SPECIAL CARE UNIT:

PAST AND PRESENT DEVELOPMENTS

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INTRODUCTION

The Special Care Unit is housed in a prison wing formerly used to accommodate inmates in the Metropolitan Reception Prison, one of the maximum security goals situated in the Malabar Complex of Prisons in Sydney, Australia. During the period 1979-81, the building was renovated by the New South Wales Department of Corrective Services at a cost of approximately one million Australian dollars to up-date cell accommodations, provide living amenities and work space (offices, security areas, storage rooms for supplies and prisoners' property, therapy rooms, library, kitchen/dining area, and landscaped yard) and install a security system of closed-circuit television cameras throughout the building. At the conclusion of this work, the old prison wing had become a fully autonomous maximum security prison within the walls of another maximum security institution, housing a maximum of eighteen prisoners in single cell accommodation.

The building houses two separate programmes at the present time: the Special Care Unit and the Malabar Assessment Unit (a living area for psychiatrically disturbed prisoners, staffed by psychiatrically trained nurses and prison officers). The dimensions of the entire building are as follows: 14.1 metres in width, 43.6 metres in length and 21 metres in height as measured from the ground to the apex of the roof, providing a total floor space of 1,116 square metres. The working area of that portion of the building utilised by the Special Care Unit are as follows: floor space of 748 square metres and a landscaped yard of 320 square metres.

The custodial staff structure of the Special Care Unit consists of a Superintendent, Assistant Superintendent and four Principal Prison Officers, all of whom are permanently attached to the institution, as well as twenty-one prison officers temporarily seconded to the Unit from other New South Wales penal institutions. In addition, a Senior Psychologist (designated as Second Officer-in-Charge) is permanently attached to the Unit to oversee the programming and therapy of inmates, as well as the selection and training of staff. There are three shifts of custodial staff in the Unit: 0630 - 1430 hours (five officers), 1430 - 2230 hours (six officers) and 2230 - 0630 (two officers), plus a day shift to perform additional security and escort duties between 0830 - 1630 hours (two officers). During the busiest portion of the day when officers are required to supervise prisoners' visits, escort inmates to hospital, interview inmates applying for the programme, perform various miscellaneous duties and maintain the security of the institution, there are ten custodial officers on duty. It should be noted that the staff requirements are determined by the fact that the Special Care Unit is "open" sixteen hours per day, every day of the year.

It has often been remarked that a home cannot be defined by a description of the furniture in it or the amount of space it contains. Likewise, the foregoing information gives no indication of the Special Care Unit, its historical background, philosophy, programme or accomplishments which far transcend the physical descriptions above.
I. HISTORICAL BACKGROUND

The Special Care Unit at the Malabar Complex of Prisons was set up following the recommendations of a Departmental Working Party whose brief was the disposition and treatment of certain prisoners within the prison system who suffered from some form of emotional disturbance. Previously these inmates were housed in the Observation Unit at Malabar, but this facility was considered to be woefully inadequate.

In addition to the departmental concerns about that facility, the Observation Unit (OBS) at Long Bay was the subject of strong criticism by Mr. Justice Nagle in the Report of the Royal Commission into New South Wales Prisons (1978). The old OBS Unit accommodated a wide range of prisoners: individuals who, while not sick, were very emotionally disturbed, sometimes violent and often unpredictable in their behaviour; prisoners who were being protected from other inmates, and men who were in need of continuing psychiatric treatment. It was clear that this Unit did not represent a solution to the difficult issue of mental health care delivery.

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

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

To cater for the needs of prisoners exhibiting signs of psychiatric illness, the Corrective Services Commission, with the participation of the Health Department of New South Wales, set up the Malabar Assessment Unit. This facility is managed by a Psychiatrist and staffed with psychiatrically trained nurses and an occupational therapist, as well as custodial staff.

II. PHILOSOPHY OF THE SPECIAL CARE UNIT

Over the years, there has been heated debate among individuals working in various phases of correctional work as to the impact of prisons upon the incarcerated offender. Considerable lip-service was given to the elusive concept of "rehabilitation", but little substantive progress was made in articulating the sorts of goals and mechanisms necessary for the achievement of this objective. In time,
the more workable notion of "re-education" replaced "rehabilitation" as the desired goal for a correctional system. This concept suggested a programme of attitude change and skills training that seemed to the more readily understandable to both prisoners and prison officers, the central actors in the correctional drama. In addition, "re-education" implied a participative process that was missing in the other notion, as well as more realistic criteria for measuring the success of programmes designed to achieve such an objective (i.e., qualitative changes in skills and/or the ability to understand and utilise new ideas). "Rehabilitation", on the other hand, was suggestive only of a desirable end-point that seemed to defy measurement or precise specification.

The Special Care Unit was conceived as a "re-education" programme. It was designed along the lines of a therapeutic community in which prison officers were the therapeutic agents who would be responsible for the day-to-day programming of the Unit in consultation with other professionals, such as psychologists, probation and parole officers, medical staff and clergy. The emphasis implied by the phrase "other professionals" was an important one because we wanted officers in this unit to feel that they were performing a job that was professional in every sense of the word. That is, they would be carrying out services the value of which could be seen and respected by others in the System.

It follows from the above statement that we also conceived of the Special Care Unit for staff development, a programme for "prison officer re-education". In recent years, the role of the Custodial Officer has come under increasing criticism, not the least of which has been from the officers themselves. A sincere desire for work satisfaction and a need on the part of custodial staff to earn the respect of the general community had lead to an examination of the prison officer's role in correctional work. Many of these men and women in prison work were seeking an identity as professionals, but had no idea of how to improve the sorts of jobs they were required to do. Much of their difficulty could be traced to a very narrow definition of the custodial role on the part of both prison officers and officials. It was felt that the therapeutic community was an excellent model in which to pursue this task of role re-definition for officers. From the start, "therapy" was seen as a process involving the mutual growth of all participants.

III. STAFF SELECTION

In the early planning for the Special Care Unit, it was decided that very few of the staff would be permanently appointed to the Unit (i.e., four Principal Prison Officers, the Assistant Superintendent, Superintendent and Senior Psychologist). All the other custodial positions are filled by officers who volunteer to work in the Unit and are interviewed for secondment to the institution for an initial probationary period of six months, renewable for an additional period of twelve months if the officer was assessed as suitable to carry out the duties required and desired to remain attached to the Unit. The rationale behind the decision to staff the facility with seconded officers rather than permanently appointed ones related to the desire of the Corrective Services Commission of use the Special Care Unit as a training facility in which officers could experience
an expanded work role and subsequently return to the main prison system with the benefits of this training. The description for these seconded positions reads as follows:

"The Special Care Unit is an experimental therapeutic community run by a team of custodial, psychological and other professional staff. It will operate in an informal, non-traditional manner, which will be characterised by a high level of democracy, where frank and open discussion will be encouraged, and where there will be a maximum involvement in the decision-making process.

