DOCTOR OF PHILOSOPHY

Against the Odds: Maintaining Order on a Personality Disorder Unit

Willmott, Lucy

Award date:
2001

Awarding institution:
University of Wales, Bangor

AGAINST THE ODDS:
MAINTAINING ORDER
ON A
PERSONALITY DISORDER UNIT

By Lucy Willmott

Submitted for the degree of PhD in criminology

2002

to the Centre for Comparative Criminology and Criminal Justice
at the University of Wales, Bangor

ACKNOWLEDGEMENTS

I would like to take this opportunity to thank the many people who have given me their help and support throughout this project.

Firstly, I would like to thank the ward staff and patients who showed enthusiasum and support for this investigation despite the fact their lives had been under close scrutiny for many months at the time I entered the Hospital to start the fieldwork.

I would like to offer my sincerest gratitude to my supervisor Roy King who has both inspired and encouraged me and been particularly patient and supportive throughout the writing up period of this project.

I would also like to thank my colleague in the field Hillary Bradshaw for retaining her enthusiasum for the research and for being ever ready to discuss the project and oversee my progress.

I am also grateful for the support I have received from other members of my department and offer particularly thanks to Claire Davis for putting this thesis together.

I would now like to say a big thank you to my Dad for delivering me to and retrieving me from Ashworth Hospital at some particularly unsociable hours and for always being ready to talk about my day. I would also like to say thank you to Rob Hall for helping him in this task. And to all my family and friends thank you for keeping faith with me.

ABSTRACT

Staff who work on the wards of a Personality Disorder Unit located within a Special Hospital are directly responsible for caring for patients contained in conditions of high security. This research looks at how staff manage personality disordered patients in this environment. This group of patients represent complex practical (in terms of where and how they should be managed) and conceptual (in terms of the nature and treatability of their condition) problems at the heart of which is their perceived dangerousness. The remit of the Special Hospital demands that ward staff deliver the care and treatment of its patients while simultaneously maintaining conditions of the highest security. Ward staff are faced daily with having to reconcile these apparently conflicting objectives.

In this thesis I have argued that ward staff resolve this complex situation by concerning themselves primarily not with delivering care and/ or control but with the maintenance of 'order' on these wards. Specifically ward staff use their first-hand gathered knowledge and experience to choose the most appropriate course of action to avert or reduce potential incident situations. They do this by appearing able to confer legitimacy on their responses to patients which provides conditions conducive to the maintenance of a relatively stable order on the wards. This they do through the negotiation of 'right' staff-patient relations.

CONTENTS

PART ONE

INTRODUCTION

Background of the Thesis

The empirical research for this project took place in the Personality Disorder Unit (PDU) at Ashworth Special Hospital which was set up in 1994 for the treatment of patients who had a primary medical diagnosis of personality disorder (see Chapter Two). The thesis theorises and investigates the ways in which ward staff maintain order on the wards of the PDU at Ashworth Special Hospital.

England and Wales are currently served by three Special Hospitals: Broadmoor, Rampton and Ashworth. Broadmoor was the first Special Hospital established in 1863 under the 1860 Act for the Better Provision for the Custody and Care of the Criminal Lunatic. Rampton followed in 1912. A site at Moss Side was purchased in 1914 and became fully functional as an institute for the containment of dangerous mentally disordered offenders in 1933. Overcrowding in the 1960's led to the need to build a new Special Hospital which was to be situated next to the existing Moss Side Special Hospital. Park Lane Special Hospital was fully opened on the Maghull site in 1984. In 1989 Moss Side and Park Lane Special Hospitals were merged to become Ashworth Special Hospital.

Since 1960, following the Mental Health Act (MHA 1959) and re-enacted in the Mental Health Act (MHA 1983), Broadmoor, Rampton and Moss Side, now Ashworth, Hospitals have been able to admit patients suffering from one or more of four categories of mental disorder: mental illness, psychopathic disorder, mental impairment and serious mental impairment.

