The State of the Prisons

What are prisons for?

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Theories as to what prisons should be for have been through some dramatic changes in the past 20 years, and these changes have affected prison doctors as much as any other prison workers. In the 1960s, particularly in the United States, the idea that the main function of prisons was to treat, reform, and rehabilitate the prisoner reached its zenith. Many prisoners were given an indeterminate sentence on the understanding that they would be released when "cured." But research showed that these treatment regimens in terms of reconviction rates (which have always, and perhaps wrongly, been the "gold standard" in penal studies) were no more successful than any other regimen, and confidence in the ability of prison to reform dwindled and for many disappeared. Now the prevailing fashion in criminological circles, if not in the prisons themselves, is to see prison as inevitably a bad place and to encourage the courts to keep people out of them as much as possible.

But some agreement must be reached on the purpose of imprisonment before those running the prisons and those working in them can plan effectively, and all the British systems at the moment seem vague about what exactly they are trying to achieve. The May committee, which was set up by the Home Secretary in November 1978 in response to deteriorating industrial relations in the prison service, did discuss the purpose of imprisonment.¹ But it was rushed in its deliberations, and wasn't specifically asked to consider such broad issues. It thought, however, that it could not ignore them and cobbled together a few thoughts which I will discuss in detail later but which seem contradictory. Its conclusions, which have been strongly criticised,² leave an impression that like so many royal commissions and committees of inquiry it was trying to say something to please all parties and nothing to upset anybody too much.

Serving the courts

The stock answer to the question of what prisons are for is that they are there to serve the courts. The prisons receive sentenced prisoners, hold remand prisoners and prepare reports on them, and provide staff to see prisoners to and from the courts. But to say that the prisons are there simply to serve the courts is in many ways just to restate the question in a different form—for it begs the question of what the courts see as the function of imprisonment. The stock answer does, however, introduce the important constitutional point that the executive which runs the prisons should not theoretically influence the courts. Neither the prison governor nor the bureaucrats in the prison department can ring up the local magistrate or judge and say, "Don't send anybody else to prison today or this week because we're full." Constitutional

purists, who rate highly the principle of keeping the government, the judiciary, and the executive as wide apart as possible, thus tend to respond to the problem of prison overcrowding by simply saying that more prisons must be built. If the courts want to send 88 110 people to prison for an average of 613 days

(excluding life sentences) as they did in 1981, then it is up to the prison department to accommodate them, not to tell the courts that they are sending too many people to prison for too long. But it does seem to be acceptable for the Home Secretary to insist, as he did at the Conservative Party conference,³ that some prisoners receive sentences of at least 20 years.

Some groups, including the Parliamentary All Party Penal Affairs Group, think differently, and see it as mandatory that the government introduce legislation to restrict courts' sentencing power.^{4 5} I will return to this point in my next article when

I discuss the problem of overcrowding, but it is worth pointing out that the courts do not live in a complete fairy land and do take some notice of what is possible and what is not in disposing of prisoners. Thus they are willing to accept that places cannot be found, for whatever reason, in National Health Service hospitals for prisoners they have decided should be in hospital and are content to leave them to languish in prison. The Parliamentary All Party Penal Affairs Group is also unhappy with this and has called on the Department of Health and Social Security to accept its responsibility for mentally disordered offenders.^{4 5}

Punishment

One obvious function of imprisonment is punishment, but it has been accepted by the prison authorities since the report of the Gladstone committee,⁶ which concluded in effect—though the famous words come from a few years later⁷—that prisoners are sent to prison *as* punishment not *for* punishment. Mr Leon Brittan confirmed this in his recent speech at the Conservative Party conference.⁸ Deprivation of liberty is the punishment, and prisoners should not be forced to live in appalling conditions or suffer all sorts of other deprivations.

But although the authorities have accepted the Gladstone committee's principle since 1895 the reality has been rather different. Because all prisoners do suffer extra deprivations. Their mail is censored; visits are limited and conjugal visits forbidden; telephone calls are not allowed; they cannot choose their doctors; and they must do certain, often dreary, jobs. They also have limited rights when they are tried by prison committees for offences committed while in prison. In addition, most British prisoners live in cells without sanitation, often with two or three other occupants. That convicted prisoners should enjoy better conditions than those living outside would be unfair (and whenever there is any suggestion of it happening the popular press becomes suitably strident), but that they should suffer so many other deprivations apart from loss of their liberty does not seem to accord with the widely accepted statement of the Gladstone committee. The poor conditions continue not only through historical inertia but also because it would be politically and economically difficult for any government to do much at the moment to improve them. Furthermore, some of the conditions are justified in the name of some of the prison's other functions—namely, deterrence and security. But, at the same time, they make more difficult another aim of the prison service—reform and rehabilitation. Making people live in conditions very different from those prevailing in the outside world is a poor start for trying to rehabilitate them for life in that world. As Alexander Paterson, a famous and influential prison commissioner, put it in a second important aphorism: "It is impossible to train men for freedom in a condition of captivity."⁹ This paradox of Paterson's still traps all prison staff, and not least the prison doctors.

