke i arbejde.

Vareølget fra anstaltens produktion andrager ca. 2½ mill. kr.
pr. år. Der fremstilles tryksager til statstilnstitutioner, mobler
til kontorer samt montagearbejde til det private erhverv.

Anstaltens areal andrager ca. 35 tdr. land, der dyrkes med korn.


/.../...

Lars Nielsen.
1. The institution at Herstedvester acts as the psychiatric institution for the Department of Corrective Services. Its purpose is to receive, observe and treat inmates in need of psychiatric care.

2. The capacity of the institution is 106 + 23 in special care.

3. The institution is headed by a psychiatric medical superintendent, assisted by a prison inspector (lawyer), a social advisor, an educational supervisor (teacher), a prison superintendent and a chief prison officer.

4. The staff of the institution consists of 3 psychiatric doctors, 2 junior doctors, 1 charge nurse, 3 nursing sisters, 6 social advisors, 4 teachers, 1 part-time Greenland interpreter, 24 overseers and 125 prison officers. The administrative staff (including secretaries for doctors) totals 28, part-time and full-time positions.

5. In 1978, 135 people were admitted to the institution. Of these, 44 were remands, 15 of which were convicted during 1978. Of the total of 106 convicted admissions during 1978, one was sentenced to life imprisonment, 2 to indeterminate sentences, 2 to balance of parole, 5 under the Greenland Criminal Code, 1 under Paragraph 68, the balance of 195 were given sentences as follows:

<table>
<thead>
<tr>
<th>Sentence Duration</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 6 months</td>
<td>10</td>
</tr>
<tr>
<td>Over 6 mths to 1 year</td>
<td>24</td>
</tr>
<tr>
<td>6 months to 1 year</td>
<td>36</td>
</tr>
</tbody>
</table>
6. The 106 were convicted of the following offences:

- Manslaughter or attempted Manslaughter: 11
- Violent Crime: 8
- Robbery: 15
- Sexual Offences: 9
- Arson: 3
- Misappropriation and Stealing: 44
- Drug Offences: 9
- Criminal Code Paragraph 191: 4
- Revocation of Parole: 2
- Traffic Offences: 1

The following Index has been used:

(a) Violent crime includes, bodily harm, abduction and holding hostages.
(b) Robbery includes, stealing with violence or the use of force.
(c) Sexual offences includes, incest, rape, etc.
(d) Misappropriation and Stealing includes larceny and stealing without violence.

People who have been convicted of more than one offence in the above statistics, appear in only one category.
The major offence determines each offenders placement.

7. The total discharges from the institution during 1978 were 141. They were discharged as follows:

<table>
<thead>
<tr>
<th>Type of Discharge</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full time served</td>
<td>21</td>
</tr>
<tr>
<td>Paroled at half sentence</td>
<td>8</td>
</tr>
<tr>
<td>Paroled at two-thirds sentence</td>
<td>43</td>
</tr>
<tr>
<td>Balance of parole served</td>
<td>2</td>
</tr>
<tr>
<td>Greenland Criminal Code</td>
<td>2</td>
</tr>
<tr>
<td>Indeterminate sentence (License)</td>
<td>1</td>
</tr>
<tr>
<td>Suicide</td>
<td>1</td>
</tr>
<tr>
<td>Special Parole</td>
<td>2</td>
</tr>
<tr>
<td>Transfer to other prisons</td>
<td>37</td>
</tr>
<tr>
<td>Remands (transferred to other institutions or not convicted to custodial sentence)</td>
<td>24</td>
</tr>
</tbody>
</table>

8. On the 15th November, 1979 the institution held 110 inmates:

<table>
<thead>
<tr>
<th>Type of Sentence</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>7</td>
</tr>
<tr>
<td>Indeterminate sentence</td>
<td>12</td>
</tr>
<tr>
<td>Remands</td>
<td>11</td>
</tr>
<tr>
<td>Convicted in Greenland</td>
<td>9</td>
</tr>
<tr>
<td>Convicted under Section 68</td>
<td>1</td>
</tr>
<tr>
<td>Balance of parole</td>
<td>1</td>
</tr>
<tr>
<td>Others</td>
<td>69</td>
</tr>
</tbody>
</table>

Sentences of the 69 others were:

<table>
<thead>
<tr>
<th>Sentence Duration</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 mths or less</td>
<td>0</td>
</tr>
<tr>
<td>Over 6 months to 1 year</td>
<td>4</td>
</tr>
<tr>
<td>&quot; 1 year to 2 years</td>
<td>19</td>
</tr>
<tr>
<td>&quot; 2 years to 3 years</td>
<td>8</td>
</tr>
<tr>
<td>&quot; 3 years to 4 years</td>
<td>11</td>
</tr>
<tr>
<td>&quot; 4 years to 5 years</td>
<td>4</td>
</tr>
<tr>
<td>&quot; 5 years to 6 years</td>
<td>5</td>
</tr>
<tr>
<td>&quot; 6 years to 9 years</td>
<td>0</td>
</tr>
<tr>
<td>2 years to 3 years</td>
<td>5</td>
</tr>
</tbody>
</table>
Over 10 years to 11 years - 0
" 11 years to 12 years - 4
" 12 years to 13 years - 2
" 13 years to 14 years - 4
" 14 years to 15 years - 0
" 15 years to 16 years - 4

9. Of the 110 inmates, 5 were not Danish.
   From Poland - 3
   From Israel - 1
   From Sweden - 1

10. On the 15th November, 1979 the institution contained 14
    inmates from Greenland, two convicted under Danish law,
    9 convicted under Greenland law and 3 remands.

11. On the 19th November, 1979, 17 (18.7%) of the inmates
    were psychotic.

12. Breaches of day leave provision during the first 9 months
    of 1979 included:
    Late without committing new offences - 24
    Late and committed new offences - 0
    Failure to return without committing new offences - 15
    Failure to return and committed new offences - 0
    New offences committed without failure to return or late return - 3

    During this period 537 applications for leave were approved

    Escapes - 7
    Attempted Escapes - 5

The institution has employment for 125 inmates, 65 in the workshops (printing, cabinet making, fitting, work in cells), 35 in building maintenance and domestic cleaning, 25 in school, therapy and library. At present with 106 inmates, $\frac{2}{3}$ are employed in the workshops, $\frac{1}{3}$ maintenance and cleaning and $\frac{1}{3}$ are unemployed.

The sale of items produced in the institution raised about 2½ million D.Kr (A$850,000) in the last year. Items sold included printed forms and stationery for Government Departments, office furniture and assembly work for private industry. The institutions farm area is approximately 30 acres. The main crops are rye and barley.

Anstalten ved Herstedvester, on 23rd November, 1979.

Lars Nielsen.

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Original Danish Document Translated By:
Prison Officer Kai Duetoft,
Malabar Training Centre.
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APPENDIX A:

THE ENGLISH SPECIAL HOSPITAL SYSTEM

Dr. P. G. McGrath, M.B., Ch.B., Dip. Psych. Ed.

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Broadmoor Hospital

This contribution does not necessarily reflect the official views or policy of the Department of Health and Social Security

The Special Hospitals are those at Broadmoor in Berkshire, Rampton in Nottinghamshire, and Moss Side near Liverpool. When the Minister of Health, by the provisions of Part VII of the 1959 Mental Health Act, was authorised to establish special hospitals for the treatment, in conditions of special security, of patients of "dangerous, violent, or criminal propensities" he designated these three already existing psychiatric units as Special Hospitals. The Hospitals have different histories, and serve rather different clinical ends, but must be considered together as they have a common statutory authority for their existence, a common purpose of treating their patients in secure conditions, and a common administrative background, all being managed directly by the Department of Health and Social Security without the intervention of Regional Boards or local Management Committees.

There is a further important point of uniformity between them. Authoritative legal opinion has been given that the Special Hospitals cannot admit informal or 'voluntary' patients, as Section 97 of the Mental Health Act of 1959 specifically states that the special hospitals shall be established for the treatment of compulsorily detained patients. It is true that, for a variety of reasons, ranging from insight to psychotic apathy, a proportion of the patients actually want to remain in these secure hospitals, and at least one patient was 'voluntary' to the extent that he co-operated actively in the process of his own compulsory admission for treatment under Section 26 of the Act. This does not alter the fact, however, that no patient may be discharged except on the authority of those persons or agencies specified in the Act - the responsible medical officer, managers, Home Secretary, Mental Health Review Tribunal, or next of kin, depending on the section or sections of the Mental Health Act under which he is detained. The Special Hospitals differ in this respect from the other facilities described elsewhere in this book; from the Henderson

1. Written prior to establishment of Park Lane Hospital.
Hospital, the 'permissive' component of the Balderton Unit described by Craft, and even from Grendon Psychiatric Prison or the other psychiatric services offered by the Prison Department, as no prison inmate may be exposed to formal psychiatric treatment against his will.

Broadmoor, the oldest of the three hospitals, was opened in 1863, being then directly under the control of the Home Office, both as to management, and selection and disposal of patients, all of whom came from the Courts or prisons. The patients from the Courts had been found insane on arraignment and thus unfit to plead, or else "McNaughton mad", and could only be discharged when the Sovereign's pleasure was expressed through the Home Secretary; those from the prisons had become certifiably insane during the currency of a sentence, and were sent to Broadmoor for treatment. In 1949 as a result of one of the provisions of the Criminal Justice Act of 1948, the management of Broadmoor was transferred from the Home Office to the Board of Control, but without altering at all the role of the Home Office in the admission and discharge of patients. Finally, on the abolition of the Board of Control in 1960, Broadmoor came directly under the administration of the Department of Health and Social Security, and broadened its basis of admission, now taking in the old "Her Majesty's pleasure" cases, under Section 71 of the Mental Health Act; transfers from prisons (Section 72); patients the subject of Hospital Orders (Section 60) and direct admissions, or transfers, of patients subject to compulsory detention under Part IV of the Act, without the intervention of any penal or judicial procedure.

Rampton similarly was founded by the Home Office in 1914 to fulfil exactly the same functions as Broadmoor, but in 1920 it was handed over to the Board of Control, and under the title of Rampton State Institution, became a central hospital for the care and treatment of Mental Defectives, as subnormal patients were then called, of dangerous and violent propensities. Its population was drawn from
other hospitals for mental defectives, and all were detained under the provisions of the Mental Deficiency Acts. As with Broadmoor, in 1960, Rampton became vested in the Minister of Health, and drew its patients from the same sources and under the same sections of the Act.

Moss Side, on the other hand, had never come under theegis of the Home Office, but was opened, under the Management of the Board of Control, in 1914 for the treatment of Mental Defectives of dangerous or violent propensities. For a period between the wars, 1920 - 1933, it was closed; but from 1933 onwards it fulfilled its stated function again until its designation as a Special Hospital in 1960.

The common administrative background to the three hospitals emphasizes their identification with the medical rather than the penal system of the country. They are run by the Department of Health and Social Security, their professional staff, medical, nursing, and medical ancillary, are conditioned to National Health Service terms of service; and their patients are detained, and protected, under the provisions of Mental Health rather than Penal legislation. They differ administratively from conventional psychiatric hospitals in that their executive and clerical staffs are drawn from the Civil Service, and the nursing staff have maintained their tradition, established in Broadmoor, of belonging to the Prison Officers Association as a professional bargaining and protective body.

The hospitals differ clinically in that Broadmoor - approximately 820 beds, 680 men and 140 women - deals, by and large, with psychotic or psychopathic patients within the normal range of intelligence. Rampton - 960 beds, twice as many men (640) as women (320), and Moss Side - 350 beds, 260 men and 90 women, have mainly subnormal patients, though in each hospital there are a number of patients who fall within the normal range of psychometric scoring.
The role of the Special Hospital in the treatment of psychopathic disorder, though important, can readily be over-evaluated. It is probably true that the most extreme of the aggressive and sexually deviant psychopaths are to be found in the special hospitals; but they do not appear, in returns, as an important component of the population of the hospitals, nor as a high proportion of the designated psychopathic disorders annually attracting attention in mental health statistics. In 1962, of 2,213 psychopaths (sufferers from psychopathic disorder within the definition of Section 4 of the 1959 Mental Health Act) admitted to all psychiatric units, only 49 (2.2%) were admitted to Special Hospitals. At the end of that year, on 31 December 1962, 277 of a total Special Hospital population of 2,113 were designated as suffering from psychopathic disorder. The comparable figures for 31 December 1963 were 306 out of 2,143. These gross figures would probably be modified by careful and critical re-scrutiny of all diagnoses in the hospitals; a certain amount of nosological inertia undoubtedly exists, whereby patients who have been labelled as psychotic or mentally defective, without qualification, for many years, continue so to be diagnosed, though more properly they might be assessed as suffering from "mental illness", or "subnormality" with psychopathic disorder. This is true of Broadmoor, where a small, but diagnostically and predictively worrying group of sexually abnormal homicides were found, at trial or by medical enquiry afterwards, to be 'insane', though not fitting into any neat Kraepelinian slot, and appearing as "hysterical insanity" (sic), or as variants of epilepsy, sometimes with little enough firm clinical evidence of epilepsy as defined by Ruseel Brain. Similarly, before the establishment of psychopathic disorder as a psychiatric state rendering the sufferer liable to compulsory measures for treatment, a number of psychopathic patients were transferred from prison to Broadmoor as having been certifiably 'insane'. These were men who, in a transient psychotic episode in a persistent psychopathic state (and Henderson recognised the existence of such psychotic episodes) could creditably be reported as psychotic; or who, in a flare-up of psychopathic reaction,
inflicted upon themselves injuries which could be construed as suicidal, and therefore were thought of as being psychotically depressed.

Treatment of psychopaths as of others in the Special Hospitals is very much conditioned by security needs. Each of the hospitals has 'perimeter' security in the way of walls, or wall and ditch, surrounding the whole hospital; and each group of wards offers its own security, of varying degrees of stringency depending on the clinical and security state of the patients in it. Security demands that life inside the hospitals shall in many ways, individually trivial but cumulatively important, differ from that even in conventional hospitals and, of course, even more from life in the community. Matches, money, pen knives, etc., are not carried; heads are counted regularly; locked doors check free movement within the hospital perimeter; bed time is fixed and fairly early. Much more importantly, however, than the physical components of the security system, is the fact that high security demands rules, and these rules in their turn demand people to enforce them, and sanctions to uphold them. Thus an authoritarian orientation is imposed upon the nursing staff, who are in constant contact with the patients; the drill of locking of doors of dormitories and rooms at a set time at night does not permit of discussion at the time, either group or vis-a-vis between patient and nurse. Warm and productive relationships can and do grow up between individual patients and groups of patients on the one hand, and nursing staff on the other, but this reflects only the high degree of skill of the staff in overcoming initial difficulties, and the early negative attitude of patients who see the nurse at first simply as the man who looks him up at night. This attitude of the patient is much more marked in the aggressive psychopath with a prison record who sees the nurse as nothing but a "screw", and the whole staff of the hospital as a group of 'them' who not only locked him up, but locked him up with "nut cases". Such a psychopath resents bitterly his disposal to a psychiatric unit, both because of the affront to his ideas of his own mental health, and because of the uncertainty of his future, as he is no longer confident of return to freedom at the expiry of a fixed sentence. These physical and psychological
Security factors exert a considerable influence on treatment techniques. The usual physical methods of treatment, by electroplaxy and psychotropic drugs, are used in the psychoses or during psychotic episodes, such as they are used in conventional hospitals; but there has, of recent years, been no recourse to cerebral surgery in any of the special hospitals. A number of patients showing very severe behaviour disturbances were leucotomized by standard procedures in Rampton some years ago. The results as reported by MacKay were equivocal. No leucotomies, either standard or modified, have been carried out at, or from Broadmoor or Moss Side.

Individual uncovering psychotherapeutic techniques have been employed in Broadmoor by Jonathan Gould, but it is doubtful if his cases could be described as 'psychopathic' within the terms of the Act. Few writers have claimed success with such techniques in severe aggressive psychopathic disorders and it is obvious that the basis of such therapy, the establishment of productive rapport, will be made very difficult by the "affectionlessness" which appears so consistently in clinical descriptions of psychopathic disorder. Street has recorded that such forms of treatment are not practised at Rampton; nor are they, with the exception of the cases treated by Gould, at Broadmoor. Formal group therapy, with groups of selected patients which include psychopaths, is, however, in use both at Rampton and Broadmoor.

The limitations imposed by security on analytically-orientated group and individual psychotherapy, even when these are clinically indicated, are serious. These treatments essentially aim at the discovery and recognition by the patients, of forces in his mental life which are unacceptable in consciousness, and find outlet in anti-social activity. This discovery and recognition is often accompanied by "acting out" behaviour, with overt or symbolic aggression directed to the therapist, the environment as a whole, or the patient himself; and his "acting out" behaviour is regarded as intolerable
in a disciplined, structured community, arouses repressive measures and attitudes, and so in its turn, a further phase of anti-authoritarian behaviour can be evoked. The use of deep psychotherapy demands a remarkable degree of clinical detachment on the part of the therapist, who must emphasize to his patient that he is offering nothing but eventual relief from intra-psychic tension, and nothing at all in the way of immediate rewards such as increased privileges etc. Similarly, the patient must be capable of co-operating in treatment which will be at best emotionally uncomfortable in its early stages, and possibly acutely distressing.

Group therapy, of a less structured sort, does, however, exist in all three hospitals, perhaps to a greater extent in Broadmoor, with its more intelligent population, than in Moss Side or Rampton. Patients tend to crystallize out in groups with a common interest - football, cricket, dramatics, 'pop' music, etc., and to each of these groups are attached one or more staff members, largely self-selected by their own interest in the content of the group's activities. Committees, elected by the patients, are formed, and in these Committees (membership of which attracts certain privileges) patients tend to show a real concern not only for the rights, but for the clinical interests of their fellows. A meeting of the 'casting committee' of the dramatic club will discuss whether giving Joan or Peter such and such a part will do good or harm to their recognized precarious stability (McGrath 1958).

The main theme of non-physical methods of treatment in all three hospitals is based on careful, patient training towards social conformity, with a complex system of rewards, both social and monetary, and an equivalent range of disincentives to unacceptable behaviour, by loss of privilege and amenities and a return to a more strictly structured and closely observed stratum of the hospital society (Craft and McDougall - Street 1963. McGrath 1958). This
system, which of necessity applies to irresponsible psychotics as much as to "rational" psychopaths, is frankly regarded by patients as one of rewards and punishments. These terms are harsh to the ears of clinicians, but it is unrealistic to expect them not to be used by those subject to the regime, and to those administering it. It is easy, fortunately, to rationalize the disincentive round the need of closer observation of someone whose clinical condition shows signs of deterioration, or the need for more stringent security for a patient whose behaviour suggests impending or actual risk to other patients, staff, or public.

The training, under medical control, covers all aspects of the patient's life, occupational and recreational. Here again security considerations are paramount; the newly admitted patient can only be given comparatively simple work, involving no use of tools which might aid escape or be used as weapons, till he has been assessed, both clinically and as to his level of security risk. Also in maximum security areas in the hospitals, great care is exercised in the type of skills encouraged and tools used. One very real difficulty thus encountered is how to meet the needs of the muscular young adult psychopath of average or less than average intelligeuce, who has neither interest in nor motivation towards acquiring delicate skills but who has always been, and wants always to be, a labourer. His needs, for an ultimate economically successful return to the community, are at present seen to be for his hands and muscles being kept hard, and for training in the satisfying and acceptable use of leisure. It is, however, not possible, without arousing anti-therapeutic staff tensions, to equip explosively and impulsively aggressive young psychopaths with picks, crowbars, felling axes, etc., nor would it be wise to do so. Recreation, too, is modified by security requirements, though not so dramatically. A hardy annual joke at Broadmoor is a request for the pole vault, at a spot convenient to the wall, to be included in the Annual Sports Day.
Against this general background of conditioning of behaviour, individual counselling and discussion of past, present and future difficulties, goes on between patients and nursing and medical staff. Rampton runs formal courses for patients whose early discharge or transfer to an 'open' unit has been approved in principle.

It is extremely difficult to quantify the results of treatment of severe psychopathic disorder in the Special Hospitals. Subjects of such disorder tend naturally to be long stay patients, and the condition has not been separately categorized long enough for illuminating follow-up studies to be carried out. A very careful study by Craft and McDougall of Moss Side patients was unable to split off psychopathic from intellectually subnormal factors operating on recovery rates; but the general conclusion was that 10 per cent of Moss Side patients showed amelioration to the extent of being discharged or transferred to open units. Street, in 1960, found that only 10 per cent of Rampton's population had been there for more than ten years and these were largely physically disabled patients. Tony and Mackay (1959) in a refined statistical study of 12 years cohort of discharges, carefully not identifying their material with psychopathic disorder ("high grade mental defectives" - "behaviour of a sort prescribed by the criminal law" - "not infrequently called psychopathic"), came to the conclusion that the State Hospital system was therapeutically effective in that serious relapses were relatively uncommon. So far, not a sufficient number of undoubted psychopaths in pure culture have been discharged from Broadmoor for valid conclusions to be drawn; but it is relevant that of patients who had been charged with homicide and subsequently discharged from Broadmoor, none has again been charged with murder; and of this group, which now over a century numbers some hundreds, a minority have been persons who would now be diagnosed as psychopaths. Some 3 per cent of Broadmoor discharges and transfers return to the hospital, seldom because they are "dangerous or violent" but more often at their own request, as they had not been sufficiently prepared for return to the community, or are distressed and unhappy in strange hospital surroundings. Again
not all of these returns were psychopaths, but have been e.g., recurrent depressives, returning in relapse to the familiar hospital.

The Department of Health and Social Security reports that in 1963 discharges and transfers from the Special Hospitals numbered 257, i.e. some 12 per cent of the total Special Hospital population.

Returning again to security, i.e. the protection of the public, the most dramatic breach was in 1952 when Straffen, having absconded from Broadmoor, killed a little girl during his short absence. At the time of writing there is no Special Hospital patient absent without leave; intra-murally, in all three hospitals there are frequent rumours of escape plots, usually involving psychopaths. Fortunately, by the very nature of their disorder, psychopaths seem unable to band together long enough to plan and execute an escape; inevitably tensions arise within the group, resolved by one member informing on the others, or boastfulness leads to indiscreet disclosures to patients more anxious to conform to the hospital’s standards of conduct. Actual escapes from the three hospitals vary from year to year, from nil to ten in total.

SUMMARY

Three Special Hospitals exist for the treatment, under conditions of special security, of mentally disordered persons, subject to detention, of dangerous, violent, or criminal propensities. These hospitals are vested in the Minister of Health, and are part of the nation wide Mental Health Service. They cater for persons subject to psychopathic disorder, among other diagnostic groups. The psychopaths admitted to the Special Hospitals in 1962 formed 2.2 per cent of all psychopathic admissions, and at the end of that year formed 12.8 per cent of the Special Hospital population. Treatment is modified by security considerations, and is essentially based on conditioning, educative processes rather than analytical ones. Considering that
the clinical nature of the conditions treated, and public safety, impose extreme caution in disposal policy, a satisfactory amelioration rate of between 10 per cent – 12 per cent has been maintained for some years, with a very low rate of re-admissions to the Special Hospital Service. The security provisions have provided an adequate protection to the public.

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"Dangerous" offenders obviously vary in the degree of danger they present to society; and it would be very easy to become bemused in a discussion of degrees of immediacy and specificity of the danger presented. However, the danger content of the offence of homicide can not be gainsaid; and the act itself, the ambient circumstances, the personalities and the histories of both offender and victim are likely to be exhaustively documented (McGrath 1958). Moreover nearly all homicides in this country come to institutional care. Homicide is therefore a useful model to clothe with a discussion of custody and release, and will be the primary frame of reference of this contribution.

Custody has general characteristics and effects, no matter what the danger guarded against may be. "The work of custody creates a relation of opposition between those who exercise it and those upon whom it is exercised" (Smith 1965). In secure custody, the offender-patient is subjected to a wide range of restrictions, many of them trivial in themselves, but with a cumulative effect of diminution of dignity and personality. Movements are controlled, heads counted, visits observed, programmes strictly adhered to; loose change and penknives cannot be comfortably jangled in the pocket. All this provides a soil on which resentment of the nurse-custodian readily grows.

The demands of security-custody have their effect on staff as well. It is now part of accepted psychiatric doctrine in this country that open-door in-patient units are therapeutically more effective than locked ones; nurses and others in secure units tend to feel defensive about being out-of-date and reactionary. Security demands rules, sanctions to uphold them, and people to enforce them. If those people are nurses, they will inevitably lean towards a hierarchical structure not only administratively but clinically. Breaches of security will create anti-therapeutic tensions among staff, and between staff and patients. This tension will be exacerbated if the surrounding community is security-sensitive, and censorious. We at Broadmoor have bitter knowledge of this following the escape, fifteen years
ago, of a child-murderer who killed a third child victim within a few hours of absconding. Some secure hospital staffs solve this problem by divorcing themselves from the security situation completely, and operating clinically literally within a fence of barbed wire and armed men; others over-identify with the custodial role. The burden placed on the nurse-custodian, who is seen by the offender-patient as the man who actually wields the keys, is a very heavy one; and he needs skilled and continuous support and help in clear perception of his role and self-confidence in his exercise of it.

Security needs for the "normal" offender are not uniform, a fact set out very clearly by the recent Mountbatten Report on Security in Prisons (Mountbatten 1955). This is also true of the dangerous offender-patient, whose fluctuating psychiatric state, or volatility of response to stimuli, complicates the problem even further. Fortunately, in secure hospitals we do not have to contemplate the fearsome and appallingly expensive measures envisaged by Mountbatten to guard against well-mounted liberation operations from outside. We believe that the professional criminals capable of setting up such an attempt would not be likely to do so in the case of a man whose mental state and reliability was more than suspect. Within the hospital, however, very varying security needs have to be met. Many factors are involved, and I find it hard to set out the needs as a continuum. For instance, a young, agile, intelligent psychopath who has already wantonly killed while absconding from a Borstal, is pre-occupied with ideas of escaping, has seriously assaulted nursing staff, and is cheerfully open in preparedness to kill again in the course of escape. At perhaps the opposite pole is a gentle, dreamy schizophrenic who, despite treatment, remains convinced that he has a divine mission to save the world by liberating the soul of a girl which will then inhabit his body and has liberated such a soul with a knife. He manifestly must be denied unobserved access to girls - but within the perimeter security
of a well-staffed hospital does not present a risk. At another point on the perimeter of the security problem is the man who has a fixed, non-spreading delusion about his landlord; is determined to kill him; and makes repeated, rather inept attempts to escape to achieve his object; he has already gravely injured a staff member in an escape bid. Yet again there is a compulsive alcoholic who, brain damaged, drunk and paranoid, shot dead a son-in-law; in contemporary English psychiatric practice his care can most humanely be carried out in a secure hospital. The custodial needs of this sample vary from a high degree of physical security measures and close observation to a level of peripheral security which would not have been foreign to any mental hospital in England before World War II.

Still using homicide as a frame of reference, disposal of the dangerous offender-patient is not purely a medical responsibility. Homicides who have the status of patients are practically invariably subject to actual or notional "restriction" orders, i.e. they can not be discharged to the community, given leave of absence, or transferred from one hospital to another without the consent of the Home Secretary. I should emphasise that I have never known this consent to be unreasonably withheld; and I personally have found it a useful intellectual discipline to present what is usually a technical psychiatric case in terms which will be intelligible and cogent to a layman charged with the responsibility of protecting the public.

In assessing suitability for discharge, or transfer to open conditions, one must first make a careful assessment of the psychiatric state of the patient; then its relationship to the offence; and finally the likelihood of a situation arising which would reduplicate the original, fatal concatenation of circumstances. This is sometimes fairly easy, as in the "extended melancholic suicide" described by Professor Schipowitzky. But even with this diagnosis, any psychiatrist knows that psychotic depression has an unhappy tendency to recur,
so aftercare must be arranged with this in mind. The schizophrenic homicide presents a much more difficult problem. The relationship between illness and offence may well be obscure and conjectural, as in the case of the divinity student who cut off his mother's head and put in in the oven to bake it like a pie. At the time of the tragedy he was unable to give even psychotic reasons for his behaviour, and now he can neither recall nor understand his motivation. I do not think that a Kleinian interpretation of this matricide would impress a Home Secretary; and in any event, mothers (even dead ones) can have surrogates. I am aware of no work which establishes that fatal aggression to a mother figure is completely discharged by the victim's death. In this patient careful clinical study failed to reveal any psychotic residua, and a warm and integrated personality emerged, apparently similar to the prepsychotic one. This happy state of affairs was maintained for some years to a point after which relapse was statistically improbable, and the man has now been free in the community for 7 years. A more difficult problem was the schizophrenic who wandered from another hospital and pushed a perfect stranger in front of an oncoming train because "God told him to do it". Though active in Broadmoor, the marks of his illness are still thick upon him, he is inaccessible to discussion of the offence, and his discharge or transfer has not yet been recommended. We recognize that not all schizophrenics respond completely, or at all, to treatment; we can attempt an assessment of a level of conative blunting being reached such that the likelihood of florid and fatal manifestations of illness is reduced to a minimum, after which such patients can be safely transferred to open hospitals for long-stay care, or for industrial and social rehabilitation with eventual return to sheltered conditions in the community.

Nowat (1966) has studied 63 male murderers who had been admitted to Broadmoor over a period of 20 years, and whose presenting symptom was pathological jealousy of their heterosexual partners. Eleven of the men were discharged
within the datum period, without (up till now, the present) fatal consequences. The subjects came from a mixed group of depressives, schizophrenics, mono-delusional psychotics and alcoholics. But we are still very cautious in the disposal of morbidly jealous murderers of marriageable age.

Homicides flowing from disturbed sexuality present probably the most difficult problem, particularly in the absence of a demonstrable treatable psychosis. One cannot carry out one's professional job of assessment in a social vacuum, and one must weigh, as a factor, the effects of public reaction to a repetition of a violent sexual offence by a discharged patient. These effects could be prejudicial to the discharge prospects of a whole generation of patients. Clinical and psychometric certainty of a changed sexual orientation must be practically absolute for confident recommendation of discharge; and this is practically impossible to achieve, though it can be done. A young man of impeccable family background, upbringing, employment record and sexual adjustment, sustained a head injury. His professional studies fell off dramatically and he had one amnesic episode. One evening he drank rather more than his usual quota of beer; he murdered, mutilated and attempted to cremate two prostitutes, and was found, amnesic, in a town 70 miles away. Contemporary clinical, neurological and psychological examination indicated frontal lobe damage, which studies repeated on admission to Broadmoor confirmed. After a few years of close clinical observation, which revealed nothing more than immaturity manifesting as a peacock presentation of himself to women, the studies were again carried out, even more exhaustively, and including an electroencephalogram after the ingestion of five pints of beer (the quantity taken on the fatal night). The results were entirely within normal limits. He is now discharged.

All technical aids must be called in evidence — electroencephalographic studies, as above, can be helpful, especially if a lesion susceptible to
treatment can be demonstrated or, over a given period, a significant change in the direction of maturity and stability of cerebral rhythms. Similarly, psychometric studies may show quantifiable movement in the direction of resilience and control. Such studies, even in isolation, can provide useful predictive indicators. Blackburn (1968), at Broadmoor, has recently attempted to reduce to measurable terms the "over-control" associated with exceptional aggression and the "under-control" found with histories of moderate aggression.

Some new tools are being put in our hands, whose significance requires further longitudinal studies. Price and his co-workers (1966) have established a connection between certain chromosomal disorders and some forms of antisocial activity. This work is exciting, but I would not yet let the presence of an extra "Y" chromosome weigh too heavily against the discharge of an aggressive, tall, young man.

In the last analysis, however, with homicides we are denied the basic research tools of follow-up on discharge of recognized high-risk patients, and of unselected samples. One is left with the uneasy feeling, expressed by Dr. Sturup, that we are too cautious in our discharge policies.

So far we have discussed only the actualities of homicide. A further problem is the care and disposal of the patient who entertains violent phantasies without evidence of violence in action. I am aware of no body of knowledge on the incidence of phantasies of killing or rape in the general public. On two occasions recently I have been asked to see patients entertaining such phantasies, and have arranged to admit them, as unrestricted patients, for study and observation. Having admitted them to a secure hospital, one has admitted also the potential of danger. It took a considerable effort of will to discharge one of them after studies so detailed and long-drawn-out that I had to admit I was procrastinating. So far, all goes well.

Finally, disposal does not cease when the patient leaves the hospital. In restricted cases, discharge is always conditional, and the Home Secretary
retains the right to recall as long as the restriction order lasts - usually without limit of time. This, as Dr. Sturup points out, enables us to make appropriate arrangements for accommodation, employment or aftercare. Social workers go to endless pains, after consultation with the doctor, to secure ideal conditions including, if necessary, support by a mental welfare officer, psychiatric clinic or voluntary agency.

It is enormously important for the hospital to keep in touch with the after-care agencies, who often feel out of their depths in caring for homicides in the community, and have to be supported to cope with their repugnance at their own feeling that they may be the instruments of readmission of a patient who has not yet offended again. This potential of guilt is not the sole prerogative of the lay case-worker, but is shared by the doctors, who do not delight in incarcerating the legally defenceless.

The more sure our discharge criteria are, the less will be doctors' guilt, staff tensions and public anxiety. It is through meetings of colleagues such as this that our criteria will be refined and made more accurate; and for this I am profoundly grateful to the Ciba Foundation.

REFERENCES

APPENDIX 6:

BROADMOOR INS AND OUTS: 1960 - 1977

by Dr. D. Tidmarsh, M.D.,D.P.M.
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A paper read at the meeting of the Forensic Section of the Royal College of Psychiatrists on 23rd May, 1978, at the Staff Education Centre, Broadmoor Hospital.

Mr. Chairman, ladies and gentlemen,

Dr. McGrath thought that it would be appropriate for me to describe to you how the numbers of our admissions and discharges have changed over the years since the 1959 Mental Health Act was implemented and to discuss some of the reasons for these changes. As is always the case the presentation of even the simplest statistics raises all sorts of questions which need answering and which I hope, in the not too distant future, to provide answers to. Meanwhile my interpretation of the figures inevitably reflects my own prejudices and preoccupations and I am sure that nobody here will think that I am speaking in anything other than a personal capacity.

Let me begin therefore in a rather pedestrian fashion. According to some figures bequeathed to us by Gavin Tennet which he had extracted from some annual returns, one hundred years ago an average of forty men and fifteen women were being admitted to Broadmoor each year. These figures did not change greatly from 1876 to 1957 being fifty-two male and fifteen female admissions each year on average. There was a rise during and just after the first war and a rising trend after the second.

My first diagram shows what has happened to our admissions since the 1959 Mental Health Act was implemented. The figures for 1960 and 1961 are virtually the same as those for the preceding ten years. Thereafter you will see that the number of female admissions did not change very much, the average for 1960 to 1977 being eighteen instead of the fifteen of the previous one hundred years. The males however did increase reaching one hundred and forty-four in 1970, more than doubling the figures for earlier years. You will also see that from 1973 there has been a steady descent from the plateau of the 1960s. The figures for 1977 are sixty-nine males and ten females, and very similar to those found before the Act came into operation.

The reason for this fall in our admissions are no doubt various, but one thing this fall was not due to was any decrease in demand. My second diagram, the figures for which were supplied by the DHSS, shows that demand, as expressed by applications from all sources to the DHSS for beds in Special Hospitals has been increasing steadily since 1961. Until 1969 only about a quarter of these applications were rejected and admissions kept pace with applications. From then until 1973 the number of patients accepted remained static at about three hundred and seventy annually, leading to an increase in rejections from a quarter to a third. In 1974 there was a sudden fall, which has since continued, in the number of patients accepted in all the Special Hospitals, so that in 1977 only one hundred and seventy-four patients were admitted and half the applications were rejected.
I do not know whether this abrupt change is in the words of "1066 and All That" a Good Thing or a Bad Thing. Clearly if previously applications were being made for trivial reasons and patients were being admitted to Special Hospitals unnecessarily, then the reduction of such admissions is to be welcomed. If, on the other hand, dangerous mentally abnormal offenders are now being diverted to less suitable establishments then one can only be disturbed at this trend. I do not know whether this increase in applications relates to patients already in hospital or to people on remand or to those serving prison sentences, but my hunch is that many have subsequently found themselves in prison. If one takes the years 1966 to 1973 to be normal for modern times with an average of three hundred and seventy admissions annually to all the Special Hospitals, then since 1973 about six hundred and twenty patients have not been found beds who previously would have been admitted. Dr. Orr, the Director of the Prison Medical Service, has stated that there are some six hundred (or is it nine hundred?) men in prison who should be in psychiatric hospitals - this shortfall in Special Hospital admissions goes at least some way to explaining his problem. I believe that the Special Hospital Research Unit have formulated and submitted to the MHS a research project designed to explore what happens to these rejected cases. It will be interesting to see how dangerous they turn out to be, how much trouble they cause other establishments and how much they and their relatives have suffered from their inappropriate placement.

Before going any further, it is worth looking at some trends in the medical-legal status of our admissions. My next diagram shows how admissions under Section 60 of the 1955 Mental Health Act, with a restriction on discharge, now almost invariably without limit of time, has become the norm - last year sixty-seven percent of our admissions come in under these provisions. Now however much MIND objects to an indefinite restriction order, there is no doubt that many patients have been released from Broadmoor earlier than they would have been without a restriction order because of the power of supervision and recall it provides. Equally there is no doubt that lives have been saved by a timely recall of patients whose illnesses have relapsed or whose propensities have re-emerged.