All Special Hospital patients are in broad terms suffering from a mental disorder, defined in the MHA 1983 as a:

> mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind. (MHA 1983: s.1(2))

The legal classification under which the vast majority of PDU patients have entered the Special Hospital System and hence the PDU is that of 'psychopathic disorder':

> a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned. (MHA 1983: s.1(2))

At present individuals who are directed to the Special Hospitals under the legal category of psychopathic disorder (MHA 1983) must also to have been found to be both treatable and to represent a danger to themselves or others. Many of these individuals are likely to have been accused and/ or convicted of a serious criminal offence. The different routes through which patients come to enter the Special Hospital are discussed in Chapter Two.

Once these patients enter the Special Hospital System they are medically diagnosed and regarded whilst they remain in the hospital to be personality disordered patients, the different categories of which are outlined in Chapter Two. As these individuals are officially regarded as *patients* whilst they remain on the PDU this will be the label attributed to them in the remainder of this thesis.

All mentally disordered offenders have been described as being a source of tension between the health service and criminal justice system as the medical care ethic is matched against the victims', public and politicians' need for justice (Peay, 1994). PDU patients could be described as being at the very heart of the tension as they epitomise the mad or bad debate:

> Insanity is accepted as a medical concept provided it does not cause violent or dangerous behaviour; if it does, then it becomes wickedness. (Gunn 1991: 22)

This is a key statement to understanding the complexities of the situation of the psychopath who is legally defined as abnormally aggressive or seriously irresponsible (MHA 1983) and medically characterised as anti-social (DSM IV) or dyssocial (ICD-10). Prins (1995) argued that penal and mental health professionals were unlikely to escape the view that psychopaths were bad rather than mad.

The policy of the Special Hospital System is to integrate the security, control, treatment and care of all its patients into a single management package. The one identifying characteristic of all its patients in the perception of all those who must deal with them is their 'dangerousness'.

This is the point from which I began to explore the complex issues surrounding the everyday management of the PDU and the problems which this created for both ward staff and patients on the ground before assessing whether it was theoretically and practically possible for them to overcome these difficulties and maintain order on the wards of the PDU.

Aims of the Thesis

(i) To identify and examine the complex issues surrounding perceptions of who PDU patients are and why they must be and where they should be contained.

(ii) To identify how these issues effect everyday life on the PDU in order to discover why ward staff and patients adopt particular styles of performance on the PDU.

(iii) To identify whether and if so how it is possible for staff to maintain order on the PDU considering the apparent complex nature of the task they must face.

Outline of the Thesis

It is fundamental to this thesis that PDU patients are actually (owing to their index offences and asocial behaviour) and perceived to be (owing to an underlying fear of those who act in unpredictable and inexplicable ways, and

their medical diagnosis and legal categorisation) dangerous. Consequently, Chapters One and Two focus on how PDU patients have come be defined as dangerous and the practical and conceptual difficulties which arise as a result of this.

It is the PDU ward staff who must deal with, in terms of the day to day management of the PDU, these dangerous individuals. Chapter Three therefore identifies and examines whether it is possible for ward staff to deal with these patients within what has often been described as the dichotomous remit of the Special Hospital System. In unravelling what it is that the representatives of systems of power actually do at ground level this chapter lays out the framework within which it may be possible to understand whether and if so how ward staff may be able to confer legitimacy to PDU patients and therefore maintain order on the PDU.

Chapter Four describes the Grounded Theory (Glaser & Strauss, 1967) research process through which the substantive theory for this thesis evolved.

Chapter Five describes the five wards on the PDU and analyses whether and why order is perceived to exist from the viewpoint of the researchers, ward staff and PDU patients and in terms of the Hospital's official statistical database.

Chapters Six and Seven analyse and examine why ward staff and patients choose to adopt different styles of performance during their PDU career. These chapters set out the various ward staff and patients' responses to the official requirements of the institution and the external issues surrounding the PDU and its patients to discover whether and how they are able to 'get on' with everyday living against such apparently overwhelming odds.