Keeping dangerous men out of the way

That prison should keep dangerous men out of the way seems to be agreed by almost all factions. Despite the title of its magazine, the *Abolitionist*, even Radical Alternatives to Prison doesn't push too hard the idea that prisons could be done away with completely. And certainly, Geoff Coggan, of PROP, the National Prisoners' Movement, accepted when I spoke to him that there were some people who were so dangerous to society that they needed to be kept apart in secure conditions.

But one immediate objection against seeing this as a prime aim for the British prison system is that only a small percentage of those in prison can with any confidence be called dangerous. Fine defaulters, habitual drunken offenders, and mentally disordered offenders account for a quarter of all receptions into prison, although because their stay is usually short they

constitute a smaller proportion of the daily population.¹⁰ Tables I and II give an indication of the kinds of crimes that prisoners have committed. These figures come from a survey of a sample of the prison population of the south east region on 2 February 1972.¹¹ (The figures were not published until 1978 and constitute the most up to date figures that are freely available. This is a good example of the paucity of good information available on prisons and prisoners.)

TABLE I—Property crimes committed by a sample of 771 prisoners

Crime	No (%)
None	40 (5)
Trivial, little or no gain	126 (16)
Slightly more serious, little or no gain	218 (28)
Property crime on modest scale	246 (32)
Much gained through careful planning	93 (12)
Spectacular crime, large gain	48 (6)

TABLE II—Crimes against the person committed by a sample of 771 prisoners

Crime	No (%)
None	345 (45)
Technical assaults or minor sexual crimes	42 (5)
Distress caused but no major injury	80 (10)
Serious sexual offences or assaults needing medical attention	142 (19)
Intentional attacks, menacing threats, or serious sexual assaults on adults or older children	140 (18)
Vicious intent resulting in serious injury or death, serious sexual assaults	23 (3)

Dr Charlotte Banks and others, the authors of the report, put the figures together and produced six categories of crime ranging from petty offences to serious offences against property and persons (table III). If we consider as dangerous those prisoners who have committed serious offences against persons then we arrive at a figure of 21% of the population. But this must be a maximum figure, as many of those committed even of murder cannot be considered dangerous. Most people who are murdered are, as we know, murdered by somebody they know well in the heat of the moment. Many of these assailants are very unlikely to kill again.

TABLE III—Overall categorisation of 771 offenders

Category	No (%)
Petty offenders	100 (13)
Minor offenders	127 (17)
Average offenders	272 (35)
Serious offenders against property	109 (14)
Serious offenders against persons	131 (17)
Serious offenders against property and persons	32 (4)

Dr Dorothy Speed, a prison doctor who has been in the service for many years, estimates that only some 4000 of the present population need to be in prison because they are dangerous. She added to the traditional division of prisoners into "mad and bad" those that were "sad," and she thinks that the sad constitute the majority. Few prison doctors seem to regard many of the prisoners with whom they work as dangerous, although they point out that a man who is quite safe within the rigid confines of the prison system may behave quite differently in the wide world. Many psychopaths exist quite happily in prison just as they do in other institutions.

The other problem with regarding the containment of dangerous men as being the prime aim of prisons is that it leads to everything being made subservient to security. Within prisons security is the all purpose excuse just as time is in the outside world. The public is rightly concerned that dangerous men

should not escape, and the Mountbatten report,¹² which was published in 1966, was produced in response to a spate of escapes by top security prisoners in the early 1960s. It was this report that led to the dispersal system, whereby category A prisoners are spread around a number of top security prisons. Several groups, including the Prison Officers Association, would, however, prefer a single impregnable "fortress prison."¹³

Many critics of the prison system and many people working within it think that the Mountbatten report led to an obsession with security.¹³ Too many prisoners, they say, are held within unnecessarily secure and therefore restrictive conditions, and the obsession inhibits work, education, and even health needs. What I mean by inhibition of health needs is not that category A prisoners are unable to have the physical treatment that they need, but more that the activities of special units like Grendon Underwood psychiatric prison and the Wormwood Scrubs annexe (both of which I will discuss in later articles) are curtailed in the name of security.