Admission under Section 71 of the Mental Health Act, now superseded by the Criminal Procedures (Insanity) Act form a dwindling minority though of course once in a Special Hospital detention, discharge and subsequent supervision are the same as for patients with a Section 65 restriction order without limit of time. Now because Section 60 on its own gives only a short lived opportunity of supervising patients in the community after discharge, we do not like it and its use is also dwindling. Transfer from conventional NHS hospitals under Section 26 of the Act has never been important numerically and also appears to be waning though I suspect that this reduction is somewhat artificial. What I think is happening is that turbulent patients are being charged for the arson they commit, for the assaults they make on fellow patients and of course for their assaults on nursing staff and then they come to us convicted under Section 60/65. Even before this reduction, the total of Section 26 admissions did not reflect the number of patients in contact with the psychiatric services at the time of their offences. As with suicide so with homicide and other forms of serious violence - the majority of our patients have had contact with the psychiatric services at varying times before the final tragedy which opens the gates of Broadmoor for them.
There have been more important changes in the numbers of patients admitted under Section 72 from prisons with a reduction from about twenty-six a year up to 1971 to only four in 1976 and seven in 1977. There has, at Broadmoor at least, been a waiting list, intermittently closed, and one has heard that doctors in the Prison Medical Service are no longer even trying to get their patients on to it. Because of the waiting list we have had to admit patients vory near the end of their sentences, a procedure which quite rightly seems to them to be a form of double jeopardy and which leads to a quite poisonous relationship between staff and patient which may last for years. It has been said that mentally ill patients in prison are not badly placed - they are after all secure and medication is available. This however is not all that is today expected for the mentally ill and I can only deplore the reduction of these admissions.

I have been unable to obtain a complete run of the Mental Categories our patients have been admitted under and can only say that as far as I can tell about seventy-five percent of our patients have come in under the rubric Mental Illness and the remaining twenty-five percent under Psychopathic Disorder, thought in 1973, some sort of annus mirabilis, the psychopath's reached no less than thirty-six percent.

I do not have a breakdown of our patients' psychiatric diagnoses though you can take it that Mental Illness almost always means a schizophrenic illness, which I take to include paranoia. We still have the occasional patient with an affective illness, though unless such patients have a strong schizophrenic or paranoid element they are not usually considered dangerous enough for Broadmoor, and we have a few patients with organic illnesses. Psychopathic Disorder covers a whole range of personality disorders with or without sexual deviation and includes a significant proportion, which I would dearly like to enumerate properly, of patients whose schizophrenia has what one can only call a pseudo-psychopathic onset and is not diagnosable until the psychosis erupts often some years after admission.

It is not my purpose to talk of treatment here, which is quite conventional, or of the hospital environment which has improved out of all recognition in Dr. McGrath's time, but it is pertinent to point out that following the opening of Park Lane Hospital, we have at last been able to do something to relieve the overcrowding commented on by the Parliamentary Estimates Committee in 1966 and by the Butler Committee in 1975. The seventy beds vacated when these patients were transferred were taken down and remain down. The fourth diagram shows that in the early 1960s there was a considerable reduction in the number of female patients in the hospital. The standing population on 31st December 1959 consisted of seven hundred and twelve males reduced to six hundred and twenty-one on 31 December 1977. The females fell over the same period from one hundred and seventy-three to one hundred and twenty-four and the total hospital population from eight hundred and eighty-five to seven hundred and forty-five.

We now come to patients leaving Broadmoor or separations as I suppose I should call them. Between 1876 and 1957 the pattern was forty percent deaths, thirty-eight percent transfers and twenty-three percent discharges, the latter including the minority who returned to prison. My fifth diagram shows the picture after the 1959 Act. Overall it is one of a rapid increase after 1960, some fairly wild fluctuations and then a plateau of about one hundred and fifty patients per annum in the late 1960s and early 1970s leading to a more recent plunge. This actually occurred in 1974 but on this graph it is masked by the thirty-five patients who were transferred to Park
Lane Hospital in 1974 and an equal group who left in the same direction in the following year. The 1976 figure was ninety-three separations and the 1977 one hundred and three – lower than any year since 1961.

The overall figure of separations hides a variety of ways of leaving hospital. You will remember that until the 1959 Act some forty percent of our patients were allowed to end their days in the hospital – discharged to cemetery is the way the old hospital registers put it. Since 1960 the picture has changed considerably. Now only eight percent of our separations are caused by deaths – perhaps two or three suicides a year and the rest by natural causes. The geriatrics were the first to leave Broadmoor in the 1960s and now we have very few patients over sixty – quite unlike conventional psychiatric hospitals overtaken as they have been by the country’s demographic changes.

Another six percent of our patients are repatriated. This is frequently a time consuming business but justified if a patient is socially isolated here and has relatives in his own country which must have an adequate psychiatric service or repatriation is not considered.

Only three percent of our patients return to prison. There is some point in returning a man with a personality disorder who has had a bout of depression or a brief psychotic episode if he is serving a long sentence but the schizophrenics admitted under Section 72 we usually retain until they are stable or manageable enough for a conventional NHS hospital.

In the last eighteen years about ten percent of our patients have been transferred to the other Special Hospitals, the traffic being from us to them rather than vice versa. The patients who have gone have, in the main, been burnt out schizophrenics selected because they have been considered not to require Broadmoor’s level of security and to be likely to benefit from being nearer their home catchment area hospitals and their relatives. These form a group whose subsequent progress we know little about though Dr. Neville of Park Lane Hospital has discharged a significant proportion of the patients we sent him in 1974 and 5.

Death, repatriations, returns to prison and transfers to other Special Hospitals together make up about twenty-seven percent of our separations and most do not pose problems to us connected with their return to the community and subsequent violence.

I have found that people visiting Broadmoor are usually under the impression that most of the patients who leave are discharged to the community. This is not so. From 1960 to 1977 discharges made up twenty-three percent of our separations. Of these two-thirds were conditional discharges under the provisions of Section 65 of the Act and one-third had no conditions attached to their discharge. By sixth diagram shows these discharges since 1960. There is no particular trend and the 1977 figures are up on 1976 – from twenty-four to twenty-nine. These figures need to be compared with those before the Act which were as many as seventeen a year in the quinquennium 1948 to 52 and about twelve a year between the wars. As we have rather few patients detained under Sections 20 or 60 there is less scope for the Mental Health Review Tribunal to discharge patients than at the other Special Hospitals. Tribunals in fact only discharged forty-two patients between 1960 and 1977 or about two a year.
The most important component of our separations comprises those transferred to conventional, as opposed to Special, hospitals. These come to almost exactly fifty percent of our separations. My seventh diagram shows how this mode of separation has fared and you will see the by now familiar rise in the 1960s, a somewhat bumpy plateau, followed by a recent fall. The maximum number was ninety-one in 1964 but this fell away to forty-four in 1976 and forty-six in 1977. This reduction in the number of patients transferred to conventional psychiatric hospitals accounts for almost all of the decline in the numbers of patients leaving the hospital as you can see in my eighth slide.

You are no doubt much better aware than I am of the pressures on conventional hospitals and their consultants which militate against the acceptance of our patients. It is now fashionable to believe that the mentally ill can do no wrong and cause no harm and that therefore a paternalistic approach to them is unjustified. Not only have locked doors gone but so it seems has the close observation of patients which is the only real way of predicting and forestalling impulsive behaviour. Without the long stop of the closed ward people are less and less inclined to stand up close to the wicket to receive the more erratic patients. Sectorisation has meant that hospitals can now no longer staff intensive care units and District General Hospitals are in practice, if not in theory, unable to accept either potentially disruptive or long term cases. We now have the problem of political activists who are prepared to disrupt or take over the management of our hospitals – for those of you unfamiliar with the local geography I would point out that the Peoples Republic of South Brookwood is but a few miles from here along the Bagshot-Guildford Road. Last but by no means least we have the objective dangers posed by our ex-patients.

What are these dangers? Here, taken from a paper by Steadman and Cocozza which was written in 1975 and seeks to play down the dangerousness of the mentally ill is a quotation – or I suspect in parts a misquotation – from Dr. McGrath himself:

"In 1968 P. G. McGrath reported the results of his study of two hundred and ninety-three murderers who were released from Broadmoor Hospital in England. Not one killed again. We got in touch with McGrath four years later, and by that time only one had killed again. Moreover, said Dr. McGrath, in the past fifty years about one hundred and forty patients were released each year from Broadmoor and only two had been convicted of murder since release".

Can one say the same today?

The answer, alas, is no. It is true however that between 1960 and the end of 1977 only three patients admitted following homicide have been convicted of homicide after leaving Broadmoor – surprisingly two of these were women. Our record for patients admitted following other offences is perhaps less good but a sense of proportion needs to be kept. Between 1960 and the end of 1977 one thousand eight hundred and forty patients had left Broadmoor either transferred to conventional hospitals, discharged to the community or returned to prison. Three of these were the homicides who repeated a few times, admitted after lesser offences, committed homicide after leaving Broadmoor. It is interesting, though of doubtful significance, that only four of these repeaters received a psychiatric diagnosis of psychosis, three were reputedly depressives and the rest psychopaths.
The difficulties here lie in the probable changes of our diagnostic habits which make comparisons of such cases difficult over a twenty year period. Of these eighteen patients only six were transferred from Broadmoor to other hospitals, four went back to prison and eight were discharged in various ways. This again does not reflect our usual pattern but probably does reflect the preponderance of non-psychotic patients in this particular group.

Thus ninety-nine percent of those who leave Broadmoor do not kill anyone thereafter — or perhaps I should say have not done so yet. This caveat is necessary for three reasons — first the population of our ex-patients is being added to year by year — I am sure deaths are not yet in equilibrium with our separations — second, the pattern of the timing of these repeat homicides is a curious one, with about half occurring within two years after leaving the hospital and the remainder strung out up to twelve years after leaving. In parenthesis here it is of some interest that a recent admission suffering from delusional jealousy waited thirty years before killing his wife’s imaginary lover all of which time he was an unobtrusive member of the community of a conventional psychiatric hospital.

The third reason for my caveat relates to the care patients receive after they leave us. Until now such care has been excellent. We have received magnificent co-operation from consultants and supervising officers. What worries me though is that the administrative pressure to "rehabilitate" patients at all costs and settle them in the community come what may could be too much for patients whose real need is for peaceful stressfree asylum away from relatives and others who may re-activate their delusional processes. It is becoming difficult in some areas to find psychiatric services which will offer long stay beds and this trend is gathering force.

In terms of objective danger, therefore, out of one thousand two hundred and three transfers to ordinary hospitals there have been six repeat homicides or 0.5 percent over the last eighteen years. None of the victims were nurses or doctors.

What about violent behaviour leading to injury? Here I can only say that our readmissions are rising though only slowly as my last diagram shows. I looked briefly at the 1976 readmissions of which there were eighteen. Of these three were prophylactic recalls of patients whose symptoms had relapsed, three were admitted following threats, three followed arson — none in a hospital setting, one followed the stabbing of a stranger in the street by a patient who had been refusing his medication as an outpatient, one followed an attack on a fellow patient with an iron bar and four involved attacks on both patients and nurses in conventional hospitals.

It is of course possible that some violence occurring in hospital and rather more occurring in the community is not known to us and that such events are leading to imprisonment and the diversion of our ex-patients out of the hospital system altogether. This certainly occurs with some patients with personality disorders but I suspect with fewer of the mentally ill. I do not however think that violence not known to us is of great significance — it has not shown up in such formal follow up studies as have been done, and I can only conclude that by and large our ex-patients are a remarkably safe collection of people especially when it is remembered that before admission they have to be considered to have dangerous and violent propensities. For the population as a whole the risk of being
killed by an ex-Broadmoor patient is about one fifth of that of being killed by lightning.

I do not therefore think that there is any real reason why the number of patients transferred to conventional psychiatric hospitals should not return to the level of the early 1970s.
Applications for Special Hospital beds and patients accepted.
Transfers to N.H.S. hospitals
Broadmoor Hospital
APPENDIX 2:

+ A FIVE-YEAR FOLLOW-UP STUDY OF MALE PATIENTS
DISCHARGED FROM BROADMOOR HOSPITAL

by

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+ This is an edited transcript of a spoken paper presented to the
NATO Advanced Study Institute on "Computer-Assisted Decision
change of context the same paper was presented to the annual
conference of the British Psychological Society, Exeter,
April 1977 and several other professional meetings. A full
report of the research, with appendices of data relationships,
is now in draft and will be available in due course.
Acknowledgements

This research was completed as a result of a Cropwood Fellowship at the Institute of Criminology, University of Cambridge, September 1975 - January 1976, the facilities for which are gratefully acknowledged by the author. Gratitude is also expressed to Rosemary Steadman-Allen for preparation of the transcript and draft; to SHRU for obtaining much of the follow-up information; to clerical staff of the Department of Psychology, Broadmoor, for painstaking searching and collating of the original data; to Dr D.P. Farrington and Miss M. Guy and colleagues at the Institute of Criminology for their help with planning and data preparation; and to the DHSS and the management of Broadmoor Hospital for affording both facilities to carry out the research and study leave to analyse the results. At the same time it must be pointed out that opinions expressed and conclusions drawn must not be attributed to these bodies or persons but are the sole responsibility of the author.
Broadmoor is one of five Special Hospitals in Great Britain which accepts mentally disordered offenders. These are mainly sent from the courts on a hospital order, having committed a dangerous offence from which it is deemed the public needs protection, but who are also presenting some psychiatric disorder which needs treatment. Such hospital orders are in effect 'indeterminate sentences' in that patients remain in hospital until they are thought to be fit to go, at which time they are recommended for discharge. The Broadmoor discharge process is thus similar to a parole decision-making situation in that a prediction has to be made as to whether the individual is fit to return to the community without constituting a danger to that community. In the context of "computer-assisted-decision-making", this is very much a preliminary exercise. What I am presenting in the context of this week's conference is a kind of case study which you might like to consider and discuss because the stage at which it ends is the stage at which the statisticians among you might be able to say "And now you need to do such-and-such to get some predictive index".

The study I shall now describe grew naturally out of psychological work done in the clinical situation at Broadmoor. Since 1960, there has been developed a psychological service for the hospital comprising the usual roles of assessment, treatment and research. Until 1964, there were no psychologists other than myself employed in the hospital and the clinical service had, therefore, to be entirely assessment whilst research capitalised on assessments by relating findings to the collection of demographic data, identifying the social, psychological and psychiatric characteristics of the various offender groups within the patient population. By 1970 when there were two of us and a trainee, plus a clerical officer, we had completed a number of descriptive and typological studies and had further collected a certain amount of follow-up data on people who had left the hospital in the period 1960-1965. While this follow-up data was gradually being collated, there occurred several incidents of discharged Broadmoor patients committing further rather sensational offences and it was at the conclusion of the trial of one of these - Graham Young in 1972 - that the Government announced the setting up of the Aarvold Committee (1973) to examine discharge and after care procedures and the 'Butler' Committee (1975) to review the law governing mentally abnormal offenders. These events made it seem imperative to hurry up the work on this discharge study so as to discover, if possible, what was the degree of success or failure of our discharging process and whether any features could be identified in the groups which might increase the efficiency of the process in the future. The problem of increased re-offending arose, I think, from the changes which followed the implementation of the 1959 Mental Health Act in November 1960. From that date and for reasons I will not discuss now, the annual admissions dramatically increased which meant, of course, that, since the hospital's resources were limited, an equivalent number were discharged. Fortunately the Mental Health Act enabled many patients to go by a route hitherto not possible namely via a local psychiatric hospital. The increase in discharges was largely accommodated in this way. Figure 1 in the Appendix shows this rise in admissions and discharges through the period of the sixties. Then in the seventies, the position was reversed and the controlling factor was the fall in discharges following the several dramatic cases which had caused public concern. Extra precautions were instituted and there was increased reluctance by other hospitals to receive our patients on transfer. This brought about the drop in the admission rate shown in Figure 1 because, as those who live in this country know, Broadmoor is over crowded and
could not maintain its increased intake once discharges had been cut back. It therefore, became extremely important to look at discharge criteria.

2. THE SAMPLE

My sample comprised all the 128 male patients discharged during the period 1960-65. Broadmoor had a population then of about 850 patients, * some 730 men and about 120 women. We chose to study the men first simply because there are more of them and they constitute a larger sample for deriving meaningful statistics. Patients are discharged by a number of methods and I have been looking only at those discharged directly to the community which, during the whole of the sixties, as you can see from Figure 2 in the Appendix was a fifth of all those who left: 24.7 or 21%. As Figure 2 also shows, the majority have left by transfer to other hospitals in England and Wales. A small proportion are returned to their country of origin (we have quite a large number of immigrants). Some go back to prison (but only those who were transferred to us from prison in the first place). Others are transferred to other Special Hospitals and a few, of course, die in hospital.

Initially I selected this community discharge group for my sample because these are the only ones for which post discharge supervision was arranged directly from Broadmoor. All the remainder become the responsibility of another authority and were thought likely to be more difficult to follow up. My sample is, therefore, a fifth/quarter of all those who left hospital during the 1960-65 period and roughly half of all those who were conditionally discharged during the whole of the sixties. They were followed up for five years, that is to say we recorded information about them for the five years after the year in which they were discharged.

The follow-up information was derived from three sources:

   i our own hospital records
   ii records kept by the Special Hospitals Research Unit
   iii The Mental Health Register

I would like to express gratitude to these two latter services for the information they provided. You may think this a somewhat sparse data collection. All we have really looked at is: did these people 'survive'? Did they stay in the community for those next five years or were they re-admitted to the same or another psychiatric hospital? Did they commit further offences? The criterion adopted is virtually "no news is good news". If we don't hear of them again, then we assume they are 'surviving'. This may seem a crude and simplistic criterion but in the context of an almost complete dearth of follow-up information on the Broadmoor type of population, this constituted quite a significant and useful advance in our knowledge and was about as much as a small department could achieve in a limited time and when providing a clinical service was our principal 'raison d'être'. Table 1 summarises this description of the sample and provides some further defining information about the group.

* The population is now down to some 700 (560 men, 120 women) due mainly to the opening of the Park Lane Hospital advanced unit and rebuilding work at Broadmoor.
TABLE 1

GENERAL DESCRIPTION OF SAMPLE

<table>
<thead>
<tr>
<th>Number Discharged (Males only)</th>
<th>128</th>
</tr>
</thead>
<tbody>
<tr>
<td>During Period</td>
<td>1960-65</td>
</tr>
<tr>
<td>Followed-up for</td>
<td>5 years</td>
</tr>
<tr>
<td>By means of</td>
<td>Hospital records</td>
</tr>
<tr>
<td></td>
<td>Criminal records</td>
</tr>
<tr>
<td></td>
<td>Mental Health Register</td>
</tr>
<tr>
<td>Average Age on Admission</td>
<td>34.07 years</td>
</tr>
<tr>
<td>on discharge</td>
<td>41.54 years</td>
</tr>
<tr>
<td>Average length of Stay</td>
<td>7.48 years</td>
</tr>
<tr>
<td>With Previous Convictions</td>
<td>77 (60%)</td>
</tr>
<tr>
<td>- Hospital Admissions</td>
<td>63 (49%)</td>
</tr>
<tr>
<td>- Broadmoor Admissions</td>
<td>13 (11%)</td>
</tr>
<tr>
<td>+ 1 Rampton</td>
<td></td>
</tr>
</tbody>
</table>

Seventy-seven (60%) had previous convictions; 63 (nearly 50%) had previous hospital admissions; 13 had previously been in Broadmoor and 1 had been to Rampton.

The diagnostic groupings are listed in Table 2 and show about a quarter to have been schizophrenic, a third some sort of affective disorder, whilst the largest group (42%) were psychopathic. A few were organic or subnormal but usually as a secondary diagnosis. A second or third diagnosis occurred quite often hence the total of 147 diagnoses for the sample of 128.

TABLE 2

DIAGNOSIS

| Schizophrenic Group       | 33 (26%) |
| Affective Disorders       | 41 (32%) |
| Psychopathic or similar   | 54 (42%) |
| Organic                   | 14 (11%) |
| Subnormal                 | 5 (4%) |
| **Total**                 | **147 for 128 men** |

It should be said here that Table 2 is not representative of the diagnostic groupings either amongst incoming patients or those resident in the hospital at any given date. The discharge process is, of course, selective. For example, the hospital population on the 1 January 1970 was 56% schizophrenic whilst in my discharge sample only 26%, i.e. less than half as many. By contrast, there is a greater proportion of psychopaths - 42% as against only 25% of the resident hospital population. Again, affective disorders are 6% of the resident population but are many more in this discharge sample at 32%. The sample is not, therefore, representative of the hospital population as it was in 1970 and any results should, therefore, be taken as referring to this sample only and not as any indication of how an equivalent number of new admissions or residents would fare if unselectively discharged at some later date.
Table 3 shows the offences for which these men were originally admitted, just under half of the sample being homicides. All other offences of violence against the person, at 33, represent just over a quarter of the sample. The majority of property offenders were acquisitive, whereas only 5% were damage - of these, most were arson and the others 'malicious damage'. Sexual offenders constitute a very small group and clearly are selected for discharge with very great caution, although it should be pointed out that they represent only about 7% of all admissions anyway.

### TABLE 3

<table>
<thead>
<tr>
<th>OFFENCES</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Homicide (Murder and</td>
<td>62</td>
<td>(48%)</td>
</tr>
<tr>
<td>Manslaughter)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other offences against</td>
<td>33</td>
<td>(26%)</td>
</tr>
<tr>
<td>the person</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property offences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Damage (incl. Arson)</td>
<td>6</td>
<td>(5%)</td>
</tr>
<tr>
<td>- Acquisitive</td>
<td>23</td>
<td>(18%)</td>
</tr>
<tr>
<td>Sexual offences</td>
<td>4</td>
<td>(3%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VICTIMS</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Wife (partner etc)</td>
<td>32</td>
<td>(25%)</td>
</tr>
<tr>
<td>Other family or known</td>
<td>44</td>
<td>(34%)</td>
</tr>
<tr>
<td>Casual or stranger</td>
<td>20</td>
<td>(15%)</td>
</tr>
</tbody>
</table>

Again, the distribution of offences in my sample is not representative of either new admissions or the resident population. Figure 3 in the Appendix, for instance, shows male admissions between 1963 and 1970 to have averaged 26% homicides whilst/resident population contained 33% in 1970 and again when sampled in 1976.
3. OUTCOME DATA

From the three sources of information - our own records, criminal records and the DHSS mental health index - we were able to assemble the set of thirteen measures listed in Table 4. These define different aspects of the two kinds of what I have called "fail" events, viz psychiatric re-admissions and further offences and they subdivide as follows: re-admissions to Broadmoor and re-admissions to other psychiatric hospitals; and offences which entail a court appearance as against those which result in imprisonment. Thus we have a rough classification of degrees of severity of 'failure'.

TABLE 4

OUTCOME VARIABLES

Subsequent Psychiatric Re-admissions
Subsequent Broadmoor Re-admissions
Subsequent Court Appearances
Subsequent Imprisonments
Time until First Psychiatric Re-admission
Time until First Court Appearance
Time until First Imprisonment
Time spent in Psychiatric Hospital
Time spent in Broadmoor again
Time spent in Prison
Time spent in Community
Subsequent Death (incl. Suicide) or Survival
Types of Subsequent Offence

We are able to look simply at the incidence of these fail events, or at other aspects such as the length of time that elapses before a fail event occurs and the period of time for which a failure lasts. These may provide other aspects of severity or degree of failure. Another important aspect of failure will be the kind of offence committed by those who reoffend (remembering that the majority of the sample were originally admitted for a serious or violent personal offence). Finally it was possible often to learn of the death of a discharged patient, sometimes by suicide, and this seemed a variable worth examining. By contrast, a measure of success was available (apart from simply recording 'nil failures') in terms of the proportion of the 5 year follow up period spent at liberty in the community (although it is to be noted that those who incurred Court appearances which resulted in fine, probation or discharge might often record a 100% 'score' on period spent in community whilst also recording one or more other sorts of 'fail' event).
Variables that we had readily available from hospital records and the Psychology department's records are listed in Table 5 and it is these which were set against the outcome data first to provide information as to which patient groups achieved success or failure and secondly, as a result, to provide possible predictors of such success or failure.

**TABLE 5 (a)**

<table>
<thead>
<tr>
<th>CRITERION VARIABLES (GENERAL) (Possible Predictors)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year of Discharge</strong></td>
</tr>
<tr>
<td><strong>Age on Admission - Age on Discharge</strong></td>
</tr>
<tr>
<td><strong>Length of stay in Broadmoor</strong></td>
</tr>
<tr>
<td><strong>Diagnosis - Schizophrenic Group</strong></td>
</tr>
<tr>
<td>Affective Disorder</td>
</tr>
<tr>
<td>Psychopathic or similar</td>
</tr>
<tr>
<td>Organic</td>
</tr>
<tr>
<td>Subnormal</td>
</tr>
<tr>
<td><strong>Mental Health Act (1959) Classification</strong></td>
</tr>
<tr>
<td>Mental Illness</td>
</tr>
<tr>
<td>Psychopathic Disorder</td>
</tr>
<tr>
<td><strong>Discharge information - Form (conditional or absolute)</strong></td>
</tr>
<tr>
<td>Initiator (Responsible Medical Officer or Mental Health Review Tribunal)</td>
</tr>
<tr>
<td>Place (Private residence in the community, or hostel)</td>
</tr>
<tr>
<td><strong>Original Admission</strong></td>
</tr>
<tr>
<td>Offence</td>
</tr>
<tr>
<td>Form ('Sentence') is section of Mental Health Act under which committed to Broadmoor</td>
</tr>
<tr>
<td><strong>Previous History</strong></td>
</tr>
<tr>
<td>Number of Convictions</td>
</tr>
<tr>
<td>Number of Psychiatric Admissions</td>
</tr>
<tr>
<td>Number of Special Hospital admissions previously</td>
</tr>
<tr>
<td><strong>Social Background</strong></td>
</tr>
<tr>
<td>Education</td>
</tr>
<tr>
<td>Occupation</td>
</tr>
<tr>
<td>Marital Status</td>
</tr>
<tr>
<td><strong>Relationship of Victim</strong></td>
</tr>
</tbody>
</table>
Table 5(a) comprises a broad range of social factors, information about the committal and original offence, previous history and, of course, information about the discharge process. Diagnoses, as also listed in Table 2, subdivided most conveniently into five main groups. The remainder of the criterion or possible predictor variables are listed in Tablo 5 (b) and comprise various psychological test information. I apologize to those who don't hold with such tests, but clinical psychology was very different in the early 1960's. (In any case, with such a small department there was little time available for any more.) So there is a range of IQ information from the Wechsler Scale and from two British measures, the Ravens Progressive Matrices and the Hill Hill Vocabulary, from which the computer was programmed to calculate the discrepancies between certain scores, indicative of impairment and hence usually indicative also of the type and extent of disorder which the patient may be presenting. The MMPI was then, as now, quite a popular questionnaire with many people and widely used both in Britain and the USA. It is particularly convenient because it can be answered by the patient at his leisure and a great deal of information can be derived from it. The scales selected (Table 5) were those that have either proved to be useful in the clinical work and previous research at Broadmoor (Blackburn 1968) or else seemed relevant to the discharge success or failure problem. I would draw particular attention to those scales that we have used and which are not in the standard display. The standard clinical
scales really are not very satisfactory as they are not factorially pure and they mix symptoms and personality variables. This is why only a selection rather than the whole clinical profile was included in the study. By 1970 we had a great deal of information from Blackburn's work as to which scales were redundant and which seemed reasonably independent and relevant to our population. To these have been added various factors scales: an anxiety measure \( A \) (Welsh 1956) which is a good measure of the first (emotionality) factor from this test; a repression measure \( R \) (Welsh 1956) which is a good measure of the second (introversion-extroversion) factor, and Extraversion (Giltat & Downing 1961) and Impulsivity (Blackburn 1971b) scales which are very relevant to our population, particularly in view of the research done by some other members of the department, for instance Blackburn's (1971a) work on personality typologies. Also from the MMPI we used two scores from the Foulds and Gaines (1960) Hostility scales. Then there was the Porteus Maze Test. The ability to solve mazes is associated with intelligence, but specifically with the ability to plan and use foresight. It also yields qualitative measures of motor control. Finally, I included the opinion on outlook expressed in the psychological report made prior to the patient leaving.

5. RESULTS

5.1 Discharge Outcome

I want to look first at what actually happened to the sample after they left, before looking at the relationships between outcome and the possible predictors. You will see the sample did rather better than does most offender populations. Figure 4 in the Appendix shows the number of fail events that occurred in the five year follow-up period. Two of the sample could not be traced and one returned to the West Indies during the five year follow-up period, so this and several ensuing figures are based on the 125 for whom the information was complete. 101 had no re-admission to any psychiatric hospital, Broadmoor or otherwise, 97 had no imprisonments and 76 had no further court appearances. The remainder of the graph shows the numbers of men who incurred 1, 2, 3, 4 and 5 or more of these events. For example, 5 had five or more court appearances, whilst only 1 had five or more psychiatric re-admissions. (This patient was an alcoholic and in fact had 14 further psychiatric admissions in the 5 year period.

Looking at how long they lasted before a fail event occurred, Figure 5 in the Appendix shows whether the first fail event occurred in the first year, second, third, fourth or fifth and indicates that the tendency for any kind of psychiatric re-admission to occur is similar to what has been observed elsewhere with reconvictions ie is most frequently in the first year.

Court appearances, of course, tend to happen earlier than imprisonments which may not happen if at all, until several court appearances resulting in conditional discharge, probation or fine. Figure 6 in the Appendix shows how long the sample spent in all the possible situations, both 'fail' and 'succeed', in psychiatric hospitals, in Broadmoor, in prison or in the community.
Exactly half the population (61.3) did, in fact, spend the entire five years out in the community. Ten of those had court appearances during that time so we cannot regard this as a sort of global 'success-failure' measure. Nevertheless, at least they were neither so ill nor so dangerous as to require removal from the community so, in terms of Broadmoor's 'raison d'être', this measure is probably as good an overall measure of success as we shall find.

The outcome events shown in Figures 4, 5 and 6 are summarised in Table 6.

<table>
<thead>
<tr>
<th>Outcome Event</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsequent Psychiatric Admissions</td>
<td>24</td>
<td>101</td>
</tr>
<tr>
<td>Subsequent Broadmoor Re-admissions</td>
<td>24</td>
<td>101</td>
</tr>
<tr>
<td>Subsequent Court appearances</td>
<td>50</td>
<td>76</td>
</tr>
<tr>
<td>Subsequent Imprisonment</td>
<td>29</td>
<td>97</td>
</tr>
<tr>
<td>Remained in the Community for the entire 5 years</td>
<td>64</td>
<td>61</td>
</tr>
<tr>
<td>Committed Further Assaults</td>
<td>13</td>
<td>112</td>
</tr>
</tbody>
</table>

(No homicides in the 5 year follow-up but 2 later)

From this it may be seen that 24 patients had further psychiatric admissions whilst 24 were re-admitted to Broadmoor. These are not the same 24 patients in both cases of course. 36 in fact, subsequently had both Broadmoor re-admissions and psychiatric admissions elsewhere. Fifty had subsequent court appearances, 76 did not. The outcome event of "committed further assaults" which is listed in this summary table when it has not been detailed elsewhere allows me to comment further on the criterion of success or failure in the Broadmoor context touched upon in the previous paragraph in connection with figure 6. The general opinion at Broadmoor is that, since we accept dangerous, violent offenders who have committed grievous assaults, including sexual offences and homicide, then a relatively minor re-offence such as taking-and-driving-away (TADA), stealing or breaking and entering, cannot be put into the same 'failure' category. It may even be classifiable as a success in so far as the new offence is trivial compared with the original one. So the important question is how many of this sample committed further assaults of a dangerous kind? From Table 6 we see that the answer was 13 out of the 125 fully known about.
In addition, however, we happen to know what has occurred after the five years in many cases (up to ten years now for many of these) and use of this information increases the number of assailter reoffenders to 17 known at the present time. None committed a homicide in the period of the follow-up, but two have since. These would not, in fact, have been missed by the five year follow-up or a prediction system based on it because both of them had already committed assaults in the 5 year period. One of the later homicides was of a fellow prisoner where the ex-patient, already a re-offender, was subsequently detained and it is perhaps not unreasonable to suggest that the public would still regard themselves as adequately protected if any further offences were committed while the offender was being detained in another secure place.

This comment conveniently brings me to the end of this first section of results describing discharge outcome. In making the comment, however, it enables me to recap on the purpose of the study which was to try to discover relationships between outcome and data obtained on the patients whilst still in hospital. Whilst it is of interest to know what the outcome was for such a sample, especially when no such information previously existed, the impetus for the study was the increasing numbers of reoffending discharges who were claiming public and official attention and who were hampering the admission and discharge procedures of the hospital. Clearly samples later than this 1960-65 cohort would include larger numbers of violent reoffenders. Yet no subsequent groups have been systematically assessed on discharge as this 1960-65 group has been. Generalisations need to be derived, if possible, from this group so that the crucial predictive signs can then be identified for use in later discharge decisions.

This, moreover, is the subject of the conference at which this research is being reported. The next section describes data inter-relationships, though the deriving of a predictive index from such inter-relationships is, as I said at the outset, something I hope you, the conference members, will be able to say how best can be done, if it can be done at all on such a sample and such data.

5.2 Relationship: Between Outcome Events & Pre-Discharge Data

Let us now therefore look at how these outcome events relate to pre-discharge data. The statistical programme used was SPS. All the interval measures of the criterion variables were compared with all the interval measures of the outcome variables and the usual t tests and correlations obtained where appropriate. The category measures were cross tabulated, using chi-square to determine any relationship. All measures were subsequently grouped into categories and finally dichotomized so that 2 x 2 contingency tables were obtained for the final analyses. All these data will be presented in appendices to the full report of this study. Today, time allows me only to draw attention to the main findings of interest. Not unexpectedly, the best predictor of success was found to be the previous record, so finally a three-way cross tabulation was done, controlling for previous history which, in context, consisted of both previous convictions and previous psychiatric events. Subsequent psychiatric events were best predicted by previous psychiatric history and subsequent offender events by previous offending history. Many of the predictor and outcome variables turned out to be significantly related only for this relationship to disappear when previous convictions were controlled for. For instance, the
Mental Health Act classification of mental illness or psychopathic disorder was significantly related to outcome; no doubt because there is an artifact of previous convictions involved in the classification "psychopathic disorder". A history of offending behaviour will increase the likelihood of a classification of psychopathy being used. Thus, again, the original offence and the form of admission are both highly related to outcome: those who commit homicide tend not to re-offend, unlike those who commit other sorts of offence. However, whereas the offence on admission is related to outcome regardless of the variable of previous convictions, (and in fact this is the only general criterion variable that is independent of previous convictions), the form of admission, by contrast, is very much dependent upon previous convictions. Those on a fixed sentence have come on transfer from prison and tend to be those with more previous convictions; they then tend also to have further convictions. Those in the sixties on an indeterminate sentence tended to have been admitted before the Mental Health Act of 1959 and therefore to have been 'detained at Her Majesty's Pleasure' i.e., to include most of the homicides who tend to be first offenders. Hence the relationship between form of admission and subsequent outcome disappears when previous history is controlled for.

Unlike the findings of some studies in which social class factors are found to be related to recidivism, the data on educational and occupational background in this sample were amongst those which showed no relationship with outcome. The relationship of victim, however, was strongly associated, homicides' victims tending to be well known, friends or family, whereas other offenders' victims tend to be casual acquaintances or strangers. The variable of "Relationship of victim", again, yields a strong statistical relationship with outcome which disappears when controlling for previous convictions; the group who offend against someone they know well tends to include most of the homicides who tend to have no conviction history whereas the other group who offend against casual acquaintances or strangers tends to include both homicides and non-homicide aggressive offenders who do have previous convictions.

Significantly more abnormal scores on psychological variables occur when the 'fail' and 'succeed' groups are compared by means of t tests of significance of differences between means but these differences fail to reach significance when previous convictions are controlled for in category based contingency tables. It seems that many of the psychological variables are in fact, independent of previous convictions as they do not show a significant statistical relationship under either condition of previous convictions - positive or negative. It may therefore be worth looking further at these variables under the more powerful conditions of interval measurement when attempting to improve on 'previous history' as a predictor. The discrepancy between two of the IQ measures, namely the Raven's Matrices and the Mill Hill vocabulary (in contrast to the non-significant discrepancy between the verbal and performance scores of the Wechsler IQ test), shows a significant relationship with success of discharge outcome. This needs to be examined more closely yet as it seems that a higher Matrices score, relative to Mill Hill, is associated with failure and that the scores are closer together in the success group. This may be a result of better vocabulary in the success group, or less good Matrices ability (in abstract 'practical' reasoning). This discrepancy measure is less straightforward to interpret than the Wechsler Verbal discrepancy.
TABLE 7
SUCCESS TENDENCIES

No Previous 'History' (offending or psychiatric)
Current Offence Homicide
Older
Been in Broadmoor Longer
Diagnosed as 'Affective Disorder'
Under Indeterminate 'Sentence' (Hospital Order now)
Victim family or well known

Psychological Assessment Prior to Discharge:
Less Emotional Disturbance
More Social Conformity and Control
More uncertainty on non-verbal problem solving tasks

TABLE 8
FAILURE TENDENCIES

With Previous Convictions
Currently Property Offender or non-homicidal Assault
Younger
Been in Broadmoor shorter time
Classified as 'Psychopathic Disorder'
Under Fixed Sentence (Section 72 of MH Act now)
Victim Stranger or Casual Acquaintance

Psychiatric Re-admissions:
- More thinking and sensory disturbance ('psychotic')
- More hostile attitudes
Re-offenders in general:
- More impulsive and extraverted ('psychopathic')
Subsequently Committed Assaults:
- More impulsive AND emotionally disturbed

Tables 7 and 8 summarise the characteristics of those who succeed and those who fail. Success is associated with a lack of previous history; with the current offence for which they are in Broadmoor being homicide; with being older; and with having been in Broadmoor longer. Some would use this last finding to argue that patients should stay in Broadmoor longer but, of course, this is another artifact of previous history. People who have tended to stay in Broadmoor longer but, of course, this is another artifact of previous history. People who have tended to stay in Broadmoor longer but, of course, this is another artifact of previous history. People who have tended to stay in Broadmoor longer but, of course, this is another artifact of previous history. People who have tended to stay in Broadmoor longer but, of course, this is another artifact of previous history. People who have tended to stay in Broadmoor longer but, of course, this is another artifact of previous history. People who have tended to stay in Broadmoor longer but, of course, this is another artifact of previous history. People who have tended to stay in Broadmoor longer but, of course, this is another artifact of previous history. People who have tended to stay in Broadmoor longer but, of course, this is another artifact of previous history. People who have tended to stay in Broadmoor longer but, of course, this is another artifact of previous history. People who have tended to stay in Broadmoor longer but, of course, this is another artifact of previous history. People who have tended to stay in Broadmoor longer but, of course, this is another artifact of previous history. People who have tended to stay in Broadmoor longer but, of course, this is another artifact of previous history. People who have tended to stay in Broadmoor longer but, of course, this is another artifact of previous history. People who have tended to stay in Broadmoor longer but, of course, this is another artifact of previous history. People who have tended to stay in Broadmoor longer but, of course, this is another artifact of previous history. People who have tended to stay in Broadmoor longer but, of course, this is another artifact of previous history. People who have tended to stay in Broadmoor longer...
or sexual assault. So they are discharged earlier, continuing their less serious re-offending, and longer stay therefore figures among the 'success' characteristics. Where psychological assessment is concerned, the 'success' group (Table 7 again) tends to show scores towards the more emotionally stable, socially conforming and controlled ends of the scales, with a slight suggestion of less confident handling of practical non-verbal tasks (Haven's Matricos and Porteous Moses).