Chapter Eight returns to the framework outlined in Chapter Three to examine and analyse by identifying specific situations whether ward staff are able to avert potential trouble by employing their extensive knowledge of patients and choosing the most appropriate course of action under the circumstances. It develops the concept that ward staff who adopt certain styles of performance are able to maintain a stable order on the wards through the

development of 'right' staff-patient relationships (Liebling and Price, 1999) which are based on their ability to confer internal legitimacy through their negotiated interactions with patients.

CHAPTER 1

A Practical Problem: 'Something Must be Done'[1] About the Psychopath

The PDU patients upon whom my thesis focuses are a practical problem for the policy-makers as they are first and foremost seen as a threat to public safety and as such must be kept out of harms way. However, what happens to dangerous individuals once their immediate threat to the public has been removed is still under debate on the grounds of insufficient empirical evidence (Home Office, 1999a). Part of the intention of my thesis is to add to the evidence of 'what can be done' with PDU patients through a detailed analysis of 'what is being done' on the wards of the PDU. This chapter therefore outlines the practical problem of dangerous individuals and highlights the fact that there is a gap in the knowledge about 'what can and is being done' about them on the ground which will be addressed in the remainder of my thesis.

Sociological Origins of the Psychopath

I refer here to the generic label psychopath - the layman's image of the psychopath:

> Psychopath . . . is an expression that most English-speaking people understand. A psychopath, in layman's terms, is a person so emotionally warped in childhood as to grow up without any moral sense of compunction. Often violent and aggressive, psychopaths betray a ruthless disregard for the feelings of others, and a total lack of remorse for conduct which normal people would deplore. Some psychopaths are highly intelligent, others backward. Needless to say, many psychopaths become criminals and some murderers. (Clark & Penycate, 1976: 5-6)

---

[1] Eastman and Peay, 1998: 95

At the root of the public, political, medical and legal debates on what is to be done about the psychopath is an underlying fear about the dangerousness of these individuals.

In sociological terms the first level at which someone might come to be perceived as dangerous is the everyday phenomenon of one person identifying another as not fulfilling the expectations of social interaction. Although everybody's perspective of the world is different there is necessarily 'a continuum of typifications' upon which humans are able to understand a common world and interact in a predictable manner (Berger & Luckmann, 1967). Those who do not conform to the expectations of others are regarded with distrust, ambivalence and as a source of potential danger (Garfinkel, 1967, Berger & Luckmann, 1967). The dangerous individual is therefore the individual who does not appear to perform within the rule-governed boundaries of a given culture (Simmons and McCall, 1966).

The dangerous individual when identified as such by enough and/ or influential people, such as medical professionals, can become someone about whom 'something must be done' (Eastman & Peay, 1998: 95). The individual may then come to be defined as the other or the outsider and a specialist framework can be created to deal with him or her (Berger & Luckmann, 1967).

In sociological terms, therefore, psychopaths are the outsiders about whom something must be done because they have been identified as not conforming to the expectations of others. As a result of this specialist medical and legal frameworks have been created to deal with them. These are discussed in detail in Chapter Two. These frameworks are currently under review because the public and the government believe that the dangerousness of these individuals has not been reduced.

Morbid Fascination

> The prospect of mental illness or disorder combined with dangerousness provokes fear in the public mind and ambivalence about the treatment of the individuals involved. None of this is helped by sections of the press

> which often emphasise the sensational aspects of incidents. (Kinsley, 1998: 82)

A review of the media attention focused on Ashworth Special Hospital at the time of the Fallon Inquiry (1997-99) clearly shows the ambivalence which is directed at those who others perceive to be psychopaths.

People are drawn to danger; deviance is inherently interesting (Goode, 1996) and, to a certain extent, the more extreme the acts of deviance the more fascinated people become. If this were not the case then extreme sports would not exist and horror films would not gross mass profits. 'Real' acts of deviance committed by fellow human beings can stir public opinion for many years as in the case of the Moors murders or more recently with the Bulger killing. The media portrayal of the abduction, torture and murder of children has held and continues to hold the nation in a state of revulsion and fascination.