Officers employed in the Unit must be understanding, accepting and empathetic. Selected officers will be stable and mature in temperament, well informed about modern penological practices and have demonstrated an interest in the Department as a career. They will also have the ability to function in a multi-disciplinary group.

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

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

All applicants are given individual interviews during which they are told about the aims of the Unit and questioned about their reactions. Following this, the applicant is presented with a number of hypothetical prison situations (e.g., a depressed prisoner, a manipulative prisoner and a physically assaultive prisoner each of whose behaviour requires the officer to respond in some unspecified fashion) and asked what action he or she would take. In this part of the interview the applicant's flexibility, interpersonal concern and ability to act in a non-traditional fashion are assessed. Finally, three role plays are done with the applicant to assess potential counselling skills. Responses to this task are graded in terms of the ability to make a positive counselling response (personal, non-judgemental, caring, etc.). These vignettes prove most difficult for the candidates, but are a valuable indication of the abilities of applicants to perform in the Special Care Unit programme.

IV. TRAINING OF STAFF

To date, two training programmes have been designed and conducted for the staff of the Special Care Unit. The initial induction programme was conducted over a four week period. The primary objectives of that exercise were as follows:

A. Establish in consultation with the officers the aims of this therapeutic community and its functions.

B. Give officers insight into the dynamics of groups and group leadership and assist officers to perceive, understand and report what is occurring in groups.
C. Develop skills in known counselling techniques to facilitate possible assessment of these techniques when applied by the officers.

D. Provide opportunities for officers to experience the dynamics of therapeutic interaction with emotionally disturbed people.

E. Introduce officers to symptoms of disturbed behaviour and their possible significance so that they can seek appropriate assistance.

In addition to these stated objectives, it was hoped that the following goals would also be achieved:-

1. Custodial staff would seriously question their traditionally passive role and begin to exercise independent modes of decision-making.

2. Staff would recognise how the traditional custodial role limits their options to care for individuals in crisis.

3. Officers would understand how they could be therapeutic agents without compromising their need to maintain security.

4. Staff would become a community and begin to develop a joint approach to problems of management.

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

The content of that first training programme included a number of exercises designed to enhance group cohesiveness. In addition, there were lectures on various topics relating to therapy (the abnormal personality, concepts of transactional analysis, behaviour modification, contributions of psychiatry in prison, etc.), as well as site visits to several psychiatric hospitals in the Sydney metropolitan area. The purpose of these psychiatric site visits was to desensitize officers to the "acting out" of mental patients, as well as allow them to observe group therapy. In the end, course participants felt more comfortable with the issue of psychiatric illness and dealt openly with their apprehensiveness in relation to personal contact with individuals exhibiting emotional disturbance.

One of the highlights of that first training programme was the discussion of "what is a therapeutic community?" This exercise required the participants to meet in small groups to define three important concepts: therapy, community, and therapeutic community. "Therapy" presented the greatest difficulty due to the insistence of participants that "it is something we, the officers, do to them, the prisoners." Though originally schedule for 2½ hours, the discussion occupied more than 6 hours, at which time the realisation occurred
that therapy was a process involving mutual growth. These moments of insight contributed immeasurably to the growth of community among the participants.

At the conclusion of this four-week training period, the Special Care Unit staff prepared the Unit to receive its first prisoners to the programme in late March, 1981.

Late in 1982, it was becoming increasingly apparent that many of the original staff were experiencing "burn-out." Accordingly, a concerted effort was made to recruit new staff to meet the needs of the Unit. For this purpose a second training programme was designed and conducted by me with the aid of a senior health educator attached to the N.S.W. Department of Health and a female prison officer who had been one of the original members of the Special Care Unit staff. This programme, which was held in mid-March, 1983, was one week in length. During this period, those prisoners currently in the Unit were placed in other nearby institutions and training was carried out in the Special Care Unit.

The aims of these sessions were identical to those of the original four-week schedule, but a number of topics from that programme were eliminated in light of the experiences gained by staff during the first two years of running the programme. Site visits and lectures on many therapy topics were eliminated and greater emphasis was given to group cohesiveness exercises and small group discussions related to problems encountered by staff in the past. For these sessions, my co-trainers and I prepared a large volume of readings dealing with therapeutic topics and other therapeutic communities. It was felt that this material would serve as a basis for these sessions, as well as for on-going professional development of officers in the institution.

V. THE "THERAPEUTIC COMMUNITY" AS TREATMENT MODEL

As previously stated, the Special Care Unit is a therapeutic community. This conceptual model defines a style of management and a philosophy of caring representing an attempt to reduce formality and humanise relationships, share input in the decision-making process by means of group discussion and consensus-taking, provide maximum communication throughout the therapy setting and reduce to a minimum the hierarchical system commonly found in institutions. All elements of the community are seen as important to the treatment programme. Thus, relationships and personalities of staff and inmates are seen to be the raw material for a therapeutic process that involves the active elucidating and working through of personal interactions.

Every effort is made to get the prisoners to become actively involved in each others' treatment. In this way, the prisoner is able to understand more clearly the extent to which he has become institutionally dependent. By highlighting and actively opposing the dependency needs of prisoners, staff are attempting to encourage growth of a perception of reality that is free of the distortions so prevalent in penal institutions. For example, the image of the "prisoner as victim" is actively opposed and every effort is made to demonstrate to the inmate how he wittingly or unwittingly places himself in a position whereby he is deprived of the opportunity to make an impact on his environment by means of appropriate actions
through legitimate channels. Thus, the encouragement of accurate reality testing is seen as an implicit goal of the therapeutic programme.

The Special Care Unit is represented to the prisoner as a place in which he may examine certain life issues that have impeded his personal development in the past. He is encouraged to delineate these issues and explain their significance to the other members of the community during the process of therapy. Typical examples of such personal issues are low self-esteem, uncontrollable feelings of anger and aggression, drug and alcohol addiction, frequent failure of personal relationships, problems in dealing with authority figures (e.g., prison officers, policemen, managers in a work situation). Thus, the Unit is represented as a self-help programme in which inmates are able to examine their own lives, as well as encourage such examination on the part of their peers. Obviously, the explicit and implicit goals of self-help and the accurate perception of reality are complementary.