Table 8 summarises the characteristics in the 'fail' group. These tend to be the converse, of course, of the 'success' group. In this group there is a greater incidence of previous convictions and of people who are currently committed for a property offence. They tend to be younger, to have stayed in Broadmoor a shorter time and to be classified as psychopathic disorder, either in their diagnosis or in their Mental Health Act category. They also tend to be on a fixed sentence (i.e. a transfer from prison); and their victims are strangers or casual acquaintances. On psychological assessment three different types are to be seen:

i) those who receive further psychiatric attention tend to have shown on their discharge assessment slightly more thinking and sensory disturbance (which psychologically defines the psychotic) and more hostile attitudes;

ii) those who re-offend tend to have shown, on discharge assessment, more impulsive and extraverted traits (which is more or less definitive of the psychopath);

iii) those who commit further assaults, although they are only a small group, do suggest some interesting differences. They show scores on discharge assessment suggestive of both emotional disturbance and more impulsivity.
6. CONCLUDING COMMENTS

These results represent the picture to have emerged from the work done during the five months period of my Cropwood Fellowship. In the context of this conference, it is probably appropriate to have been able to go no further because, from what I have presented, the methodologists and statisticians among you may be able to suggest what could best be done next. For instance, you may share my hope that, despite the best predictor having once again proved to be past record, the independence of some of the variables, especially some of the psychological measures, might make it worthwhile trying to derive a predictive index in which past record is augmented by the addition of other variables. I hope we can repeat studies such as this one to see which, if any, of the generalised relationships are replicated amongst samples discharged according to prevailing criteria. If a special hospital like Broadmoor is to continue to function as it is intended, to receive new patients and to move those who respond to treatment on to another setting, then it is clearly incumbent upon us to scrutinise the criteria upon which discharge decisions are made. In this way it may at least be possible to reassure public anxieties that those patients who 'move-on' are selected according to the best available criteria.

Aside from the topic of this conference, this much overdue study has, at any rate, given us some indication of the degree of success enjoyed by our discharged (male) patients and a kind of thumbnail sketch of the 'succeesders' and the 'failers'. If prediction is not served by this study then maybe at least an improved job can be done of identifying and explaining our patients' offending and psychiatric behaviours and hence treating them more appropriately and effectively. This, in turn, might then lead to more precise and better timed discharge proposals which, in their turn too, would supply a better data base for future prediction studies.
REFERENCES


FIGURE 1

Numbers of male patients

150
140
130
120
110
100
90
80
70
60
50
40
30
20
10
0

1959 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76

Year

males { Annual admissions X---X
only { and departures +--+-
including 36 in each of years 1974 & 75 transferred}
to the new Park Lane Special Hospital.
FIGURE 2

All the 1,127 male patients who left Broadmoor during the decade 1960-69

- Discharged to the community: 247 (22%)
- Returned to prison: 41
- Transferred to other special hospitals: 92
- Returned to country of origin: 91
- Died in hospital: 91
- Transferred to other psychiatric hospitals: 565 (50%)
### FIGURE 3

<table>
<thead>
<tr>
<th>Offences against Persons (64%)</th>
<th>Male admissions 1963-70</th>
<th>Males resident at 11.70</th>
<th>Males resident at 11.76</th>
</tr>
</thead>
<tbody>
<tr>
<td>20% Homicides</td>
<td>33%</td>
<td>33%</td>
<td></td>
</tr>
<tr>
<td>37% Other personal violence</td>
<td>38%</td>
<td>37%</td>
<td></td>
</tr>
<tr>
<td>7% sexual offences</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22% Property: acquisitive</td>
<td>9%</td>
<td>3.5%</td>
<td></td>
</tr>
<tr>
<td>7% Property: damage</td>
<td>7%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>7% others</td>
<td></td>
<td>2.5%</td>
<td></td>
</tr>
<tr>
<td>Annual average: N = 116</td>
<td></td>
<td>Total: N = 675</td>
<td></td>
</tr>
</tbody>
</table>
FIGURE 4

Number of 'fail' events in follow-up period

Key:
- Re-admissions to other psychiatric hospitals
- Re-admissions to Broadmoor
- Court appearances
- Imprisonments

Numbers of patients (male only) N=125

- None
- 1
- 2
- 3
- 4
- 5 or more

Values:
- None: 97
- 1: 16
- 2: 19
- 3: 17
- 4: 5
- 5 or more: 0
FIGURE 5

Time lapse between discharge and first 'fail' event occurring

- psychiatric re-admission (Broadmoor or elsewhere)
- court appearance
- imprisonment

Numbers of patients (N=125)

Year in which first 'fail' event occurred
FIGURE 6

Where the 5 years of the follow-up period were spent

- in other psychiatric hospitals
- in Broadmoor again
- in prison
- in the community

Numbers of patients (N=125)
I. INTRODUCTION

1. Minor acts of violence by patients in Moss Side Hospital are relatively frequent. Serious acts of violence though less so are a real possibility and a contingency for which all staff working here should be prepared.

2. Most patients admitted to this hospital have histories of violence and, therefore, it is likely that more incidents of violence will occur here than in most NHS hospitals. As most patients are also admitted against their own wishes as a consequence of their dangerous, violent or criminal propensities, there is also a likelihood of violence being used in incidents of planned violence. Experienced as well as junior staff should continually guard against being too trusting or complacent in their interactions with patients as a violent incident can take place when it is thought least likely to happen. It is often only the appropriate action of staff that may prevent a serious incident becoming a tragedy.

3. Notwithstanding all this, it should always be borne in mind that a patient, regardless of his behaviour, class, colour or creed, is in hospital as a person to be helped. Staff should maintain a professional attitude at all times even under conditions of extreme provocation. This may well demand high levels of personal control.

II. PREVENTION OF VIOLENCE

1. Ward atmosphere is to a large extent determined by the quality of the living and working conditions under which patients find themselves. The better the conditions on the whole, the better the atmosphere. Moss Side compares favourably with other hospitals from the point of view of physical facilities. This can be capitalised upon by appropriate staff procedures.

2. As far as possible, all staff and patients should be made aware of the policy pertaining to a particular ward; this being an important part of staff/patient communication.

3. The prevention of violence requires observation, knowledge and understanding by staff of individual patients and a quiet surveillance of those factors which may precede a period of disturbed behaviour. Talking and listening should be the first line of approach and it should be remembered that some patients may not be able adequately to express their needs, and indeed may have learned elsewhere that the only way to attract attention to these is to exhibit violence. One of the aims of staff, therefore, should be to educate patients in more acceptable forms of social behaviour. Staff should continually bear in mind in the prevention of violence they are fulfilling their obligation to themselves and the community.

4. Unnecessary physical contact with patients, however jovial, should be avoided as firstly this may teach patients that this is normal behaviour, and secondly it may be misinterpreted.
by other staff thus leading from a joke to a serious incident. However, it is not always possible to predict the occurrence of a violent response and staff faced with a violent situation should try to be calm, confident, objective, tactful and authoritative.

5. Physical intervention should be avoided if possible but may be necessary if it seems that someone will be hurt. In the instance of a concerted attempt to breach security, it is the staff's responsibility to attempt to impede the breach of security, but not to such an extent that it would endanger his life. In any event, any member of staff faced with a violent situation should not attempt physical intervention before adequate assistance has been obtained unless it is absolutely essential that they do so. Staff have a responsibility to go to the assistance of any victim of the violent patient's attack no matter who that victim is.

6. Medical assistance may be very important in dealing effectively with certain kinds of incident, particularly where the use of medication is called for.

III. WHEN PHYSICAL INTERVENTION IS UNAVOIDABLE

1. Where physical intervention is unavoidable, the following points should be borne in mind:

Firstly - As a general principle clothing rather than limbs should be held to effect restraint and if limbs have to be grasped they should be held near a major joint in order to reduce the danger of fracture or dislocation. Every effort must be made to safeguard the patient's vulnerable areas, for example, the neck, throat, chest or abdomen.

Secondly - A patient who has to be restrained should, when possible, not be gripped by the head, throat or fingers. A bear hug from behind to pinion the arms to the side is valuable and it is better to grip the legs together just above the knees and around the calves rather than separately. If the patient is brought to the ground, he can be very quickly subdued if sufficient members of staff lie with their weight across his legs and trunk and thus immobilise him until further action is decided upon. In exceptional circumstances, as for example, when a patient is biting, the hair may have to be firmly held.

Thirdly - If an intra-muscular injection is given great care must be taken in its administration.
Fourthly - Should a patient need to be isolated it should only be for the minimum period necessary. Isolation may mean merely the withdrawal of the patient from the problem area. The basic reasons for such isolation may be disturbed behaviour, threat of physical assault or actual physical assault. The patient may be isolated either to stop or prevent violence.

2. It may also occasionally be necessary, for example when confronted with a patient who is seriously self-injurious or where isolation is not considered to be appropriate, that the patient be dressed in a garment designed to impede physical violence. As in the use of isolation, this should be for the minimum time required to control the violence. An assessment of whether a patient requires to be kept in the garment once applied should be under constant review, and if required advice sought. Since for patients, the wearing of such a garment may be very degrading, extreme caution should be exercised in its use. Under no circumstances should a restraining garment be used as punishment.

3. The decision to dress a patient in a restraining garment or to isolate a patient in a side room should be made by the nurse in charge of the ward and the nursing officer should be informed immediately.

IV. NO MORE FORCE THAN IS NECESSARY MUST BE USED

1. The general rule to be followed when dealing with the violent incident is that the minimum of force be applied in order to control the situation.

2. Staff will get the support of management in their action to deal with the violent incident provided it is in good faith and within the framework of these guidelines.
V. AFTER THE INCIDENT

1. It is essential to have an adequate recording and reporting system. Reasons for this include the need for good management and the need to ensure that any subsequent complaints can be adequately dealt with. It may also be helpful to the patients' future treatment by suggesting preventive action against future outbursts.

2. The reporting arrangements in the hospital are therefore designed to meet both professional and managerial requirements.

3. The following indications should lead to a full written report:

   Any incident involving physical violence and/or injury by a patient to himself, other patients, to members of staff or to any other person, or any allegation of such an incident.

   Any incident which necessitates the use of physical restraint by members of staff. This also includes the use of restraining garments.

   Any incident in which isolation forms part of the management of the disturbed patient.

   Any incident causing damage to hospital property or to the property of patients or staff.

4. The recording of any incident is the responsibility of the person in charge of the ward or department. Details should be entered in the Daily Report book as well as on casualty forms etc. If a serious incident occurred on a ward/department the appropriate departmental head should be informed. The names of staff involved in a serious incident should be entered in the Daily Report. All staff should be acquainted with the wording of the report, and any staff dissatisfied with the report should see his Nursing Officer.

5. The principal contents of the report should include when and where the incident took place, a factual account of the incident which should include the general activity occurring at the time of the incident, the names of those immediately involved or witnesses, any action taken and when. A list of injury or damage should also be included.

6. Staff are strongly advised to join the appropriate professional or representative body. Such bodies can offer considerable assistance to staff if there is an enquiry following an incident.

VI. LEARN FROM YOUR EXPERIENCES

All staff who have been involved in an incident with a violent patient should try to learn from the experience. This would be a major contribution towards developing a high standard of care in the hospital.
Greetings and welcome to the Pacific Regional Psychiatric Centre of British Columbia. The next few pages have been carefully outlined to guide you on some of the main regulations which will concern you during your stay here. It is of importance and to your advantage that you read them and apply yourself accordingly, and if there is anything you do not understand, please do not hesitate to ask.

We sincerely hope to be able to offer you some help, no matter how small and to help you help yourself and trust you will have derived some benefit from your stay with us.

The Admission Team
Nova Ward
REGULATIONS

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Work .................................................... 7
1. **ADMISSIONS:**

All admissions and readmissions are usually accepted on Nova Ward on a thirty, sixty or ninety day warrant. During your stay on this ward and this Institution, you will be expected to participate in programmes offered, and on Nova Ward these are comprised chiefly of interviews and assessments with various departments of the institution. After a minimum stay of three weeks or thereabouts, a Placement Conference of your case will be held in order to determine your suitability to a particular programme, geared to your specific problems and needs. If for certain reasons you are found to be an unsuitable candidate for treatment you will be returned to your parent institution. During the assessment period, please always notify Admission Staff of your whereabouts in case you are needed for assessments/interviews.

2. **ATTIRE:**

Greens must be worn during working hours of 8 a.m. - 4 p.m. on a weekday and casual clothing is acceptable after hours, weekends and holidays, however, name badges must be worn at all times. When being visited, formal or casual attire is acceptable with shoes (no slippers please). Shorts to be worn for recreation purpose only. All whites to be worn for kitchen duties only.

3. **ASSESSMENTS:**

Assessments at this institution are conducted by qualified personnel from the following departments.

- Psychiatry: Interviews and tests
- Psychology: Interviews and tests
- Education: Interviews and tests
- Nursing: Interviews, counselling sessions, tests, observation
- Medical: Physical examination and blood work and E.E.G.
- Alcoholics Anonymous: Interviews
4. **Canteen:**

Regular canteen days are held every two weeks. Canteen registration slips should be completed and forwarded to the representative of the Inmate Committee through a collecting post on the unit, the Sunday after canteen day. An emergency canteen is available to new admissions through the representative of the Inmate Committee (for out of province patients only). Please complete all canteen slips with your name and number.

5. **Contraband:**

It is a chargeable offence to wilfully and knowingly abet, retain and or conceal any unauthorized personal effects, provisional food items or any object that constitutes a dangerous weapon. Accepting gifts, tokens and money from relatives and friends during visits also is contraband to regulations at this Institution.

6. **Counts:**

Ward counts are done by the nurses everyday of the week at the following times:

**Weekdays:** 0001 hours, 0630 hours, 0800 hours, 1130 hours, 1300 hours, 1530 hours, 2100 hours and 2330 hours.

**Weekends and holidays:** The 1300 hour count is omitted because of an extension of recreation period.

During the summer months evening recreation is extended because of daylight time. In this case the 2100 hours count is done at 2145 hours. You are requested to stand to for the count at this time and at other times when specially requested. In order to avoid a miscount, you are to remain where you are while the count is in progress.
7. **CORRESPONDENCE:**

All correspondence received at this institution will be screened for contraband. Inmates entering into correspondence are requested to do so on stationery (cards, writing paper, envelopes) purchased from the canteen. Institution stationery will not be accepted. All outgoing mail will be left unsealed except for privileged mail i.e. to the Solicitor General, the Commissioner and members of parliament. All out-going mail will be collected from a collecting post on the ward. In-coming mail is delivered to the respective nursing stations for distribution.

8. **GRIEVANCES:**

If you feel you have valid grounds for raising a grievance against an offending party, you are advised to discuss this firstly with your nurse. Should you derive no satisfaction then the matter will be dealt with by the Nursing Supervisor. If it remains unresolved, the Nursing Supervisor will issue you with the necessary forms for you to complete. This will then be sent to the Social Work Department for investigation and action.

9. **MEDICAL:**

Your medical needs will be attended to in the Medical Wing of this Institution. Initially upon your arrival here you will be given a complete physical examination. Please notify the Doctor if you require continued medications for any physical problems you may have, at the time of examination. If you wish to see the doctor for further medical reasons, an appointment is required. Times are as follows:

- Weekdays only: 1045 to 1120 hours
- 1415 to 1515 hours

For dental problems, the medical wing will handle appointments.
MEALS:

Upon your arrival at this institution, meal trays will be sent to the kitchen so that you may dine on the ward, until an initial assessment of you by Nursing staff is completed.

Meal times are as follows:

<table>
<thead>
<tr>
<th></th>
<th>Breakfast</th>
<th>Lunch</th>
<th>Supper</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Estimated</strong></td>
<td>0815 on weekends and holidays</td>
<td>1145 hours on weekdays, weekends and holidays</td>
<td>1615 hours weekdays, weekends and holidays</td>
</tr>
<tr>
<td><strong>Actual</strong></td>
<td>0715 on weekdays</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

are required to proceed to the kitchen as a ward group. Meal trays will be ordered for physically ill patients. Night trays will be provided by the kitchen for communal use.

MEDICATION:

If you are receiving medication prescribed by the Psychiatrist or Medical Doctor, you are obliged to call at the medication wicket upon an in-room announcement, made usually after breakfast, lunch and at 2200 hrs. On weekdays, the afternoon medication will be dispensed at 1300 hrs. On occasion, medication may be prescribed before meals. It is urgent to be punctual when receiving medication. Please do not wait to be reminded repeatedly. It is in your best interests to accept medication socially prescribed for you, although it is not compulsory. It becomes only if you are certified. Institutional standing orders such as aspirins, cod suspension, vitamin C, medicated throat lozenges, Dimetapp, etc.

be dispensed for medical complaints, for short periods only, and be ordained to the discretion of your nurse. If by then your medical problem is unresolved, you are expected to see the Doctor in the Medical Wing the earliest convenience. Loitering in front of the medication wicket in a queue while awaiting medication is strongly prohibited. Late television users will not receive NS or NS PRN medication after 0200. Should they request and receive night sedation before or during the viewing time, they are obliged to retire to their rooms.
12. **NURSES:**

Nurses and psychiatric aides are available on the admission ward and the living units 24 hours of everyday. In the Medical Wing they are available during office hours on weekdays. On the admission ward you will begin with an assigned primary and secondary nurse therapist to help you along with the programme and your problems while you remain here.

13. **PASSES:**

These are issued for use within the institution only. Passes are to be obtained from the nursing station and must be presented upon arrival at one's destination. Times of arrivals and departures are noted on these. It is an offence to tamper with the passes. Passes are necessary for destinations detached from the main building of the Institution eg. the Clinical Sciences Building (C.S.B.), laundry, the hobby shop. Passes are not required for regular work areas.

14. **PSYCHIATRISTS:**

Soon after being admitted you will be interviewed by your attending psychiatrist. If you require to see him further, you must notify a nurse so that this may be arranged.

15. **RECREATION:**

Recreation periods are held usually after lunch and supper everyday of the week in the gymnasium or in the yard, the choice dependent on weather conditions. Closure of the yard will and does depend on five factors: (1) Weather (2) Daylight (3) Special events (4) Staff situation (5) Patient participation (there must be a least six inmates in the yard). Release from the wards are timed upon the hour and half-hour only. If you wish to use the musical instruments in the music room, written consent is first necessary and obtainable from the Chief of Occupational Training. Late television viewing till 0200 hours is allowed on Friday and Saturday evenings and Sunday evening if followed by a statutory holiday.
16. REQUESTS:

The use of a request form is necessary when, for example, you wish to make a telephone call, or to obtain specific items from your personal effects, or to see a particular officer from e.g., the administration office, the Security department or the Social Work Department. A completed request for a transfer out of this institution remains in the nursing station for a minimum period of 5 days before activation. You may if you wish, revoke the request within the 5-day period only. Request forms are available on the ward.

17. ROOMS:

Rooms are occupied singly. The tidiness and general cleanliness of the room becomes your responsibility. If you have toilet and washing facilities installed, please ensure these are kept clean. You are expected to arrange standard furniture only for each room, in such a way so as not to interfere with nursing observation or obstruct the doorway for fire exit purposes. Furthermore it is deemed forbidden by the Security Department to drape the window of your room, whatever the reason. When smoking in your room, ensure that cigarette ends are properly extinguished. If you wish to listen to the radio during periods of lock-up, you are requested to exercise some consideration for those wishing to sleep, by keeping the volume low. Entering a room during the occupants' absence without prior permission from him is forbidden. At 2300 hours you are expected to either return to your room or stay in the lounge till lock-up time. Lingering in the corridors or kitchen is prohibited after this time.

18. TELEPHONE CALLS:

As a rule, two personal telephone calls are allowed each month. There are exceptions to this rule in cases of emergency. This is determined by the Nursing Staff. Telephone calls to your lawyer, parole officer are excluded from the personal calls. Telephone calls should be made collect or through personal funds, processed through the Inmate Trust Fund. In
Fairness to everyone, the use of the telephone is available at specified times for each ward unless arranged otherwise. A speaking time of five minutes has been recommended. On occasion telephone calls may be monitored. A member of staff is always present while you are using the telephone.

19. VISITS:

Absolutely no visiting from the admission ward to the living units and vice versa, unless on a pass for a haircut only. While on the ward there should not be more than two inmates to a room i.e. the occupant and one visitor. If you have relatives and friends wishing to visit, you should send them the required number of visiting forms - one per adult. The regulations governing these are outlined on the forms. External visits are conducted in the visiting lounge three times weekly, statutory holidays and seasonal open house days, the latter held in the yard or gymnasium. You are expected to conduct yourself with decorum when visited. A display of overly intimate and sexually suggestive behaviour is forbidden.

20. WORK:

You are expected to enlist for some form of employment, preferably of your choice, while here. Initially on the admission programme you will be excused from your area of work so as to complete your assessments and tests. Wages earned are handled through your trust fund, canteen and compulsory savings. Upgrading is held periodically and is determined by an assessment of your work record, for example, punctuality, consistency, degree of interest in the job, quality of work, etc. and your overall performance in your particular programme.
APPENDIX 11:

1. All patients are expected to be courteous and respectful at all times.

2. Each patient is expected to keep his hygiene at a socially acceptable standard as follows:
   - a minimum of one shower on alternate days
   - to shave daily or if wearing a beard, the beard should be kept trimmed
   - teeth cleaned daily
   - hair groomed and cut in an acceptable style. Clothing to be clean and in good repair.

3. First wake up at 0645. Patients are expected to be up by 0800.
   - Beds must be made prior to 0830
   - If a patient is ill and considers that he requires medical attention, he should, if possible, make the staff aware of his condition prior to 0815 hours.

4. All patients wishing breakfast must proceed to the dining room when the breakfast call is made.

5. Medications are to be taken at the prescribed times.

6. All patients will be ready to go to their work, group of appointments at the time stated.

7. At count time patients should be at their ward or scheduled work area unless otherwise detained for medical appointments or escorts. In the event of stand-to counts, all patients will return to their wards and will stand at the of their room.

8. Each request for a phone call to a relative or for an interview with resource or management personnel must be made on the official request form. This must be submitted to the Team Leader in charge of your ward.

9. Social visiting between wards will only be permitted with permission of the staff on both wards.

10. When a patient is confined to his room, no other patient is to interfere with him, e.g./ passing food or cigarettes.

11. No more than two patients in one room at any time and room door must be wide open with both men in full view.

12. Absolutely no gambling allowed. Card and table games to be played in full view on nursing station.

13. Plastic glasses are not to be taken out of the kitchen. No food can be taken out of the kitchen except that which is on the evening trays.

14. T.V. may only be viewed during leisure hours.

15. The auditorium or the yard will be open for recreation from noon until 1255 hours.
16. Any sport equipment or unauthorized electrical appliances found in patient's rooms will be removed immediately and treated as contraband.

17. There will be no unnecessary noise at any time and especially after 2200 hours. Patients must show consideration to peers in keeping radio noise to a minimum after 2300 hours.

18. No movement between floors after 2100 hours.

19. No movement during late night viewing. Both barriers to be closed on late night T.V. Doors of rooms whose occupant is yo watching T.V. to be left closed. All empty rooms (including interview rooms) should be locked at 2300 hours. Patients to be either watching T.V. or in their rooms. No unnecessary wandering about after 2300 hours, otherwise T.V. viewing may be suspended.

20. Room doors locked at 2300 hours. Only those watching T.V. news may remain up until 2325 hours. Requests to view special late programs must be processed for permission through nursing and security 48 hours in advance.

21. Curtains must leave room visible for outside observation.

22. Furniture must be placed to one of the three RPC suggested layouts. Permit must be posted for extra furniture other than 1 locker, 1 chair, 1 desklamp, 1 garbage can.

23. No hanging plants under night light or in window.

24. All wiring is to be approved and installed by a qualified electrician.

Patients residing on Nova Ward are not permitted to visit on the Living Unit. This rule will be strictly enforced.

Nova patients can join and interact with the patients from the living unit during recreational periods.

Recreational periods are held usually after lunch and supper every day of the week.

Nova patients wishing to take part in recreational activities in the evening must inform the nursing staff, who will contact Central Control to obtain clearance and have the barrier opened. Departures both for going to recreation and for return to the ward will only be permitted on the hour and half hour.

Unit Director.
MEMORANDUM

TO

All Department Heads

FROM

Medical Director

SUBJECT

PATIENT'S DRESS REGULATIONS

1. Working dress is issue green pants, shirts, and parkas.

2. Working hours are between 0700 and 1700 hrs. Working dress will be worn Monday through Friday until 1700 hrs.

3. Patients may wear casual clothing daily after 1700 hrs., on weekends, designated public holidays and while visiting relatives or friends during working hours.

4. Kitchen whites will only be worn while in the kitchen.

5. Recreational clothing may be worn while engaged in sports activities only.

6. Patients working in the grounds may be permitted to remove shirts.

This memo supersedes all previous memorandums relating to clothing regulations. For further information on Inmate Grooming and Hygiene refer to C.D.208

C. Roy, P.R.C.P.(C)
Medical Director

CR:fl

Reference: C.D.208

Division: Administration
Date: 19th November 1979
Review Date: November 1980
Medical Director
Dr. Chuni Roy F.R.C.P.(C)
Member International Academy
of Medicolegal Sciences.

Regional Psychiatric Centre
Abbotsford,
British Columbia,
Canada

Solicitor General
Canada
Introduction

Psychiatric services were introduced into the Canadian Correctional Service in 1947 — the outcome of radical penal reform following World War II. Changes were necessary to remedy a situation which had been unsatisfactory during the previous 100 years. Treatment of the mentally ill at that time, including inmates, varied from "non-existent to whatever was available." Records of Canadian penal history at Kingston Penitentiary, Ontario, show that since the early 1800's prisons and jails (later called penitentiaries) housed inmates vaguely described as "feebleminded, epileptics, incorrigible, and lunatics." But knowledge of their existence brought little help, if any at all. The medical situation in prisons, at that time, and the issues arising from poorly planned treatment, concerned the administrators of penal institutions as far back as 1865 and were still a source of concern a hundred years later.

In 1971 the Solicitor General of Canada appointed an Advisory Board of Psychiatric Consultants from nominations made by the Board of Directors of the Canadian Psychiatric Association. With Dr. F.C.R. Chaitke, Associate Dean of the Faculty of Medicine, University of Ottawa, as chairman, regional representatives of the board carried out extensive consultations with their colleagues in provincial governments, universities and with other interested individuals and agencies. The board's report, submitted to the Minister in 1972, contained recommendations defining the role of psychiatry in the correctional setting and stated the action required to fulfill this role in Canada. The outcome of one major recommendation, concerning inadequate facilities, turned the spotlight on the possibility of using existing facilities as psychiatric hospitals — the Regional Psychiatric Centre in Abbotsford, British Columbia, being the result.

The building now housing the Regional Psychiatric Centre in British Columbia was originally designed as a treatment unit for female drug addicts. It was handed over to the Medical and Health Care department of the Canadian Correctional Service in 1972 to treat mentally ill inmates in the Western Region. Structural changes required to adapt the 6-year-old complex to its new use included installation of nursing stations in the living units and an admission unit. In planning a correctional psychiatric centre, a dual responsibility is evident — treatment and security. It was decided that the therapeutic milieu would require the same level of security as a maximum penal institution. A medical director would have authority to determine the degree of security consistent with the treatment program.

In 1974 the Centre was designated a legal hospital within the meaning of the British Columbia Hospital Act, Section 2, and under Section 4 (2) of the British Columbia Mental Health Act. The same year the Centre became formally associated with the University of British Columbia.

Despite the Centre's relationship with the Canadian Correctional Service, its internal administration reflects the basic structure of any accredited hospital in the country. The medical staff organized itself into various democratically elected committees to discharge its professional responsibilities. The main objectives of the medical staff are as follows:

1. To ensure that all patients admitted to the hospital or assessed in their institutions by the staff of the Centre prior
to admission to the hospital, receive the best possible medical care.

(2) To enhance the quality of medical care in the hospital by organizing specialized committees and by providing means of communication with the Medical Director.

(3) To initiate and enact rules and regulations to govern the medical staff and to enforce compliance with these guidelines.

(4) To initiate meetings and co-operate on research programs.

A Medical Advisory body, democratically elected by the medical staff, reports to the Medical Director, who is the Chief Executive of the Centre and who reports directly to the Board of Governors.

Admission to the Centre

The 138-bed institution is not a centre providing for the treatment of criminality but rather a hospital for the assessment and/or treatment of offenders who show evidence of psychiatric disorder. Patients are referred to the Centre by psychiatrists of Federal penitentiaries in British Columbia and occasionally by physicians.

Following admission, each case is carefully assessed by a multi-disciplinary team and within three weeks a clinical case conference is held under the chairmanship of the Clinical Director. During the initial assessment phase, problems are identified and appropriate goals are set if it is decided it would be in the patient's best interest to remain at the Centre. However, during the assessment stage, if the patient decides he would rather return to his parent institution, the request is promptly adhered to.

During the initial phase the patient is assessed by the following disciplines:
- Department of Psychology (neuropsychological tests are used)
- Department of Occupational Therapy and Training
- Department of Psychiatric Social Work
- Department of Nursing
- Department of Psychiatry

Categories of Patients

Inmates are admitted to the Centre not because of their crimes but on the basis of an assessment of their mental status. At the hospital treatment is provided for all categories of psychiatric patients but recent experience has prompted the development of two unique programs:

(i) Treatment for Sex Deviants
(ii) Treatment for Violent Offenders

Treatment is not contingent upon early release and patients can terminate therapy at any time according to their own choice. Psychosurgery, electric shock therapy and experimental treatments are not used at the Centre.

Objectives of the Centre

The following objectives have been clearly defined for the Centre:

(a) To provide up to date, ethical treatment for mentally ill or emotionally disturbed offenders.
(b) To engage in research benefiting the Canadian Correctional Service in general.
(c) To ensure the security of inmate patients, staff and the general public.
(d) To expand and strengthen the total Canadian
forensic psychiatric program.

(e) To attain and retain accreditation status with the Canadian Council on Hospital Accreditation.

To achieve these objectives the hospital has different departments and a number of units of services. These departments are as follows:

Nursing
Occupational Training
Psychology
Research
Psychiatric Social Work
Psychiatry
Security
Medical
Administration

There are nine wards in the hospital divided into four units of services, under four psychiatrists. Nurses are led by a Team Leader who essentially works as a case manager for each patient.

Apart from providing clinical services, the Centre also offers:

(1) Out-patient services to various federal institutions.
(2) Advisory services to various prison officials as required.
(3) Training services including on the job training for staff and training for selected prison officials as the need arises.

The training program of the Centre attracts students from various disciplines and visitors from other countries are received on a regular basis. As part of the training centre for the World Health Organization in Vancouver, the hospital is also committed to provide training for appropriately selected Fellows from abroad.

An integral part of clinical activity is the research service. All research proposals are screened by the Hospital Research Committee and forwarded to the Ethics Committee of the University of British Columbia for their scrutiny. The proposals are then forwarded by the Director General, Medical and Health Care Services to the Commissioner of Corrections for approval. The Centre has developed research programs in the following areas:

(a) Evaluation of individual treatment using Goal Attainment Scaling.
(b) Application of behavioural medicine in the treatment of psychosomatic conditions.
(c) Basic research on medical information systems. The department is currently preparing extensive proposals to investigate the biological basis of some forms of criminality and devising ways and means to predict future behaviour of patients.

The Regional Psychiatric Centre in Abbotsford, British Columbia was considered a prototype from which valuable experience could be gained when planning staffing patterns, building design, and treatment programs for future hospitals of this type in Canada. These expectations have been realized. It also became obvious that running a hospital for offenders poses a number of problems. The criteria for admission, the issue of informed consent, the ethical consideration in the practice of medicine among confined inmates, and public expectation are only a few of the problems encountered.
The Abbotsford experience indicates clearly that medicine has a very important role to play in the field of corrections. Despite the criticism against psychiatric involvement, it is obvious that psychiatry cannot ignore or fail to respond to the critical needs of the inmate. This can be accomplished ethically and in a professionally competent manner, the Centre in Abbotsford is a prime example. The Psychiatric Centre in Abbotsford, British Columbia builds hope.
It's a kind of magical place, wonderfully spirited, almost religious in its medical commitment. I watched the Regional Medical Centre and its staff tame and heal some of the most profoundly damaged humans. I think it is among the most remarkable places in Canada and on the continent.

Milton H. Miller, M.D.
Professor and Vice-chairman
Dept. of Psychiatry U.C.L.A.

There is a unique hospital in Canada and perhaps in the world — because it is built outside prison walls and it exists specifically for the psychiatric treatment of prisoners. It is on the one hand a hospital and on the other a prison. Moreover it has to provide the same quality and standard of care which is expected of a hospital associated with a university.

Journal of Medical Ethics (U.K.)
1975,2, p 180
DEPORTMENT AT THE GOVERNMENT'S PLEASURE

TREATMENT OF CRIMINAL PSYCHOPATHS IN THE NETHERLANDS
I. Origin of the present treatment
II. The nature of T.B.R.
III. Some figures
IV. The offender
V. Execution of the T.B.R. order
VI. T.B.R. viewed as a process
I. Origin of the present treatment

'Detention at the Government's pleasure', as it is officially known in the Netherlands, is a measure which may be applied by the criminal court. Statutory regulations governing this type of detention (hereinafter given the Dutch abbreviation of T.B.R.) are therefore included in the Criminal Code and in implementing acts and decrees based on the Criminal Code. T.B.R. is statutorily classified under the heading relating to the 'lack of, diminished and increased responsibility for criminal behaviour'.

Section 37, para 1 of the Criminal Code provides that

'no one shall be punished for a crime for which he cannot be held responsible due to defective development or impairment of his mental faculties'.

Cases in which this provision applies are not subject to criminal jurisdiction. Thus the court refrains from sentencing the accused because he has been found to suffer from mental disturbance so severe that there can be no question of criminal responsibility. Under criminal law the accused can in no way be regarded as guilty. In such cases the court may order the accused to be committed to a mental hospital for a period not exceeding one year, though this period may be extended as often as required out of court under the Lunacy Act.

1 In Dutch criminal law 'measures' are contrasted with punishment.
Soon after the Criminal Code came into force in 1885 it became apparent that further provisions for mentally disordered offenders were needed. The main objection to existing legislation was that all offenders were placed squarely in one of two categories, viz. those held fully responsible and those not held responsible at all for criminal offences. Persons falling into the first category were punished while those in the second might be committed to psychiatric hospitals. The rigid division between the two groups gave rise to practical difficulties from the very first. Courts frequently found themselves in difficulties when dealing with persons who, though not insane, had, at least in some degree, 'defective development or impairment of their mental faculties'. On the one hand such offenders could hardly be held fully responsible for their crimes but on the other there would always be a few dangerous, recalcitrant criminals among them whom society had to be adequately protected. The law as it stood did not provide for this. In 1925 a number of new provisions were made for the 'partially responsible' group of offenders in the Criminal Code. The most important of these provisions was that offenders who had 'defective development or impairment of their mental faculties' at the time of the crime, could be detained at the Government's pleasure and ordered to undergo treatment. However, this penal measure must always be definitely the 'interests of public order'. The detention order is for a period of two years but may be extended any number of times by one or two years by the courts as required. The detention order may also be suspended.

The following sentences can now be passed on offenders found to be not responsible at all for their crimes:
1. discharge
2. discharge and committal to a mental hospital
3. discharge and T.B.R.
4. discharge, committal to a mental hospital and T.B.R.

Offenders with diminished responsibility for their crimes must be given a penal sentence. The judge may order T.B.R. as well, if the protection of society warrants it. For each separate case it must be ascertained to what extent the offender's mental disorder admits of responsibility for the crime and what punishment will apply. Punishment must be imposed according to the degree of guilt. However, while the 'Psychopath Acts' were still being prepared protests were already being lodged against the compulsory imposition of punishment in addition to the T.B.R. It was held that either a punishment or a committal order should be imposed and that the choice should be governed by considerations of effectiveness. In 1972 the Minister of Justice presented to the Second Chamber of the States General a 'Memorandum on Detention at the Government's Pleasure', proposing that courts be granted statutory authority to refrain from imposing an additional punitive sentence when a committal order is to be made. In practice complications are currently arising, particularly when the committal follows a long prison sentence. Such situations are of no benefit to the mentally disturbed offender in need of help.