Deterrence

Even if prisons cannot manage to reform felons into law abiding citizens, many members of the public would like to think that prisons would deter them from offending again. Many people would like to see prisons made even more unpleasant than they are now. In the last century this sort of philosophy led to the treadmill, but apart from objections to the barbarity of such systems they do not seem to work anyway.¹⁴ Harsh regimens have not in the past led to reduced reconviction rates, and they may lead to a hardening of attitudes on both sides of the cell door. Jimmy Boyle in his moving and disturbing book, *A Sense of Freedom*,¹⁵ makes it quite clear that for him the only legitimate response to a violent system was violence. Many people believe that far from deterring prisoners from reoffending the prisons, and particularly the borstals and detention centres, serve as "schools for recidivists."

But even if they fail to deter those inside them, prisons may succeed in deterring those of us on the outside. This idea, and a much more sophisticated variant of it, has been peddled by the French structuralist philosopher, Michel Foucault.¹⁶ For him prisons—along with hospitals, schools, barracks, and factories—are there "to exercise a power of normalisation." Prisons are not marginal institutions concerned with only a tiny proportion of the population; they are at the centre of our society and have developed techniques which have been taken up by other institutions. Foucault makes his case in a powerful but difficult book, *Discipline and Punish*,¹⁶ and includes a purple quote from a French magazine, *La Phalange*, published in 1836 (see box).

This is maybe a little fanciful for the *BMJ*, but I include it because although Foucault's thinking is not clear and easy to follow it seems to me to contain many seeds of truth and to point towards associations that we as doctors are not keen to see. But apart from Foucault's philosophy, there is much more concrete evidence of the inability of prison and harsh punishments to deter crime. For example, a study of the effect of a 16 year old boy being given a 20 year sentence for mugging did not show any evidence of a fall off in the crime in six urban areas immediately after the conviction.¹⁷

Treatment and training

Rule One of the Prison Rules for England and Wales states: "The purpose of the training and treatment of convicted prisoners shall be to encourage and assist them to lead a good and useful life." The idea that British prisons should aim to reform and rehabilitate prisoners originates in the report of the Gladstone committee in 1895. It was a reaction to the treadmill philosophy of the earlier part of the century, which had failed. The idea has put down a deep root in the British prison system,

and only in the past few years have prison reformers become interested in pulling up that root.

The idea that prison could reform had its heyday in the 'sixties and early 'seventies—at the same time as other optimistic philosophies. A White Paper of 1959, *Penal Practice in a Changing Society*, stated that: "The constructive function of our prisons is to prevent the largest number of those committed to their care from offending again." This was to be done "through more precise methods of classification and continual search for improved techniques . . . (and) by more personal training."¹⁸ The paper also stated that work would begin soon on a psy-

"Moralists, philosophers, legislators, flatterers of civilization, this is the plan of your Paris, neatly ordered and arranged, here is the improved plan in which all like things are gathered together. At the centre, and within a first enclosure: hospitals for all diseases, almshouses for all types of poverty, madhouses, prisons, convict-prisons for men, women and children. Around the first enclosure, barracks, courtrooms, police stations, houses for prison warders, scaffolds, houses for the executioner and his assistants. At the four corners, the Chamber of Deputies, the Chamber of Peers, the Institute and the Royal Palace. Outside, there are the various services that supply the central enclosure, commerce, with its swindlers and its bankruptcies; industry and its furious struggles; the press, with its sophisms; the gambling dens; prostitution, the people dying of hunger or wallowing in debauchery, always ready to lend an ear to the voice of the Genius of Revolutions; the heartless rich. . . . Lastly the ruthless war of all against all."

chiatric prison hospital and recommended that psychiatric services should be available in all the larger prisons. "The value of psychiatry," it said, "is not limited to the treatment of those abnormal states of mind which require the kind of psychotherapy that will be given in the new establishment. A psychiatrically experienced doctor can do much to help disturbed prisoners not only to adjust themselves to prison life but also to change their general attitudes so that they make a better adjustment in society after release." The authors of the paper imagined that the psychotic would be swept out of prison and into the National Health Service hospitals under section 72 of the new Mental Health Act; the new psychiatric prison hospital, Grendon Underwood, would "explore the problem of dealing with the psychopath"; and the psychiatrists in the main prisons, some employed full time by the Home Office and some working part time in the NHS, would help the ordinary prisoners towards a better life. Other groups in the prisons would reform with similar zeal.