VI. PROCEDURES OF THE SPECIAL CARE UNIT AS AN EXTENSION OF THE PHILOSOPHY OF THE UNIT PROGRAMME

The formal work of the Special Care Unit is carried out in groups of various sizes. Dyadic therapeutic interactions ("one-to-ones" between an inmate and an officer, another inmate or the Unit psychologist) are discouraged because work carried out in such a social configuration is easily distorted by one or the other member of the dyad at a later date when these conversations are used as the raw material for formal therapeutic intervention. This issue of distortion is closely related to the second concern about "private therapy": such contacts are not accountable to the community because they are often delivered as "confidential communications". In other words, access to these interchanges by the community is difficult to obtain and, in a very real sense, such forms of exchange work against the very nature of "community". However, such contacts are useful for aiding the inmate to clarify his feelings and "rehearse" personal material to be brought up in group therapy. The emphasis on the public nature of therapy is central to the Special Care Unit programme. In this way, the entire community is able to function as "therapist" for individual members. The mechanism for this therapeutic intervention is the "social mirror" in which the individual is given accurate and immediate feedback by the group. Thus, there is encouragement for prisoners to evaluate their own actions in the presence of prison officers as part of therapy. This "social mirroring" becomes the means through which inmates develop and express care for others (including officers), attain insight about their motivation, recognize and accept consequences for their behaviour and overcome the sort of egocentrism that is fostered and maintained in prison by such ideology as "the prisoner code". It must be emphasized that every effort is made by staff to reinforce realistic attitudes and social perceptions among members of the community.

A number of procedures have been devised to carry out various aspects of the Unit programme philosophy, including the following:
1. Admission procedure
   a) initial screening/goals clarification interview
   b) entry assessment

2. Formal therapeutic groups
   a) small therapy groups
   b) large therapy groups
      i) community meetings
      ii) crisis meetings
      iii) communication/debating groups

3. Self-assessment procedure

4. Body corporate

It must be stressed that all of these procedures are social situations that share two aspects of Unit philosophy:

- presence of custodial staff working with prisoners to arrive at insights about attitudes and behaviour, and
- the public nature of therapeutic intervention as central to the concept of community.

In the following section, each of these procedures will be described in terms of its contribution to the therapeutic programme.

1. Admission Procedure

The admission procedure is a two-phase process, enabling the candidates for admission to the Unit to clarify their motives/goals and provide an opportunity for community members (officers and inmates) to participate in the admission process. During the initial screening/goals clarification interview, conducted by me and a prison officer, a number of purposes are accomplished. Initially the inmate's reason(s) for coming into the Special Care Unit is reviewed in a discussion of either his application for interview or the referral that has been submitted on his behalf. It should be noted that referrals may come from any number of sources: psychologists, probation/parole officers, clergy, prison officers, solicitors, judges, the Ombudsman's Office, other prisoners, etc. This discussion involves a description of the Unit programme, as well as a number of misconceptions about the facility commonly held among members of the inmate population. Examining the prisoner's need to enter the Unit is often a difficult process. In a large number of cases, the inmate is unclear about what he could do in the programme other than "get my head together". Obviously that sort of response is unacceptable as the basis of a therapeutic contract for the simple reason that there is no opportunity to evaluate when such a global and undifferentiated objective had been met. This process of negotiating the therapeutic contract is of central importance inasmuch as most of the applicants have been unaware that the Unit programme involves contracted self-help. Thus, a central task of the initial interview involves the explanation of the contract as a public statement of goals and objectives that can be evaluated during the course of the therapeutic intervention. Often the inmate is asked to more carefully define his goals and objectives with the help of psychologists in his particular goal, after which another
interview is arranged. In these interviews, the prison officer provides details about the function of the Unit, while the psychologist involves himself in the negotiation and clarification of the material that will become part of the therapeutic contract. The presence of the custodial officer in this phase of the admission procedure is of symbolical importance: the officer is seen to be a therapeutic change agent working in partnership with the psychologist.

The entry assessment is carried out by a panel of three inmates and three officers, one of whom had been on the initial screening interview. It is this officer's job to introduce the candidate to the panel and, if necessary, aid the prisoner in clarifying his goals for entering the programme. I, as Unit Psychologist, am not present at this interview. It is relevant at this point to highlight the participation of inmates on this panel and relate it to the programme. The greatest barrier to therapeutic progress in any prison setting is the "prisoner code", a set of traditions dictating a rigid code of conduct regarding the relationship of inmates and officers. During the early history of the Unit, entry of candidates was determined entirely by staff; inmates were informed after candidates had been discussed and accepted. As prisoners began to identify more and more with the goals of the programme, they sought a greater voice in the selection of future residents. At this stage, they asked to be informed of potential candidates; they, in turn, discussed these individuals informally and communicated these perceptions which figured in the final decision process. The final stage in this progression was the formalisation of prisoner participation on an elected panel. This represented a "giant step forward" because previous prisoner input was informal and "off the record", whereas the election of an assessment panel represented a formal "break" with the prisoner code which implies the following: no inmate may sit in judgement of another prisoner, particularly in company with prison officers. Surprisingly, this participation of inmates has met with little comment from prisoners who have been interviewed; it is seen as part of Unit programme strategy.

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

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

b) The commitment that a candidate makes concerning his work in the Unit (the therapeutic contract) is a public one, stated before officers and prisoners. This aspect of the assessment process has been important in countering manipulation by inmates who, once they have entered the Special Care Unit, have attempted to renge on their commitment. We have noticed, by the way, that prisoners are far more straightforward in pressing for a work commitment than are the staff.

Following the assessment interview, the candidate is asked to leave the room while the panel discusses his case and votes on his entry, after which the inmate is recalled to hear the decision. In those cases where entry was refused, both inmates and officers were very forthright in explaining those doubts concerning the candidate and
often suggested various areas that the inmate might examine before reapplying to the Unit. In those cases where the prisoner has been accepted into the programme, an informal orientation discussion about Unit rules and operating procedures is then held, after which the inmate is asked to sign copies of the following two documents:

- Contract for Residents of the Special Care Unit
- House Rules and General Information

**CONTRACT FOR RESIDENTS OF THE SPECIAL CARE UNIT**

The following sets out the terms of contract for each resident of the Special Care Unit. The contract is divided into three areas of commitment: (a) Therapeutic Commitments, (b) Unit Commitments and (c) Individual Commitments. Parts (b) and (c) are uniform for all residents, whilst Part (a) is individually contracted.