II. The nature of T.B.R.
As the foregoing indicates, T.B.R. meets two distinct needs, the protection of society from sometimes serious crimes committed by mentally disturbed offenders, and the right of the mentally ill to suitable treatment. The two interests are united in the execution of a committal order. At any rate it has become obvious that punishment alone is not an effective means of preventing crime by mentally disordered offenders, as no regard is had for cause or motivation. T.B.R. is specifically aimed at the 'special prevention' of criminal behaviour, since it endeavours by therapeutic means to set processes in motion that will allow the offender eventually to find a place in society. These processes relate not only to the offender himself but also to the environment from which he came and to which he is hoped he will return one day. Obviously, treatment usually begins by the admission of the offender to an institution. This is indicated on both therapeutic and social grounds. As will be contended at greater length later, it is most important that during the entire treatment period with the outside world be maintained as much as possible. After all, the main purpose of a committal order – this is laid down in the Act – is to prepare the offender for his return to normal society. A prolonged stay in an institution is not conducive to this. Unfortunately, in serious cases it cannot at present be avoided.

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1. The Criminal Code still contains this outdated name. Nowadays it is called a psychiatric hospital or centre.
III. Some figures
About 40,000 criminal sentences are passed annually, and approximately 12,000 prison sentences are carried out. In recent years about 100 persons a year have been ordered to await the Government’s pleasure, including a number of suspended committal orders subsequently executed. Considerably more T.B.R. orders were made in the period between 1947 and 1960 than there have been since.

Table 1. T.B.R. orders

<table>
<thead>
<tr>
<th>Year</th>
<th>Combined with</th>
<th>Converted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>after dismissal</td>
<td>penalty</td>
<td>suspended T.B.R. orders</td>
</tr>
<tr>
<td>1905</td>
<td>14</td>
<td>128</td>
<td>41</td>
</tr>
<tr>
<td>1966</td>
<td>16</td>
<td>114</td>
<td>43</td>
</tr>
<tr>
<td>1967</td>
<td>16</td>
<td>119</td>
<td>29</td>
</tr>
<tr>
<td>1968</td>
<td>29</td>
<td>122</td>
<td>25</td>
</tr>
<tr>
<td>1968</td>
<td>23</td>
<td>107</td>
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</tr>
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<td>1970</td>
<td>14</td>
<td>64</td>
<td>22</td>
</tr>
<tr>
<td>1971</td>
<td>10</td>
<td>114</td>
<td>15</td>
</tr>
<tr>
<td>1972</td>
<td>14</td>
<td>61</td>
<td>14</td>
</tr>
<tr>
<td>1973</td>
<td>14</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>1974</td>
<td>16</td>
<td>70</td>
<td>14</td>
</tr>
<tr>
<td>1975</td>
<td>13</td>
<td>68</td>
<td>10</td>
</tr>
<tr>
<td>1976</td>
<td>18</td>
<td>79</td>
<td>8</td>
</tr>
</tbody>
</table>

IV. The Offender
Offenders detained under a committal order may be divided into two categories according to their criminal past. On the one hand there are the habitual offenders, receiving a T.B.R. order not only on account of their latest crimes but also for a string of previous offences. The other group comprises the first offenders, those committed after their first offence; they are in the minority. Both groups consist almost exclusively of aggressive offenders guilty of serious crime. The group of habitual offenders also contains offenders against property and sexual offenders, giving us three groups altogether.

Table 2 compares the composition of the categories. (It should be noted that the figures are drawn up on the basis of the criminal offences for which the T.B.R. order was imposed. The offenders’ ‘criminality’ is actually many-sided.)

Table 2. Offenders on committal orders detained in institutions from 1971 to 1975, classified according to the offence

<table>
<thead>
<tr>
<th>Year</th>
<th>Offences against property</th>
<th>Crimes of violence</th>
<th>Sexual offences</th>
<th>Other offences</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>End 1971</td>
<td>311</td>
<td>43</td>
<td>186</td>
<td>26</td>
<td>190</td>
<td>26</td>
</tr>
<tr>
<td>End 1972</td>
<td>238</td>
<td>38</td>
<td>193</td>
<td>31</td>
<td>151</td>
<td>24</td>
</tr>
<tr>
<td>End 1973</td>
<td>162</td>
<td>35</td>
<td>191</td>
<td>37</td>
<td>130</td>
<td>25</td>
</tr>
<tr>
<td>End 1974</td>
<td>132</td>
<td>30</td>
<td>135</td>
<td>42</td>
<td>104</td>
<td>24</td>
</tr>
<tr>
<td>End 1975</td>
<td>100</td>
<td>25</td>
<td>193</td>
<td>47</td>
<td>88</td>
<td>24</td>
</tr>
</tbody>
</table>

It is clear from the foregoing that many of the offenders committed on a T.B.R. order have already served other sentences, including imprisonment. This fact often hampers effective therapy. A checkered criminal record, frequently going back to the offender’s youth, does not make him pre-eminently disposed to cooperate in ‘compulsory treatment’ imposed, once more, by a criminal court. The offender will usually have a great aversion to the strong arm of the law and he will have to be won over before any treatment can produce results. Moreover many offenders committed for treatment find it very difficult to accept the role of patient and to admit that here is anything wrong with them. From the point of view of treatment and crime prevention it would be more efficient not to wait until other measures have proved ineffective before committing offenders for treatment. Such action would scarcely be possible, however, while the law retains the condition that the interest of public order must demand it. This imposes obvious restrictions. The law regards T.B.R. as a drastic measure and does not wish to see it treated lightly.

The term ‘psychopath’ is used in common parlance to denote those made subject to a T.B.R. order. Apart from its various emotional connotations this use of the word is not covered by any medical definition of the term ‘psychopath’. At most the legal use of the word can be justified as denoting any offender to whom the Psychopath Acts are declared applicable, thus including those made subject to a T.B.R. order suffering from a mental disorder.
other than what could be medically diagnosed as psychopathy, such as mental defectives, psychotics, neurotics, epileptics, etc. Conversely there are many psychopaths in the medical sense who are not delinquent, or at least have not been committed for treatment. A very considerable proportion of offenders committed under a T.B.R. order have developed behavioural disorders as a result of character disorders stemming from serious emotional neglect in early childhood.

V. Execution of the T.B.R. order

Altogether three authorities are concerned with the execution of a T.B.R. order: the court, the Government and the institution giving treatment.

To ensure the smoothest possible execution of the order each authority must have an appreciation of the functions of the others. There can be no effective cooperation without it.

The judiciary

The court has sole right of 'handing over' the offender. Only by a decision of the court can an offender be subjected to compulsory treatment and the court will reach that decision only after careful consideration of the relevant facts. At least once every two years, for each case, the court has to decide whether the order is to be extended. In principle, the same criteria apply as were used in the initial decision. Needless to say the offender's condition will be a major consideration and the opinion of the institution treating him will carry much weight.

The aforementioned Bill proposes several modifications to the existing system of prolonging the order. The regulations at present in force contain some obvious shortcomings, particularly where the machinery for consultation on T.B.R. extension is concerned.

The court which made the original order is, as a permanent authority, also responsible for periodic decisions on whether or not to extend the term of the order. The place of detention, on the other hand, is a variable factor, owing to frequent transfers from one institution to another. The court has to deal with different advisers all the time, often at a considerable distance. This sometimes hampers effective communication, which is necessary, especially in the more complicated cases, in which a variety of interests and responsibilities must be given careful consideration. The present proposal, therefore, is to have the District Court of the area in which the patient is being treated at the time deal with the matter of prolonging the detention, so that there will be closer cooperation between public prosecutor and court on the one hand and the institutions treating the patient on the other. In determining whether or not the order should be extended by a year or two, essentially the same interests are at stake as when the order was initially made. If the order is to serve a useful purpose, treatment will generally have to be continued until it can be assumed with a reasonable degree of certainty that the patient will be able to live a normal life in society without undue risk. Nor must we be blind to the magnitude of every new decision to extend an order. A basic human right is also at stake: that of individual freedom. Extensions to committal orders must therefore be accompanied by the necessary legal safeguards.

With this in view the aforementioned Bill on Detention at the Governor's Pleasure proposes that offenders in institutions, if they so wish, be allowed the services of a legal adviser when the public prosecutor applies to the court for an extension of the order. In addition, the Bill empowers the court to assign a legal adviser if the offender is without one. If the application is granted and the court orders an extended term the offender would then be able to appeal to a higher court which will centralise such appeal cases. Of course, the public prosecutor would then in his turn be able to appeal against a court decision which rejected an application that had already been granted.

The Government

The Government is solely responsible for the execution of a T.B.R. order. The task is delegated to the Minister of Justice, and special departments of the Ministry, T.B.R. Policy and the Management and Staff Affairs sector, assist him in this. This Branch, together with the Prison Service and the Probation and After-Care Branch, is part of the organisational structure of the Directorate for the Application of Criminal Law. The Minister also uses the services of a psychiatric adviser for the treatment of criminal psychopaths.
in one of these special institutions. Selection generally takes place at the Selection Institute in Utrecht.

There are two State institutions: the 'Dr. S. van Mesdag Clinic' in Groningen, which is the most heavily guarded centre for offenders in detention, and the 'Veldzicht' institution in Avereest. There are also five private institutions which under an agreement with the Government reserve most of their capacity for offenders on unconditional detention: the 'Dr. Henri van der Hoeven Clinic' in Utrecht (the most "closed" of the private institutions); the 'Prof. mr. W. P. J. Pompe Clinic' in Nijmegen; the 'Oldenkotte' Division of the Association of Institutions in Rekken (Vereniging Rekkense Inrichtingen) at Rekken; the 'Hoeve Boschoord' Institution for the Mentally disabled in Boschoord in the municipality of Vledder and the 'Groot Batelaar' Probation and After-Care Community which is an open centre.

The Ministry of Justice meets in full the costs of running these establishments.

The private institutions may also accept other types of patients: those conditionally pardoned or released and those sentenced by a Juvenile Court. Sections 47 and 120 of the Prisons Act allow for those sentenced to a term in prison to be admitted to the State and private TBR establishments on the grounds of their being mentally disturbed. In addition, offenders detained unconditionally may also be assigned to psychiatric institutions in the field of general mental health care. Numerous patients are being kept at the cost of the Ministry of Justice at the state Psychiatric Institution in Eindhoven. The capacity of the private TBR establishments i.e. the total number of beds minus the capacity of the sick bay and the separation and isolation units, ranges between 35 and 85. All centres for TBR detainees have been provisionally designated as institutions within the meaning of the Exceptional Medical Expenses (Compensation) Act, whilst the 'Dr. mr. W. P. J. Pompe Clinic' in Nijmegen have been designated "appointed institutions" within the meaning of Section 7, sub-section 2 of the Lunacy Act of 1884. Until recently the State Institutions took the majority of patients although the law expresses a preference for private care.

Nowadays the balance has shifted and slightly more than 50% of those in care are in private institutions. Architecturally State institutions are reminiscent of outdated prisons. However,

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The organisational chart of the Ministry, in so far as it is of importance, is shown below:

<table>
<thead>
<tr>
<th>Ministry of Justice</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Secretary for Justice</td>
</tr>
<tr>
<td>General Secretary</td>
</tr>
<tr>
<td>Deputy Secretary General</td>
</tr>
<tr>
<td>Psychiatric Adviser for offenders in detention</td>
</tr>
<tr>
<td>T.B.R. and Probation and After Care Department</td>
</tr>
<tr>
<td>T.B.R. Policy Sector</td>
</tr>
<tr>
<td>Production and After Care Policy Sector</td>
</tr>
<tr>
<td>Prison Directorate</td>
</tr>
<tr>
<td>Management and Staff Affairs Sector</td>
</tr>
</tbody>
</table>

The Ministry's responsibility is mainly an administrative one. The Ministry directs and controls policy-making and implementation, is responsible for continuity in the implementation of policy, takes decisions regarding the selection, admission and discharge of patients and provides the necessary financial resources. In addition, the Ministry 'keeps a record' of all the activities associated with the process of executing T.B.R. orders. In short, it is the machinery creating the right internal and external conditions to ensure the success of the measure. The Minister bears political responsibility for whatever is done on his orders in the treatment and nursing of patients.

The Institutions

The institutions treating the offender are the real implementers of a T.B.R. measure. It is their job to make the treatment meaningful, and treatment is nearly always begun with institutional care. The institutions should be regarded as a special type of psychiatric institution. They may be termed institutions of 'forensic psychiatry'.

After having been selected, offenders in detention may be placed
extensive reconstruction and modernisation is currently taking place. In the private sector the 'Dr. Henri van der Hoeven Clinic' and the 'Prof. mr. W. P. J. Pompe Clinic' are new buildings designed to take mentally disturbed offenders and therefore meet all the requirements of modern treatment.

When institutional treatment is no longer required, care of the offender becomes the responsibility of a rehabilitation and after-care organisation. As far as the Government is concerned the committal order has then been suspended, but in fact extra-mural treatment is continued for a time under the guidance of the National Probation and After-Care Association which has regional rehabilitation units specialised in socio-psychiatric guidance.

VI. T.B.R. viewed as a process
As soon as a committal order becomes final, the most suitable institution for the offender is decided upon. Full particulars of each patient must be available, and since 1952 the Selection Institute in Utrecht has performed a complete clinical personality test. On the basis of its report, the Minister of Justice decides in what institution the offender shall be placed. There are no fixed norms though a number of factors are always carefully considered. They are, for instance, the diagnosis of the personality disorder, the history of the social conflicts at work, the crimes committed, the danger of escape, the threat to the community and, of course, the most suitable treatment.

Patients who still constitute a serious danger to the community are in the main placed in the high-security State institutions. Patients are re-assessed and transferred at regular intervals for various reasons.

'A therapeutic environment'
Treatment in an institution is a particularly difficult and complicated business, to which a brochure such as the present cannot really do justice. One or two general remarks are perhaps called for. The principle is that forensic psychiatry provides the framework within which treatment is to take place. This means that the medical diagnosis of behavioural and personality disorders determines the therapy.

Psychiatry is continually developing and the institutions for offenders use some of the more modern methods of treatment, including various types of psycho-therapy, drug therapy, social therapy, creative therapy and movement therapy. The organisational pattern of the institutions as a social system, and the role assigned therein to the patients, are becoming increasingly important. The behavioural sciences, such as psychology and sociology, have been prime movers in the creation of institutional conditions usually termed 'therapeutic environment'. In the daily routine of the institutions the concepts of free activity, responsibility, social awareness, etc. are applied as much as possible. Understandably enough, heavy demands are made on all the staff, particularly those known as group leaders or social therapists, 'front line' workers in charge of the continuous supervision of groups of patients. Such staff are therefore carefully trained. They received their training in the schools of Social Work where they study psychology, psychiatry, sociology and criminology to give them a wide knowledge of the behavioural sciences which enable them to cope with their difficult work.

Progressive freedom
Working with offenders committed for treatment requires much tact and patience. Rapid results are rarely obtained. Allowance must be made for resistance on the part of the patient and repeated disappointments must not result in discouragement. Treatment is often a long process of trial and error. In accordance with the purpose of the T.B.R. order, treatment is designed systematically to achieve social rehabilitation and the return of the patient to a normal independent life. Obviously return to normal life cannot be achieved from one moment to the next. Many of the offenders have been cut off from the outside world for years and it is highly improbable that they would be able to maintain themselves if suddenly released from the institution. For this reason a system of progressive freedom is regarded as part of the treatment, and is used according to the individual progress of the patient. The amount of freedom granted is gradually increased and the success or failure is checked at every stage. The possibilities include escorted leave into town or to visit relations, attending sporting or other events, visits to 'adopted' families, leave of several days' duration for
visiting friends and acquaintances, transfer to the 'open department' of the institution, employment in industry during the day, etc. If favourable results are obtained application may be made to the Ministry to authorise the granting of a 'provisional release', whereby a link with the institution is maintained but the patient lives more or less independently in the community. If the provisional release proves successful the committal period is conditionally terminated and the after-care stage begins, in which the patient receives further support and assistance from the probation and after-care service until such time as the judicial authorities decide that the order need no longer be extended.
The Dr. Henri van der Hoeven Kliniek: Background and treatment credo

Sketch of Dutch penal practice
In the early part of 1974, the Dutch population numbered over 13.5 million - a very high population density, averaging 399 persons per square kilometre. This density figure contrasts sharply with that of the Dutch correctional en treatment institutions. In the same period, 2,856 people were detained, 2,503 of them in correctional en treatment institutions, 44.1 per cent of the former category were remand prisoners.

The treatment institutions comprise five private and two state institutions as well as the Selection Institute at Utrecht. The Selection Institute is a state institution which decides on the institution that is most appropriate for a mentally disturbed offender who has been sentenced. The decision is taken on the basis of very comprehensive reports, compiled by the staff of the institution, and of intensive observation carried out over a period of at least six weeks. An institution of this kind is necessary as the treatment institutions do not yet operate regionally, and also vary widely in treatment methods and facilities and in grades of security.

More than 80 per cent of the mentally disturbed offenders committed to the treatment institutions have gone there under a special penal measure, which came into force in 1929. When this measure is ordered, the offender is "placed at the disposal of the Government" (the literal translation of the relevant Act) for the purpose of treatment. In common parlance this measure is called "TBR", the abbreviation of the Dutch phrase.

The Court may impose a TBR when it presumes "diminished responsibility" of, in exceptional cases, "no responsibility" on the part of the accused. Psychiatric reports provide the basis for a judgement like this. But diminished responsibility is not enough for imposing a TBR: a serious crime (or a series of crimes) must have been committed and there must be an obvious risk of further criminality.

Under the present legal system the Court must impose a prison sentence if it presumes diminished responsibility. In addition the Court may order a TBR. The prison sentence must be served first. Only then, after the selection stage, does the treatment follow that was considered to be necessary. There is a Bill before Parliament at present which proposes to do away with this ambiguous system by dropping the obligation on the Court to impose a punitive sentence.

A TBR term lasts two years. At the end of this period - and, if applicable, at least every two years after that - the Court must decide whether to extend the order. Irrespective of the duration of the TBR term, the Government, i.e. the Ministry of Justice, has the right to terminate the order at any time. If they do so, a period of probationary leave and a period of conditional discharge precede the unconditional discharge from the TBR. During both periods supervision of the patient by a rehabilitation and after-care organisation is obligatory.

Overview of the treatment centre
The new Dr. Henri van der Hoeven Clinic is situated near the centre of Utrecht, a town in the central part of Holland with approximately 275,000 inhabitants. The clinic is one of the five private institutions for the treatment of mentally disturbed offenders. The new premises came into use in December 1974. Previously the clinic had been housed in a converted soft drink factory, a wooden prefabricated building and the inadequate wing of the Willem Arntsz Hospital, a large mental institution.

The Van der Hoeven Clinic, which was set up in 1955, is an autonomous unit of the Willem Arntsz Stichting, a non-profit making corporation that has been active in the field of mental health for more than 500 years now. The corporation operated in the city of Utrecht and its surroundings.
In 1955, the Willem Arntsz Stichting concluded a contract with the Dutch Government to establish a clinic for the treatment of mentally disturbed offenders. One hundred places were made available to the Ministry of Justice. The contract is still in force. It gives the Ministry the right to designate the persons to be treated; the Willem Arntsz Stichting is obliged to admit those persons unless they judge them unfit for treatment in the Van der Hoeven Clinic. Although the decision of the director of the clinic is final, she seldom exercises her right to refuse admission. The contract also includes provisions concerning the costs of building, fitting out and running the clinic; these costs are borne by the Government.

That the clinic is autonomous is demonstrated by the fact that the clinic is not controlled directly by the governing board of the corporation; since 1963 it has had a board of its own. A great deal of authority has been vested in the board of the clinic. Dr. Anne-Marie Roosenburg, a psychiatrist, is the head of the clinic; her deputy is Mr. H.L. Wiertsma, an economist.

At the moment, some 70 in-patients are being treated in the Van der Hoeven Clinic, which can accommodate 90 persons. The majority (80 per cent) of them have received an unconditional THW order. The legal reasons for the admission of the remainder vary. There is no age ceiling, but at present the oldest patient is 50 years old. 75 per cent of the patients are within the age range of 20 to 30; of this group another 75 per cent are 20 to 30 years old. The lowest age for admission is 16 (sometimes 17) years. The criminal records of the patients admitted include swindle, burglary, violence, sexual offences, infanticide, manslaughter, murder and other offences. Many of the patients have a record of combined offences such as burglary with indecent assault and stealing with arson.

The patients - at the moment some 60 men and 10 women - are divided into groups of eight to twelve. The members of each group have close contact with four group workers of both sexes. Most of the group workers are qualified personnel, social workers or general and/or psychiatric nurses.

In the new premises the groups are housed in units. There are four different units, three of them accommodating two groups each and one embodying three small groups. In the units the patients have their own bed-sitting rooms, which can be locked from the inside (in an emergency, the group workers can enter with the aid of a master key, though other patients have no access). The patients and group workers have a key to the door of their part of the unit; other persons wishing to enter have to ring the door-bell.

There is a regular staff of 110, both full-timers and part-timers. They help and stimulate the patients to carry out their individual treatment programmes. In addition there is a small group of persons, among them four sessional psychotherapists and some ten teachers (students from the university of Utrecht) who are paid for their services on an hourly basis.

The staff also includes those not directly involved in the treatment of the patients, such as the personnel officer, the accountant, four research workers, receptionists, secretaries, typists, two domestic superintendents, the gardener, the librarian and the public relations officer. There is no security staff. Although both internal and external security is given the utmost priority, it mainly finds its expression in a cautious handing-over of responsibilities to the patients and in prudent personal contacts with them. The new, purpose-built building makes security efforts easier: in any case it prevents the patients from absconding on impulse. Moreover, it is possible by means of a television monitor-system to lock the main inside doors electronically. The possibility of creating varying physical limitations increases the internal security and enables the staff to work efficiently. In the old clinic the staff had to carry a great number of keys about with them, and locking and unlocking doors was a very time-consuming business.
Development over the Last Twenty Years

The Van der Hoeven Clinic originated from a coincidence of the wishes and ideals of three interested parties. In 1949 the Psychiatric Observation Clinic of the Prison Department had been set up in Utrecht. It was no long before the then medical superintendent, the psychiatrist-lawyer Maa, and his closest assistants, Rosenberg, a psychiatrist, and Van Ralingen, a psychologist, started looking for ways in which they could themselves carry out the treatment recommendations they made in their reports for the Courts.

Medical superintendent Engelhard of the Willem Arntsz Stichting wanted a forensic psychiatry unit added to his institution; it fitted in with his ideal to concentrate a service for a variety of needs in a single organisation. The Ministry of Justice for its part was faced with both a shortage of places in existing institutions and a shortage of institutions with all-round treatment facilities. The concurrence of these desires resulted in the foundation of the Van der Hoeven Clinic in 1955.

Before the new institution began to operate, the management and staff familiarised themselves thoroughly with the experiences of foreign pioneers. They visited Dr. Main's Cassel Hospital and Maxwell Jones's institution in England; in France they saw Sivadon, Baumezon and Henry Ey.

Initially there were less than 20 patients and about 35 staff members. The clinic was only partly in working condition then. Intensive talks were conducted with the patients before they settled in. The talks were meant to involve the patients as much as possible in the management of the institution, in each other's welfare and in the setting up and carrying out their own treatment programmes. The emphasis on their own responsibility was something new and daunting to the patients. Most of them had had wide institutional experience from long stays in children's homes, borstals and prisons. Their responsibility had been completely taken away from them in these institutions, the 'do-end-them'-attitude had been rigorously maintained and there had been no personal relationships at all.

The talks with the patients produced a number of house rules: a consultative committee was also set up to represent the patients at regular meetings with the staff. A wide variety of committees, composed of patients and staff, were started: the financial committee for the management of the individual patient's income; the clothing committee which saw to it that the patients built up a reasonable wardrobe; the arbitration committee, which acted as peacemaker in conflicts between staff and patients and among patients themselves; the committee for culture and recreation, which was in charge of planning and financing cultural and other leisure activities; the workshop committee, for consultations on the atmosphere and conditions in the workshop and the domestic service, and on pay, merit-rating and the allocation of the jobs available.

The house rules (adapted according to experience and new circumstances), a regular consultative committee (which has changed several times as regards composition, terms of office and tasks; it now includes staff) and the committees are still operating.

At first only the restricted, traditional means of treatment of those days, i.e. psychotherapy and work therapy, were used. Actually it was not long before the phrase "work therapy" was replaced by "work training" because the aim was to train patients in proper skills instead of keeping them busy with simple work on the pretext of giving them therapy. The premises, which had been designed without consulting the originators of the treatment project, did not contain adequate room for work training. Accordingly the first annex was built as early as 1956. As regards psychotherapy, during the first few years individual psychotherapy was compulsory for every patient. There was also some group therapy, in which role-playing was used.
Within a few years education and sports were added to the psychotherapy and the work training, though on a small scale. The range of treatment facilities was to be extended over the years, not only because of the growth of the existing sectors (addiction of judo and swimming to the sports activities, of training in social skills and sex instruction to the education department and of married couples and family therapy to the types of therapy available), but also because of the adoption of new methods. The "creative subjects", especially, have expanded rapidly: at present there are teachers of modelling, sculpture, drawing, free expression, mine, crafts, music and drawing. Role-playing, psychodrama and simulation-play have become much used means of treatment. Though it had been considered important right from the beginning to involve the relatives and close friends of the patients, a larger staff and an increase in know-how made it possible to adopt a more efficient approach. A Protestant and a Roman Catholic minister of religion have also been on the staff from the very first.

The growing number of patients (from 20 to 70), the widening range of treatment facilities and accompanying increase in staff soon caused a serious lack of space. The purchase of the soft drink factory adjacent to the existing building, which brought forth a conference room, a gymnasium and a creativity room, relieved the situation somewhat. Further, part of the staff had their offices in a wooden prefab building during the years immediately preceding the move to the new clinic. Apart from the lack of space as such, the lack of space to satisfy the ever-growing demand was an obstacle to treatment. The original building contained, for example, open dormitories for 25 patients each; after some time these dormitories were divided into two, and later on they were sub divided up into small wooden cubicles to meet the justified claim of the patients to more privacy.

Slowly, the idea to set up a new, purpose-built clinic received a definite shape. A thoroughgoing process of thinking, organising and negotiating was started. The fine result is here before us today, and it offers an abundance of new possibilities, difficulties and incentives.

**Ideas and beliefs of our Treatment Credo**

I. "Society is a prerequisite for any programme of resocialisation."

The implications of this idea, as expressed by Dr. Roosenburg are:

- That an institution which aims to bring its patients back into society in the proper way should be situated within this society.

In other words, no idyllic setting in the countryside, but a location in a town of some size. This guarantees enough potential employers and "contact families" (families that volunteer to entertain a patient in their homes at regular intervals) to cope with the turnover of patients. It also guarantees a reasonable variety of clubs and youth centres.

- That running an institution means informing society about what you are doing and why you are doing it. The Van der Hoeven Clinic has from the very first been willing to receive visitors both from Holland and from abroad, it has answered numerous questions by letter, it has obliged broadcasting companies and the press and it has participated actively in congresses, both national and international. The Clinic was also the first institution to engage a special public relations officer.
All these activities have been based on the belief that resocialisation can only be achieved through the society in which the patient is to be placed. This society must be taken seriously if it is to show sufficient tolerance and understanding. This makes an extra demand on institutions which tend to alienate themselves from their environment by means of an inward-looking policy.

II. "The staff of an institution must only bear those responsibilities which the patients cannot bear themselves." It is the task of an institution like the Van der Hoeven Clinic to allow people who have shown irresponsible or noxious behaviour to develop in such a way that they will be able to take their places in society again without being a danger to others. To do this the institution must teach patients to bear responsibilities, both for themselves and for others. This is a most important point, to which constant attention should be given. The staff, influenced by tradition and conventional attitudes, keep wanting to play caring and protecting roles. This fits in with the need of many patients to be cared for and to get basic things in life done for them by others. Even if some patients do not feel such a need, many of them are accustomed to infantilizing treatment from previous stays in institutions. The staff's tendency to nurse and the patients' need to be nursed produce an infantile, hospitalizing atmosphere. This does not help patients to achieve an independent position in society.

Practical consequences of the second preposition are that:

- The patients are very much involved in the setting-up of their own treatment programmes and in evaluating the progress they make;
- They sit, as stated above, on a variety of consultative, advisory and decision-making committees, which take responsibility for the proper functioning of the whole clinic or part of it;
- The groups have to do their own household chores and obtain a housekeeping allowance in cash;
- The mending of broken windows or damaged furniture and the replacement of household utensils are automatically charged to the patients' accounts.

III. "To keep the harmful side-effects of the intramural treatment to a minimum the normal desires in life must as far as possible be kept intact." This means to us:

- That contact with the opposite sex is an everyday affair because of the composition not only of the staff but also of the patients in their house groups, the committees, therapy groups and workshop groups;
- That handling real money (i.e. no credit coupons and such like) is part of the daily life of the patients;
- That in the treatment sector more and more stress is put on the awareness of time; the fact that the TBR is actually of indefinite duration makes dividing the treatment programmes into phases especially important;
That all house rules must be subject to constant revision, since
the strong desire of both staff and patients for peace and order
tends to create a red tape organization, excluding all unexpected
events and leaving no room for individual initiative.

IV.

"Sixty patients are the ideal number for an institution for the
treatment of mentally disturbed offenders." Economists, financiers
and the building trade strongly urge the building of institutions
that can accommodate hundreds of patients. The argument that certain
economies of scale increase efficiency is valid for normal institutions,
but not for treatment centres, since large numbers of patients would
be disastrous for their treatment. They would reinforce the existing
"us and them" attitude and diminish the chances of building up the
necessary personal relationships. In addition the difficulty of supervising
the institution would reduce internal and external security.
The impersonal, factory-like climate would increase the duration of
the treatment; this would result in a decline in discharges. On the
other hand, an institution for some 20 or 30 patients would be equally
inadequate, since there would not be enough money to pay for large
buildings of staff with a sufficient variety of skills.

To the board of governors and the directors of the Van der Hoeven
Clinic sticking to proposition IV has meant a hard fight with the
subsidizing authorities, who had been instructed by their financial
and economic advisers. At last a compromise between "at least 200" and
"no more than 60" has been reached: 90 permanent places and twelve
places for intensive care and isolation.

Peter A.M. Hendriks
former staff co-operator for
information and documentation

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also in: "International Journal of
Offender Therapy and
Comparative Criminology",
1976, vol.20 no. 3
The Dr. Henri van der Hoeven-clinic, Utrecht, The Netherlands: The new building and the ideas which underlie it.
A.H. Roosenburg, Director.

**APPENDIX 15:**

A new clinic: Why?
In 1955 at the time when the first building of the Dr. Henri van der Hoeven-clinic was established none of the methods of treatment, which were slowly developing after World War II, had been applied to delinquents not voluntarily seeking treatment.
Neither the Institute for grouptherapy "Groot Batelaar", opened in 1953 by the Salvation Army, nor the Van der Hoeven-clinic had therefore been able to profit from the experience of others. As a consequence both institutions showed from the start shortcomings in the design of the building, distribution of space, and furnishings. These shortcomings increased with the development of treatment possibilities and with the higher living standard demanded generally by society-at-large.
In the 20 years which followed, these shortcomings were partially attended to and many plans were made. At first it was thought that a new building could be erected in the grounds of the Willem Arntsz Foundation in the centre of the old town. It was hoped that both the Willem Arntsz House (a mental hospital) and the Van der Hoeven-clinic would get new buildings there. However the Local Authority of Utrecht drew up redevelopment plans for the inner city in which the end of the Lange Nieuwstraat was rerouted. This made the previous plan impossible and a new building site had to be found.

The new clinic: Where?
With Dr. Engelhard and Dr. Hut, the medical directors of the Willem Arntsz Foundation under whose directorship in the 1950's the plans for the Van der Hoeven-clinic were successively finalised and realised, Dr. Baan shared the conviction that the clinic should be placed in the middle of the everyday community. Although the Willem Arntsz Foundation had ample grounds at its disposal in Den Dolder, building did not start before a small area behind the Willem Arntsz House could be cleared. In practice the situation of the building has proved to be ideal.
While looking for a new site the board and we - the staff involved - stubbornly rejected all offers of "attractive sites" in polders and even in a fort. We were vigorously supported by the section "Psychopatienzorg" and the psychiatric advisor of the Department of Justice. It goes without saying that it was no easy task for the Local Authority to find a site that could compare favourably with that behind the old hospital. We are thankful for the place in which the clinic is now situated. Although industrial and office buildings are now our nextdoor neighbours and we are pretty isolated in the evenings, at nights and at weekends, we have an easy access to the different city districts.

*The jurist and psychiatrist Baan was one of the founders and the first director of the clinic.*
The new clinic: For whom?

Dr. C. F. Engelhard, medical-director of the Willem Arntsz Foundation from 1926-1952, was of the opinion that the subdivision of psychiatry, which became more and more in vogue, in clinical psychiatry, social psychiatry, child psychiatry and also forensic psychiatry was an artificial one and harmful.

The task of a psychiatrist was, as he saw it, to assist people with psychic difficulties. And he perceived the Willem Arntsz Foundation as a foundation with the task of giving assistance in all areas of Public Mental Health. The out-patient department of the Foundation recognised therefore among their patients many delinquents who were in need of after-care and several after-care organisations had a consulting-hour in the Willem Arntsz House.

When the Department of Justice was looking for possible in-patient treatment facilities for offenders who they judged to need this type of care, it could convince the Board of Governors that the Foundation had a duty. Dutch law prefers private care above state care for the treatment of people detained in Her Majesty's Pleasure (Psychopatenreglement art. 2). The Willem Arntsz Foundation is one of the few private organisations which realised this preference.

The contract between the Willem Arntsz Foundation and the Department not only guarantees therapy places for delinquents detained in Her Majesty's Pleasure, but also for all others for whom the Department of Justice wants treatment facilities. So it is possible to admit people sentenced to a penal institution or sentenced to undergo treatment with the alternative of prison in default, young people ordered by the Juvenile Court and even those subject to deferred sentences.

The new clinic: How?

What now is wrong with these people for whom the Department wants treatment facilities and what is needed to help them? It concerns people whose behaviour in the eyes of the courts has posed unacceptable risks; about whom there is the expectation that their behaviour will not be corrected through the usual sentences, but will go on endangering persons or property. These expectations are normally based on a social and psychiatric, or psychological report covering the history of the patient and the present situation.

We have never set eyes on a report in which the offence leading to the recognition that treatment was necessary suddenly seemed to emerge within a reasonable harmonious life.

On the contrary, the reports almost without exception describe very unsettled living-patterns frequently with a strange monotonous repetition of behaviour and failures; and, as response, an often monotonous reaction by other individuals and agencies. Again and again when we try to discuss

* In the Netherlands this type of measure with which the State receives the task to treat special delinquents can be used by the court in case of declared diminished responsibility or irresponsibility for the crime committed.
this with the patients we find an incapacity to change this behaviour, the inability to ask for help with this, or even the inability to recognize this behaviour and its consequences; although for an outsider it seems so clear.

In general it seems that patients have not been able to achieve satisfactory personal relationships, and the crimes are often the result of an inadequate effort to realize these or the result of all kinds of emotions when these efforts fail.

The aim of the treatment cannot only be to stop the interaction harmful both for the patient and for others. If one does not succeed to reach a for him more satisfying interaction, then it will be inevitable that the patient, who will attempt all the same to occupy an own place among others, will relapse into his old and thus disruptive behaviour. Now his removal from the free community is thought necessary, the clinic will have to offer him the chance to face up to his share in the development of the collisions in society which have led to his admission. And he will only be able to look at himself seriously when he feels reasonably safe.

If it is not possible to achieve this, then all that can be expected is self-defence and egocentric self-preservation. It is exactly the feeling of being safe which seems to be missing in these patients. Again and again one hears the complaint that they cannot trust anyone in spite of the longing to do so. One difficulty is that they cannot cope with the consequence of such trust, namely to be trustworthy themselves. For those who have a long experience of institutionalisation this can be a rather unusual frame of mind, used as they are to conforming to the expectations of the staff and to displaying a sort of sham-reliability among themselves within the subculture of the institution.

The illusion of two worlds, namely that of the powerless patient and that of the powerful staff is a seductive illusion, especially when the consequences of working together on a basis of trust become heavy to bear and demand a new attitude of mind. Researchers like Coffman have made it clear that the classic institutions offer little suitable space to develop new personal behaviour.

The institution is a necessary evil, it is necessary but also evil. We were bound therefore to try and minimize the harmful side effects of admission to an institution and not to exclude, through the manner of organizing ourselves, the possibilities for varied behaviour as are offered in society.

This has led to architectural provisions in which there are training grounds for the development of personal, mental and physical talents, and this has also led to the creation of a living area in which together one can learn to live with others while preserving one's own personal sphere.

But, however well designed the architectural provisions, the climate of a "total institution" could in our opinion only be avoided if we would take our conviction seriously that members of staff should not do more for patients than that which they can not do themselves. To achieve this we made changes in the day to day living arrangements. Out of the nursing costs were set aside those amounts which were earmarked for cold meals, cleaning and upkeep of living and sleeping quarters, depreciation of the furniture of the patients' own rooms etc. These sums have been placed at the disposal of the patients with the instruction to provide themselves with the items which the money was intended for.
Of course certain requirements have to be met as to furnishing and care of the house, and there are checks which have consequences attached to them. For a new patient this means that the room which is allotted to him is unfurnished and has no curtains. Immediately on the day of his arrival it is up to him how he wants to arrange his room. Does he want to use the available funds to buy furniture on hire-purchase, and if so what kind of furniture? Or will he have furniture sent to him from home and put the money aside for something else?

For the cold meals one has the choice of buying food with a group or individually. In this one has to balance the consequences of having to trust others and maybe granting someone a bit more, against the advantages of buying cheaper in bulk.

