The State of the Prisons

History of the prison medical services

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Prison doctors labour behind high walls and are usually neither seen nor heard. Most come out occasionally to appear in court; some teach medical students; most have contact with specialists and general practitioners; some write articles for their hard to find (if not actually secret) *Prison Medical Journal*; and some speak at conferences. But most of Britain's doctors rarely meet one of the 87 full time doctors, or even one of the 100 part time doctors, who work for the prison medical service, and nor do they have much chance to read the prison doctors' writings. Britain's doctors do, however, have abundant opportunities to

so proud of the fact that a good chunk of most of the few articles written by prison doctors about their work is about the history of the service. But, although this looking back may arise from a discomfiture with the less auspicious present, a glance at the past is essential to understand the nature of the present service.

John Howard provided the impetus for the reforming of the prisons with his untiring inspections of every prison in Britain several times over at the end of the eighteenth century. His famous book *The State of the Prisons* was published in

read articles, and watch television programmes—most of them polemical—written by outsiders about the prison medical service.

Similarly few of the general public have much direct experience of prisons. Few of us have been into prisons and few of us know anybody who has; but the media are full of tales of prisons and prisoners. In these circumstances of minimal contact with the reality but generous exposure to the mythology of prisons, our fantasies about what goes on behind those walls can flourish unimpeded. And they do. The prison medical service has suffered particularly from this problem.

The oldest civilian medical service

Prison doctors are proud that the prison medical service is the oldest civilian medical service in Britain. Indeed, they are

1777,¹ but his labours had already led to the 1774 Act for Preserving the Health of Prisoners in Gaol and Preventing the Gaol Distemper. The main aim of this Act was to prevent gaol fever, a form of typhus, which may reflect self interest on the part of legislators because, as the Webbs put it, gaol fever could stretch out of the prison "like the arm of an avenger . . . and sweep away in a few days judge and advocate, jurymen, and witnesses alike."² The 1774 Act and others about the same time required all prisons to appoint a surgeon or apothecary, but, as prisons were the responsibility of local authorities and not central government and as there was nobody to enforce the Act, not all the intended improvements actually happened.

Transportation to New South Wales came to an end in 1840, and many of the prisons that we still use today were thus built between 1840 and 1850. The prison system was taken over by central government in 1877, and the prison medical service came into existence at this time. It did its work within a system that might well have been as abhorrent to John Howard as it seems to us looking back from the late twentieth century. Edmund du Cane, the first head of the centralised system, had one purpose for his prisons—that they should be an effective deterrent to crime. An 1863 House of Lords Committee recom-

mended "hard fare, hard labour, and hard bed." Silence was the rule; prisoners in local prisons were kept in solitary confinement for the whole of their sentences; and the crank and the treadmill were generously used.

Professor John Gunn and others have included in *Psychiatric Aspects of Imprisonment*³ an excellent history of the British prison medical service, and I have borrowed generously from it in preparing this account. The history illustrates clearly the chronicity of many of the problems that confront the service, and the authors point out that in such a system the doctors could do little more than tend to the essential physical health problems of the inmates and speak up against the harshest aspects of the life. And speak up they did, particularly on behalf of what we might call mentally abnormal offenders. Dr William Baly, who was a doctor at Millbank, a notorious prison, wrote that prisoners with "any degree of imbecility or great dullness of intellect will certainly be rendered actually insane or idiotic by a few months' separate confinement." Later a doctor from Parkhurst appealed for the "feeble minded" to be removed from prison because in prison there was an "exclusion of the working of the omnipotent law of human kindness and sympathy so important in the treatment of the mentally affected. . . ." Later in the century the feeble minded were removed to special prisons with "a relaxed regimen"—they were allowed, for instance, to talk.

Towards the end of the century the idea that prisons might reform as well as deter began to break the surface. The famous Gladstone Committee of 1895 was the first to introduce the idea that prisons should attempt to release prisoners in a better physical and moral condition than when they went in.⁴ That committee thought, too, that "it might with advantage be made a condition of medical appointments in prison that the candidate should produce evidence of having given special attention to the subject of lunacy." Slowly the idea took root that prison doctors might use psychiatric techniques not only to diagnose mental complaints and report them to the courts and prison authorities but also to treat the mentally abnormal who have always been present in prison. Eventually the aspirations went even higher, and the authorities hoped that doctors could help the mentally healthy adapt to prison life and turn towards a life which would not lead to reconviction.