Date for leaving Unit**                      **first escort prior to this date

(a) **Therapeutic Commitments**

These are the issues that the resident will bring to Small Therapy Groups for discussion:

1. ...........................................
2. ...........................................
3. ...........................................
4. ...........................................
5. ...........................................
6. ...........................................

(b) **Unit Commitments**

1. The resident will attend all Small Therapy Groups.
2. The resident will attend all Community Meetings for at least the first hour.
3. There will be no physical violence or threats of physical violence by the resident.
4. The resident will not damage Unit property.
5. The resident will not partake of any alcoholic beverage whilst residing in the Unit.
6. The resident will not partake of, or traffic in, any non-prescribed drugs whilst in the Unit.

7. The resident will be courteous to all visitors to the Unit.

8. No acts of provocation to officers and/or inmates.

(c) Individual Commitments

These are additional issues that the resident will deal with whilst in the Special Care Unit:

1. Work detail as rostered. Work standard may affect phone/visit entitlement,

2. Attendance on Monday Evening Public Speaking Groups,

3. Blood/urine/breath tests on demand,

4. Initial phone call (2 per week) and visiting (one contact visit of 4 hrs.) entitlement reviewed fortnightly and altered on basis of therapy group work by Superintendent and Psychologist,

5. ...........................................

The resident will understand that failure to meet all the terms of this contract will mean removal from the Special Care Unit as soon as practicable, subject to decision of Unit Management.

I do hereby agree to all the terms of this contract.

RESIDENT'S NAME ...........................................

RESIDENT'S SIGNATURE ...........................................

WITNESS' NAME ...........................................

WITNESS' SIGNATURE ...........................................

WITNESS' NAME ...........................................

WITNESS' SIGNATURE ...........................................

DATE: ...........................................
In addition to your obligations to meet standards which exist in all establishments, the following House Rules have been formulated to assist in the smooth running of the Community:

1. Your cell must be kept clean and tidy. Writing on walls and/or "pin-ups" are permitted only on wallboards provided in cells. Any further decoration must be approved by the Superintendent.

2. All work duties must be carried out daily and completed before commencement of Groups.

3. Excessive noise will not be permitted.

4. Inmates are not permitted to enter security areas.

5. Inmates will be suitably dressed when visitors are in the Unit (i.e., shirts will be worn).

6. All visiting officers will be formally addressed (Mr., Mrs., Ms., Sir or Officer).

7. Inmates will not take visitors into cells without a member of staff being present.

8. Inmates will attend Groups and Community Meetings. If they have a visit, they will attend the first hour of the Community Meeting before returning to their visit.

9. Visits to inmates on weekdays will not commence before 1200 hours when Groups cease.

10. Incoming phone calls are not allowed before 1800 hours. Outgoing phone calls are not allowed during Groups.

11. Phone calls must not exceed 20 minutes.

12. Inmates will conduct themselves in a proper manner on visits.

13. Inmates will not stand at Unit windows and converse with inmates in the M.R.P.

14. All Members of the Community will keep the Unit clean and tidy by emptying ashtrays when required and washing up their dishes after meals.

15. All medication will be consumed at time of issue unless otherwise directed by the Superintendent.
16. All visits will be held in the yard, the ground floor and the mezzanine areas of the Unit.

17. All information discussed by residents either in conversation with staff or during group therapy must be regarded as a potential part of the therapy programme of this Unit. NOTHING CAN BE REGARDED AS CONFIDENTIAL WITHIN THIS UNIT PROGRAMME.

RESIDENT: ..........................

WITNESS: ..........................

The openness and formality of this contracting process is a necessary part of the therapeutic programme; it is meant to signify to the prisoner that the Special Care Unit operates within a framework of obligations and commitments between residents and staff that is more similar to society than the prison environment from which he has come.

2. Formal Therapeutic Groups

Therapy in the Special Care Unit consists of many elements; including relationships with prisoners and officers, the resolution of interpersonal crises in the Unit and coming to terms with situations arising outside of the prison (e.g., breakup of relationships, deaths, family problems). Each of these experiences provides a potential for learning. The function of both small and large therapy groups is to give the prisoner an opportunity to discuss these learning experiences and evaluate them in the light of feedback from peers and officers - "the social mirror".

a) Small therapy groups meet daily in the morning for one and a half hours and consists of 7-10 members; there are two therapy groups functioning in the Unit. At the time of prisoner's entry into the Unit, he is assigned to one of these therapy groups by me. I co-facilitate both of these groups with two officers. The focus of these meetings is on intrapersonal issues: inner concerns and problems that have been identified by the prisoner as part of his therapeutic contract. Low self-esteem, inappropriately aggressive tendencies, poor communication skills and lack of assertiveness are typical examples of contract-related topics dealt with in the small group.

The expectation that the inmate should participate in therapy is made explicit in the first week of his stay in the Unit when he is asked to read and explain the personal goals of his therapeutic contract to his group. In effect, this is a ritualised request from the prisoner to his group for help. During the course of therapy, each prisoner is expected to speak openly about himself; the group, in turn, provides the speaker with honest and realistic feedback. This "social mirroring", is very necessary since many inmates maintain very distorted and unrealistic images both of themselves and their social reality. Of course, everyone benefits from this interchange: the inmate gains a more accurate sense of self, the other prisoners in the group are called upon to break through the boundaries of self-preoccupation (an all-too-
prevalent issue with most of the prisoners so far encountered) and place themselves in a "helping role", and the officers are in a position to experience prisoners as individuals who are dealing with fairly universal life issues. Thus, therapy is able to foster mutual growth.

At the conclusion of each therapy session, I hold a debriefing with my co-facilitators to discuss the content of the meeting, offer suggestions about the subsequent course of therapy, explain particular cases, describe and clarify group dynamics and assess the participation of each inmate-member in the following areas: personal content disclosure, active discussion/probing, and ability to summarise the points dealt with by the group. In addition, I provide my custodial colleagues with feedback on their work during the therapy session. This last function is central to my training role in the Unit, whereas the other information discussed relates to directing the therapeutic programming of the Special Care Unit.