The psychopath is depicted, in the popular press, as the most deviant of all human beings. He, for almost exclusively in the media the psychopath is male, is judged inexplicably and irreversibly mad and irredeemably bad - an individual who defies all our normal expectations.

Under the headline: 'Psychopaths to be denied liberty' a newspaper correspondent referred to both high profile murder and paedophile cases:

> Michael Stone, jailed last year for the 1996 hammer attack that killed Lyn Russell and her daughter Megan, and nearly killed her daughter Josie. He has claimed that he told a nurse five days earlier of violent fantasies about killing and asked to be admitted to hospital, but he was deemed untreatable and refused a place.

and:

> Robert Oliver left prison in 1997 after serving 10 years for the gang rape of Jason Swift, aged 14. He is one of a handful of predatory paedophiles convicted before the courts had the power to order a risk assessment before their release. (Travis, 16/2/99: 9)

This newspaper article clearly places the paedophile under the banner psychopath. The tag of paedophile is arguably even more detrimental than psychopath as the sex offender, particular those who prey on innocent children, has become the modern folk devil (West, 1996).

> The danger to children from sexual offenders has become a matter of obsessive public concern. Sexually motivated child abductions and murder are extremely rare but receive massive media attention when they occur. (West, 1996: 52)

The hatred directed towards this very small group of individuals has once more flared up, in the form of public demonstrations and attacks, in the wake of the Sarah Payne abduction and murder, and the News of the World's (23/7/00) publication of the names and photographs of those individuals who appear on the sex offender register.

In the wake of the Fallon Inquiry (1997-99) the PDU patient has been depicted as both a psychopath and paedophile in the press.
The Fallon Inquiry (1997-99) and subsequent Report (Home Office, 1999a) will be discussed at the points where it influences the debate surrounding PDU patients throughout Part I. At this time it is sufficient to mention its disclosure of alleged paedophile activity, pornography rackets and fraudulent businesses amongst patients on the PDU. This most recent inquiry was only the latest outrage in a long list of media revelations relating to all three Special Hospitals.

In the past the media have sided with patients at Ashworth focusing on their sick role (Parsons, 1953) rather than their criminality. This was the case with the Blom-Cooper Inquiry (1991-92) which resulted from a Channel Four documentary exposing a number of hospital staff as being abusive to patients in their care (Home Office, 1992). At this time the newspapers described patients as vulnerable to cruel maltreatment by nurses.

However, the newspaper coverage of the Fallon Inquiry (1997-99) firmly focused the blame for the break down of control on the PDU patients who had been able to manipulate a weak management team. Each new discovery made

by the inquiry team further sullied their image: 'Paedophile inquiry at mental hospital' (Cooper, 8/2/97: 1); 'Sex and drugs ring in high security wards' (Kennedy, Laurence & Jenkins, 8/2/97: 1); 'Secure hospital 'out of control'' (Brindle, 4/11/97: 4); 'How sex fiend fled nurse on shopping trip' (Powell, 4/11/97: 10); 'Ashworth inmate ran holiday firm' (Powell, 4/11/97: 1).

The latest Inquiry led the press to query Ashworth's status: 'prison or hospital?' and its function: to punish criminals or treat patients? In the past the question of criminal or patient status has meant acceptable medical practices have been misrepresented in the tabloid press:

> Each time a group of patients goes on a day trip as part of their rehabilitation, they become targets for the tabloids (although some 20 per cent of Ashworth's 473 residents have committed no crime but have been sent there, by local authorities, for their own safety): a party which went on a tour of the Coronation Street studios in Manchester found themselves 'exposed' by the Sunday Express 18 months ago. (Harding, 17/2/97: 2)

The public are left with an image of a hospital which is out of control, run by dangerous patients who are on occasions allowed to roam freely outside the hospital. The PDU population has been identified as devious and capable of manipulating both the hospital rules and staff. It appears that even in the high security environment of the Special Hospital PDU patients are uncontrollable and that to release them would be nothing less than an act of mass murder. The following section focuses on government attempts both past and present to appear to be doing something positive about the psychopath.