In 1971 Lady Megan Bull was promoted to be governor of Holloway through a similar belief in the power of medicine and psychiatry to sort out problems of prisoners, and particularly of women prisoners. She had been in the prison service for only four years (enjoying incidentally, she says, the best years of her professional life) and had spent all that time as a prison doctor in Holloway. She wasn't well qualified for the job of governor and didn't apply for the job. But so strong was the belief that women prisoners' problems could best be managed on medical lines that she was pressurised into taking it on. As it turned out, she felt that her medical training was of little use in her 11 years as governor—for those were the years in which belief in the power of prisons to treat, train, and reform died. The belief died all over the world in the face of abundant evidence that treatment and training could not reduce reconviction rates.¹⁹ In all systems about half to two thirds of prisoners reoffend.

Table IV gives the depressing reconviction figures for various categories of offenders from the annual report for 1982 of the prison department.²⁰

Reconviction rates, just like death rates, are a blunt measure, but they are rightly given considerable importance when prisons claim to reform. But, undoubtedly, even if few prisoners come out of prison better men than when they went in, many come out in better physical and mental health. Professor Gunn and others' study of prisoners in Grendon Underwood show that the mental health of some prisoners can improve while in prison.²¹

TABLE IV—Percentage of prisoners reconvicted after two years

Type of custody on discharge	Males	Females
Adult prisoners	51	35
Young offenders:		
Detention centre	64	
Borstal training:		
aged 15-16	83	54
aged 17-20	65	45
Young prisoners	69	46
Total	66	47
All offenders	58	42

The May committee

Although belief in the ability of prisons to reform is dead among researchers and academics, and never existed at all among many of those working in prisons, it lives on at least in the minds of those who sat on the May committee. It continues too in the minds of some ex-prisoners. Jimmy Boyle, for instance, refuses to accept the pile of depressing evidence that progressive regimens cannot reduce reconviction rates. He says that there has never been an experiment conducted with sufficient commitment. The researchers may design new regimens, but it is prison officers and prisoners who must work within them, and both of these groups are steeped in prison culture that allows no individual responsibility. Jimmy Boyle in his 15 years inside saw many prisoners come and go, and never, he says, did prison officers challenge the prisoners when they returned as to why they had failed to build a life outside the prison: most prison officers and prisoners simply accept it as inevitable that many prisoners will be coming in and out of prison regularly. Jimmy Boyle also had experience of the Barlinnie Special Unit, which is one of the few schemes in any British prison where prisoners are expected to be responsible for their own actions—and those of each other. I will discuss the Barlinnie Special Unit in a future article, but enough to say for now that there are a few half developed studies that suggest that giving prisoners much more responsibility might lower reconviction rates.

Obviously those who foot the bills for the increasingly expensive prison system and those who spend their lives working within it would like to believe that prisons can reform. The May committee recognised this need and so was led to some curious circular thinking. It recognised that "the rhetoric of 'treatment and training' has had its day," but then said that "the rhetoric alone should be changed and not all the admirable and constructive things that are done in its name." It recommended that "if Rule One is to continue" it should be rewritten: the committee wanted the philosophy of "treatment and training" replaced with a philosophy of "positive custody." The difference between "treatment and training" and "positive custody" seems to me purely semantic, but another similar sounding euphemism, "humane containment," does offer a genuine alternative. It is the philosophy of the moment. One of its main architects was Professor Norval Morris,²² a Chicago academic, and it is advocated most forcefully in Britain by Roy King and Rod Morgan.²³

They argue that those who run the prison system should recognise its limitations and so avoid committing too many resources to prisons or keeping people in prison for a long time

in the mistaken belief that it will make them less likely to reoffend. Humane containment is based on three principles: minimum use of custody; minimum use of security; and normalisation of the prison. It has great advantage over the nebulous philosophy of "positive custody" of having been tried out in a scientific study. In Butner Federal Correctional Institute in North Carolina a controlled trial has been underway for several years to test the philosophy of humane containment. I have visited Butner and will describe the study and the prison in greater detail in a future article, but it is proving a success in making prisons less dangerous but not in lowering reconviction rates.²³

The May committee were unhappy with humane containment because it suffered from the fatal defect of being "a means without an end." It would make "prisons into human warehouses—for both inmates and staff" and leave prison staff "in a moral vacuum" that "can in the end lead only to the routine brutalisation of all the participants." Although it used such strong terms in damning human containment, the differences between the committee and King and Morgan are not so extreme: much of the debate is just the semanticism it seems to an outsider. Both parties would like to see fewer people in prison, and neither wants low security risk prisoners to be kept in unnecessarily secure conditions.