The fact that each patient can lock the door of his own room from the inside is one of the factors which made it at least possible for men and women to live together in a group. Now it is not anymore the staff, but the patients themselves who have to see to it that no undesirable visitors can come in the night. And with that it has become clear how difficult it is to define one’s position about this.

Of course learning to deal with others more carefully than one used to, includes a continuous concern with the safety of patients and staff within the clinic, just as with the safety for the outside community. Especially in this clinic the attention of patients and staff is often focussed on that issue. Maybe it is interesting to note that our principle that staff should only do that which can not be fruitfully done by patients has led to a larger choice of work-training placements for the patients. This means that in the kitchen there is only one cook who manages all the meals and the budgeting with the patients and who also plans the menus with the patients. The maintenance staff, the domestic service, the administration, the storeroom and the gardener also provide jobs for patients. The shop within the house is partially managed by a patient.

Design of the new clinic.

Only after the situation and shape of the building site became known it was possible to convert the program of demands into a design for a new building. It makes a big difference if a site possesses in part a natural boundary, if it is enclosed by houses or, as is the case in question, lies free to all directions and borders on an estate with industrial and office buildings.

It has been especially the sociologist Jessen who in the last years of his life, first while working in the clinic, later in addition to his lectorship in Groningen, has acted as adviser to the architects and assisted them in finding appropriate designs.

The buildings are situated along the outside of the grounds. In this way a spacious inner garden is created which is not broken up and is surrounded quite naturally by buildings with a minimum height of 6 meter. This is necessary in our opinion because the behaviour of some of the patients constitutes for a considerable time, even during treatment, a risk too great for the society outside. In the old, so much more cramped, building we experienced the oppression which lack of space and want of privacy give, especially to those who are totally dependant on facilities within the clinic. There it was rather easy for the patients to escape from that oppression. Keys were copied and circulated and it was a trifle to open a window.
In this new building we have tried to prevent this impulsive running away without aiming for absolute security. Breaking out has been made more difficult, not impossible, by fitting reinforced glass on the outside of those buildings which patients use, accompanied or alone. One has to wait and see if these solutions give the best results; it is possible that improvements have to be made.

The building contains 4 parts:

a) The part in which the patients normally move freely without encountering locked doors.
There are 4 "houses", 3 of which are occupied by two groups in each of which 11 or 12 patients live together.
Each group has at its disposal 2 sitting rooms with doors opening to the garden, kitchen facilities, cloakroom and toilets. Besides this each group has a first floor unit with a single room for each patient. Each patient has a key which fits the front door of his group and the door of his own personal room. The 4th "house" has the same facilities but then for 3 smaller groups of 7 patients living together. The area in which the patients can move freely also includes: the enclosed garden and the wing in which are situated meeting-rooms for the council of patients, space for leisure activities, the hairdresser and the shop.
This is the first layer of building; garden, "houses" and in between what is called the social wing, the wing in which there are all kind of leisure provisions. In normal circumstances nothing is locked here. If it becomes necessary for reasons of safety then it is possible to sectionalize this area at several points.

b) The second part.
This is the part in which the patients with the assistance of the staff work at their treatment programs of development.
In this category belong the sportscomplex, the different craftworkshops, the recreation hall with side rooms, the education department, the room for pastoral care, the room of the career guidance councillor, those of the psychotherapists, rooms for grouptherapy with or without one-way screens and possibility of video recording, the trade workshops, the kitchen and the doctors' surgery.
Apart, above the wing for leisure activities, lies the intensive care unit for patients whose behaviour shows a pattern of repetition which is maintained because the reactions which they provoke in others with whom they come into contact, are precisely those which again strengthen and confirm their own. If in the group in which they live the other patients keep showing the expected reactions then it might be necessary to take them into a much more controlled environment in which this can be avoided.
The unit does not only offer the opportunity to introduce within the living-space of a patient those limits which are necessary for his treatment but also to enlarge this living-space again in a controlled manner. Patients admitted there sometimes seem to be able to go through a very rapid phase of development when they are not able to provoke their surroundings into the usual reactions to their behaviour; provided that there is an intensive program specially tailored to their capabilities.
Besides these patients it is possible to admit to this unit those for whom living in a group is too disorientating and confusing; for instance a new patient.
Finally there is a small ward for the care of the physically ill.

c) The third part of the clinic is that in which no patient should come; the part in which is located the necessary office space for staff members.

d) The fourth part, finally, could be called "between inside and outside". Here are situated the rooms of those staff members who maintain and stimulate contact with the outside world, and it is possible to receive here those relatives whose presence is not desirable where patients have freedom of movement. Here also are the small flats and guestrooms which for us in this clinic are a novelty. It offers the patients the possibility to receive their relations in a much more personal manner than would be possible within the group they live with.

Just imagine a couple that has to live apart because one of the partners has to receive in-patient treatment. In a flat, perhaps with children and other family members for whom one can rent a guestroom, they are able to cook for themselves, maybe receive visitors by themselves, occupy themselves with their children; in short, experience what being together really means. If intensive supervision or treatment of the family is necessary, then there are all the other facilities of the clinic near at hand. For patients who possess a long history of institutionalisation and a poor knowledge of society the threshold to this society is often a very high one. These patients so used to institutions find it hard to live without the supervision and continuous presence of others. They are not used to taking part in other forms of companionship and family life. A temporary stay in a guestroom or flat as half-way house can for them be a useful transition.

Maybe it seems that some parts have been designed rather too spacious for the 90 patients who are being treated here. That is quite true, and it might provoke amazement that those parts have become so beautiful exactly because we did not want to push up the nursing cost higher than necessary. We found that it is very important for the treatment of our patients to have a large choice of possible lessons in creative subjects and in sport. We thought it necessary to provide an own swimming pool, a gymnasium and a judo hall. We also needed a recreation hall where, on occasions, all those who are treated in the clinic and those who work there can come together with or without relations. Of course provisions like these will make any building expensive for such a small number of patients. Besides one does not use them 7 days a week, all working hours of the day. As a consequence they frequently stand empty. We looked into the possibility of making them useful for the neighbourhood in which the building would be situated and so justify their construction. We found a great shortage of teaching pools, gymnasia and of halls suitable for different types of meetings. By taking into account the demands of future patrons these rooms turned out more beautiful and better equipped than might have been justifiable for the use of our patients alone. At the same time the income out of rent seems to it that the nursing cost is less burdened than would have been the case if the design was more modest. The sceptics in the Department of Health who suspected that we were just trying to press through a rather too fancy clinic are without doubt reassured by the knowledge that we have been able to let the swimming pool already to O.A.P.'s, a neighbourhood club, a swimming club and a teacher-training-college. The gymnasium has been let for a large number of hours to two primary schools nearby.
The usefulness of the building for the neighbourhood has, of course, a totally different aspect besides the financial one. Because of it it has become easier to discuss the work which we do with our patients. We hope that overcapacity of any kind can be made beneficial to the community we work in. Talks are thus in progress with different bodies about possible day-nursing and work-training facilities for others than our own patients.

The attached map intends to give a global impression of the spatial distribution of all these elements which together make the building of the Dr. W. van der Hoeven-clinic.

May 1975. (speech at the official opening of the new building by dr. Roosenburg).

Dr. Henri van der Hoevenkliniek
Willem Dreeslaan 2
Utrecht
Holland
Tel. 030 - 716822
1. Porter's lodge, central control station
2. Reception rooms, corridor between inside and outside social work for outside contacts
3. Hall for general meetings
4. Foyer
5. Physician and dentist
6. Shop
7. Hairdresser
8. Hobbyroom
9. Library
10. General coordinator
11. Meeting room, clinic, council
12. Central kitchen
13. Canteen
14. Factory (metal)
15. Laundry (self-service)
16. Church
17. Music room
18. Drawing room
19. Mime-studio
20. Workshop
21. Swimming pool + sauna
22. Living units
23. Garden
24. Service court
Symposium 13

Treatment results at the Dr. Henri van der Hoeven Clinic, Utrecht, The Netherlands

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INTRODUCTION

The Netherlands has 2 State institutions and 5 private ones where criminals can be sent if they are considered by a court to be not at all or only partially responsible for their crimes. Besides punishing such persons, it is possible to place them at the disposal of the Government for compulsory treatment, although only if this measure is considered essential in the interest of the safety of society.

The court is obliged to review the situation at least every other year to determine whether it is necessary to prolong the measure. It seeks advice from the institution where the person in question is undergoing treatment. It is also possible for a person who cannot be held responsible for his crime to be sent directly to a mental hospital without being punished in advance. The following figures may give an idea of the position in The Netherlands:

The total population numbers over 13 million. The prison and remand prison population from day to day is approximately 2,900, some 1,250 of these being detained pending trial. Roughly speaking, 70 persons placed at the disposal of the Government receive treatment in mental hospitals, 250 are cared for at State Asylums and 300 at private institutions. Some of the latter institutions, including the Dr. van der Hoeven Clinic, take not only patients who have been committed to Government care unconditionally, but also patients who are under suspended sentence or subject to a suspended measure and even, should it be necessary, persons sentenced to prison.

There are usually 70 to 80 patients at the Dr. van der Hoeven Clinic, about 8 of whom are women. It is a rather open institution and patients can walk out fairly easily. The hospital offers a wide variety of treatment and an extensive resocialization programme. The transition from being under complete institutional care to having unlimited freedom in the community can be arranged in various forms by the hospital. If a patient who is about to return to the community not only works outside the hospital but lives outside as well, the hospital may advise the Minister to grant him probationary leave. From then onwards, although the hospital retains ultimate responsibility for him, the patient will be cared for by a probation and after-care association. If all goes well during his probationary leave, the patient will then be discharged conditionally at the recommendation of the probation and after-care association, which takes over responsibility from the hospital.
If nothing inappropriate occurs during the period of conditional discharge, the probation and after-care association may ultimately recommend that he be granted full discharge from Government care.

A question repeatedly asked by visitors to the Dr. van der Hoeven Clinic, and probably to any other institution for mentally disturbed criminals, is: What are the results of treatment? It is one of the most difficult questions to answer.

RESULTS OF TREATMENT

When is treatment successful? Obviously the criterion should not be whether or not committal to the care of the Government can be terminated; at what point this measure will be terminated depends largely on the advice of the superintendent of the institution concerned. As a rule, the court follows the advice of the institutions. The policy regarding advice is apt to differ from one institution to another; some advise termination much sooner than others. This means that, if the criterion for success of treatment were to be whether or not the measure was terminated, the institutions would, to a certain extent, be able to determine themselves whether or not their treatment has been successful.

However, it would not always be the case, since there appears to be a tendency for certain courts to commit criminals to Government care for no longer than the prison term to which they would otherwise have been sentenced for the offence for which the measure is imposed. Some courts appear to be less afraid of the risks involved in termination than others. This means that if one of these courts has to decide on prolongation, the measure is likely to be terminated while a patient is still undergoing treatment or shortly after he has been given probationary leave (PL) or is discharged conditionally (CD). Here again, there would be little point in applying the above criterion.

It is more usual, and better we think, to base the choice of criterion on data concerning the occurrence of new crimes. Treatment can then be regarded as successful if a patient leaving an institution commits no new offence within a certain period after his departure. The only question then is how long the test period should last. It could be a fixed period, e.g. 5 years, but the tendency to repeat an offence appears to vary. For example, on the whole crimes against property are likely to be repeated sooner than sexual offences, although obviously we only know of the offences that come to light. In deciding on the length of the test period we shall therefore have to take into account the varying degree to which different types of criminals are likely to repeat their offences. Too little is known in this respect. On the other hand, the fact that a patient repeats an offence does not necessarily mean that treatment has been a failure. Perhaps the offence he commits will be less serious. Perhaps his relapses will be less frequent and perhaps on the whole he will be better able to fit into the community.

Another point is that if a patient does not relapse after treatment, we cannot automatically regard this as being a result of the treatment itself. He may simply be a little older and wiser. Or perhaps the duration of the treatment is a decisive factor, and particularly the deprivation of liberty it involves. Moreover, we must remember, that, on the one hand, a considerable number of patients will already have been treated elsewhere, and, on the other, many are likely to go on to other institutions before returning to the community. Hence in many cases the result of treatment is likely to depend on the combined efforts of several institutions. This will certainly have to be taken into consideration when assessing and comparing results at the various institutions.

Obviously it would be possible for the time being to confine our comparative research on treatment results to patients who have undergone treatment at one institution only.
We could try to find out how many of that particular group repeated their offences after treatment. But whether or not offences are repeated depends on a number of factors which, for the time being, are largely unknown.

If we wish to compare the degree of success achieved by treatment at the various institutions, we shall first have to ensure that the patient population at each one is equally likely to repeat its offences. For this reason there would appear, at present, to be little use in comparing results of treatment at the various institutions.

**SUCCESS OF TREATMENT AT AN INSTITUTION**

Whether or not treatment at a particular institution is successful does not usually mean whether or not any of its patients succeed in returning to the community. The important thing in most cases is *how many* patients succeed in returning, what is the percentage and how can we calculate it.

In the period from 1955 to 1968, 338 male patients were admitted to the Dr. van der Hoeven Clinic (as well as 48 women, whom we shall disregard in this paper). On 1.7.70, 116 had been on probationary leave from the hospital at some time or other. There were still 19 patients of this group at the hospital. Two patients had died in the meantime. Of the remaining 201, 9 were granted probationary leave later on. Treatment of 21 patients was terminated by the court before we advised probationary leave, 94 patients were transferred to other institutions and 77 left without consent and somehow did not come back.

Supposing all 116 patients who where given probationary leave had remained at liberty without repeating their offences (which in fact was not the case), what would have been the percentage of successful treatment? Assuming the criterion to be recurrence of the offence, 116 out of 338 patients were successful, i.e. 34%. Perhaps it would be more accurate to disregard the 19 patients still at the hospital, as well as the 2 who died. In that case, 116 out of 317 were successful, i.e. 37%. Or perhaps we should also disregard the 94 patients who were transferred, most of them fairly soon, and the 77 patients who walked out without returning. In that case, 116 out of 146 were successful, i.e. 79%. If we also disregard patients who were 'dismissed' by the court, as well as those who were given probationary leave later on, the percentage of those who were successful rises to 100. Each one of these percentages is calculated correctly.

As stated above, if we want to find out how successful treatment is at a particular institution, it is important to know who has been admitted to the institution and whose treatment has been completed successfully. As we shall see later on, the 116 patients who were given probationary leave from the clinic at some time or other formed a ‘positive’ selection out of all the patients admitted. In fact, the patients who were given probationary leave from the hospital differed in numerous respects from those who walked out or were transferred. This will have to be taken into account when interpreting the results of the hospital as given below.

The remainder of this article consists of a report on the outcome of research into the results of treatment at the Dr. van der Hoeven Clinic. In view of the foregoing, we need not emphasize that it should be read with the necessary reserve.

**IS THE PI GROUP A SELECTION?**

In attempting to find out whether or not treatment at the hospital was successful we shall base ourselves on the 116 patients who went on probationary leave. The first question that arises is: Was this group a selection out of all the patients admitted?
In a previous study (Jessen, 1961) on patients who walked out, we remarked that patients who have at some time or other been 'long absent without leave' (LAWL) differ from the rest. 'Absence without leave' (AWL) includes leaving the clinic without permission, failing to return on time from short leave (weekend leave etc.) or spending leave elsewhere than arranged. For example, a patient who was allowed to go home might spend his leave staying with friends. 'Long absence without leave' means that a patient is still absent at 5 o'clock in the morning.

LAWL patients spent shorter periods at the hospital. They were transferred more often. A number of them did not return after they had been LAWL for the first time. As seen from Table 1, LAWL patients evidently had less chance of completing their treatment at the hospital or of ending up with probationary leave. We might well assume that if we were to compare PL and non-PL patients, we should find differences similar to those resulting from a comparison between LAWL and non-LAWL patients.

Column A of Table 4 gives a list of the differences between the PL and non-PL groups (indicated as PL and NPL) for a number of the main variables in our investigation into 'absence without leave'. Column A of Table 3 shows the significant differences, i.e. those that cannot be attributed to chance factors. This applies in no fewer than 11 of the 22 variables chosen.

The conclusion is inevitable — there is a difference between the PL and NPL groups.

Sometimes individual variables show no differences, whereas a combination produces a very different picture. Partly for this reason, and also to find simple predictors, we tried to find a few variables in our 'absence without leave' investigation which would enable us to predict the difference between the LAWL and non-LAWL groups as accurately as possible. The 4 predictors we found and their b weights (which are used to determine the weight of the variables) were:

- age at first commitment to Government care (under 30) 32
- crimes against property 22
- running away from institutions after the age of 17 19
- running away from home 17

On the grounds of these 4 predictors a total score was worked out for each patient. A patient placed at the disposal of the Government before the age of 30 was given 32 points, a patient who had run away from home 17, etc. The maximum total score for one person was 90. By comparing the PL and non-PL groups we obtained the picture shown in Tables 2, 3 and 4. Patients with a higher score and usually with a less favourable case history have less chance of going on probationary leave from the hospital. Hence the PL group is clearly a selection.

### Table 1: LAWL and probationary leave

<table>
<thead>
<tr>
<th></th>
<th>LAWL</th>
<th>Non-LAWL</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>PL</td>
<td>70</td>
<td>46</td>
<td>116</td>
</tr>
<tr>
<td>Non-PL</td>
<td>167</td>
<td>55</td>
<td>222</td>
</tr>
<tr>
<td>Total</td>
<td>237</td>
<td>101</td>
<td>338</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 8.05, \quad p < 0.01 \]
## INSTITUTIONAL TREATMENT OF VIOLENT OFFENDERS

### TABLE 2
Comparative Scores for PL and non-PL Groups

<table>
<thead>
<tr>
<th>Score</th>
<th>PL</th>
<th>NPL</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>abs.</td>
<td>%</td>
<td>abs.</td>
</tr>
<tr>
<td>0 - 13</td>
<td>41</td>
<td>47</td>
<td>88</td>
</tr>
<tr>
<td>14 - 33</td>
<td>41</td>
<td>41</td>
<td>82</td>
</tr>
<tr>
<td>34 - 63</td>
<td>23</td>
<td>23</td>
<td>46</td>
</tr>
<tr>
<td>64 - 93</td>
<td>11</td>
<td>33</td>
<td>44</td>
</tr>
<tr>
<td>Total</td>
<td>116</td>
<td>34</td>
<td>222</td>
</tr>
</tbody>
</table>

χ² = 16.50, p < 0.001.

### TABLE 3
List of values found for χ² in Table 4

<table>
<thead>
<tr>
<th>Variable</th>
<th>A/B/PL</th>
<th>B/L/NL</th>
<th>C/R/NR</th>
<th>D/R/NR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.34 ns</td>
<td>4.44 xx</td>
<td>0.89 ns</td>
<td>1.30 ns</td>
</tr>
<tr>
<td>2</td>
<td>2.69 ns</td>
<td>7.03 xx</td>
<td>1.46 ns</td>
<td>1.27 ns</td>
</tr>
<tr>
<td>3</td>
<td>0.07 ns</td>
<td>4.70 x</td>
<td>1.46 ns</td>
<td>1.75 ns</td>
</tr>
<tr>
<td>4</td>
<td>4.25 x</td>
<td>0.07 ns</td>
<td>0.75 ns</td>
<td>0.75 ns</td>
</tr>
<tr>
<td>5</td>
<td>2.11 ns</td>
<td>0.21 ns</td>
<td>0.30 ns</td>
<td>0.30 ns</td>
</tr>
<tr>
<td>6</td>
<td>2.45 x</td>
<td>9.73 xx</td>
<td>3.63 ns</td>
<td>6.60 x</td>
</tr>
<tr>
<td>7</td>
<td>7.6 x</td>
<td>2.00 xs</td>
<td>0.17 ns</td>
<td>0.42 ns</td>
</tr>
<tr>
<td>8</td>
<td>0.17 ns</td>
<td>3.97 x</td>
<td>0.17 ns</td>
<td>0.99 ns</td>
</tr>
<tr>
<td>9</td>
<td>15.27 xxx</td>
<td>13.11 xxx</td>
<td>0.21 ns</td>
<td>0.81 ns</td>
</tr>
<tr>
<td>10</td>
<td>20.12 xxx</td>
<td>6.68 xx</td>
<td>0.12 ns</td>
<td>0.62 ns</td>
</tr>
<tr>
<td>11</td>
<td>12.96 xxx</td>
<td>13.49 xxx</td>
<td>2.40 ns</td>
<td>3.45 ns</td>
</tr>
<tr>
<td>12</td>
<td>13.49 xxx</td>
<td>12.54 xxx</td>
<td>2.40 ns</td>
<td>3.45 ns</td>
</tr>
<tr>
<td>13</td>
<td>9.49 xx</td>
<td>20.01 xxx</td>
<td>0.04 ns</td>
<td>0.24 ns</td>
</tr>
<tr>
<td>14</td>
<td>2.39 ns</td>
<td>15.28 xxx</td>
<td>2.81 ns</td>
<td>4.37 x</td>
</tr>
<tr>
<td>15</td>
<td>7.71 xx</td>
<td>13.87 xxx</td>
<td>2.59 ns</td>
<td>3.52 ns</td>
</tr>
<tr>
<td>16</td>
<td>0.07 ns</td>
<td>2.90 ns</td>
<td>0.17 ns</td>
<td>0.28 ns</td>
</tr>
<tr>
<td>17</td>
<td>1.84 ns</td>
<td>2.04 ns</td>
<td>1.71 ns</td>
<td>2.09 ns</td>
</tr>
<tr>
<td>18</td>
<td>3.80 ns</td>
<td>1.94 ns</td>
<td>0.12 ns</td>
<td>0.00 ns</td>
</tr>
<tr>
<td>19</td>
<td>3.80 ns</td>
<td>3.22 ns</td>
<td>2.36 ns</td>
<td>2.28 ns</td>
</tr>
<tr>
<td>20</td>
<td>7.05 xx</td>
<td>1.44 ns</td>
<td>4.04 x</td>
<td>4.85 x</td>
</tr>
<tr>
<td>21</td>
<td>12.33 xxx</td>
<td>11.45 xxx</td>
<td>0.42 ns</td>
<td>0.80 ns</td>
</tr>
</tbody>
</table>

ns = not significant, x = p < 0.05, xx = p < 0.01, xxx = p < 0.001.
TABLE 4  Relationship between a number of variables in the case histories of male patients at the Dr. van der Hoeven Clinic and the granting of probationary leave from the hospital, chances of L+1041, and chances of their repeating their offences on return to the community

<table>
<thead>
<tr>
<th>Variables</th>
<th>Subcategory</th>
<th>All patients</th>
<th>Patients on probationary leave</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A(n=334)</td>
<td>B(n=116)</td>
<td>C(n=114)</td>
</tr>
<tr>
<td></td>
<td>NPL</td>
<td>PL</td>
<td>Total</td>
</tr>
<tr>
<td>1 Misdemeanor father</td>
<td>yes</td>
<td>31</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>no?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Misdemeanor mother</td>
<td>no?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Misdemeanor mother</td>
<td>yes</td>
<td>185</td>
<td>96</td>
</tr>
<tr>
<td>4 Misdemeanor mother</td>
<td>no?</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>5 Misdemeanor brothers or sisters</td>
<td>no?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Misdemeanor brothers or sisters</td>
<td>yes</td>
<td>162</td>
<td>94</td>
</tr>
<tr>
<td>7 Running-away from home</td>
<td>yes</td>
<td>57</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>no?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Secondary school diplomas</td>
<td>yes</td>
<td>184</td>
<td>81</td>
</tr>
<tr>
<td></td>
<td>no?</td>
<td>38</td>
<td>35</td>
</tr>
<tr>
<td>9 Playing truant</td>
<td>yes</td>
<td>66</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>no?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Children's home</td>
<td>yes</td>
<td>101</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>no?</td>
<td>79</td>
<td>67</td>
</tr>
<tr>
<td>11 Permanent removal from home</td>
<td>yes</td>
<td>121</td>
<td>92</td>
</tr>
<tr>
<td></td>
<td>no?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Running-away from children's home</td>
<td>yes</td>
<td>73</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>no?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 Age when first sentenced                  &lt; 18</td>
<td>129</td>
<td>43</td>
<td>172</td>
</tr>
<tr>
<td></td>
<td>&gt; 18</td>
<td>93</td>
<td>73</td>
</tr>
<tr>
<td>14 Age when first committed to Government care</td>
<td>&lt; 30</td>
<td>176</td>
<td>74</td>
</tr>
<tr>
<td></td>
<td>&gt; 30</td>
<td>46</td>
<td>42</td>
</tr>
<tr>
<td>15 Number of convictions                      &lt; 4</td>
<td>158</td>
<td>73</td>
<td>231</td>
</tr>
<tr>
<td></td>
<td>&gt; 4</td>
<td>64</td>
<td>43</td>
</tr>
<tr>
<td>16 Crimes against property                   yes</td>
<td>196</td>
<td>89</td>
<td>285</td>
</tr>
<tr>
<td></td>
<td>no?</td>
<td>26</td>
<td>27</td>
</tr>
<tr>
<td>17 Sexual offenses                           yes?</td>
<td>158</td>
<td>81</td>
<td>239</td>
</tr>
<tr>
<td></td>
<td>no?</td>
<td>64</td>
<td>35</td>
</tr>
<tr>
<td>18 Aggressive offenses                       no?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 State institutions                        yes</td>
<td>99</td>
<td>39</td>
<td>138</td>
</tr>
<tr>
<td></td>
<td>no?</td>
<td>123</td>
<td>77</td>
</tr>
<tr>
<td>20 Private institutions                      yes</td>
<td>99</td>
<td>39</td>
<td>138</td>
</tr>
<tr>
<td></td>
<td>no?</td>
<td>123</td>
<td>77</td>
</tr>
<tr>
<td>21 Running-away from institutions after the age of 17</td>
<td>yes</td>
<td>116</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>no?</td>
<td>106</td>
<td>73</td>
</tr>
<tr>
<td>22 Age when first admitted to the hospital    &lt; 30</td>
<td>140</td>
<td>50</td>
<td>190</td>
</tr>
<tr>
<td></td>
<td>&gt; 30</td>
<td>82</td>
<td>66</td>
</tr>
</tbody>
</table>
INSTITUTIONAL TREATMENT OF VIOLENT OFFENDERS

A FEW DATA CONCERNING THE PL GROUP

The following are a few data regarding length of treatment and the trend as regards
probationary leave. Averages and ranges will be quoted both, as regards the duration
of treatment and the time that the persons concerned remained at liberty. The average
chosen is the median. A median of 40 months means that equally as many patients were
acted or remained at liberty for less than 40 months as for more than 40 months. The
range gives the lowest and highest values found.

Duration at liberty means the total duration of the period during which the patient
was at liberty. Hence not only the length of probationary leave is important, but also the
duration of the entire period following termination of commitment to the care of the
Government.

Recidivism occurs if a patient commits a new offence during the period at liberty. 26
of the 116 patients were recidivists. The average duration of their treatment had been 58
months (range: 9 - 134). The average length of time before their first offence was 31½
months (1 - 113½).* 19 of these 26 patients received one or more unconditional sentences
(14 once, 1 twice and 4 thrice). 5 patients received only suspended sentences and 2 cases
were set aside. 4 patients were sentenced for sexual offences (3 for abuse of minors and
one for indecent assault). The remainder had committed only 1 or more economic of-
ences, with the exception of 2 who also committed aggressive offences (maltreatment
and severe maltreatment).

10 of the 90 non-recidivists had their leave cancelled by the hospital; 7 were trans-
ferred; 1 patient failed to return after being absent without leave; 1 patient is still at
the hospital and 1 recently went on probationary leave again.

The average duration of treatment was 46 months (13 - 90). The average time at
liberty was 4 months (1 - 33). Of the remaining 80 patients, 59 went on probationary
leave once and 21 more than once. The average duration of their treatment was 49
months (12 - 152). The average time at liberty was 6½ months (12 - 158½).

DIFFERENCES BETWEEN RECIDIVISTS AND NON-RECIDIVISTS WITHIN THE PL

If we were to compare recidivists and non-recidivists, should we find differences within
the PL group itself similar to those found when comparing the PL and non-PL groups or
LAWL and non-LAWL groups? As will be seen in column C in Tables 3 and 4, only one of
the variables shows any difference worth mentioning between recidivists and non-re-
cidivists, namely the number of people who ran away after the age of 17. For the rest, the
variables that predict LAWL - generally speaking the unfavourable variables in the case
history - were of little significance (at least in our investigation) for predicting with what
chance of success probationary leave from the hospital could be granted. The same
applies if we compare the total scores for recidivists and non-recidivists (Table 5).

In the results shown in Table 5 the fact that the non-recidivists included 10 patients
whose probationary leave was terminated by the hospital or who were transferred else-
where has been disregarded. It is worth finding out whether, if we disregard the cases in
which probationary leave was a 'failure', there are any differences at all. The results are
found in column D of Tables 3 and 4. A number of results differ from those in column C.

Significant differences occur under the headings: running away from home, number of
convictions and running away after the age of 17. Since 2 of these variables were also
used as predictors for the total scores, it is not surprising that on the grounds of the total

* See Addendum 1.
In view of the limited numbers the last 2 scores were combined in our test. There was then no significant difference between the groups: $\chi^2 = 5.71, p > 0.05$.

In contrast, differences were also found between recidivists and 'successful' non-recidivists (Table 6).

**Conclusion:** unlike the situation with regard to LAWL, most of the variables chosen did not allow us to discriminate with regard to recidivism. Only one purely 'criminal' variable – besides two running-away variables – showed differences between recidivists and 'successful' non-recidivists. (See Addendum 2.)

**IS THE PL GROUP A 'SCREENED' GROUP?**

The question arises whether, in relation to the variables chosen, those who went on probationary leave were not over-screened. Supposing, for instance, that patients with red hair were often LAWL but had practically no chance of being sent on probationary leave; we might then find that there were few or no patients with red hair in the PL group. Obviously this characteristic would have lost all significance for further differentiation between recidivists and non-recidivists. However, it was not the case, as we had anticipated. We found that, as regards most of the variables chosen, LAWL and non-LAWL patients differed, even within the PL group.

As will be seen from column II in Table 1, significant differences were found with no less than 13 of the 22 variables used for testing. When we compare the total scores we obtain the picture seen in Table 7.

We must therefore conclude that, as far as the majority of the variables were concerned, our inability to discriminate within the PL group applied only to recidivism and not to LAWL. The total score, on the other hand, allowed us to discriminate with regard to recidivism.

### Table 5: Comparative scores for recidivists and non-recidivists

<table>
<thead>
<tr>
<th>Score</th>
<th>R</th>
<th>NR</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-33</td>
<td>5</td>
<td>36</td>
<td>41</td>
</tr>
<tr>
<td>34-66</td>
<td>9</td>
<td>32</td>
<td>41</td>
</tr>
<tr>
<td>69-73</td>
<td>6</td>
<td>17</td>
<td>23</td>
</tr>
<tr>
<td>90</td>
<td>6</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>90</td>
<td>116</td>
</tr>
</tbody>
</table>

In view of the limited numbers, the last 2 scores were combined in our test. There was then no significant difference between the groups: $\chi^2 = 5.71, p > 0.05$.

### Table 6: Comparative scores for recidivists and 'successful' non-recidivists within the PL group

<table>
<thead>
<tr>
<th>Score</th>
<th>R</th>
<th>NR</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-33</td>
<td>5</td>
<td>35</td>
<td>40</td>
</tr>
<tr>
<td>34-66</td>
<td>9</td>
<td>30</td>
<td>29</td>
</tr>
<tr>
<td>69-73</td>
<td>6</td>
<td>14</td>
<td>20</td>
</tr>
<tr>
<td>90</td>
<td>6</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>80</td>
<td>106</td>
</tr>
</tbody>
</table>

The test was carried out anew, combining the last 2 scores. There was now a marked difference, namely $\chi^2 = 8.96, p < 0.02$. 

---

**TABLE 5** Comparative scores for recidivists and non-recidivists

<table>
<thead>
<tr>
<th>Score</th>
<th>R</th>
<th>NR</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-33</td>
<td>5</td>
<td>36</td>
<td>41</td>
</tr>
<tr>
<td>34-66</td>
<td>9</td>
<td>32</td>
<td>41</td>
</tr>
<tr>
<td>69-73</td>
<td>6</td>
<td>17</td>
<td>23</td>
</tr>
<tr>
<td>90</td>
<td>6</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>90</td>
<td>116</td>
</tr>
</tbody>
</table>

In view of the limited numbers, the last 2 scores were combined in our test. There was then no significant difference between the groups: $\chi^2 = 5.71, p > 0.05$.

**Conclusion:** unlike the situation with regard to LAWL, most of the variables chosen did not allow us to discriminate with regard to recidivism. Only one purely 'criminal' variable – besides two running-away variables – showed differences between recidivists and 'successful' non-recidivists. (See Addendum 2.)

**IS THE PL GROUP A 'SCREENED' GROUP?**

The question arises whether, in relation to the variables chosen, those who went on probationary leave were not over-screened. Supposing, for instance, that patients with red hair were often LAWL but had practically no chance of being sent on probationary leave; we might then find that there were few or no patients with red hair in the PL group. Obviously this characteristic would have lost all significance for further differentiation between recidivists and non-recidivists. However, it was not the case, as we had anticipated. We found that, as regards most of the variables chosen, LAWL and non-LAWL patients differed, even within the PL group.

As will be seen from column II in Table 1, significant differences were found with no less than 13 of the 22 variables used for testing. When we compare the total scores we obtain the picture seen in Table 7.

We must therefore conclude that, as far as the majority of the variables were concerned, our inability to discriminate within the PL group applied only to recidivism and not to LAWL. The total score, on the other hand, allowed us to discriminate with regard to recidivism.

**TABLE 6** Comparative scores for recidivists and 'successful' non-recidivists within the PL group

<table>
<thead>
<tr>
<th>Score</th>
<th>R</th>
<th>NR</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-33</td>
<td>5</td>
<td>35</td>
<td>40</td>
</tr>
<tr>
<td>34-66</td>
<td>9</td>
<td>30</td>
<td>29</td>
</tr>
<tr>
<td>69-73</td>
<td>6</td>
<td>14</td>
<td>20</td>
</tr>
<tr>
<td>90</td>
<td>6</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>80</td>
<td>106</td>
</tr>
</tbody>
</table>

The test was carried out anew, combining the last 2 scores. There was now a marked difference, namely $\chi^2 = 8.96, p < 0.02$.
INSTITUTIONAL TREATMENT OF VIOLENT OFFENDERS

TABLE 1  Composite scores for LAW and non-LAW patients within the PL group

<table>
<thead>
<tr>
<th>Score</th>
<th>L</th>
<th>N</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-23</td>
<td>16</td>
<td>25</td>
<td>41</td>
</tr>
<tr>
<td>24-68</td>
<td>26</td>
<td>15</td>
<td>41</td>
</tr>
<tr>
<td>69-73</td>
<td>17</td>
<td>8</td>
<td>25</td>
</tr>
<tr>
<td>74-90</td>
<td>11</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Total</td>
<td>70</td>
<td>46</td>
<td>116</td>
</tr>
</tbody>
</table>

We again combined the last 2 scores and again there was a marked difference between LAW and non-LAW patients: $\chi^2 = 14.83, p < 0.001$.

SUMMARY AND DISCUSSION

In this report the outcome of research into the results of the treatment of mentally disturbed criminals at the Dr. van der Hoeven Clinic is surveyed. The criterion for success of (or failure of) treatment was the avoidance of recidivism after return to the community, after probationary leave (PL) or conditional discharge from commitment to the care of the Government (CD).

The only data we had as regards recidivism was for patients who returned to the community from the hospital temporarily (PL or CD). The report accordingly had to be confined to this category. We were able to establish that these patients were not a random group out of the total male population of the hospital. The less favourable a patient's previous history is, the less chance there is of his treatment at the hospital being rounded off with PL or CD.

Within this PL-CD group, patients whose case history was less favourable were 'long absent without leave' (LAW) more often (i.e. they ran away). In other words, to a certain extent it was possible to predict the likelihood of LAW on the grounds of a (large) number of variables in the patients' case histories.

On the other hand, it was less easy — using the same variables — to predict the chances of success or recidivism after treatment. All we could discriminate in an uncorrected group of recidivists was running away after the age of 17. After correction, we found that we could also discriminate for the variables: running away from home (under 18) and the number of sentences. We must point out that our results in this investigation, concerning 106 and 116 patients who went on probationary leave, differed from those in a previous investigation (Jessen, 1969), concerning only 59 and 68 patients. On the whole, largely due to the fact that this investigation was a continuation of the first, the results corresponded. However, there was a difference. Although in this investigation we again found that only a few variables allowed us to discriminate as regards success of (or after) treatment, they were nevertheless slightly different. The first time, they were factors such as criminality, misdemeanor of the father and age of the patient when first sentenced.

The second time, the 'running away' variables were important. In both cases the number of sentences played a significant role.

In our opinion, the explanation for these differences can probably be sought in the fact that for the past 21 years the hospital has taken in a different kind of patient.

If we compare the first 191 male patients with the last 147, we find that 50% of the former ran away (from institutions) after the age of 17, as compared with 44% of the latter. The percentages for running away from home under 18 were 29 and 18, respectively. 51% of the former category went to children's homes and 65% of the latter. 51% of the former category was under 30 when first admitted to the hospital as against 63% of
the latter. In short, for the past 9 years the kind of patient admitted has not been the same, nor the kind sent on probationary leave. We consider that such facts illustrate the relative value of this kind of research. Not only has the hospital admitted a different kind of patient in the course of the years, but for some reason or other the kind of patient sent for admission has also been different.

It is particularly worth mentioning that quite a number of the patients admitted to the hospital during the last few years were not committed to Government care unconditionally. It is difficult to say what effect this has had on the hospital's policy in general. At the same time, it is bound to have affected the policy of granting probationary leave or conditional discharge and also of final discharge from the hospital. This shows once more how important it is to know something about the inmates of each institution before a reasonably justified opinion can be formed as to the success or otherwise of the treatment it provides.