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

Yet another problem encountered in traditional counselling situations, one that is a far more serious one in the long term, is that of the client's dependency on the therapist. All therapeutic contacts are finite; they must come to an end at some point. All too often, the client particularises his personal growth to this relationship with the therapist and suffers a setback at the termination of therapy. In an effort to avoid the debilitating effects of such dependencies, we have endeavoured to limit "one-to-one" contacts between inmates and officers to the focussing of work that will ultimately be carried out in the small group. Rita Nicholson (1982), one of the officers in the Unit, has stated this process in the following extract from a position paper about her counselling work:
"We are dealing with individuals. Some inmates can unravel their tangles by remaining detached and analytical. Some allow their emotions to cloud the issues. Many are afraid of introspection lest they destroy their own self-esteem, or lose the respect of others. Yet others (mostly those with repressed guilt and low self-concept) will reveal themselves only to someone they have learned to trust and can accept as -- in psychological jargon -- "a significant other". Fortunately, those who make the heaviest demands also give the greatest payoffs."

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

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

To date, this practice has proved most useful. I become personally involved only at the point of the triadic contact, but the inmate is aware that his progress up to that point has been monitored by me in consultation with the staff member, "his significant other." These triadic counselling sessions represent the rare instance when work is carried out by me in the privacy of my office. At all other times, meetings with inmates are held in the public spaces of the Unit, symbolically reinforcing the public process of work being carried out.

The problem of self-disclosure in small groups was initially very difficult to overcome. As stated previously, self-examination and self-disclosure are antithetical to the prisoner code. In the prison system, such activities are considered to represent weakness, an admission on the part of the prisoner involved in such activity that "something is wrong with him." To complicate this difficulty by placing a prison officer in the role of therapy group facilitator might seem to be foolhardy, but we knew that one of the most important lessons to be learned by residents of the Special Care Unit was that of relating to prison officers on a personal basis. To achieve this end of building a meaningful personal contact that would ultimately allow officers to facilitate therapy, inmates were brought into the Unit very slowly during the first weeks of operation. In this period, personal relationships were established among inmates and officers. Once this was accomplished, a group discussion period was established that was essentially unfocussed. No effort was made to facilitate this interchange in any formal manner. During the second week of operation, when there were eight inmates in residence, we broke up into two groups with officers sitting in on each group along with me. From that time, officers were always present to co-facilitate group therapy with me and the practice was not questioned. Every new inmate is now socialised by the "old hands" into dealing with the custodial presence in therapy and working through the issue of trusting officers in spite of previous negative experiences in the mainstream gaol system, perhaps involving officers now attached to the Unit, as part of the initial "work" of his residency.
Recently, there has been some discussion among staff and residents about bringing "outsiders" (non-residents) into the small therapy group. To date, a number of prisoners and staff (including myself) have opposed this move, viewing this as an erosion of the purpose of this group. An alternative proposal has been made that special small groups be convened for inmate volunteers and outsiders (e.g., family of residents, friends).

b) Large therapy groups in the Special Care Unit include the following:

1) Community meetings,
2) Crisis meetings, and
3) Communication/debating groups

The most important of these groups is the community meeting. Initially, the community met every weekday, but formal meetings are now convened on Tuesdays and Thursdays at 1230 hours with no fixed time for conclusion. Inmates are required to attend for at least the first hour and all available officers are strongly requested to attend as well. The following issues are discussed during community meetings:

1) Problems relating to housekeeping issues, as well as allocation of work assignments for cleaning the Unit,
2) Needs of the community (e.g., replacement of broken equipment, furniture in need of repair),
3) Rules relating to the management of inmate privileges, such as amount of time allotted for telephone calls, inmate conduct during contact visits, areas to be used for visits, etc.,
4) Resolution of interpersonal conflicts among members of the community,
5) Sanctions to be imposed for failure to meet "standards" of the community (i.e., breaking rules),
6) Procedures for carrying out elements of the Unit programme (self-assessments, induction of new inmates, etc.),
7) Election of various Unit officers (Chairperson, Secretary, Assessment Panel members, Body Corporate members),
8) Orientation of visitors to the Special Care Unit,
9) Issues that have been discussed during small group therapy as a means of informing community members of the nature of "work" being accomplished ("the daily share").

The last item on the list, the most explicitly therapeutic feature of the community meeting, occurs at the end of the session. In addition, this agenda item, known as "the daily share", occurs on days when no community meeting is scheduled. It is a formal mechanism designed to "bridge" groups and consists of a report by members of each group on the topics discussed. When either (or both) groups have been focussed on one member, he is asked to lead the "share" for his group.
Aside from enabling individuals the opportunity to understand and relate to the difficulties of all community members, "the daily share" is designed to provide a formal means by which inmates can make self-disclosures. In this fashion, the programme works against the negative effects of the "prisoner's code" and enables the inmate to gain better awareness of himself and his impact on his social environment.

Because the focus of the community meeting is on interpersonal issues, the working through of material involving relationships among members of the entire community of staff and inmates, it is not surprising that these interactions have proved to be the occasion for the expression of considerable negative affect from inmates. An analysis of underlying reasons for the conflicts witnessed at these meetings seems to indicate two major themes:

1. A failure to come to terms with the central notion of "community": a state of affairs in which everyone feels a sense of responsibility to self and others, as well as meaningful personal involvement with one another.

2. A misunderstanding among inmates about the management of therapeutic community that might best be described as revolving around the difference between democracy versus participatory decision-making and problem-solving.

From a psychological perspective, those difficulties emerging from the second of these themes certainly relate to personality deficits that account for problems in areas of responsibility and personal involvement. An attempt will be made to briefly explain these two sources of conflict, as well as their interrelatedness.

During the community meetings, situations have often arisen in which an inmate wishes to fulfil his needs without regard to his obligation to the community. For example, one area of the Unit, the only quiet public area for reading and study available to residents, was also regarded as the most comfortable space for visits. It was suggested that this area be "off limits" to visitors in order to accommodate those individuals who had expressed unhappiness at having to take refuge in their cells during the weekends in order to avoid the visitors. Because the prisoners in question were fearful at having to make this suggestion, the staff brought up this contentious matter at a community meeting. The anger and hostility that resulted was instructive: prisoners do not seem to grasp the concept of "community" as an embodiment of the "social contract", a living arrangement in which the individual is given the opportunity to fulfil his needs, but does this in a way that does not interfere with another community member's ability to fulfil his needs as well. It is sad to report that the staff ultimately had to declare the quiet area "off limits" for visits because community members were unwilling to arrive at this decision justly and without prejudice.