The differences come about because the committee seemed to imagine that King and Morgan wanted to do away with work, education, some caring services, and other activities that go on under the title of "treatment and training." But this is not so. King and Morgan don't want these activities stopped; they just want their objectives to be reconsidered and for them to be reorganised. In terms of medical services this might mean an end to elaborate attempts to help prisoners reform with psychiatric techniques (not that much, if any, of this goes on anyway). The mentally ill would be taken out of the prisons, and, in the name of normalising the prison, ordinary general practitioner care would be provided by local doctors rather than by prison doctors. These are ends that have been argued for by several doctors, including some prison doctors.

Prison as a sump

Before finishing, I must point out that one of the real functions of British prisons, although it doesn't feature in anybody's ideal plans, is to serve as a refuge for all sorts of inadequate and desperate people. Since the emptying out of the asylums and the closure of many hostels and reception centres more and more mentally ill, alcohol and opiate addicted, homeless, and mentally subnormal people have drifted into prisons. Most pass through only briefly, but they present great problems to prison authorities and officers and particularly to prison doctors. At Brixton prison, for instance, which is the remand prison for London, some 77 000 prisoners come through the gates each year, and many of these are inadequate and desperate. The prison doctors have great difficulty sorting out the new prisoners, many of whom are in a dreadful state and uncooperative, and it is no surprise that Brixton has the highest suicide rate in the country. Three prisoners killed themselves in Brixton in 1981. Everybody is agreed that prison is not the right place for these people, but there is an appalling lack of political will to find a better way of dealing with them.

Conclusion

In the last analysis no neat answer can be found to the question "What are prisons for?" They serve many functions; the functions change with time; and in a complicated society such as Britain different parts of the population have different ideas as to what prisons are for. But I can conclude that we do need prisons; that keeping dangerous people securely locked

away is one essential function; and that the idea that prison can reform has had its day. Accepting the last conclusion means to me that we should follow much of the thinking of King and Morgan and use prison as little as possible and make prison as much like the outside world as is compatible with security.

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Communicable Diseases

Respiratory syncytial virus infection in the elderly 1976-82

Compiled by the Public Health Laboratory Service Communicable Disease Surveillance Centre

Between 1976 and 1982 there were 13 723 laboratory reports to the Communicable Disease Surveillance Centre of respiratory syncytial virus infections. The annual number varied between 1193 and 1895 during 1976-81; however, the number of reports (4324) received in 1982 was more than double that received in any of the preceding six years. One hundred and ninety two (1.4%) of the 13 723 reports were in people aged 65 years or older, the proportion varying year by year from 0.9 to 2.5%. The age and sex distribution of these cases shows an increasing female to male ratio with increasing age, reflecting the preponderance of women in these age groups.

Four methods of identification of infection were used: isolation of the virus, fluorescent microscopy, detection of a fourfold rise in antibody titre, and a single high antibody titre. Isolation of the virus at first accounted for just over half the reports, but fluorescent microscopy has become more frequently used. Antibody measurement did not account for more than 16% of all reports in any year. In the elderly, however, antibody tests were the most frequent method of diagnosis, accounting for 94% of all reports (table).

Clinical features

Pneumonia and bronchopneumonia were the main clinical conditions associated with respiratory syncytial virus infection and were reported in 87 of the cases among the elderly. A further 38 patients were described as having a lower respiratory tract infection, bronchitis, or chest infection, and general or influenza-like symptoms were reported in 32 patients. Thrombocytopenic

purpura was reported in three patients, pericarditis in one, and erythema nodosum in another.

In February 1976 an outbreak of influenza-like illness occurred in a geriatric hospital. Fifteen patients were affected altogether and in one week alone seven patients died. An eighth patient also died before virological tests began. Of the seven surviving patients, respiratory syncytial virus was isolated from one, and two had

Method of identification of infection

Method	Total	Elderly
Isolation	6353	11
Direct fluorescence	5709	
Rising titre	757	49
Single titre	904	132
Total	13723	192

high titres of antibody. Three patients who had not been ill had very low or absent respiratory syncytial virus titres. In 1977 single high titres were detected in three patients in another geriatric hospital 10-12 days after influenza like illnesses. These were thought to be sporadic cases, and they occurred in May, June, and July.

In 1980 there were two reported outbreaks. In one 24 out of 27 patients in a reception ward of a psychogeriatric unit became ill over a period of two weeks in January with a mild upper respiratory tract infection, which was followed by a cough and evidence of chest infection. There were two deaths. Of six convalescent