But, as already indicated above, even the population of each separate institution is likely to fluctuate considerably -- with obvious repercussions. We therefore see no point at all in continuing to study the results at separate institutions. It is of the utmost importance that research of this kind be undertaken on a nationwide scale, as is being done at present with regard to the mental homes in the Netherlands. National research should be based not on institutions, but on patients. The questions then to ask are: What patients find their way back into the community after “official treatment”? How soon do they relapse? What about the “type” of treatment they received previously? What is typical about their kind of criminality? The object of such research cannot be to find out which of the institutions function properly and which do not. There are probably numerous institutions with all kinds of possibilities, although the possibilities may vary for different kinds of patients. The object of a nationwide research scheme should be to find out the possibilities of each separate institution, either on its own or in combination with others, and what kind of patients can be treated there. This may be of little interest to the institutions themselves, but it is all the more interesting for the patients -- for whom, after all, the institutions are supposed to exist.

ADDENDA

I. The question of how many patients recidivated is not easy to answer. Although it is stated that 26 out of 116 (or 10%) were recidivists, we take into account the period during which they were at liberty, not all of them ran an equal risk of recidivating. Some of the patients had just returned to normal society when we terminated our inquiry, others had already been at liberty for many years. Table 8 gives a general idea of the rate at which they recidivated.

In the first place, the Table indicates how many patients had been at liberty for at least 2, 3, 4, 5 or 6 years, both in the test group as a whole and in the “selected” test group. Next, each column indicates how many patients in each of the “test groups” recidivated within 1, 2, 3, 4 and 5 years, respectively (in absolute figures and percentages). The percentages are cumulative. For example, the particulars for the 5-year group show that out of 77 patients 3.9% recidivated in the 1st year, 2.6% in the 2nd, 6.5% in the 3rd, 6.5% in the 4th and none (0%) in the 5th. Hence recidivism in this group was 3.9, 6.5, 13.0, 19.5 and 19.5% within 1, 2, 3, 4 and 5 years, respectively. The fact that the various columns in the two groups correspond so closely supports the assumption that the percentages given here in fact give a good picture of the rate of recidivism.

The top figures in each of the 6-year test groups show the total percentage of recidivists. The cumulative tables are based on those 22 of the 26 patients who recidivated within 6 years after discharge from hospital. The remaining 4 recidivists have not been
INSTITUTIONAL TREATMENT OF VIOLENT OFFENDERS

TABLE 8
Recidivism in 5 test groups (absolute figures and percentages)

<table>
<thead>
<tr>
<th>Recidivism (yr)</th>
<th>Total test group</th>
<th>&quot;Selected&quot; test group</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>19.7</td>
<td>21.9</td>
</tr>
<tr>
<td></td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>5</td>
<td>19.5 10.5</td>
<td>21.4 20.3</td>
</tr>
<tr>
<td></td>
<td>15 13</td>
<td>17 15 13</td>
</tr>
<tr>
<td>4</td>
<td>19.8 10.8</td>
<td>21.8 20.8</td>
</tr>
<tr>
<td></td>
<td>17 15 13</td>
<td>17 15 13</td>
</tr>
<tr>
<td>3</td>
<td>13.1 14.0 13.0 11.3</td>
<td>14.4 15.4 14.3 12.5</td>
</tr>
<tr>
<td></td>
<td>13 12 10 8</td>
<td>13 12 10 8</td>
</tr>
<tr>
<td>2</td>
<td>9.5 8.1 8.1 6.5 5.6</td>
<td>10.4 8.9 9.0 7.1 6.3</td>
</tr>
<tr>
<td></td>
<td>11 8 7 5 4</td>
<td>11 8 7 5 4</td>
</tr>
<tr>
<td>1</td>
<td>4.3 5.1 4.7 3.9 4.2</td>
<td>4.7 5.6 5.1 4.3 4.7</td>
</tr>
<tr>
<td></td>
<td>5 5 4 3 3</td>
<td>5 5 4 3 3</td>
</tr>
<tr>
<td>Test group (yr)</td>
<td>2 3 4 5 6</td>
<td>2 3 4 5 6</td>
</tr>
<tr>
<td>Numbers of persons</td>
<td>116 99 86 77 71</td>
<td>106 90 78 70 64</td>
</tr>
</tbody>
</table>

included as the size of the group consisting of discharged patients initially decreases in a rather systematic way with the years during which they could have been in free society, but decreases very rapidly after the 6th year. For that reason computing percentages would be less meaningful. One patient recidivated in the 7th year, 2 patients in the 8th and 1 in the 10th year.

Summing up, the authors consider it a good prognosis to assume that the total recidivism percentage is likely, eventually, to be about 30%.

2. After completion of this paper, Mr E. Langerak, a psychologist at the Van der Hooven Clinic, drew our attention to an inaccuracy in testing the significance of the differences in those cases where sum-scores were used. Because of the ordinal character of these scores a more powerful test should have been used, e.g. the Mann-Whitney U-test. In that case the differences in both Table 5 and 6 would have been significant. Consequently, the conclusion given at the foot of Table 5 should be that by means of the sum-scores it is possible to predict the recidivism for patients on probationary leave from this Clinic.

REFERENCES


APPENDIX 17:

ENGLISH REPORT RESEARCH TO GRENDA

Section 2.54. Grendon is mentioned, along with Wormwood Scrubs, Parkhurst and Liverpool, as having a surgical unit.

Section 2.55. Grendon is spoken of as having a psychiatric unit, along with an earlier psychiatric unit being started at Wormwood Scrubs in 1936. Grendon is spoken of as being the largest and most important, opened in 1962. "None of these psychiatric units is equipped to deal with acute or severe mental illness; such cases require transfer to a National Health Service local psychiatric hospital or a special hospital under the powers given to the Home Secretary by sections 72 and 73 of the Mental Health Act 1959."

Section 5.37. Treating the dangerous psychopathic offender. There is a suggestion in this section that Grendon is selective in choosing the psychopathic patient and it is suggested that more aggressive offenders are not willing or able to co-operate in the treatment offered. Over the years Grendon has developed a system of handling and treating extremely aggressive men and fulfils one of its purposes as receiving emotionally disturbed aggressive men from other establishments where they have gone into the vicious cycle of aggressive behaviour, punishment, escalating aggressive behaviour, very restrictive punishment until an impasse is reached. Grendon serves the purpose of taking these men into treatment and hopefully, and in many cases breaking this vicious cycle and so allowing the person to operate in a less destructive manner. (See recent figures from the Research Department on Grendon's handling of this group of men). Methods of handling this group of patients, as well as allowing them to undergo treatment, depend on a series of factors:

1. Continuity of staff. It is important that a core of at least 4-5 staff members remain on the wing for at least 1-2 years.

2. There must be more space than is immediately needed in order to allow movement within the wing, that is more rooms, more beds.

3. Free movement within the wing. The most explosive and counterproductive measure as suggested by the manpower team would be a mid-day lock-up in order to economize on staff.

4. Multiple, varied and frequent opportunity for verbal expression of violent and aggressive feelings in an open but structured area, such as the daily group and wing meetings.

5. Regular staff meetings in order to assist the staff in absorbing the tension and aggression of the patients and at the same time maintain a relaxed atmosphere where treatment can occur.

6. Full honesty between the officers and the patients. Information given to the patients as soon as it is possible and taking steps to avoid any long ongoing period of insecurity between the two groups, for instance, if there is a security investigation occurring, this must be carried out rapidly and full information referred back to the patient group as soon as possible. These investigations should be avoided except on rare occasions of extreme danger, such as planned serious violence, eg hostage-taking or threats of violence.

The aim of the staff is to engender an atmosphere of mutual trust within the limitations of the system. This is brought about by honesty of staff in the staff/patient relationship and a demand for a return of
No more than one new member is introduced to the community in one week.

A common aim and goal, such as "treatment" with staff and patients are directed towards this goal.

Staff and patients mix freely and are involved collaboratively in the internal management and treatment processes in the wings.

No sudden decision-making by the staff or the community. Slow careful exploration in depth of issues such as the transfer of a patient or an innovation to the regime. This should be done in slow deliberate processes requiring participation of as many members of the community, staff and patients, as possible and hopefully after this careful deliberation, voted on and enforced by the community.

Real decision making, not apriori decision making, is important. Repetitive specification of the areas, for example a person becomes angry on the wing, he may be permitted to express this verbally even direct it at members of staff but when he is off the wing he is not permitted to display his anger towards other staff members. If he does, this is examined in the group.

Flexibility within the framework of the rules; the community must be able to move first in one direction, then in another direction. For example when the community is threatened by perhaps an intake of 5 violent men, it may at this time wish to reinforce the no-violence rule and if necessary for minor explosive behaviour, and have the need to send somebody away. At other times, more explosive behaviour may well be permitted. This flexibility depending on the explored, expressed opinions of staff and patients, operating together in collaborative groups.

No psychotropic drugs or night sedation are used in the treatment processes of Grendon. There have been several accounts of the use of Librium and Valium in explosive psychopathic personality disorders, particularly in the field of child injury when it is the opinion that the use of these drugs can result in loss of control of the patient and therefore result in more explosive extreme behaviour in violent aggressive people. It is well known in the abuse of alcoholic liquor and a similar effect can occur with the use of hypnotics.

The second feature why these drugs are not used is that the patient is seen to be responsible for his behaviour and he sees himself as being responsible for his behaviour and develops an understanding of his aggressive feelings and can handle these in himself and appreciate these in others. When only partially aware of these feelings and the effect of tranquilisers, he loses the opportunity of developing this control and understanding his areas of vulnerability.

Carry out these principles of the handling of aggressive and treatment of aggressive men, some modification in the classic prison regime is necessary.

Section 5.44 The comment on this section is that when the evidence was submitted Butler about 1970-71, Grendon had not at this stage developed its now definitive pattern of treatment. It had at this stage, although considerable work had been one, little formulation of the aims and goals of the different wings, understanding and statement of areas of limitation, such as the exclusive criteria. We are still warning to understand the type of patient we could deal with, or not deal with. Here are at present 6 exclusive criteria for Grendon:

Intelligence. The intellectual capacity must be in the range of the average. Although this figure is not precise, one would say at least about an IQ of 95. If one is in doubt, one repeats the intelligence testing by different methods.
2. Age. Patients over the age of 40 do not respond satisfactorily to psychotherapy, particularly in a group made up of much younger peers. However, there is flexibility in this area and a "young 40" may be accepted as an exception.

3. Severe organic brain disorder, such as occurs as the result of a brain damage injury. (This, along with epilepsy, if it is minimal and almost symptom-free, could be accepted, but if the person can attribute his disordered behaviour to some organic lesion, he has little incentive to alter his emotional life, his behaviour or methods of relating.

4. No active psychosis. (This requires other types of treatment, such as physical methods, hospitalisation, rehabilitation processes and therefore is not suitable for Grendon). This includes the rigid fixed paranoia, the so-called paranoid psychopathic personality disorder.

5. Time. It is desirable that a person spends in the treatment regime a period of at least one year to 15 months. (From time to time we will accept people for a shorter period but, and we are looking at setting up a regime for short-timers in the adult department, to see if we can operate at a perhaps 6-month period). At the present moment, in general, a person requires a year.

6. He must desire or wish to enter into treatment, but he must be free to remain or remove himself from treatment. If an appeal or parole is pending, it is not desirable that he enter into treatment until these matters have been dealt with.

Grendon will then at the present time accept any other type of patient. Any variation in the sexual spectrum, any degree of explosive aggressive behaviour, a history of drug-taking, a history of alcoholism, a history of chronic recidivism, but by taking this group of people, one realises that the potential for treatment is limited and marginal. There will hopefully be some improvement in methods of relating and behaviour.

Section 5.45. The objectives of Grendon are:

a. To investigate and to treat offenders suffering from disorders which call for a psychiatric approach.

b. To investigate the mental condition of offenders, the nature of whose offences suggest mental disorder.

c. To explore the problem of the psychopath and to provide treatment or management to which he might respond. These are the objectives of Grendon at the present time.

Objective c. has been developed by the institution of the Assessment Unit but for further progress in this area, it is important that we endeavour to work out some formula of predictability of response to Grendon. This would result in more selectivity, that is the selection of cases who are appropriate for this form of treatment with a consequent improvement in the results particularly in measuring the results in terms of re-conviction rate. As I have stated in other areas, there is a movement away from selectivity. I suggest that at least one wing operates on a more rigid selection; namely in choosing people who have a considerable potential for alteration. However this tends to create an elite staff and patient group and poses the old question of streaming, and this area is open for considerable discussion by the therapists and staff in general.
On the one hand there is the need to provide a treatment regime to enable a person with a grossly damaged personality to develop some degree or potential for growth, resulting in his no longer resorting to extreme violent behaviour with the limited aims in view. On the other hand selecting a person who despite his present emotional state shows definite indications of potential for alteration and therefore total personality change and reduction in reconviction probability.

Grendon fills an important role in the prison service by providing a "first aid" rescue centre for acutely disturbed and psychotic prisoners who at this stage show little potential for structural personality alteration and therefore show predictability in terms of reconviction, but who can respond to a period in the Grendon regime by which they are no longer acting in a self-destructive or destructive manner towards the prison staff in their parent prison. In practice it is important to establish a balance between this group of patients and the other groups mentioned. To take a large number of these "Rescue jobs" would result in "The tail wagging the dog" in the therapeutic community on the wing.

Section 5.46 is, in essence, the principles of Grendon. However it is quite out of date on two counts. In the earlier part, when the variety of forms of treatment are described, this is now incorrect. No electro-convulsion therapy is in use. No insulin treatment, no narcosis, no aversion therapy.

Psychotherapy, both individual and group therapy are provided in greater or less degree in the 6 therapeutic communities and Assessment Unit that makes up the Grendon psychiatric unit. The treatment is intense psychotherapy in a therapeutic community setting. The communities vary in the methods although are similar in their aims and goals. Some taking the more isolated men who require the close relationship of individual therapy and more paternalistic officer counselling to the open full community approach. The basic grade officer is the main treatment agent. One wing community operates on transactional analysis (encounter work, role playing, social skills training with the use of audio and visual equipment play an important part in the treatment process).

The second section that is now questionable is the last sentence of Section 5.46. Although violent behaviour and unco-operative patients are transferred from Grendon, the word "quickly" could now be eliminated. Before a patient is transferred there is careful evaluation by himself and the staff and his peers. Rarely is the need for a rapid transfer although it is important that these facilities are available and because they are available, the need for their use is less likely. The rapid transfer only occurs once or twice a year.

Section 5.47. This section is true for Grendon at the present moment but the process of evaluation of the work Grendon is doing has been elaborated over the last 3 years and there is now a functional Assessment Unit which is there to evaluate change in the patients with an attempt to evaluate the efficacy of the regime in terms of its aims and goals and the efficacy of the different regimes in Grendon, to find the suitable patient for the regime that most suits his treatment needs.

Butler reports on the fact that although Home Office Research Unit has looked into a number of aspects of the Grendon regime, it is still too early to assess its results. The few early results in relationship to reconviction rate are commented on. Butler then states "Reconviction rates are not the only, or even necessarily the most valuable yardstick for evaluating the success of an institution such as Grendon", and other researches concluded that the therapeutic community model is particularly successful in the management of disturbed prisoners, by lessening their general opposition to authority, breaking down the traditional prison sub-culture and improving inmate's own self-esteem.

Comment. Work is now being done in the Assessment Unit Grendon to evaluate the degree of change that occurs in a patient entering into the Grendon regime.
Section 5.48. Talk of the limitations of the Grendon regime states though composed predominantly of non with personality disorders is a highly selected group (I very much question the term 'highly selected'). By fulfilling the objectives of Grendon as stated in 5.45 a. to investigate and to treat offenders suffering from disorders which call for a psychiatric approach, b. to investigate the mental condition of offenders, the nature of whose offences suggest mental disorder and c. to explore the problem of the psychopath and to provide treatment or management to which he might respond.

Grendon, in fact, receives a group of patients who predominantly fit into the character of personality disorders, the majority of whom would fit into the diagnosis of "aggressive psychopath or inadequate psychopath". Grendon fulfills an important role in bringing patients who are unmanageable in other prison settings, and therefore relieves the requirements of heavy staffing and heavy sedation and hospitalization from the other prisons. This also serves the purpose to interrupt the vicious cycle of aggravation - punishment - escalation, as described earlier. Therefore by providing a person in this emotional state with an environment in which he can operate without recourse to extreme, aggressive, persistent, violent behaviour, aids in enabling him to undergo some process of growth. Grendon is selective but by no means highly selective.

Section 5.49. The New Units. There will be set up to treat people diagnosed as having personality disorder who cannot fit into the Grendon pattern. Butler's talk of the Grendon approach towards recategorization is based in considerable part in promoting insight through self-analysis and self-questioning on the part of the offender in the hope of enabling him to come to terms with the problems which lie behind his law breaking. This, by no means, fully describes the Grendon treatment method. Grendon regime is a learning situation; it is the correction of faulty patterns of behaviour, social and emotional that are normally acquired during childhood and adolescence but have never been satisfactorily learned by the psychopath. The Grendon regime is insufficiently structured in order for these behaviour patterns to be examined and modified.

It seems that the new units will find great difficulty in operating as "new units" and are not just a reproduction of the prison as before. They will, by definition, require to operate in some sort of Grendon type regime. Whatever the type of unit instituted it will require, as with Grendon, a heavy staff/inmate ratio. Chapter 6 of the Butler report talks of provision for inadequates. At least 20% of the Grendon population could be described as socially inadequate and it may well be this group, and the caring for this group, that holds back the process of change in others.

Section 8.11. The Half-way House. Here it talked of the Grendon Club and the Pelican Club and the lack of development of a half-way house for Grendon. It talks of the need of a post-release hostel that could be staffed by Grendon officers in order to continue the personal relationships formed during the period of treatment. It seems at this time that this area could be re-thought and investigated, at least keeping the book open.

In Summary. The Butler report, in certain areas, is totally incorrect on treatment methods at Grendon as they exist at the present time. It is also incorrect in its discussion of the high selectivity at Grendon at the present time. When it talks of Grendon's methods, such as the gaining of insight by psychotherapy, it totally omits the forces of the therapeutic community peer group and the social learning and relearning that is the fulcrum of the Grendon treatment regime.

B J Barrett
Senior Medical Officer

22 February 1978
CRITERIA FOR TREATMENT AT GRENDOH

1. Age. Borstal and YP Wings - age range is 16 to 21.
   Adult Wings - age range between 21 and 35 years.

Since we are aiming at maturation taking place, the younger we get the patients the better. From time to time, if other factors are indicative we will accept people 35 and over up to the early forties. However, this group does not fit into the intensive treatment regime, it can become too stressful for them and also they do not respond to psychotherapy.

NOTE: We have found that people who have difficulties with regard to sexual offences against children in the late twenties and early thirties onwards have little capacity for change and perhaps do better remaining in individual psychotherapy from the visiting psychotherapist in their parent prison. However up to the age of 25 this group respond well to Grendon regime and treatments. Twenty-five to 30 - less well, but still acceptable, otherwise being equal.

2. Time. Our wings demand a time stay of at least one year in treatment. The optimum being stated as 15 months. It is desirable that time should be available in order that following Grendon treatment there is an opportunity for a period of complementary ongoing treatment on parole. However, people should have at least one year from the time of coming to Grendon to their EDR.

3. Voluntary Consent is required both at the initiation of treatment and during the continuation of treatment. People who do not wish to continue treatment are able to return to their parent prison and terminate their treatment.

4. Legal Consideration. Treatment should not commence at Grendon until any legal matters have been dealt with such as appeals, further charges or if a person has applied and been recommended for parole, until a decision has been made.

5. Presence of Active Psychosis requiring hospitalisation. These are unsuitable for treatment at Grendon. They require psychiatric hospital treatment.


   Patients must be prepared to admit their responsibility for the offences for which they are serving prison sentences.

7. Intelligence. Patients must be of average intelligence or above average intelligence. No figure is fixed as exclusive, but people below 90 IQ do not fit into the treatment regime. The majority of Grendon men have IQs over 105. However on admission we do a Raven's Progressive Matrices and if there is any doubt we do a Wechsler.

B J Barrett MA ChB DPM
Clinical Director
15 March 1979
CRITERIA FOR TREATMENT IN ADULT WINGS AT GRENDON

1. Sex:
The suggested age range being between 21 and 35. In general the younger the better, although the treatment requires some degree of maturity and some people may be more suitable in the middle twenties. In the rare case of a first or second offender at the age of 36 or over treatment may be suitable, but in general over 36 in the classic psychopathic personality the age range should be close to the middle twenties, but, of course, exceptions with other things being present could be well considered.

2. Institutionalisation:
Long repetitive periods of institutionalisation from the earliest years, up to the middle twenties/middle thirties, is a contra indication for satisfactory treatment. However, if there have been periods out of institutions, or if the person is in the younger grouping and shows some degree of personality initiative, on its own, does not exclude, but along with the other groupings as described this is a very bad contra indication to satisfactory treatment as practised in Grendon adult wings.

3. Mental Inadequacy and Gross Dependency:
These features will usually be found in number 2, but with associated anti-authority. Anti-authority on its own could be considered a reasonably good prognostic feature, but associated with gross dependency in an institutionalized person can augur badly for treatment.

4. Aggressiveness and Anti-authority:
These, on their own, I perceive as a reasonably good sign for involvement in treatment, but will require a good community to handle them.

5. Types of Offence:
There is no reason to exclude people with any type of offence, such as paedophilia, arson etc. Drug abuse, alcoholism, but if too many get on to one wing, such as a group of drug offenders, they will form a firm clique and act as counter to the therapeutic community regime.

For completeness I add the three features to be avoided, but these are generally accepted in our referrals.

a. The I.Q. must be close to average as possible, as Grendon men in general are above average, and the person will lag behind and become a pet, act out as a reaction to his inability to verbalise in this extremely verbal setting.

b. Psychosis. Any person whose connection with reality is so tenuous that they can not enter into ordinary verbal and emotional interchange, and can not accept the fact that they are responsible for their behaviour, are unsuitable for treatment in this regime, and in fact require the treatment of another therapeutic setting, such as a depressive is better treated in a prison hospital with anti-depressants, ERG etc. However, many of our candidates at times, under the stress of the therapeutic community setting may move into the areas of psychosis and pre-psychosis, and these actually can be carried, but if a person is frankly psychotic on arrival, or referred with a frankly psychotic emotional and
behavioural mechanism, he is unsuitable for treatment.

c. The third category is people who suffer from extensive or even moderate brain damage, where their behaviour cannot be assessed as their own responsibility. Epileptics fit into this category because epileptics in the centre of their condition will require heavy drug usage. Under heavy drug usage the epileptics is separated from his feelings, and as this treatment regime requires a person to be in close touch with his feelings and behaviour it rules out this particular group.

POSITIVE REASONS FOR ENTERING INTO THIS OR TION REGIME

1. Age
The younger age group in general are more amenable to treatment, and a person's worth will be, with all things being considered, a high enough positive reason for introducing the treatment regime.

2. Some previous treatment, some insight or some understanding, even though it has not been put into practice, can be of value as a positive suggestion for treatment.

3. Some drive, even aggressive. This can be seen as a positive attribute, as all destructive aggression is displaced, this can at times be directed into creative and constructive behaviour. This would depend on the individual wing and the individual situation from time to time.

Family Background

A person with some degree of family stability or social stability in general, has more chance on entering and succeeding in the treatment situation, but with the use of family groups a good family, on the surface, may turn out to be an internally destructive psycho-dynamic situation. However, in general the drifter is less liable to enter into a satisfactory rehabilitation than a person from a more stable social setting.

Some Degree of Achievement

This is a very important positive quality. The degree of achievement may be very small in general standards, for instance - a period in early life when one 'O' level is gained, a period as a prefect for a short time, a corporalship in the Army for even a short time, an election to a shop steward for a few months at work. On the converse if there is no evidence of any achievement whatsoever, the prognosis by its very nature, associated of course with the other factors, is very poor - the eventual prognosis (excepting under protective regime) and the prognosis in survival and benefiting from treatment.
week went to the unit. The group, could also be used in helping still to place one

It was noted that some modifications of the should not be allowed as some modification of the prior to joining the unit, but settling in detestations that start have had the benefit of a "training period," would have led to one of a class. It should be remembered proceedings at one time, usually smaller programmes are

W.C.T.U.
When you allowed me to attend a discussion meeting of the community two or three months ago, Mr Duncan Maciver posed the question: How do you measure the success of the Special Unit? If you believe it is successful, how do you convince other people? This started me thinking. I am convinced that a study of how the Unit works, what happens in it, and what results it produces, must be valuable. So I have tried to work out a number of central topics or issues. My argument is that any inquiry, to be really fruitful, must state and try to answer central issues of this kind.

I have set out ten possible central issues on the attached sheets thus:

A. Aims of the Unit
B. Sources
C. Types of inquiry
D. Specific research questions
E. Who benefits?
F. What must be revealed?
G. What public?
H. Confidentiality
I. Constraints
J. Conroy was here

For the first three of these (A to C) I have added a few of the possible answers or sub-headings (for example, under A, some of the aims or results which the Unit might be seeking to achieve). I have made no attempt to do this for issues D to J.

You gentlemen will, I am aware, be far ahead of me in your thinking about these questions, and you have learnt things that I do not yet suspect. Very likely you could state central issues that I have not thought of, and certainly you could write down many other answers or relevant considerations. I have no illusions about that. And it is not for me to say what sort of inquiry should be done - that should emerge by discussion within the community. Still I am sure that we can all of us benefit if we start our argument from central issues of the sort I have listed, and build up a structure from there.

I should be grateful if I may attend a discussion meeting of the Unit one week soon, and I hope that we could discuss these notes and try to move forward from them. I have mentioned this idea to Mr Tom Melville of the Department, who sees no objection to this procedure if it is acceptable to the community.

D Webster
Department of Sociology
University of Salford
Salford
M5 4WT

18 June, 1974.
Aims of the Unit:

In judging how far the Special Unit is a 'success', what aims do we have in mind? What possible results or considerations are relevant? How much weight should we place on each? How do we measure them? What if they conflict? (That is, you can achieve one but only at the cost of losing another.)

1. Behaviour/character/internal life/probable future behaviour of individuals has changed. 'So-and-so is coming to terms with the world, is accepting responsibility and doing things for himself, is acting rationally.'

2. Persons in the Unit believe/maintain that the Unit is successful.

3. Level of trouble/tension/number of assaults in the Scottish Prison System as a whole falls: assaults between prisoners, between prisoners and prison officers, feuds and vendettas. 'The level of tension in Peterhead has fallen.'

4. Public/newspaper comment on the aims, working, activity of Prison Department and Prison Service.

5. Effect on 'the criminal community' outside, especially in Glasgow.

6. Knowledge is gained which helps therapeutic communities elsewhere.

7. Techniques and knowledge are gained which produce a more successful/acceptable/humane/positive prison system in Scotland: use of home parole, correspondence, visits, trust, etc.

Sources:

What sources of information or material are available to us, or can be or in in principle could be available to us? Which of them can be got easily, which with difficulty, which can not be got at all? And why?

1. Minutes of weekly meetings of the community.

Annual Reports of Prison Department.

Prison Department internal reports and working documents on the Segregation Unit in Inverness and the possibility of setting up a Special Unit.

Diaries kept within the Unit.

Letters sent out and in.

Internal staff reports, memos, documents.

Dr Whatmore's records.

Collated unpublished material on Special Unit in the hands of the Prison Department.


Opinions of the Inspectors of Prisons.

Opinions of individual prison officers and of POA.

Opinions of main Karlinnie staff.

Opinions of Prison Welfare Officers.

Opinions of other persons elsewhere in Scottish Prison Service.

Material in possession of Ian Stevens (nature not known).

Newspaper discussion.

Structured interviews with members of community.

Questionnaires.

Opinions of visitors to Special Unit.

Opinions of relatives of members of community.

Types of Inquiry

What type of inquiry is possible? Which type is needed?

A psychiatric or psychological report on separate individuals.

A study of a small or primary group as an acting and decision-making group or organization – like a team, or a family.

A therapeutic community in action.

A number of people who have temporarily come together in one place. All of them have some aims and tasks in common or shared (e.g. those created by the community) and some aims and tasks not shared (e.g. relations with family and relatives).
All of them have come here from different places and backgrounds and interests and motives; are here temporarily together; and will separate again and all go their own ways. Some are here for short periods repeatedly, some occasionally, some for almost all of the time. At no time is everyone present together, and the population varies all the time. So an unusual group or collection of people, and what other groups or organizations does it most resemble?

(5) A statement not in terms of the community at all but in terms of the rest of the prison system, or perhaps the rest of the penal system.

(6) A history, a straight recital of events.

(7) An analysis, in terms of "If you want to achieve X, you should do Y".

(8) Comparison of different prison regimes - size of establishment, staff ratios, cost, intake, result (how measured?)

D. Specific Research Questions

The sources in B are sources only. What questions would we want to direct to them, what knowledge to elicit from them, what conclusions to draw from them? What relative weight should be placed on these sources and the information from them, and why? What if they disagree or conflict? (These questions bark back to A. A asks what possible aims are relevant? D says: what questions do we ask about these aims, how do we measure whether we are achieving them? E.g., what if So-and-So is much healthier and happier in the Unit, but a home parole never works well?)

E. Who benefits?

What forms of benefit might follow from the existence of the Special Unit, from the work done at and the experience gained in the Special Unit? Who can be argued to benefit? Members of the Unit itself, persons strictly within the Prison Department only, or within the prisons and prison service generally, or what wider range of persons?

F. What must be revealed?

How serious are we in any systematic study being done, how serious are different people and interests? There is bound to be prying and uncomfortable heart-searching, release of some facts or information that persons would prefer to remain hidden, and perhaps unwelcome or painful or simply undiplomatic things revealed, perhaps conflicts or interest or policy stated which as a rule are tactfully left unsaid. Do people really mean to go through with this or not?
G. What public?
Is any conclusion or report for the eyes of the Special Unit community only? The Special Unit plus interested people in the Department? The Governors' Conference? The POA? The medical community? Can anything ever be published openly, so that others can benefit? If not, is there any point in a study of the Unit at all?

H. Confidentiality.
Can anything be published outside the Prison & Forstal Service (the Official Secrets Act circle) without names being named? Who may be harmed?

I. Constraints.
What constraints are there on our action (cost - professional opinion and tradition - pressure groups - competing demands for other needs - physical plant - training - general public opinion - and so on) and how best do we tackle these?

J. Conroy was here.
And what do we learn from Bernard Conroy?
Secretary of State's Instruction on the Operation of the Special Unit at Barlinnie Prison (21st February, 1976)

THE FUNCTION OF THE UNIT.

The Secretary of State proposes no change in the concept of the Unit and the integral part played in it of discussion and consultation - involving Department, Governor, staff associations, and staff and inmates, both separately and as a community. In particular, the community will continue to discuss and, where appropriate, resolve matters relating to the domestic arrangements within the Unit. At the same time it is desirable that the ultimate responsibility for matters relating to the Unit and its operation should be more clearly defined.

DEPARTMENT.

1. Overall responsibility for the operation of the Unit will lie with the Department.

2. All matters of security, including recommendations for changes in the security categories of inmates, will be referred to the Department.

3. The approval of the Department will be required for any change in operation which (1) affects the concept of the Unit, or security, or (2) requires an amendment of these instructions. The Department will consider proposals for any such changes which may be made by the Governor, by staff associations concerned or by members of staff (to be submitted through the Governor), and its decision will be final.

GOVERNOR.

4. The management of the Unit is the responsibility of the Governor who will administer the establishment in accordance with the Prison Rules and Standing Orders, and as instructed by the Department.

5. The Governor will determine all matters affecting the
internal operation of the Unit.

**STAFF.**

6. All members of staff will carry out their duties in accordance with the Prison Rules and Standing Orders and as instructed by the Governor.

7. Staff meetings, which the Governor will normally attend, will be held at such intervals as the Governor and staff consider necessary.

8. Any irregularities which are brought to the attention of a member of staff will be reported immediately to the senior officer on duty and confirmed in writing to the Governor.

**COMMUNITY.**

9. A community meeting will be held once each week and may be attended by the Governor, members of staff, inmates and professional visitors to the Unit.

10. At least 24 hours notice will be given of any change in the normal arrangements for the regular weekly meeting of the community.

11. Domestic arrangements within the Unit will continue to be discussed and considered by the community under the overall authority of the Governor.

12. All community recommendations will be considered by the Governor and his decision will be final.

13. Security, staffing and confidential matters will not be discussed at community meetings.

14. The community may discuss the progress of individual inmates provided they do not object and are present at the meeting.

15. Representatives of the Department will not normally attend community meetings.
16. Cell security checks will be carried out in accordance with the normal Prison Rules and Regulations.
17. Cell searches will be carried out at irregular intervals.
18. Members of staff will be present in the cells area while visits are taking place there.
19. Inmates returning to the Unit from home or other outside visits will be searched.

VISITORS TO THE UNIT.
20. Former inmates of the Unit may be permitted to visit the Unit subject to the prior approval of the Governor.
21. Visits by other ex-prisoners may be permitted, as in other prisons, only in exceptional circumstances and with the prior approval of the Governor.
22. Visits by other persons and groups to the Unit will be permitted subject to the discretion of the Governor.
23. The Governor will be responsible for the appointment of official Prison Visitors and he will prepare appropriate guidelines for their information.
24. Persons who are involved in a professional capacity with the Press, Radio or Television will not be permitted to visit the Unit without the authority of the Department.

HOME AND OTHER VISITS BY INMATES.
25. Escorted visits will not be permitted without the authority of the Department and they will be carefully controlled by the Governor.

ASSESSMENT TEAM.
26. The assessment team which interviews all prisoners recommended for transfer to the Special Unit will comprise the consultant psychiatrist, two members of staff, and the Governor of the Unit who will be an ex-officio member of the team.
27. In addition to interviewing the Governor of the classification prison, the assessment team should also meet members of the staff who have been closely associated with the prisoner.

28. When the admission of a prisoner to the Unit is being considered, the matter may be discussed at a community meeting prior to the prisoner being interviewed by the assessment team.

MISCELLANEOUS.

29. The standard recording procedures for inmates' requests, letters, visits etc. will be maintained.

30. The privilege of receiving and sending uncensored mail will continue, but will be monitored as considered necessary by the Governor.

31. Parcels received for inmates will continue to be opened in the presence of an officer.

32. Inmates may continue to receive for their personal use small amounts of money and tobacco from visitors. All such items received will be declared and recorded in their personal records.

33. The present arrangement which allows inmates to augment the basic prison rations by purchasing additional items will continue.

34. The use of the telephone by inmates will be subject to normal prison regulations and may be authorised only in exceptional circumstances by the Governor.

35. The procedure for dealing with inmates reported for breaches of discipline will be reviewed and determined by the Governor.
Inmates of prisons, or other types of penal establishments in Scotland, are punished by the courts by being deprived of their liberty. It is the duty of the Scottish Prison Service to contain them within secure conditions appropriate to their needs; and the aim of the staff is to work together to treat their charges in a way which is most likely to send them back into the community better men and women than when they came in.
Responsibility to Parliament for the Scottish Prison Service belongs to the Secretary of State for Scotland, and within the Scottish Office the Scottish Home and Health Department is principally involved in administering the service. After-care of people who leave penal establishments after serving their sentence is the responsibility of the appropriate local authority social work department. The prison welfare service formerly run by the Scottish Home and Health Department was integrated with local authority social work services in November 1972. This provides more opportunities for continuity in social work services for inmates before and after release and for work with their families.

There are thirteen prisons in Scotland for persons aged 21 or over; twelve for males, and one for females.

Prisons generally have the dual function of holding adults on remand and after they have been sentenced. There are two types of prison - local and regional. Peterhead, Dungavel, Penninghame and Broughton are regional prisons which do not accept admissions direct from court. Only prisoners from other prisons who have been selected as suitable may be transferred to the less restrictive conditions at Dungavel or to open conditions at Penninghame.

In 1973 a new female institution was opened at Cornton Vale, near Bridge of Allan, which now accommodates all categories of female inmates. There is no open establishment in Scotland for female offenders.

For offenders aged between 16 and 21 there are four young offenders' institutions, four borstal institutions, one detention centre, and a remand institution which accommodates youths under 21 who have been remanded by courts awaiting trial, or after conviction awaiting sentence.

Young offenders' institutions were brought into operation in January 1968 so that nobody under 21 is sentenced to a period of imprisonment. Instead, he or she can be sentenced to a similar period of detention in a young offenders' institution where a programme more appropriate to their age group can be operated.

Borstal institutions may hold inmates for a maximum term of two years' training, though the period served is determined by inmates' response to training, and tends to average slightly less than one year.

At the detention centre (at Glencroft, near Ayr) sentence is for a fixed three-month period, less one-third remission for good behaviour.

The average daily number of persons detained in penal establishments, which stood at 4,238 in 1967, peaked in 1971 at 5,338.

The average daily population for each of the years from 1972 to 1979 was 5,220, 4,810, 4,689, 4,951, 4,884, 4,871, 5,062 and 4,579 respectively.

The number of prison officers at 31 December, 1977 was 2,034; total staff at penal establishments at the same time was 2,566.

Administrative Development

When the first Secretary for Scotland was appointed in 1885 the old Prison Commission was one of several boards and commissions already established in Edinburgh which helped to make up his portfolio. A feature of this system of administration was that the boards and their staffs were not servants of the Secretary for Scotland, and though he answered for them in Parliament he might find himself disagreeing with their actions.

In 1918, two years after the office of Secretary for Scotland was elevated to that of a Principal Secretary of State, the Scottish Prison Commissioners were abolished. Their place was taken by a Prisons Department for Scotland which, though under the control and direction of the Secretary of State, existed as a statutory body independent of him. It was left to the Reorganisation of Offices (Scotland) Act of 1939 to abolish the department (and other similar departments) and vest its functions in the Secretary of State who was free to make such arrangements as he thought fit for discharging the business of his office.