It has been stated elsewhere in this paper that one of the goals of therapeutic community is to give its members a less distorted perception of reality. Clearly, the example of the problems arising over the visiting/reading area typifies such a
distortion: in this case, an uncaring desire to fulfil one's needs at all costs, regardless of the very real personal needs of other community members. It should not be surprising to us that prisoners in the Special Care Unit would have deficits in this area. The criminal careers of most, if not all, of these individuals has been the result of an inability to come to terms with the values of a particular social order.

The other source of difficulty experienced during community meetings arises from a basic misunderstanding about the management of the community. Though numerous efforts have been made to explain the Special Care Unit in terms of participatory decision-making and problem-solving, the prisoners have construed this to mean "democracy". Because much of the content of community meetings has been concerned with the discussion of rules and guidelines for behaviour and, at any one time, has involved all levels of the Special Care Unit management (Superintendent, Psychologist, Principal Prison Officers, and prison officers), inmates have chosen to believe this implied they had an equal voice in management decisions. Conflict arose from this very basic misunderstanding whenever an attempt was made by staff members to set limits to inappropriate demands. Likewise, tempers have flared when staff reminded prisoners that their current desires conflicted with the therapeutic policy of the Unit (e.g., missing therapy group to have a visit that could have been scheduled at another time). It was suggested earlier that this problem of "misinterpreting" the management style of the Unit relates to a distortion of reality on the part of inmates to suit their current needs. The characteristic response of prisoners when staff have attempted to suggest responsible communal decisions tends to support this hypothesis: inmates inevitably raised the issue of "screws versus crims", called for a vote and overruled staff since at any one time there are more inmates than officers present at a meeting. Of course, the taking of the vote served only to foreclose the debate in an arbitrary and artificial manner. As a result, the matter had to be brought up again at a later date, causing irritation among those residents who felt they had dealt with the issue previously, at which time another attempt was made to critically examine the problem and resolve it in a responsible manner, if possible.

To date, the community meetings present a dilemma: the experiences encountered during them are certainly growth-producing, but the attacks that staff have endured during them have been painful and destructive, requiring considerable debriefing in order that the officers could understand fully the issues and dynamics involved.

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

The communication/debating group meets once a week and is run by a public speaking instructor. Because of the communication deficits of most of our inmates, this group has proved to be an extremely valuable educational adjunct to the programme. It has served to highlight the contribution of other professionals to our work and encouraged thinking among staff that more structured activity should be required from inmates as a work commitment (educational courses, hobby-crafts, etc.). Thanks to the efforts of the Programmes Division, classes in literacy, numeracy and a number of hobby-crafts are regularly taught in the Unit.

3. Self-Assessment Procedure

One of the most important elements of the Special Care Unit programme is the self-assessment which every inmate in the Unit is required to take part in before leaving the programme to return to his gaol of classification. This procedure is carried out in the setting of the morning small therapy group. In a formal sense, it is a ritual of farewell and a means by which the inmate can sum up his accomplishments in the programme. The session is designed to deal with the following content areas:

-- **self-concept:** the personal self, or the inmate's awareness of his core identity, the social self, or the inmate's accuracy in understanding how he is being perceived by others, and the ideal self, or the sort of individual the inmate would like to become in the future.

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

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

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

This self-assessment is structured by the inmate's responses to the Self-Assessment Checklist, a copy of which is given to all members of the group for this discussion.
SELF-ASSESSMENT CHECKLIST

1. Why I felt the need to come into the Special Care Unit:
   - What sort of person was I before?
   - How did I behave in the past?
   - What was I like when under stress?

2. What changes are there in me now:
   - How do I behave differently?
   - What am I like now?
   - How do I now behave under stressful conditions?

3. What aspects of myself do I want to work on in the future:
   - What sort of person do I want to become?
   - What areas of my personality need improvement?

4. How I think other people see me:
   - I believe that other inmates used to think of me as...
   - Now I believe that others see me as...
   - Relatives and friends (visitors) have identified my faults as...
   - How would I like others to experience me?

5. My work in the Special Care Unit:
   - What do I think of my group work?
   - What support did the staff give me?
   - How have I helped others in the Unit?
   - How well did I deal with the goals on my contract?

6. What sort of realistic programme could be set for me after release from the Special Care Unit:
   - What skills could I acquire in gaol?
   - How can I improve my post-release prospects whilst in prison?
   - What have I done in the past to improve myself?

NOTE: AVOID THE USE OF THE WORD "PROBLEM": BE SPECIFIC ABOUT YOURSELF. AVOID GENERALISATIONS.

Central to the self-assessment process is the concept of the "social mirror", that mechanism of giving the inmate clear and accurate feedback about himself and his presentation. In this sense, the self-assessment is another aspect of therapy, inasmuch as it provides the prisoner with an opportunity to identify and summarise the work he has carried out in his therapy group. The process also is meant to be therapeutic for the group: the other prisoners are able to gain insight into the ways in which they, too, may distort their "reality" and, in doing this, they are in a better position to deal with their own life issues, as well as provide the prisoner under
assessment with feedback of a positive and constructive nature; the officers, in turn, are able to gain a clearer understanding of the prisoner's achievements and future goals and, it is hoped, use this information about the "process" of therapy in the Unit to better focus future work with other inmates in the programme.

4. Body Corporate

The Body Corporate consists of a panel of three inmates and two officers elected by the community to enforce communal responsibility. The issues relating to the difficulties experienced at community meetings, particularly that of coming to terms with personal responsibility and Unit involvement apply here as well. The setting of limits to assure that everyone could avail himself of the Unit privileges has been an onerous task for the inmates to carry out. It has meant that a group of elected prisoners were working with prison officers to "police" standards which were often foreign to them in the first place. When one considers that prisoners, in general, often live for self-gain and, in addition, see every ill-gotten benefit as a successful manipulation of the "System", the recurring failure of this self-regulating body is not surprising, representing, as it does, an indication of the extent to which these individuals are poorly socialised to deal effectively with the legitimate commitments of life outside of prison (i.e., the "fine print" of the Social Contract by which most citizens live). However, it must be emphasised that something has been learned every time the members of the Body Corporate resigned, attempted to cancel meetings or found themselves to be the focus of disapproval or sanction for violating/abusing Unit principles because every aspect of life in a therapeutic community, be it positive or negative, can be focussed for the personal growth of inmates and staff.