Political Demon

> The politicisation, and perhaps even the demonisation, of psychopaths has singled them out as a group about whom 'something must be done'. (Eastman & Peay, 1998: 95)

Extensive media coverage and public reaction to the dangerousness of those who have come to be labelled psychopaths has placed the government in a position where they must be seen to be doing something positive on the

grounds of public safety and patient care. In the most recent policy proposals, a small group of dangerous individuals which would include the PDU population, have been constructed as dangerous cases of severe personality disorder; as such they do not fit neatly under the directorship of the Prison Service or National Health Service. As dangerous individuals they warrant secure confinement to protect the public but as patients with a medical disorder they need to be hospitalised and treated. These are arguably the impossible requirements which successive ruling bodies have attempted to fulfill when dealing with the insane criminal.

A challenging problem - ensuring security and treatment under one roof

The management of dangerous psychopaths in secure psychiatric hospital settings has long been debated as a challenging and difficult problem as institutions struggle to deal with the sometimes conflicting issues of treatment and security, and care and control (Scull, 1981). The Ashworth Special Hospital of the 1990's has again brought this problem into sharp relief (Home Office, 1992, 1999a)

Pre-nineteenth century this problem did not exist as the focus of madhouses had been primarily to secure madmen out of harms way and whilst in the institutions to control them through the means of physical restraints (Scull, 1981). However, the nineteenth century brought a new perspective to madness where sufferers were seen as the innocent who had to be cared for and physical restraints were viewed as outmoded.

The philanthropist John Howard condemned the conditions in which the insane were kept at the end of the eighteenth century. New institutions were built for the containment of the mad, now regarded as mental patients, which were to operate regimes in which patients were to be cared for as well as controlled. Moral therapy was heralded by Pinel in France and Tuke in England as a modern and humane way to care for (Bynum, 1981) and yet still control mental patients (Scull, 1979, 1981).

Whilst at the start of the nineteenth century there was a hope amongst the

medics of the time that mental patients could be cured, the 'asylums increasingly degenerated into little more than custodial warehouses.' (Scull, 1981: 12) Parry-Jones (1981) quoted the feelings of a former hospital supervisor on the state of the asylums, written in 1859:

> many asylums have grown to such magnitude, that their general management is unwieldy, and their due medical and moral care and supervision an impossibility. They have grown into lunatic colonies . . . inhabitants, comfortably lodged and clothed, fed by a not illiberal commissariat, watched and waited on by well paid attendants, disciplined and drilled to a well-ordered routine, gratified by entertainers, and employed where practicable, and, on the whole, considered as paupers, very well off; but in the character of patients . . . far from receiving due care and consideration. (Arlidge in Parry-Jones, 1981: 207-208)

The warehouse or lunatic colony effect was a result of: overcrowding, oversized asylums reducing personal contact, a shortage of qualified medical staff, the vulnerability of moral therapy to routinization and a lack of results in terms of patients not being cured. The failure of the system to fulfil its promise was addressed by the asylum keepers of the time redefining their

> success in more limited terms: comfort, cleanliness, and freedom from the more obvious forms of physical mistreatment rather than the often unattainable goal of cure. (Scull, 1981: 14)

The opening of Broadmoor Special Hospital in 1863 as the first purpose built institution to combine the secure confinement of the dangerous criminal with the treatment of the lunatic was intended to relieve the asylums of their most difficult and disruptive patients who were perceived to be hampering the treatment of curable patients (Busfield, 1996). The first Special Hospital Inquiry closely followed in 1876 and concluded that patients would be more humanely and safely confined in prison. The Special Hospital System has been embarrassed by successive inquiries ever since as it has attempted to meet its complex remit of providing security and control, and care and treatment, for dangerous, mentally disordered people.