Life “Inside”

For inmates, prison is a life of routine. The whole day is timed and scheduled. Unless actually experienced, it is difficult to appreciate how strong can be the effect on an individual of losing the freedom to do as he wishes whenever he wishes. Although there have been continuing reforms and development of the system, particularly over the last thirty or forty years - it used to be possible, for example, for a prisoner serving a long sentence to be able to predict exactly what he would be eating for years ahead - the discipline of routine is still a major factor of prison life.

The prisoner’s first links with the administration of the prison service are the prison officers. Prison officers are no longer simply custodians or turnkeys. They take an increasing part in day-to-day management, and the intention is to develop this trend. Officers have to set an example of
6 am
Cell unlocked and each prisoner seen by staff.

6 - 7:20 am
Stop out; wash; make bed and clean cell.
During this period a prisoner may notify staff if he wishes to see doctor, social worker or Governor.

7:30 - 7:50 am
Breakfast - tea, bread and margarine, porridge, cooked bacon or sausage or egg, etc.

7:55 am
Parade for work.

8 - 12 noon
Work. There is a mid-morning tea break (ten minutes) at most establishments during which prisoners may smoke.

During this work period, a prisoner who has asked to do so is seen by the social worker. He may also be called to the Governor's orderly room to be notified of answers to petitions, informed of Parole Board decisions or to have misconduct dealt with.

12 noon -
Midday meal - soup and roll, main course and sweet. Usually a choice of main course is available. This element of choice has resulted in less waste.

12:45 - 1:45 pm
Exercise in open air, weather permitting.

1:50 pm
Parade for work. Numbers checked by staff.

2 - 4:55 pm
Work. Ten-minute break at 3:00 pm.

5 pm
Meal - tea, bread and margarine, jam, a hot dish usually with chipped potatoes.

5.30 - 6:30 pm
Locked in cell while staff are at tea.

6:30 - 8:45 pm
Recreation periods. Handcraft classes and educational facilities available. Some establishments arrange visits from prisoners' friends and relatives during these periods. Others arrange visits only at weekends.

1 These are special request or complaints on any matter which the prisoner may address directly to the Secretary of State (see page 3).

8.45 - 9.00 pm
Supper - tea and bun or filled roll.

9 pm
Locking up commences.

10.00 - 10.15 pm
Lights out.

Typical Cell or Room
Dimensions of a traditional cell or room for prisoners are some ten feet by seven and a half feet. The floor is covered by linoleum or vinyl tiles. An aperture in the door permits staff to keep inmates under observation. There are security bars in the cell window, and furniture is a bed with mattress, four army-style blankets, two sheets, and a wardrobe. On the wall is a small mirror, a small metal basin, and a picture/notice board; and there is a roof light. In establishments completed in recent years rooms are designed and furnished to modern standards.

Education
There has always been a place for education in custodial treatment and training. Work is proceeding to expand educational activities in penal establishments and to make programmes more relevant to the needs of individuals. At Edinburgh, Perth and Barlinnie prisons, Glenochil Young Offenders Institution and Detention Centre, Dumfries Young Offenders Institution, Polmont Borstal and Cornton Vale Institution and Longriggend Remand Institution there are full-time education officers, assisted by full-time or part-time teachers. Most of the remaining establishments have the professional services of full or part-time teachers or evening class teachers. Levels of intelligence of inmates vary widely, but though educational histories of many prisoners show little motivation for education before they come into prison it appears that in the prison situation a good number are prepared to give education a try. A revised system for progressively assessing borstal inmates has been introduced to try to ensure that each lad is allocated to an institution with training and other facilities best suited to his needs. The assessment programme covers six weeks, during which the inmate is given educational, intelligence, personality, psychological and mechanical aptitude tests as well as practical vocational tests. In deciding his allocation, the views of the inmate are taken into account along with all other relevant information.

Response to educational facilities differs greatly. At one end of the scale some inmates learn to read and write, while for others acquisition of educational skills make vocational training a realistic goal. Much effort has
been directed towards seeking to remedy illiteracy, and there are success stories at different establishments.

For younger inmates who have not reached school leaving age, and for some others who intend to return to school or who are continuing higher education, every encouragement is given to continue studies through day and/or evening classes, private study and correspondence courses.

Vocational training in accordance with the recommendations of the training boards operate at a number of establishments and cover a wide range of skills. Assistance in the theoretical content of some courses is given by lecturers from local technical colleges. Practical projects have been made an integral part of some courses and this as well as helping with the development of inmates giving them actual site experience has made it possible for improvements to be carried out at establishments.

The following numbers of inmates received industrial and vocational training during 1979:

<table>
<thead>
<tr>
<th>Course</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic engineering</td>
<td>48</td>
</tr>
<tr>
<td>Motor vehicle mechanics</td>
<td>37</td>
</tr>
<tr>
<td>Domestic appliance servicing</td>
<td>18</td>
</tr>
<tr>
<td>Radio and television servicing</td>
<td>20</td>
</tr>
<tr>
<td>Bricklaying</td>
<td>35</td>
</tr>
<tr>
<td>Carpentry and joinery</td>
<td>50</td>
</tr>
<tr>
<td>Painting and decorating</td>
<td>159</td>
</tr>
<tr>
<td>Hairdressing</td>
<td>22</td>
</tr>
<tr>
<td>Upholstery</td>
<td>12</td>
</tr>
<tr>
<td>General building work</td>
<td>122</td>
</tr>
</tbody>
</table>

The standards taught in day classes range from remedial education to presentation at higher grade level for the Scottish Certificate of Education. A number of inmates have gone on, while in custody, to take Open University courses.

Physical Training and Recreation

Most establishments devote a significant part of the training programme to physical training and recreation. There are obvious difficulties of security and space, but inmates nevertheless are able to take part in activities such as gymnastics, circuit training, weight-lifting, swimming, badminton, boxing, basketball, hockey, bowling, football, tennis, croquet, lawn bowls and indoor hockey. As part of the programme of helping inmates keep themselves physically fit and mentally alert, several establishments hold sport days. Football is in general the most popular sport, and

there are playing facilities at most establishments. The most popular indoor activities are snooker, billiards, table-tennis, dart and dominoes. Several borstal inmates have won swimming certificates and bronze medals for lifesaving tests and inmates have taken part successfully with people from the surrounding community in activities such as football, table-tennis, chess, athletics, weightlifting, the Duke of Edinburgh Award Scheme and the Thistle Award Scheme.

Community Service

Inmates at most establishments undertake projects of voluntary help to the community. Help is given to the aged and infirm in redecorating their homes and tending gardens. Food is prepared for the meals on wheels service. Other activities undertaken include tidying holiday beaches, restoring canal banks and paths, help in local children's homes and community centres, assisting at fêtes run by voluntary organisations, and helping to build a leisure centre for a mentally handicapped society. Some establishments are involved in a project washing coins collected in public houses for the Royal National Institute for the Blind; a pioneer project is being undertaken to transcribe Open University texts into Braille for blind students.

Selected borstal trainees take part in camps at venues throughout Scotland. Each camp, as well as having a recreational content also includes a project such as assisting with mentally or physically handicapped children or adults who are at the camp or undertaking a work project in the vicinity.

PRISON INDUSTRIES

In the old days, prisoners worked in their cells, mainly on making and repairing mailbags and similar simple occupational tasks. Since the late 1930s, there has been a trend towards more productive work, and in recent years there has been a positive attempt to provide workshop conditions comparable to those of manufacturing employment in the outside community. Up-to-date equipment is now supplied wherever workshops are constructed or modernised. A prisoner works a week which, at a current maximum of 35 hours, is near the basic working week of an outside factory. The Headquarters organisation responsible for prison industries provides planning and co-ordination of production, and centralised marketing. Work is seen as part of the inmate treatment and training process, the objectives of rehabilitation are kept in focus, and though industrial efficiency is sought as part of the workshop environment, the provision of useful activity takes priority.
over the economies of commercial production. Work should provide an outlet and perhaps an education for the prisoner, exposing him to the habit of regular work, and to the demands for application, discipline and co-operation which are found in the manufacturing unit outside.

Rates of pay are on two basic scales. Earnings for piece-rate work can range from all to £2.20 a week; and for prisoners on flat-rate from 71p to £1.77p. Earnings in battles and young offenders institutions are generally lower. These rates do not mean that the labour is cheap: to the wage costs must be added expenditure and a lower return on overheads and capital employed because of the need for training and the shorter hours worked. Prices for the products of prison industries are set at levels appropriate to market conditions.

In the planning of prison workshops and activities, through selection and diversification, care is taken to minimize any effects on private sector industry and employment. Regular meetings are held with the representatives of the Confederation of British Industry and of the Scottish Trades Union Congress, also with representatives of certain other trade unions and associations. Some 210 prisoners are currently employed in prison workshops: 125 in workshops; 125 in workshops; and 22 in outside employment. Other inmates are employed on domestic tasks within the establishment, such as kitchen and cleaning work, or on trade and vocational courses. A proportion of inmates — 12.5 or 25 per cent — is not effectively employed. These include inmates held pending trial and those not required to work for medical or other reasons.

Domestic consumption accounts for some 15 per cent of all production in Scottish Prison Industries, and about 30 per cent of production is undertaken to meet needs of other Government departments, leaving the balance of some 35 per cent to be taken up by the private sector market. This means of course that prison products must be competitive in terms of price and quality. The workshops include facilities for manufacture of a wide range of products. These include a number of products in light and heavy textiles, in panel and upholstered furniture, toys and general woodwork. Woodwork products include beds, tables, beds and tables for garden use, and toys for the private sector market. Plant and garden ornamental work in concrete is made at Barlinnie. At Aberdeen and Peterhead work in ropes and nets is undertaken for marine work. The Young Offenders establishment at Glenochil includes facilities for manufacture in glass reinforced plastic, and there are metal fabrication workshops at Polmont, Glenochil and Edinburgh. At a number of establishments, in particular at Penninghame and Noranside, horticultural and agricultural operations provide productive employment for inmates.

The value of goods and services from Scottish prison industries amounted to £2,900,000 in 1972/73. Thirty-five per cent of this output went for domestic use, including such items as prisoners' clothing, cell furniture and officers' uniforms; 30 per cent represented sales to other Government departments, and the remainder (35 per cent) sales to the private sector. Sales to the private sector have increased since 1972 and it is planned to expand this penetration even further as new production resources come on stream.

Spiritual Welfare

Chaplins and visiting clergymen play an important role in all establishments. They are concerned with the spiritual welfare of the inmates, and give support both by visiting and giving day-to-day help in religious and personal matters by holding services. All religious beliefs are catered for. Attendance at services by inmates is voluntary.

Health Care

All prisoners are medically examined on admission and receive medical attention as required during their sentence.

Barlinnie Prison is the only establishment with full-time medical staff. At other establishments general medical services are provided by visiting general practitioners who, with their partners, provide full-time cover. Psychiatric and psychological services are provided by visiting consultant psychiatrists and psychologists who hold joint appointments with the Prison Service and the National Health Service. Dental treatment facilities are provided.

Prison nurse officers are trained to Enrolled Nurse standards at NHS schools of nursing.

Letters

Prisoners are at present allowed to write one letter each week to relatives and friends, with postage paid from public funds. Postage for additional letters is met from the prisoner's earnings but before being allowed to write extra letters he has to submit for the Governor's approval a list of people with whom he intends to correspond. Prisoners' incoming and outgoing letters are inspected. Prisoners at Penninghame open prison and on training for freedom schemes are in general allowed uncensored correspondence.
Permission may be granted for prisoners to write to their children (under 16) on plain paper which does not indicate place of origin.

Home Leave
Prisoners who are classified as tailees and serving two years or more may be granted a period of five days' home leave in the final three months of their sentence. Conduct and industry must normally have been exemplary during the year before the date of eligibility and home conditions must be satisfactory.

Petitions and complaints
Inmates have a number of avenues open to them should they wish to complain about treatment within prison. They have the right to (a) see the Governor or the Visiting Committee, (b) write a letter of request or complaint to the Secretary of State or the Visiting Committee — this letter not to be opened inside the prison if the inmate has elected to close the envelope, (c) write to a Member of Parliament and (d) write to the European Commission on Human Rights. Inmates are also perfectly free to seek advice, file a complaint through internal channels, or seek legal advice and to take legal action over civil matters.

Members of Visiting Committees, which provide a valuable link with the outside community, are appointed by local authorities in the case of prisons and by the Secretary of State in the case of establishments for under 21s. Members also deal with certain disciplinary offences by inmates.

Prison Visitor Scheme
Friendship and understanding often form important needs in the lives of many prisoners, and these needs are met to a considerable degree by operation of a prison visitor scheme that started at Edinburgh Prison and since extended to Aberdeen and Dunbar. The scheme was started by members of local churches in Edinburgh. Selected prisoners are allowed the privilege of receiving visits from members of the general public who have kindly offered their services. Normally, the approach is made in the first place by a prisoner who wishes to be included in the scheme; and, if he is considered suitable, arrangements are made by the prison chaplain to put him in touch with a visitor. Visits are made to a prisoner in his cell normally once a week; and although there are no specific restrictions on subjects discussed it is clearly advisable that these should not include legal matters, prison conditions or references to prison staff. Selected prisoners may be considered for special

escorted local short leaves, each lasting about four hours. These take place every three months and escorts are provided by prison visitors or prison staff who have volunteered. Mutual trust is involved in the scheme, which works well and is useful for improving relationships and helping prisoners maintain contact with the outside community. The support and friendship of prison visitors is greatly appreciated by both prisoners and prison staff.

Parole
The parole system allows prisoners to be released, under specified conditions, to serve part of their sentence under supervision in the community. A person in prison or detained in a young offenders institution may be released on parole after completing at least a third of his sentence or one year, whichever is the longer period. Since normal remission a prisoner is released after two-thirds of his sentence, parole is limited in practice to those serving more than 18 months. Certain young people sentenced on indictment and placed outside prison service establishments (e.g. in a List D school) may also be eligible for parole. The decision to release on parole is taken by the Secretary of State on the recommendation of the Parole Board for Scotland. Once on parole, a licence requires the parolee to comply with certain conditions; and to secure compliance he is supervised by a local authority social worker from the area in which he will stay. During the period of the licence he is subject to recall to custody for breach of any of its conditions.

Unless the inmate has opted not to be considered for early release on parole, a first review of his case is put in hand in advance of the date on which he would be eligible. A dossier of information is laid before a local review committee (appointed by the Secretary of State and comprising the inmate’s Governor, an officer of a local authority social work department and at least one independent member) and this is followed by scrutiny of the case by the Secretary of State, acting through his officials. Cases in which the Secretary of State is prepared to contemplate release are formally referred to the Parole Board for Scotland; if the board makes a recommendation for parole then (exceptional circumstances apart) the Secretary of State will authorise release. Cases in which the Secretary of State is not prepared to authorise release go to the board for information only, though if the board feels that any such people might be released their case will be reconsidered by the Secretary of State.

Of the 379 cases referred to the Parole Board for Scotland in 1978, 262 were recommended for parole, 70 were not recommended for parole but of this total 15 were recommended for ‘early review’. The chairman of the
Parole Board for Scotland is Mr D A P Barry, an Edinburgh company director. One of the board’s prime considerations in recommending early release must be the safety and protection of the public. A very serious view is taken of breaches of parole licence, and the board does not hesitate to recommend recall of a parolee when such a course seems apt.

Special arrangements apply to the release on licence of persons sentenced to life imprisonment or to detention during Her Majesty’s pleasure. The decision to release is taken by the Secretary of State after consultation with the judiciary and on the advice of the Parole Board.

Training for Freedom
The Training for Freedom scheme aims to ease selected prisoners serving sentences of three years or more into a situation where they can work with an employer outside the prison. Prisoners taking part in the scheme - a total of about 20 - receive some privileges intended to increase their sense of responsibility and enjoy improved living conditions in an atmosphere which calls for a positive response. They live in hostels adjacent to Aberdeen, Edinburgh and Perth Prisons, and thus have no contact with the main prison population. The Parole Board has recognised the value of the scheme for pre-release training and in some cases has recommended that a period of training for freedom would be beneficial before release on licence. Progress by prisoners during this testing period is carefully studied and analysed. Occupations taken up include building labourer, joiner, electrician and clerk. Hostel institutions also have a scheme where selected inmates work regularly outside the institutions with local employers.

Untried prisoners
As far as possible, untried prisoners are kept apart from convicted prisoners. They may request to wear their own clothing provided it is suitable and clean. They are not required to work, but may do so if they wish and receive payment. On payment, untried prisoners can have rooms or cells furnished with suitable bedding and other articles in addition to, or different from, those supplied for ordinary cells and can have at their own cost the use of private furniture and utensils approved by the Governor. Cash may be lent in far untried prisoners to enable them to purchase food and other items from the canteen or kitchen. Such prisoners may also have food brought in from outside.

SPECIAL UNIT, BARLINNIE
The Unit was set up in March 1973 on an experimental basis following the recommendations of a departmental working party on the treatment of certain male long-term and potentially violent prisoners. Housed within, but segregated from, Barlinnie Prison. It has its own governor and staff comprising both discipline and nursing officers and supported by a consultant psychiatrist and clinical psychologist.

An essential feature of the Unit has been that the staff/inmate relationship should be a close one in an attempt to break down traditional antagonisms.

The “community” of staff and prisoners within the Unit is regarded as having played a positive part in establishing meaningful relationships.

Inverness Unit
A unit exists at Inverness Prison to accommodate certain prisoners. The type of prisoner likely to qualify is one who has a bad influence on other inmates, persistently refuses to co-operate or exerts generally a subversive influence in the prison to which he has been allocated and who has not responded to appropriate measures in his prison of classification. Prisoners are not kept in this unit, with its strict but nonetheless humane regime, for longer than three months save in exceptional circumstances. A minimum of privileges is granted, all dining is in cells, and there is no recreation in association with other inmates, although there are normal exercise periods. Television viewing is not permitted and accumulated visits, where due, are deferred until the prisoner is returned to his original prison from the unit. A board meets each month when the unit is occupied to consider all cases in custody.

BUILDING PROGRAMME
Prisons and other institutions, many built in the late 19th century and at the beginning of this century, have often been overcrowded. The average daily number in custody in 1978 was 50,625 higher than ten years earlier. Programmes of new construction and improvement have, like many other areas of public expenditure, been subject to financial restrictions over the years, although work has been carried out as finance becomes available.

The new female institution at Cornton Vale, the medium security prison at Dungavel, the new young offenders institution at Glenochil and the first phase of the new Shotts prison have all been completed since 1975 and spending on building work in 1978/79 was almost £1 million.
The Government announced last year a £1 million programme of redevelopment and refurbishment at Peterhead, to commence in 1980 and approval has been given for planning to begin on the second phase of Shotts prison, which when completed will increase the number of places there from 60 to 540.

The completion of Dungavel and Glenochill has also released accommodation for adults at Edinburgh prison.

LIST OF ESTABLISHMENTS (INMATE POPULATIONS ARE FOR 1979)

**Prisons**

**Abertay:** Local untried prisoners. Local prisoners with sentences of 18 months or less and certain older ordinary prisoners with sentences of over 18 months. Average daily number of prisoners - 159 men, 3 women.

**Bellahouston** (Glasgow): Local untried prisoners of 21 and over; local prisoners with sentences of 18 months or less (also includes special unit for disturbed and resistant prisoners). Average daily number of prisoners - 914 men.

**Cornton Vale:** All categories of women prisoners. Average daily number of prisoners - 58.

**Dumfries:** Local untried prisoners. Average daily number of prisoners - 21 men.

**Dungavel:** For selected prisoners who, by their behaviour and outlook are considered suitable for less restrictive conditions. Average daily number of prisoners - 111. (The number of prisoners here will be gradually built up to the design capacity of 156).

**Edinburgh:** Local untried prisoners; local prisoners with sentences of 18 months or less; first offenders with sentences of over 18 months. Average daily number of prisoners - 579 men.

**Grendon:** At present under redevelopment as a male adult establishment. Average daily number of prisoners - 27 men.

**Inverness:** Local untried prisoners; local prisoners with sentences of 18 months or less (also includes segregation unit). Average daily number of prisoners - 91 men, 1 woman.

**Low Moor (Kirkcudbright):** Selected prisoners with sentences mainly of six months or less. Average daily number of inmates - 222 men.

**Penninghame Open Prison (near Newton Stewart):** Prisoners selected as suitable for open conditions. Average daily number of prisoners - 47 men.

**Perth:** Local untried prisoners; local prisoners with sentences of 18 months or less, certain ordinary prisoners with sentences of over 18 months. Average daily number of prisoners - 525 men.

**Peterhead:** Certain younger ordinary prisoners with sentences of over 18 months. Average daily number of prisoners - 274 men.

**Shotts:** For selected prisoners, mainly of 'B' category, serving a wide range of sentences, and transferred from other prisons (No untried prisoners). Average daily number of prisoners - 51 men.

**Young Offenders Institutions**

**Cornton Vale:** All female young offenders. Average daily number of inmates - 19.

**Dumfries:** Youths with sentences of over two years. Average daily number of inmates - 116.

**Edinburgh:** Local youths with sentences of six months or less. Average daily number of inmates - 40. (Closed in February 1979 and inmates transferred to Glenochill).

**Frinton (Perth):** Youths with sentences of six months or less. Average daily number of inmates - 63.

**Glenochill:** A new institution which can accommodate 500 inmates. Average daily number at present - 379.

**Borstal Institutions**

**Castle Huntly** (near Dundee): Open institution for youths likely to respond in rural conditions to more individual methods of training including engineering skills who may become suitable for outside employment. Average daily number of inmates - 87 youths.

**Cornton Vale:** For girls; although this is a closed institution, inmates may qualify for outside employment. Average daily number of inmates - 41.

**Noranside** (near Forfar): Open institution for youths judged suitable for a fairly strenuous open-air life and likely, in the latter part of training, to be able to work without constant supervision. Average daily number of inmates - 67.
Polmont (near Falkirk): The main borstal institution in Scotland at which all youths are received initially; some are subsequently allocated after assessment to one of the other institutions. Average daily number of inmates - 205.

Detention Centre
Glencoeil (near Aboyne): The only detention centre in Scotland - for youths aged not less than 16 and under 21 - which provides what is often referred to colloquially as a “short, sharp shock”. Average daily number of inmates - 59.

Remand Institution
Longriggend (near Airdrie): For youths remanded to Barlinnie Prison for examination or trial. Average daily number of inmates - 250 youths.

FACTS AND FIGURES
Figures in the table below relate to prison receptions in 1978 and average daily prison population in 1979.

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<thead>
<tr>
<th></th>
<th>Receptions (1978)</th>
<th>Average daily population (1979)</th>
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<tr>
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<td>Male</td>
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<tr>
<td>Total of remand and sentenced* prisoners</td>
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</tbody>
</table>

*No figures are included here because some of these persons received under sentence are also included in the figures of those on remand.

Further Reading
More detailed information on specific subjects may be found in the following:

- **Prisons in Scotland — Report for 1978** (also published for previous years) Command 7749 HMSO £3.25
- **Criminal Statistics — Scotland — 1978** (also published for previous years) Command 7676 HMSO £3.75.
- **Parole Board for Scotland — Report for 1978** (also published for previous years) HC Paper 95 HMSO 85p.
Pilmuir (near Falkirk): The main borstal institution in Scotland at which all youths are received initially; some are subsequently allocated after assessment to one of the other institutions. Average daily number of inmates - 763.

Detention Centre
Glenrothes (near Alloa): The only detention centre in Scotland – for youths aged not less than 16 and under 21 – which provides what is often referred to subsequently as a "short, sharp shock." Average daily number of inmates - 59.

Remand Institution
Lonyre (near Airidrie): For youths remanded to Barlinnie Prison for examination or trial. Average daily number of inmates - 250 youths.

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<tr>
<td>Total</td>
<td>16,773</td>
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<tr>
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<td>of which time defaulters</td>
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<td>of which time defaulters</td>
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<td>Detention Centre inmates</td>
<td>720</td>
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<tr>
<td>Total of remand and sentenced* prisoners</td>
<td>919</td>
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Criminal Statistics – Scotland 1978 (also published for previous years) Command 7676 HMSO £3.75.
NOTES ON TREATMENT IN HOMING

PHILOSOPHY

A person is considered to be responsible for his behaviour.

He must have some degree of self-activity for change.

His aim is to become aware of his behaviour and how this is regulated by his emotions/feelings. How these two affect his relationships.

Behaviour

\[ \text{Feelings} \rightarrow \text{Relationships} \]

To develop and correct social skills by involvement in the community.

To completely examine and bring about an alteration in lifestyle.

A person is in treatment in the community. He is not sick, being treated by a doctor and nurses. He is a person allowing himself to share in the support, examination, confrontation of his peers in his whole life situation.

Viz: His emotional needs
His physical needs
His disordered behaviour
His disordered feelings
His disordered relationships
His resources, emotional and physical

To develop and enhance those positive qualities he may possess and so produce some feeling of worth.

ACCEPTANCE CRITERIA

A. Personality Disorders

1. Inability or disability in forming and sustaining satisfactory emotional relationships.

2. Inability to perceive one's own needs in relationship to the needs of others.

3. Practice of extreme behaviour. Violent attacks on others or property or self.

4. Persistent repetitive destructive or delinquent acts which show a lack of judgment.

5. Displacement or deviation of emotional drives, eg violence, sex, gambling, drink, drug usage, delinquent behaviour.

B. Voluntary consent is required both at the initiation and during the continuation of treatment.

C. At least 3 year sentences with maximum stay of 2 years, optimum stay of 15 months (+ or - 2) and minimum of 12 months.
EXCLUDED FROM ADMISSION

1. Any individual with active psychosis;
2. Of low intellectual capacity;
3. Presence of significant organic brain damage;
4. Age. It is highly desirable that people in this work are below the age of 30, but depending on the needs, up to the age of 35-40;
5. Strongly paranoid individual.

POSITIVE FACTORS FOR ADMISSION

1. Some degree of insight, no matter how slight, that he is in some way going about his life in an unsatisfactory manner.
2. Some degree of achievement, eg one 'O' Level
   a. Lance-corporal in the Army
   b. Union representative at work
   c. Duke of Edinburgh's award
   d. Some success in team work or athletics, no matter at what level.
3. Some degree of drive, some creativity, even if associated with aggressive behaviour.
4. Some degree of social stability - a period of marriage or cohabitation no matter how short lived
   a. Period in his parental or fostered home of 3 or 4 years

TRANSFER FROM THE COMMUNITY

Decision-making process

3-tiered to meet 3 different sets of circumstances.

1. Doctor will transfer in event of medical reasons:
   (a) surgical etc
   (b) the emergence of a psychosis
   He will confer with the wing and staff, and make the decision.

2. Disciplinary matters, eg a fight
   The staff have the power to decide after careful exploration of the whole situation.
   The Doctor delegates this decision making and is an active collaborator in the exploration and evaluation and decision, but in the staff group it is one man one vote.
In most cases the staff, after discussion, may hand the decision-making on to the community and after further exploration and evaluation, the community will come to a decision on transfer by one man one vote.

In consideration of transfer when a person is seen by the community not to be responding or being unable to take part in the treatment regime, the assessment group, after deliberation, will take a vote, the assessment group being made up of two members of the community and at least four staff members. The assessment committee's decision is final.

All these decision-making procedures can apply only to matters that occur on the wing. If a person commits a disciplinary breach outside the wing or in relationship to somebody outside the wing, he is subjected to a report and adjudication by the Medical Superintendent.

All wing decisions are, by their nature, recommendations to the Medical Superintendent.

**Reasons for Transfer**

1. Physical violence which can't be tolerated by the community.
2. Opting out of treatment. Persistent inability or refusal to conform to the rules of the community, say, 4 times in 1 month.

**List of Rules:** All Prison Rules apply, plus:

1. No confidences. On arrival a person agrees to enter into the situation where no confidences are permitted between himself and any other person on the wing.
2. No violence to self or to others is permitted.
3. If a person wishes to leave he must discuss his wishes and after careful deliberation he then may take his wish to the wing meeting. He makes an open statement on the wing meeting and his decision is final and irrevocable.

3. The development or uncovering of other treatment needs, eg

- psychosis (therapists decision final)
- physical treatment
- other treatments, ie the need for conditioning or individual treatment
- the emergence of the patient as a professional criminal
- the second offence of a serious nature, ie smuggling in drugs or brewing up
- gross emotional dependency, associated with institutionalisation.
  (The person must have some capacity for taking action in altering his own methods of behaving. He must also experiment and have sufficient drive and motivation to involve himself. If this is not present and he is totally dependent, he is unsuitable for this form of treatment)
- threats associated with homosexuality.

*He has come to Crandon to serve his sentence in a less rigorous environment; has no motivation for change.*
No chemotherapy is usually necessary; chemotherapy drugs are not given. (Aspirin would be given for headache but this would be open to group discussion.) Medical drugs, eg Penicillin, if required.

Reasons:
1. A person is considered responsible for his behaviour and he and the community have resources to control this behaviour without the protection of medication.
2. In the intensive treatment he must be aware of his feelings in relationship to his behaviour and how this affects his interpersonal relationships. His perception is dulled or altered by medication.

Options must be provided for sleepless nights, namely use of dormitories, opportunities to read, do craft work, listen to music.

Full involvement in Therapeutic Community Regime. If a person is under stress he may be permitted to stay on wing.

Group meetings involving staff and men with:

- community meetings
- small group meetings - no movement between groups
- interaction groups
- role-playing groups
- work groups
- discharge groups
- family groups
- committee meetings
- reception groups - the reception group is held the day after a new patient's arrival and is to examine his expectations in the field of change and is made up of chairman, secretary, assessment rep, group rep and staff.
- assessment groups - held at the end of the first month's treatment and are complementary to the reception groups. The assessment group is made up of the assessed, assessment representatives (2) and at least 4 staff, one of whom is the group officer involved or, in his absence, an allocated group member. The assessment group may decide:
  1. for transfer - this is binding on the community
  2. an assessment at a period less than 3 months
  3. for a normal further 3 months review

full free communication (feedbacks - no one/ones)

Areas of decision making, management and control groups using therapeutic community principles such as Democracy:

- Boundaries and limit drawing
- Permissiveness
- Role mobility
- Communication

The community or wing meeting is the central point of the treatment. There are small groups who operate in a close intimate manner. All welfare and other needs are dealt with by the small group with the consent of the community.

The welfare officer acts as a consultant in welfare matters.
GOALS

To develop skills of communication and experimental allow for experiment with feelings and so for a person to improve his ability to relate with others in a productive way and correct methods of relating which are destructive to himself and others.

By the development of communication and social skills it is hoped a better method of communicating results, particularly in deep emotional relationships and because of this improvement in the person he ceases to use extreme delinquent behaviour patterns, e.g. theft, drug abuse etc. He develops some insight into his emotional needs and develops some feelings of his own worth as a person.
This booklet is designed to give the reader information about the way in which the Special Unit at Barlinnie has developed since its inception in February 1973. Although the Unit has a relatively short history, the concept has caused considerable interest in the world of penology; and much discussion within the Scottish system. It is hoped that the information given in this paper will make the reader more factually aware of what the Unit is about.

Original

The Special Unit at Barlinnie was set up following the recommendations of a Departmental working Party on the Treatment of Certain Male Long Term Prisoners and Potentially Violent Prisoners which reported in 1971. The main result of the Working Party was to consider what arrangements should be made for the treatment of certain inmates likely to be detained in custody for very long periods or with propensities to violence towards staff. In the 10 years 1961-1970 about 40 prison officers were assaulted by inmates using a weapon or sharp instrument - in the period since there have been seven such incidents. Prison staff were particularly concerned about violent prisoners serving long determinate sentences and since the abolition of the death penalty, shut the prospect of very violent prisoners serving life sentences, who might take the view that they had nothing to lose by violent and recalcitrant behaviour and about the effect that these prisoners might have on others.

The main conclusion of the Working Party was that a special unit should be provided within the Scottish Penal System for the treatment of known violent inmates, those considered potentially violent and selected long term inmates. It was envisaged that the regime in the Unit would be psychiatrically orientated and that for this purpose there should be psychiatric support, that staff should be a mixture of discipline and nursing officers are that the traditional officer/inmate relationship should be modified to approximate more closely to a therapist/patient basis while retaining a firm but fair discipline system. The Unit would have its own Governor and would be run separately from any other establishment.

It proved impracticable to set up a new purpose-built unit and it was decided to adapt the former women's section in Barlinnie Prison for use as a Special Unit to accommodate up to 10 prisoners. The highest number accommodated at any one time has been seven (?). The Unit was opened in February 1973 and the first prisoners were admitted shortly afterwards.

A basic concept of the Unit is to involve the prisoner not only in his own treatment but also that of his fellow inmates. During the first 18 months that the Unit had been in operation, the involvement of both staff and inmates had developed to the point that they regarded themselves as a single community wherein each has equal voting power and equal responsibility. All members of the community are accountable to the weekly community meeting and in the words of one of the prisoners “if someone does something detrimental to the community he has to answer to the community and it is no secret that the 'hot seat' can be, and is, a harrowing experience and is much more effective than any Governor's punishment.”

Imprisonment does not only deprive a man of his liberty, but, because he must conform to the routine of an institution, it also deprives him of the need to take many of the decisions which are an every day part of life outside. On the other side of the coin, staff are accustomed to making the decisions and having the inmates carry them out. Therefore, both staff and inmates have to adjust themselves to a situation where all are involved in the decision making process. This has led to the questioning of many long accepted prison practices.
At the crux of such a concept is whether one aims at 'control and permissiveness' or 'responsibility and freedom'. We believe we have to talk about 'responsibility and freedom'; the freedom which leads to responsibility and free people from some of the restrictions which we might otherwise have to impose. It is, we believe, a more appropriate kind of spectrum 'responsibility and freedom' than 'control and permissiveness' because the concepts around these first two words are appropriate not only for inmates, not only for staff, but for staff and inmates together.

RELATIONSHIPS.

The development of relationships has always been the first and prime objective in the Unit, based on the logic that it is only by a proper understanding between people that real progress can be achieved.

The methods used to reach this understanding were based on the creation of an atmosphere where prisoners and prison officers could get together to debate, argue and confront each other. There was a marked level of suspicion and apprehension shown by everyone in the initial period. The intensity of this highly charged situation was breached by allowing for free discussion. From this emerged a variance in relationships amongst staff and staff, prisoner and prisoner, and staff and prisoner. The real effect of these relationships has meant that everyone is allowed to operate individually, casting aside traditional roles and loyalties.

COMMUNITY MEETINGS.

When the Unit opened in 1973, the practice was to have regular staff and inmate and staff meetings. During these early days there was one staff meeting and two staff/inmate meetings weekly with the further addition that 'special meetings' could be called at any time by any member of the group. As relationships and trust developed, the need for that number of formal meetings decreased and it has evolved to the present position where we have one formal, statutory community meeting normally held on a Tuesday and an informal community meeting held on Friday. The facility for any member of this group to call 'special meetings' is available.

Meetings are conducted in the following fashion:

FORMAL COMMUNITY MEETINGS.

The Tuesday formal meeting is regarded as compulsory with everyone expected to attend. The conduct of this meeting is based on the normal rules of debate: (a) A Chairman is elected from amongst the members present; (b) a record of the proceedings is minuted. During the course of the meeting the Chairman asks each individual member if there is anything he wishes to raise. If so, then this is open to discussion and debate. This meeting is regarded as the instrument for discussing general issues and proposing individual programmes and the ongoing development of the Unit. General decisions are reached by consensus, but there are occasions when a vote is required. Individuals are not discussed when not present, except when circumstances demand the alleviation of a crisis.

The ideas and propositions emanating from this meeting are processed for decision through the Governor and can be referred to the Department. Minor domestic decisions, i.e., handicrafts etc., are resolved locally.

Matters affecting the staffing and security of the Unit are not normally discussed at this meeting except where these factors have implications for the community as a whole. Decisions on such matters are not taken by the community.
This meeting is held on a Friday and is the opportunity for the community to meet with the Consultant Psychologist to air views informally. The meeting is generally used to discuss individual and group behaviour both in theory and practice.

SPECIAL MEETINGS.

These have evolved as a method designed to resolve immediate problems of concern or tension and can be called by any member of the group at any time. Minutes are taken of these meetings and discussed at the next statutory community meeting.

GROUP MEETINGS.

This group comprises of 4 people made up of staff and inmates. These were instigated for the benefit of new members within the community and are structured to inform the individual about the Unit philosophy. They are also used by individuals who may have difficult in coping with the larger group.

STAFF MEETINGS.

The early practice of having regular staff meetings which were designed to discuss individual inmates, in their absence, became unnecessary because staff felt more able to resolve these issues at a community meeting.

Opportunities remain for staff meetings to be held to discuss staffing and security matters.

AIMS:

(Prison Scotland Rules 1952: Number 5: 'The purpose of training and treatment of convicted prisoners shall be to establish in them the will to lead a good and useful life on discharge and fit them to do so').

We believe the practice evolved since the Special Unit opened is the best for achieving the objectives of the rule above.

The individual choice of programme is to some extent determined by the stage in sentence, but despite the realism of a long time still to serve, in some cases, our belief is that we are preparing everyone for living outside. The only difference being time scale. The process by which this is achieved is:

ADMISSIONS

(a) Prisoners are nominated by Governors in their parent prison.

(b) This recommendation is discussed at the Community meeting where 2 staff are elected to accompany the Governor and the Consultant Psychiatrist to interview the nominee and others associated with him.

(c) Each nominated inmate is given a description of the Unit's activities. The interview team base their recommendations on their views of the prisoners' ability and willingness to participate in and derive benefit from the Unit.