A growing belief in psychiatry

The Commissioners of Prisons wrote in 1921⁵: "The opinion has been growing in intensity for some years that mental and physical disabilities may largely contribute to the commission of crime." They wondered, too, "Whether some form of treatment rather than punishment by imprisonment can be devised which shall be more scientific, efficacious, and humane." In 1933 Dr W H de Hubert was appointed to try out psychological treatment on selected prisoners at Wormwood Scrubs. In collaboration with Dr Norwood East he produced a report in 1939 which concluded (on very shaky scientific grounds) that: "Psychotherapy as an adjunct to an ordinary prison sentence appears to be effective in preventing . . . future antisocial behaviour. . . . The main object of psychotherapy in criminal work is to prevent crime being committed and repeated by the individual." Hubert and East were concerned with a particular category of prisoner, but by 1959 the prison department wanted doctors with psychiatric experience to work with all prisoners: "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."⁷ As late as 1969 a Court of Appeal judged that: "It may be perfectly proper to increase the sentence to enable a cure [for alcoholism] to be undertaken whilst in prison."

But all the time that this faith in psychiatric services as a means of reforming some or all prisoners was growing there were those who were doubtful, particularly that prison was the

place to use these techniques. Sir Godfrey Lushington, who was the permanent secretary at the Home Office at the time of the Gladstone committee, thought that prisons would never be able to reform because they were characterised by "the crushing of self-respect . . . the continued association with none but criminals . . . and the denial of liberty."⁴ Penal history has tended to see Sir Godfrey as a reactionary, but now his ideas are coming strongly back into fashion and he may soon be seen as a man ahead of his time. Later Dr M Hamblin-Smith, a prison doctor from Birmingham who had attempted to treat mentally abnormal remand prisoners, concluded that prisons were not suitable for the effective psychological treatment of offenders, mainly because of the prison's punitive ethos. In 1934 he wrote: "There are the strongest objections to combining the ideas of punishment and medical treatment: the subject is certain to look upon the treatment as part of the punishment."⁸ Dr East himself warned against the exaggerated claims made for treatment in prison, and Professor Gunn and his colleagues in reviewing this history clearly feel that the courts have tended to have, and continue to have in some cases, an exaggerated idea of what prison doctors and psychiatrists can do.

Preoccupied with problems like overcrowding, prison authorities have lost interest in the idea that prison can reform to any appreciable extent and that psychiatric techniques have an important part to play in the process. Experiments such as Grendon Underwood, the psychiatric prison, the Wormwood Scrubs Annexe, which takes sex offenders and addicts, and the Barlinnie Special Unit continue, but their function is more now to keep difficult prisoners from disrupting the whole system. Indeed, this has always been the prime aim of the Barlinnie unit.

These changes in fashion have affected the types of doctors who are found in prison. The Medical Commissioner wrote in 1946: "There is a considerable amount of medical and social work to be done in the prisons and though the psychiatric work is equally important it does not represent by any means the major part."⁹ But four years later the commissioners wrote: "While prison medical practice affords considerable opportunity for experience in physical medicine, it is recognised that the greater part of the work lies in the psychiatric field."¹⁰ These changes of priority have been reflected in recent directors of the prison medical service. Dr Ian Pickering, who was director until 1976, believed in reform and the importance of psychiatric experience, but his successor Dr Jim Orr, who resigned in 1982, thought that prison doctors should concentrate on being general practitioners to the prisoners. Understandably these changes have left some prison doctors a little confused as to what exactly they are trying to do, but few if any now see themselves as having much to do with reforming inmates.

Failure to integrate with the NHS

The founding of the NHS in 1948 presented an opportunity for the prison medical service to be absorbed into the new national service, but this didn't happen. In 1964 a Home Office working party was set up to consider how the prison medical service was organised and how relations with the NHS could be improved.¹² In giving evidence to the working party the Institute of Psychiatry, the National Association for Mental Health, the Royal College of Physicians, and the Royal Medico-Psychological Association all recommended that the prison medical service should be fully integrated into the NHS. The BMA and the Institution of Professional Civil Servants were against, however, and the working party eventually agreed with them. It made various recommendations about how relations between the two services might be improved, and one central one was the creation of joint posts in forensic psychiatry between the prison department and the NHS. These posts were established but have since floundered.

A further chance to fuse the two services came with the setting

up of the Committee of Inquiry into the United Kingdom Prison Services (the May Inquiry) in 1978.¹³ Various bodies, including the Royal College of Psychiatrists,¹⁴ gave evidence supporting integration, but again it was rejected.