Introducing the specific category of psychopathy into the Special Hospital equation further complicated matters within the hospitals and sharpened political debate. The Royal Commission of 1954-57 on Law Relating to Mental Illness and Mental Deficiency wanted to liberalise and modernise the laws pertaining to mental disorder in line with the interventions available for physical illness. However, the commission was reluctant to propose compulsory detention for the relatively undefined and difficult to distinguish category of psychopathy, fearing it would simply be creating a quasi-criminal code especially for this group.

The MHA 1959 reflected the concerns of the policy-makers and medical professionals regarding the compulsory detention of psychopaths. It recognised the views of the Royal Commission (1954-57) including the stipulations: voluntary and informal admissions where possible; safeguards for compulsory admission; steering individuals towards community care where possible.

The compulsory detention of psychopaths in hospital accommodation has always been questioned to such an extent that it is surprising the law was ever passed. As early as the 1940's the psychiatrists of the day were raising the possibility of separate penal accommodation for the disruptive psychopath. In an attempt to avoid becoming responsible for a large group of untreatable, unmanageable and disruptive psychopaths the psychiatric profession immediately placed a narrow interpretation on the treatability clause in the MHA 1959 (Robinson, 1966; Walker & McCabe, 1973).

The Working Party on the Special Hospitals, appointed in 1959, expressed concern about the new legal category psychopathic disorder, discerning the lack of knowledge surrounding this group would impact on the numbers of secure beds required. Its suggested solution was to place this group of patients in a separate unit or hospital where they could be researched and undergo intensive therapy.

The Butler Report (1975) noted a failure of medical treatment for psychopathically disordered patients and advocated the development of training units to apply a therapeutic intervention in a penal setting. In tandem

with this, the committee recommended the instigation of reviewable sentences to avoid the release of those individuals still considered to be dangerous. The prison department objected on the grounds that it was a waste of resources for a group of individuals who were recognised as untreatable.

The Home Office Consultation Paper (1986), Psychopathic Disorder: The Need for Reform, cited three principal problems: (i) the uncertainty regarding the concept, diagnosis, treatability and relation to offending behaviour; (ii) the difficulty of assessing real change, particularly in an artificial environment; (iii) the small number of patients who were found to be no longer of unsound mind being released. Their immediate solution was to recommend increased use of s.47 (MHA 1983) whereby individuals were only transferred to hospital after being awarded a prison sentence. The Reed Committee (1994) identified similar problems, arguing for a review of the services and legislation pertaining to personality disordered individuals.

The condemnation of Ashworth Special Hospital

The current crisis at Ashworth began in April 1991 when a Committee of Inquiry chaired by sir Louis Blom-Cooper Q.C. was set up to investigate allegations of inappropriate care and treatment of patients by nursing staff made in a Channel Four television documentary. The findings of the Inquiry were far reaching, covering both specific allegations and more general issues. It highlighted a number of key institutional issues regarding the care and control of all dangerous patients. A primary concern was that staff put the dangerousness of the patient above all other aspects of their care and treatment (Home Office, 1992). Focusing on the security and control of dangerous patients had led to an anti-therapeutic and restrictive regime which meant the principles of care and treatment of patients had been buried. The report concluded that Ashworth had become a 'dumping ground' for which the goals of positive therapeutic input and patient transfer to places of lesser security had come to be seen as inaccessible.

> The over-riding impression is of therapeutic pessimism, of lack of expectation of positive change, of a depressing acceptance that patients will stay in the institution for many years. (Home Office, 1992: 158)

The Blom-Cooper Report (1992) therefore concentrated on the failure of the Special Hospital System to provide care and treatment for its patients owing to overriding concerns about the dangerousness of patients. It recommended a total overhaul of the system where staff must be trained to prioritise patient care and patients were given rights in alignment with the rest of the National Health Service. The Report (1992) made ninety recommendations for the improvement of the care and treatment of all patients at Ashworth Hospital. As the original allegations which led to the inquiry had been made in a very public manner the government had to be seen to act quickly and in sympathy with the patients. The inquiry recommendations were accepted in full by the government and an outside task force was set up to implement them (Home Office, 1992).