(d) The interview team, after interviewing the nominee, have further discussions with the Community and a recommendation is made to the Department.
In the event of a positive recommendation the prisoner is escorted to the Unit by the Special Unit staff, preferably the staff who interviewed him. The value of full community discussion prior to admission is that it means everyone can participate in the way in which the inmate is introduced to the Unit. The experience of the Special Unit has shown that new admissions do have difficulties in dealing with the problem of making simple decisions and accepting responsibility.

SETTLING IN PERIOD.

We recognise that the new inmate, in coming from the traditional institutional setting, needs time to accept the concept of 'freedom with responsibility'. It is normal practice for the community to monitor the introductory period as a safeguard to the new entrant and to the community. This takes the form of structured daily 'groups' consisting of 2 experienced members and the most recent member of the community. The purpose of this being, to lend him support, give him information on the philosophy behind the Unit and to be able to assess his maturity in accepting responsibility. There is also the informal ongoing contact with other members of the community.

On a physical level his visits are closely supervised by a member of the community. This has the added advantage of introducing members of the community to the inmates' relatives and friends, therefore giving them a deeper understanding of the aims of the Unit so that they in turn can support him and become involved in helping him shape his future.

Another precautionary measure taken by the community is the censoring of mail. Normally this is carried out by a member selected by the community.

The close monitoring and supervision of the new inmate has no fixed time scale. It is our experience that this does vary from individual to individual, therefore flexibility is essential. Any decision to remove the close monitoring must be done at a community meeting after full discussion.

FREEDOM WITH RESPONSIBILITY.

We believe that it is important for any new addition to the community to have a full understanding of the way in which the Unit has evolved. At this point it would be appropriate to remind the reader that the Special Unit is experimental and that the standard it maintains is by learning through experience as opposed to any rules imposed from the outside. This can best be illustrated in dealing with the problem of violence.

When the Unit first opened, the majority of inmates admitted had long histories of violence within the penal setting. Thus, the emphasis was on how to resolve this. In allowing inmates the freedom to express verbal aggression without fear of being punished, one was preventing the build-up of tensions which could have resulted in physical violence. In those days, lots of anger was expressed and staff found this difficult to cope with, but through enduring such confrontations a more meaningful understanding began to form which eventually developed into meaningful relationships. As a result of the relationships, the confidence in the group grew to allow physical changes such as the use of metal cutlery instead of plastic cutlery, of proper crockery instead of metal trays, and the freedom to use tools without supervision.

As a community we extensively discussed the problem of violence and concluded that we would find the use of physical violence intolerable. To date no member of staff has been physically assaulted. There has been one occasion of violence by one inmate on another inmate.
In retrospect, it is interesting to note that the level of verbal aggression has largely diminished and, indeed, comes mainly from new inmates. Although the community finds difficulty in dealing with this in the early days, the experience gained has provided a development of skills and expertise to deal with this constructively.

When the community feel that an individual is capable of being able to accept freedom with responsibility, he finds himself in a less supervised situation.

This includes uncensored mail, incoming and outgoing, though it is made clear to the inmate that any correspondence with a Member of Parliament must first go through the normal channels. He is allowed his visits in his cell with a member of staff being in the area, though it should be emphasised that initially most inmates find it difficult to converse and relate to their visitors, therefore members of the community take part in supporting him through this. Again the reader should be reminded that there is a great deal of movement and interaction between the community and visitors to the Unit. It is not uncommon for the family visitors and friends to become involved in the recreational facilities. There is no structured daily routine which gives the inmate the freedom to plan his own daily routine. This can be a difficult experience for an inmate who has been used to his day being structured for him. The only collective demand made on him in terms of work is that he must share in the domestic chores and for this he is paid in cash. The normal practice is that inmates usually pool their weekly wages to supplement their diet and to purchase other extras. We recognise that all of these areas could be opened to abuse. On the few occasions that this had occurred, the inmate responsible is made to account for his actions to the community and as quoted in the Scottish Office Press Handout 1974: ‘If someone does something detrimental to the community he has to answer to the community and it is no secret that the “hot seat” can be, and is, a harrowing experience and is much more effective than any Governor’s punishment’. In conclusion it is worthy of note that new members of staff have to undergo the same introductory machinery in order to gain confidence in expressing his views. He also has parallel problems of structuring his own daily routine.

ONGOING PROGRAMMES.

There is no stereotype training programme laid down for inmates, rather after the initial period the inmate develops, in discussion with the community, a programme which is appropriate to his needs.

Those needs can change from time to time and in discussion with the community, programmes evolve which are seen to be of benefit at any given point in time.

The aim of the programme is to allow for the agreed development of the inmate’s total personality and will include opportunity for emotional development, the opportunity to try and possibly reject a variety of educational and cultural activities and, depending on sentence stage, an appropriate pre-release programme.

One of the difficulties in developing a programme is the uncertainty of how release is arranged. It is our belief that some inmates would choose and benefit from being released through the traditional programme, but it is also our strong belief that there should be the opportunity for others to be released direct from the Unit.

SUMMARY.

The Secretary of State in his statement of Monday 13 February 1978 said: ‘It is my intention that the work of the Unit should continue and that the broad principles on which the Unit has been run should be maintained. We hope that the Working Party in referring to the Secretary of State’s statement above will accept the collective experience as outlined in this document, from all associated with the day to day running of the Unit, as being the most appropriate basis for the future management and
APPENDIX A

CELLS.
Inmates have free choice of decorating their cells, wallpaper, paint, etc. Furniture: free choice of layout and style (inmates can make items in joinery shop).
Electrical facilities: television, radio, recorders, bed lights, etc.
Cells have electrical points.

Note: Sanitary conditions same as most other prisons - chamber pot.

ROUTINE.
Doors unlocked Monday - Friday 6.00 am - 9.00 pm.

Inmates are locked into the cell area behind metal grill gate between 5.00 - 6.30 pm. while staff leave for evening meal. Two staff are left on patrol during this period. Inmates can go to their cells, have access to joiners' shop, individual workcells, shower and each other's cells. Saturday and Sunday doors unlocked 7.30 am - 5.00 pm. (unlocked at 6.30 pm. for inmates to slop out and make cup of coffee).

CLOTHING.

Own clothing and footwear is allowed, also wristwatches and jewellery.

VISITS.

No restrictions on the number of visits. A visit pass must be made out by inmate for each visitor and signed by staff member. Visits take place in cells.

Visitors are allowed to bring small amounts of cash, food and tobacco for inmates.

TELEPHONE.

Inmates are allowed to talk briefly to incoming callers, under supervision, to confirm visit arrangements.

One suggestion for discussion is whether a pay telephone should be fitted in the Unit.

WAGES.

Inmates are paid in cash £1.77 per week.

FOOD.

Dry rations collected from main kitchen in Barlinnie Prison. These are supplemented by inmates combining their weekly wages in order to make a more interesting diet. An inmate does the cooking.

RECREATION.

Billiards, darts, cards and coloured television are available.
There is no collective or set out working day. Work is an individual choice: Art, Open University, Educational Courses, Woodwork, Crafts, Pets.

There is a collective morning cleaning task to keep the Unit reasonably tidy.

TOOLS.

Inmates involved in individual interests where there is the use of tools take responsibility for them. There is no daily shadow board check.

OUTSIDE YARD.

Free access during open periods.

NOTE:

All equipment to decorate inmates' cells, the use of electrical goods, clothing etc. are all paid for by the inmates.

The coloured television is paid for by weekly contribution from staff and inmates.
APPENDIX B.

STAFFING.

The Unit staff are made up from selected volunteers from the Service. All prison staff are given the opportunity to spend a period of one week in the Unit as a means of observing, at first hand, the day-to-day working of the Unit and its general philosophy.

This opportunity is given in order to give staff a chance to assess the potential of the Unit and also as a means of giving individuals some idea of what is expected from staff employed in the Unit.

Volunteer applicants are screened for fitness to work in the Unit by means of direct interview with a board composed of a Consultant Psychiatrist and Psychologist and the Unit Governor and Chief Nurse Officer.

A critical factor in the Unit's development has been related to the staffing issue. The principle of the staff being selected from volunteers is considered vital to the operational requirements of the Unit and indeed, it has been consistently suggested that the Governor should also come from those who volunteer.

The fairly high turnover in staff has been rather destructive in the sense of the way in which developing relationships of a positive nature are prevented.

We consider it essential that staff continuity should be preserved and we concur with the view expressed in the Working Party Report of 1971 which suggested that there must be only limited movement of staff. We are of the opinion that staff who wish to leave the Unit should be allowed to do so, but we are convinced that there must be no set 'cut off' time for individual length of service in the Unit. Our experience tends to prove that the best value gained from individual staff is provided by those who have the benefit of a fairly long experience of work in the Unit.

APPENDIX G.

ADMISSIONS.

Further to the statement described in the admission of inmates to the Unit, it should be remembered that the Unit's aim is to provide a service for the rest of the system and it is a matter of concern that more use is not made of the facility provided.

There have, in fact, been 16 admissions to the Unit since it opened: 10 serving indeterminate sentences and 6 serving determinate sentences. Of these, 7 are still in the Unit.
After a five year experimental period capital punishment for the crime of murder was abolished in 1970. The Scottish Prison Officers' Association expressed concern about the vulnerability of its members particularly in regard to prisoners serving life sentences. A Departmental Working Party was therefore set up within the Scottish Home and Health Department to consider the treatment of certain male long-term prisoners and potentially violent prisoners.

The membership of the Working Party included senior officials of the Scottish Prison Headquarters, a consultant psychiatrist, two prison governors and representatives of the Scottish Prison Officers Association.

The Working Party took oral evidence from senior medical officers, psychiatrists and governors in the following institutions - Perth Prison, Peterhead Prison, Inverness Prison, Parkhurst Prison, Broadmoor Hospital, Grendon Underwood Prison and the State Hospital, Carstairs. Practice in other countries, particularly Denmark, where capital punishment has not been used for very many years, was also studied.

The Problem.

Violence in the penal setting has existed as long as prisons have existed. This is understandable since very few men will accept lightly the loss of their freedom. To that loss they may react in many different ways of which violence against themselves, their fellow prisoners or their custodians is only one, but it can be considered as the most serious.

It should be recorded, however, that the incidence of violence in Scottish prisons is, comparatively speaking, very small. This is all the more remarkable when it is considered against a penal population which has increased steadily since the end of the second world war and the increasing number of crimes of violence in the community over the same period. The problem of prison violence is very much a personal one, specific to the individual who is violent. To attempt to produce an omnibus label for this type of prisoner would not only be misleading, but
could be dangerous, since people, and perhaps prisoners in particular, have a tendency to try and live up to the reputation (or label) placed on them by others.

With the abolition of capital punishment the Scottish Prison Service had to accept that it would be called upon to keep in custody some persons sentenced to indeterminate periods of detention, for very long terms, i.e. in excess of twenty years, and in some cases, literally for life. This was a task of which the Service had no experience. How will a prisoner react when he realises that eventual release is unlikely or, at best, is so far distant as to be meaningless?

Earlier attempts to solve the problem.

In the 19th century in England and Wales violence by a prisoner was usually met with violence in the form of corporal punishment. This, however, did not apply in Scotland, where, until the setting up of the Prison Commission in the latter half of the century, prisons were locally administered and no statutory power to inflict corporal punishment on prisoners for offences against prison discipline was available. The situation was altered, but only in a limited fashion, with the opening of Peterhead Prison in the 1880's.

The building of Peterhead Prison was authorised by an Act of Parliament, the main purpose of which was to build a harbour of refuge at the fishing port of Peterhead and for which convict labour was to be used. Peterhead Prison was therefore operated under the rules which applied in English convict prisons; and one of these rules empowered the then prison authorities to inflict corporal punishment for certain offences against prison discipline of which violence to members of the prison staff was one. In the 60 or so years for which the power to inflict corporal punishment was available it was seldom used and fell into disuse after 1933, although it was not finally abolished until 1949. From 1949 onwards acts of violence by the inmate population were punished by various means such as loss of remission, forfeiture of privileges, deprivation of association and perhaps restricted diet. The heaviest penalty of these was forfeiture of remission since, in serious cases, powers existed to deprive the prisoner of all remission and, in the
case of a prisoner serving long sentences, this could be equivalent to a substantial additional sentence.

As part of their study the Working Party visited the Special Unit set up within Parkhurst Prison, the psychiatric prison at Grendon Underwood and the special hospitals at Broadmoor and Carstairs. In addition the chairman of the Working Party had the opportunity in June 1970 of studying Danish methods of treating long-term prisoners.

Punishment and treatment.

Generally speaking the public considers that the function of the prison is punishment. Punishment of offenders is a function of the court. The prison has two functions. The first to implement the punishment imposed by the court by depriving the offender of his liberty. The second, equally important and much more difficult, so to treat the offender that he will lead a 'good and useful life' on release. Where, however, the reaction of a person to imprisonment is such that he commits offences within the institution, the prison will appear to take on a punitive role. And yet this punishment, in so far as it seeks to persuade the prisoner that his lack of co-operation is unlikely to assist his rehabilitation, does have a rehabilitative element. But where the prisoner reacts to punishment by committing more serious offences, the question is raised whether this form of treatment is counter-productive. In accepting that there could be no easily discernible line between punishment and treatment, the Working Party sought to establish why certain prisoners behaved violently in prison and to consider, from the information gained, how such violence might be eliminated or, at worse, reduced and contained.

The Working Party's enquiries suggested that there were a number of causes of violence. Despair and frustration at the beginning of a long sentence are not uncommon causes, but violence caused by these tends to be of a minor nature and disappears after the first year or so when the prisoner settles down. The immaturity of the psychopath, or some other form of personality disorder, can manifest itself in serious violence and while the degree of disorder may be insufficient to warrant transfer to a mental hospital the Working Party felt that some provision should be made
In the view of the Working Party, the most dangerous prisoner was a creation of the prison sub-culture itself. A notorious criminal committed to prison immediately becomes an object of respect and admiration by the lesser criminals in the prison population. If he wishes to retain that respect, it is necessary for him to demonstrate that he is among the top men in the prison. He may do this by challenging the existing leader or leaders, but more likely by overt actions against the prison authorities. The more serious the offence, the greater respect will be accorded by his fellow prisoners. However, he will only maintain his position by frequent demonstration of his prowess; by accepting and meeting the demands of inmate pressure.

The admission to prison of a notorious criminal is also carefully observed by staff. If, as a result of inmate pressure, he behaves as above, or even in anticipation of any trouble, staff will quite rightly keep a very close watch of such a prisoner. Such close surveillance may well be seen by the prisoner not only as irksome, but a form of victimisation; in other words, staff pressure. The Working Party came to the conclusion that some means had to be devised of placing such a prisoner in a setting where such pressures could be reduced thereby lessening the chances of violent outbreaks.

Recommendations.

In concluding their report, the Working Party included the following recommendations:
1. A special unit should be provided within the Scottish penal system for the treatment of known violent inmates, those considered potentially violent and selected long term inmates.
2. Adequate working and recreational facilities should be provided both internally and externally and the unit, as a whole, should be completely separate from the main prison.
3. Initially the staff to man the unit should be recruited from volunteers.
4. Staff should be a mixture of discipline and nursing officers who, except for strictly nursing duties, would be wholly interchangeable.
5. The Unit should have its own Governor who will be independent of the main prison and his appointment should be made well in advance of the opening of the unit so that he may consider and be involved in the training of the staff.
6. The Governor should be closely supported by a consultant psychiatrist employed on a part-time basis.

7. The senior member of the uniformed staff should be a chief nurse officer.

8. The chief nurse officer should be supported by two principal officers and two senior officers, one of each of whom should be nurse trained.

The staff should be sufficient to ensure that there are never less than 4 officers on duty at any one time.

9. Staff should obtain experience in the treatment of the mentally disordered.

10. Replacement of staff should be gradual and not more than two at any one time.

11. The traditional officer/inmate relationship should be modified to approximate more closely to a therapist/patient basis for retaining a firm but fair discipline system.

All of the recommendations have been implemented, although not necessarily in the form envisaged by the Working Party. The present unit is housed in what was formerly the women's section of Barlinnie Prison. This accommodation is far from ideal but from our experience of operating the unit in less than satisfactory conditions, the design and lay-out of a purpose built unit can be devised.

**Progress to Date.**

The recommendations of the Working Party were accepted by the Secretary of State. After investigating various possibilities, it was decided that, to provide the unit as quickly as possible, the former women's section of Barlinnie Prison should be adapted for the purpose. Work started on the adaptation in the early autumn of 1972 and was completed in February 1973. The Unit staff interviewed and assessed those prisoners who had been recommended as suitable for such a unit and, by the beginning of March, five prisoners had been transferred to the Unit.

Initially the relationships between staff and inmates was strained, but this was very soon overcome and the majority of inmates became involved in the painting and decorating of the unit. A basic concept of the unit is to involve the prisoner not only in his own treatment, but also that of his fellow inmates.

During the 18 months that the Unit has been in operation, the involvement of both staff and inmates has developed to the point that they now regard themselves as a single community wherein
each has equal voting power and equal responsibility. All members of the community are accountable to the weekly community meeting and in the words of one of the prisoners "if someone does something detrimental to the community he has to answer to the community and it is no secret that the 'hot seat' can be, and is, a harrowing experience and is much more effective than any Governor's punishment."

Imprisonment does not only deprive a man of his liberty, but because he must conform to the routine of an institution, it also deprives him of the need to take many of the decisions which are an every-day part of life outside. On the other side of the coin, staff are accustomed to making the decisions and having the inmates carry them out. Therefore, both staff and inmates had to adjust themselves to a situation where all were involved in the decision-making process. This has led to the questioning of many long-accepted prison practices. An example, early in the experience, of the Unit, was the suggestion that the "silent cell" (designed to hold recalcitrant inmates) should be done away with. Some of the staff were apprehensive about this because of the past history of some of the inmates. However, the majority was in favour of doing away with the cell and after the meeting the door of the cell was taken off its hinges. At present it is used as a weight lifting room. The need for its original use has not arisen.

The inmates are, so far as the physical limitations of the unit allow, encouraged to devise their own work programme and their own hours of work. This has resulted in their working longer hours than usual and in a higher standard of work. Together with staff they have drawn up their recreation programme which relies heavily on outside speakers from various walks of life. Other forms of recreation involving the co-operation of outside experts have resulted in one of the inmates, who is both the most notorious and most violent, discovering a talent of a very high order for sculpture, and this is being encouraged.

It is not yet possible to draw many conclusions from the operation of the Unit. It is remarkable, however, that since its opening there have been no serious assaults on staff anywhere in the Scottish prison service.

What the Unit holds for the future.

So far as can be ascertained, the Unit is unique in penal practice. Its experimental nature will therefore continue for some considerable
following several discussions on the problems of helping new arrivals - staff and prisoners - settle into the Unit community model which has evolved over three years, highlighted by incidents involving two recent arrivals, it was agreed that a form of induction programme be introduced. One-to-one contact has its values but it was considered that this put people into rather vulnerable positions. Recent work in America involving 'Triadic Therapy' has shown the value of utilising the previous experiences of others who have undergone crises situations in helping those who are presently undergoing them. It was felt that something incorporating this model should be experimented with to assess its induction value but that four could be the number involved in the following permutations depending on whether a new prisoner or a new staff member is the subject.

(a) Experienced Staff  <>  Recent arrived Prisoner

Experienced Prisoner  <>  New Staff Member

(b) Experienced Staff  <>  New Prisoner

Experienced Prisoner  <>  Recent Arrived Staff Member

The recently arrived member should have graduated from his '4-Group'. The rationale is that a balance is maintained by the experienced staff and prisoner with possibly the more recent settling in of the complementary group member.

Prior to the arrival of the new member of the community, the three existing members of the '4 Group' are designated at a meeting. The task and responsibility of the group is two-fold:

(1) INDUCTION:

The newcomer is introduced to the daily programme and the events in the community. Following significant experiences, i.e. community meetings, etc., it is the responsibility of the group to explain what has happened in the context of the development of the Unit. The newcomer should be made to feel free to ask any questions but it should not be assumed that there are no questions that there is nothing to be explained as there is a natural reluctance to appear ignorant in most people.

(2) ASSESSMENT:

Another vital function during the initial period is assessment, i.e. identifying any problems which may need to be considered to help the newcomer settle in, any interests which should be encouraged, any personal difficulties in adjusting to the Unit etc. The length of life of a particular '4 Group' was not fully determined but it may be that at least once daily during the first month should be the minimum with the length of the session determined by daily contingencies; following that at least once weekly or more if it is felt of value in particular instances during the next two months.
APPENDIX 2:

List of individuals contacted during the Planning and Execution of the Trip.

A. Overseas contacts:

Regional Psychiatric Centre (Pacific)
Abbotsford, British Columbia,
Canada.

Dr. Chuni Roy, Medical Superintendent/Director
Mr. Roger Marceau, Research Psychologist
Mr. John Boileau, Acting Assistant Director of Security.

Department of Criminology
Simon Fraser University
Burnaby, British Columbia
Canada.

Professor Duncan Chappell
Dr. William E. Lucas

Regional Psychiatric Centre
Kingston, Ontario
Canada

Dr. R. Brown, Medical Superintendent/Director
Mrs. Sharon Williams, Principal Psychologist
Mr. C. Turner, Director of Security.

Regional Headquarters (Ontario)
Ministry of the Solicitor General of Canada
Correction Service of Canada
Kingston, Ontario
Canada

Mr. Ross Duff, Regional Manager of Security.

Correctional Staff College (Ontario)
Ministry of the Solicitor General of Canada
Correctional Service of Canada
Kingston, Ontario
Canada

Mr. M.E. Millar, Director
Mr. C.Q. Burton, Regional Training and Development Officer

Federal Bureau of Prisons
United States Department of Justice
Washington D.C.
U.S.A.

Mr. J.D. Williams, Assistant Director, Correctional Programs Division
Mr. George Diffenbaucher, Executive Assistant to Mr. J.D. Williams
Mr. Robert Powitzky, Chief Psychologist
Mr. Garland Jeffers, Training Programs Development Officer
Radical Alternatives to Prison (RAP)
THE HOSPITAL encircled by a wall 6½ metres high topped with a radar head anti-climbing device (21 ft total) will provide nursing care and a full range of psychiatric services for the treatment of 400 patients in a very secure environment. It will provide much needed relief to Broadmoor Special Hospital where there are staffing and overcrowding problems.

PHASE 1 is made up of 2 pairs of linked wards named as will be all the later ones after prominent figures in English literature. The linking of wards permits the closing down of one end the concentration of activities in its neighbour when the majority of patients are elsewhere eg at work or recreation. This in turn releases ward staff for duties elsewhere and no economies in manpower.

EACH WARD provides patients up to a maximum of 25 with their own individual self-contained rooms. The large communal rooms have all been designed in the interests of economy and efficiency to serve more than one purpose. The dining room is equipped so as to make it an ideal reception room where patients may entertain visitors. Similarly the television lounge provides the setting for group psychotherapy and similar therapeutic activities which feature significantly in the treatment prescribed for many patients. The library is not only a quiet room where patients may read and study or write letters but may also be used for case conferences, staff training and other group activities. The central recreation area provides ample space for cases of smoker and table tennis and for social events. The general spaciousness of the larger rooms allows good but unobtrusive observation of the patients by their nurses.

INTERIOR DECORATION has been influenced in the main by the need to keep maintenance costs as low as possible without ever exposing the security features embodied in the structure. Fair faced brickwork, exposed beams, painted concrete surfaces and melamine faced furniture are cases in point. The long life carpets bonded directly to concrete floors are stain resistant and easy to clean or repair.

HEATING of the hospital will be from 12 separate boiler houses each serving a small group of buildings and burning gas-oil. The fuel with 3 months reserve will be stored centrally and piped round the site. In addition to its flexibility the great advantage of this scheme is the elimination of the cost and energy dissipation inherent in a site heat distribution system. The amount of regular maintenance required will be small as both the dual purpose burners and fuel distribution pipes are equally suitable for natural gas should gas-oil become too expensive or difficult to obtain.

SECURITY is inevitably a very important factor in any Special Hospital catering as it must for patients with dangerous violent or criminal propensities. At the same time the visible levels of security must not be so overpowering as to be counter productive in making patients take extreme risks to escape from an intolerable environment. Successive Secretaries of State have given assurances that there would be no compromise in the levels of security in the new hospital so not only is each ward a secure building in itself but whole sections down to individual rooms can be securely locked off according to the level of security required at any given time. The nurses and other alarm systems all incorporate printed circuitry for reliability and ease of maintenance. Provision has also been made for the isolation of services to a patient’s individual room should his mental condition at any time make this necessary.

THE PREVENTION AND SAFETY MEASURES have been incorporated extensively both in the structure of the buildings and in the materials used for furniture. Corridors are protected by magnetically held fire doors which close automatically immediately an alarm is sounded. Fire hoses capable of reaching the farthest point in each building and emergency fire exits from each area have been provided.

LANDSCAPING has been used to improve the visual amenity of an otherwise featureless site. To soften the impact of the security wall on the landscape there will also be extensive tree planting outside the wall especially on the northern and eastern boundaries.
APPENDIX 2C:

THE GROUP OF PEOPLE WE TREAT AT GRENDON ARE THOSE WITH PERSONALITY DISORDERS:

1. Personality Disorder.
   a. Inability or disability in forming and sustaining satisfactory deep emotional relationships.
   b. Inability to perceive one's own needs in relation to the needs of others - egocentricity.
   c. The practice of impulsive extreme behaviour, such as violent attacks on others, or property, or self.
   d. Persistent repetitive destructive or delinquent acts which on examination show lack of judgment.
   e. Displacement or deviation of emotional drives, eg violence, sex, gambling, drink, drug abuse, delinquent behaviour.

2. Types of Offence. We take people with every type of offence, such as arson, drug abuse, all the many varieties of sexual offences, with the exception of sex offences against children when the offender is over the age of 30. History of violent offences does not exclude treatment at Grendon.

POSITIVE REASONS FOR ENTERING GRENDON

Age. Younger age groups in general are more amenable to treatment.

Insight. Some degree of insight or understanding, even though he has been unable to put this into practice, or has not wished to, can be of value as a positive recommendation for treatment.

Motivation. This is very hard to estimate. If a person agrees to come to Grendon this is sufficient. We have found that motivation will increase as treatment and understanding develops. The patient will be asked to decide whether he chooses treatment or parole. It is desirable if this question is put to him before he comes to Grendon, the patient should not come to Grendon pending a parole review or parole decision.

Drive. Some drive even aggressive. This can be seen as a positive attribute as the destructive aggression can be directed into creative and constructive behaviour.

Some Degree of Achievement. If a person is totally unachieved in the late twenties or thirties, is totally institutionalised, is grossly overdependent on authority figures, he does not respond well to treatment.

Criteria for Life. As well as the above criteria, timing of the life sentence is important. We will accept people early in sentence under certain conditions, depending on the nature of the offence, in order to enable the person to enter into treatment while his memory is still alive to his emotional state prior to and at the time of the committing of the offence. We will receive people serving a life sentence in the middle of their sentence if they are undergoing emotional strain of a non-psychotic nature. The third, we accept as they are moving along their life sentence and it is apparent that following a period of treatment a release is being considered. This third group is the most desirable to enter Grendon.

Over the last 3 years we have been accepting people to Grendon with less rigid criteria as we have had an operative assessment/induction unit which has been able to screen suitable candidates. In general we have taken 80-90% of all referrals. If there is any further information needed in a particular case a telephone discussion with the Medical Superintendent or SNM will clarify.

D J Barrett MB ChB DPM
Clinical Director
1. **Acts of Violence:-**

   (1) Neither verbal nor physical provocation should be justification to resort to violence.

   (2) Violence is defined as against person or persons not "things".

   (3) Whenever possible any incident that could possibly be classed as an act of violence be brought to the wing meeting for discussion.

   (4) When note (3) above applies, a vote will be taken by the Wing to decide if the incident warrants transfer.

2. **Asking for a transfer.**

   (1) If any member of 'B' Wing wishes to terminate his treatment and be transferred, the following procedure must be followed.

   (2) In the first instance discuss on your small group. If the person still wishes to be transferred, the person will then inform his small group.

   (3) If, after discussion on group, application for a transfer is still wanted, the applicant must then inform the wing on a wing meeting.

   (4) Once the application has been to the wing, it is an irreversible decision.

3. **No Confidences.**

   (1) Anybody on 'B' Wing is free to quote anything he might have seen or heard.

4. **Plastic Dinner Plates and Meal Trays.**

   (1) Dinner plates and metal meal trays are not to be taken upstairs.

5. **Shop Working.**

   (1) Before a labour change from the shop to a job "off" the wing, a person must have served at least three months in the shop.

   (2) Boots or shoes must be worn to work in the shop.

6. **Chairman:-**

   (1) The Chairman is elected by the community with a 50% majority.

   (2) A Chairman must have served at least six months on 'B' Wing.
(5) The Chairman is a part of the Senate and an
Amendment Member.

(6) The Chairman is responsible for:
   (a) The Chairing of Wing Meetings on Mondays
       and Fridays.
   (b) The meeting of visitors to the Wing.
   (c) The distribution of the Wing newspapers.
   (d) The organising of Special Wings, groups, etc.
       when asked.

7. Vice-Chairman.
   (1) The Vice-Chairman is elected by the community with
       a 50% majority.
   (2) The Vice-Chairmanship lasts for three months.
   (3) The Vice-Chairman is responsible for:
       (a) Assisting the Chairman and standing in
           for him when it is needed.
       (b) Chairing Wednesday Wing Meetings.
       (c) Organising reception groups with the
           secretary and chairing same.
       (d) Organising a cell and all cell furniture
           for each new reception.

8. Secretary.
   (1) The Secretary is elected by the committee with
       a 50% majority.
   (2) The Secretary holds that position on the committee
       for 3 months.
   (3) The Secretary is responsible for:
       (a) Organising the reception groups with the
           Vice-Chairman.
       (b) Putting notices on the board when jobs
           are to be voted on.
       (c) Taking notes on Wing Meetings, Senates, etc.

9. The Senate.
   (1) Composed of the six men who have been on 'B' Wing
       for the longest period of time, plus the serving
       Chairman.
   (2) Any person may call a Senate at any time, after
       first consulting with the Chairman.
   (3) The Senate can only recommend to the Wing courses
       of action.
10. ELECTION OF MEMBERS.

(1) Four members to be elected by the Wing with a 50% majority. One of these to be the current Chairman.

(2) Any member elected to this post must have served at least six months on 'E' Wing.


(1) This is the man who works in the pantry.

(2) He is responsible for conveying any reasonable complaints to the Catering Officer.


(1) Elected by the Wing for a period of three months.

(2) Liaises between Library Officer and Wing.


(1) Elected by the Wing for a period of three months.

(2) Liaises between the film committee and Wing.


(1) Elected by the Wing for a period of three months.

(2) Liaises between the P.E.I. and the Wing.

(3) Is responsible for organising any Wing team for official sports or games.

GROUPS AND MEETINGS.

15. Special Groups.

(1) These fall into categories:

(a) A special meeting of one of the small groups

(b) A Senate

(c) A special Wing meeting.

(d) The Chairman’s approval is required and the group is compulsory.

(e) This is reserved for special circumstances and can be requested by anyone. The Chairman decides whether it is necessary. The usual use is a particularly vehement argument between two or more men, discussion of which cannot wait for a normal group or normal Wing meeting. A Senate group is compulsory.

(f) This can only be called by the Chairman, although anyone may request it. A special Wing meeting is compulsory.

If any person misses two or more consecutive groups of any description, through any reason, other than those beyond his control, i.e. visits, hospital, etc. it will be seen as opting out of treatment and TRANSFER will follow automatically.
16. **Wing Meetings.**

(1) Presided over by the Chairman, of sixty minutes duration.

(2) Monday and Friday are Open Meetings. Wednesday is a business meeting and is chaired by the Vice Chairman.

(3) If there is urgent business to be dealt with then, at the Chairman's discretion, this may be dealt with on Monday or Friday.

(4) Extensions of Wing meetings must be proposed a minimum of 5 minutes before the end of the meeting.

17. **Assessment Committee.**

(1) Quorum is the four elected members and a minimum of four permanent staff. If this is impossible, quorum may be dropped to three.

(2) Visitors to the wing may attend at the unanimous approval of every person being assessed.

(3) Attendance when due for assessment is compulsory.

(4) Every effort should be made to see that a man being assessed has his group officer present. If this is not possible, the substitute should be provided from among his group members.

18. **Reception Committee.**

(1) Consists of the Chairman, assessment member, secretary, plus one representative of each small group not represented by either the assessment member or the secretary. Any staff members that are available are to attend.

(2) Any visitors are allowed to attend.
The destructive, anti-social behaviour of most of the inmates in Bredon, and therefore on each wing, can be thought of as the child-like behaviour of frightened, deprived children, lacking in basic security, a sense of their own identity, and self-esteem. Thus uncontrolled, impulsive violent behaviour, deviant sexual behaviour, alcoholism, and other forms of criminal behaviour and disturbed social functioning can be seen in this way.

Given the correct environment, there is a general tendency for some human beings to grow, and in some way to strive towards healing.

If we can provide an atmosphere of tolerance, acceptance and understanding, we may facilitate this tendency, while acknowledging that we can only too often fail to supply the original deficiencies and deprivations experienced by any one individual.

In general our men have personality defects, but are physically healthy, and are not mentally ill. Therefore they are not treated as if they are sick. Opportunities are provided for them to learn about themselves, and to develop a sense of responsibility for how they behave. Healthy neglect, and an attitude of "It's up to you - get on with it yourself" are the underlying aspects of so-called permisiveness.

Open, honest communication, and feedbacks, give a man a picture of how his behaviour is affecting others, and what sort of image he creates. Ideally each man is in a continual state of adjustment - one hopes towards better relationships with others, less impulsive destructive behaviour, and a little more perseverance towards obtaining acceptable goals - eg. remaining in a job for a longer time than previously, or working for an educational qualification. These aims are to some extent realised - thus a man with a history of violent, aggressive behaviour because less impulsive, more relaxed, and feels less threatened by confrontation; or a man who has never stayed in a job for more than a short time is able to work for a few months in one of the shops. Communication with significant people in his life improves - his parents, wife or girl friend, children, and authority.

Criteria for Acceptance

It is easier to say who are not suitable. The criteria are not clearly defined, but are becoming more so. In general we prefer not to accept men in the following categories:

1. Mentally disturbed, psychotic men.
2. Men with very paranoid attitudes.
3. Men with an IQ below 100 find the regime difficult to cope with, as generally they are unable to understand what is happening, and tend to be made a butt of by the other inmates.
4. Men with nothing to build on - eg no family or other relationships; poor educational background and no persistent work record.
5. Men with a long career of criminal behaviour, and more than two or three periods of imprisonment. Any man over 40 years of age.
6. Men who demand other forms of treatment, such as drugs, aversion therapy, or individual psychotherapy.

7. Men who cannot accept the requirements of the regime - open communication, no confidentiality, attendance on small groups and community meetings.

8. Men coming to Bordon with a long sentence, say more than 2 years, ahead of them, and lifers.


A period of time may elapse before a man is considered to be unsuitable, as it takes some time for his underlying attitudes and expectations to emerge. In this sense a man is under continual assessment both by his peers and by members of the staff.

In general the theoretically ideal candidate would be a man in his middle twenties, who has had some experience of the vicissitudes of life. He should have an IQ of over 100, and have some educational achievement, even if nothing more than a regular attendance at school. He should have some positive relationship in his life, either with a member of his family or a member of the opposite sex. There should be some indication that he is able to work and keep a job. He should not have had more than 2 or 3 previous prison sentences.

Treatment Regime

This involves all members of the wing community, staff and inmates.

The treatment agents are the small therapeutic groups, community meetings, and informal contacts between all members of the wing.

1. There are two small therapeutic groups per week for each inmate. Each group consists of about eight inmates, and where possible is taken by two members of the staff. The groups are for a little over an hour - men almost never transfer from groups to groups.

2. There are two community meetings per week. Each of these meetings starts with a feed-back either from all of the small groups, from the business staff meetings, or from other groups or events. After the formal feed-backs have been completed the meeting is open to all members of it to discuss any topic they wish.

3. There is one other weekly group - which is voluntary. This is a women's group started by Mrs Miller Smith. This has been a loosely organized open ended group made up of different women from Ruskin College in Oxford and a number of men from the wing. Its main purpose and effect is to improve the ability of the men to communicate with women. About eight men and eight women attend.

4. There are five formal staff meetings per week, one on each working day. In addition there are brief informal staff meetings after each community meeting. Each of the formal staff meetings has a different purpose.
(a) One is taken up with feedbacks from each group leader about the small groups.

(b) One is a support group in which problems of staff relationships and behaviour are discussed.

(c) One is a business meeting, in which practical matters to do with the inmates such as home leave, change of labour, progress, and any other aspects of the life of the community are discussed.

(d) A "clinical" meeting at which a new inmate is interviewed, or one who has been on the wing from one to three months, is seen and his progress discussed. One or two representatives from the reception group attend with the new inmate. Any inmate who is posing a problem may be asked to attend this meeting, or he may ask to come on the staff meeting himself.

(e) The final meeting of the week is used to look at the programmes for the coming week, make sure groups are covered when the leaders are on leave or away, and note receptions, discharges, and visitors expected.

The post-community meetings are short meetings in which the reactions to the recent community meeting are aired, and any points of view about what has happened are mentioned.

In addition each new inmate attends three reception groups which are made up of a representative from each small therapeutic group. An attempt is made to assess a man's suitability for Grendon, and a recommendation, by subjective criteria and present group size, is put forward as to which small group he should be on.

As much as possible inmate participation in the staff meetings, apart from the interaction meeting, is encouraged, and any inmate who is being discussed is asked to come to the meeting and to take part. Where education, work, etc are being considered, the appropriate member of staff will also be asked to attend.

Any visitors who are working on the wing for more than a day are automatically incorporated into the community and attend the various meetings, and are entitled to express their points of view.

Probation Officers and members of the family such as wives or parents are also asked to come to the groups on at least two or three occasions during the man's period in Grendon.