Recent history in Northern Ireland

This account has dealt almost entirely with the English and Welsh prison system rather than the Scottish and Northern Ireland systems for three main reasons. Firstly, the important swings in the aims of prisons and prison doctors have applied to Scotland and Northern Ireland as well. Secondly, much more has been written about the English and Welsh system. Thirdly, although the systems in Scotland and Northern Ireland are different from the English and Welsh system, they have until recent times been on a small scale and have been staffed almost entirely by part time doctors.

But the history of prisons and prison medicine in the past 15 years in Northern Ireland is quite different from that in England and Wales. In 1968, when the troubles began, there were only about 700 prisoners in Northern Ireland. This meant that 40 of every 100 000 people in Northern Ireland were in prison, a low imprisonment rate. Internment was introduced in August 1971, and by 1974 there were nearly 3000 people in prison, giving Northern Ireland one of the highest imprisonment rates in Western Europe. The numbers increased threefold between 1970 and 1974. Remand prisoners increased 20-fold over 10 years, and the nature of the prisoners changed enormously. In 1970 only 11 prisoners were serving more than five years; by 1980 this number had increased to 171. About three quarters of the current prisoners are sentenced for terrorist offences, and many of them are serving very long or indeterminate sentences. About 23% of Northern Ireland prisoners are serving life sentences (as opposed to 6% in England and Wales), and just under 200 of them are special category prisoners who are in compound prisons—prisoner of war type prisons.

Thus in Northern Ireland a prison medical service had to be created almost overnight, and once it was created it had to cope with some extraordinarily difficult problems. Before the troubles began the Northern Ireland prison department had run its own small medical service, which consisted entirely of part time doctors. The Chief Medical Officer in the Department of Health and Social Services gave advice when necessary, but there were few problems. When the size of the problem increased so rapidly—particularly when internment was introduced—the Chief Medical Officer and his department took over responsibility for the prison medical service. They were advised by Dr Orr, the director of the English and Welsh prison medical service. Not only did they have to find doctors and nursing

officers very quickly but they also had to concern themselves with serious security problems. Then hardly was the service established than it had to start coping with hunger strikers and the dirty protests in the Maze prison.

Someday, I hope, somebody—perhaps an insider—will write a detailed account of those extraordinary years, but here I must restrict myself to saying that the service seemed to cope extremely well. Curiously enough, the prison medical service in Northern Ireland has never received quite the same bad press that the service in England and Wales has had. This is partly because accusations of brutality and assault have been so common in Northern Ireland (usually against the Royal Ulster Constabulary, the army, or the prison officers) that the doctors are constantly on the alert for complaints about and signs of injury and carefully record their findings for when accusations arise; they are prepared. Another reason for the comparatively smooth running of the service has been that money has been much more readily available for the prisons in Northern Ireland than for those on the mainland. But a final, important reason for the “success” of the medical services has been that the doctors have always been seen to be responsible to the Chief Medical Officer not to the civil servants running the prisons. The Chief Medical Officer has also been able to use his extensive contacts within the NHS in Northern Ireland to help pull the prison doctors through extremely difficult times: many consultants in Northern Ireland have seen the inside of a prison.

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Is there any evidence of an increased risk of acquiring sexually transmitted disease for women taking oral contraceptive pills when compared with a similar population using no contraception?

The existing evidence, such as it is, has been interpreted as suggesting that users of the oral contraceptive pills have a diminished risk of acquiring sexually transmitted diseases when compared with control groups using no contraception. At a clinical meeting in Seattle in July 1983 Lars Weström of Lund, Sweden, who has studied pelvic inflammatory disease for many years, put it as follows. “Contraceptives both increase and decrease the risk of sexually acquired disease depending on the method used. If the risk in sexually active non-contraceptive users is denoted as unity, then the risk for intrauterine contraceptive device (IUD) users is 1.5 to 4, for barrier methods 0.4, and for oral contraceptive users 0.3.” Most reported studies have been concerned with the relation between pelvic inflammatory disease and

the use of intrauterine contraceptive devices. At the International Symposium on Pelvic Inflammatory Disease in 1980 in Atlanta there was general agreement that the risk of pelvic inflammatory disease was increased among users of intrauterine devices, and three separate workers reported a decreased risk of pelvic inflammatory disease in oral contraceptive users after corrections for other risk factors.¹ The behavioural question as to whether women using an oral contraceptive are more likely to change sexual partners or have casual sex than women using no contraception cannot yet be answered as no credible scientific studies have been undertaken, and the number of variables is so great that interpretation of the results would be very difficult.—R D CATTERALL, consultant physician in genitourinary medicine, London.

¹ Weström L. Incidence, prevalence, and trends of acute pelvic inflammatory disease and its consequence in industrialised countries. *Am J Obstet Gynecol* 1980;138:880-92.