In summary, an attempt has been made to demonstrate how the therapeutic community philosophy of reduced formality, maximised communication, greater concern for the quality of inter-personal relationships and shared input in the decision-making process can be translated into a model for the treatment of inmates. Various aspects of the Special Care Unit programme were reviewed to highlight therapeutic intentions and mechanisms (therapeutic contracts, public process in the evaluation of inmate candidacy and self-assessment, joint involvement of inmates and officers, work commitments etc.), as well as the functions for specific aspects of the programme (i.e., the difference of focus in small therapy groups, large groups, such as the community meetings, and the self-assessment). In addition, attention was given to an analysis of the reasons for problems encountered in the large community meetings with regard for the lessons to be learned from these experiences, as well as the difficulties experienced by the Unit's self-regulating body.

VII. EVALUATION AND CHANGE IN THE SPECIAL CARE UNIT PROGRAMME

The very nature of this programme implies constant evaluation by staff as to its effectiveness. In general terms, this on-going "self-study" has been concentrated in three areas: increasing the therapeutic impact of the formal programme, making the programme
objectives relevant to the prison system and the prisoners, improving old procedures and formulating new procedures as expressions of programme philosophy. I will briefly discuss each of these areas and cite an example of how staff evaluation has brought about change in the work we are doing.

As stated earlier in this paper, "therapy" was conceptualised in our programme as a process involving mutual growth for all participants in the Unit. There have rarely been problems with staff in becoming involved in the therapeutic process. Inmates, on the other hand, have demonstrated on a number of occasions their fear of the therapeutic process, even when they have realised that their present mode of functioning was ill-suited to life circumstances both inside and outside of prison. In psychological terms, I see this fear as revolving around the issue of change, the abandonment of a set of known (albeit imperfect) solutions for alternative patterns of behaviour that may or may not have a positive "payoff" for the inmates. Throughout the two-and-a-half year history of the Unit, the staff have witnessed a large number of ploys designed by prisoners to avoid becoming involved in group therapy, the formal focus of the programme. One typical example of such a ploy was the use of a staff member as a confidante-cum-therapist. When questioned about why the inmate in question was not participating in group therapy, he often stated that he was working with the officer and "that work was more effective than what he was getting out of his group work". To counter this and other means by which the prisoners sought to renege on therapeutic commitments, staff have been briefed on how to counsel inmates without precluding work in group therapy. In addition, a system was developed by the staff to evaluate daily involvement of inmates in therapy. This work assessment is then fed back to the inmate to provide him with some indication of how staff viewed his functioning in the therapeutic setting of the group (as opposed to his behaviour in the Unit when not involved in formal therapy or household responsibilities). Both the instruction to staff and the development of therapeutic assessment measure have enabled us to better focus the involvement of inmates in the programme.

Another area that has concerned staff was making the programme objectives relevant to the prison system and prisoners going through the Unit programme. When the Special Care Unit was opened, staff were very concerned with establishing good interpersonal relationships with prisoners. To that end, a considerable amount of time was spent in attending to a great many superficial problems presented by inmates. This seemed quite reasonable at the time, but we discovered that when these men left our Unit, they expected the same level of attention and involvement from staff in other institutions. In addition, during the early days of the programme, inmates were encouraged to express their irritation with staff members at any time and in any fashion, as long as it did not involve physical violence. After considerable examination, staff came to realise that such "acting out" did not serve a therapeutic purpose. On the contrary, the level of verbal abuse escalated, tempers became frayed and the inmates rarely understood the source of their anger after the episode had passed. It was decided to insist that any such outburst would become the subject of therapeutic encounter, a process that had been avoided in the past by prisoners when such behaviour had occurred. This served to clarify appropriate interpersonal behaviour for inmates (and staff) and made such outbursts a compulsory subject for therapy. As a
consequence, we have witnessed a marked decrease of these incidents in the Special Care Unit. In addition, there is anecdotal evidence to suggest that prisoners who have been in the programme since this change in operating procedures was introduced are less likely to engage in verbally abusive behaviour with prison officers outside of the Special Care Unit, and more likely to reflect upon the source of their irritation. Thus, the work in the programme has been made more relevant to institutional demands of the prison system in general.

Finally, staff have sought to improve old methods and formulate new procedures as expressions of programme philosophy. With regard to old methods, the staff have better articulated objectives for the initial contact and goals clarification interview with inmates applying to enter the Unit. This has enabled prisoners to better clarify their objectives for entering the Unit, as well as come to a greater appreciation of the work carried out in the programme. In the area of new procedures, the central development has been the introduction of the formal contract. In the past, there were a number of demands and commitments that were unclear to inmates entering the Special Care Unit, including such important points as issues to be dealt with in group therapy (as defined by the inmate prior to entering the programme), behavioural expectations of staff with regard to attendance at groups and the performance of household duties, as well as the period of a prisoner's tenure in the Unit programme. This last area was a source of great difficulty in the early days of the Unit when staff witnessed, and became involved in, the manipulative attempts by inmates to stay in the Unit long after they had ceased to experience gains in therapy. This was understandable, in a sense, because the Special Care Unit was defined by these prisoners as a place - perhaps the only place in the prison system they had ever experienced - where they could be treated with humanity and concern by staff. However, in expressing a need to stay in the Unit, they were losing sight of the fact that the programme was set up to cater for the needs of many prisoners and had only a limited amount of room to do this. More important, these manipulating inmates seemed to be denying the fact that any change and growth they had achieved in the programme could only be put into action outside of the confines of the Special Care Unit. As a result of the staff's ongoing evaluation of this problem, the issues of separation from the Unit, fear from the prisoners about their ability to cope in the mainstream system and the need to deal with feelings of "rejection" when inmates were leaving the programme have been confronted and worked through in a more direct and positive manner than was the case prior to the introduction of contracts.

In summary, as a result of the evaluation of the programme by staff, a number of initiatives have been introduced in order to better articulate the aims and goals of the programme, enabling the Special Care Unit to realistically serve the therapeutic needs of prisoners and requirements of the mainstream prison system.

The Corrective Services Commission conducted a preliminary evaluation, the report of which was completed on 7th June, 1982. The working party convened to carry out this review of the Special Care Unit was given a very general brief to investigate the procedures of the Unit, its cost effectiveness to the mainstream prison system, staffing of the facility and the nature of therapeutic work carried out in the Unit. Out of this investigation came a series of recommendations (many of which were being put into
operation at the time the final report was submitted), as well as
the establishment of a group of advisors for the Unit Superintendent
(formally referred to as the Special Care Unit Consultants)
consisting of the Director of the Probation and Parole Service, the
Director of the Programmes Division, Superintendent in charge of
Prison Officer Training and a representative of the Prison
Chaplaincy Service. The Consultants have met with the Superintendent
and me on a monthly basis to offer advice and aid for the programme
and have proved to be a useful forum in which management issues
relating to improved effectiveness of our work can be discussed.

VII. ACHIEVEMENTS OF THE SPECIAL CARE UNIT

Since the opening of the facility, approximately one hundred
prisoners have gone through (or are currently resident in) the Unit
programme. Because of the personal nature of officer/inmate
relationships in this work, discharged prisoners often communicate
with custodial staff after leaving the Special Care Unit. This fact
prompts the first (and, possibly, our most remarkable) area of gain:
prisoners in the programme perceive prison officers as people rather
than merely as figures of authority to be abused, discounted and
despised. Officers often receive letters and calls from former
inmates informing the staff about their progress in work, their
relationships and other personal issues. In addition, officers from
the Special Care Unit often visit other institutions to see former
Unit residents in order to maintain contact. Budgetary restrictions,
however, have severely curtailed the "out-reach" function of the
programme. Finally, one must cite the verbal reports of inmates who
have left this programme as a summary of achievements made with
regard to prisoners: to a man, they have all felt that their lives
were "changed" after having been in the Unit. Future evaluation will
better document the quality and nature of this change and its
benefits to the prison system.

Though statements about the impact of the Special Care Unit upon
prisoners must be accepted with a certain degree of faith, one can
be more definitive about the worth of this programme for officers.
The Special Care Unit, from the early planning phases of the
project, has been designed to serve a staff-development function in
addition to its therapeutic mission for prisoners. Throughout
previous sections of this report, various aspects of prison officer
training have been touched upon. We shall therefore only underscore
a number of points that have been made in other contexts. Broadly
speaking, staff development in the Special Care Unit takes place in
two areas:

1. Skills development
2. Personal development

The category of skills development relates directly to the inter-
disciplinary nature of the Unit. In no other institution of the New
South Wales Correctional System is there such a close working
relationship between a psychologist and the custodial staff. My role
as the Unit Psychologist encompasses a number of functions.
Principally, I am responsible for the integrity of the therapeutic
programme of the institution (management of therapy groups and
counselling contacts maintained by officers from time to time).
Since so many aspects of policy relate to the therapy taking place
in the Unit, I am also in constant consultation with the
Superintendent. Finally, I have a major responsibility for training custodial staff to carry out therapeutic objectives. It should be emphasised that I rarely perform the traditional therapist's role; the community is the therapist and all "helping responsibility" is diffused throughout the entire community. It is my responsibility to aid this process.

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

Learning the role of small therapy group facilitator is the most complex task for custodial staff to master in the Unit. The greatest hurdle involved in this particular job is convincing officers to feel comfortable in a "professional" role. Having accomplished this, officers have experienced little difficulty in carrying out the individual responsibilities of the group facilitator: active listening, involving all members of the group, activating issues pertinent to the group members, appropriate questioning and feedback techniques.

Carrying out counselling relationships has been yet another area of skills development. After an inmate has sought help from a particular staff member, that officer and I develop certain objectives for the counselling relationship, taking care to focus and point the work that is accomplished to the ultimate arena: the therapy group. In these cases, the dynamics of the inmate's case are discussed with the officer and strategies are arrived at for work to be done in the "one-to-one" interaction. At various points in this work, the officer and inmate may become involved in intensive counselling sessions with me, after which the officer and I would discuss the dynamics of the session and the skills utilised to achieve the appropriate goals.

Participation of officers in panels with inmates provides another opportunity for professional development. This is particularly the case when officers sit on the Assessment Panel, inasmuch as the staff member is in a position to observe the inmates on the panel and the prisoner being assessed. After these sessions, I meet with the two staff members involved and discuss both implicit and explicit issues that have arisen from the session, in addition to answering questions about their participation.

Personal development of the prison officers in the Special Care Unit is also viewed as important to the staff development function. In the past, two venues for this important process have existed: staff meetings and the prison officers' therapy group. In staff meetings, every opportunity is given for the officer to communicate his concerns about the work taking place in the institution as well as his/her relationships with other Unit officers. In a sense, this meeting, which is analogous to the large community meeting, gives staff a chance to participate in the management of the Unit,
examining and articulating issues of programme direction and policy implementation. Above all, honesty in communication is stressed during these sessions which take place once a week during the early morning (0630 - 0800 hours), prior to the "let-go" of prisoners.

The prison officers' therapy group, though not currently meeting, has been one of the most innovative features of the Unit programme. It was similar to the daily small therapy group for inmates and was held once a week. During these sessions, officers were encouraged to discuss personal issues relating to job satisfaction, personal happiness, employment aspirations and family problems, for example. The only restriction placed on this discussion was that Unit matters were not dealt with (i.e., this could not become another staff meeting); the principal focus was personal growth and the development among therapy participants of mutual respect and caring. However, this therapy group also served a training function. Following the formal end of the session, a de-briefing was held in which the participants discussed specific techniques used by me during therapy. These therapy groups, though initially requested by some officers out of concern for what they perceived as deteriorating interpersonal relationships among members of staff, were beneficial for both morale among staff and professional development of the Special Care Unit officers. It is hoped that this feature of the Unit programme can be revived in the near future as interest in these sessions remains very positive; scheduling these meetings presents the only obstacle at the present time.

Finally, consideration must be given to one of the central aims of this project: the "seeding" of the New South Wales Correctional System with prison officers equipped and experienced to perform a complex role in the management of prisoners. These officers, it was hoped, also would be better equipped to understand difficulties facing those charged with the running of other penal institutions. When staff selections were held for promotional positions at the newly re-opened Bathurst Prison, a number of ex-Special Care Unit staff were chosen for these jobs, providing some proof that we are meeting this goal. It is encouraging to note that these men and women have been instrumental in establishing a number of innovations in the programming of that institution.

In summary, the Special Care Unit, in addition to its therapeutic function for inmates, was designed to offer staff the opportunity to develop a number of skills (interviewing, group facilitation, counselling). Provisions for the personal growth of custodial staff are no less important for the developmental functions of the Unit programme. The benefits of this work experience to the mainstream prison system are only now beginning to be seen.

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