The Personality Disorder Unit (PDU) which is the focus of this study was established as a consequence of the Blom-Cooper Report (1992) and the Special Hospital Service Authority (SHSA) Task Force which was sent in to overhaul the hospital. They elected to split Ashworth up into four separate, more manageable units: two mental illness, one special needs unit and the personality disorder unit.

In 1996 members of the task force and hospital management were interviewed as part of a project reviewing the development of the PDU. The consensual view expressed was that it would not be possible to deal with PDU patients' complex therapeutic needs until a satisfactory way of managing the group was found. They believed the group to be the source of the majority of trouble in the hospital, particularly in terms of disruptive and manipulative behaviour, and that staff spent their time policing rather than caring for them. A number of the PDU population were perceived to be chronically dangerous (Willmott, 1997).

There were two main reasons given for the development of the PDU. First, it was felt that whilst personality disorder (PD) patients remained spread throughout the hospital much of their insidious behaviour went undetected. It was therefore hoped that housing PD patients together would highlight any problems which were specific to this group. Secondly, this in turn would give the hospital a chance to decide where to go next. The expectation was that there would be a wide number of problems which would have to be tackled before the PDU ran smoothly and effective treatment programmes could be implemented (Home Office, 1999a). The PDU was always regarded as a high risk venture by the original task force but they could not see any other way forward (Willmott, 1997).

In 1997 Ashworth faced its second major public inquiry of the 1990's. The Committee of Inquiry chaired by Fallon Q.C. was set up to:

> investigate the functioning of the Personality Disorder Unit (PDU) at Ashworth Special Hospital, following allegations made by a former patient, . . . about the misuse of drugs and alcohol, financial irregularities, possible paedophile activity and the availability of pornographic material on the Unit; its security arrangements; the management arrangements for assuring effective clinical care and appropriate security for patients; and the arrangements for visiting on the PDU. (Home Office, 1999a: 1)

The Inquiry was triggered by a patient who, having escaped whilst on a leave of absence (LOA) shopping trip, compiled a dossier of events and activities alleged to have taken place on Lawrence Ward. The investigation was aimed at the PDU as a whole but focused on Lawrence Ward and Owen Ward, the latter having been the subject of an internal investigation and security clamp-down following a breakdown of control and a hostage incident. Unlike the 1992 investigation the focus of this inquiry was firmly directed at the PDU patient group as the root of the disruption.

Fallon (1999a) concluded that the Blom-Cooper (1992) recommendations had been introduced too quickly, with little thought for the exceptional patient population of a special hospital. The introduction of the NHS Patient's Charter was described as the 'promotion of patients' rights at the expense of

maintaining a safe and secure environment' (Home Office, 1999a: 1.20.10). Fallon described the introduction of the PDU as a rash move which could only exacerbate any problems that existed amongst the PDU patient group, particularly in the new era of patient power.

> Even at the time this was recognised to be a bold, perhaps foolhardy step. Those classified as 'psychopathically disordered' (in legal terms) or 'personality disordered' (in clinical terms) have an unenviable reputation for being difficult and resistant to treatment. . . . the men in the PDU at Ashworth are at the severest end of the spectrum of personality disorder. Most, if not all, have extremely disordered personalities and many have a history of very serious violent and sexual offending. They tend to test boundaries between staff and patients to destruction and undermine, sometimes even corrupt their carers and therapists. . . . Thus putting together over 100 highly disordered men in just six wards was not something done lightly. (Home Office, 1999a: 1.23.3)

> Consider now that approximately 150 of the most dangerous and disruptive personality disordered patients were put together in a single unit of six wards at Ashworth, on the same campus as mentally ill patients, with few effective restrictions on interactions between the two groups. Most had been in the Special Hospital system for some years. When the hospital began to become more liberal, post-Blom-Cooper, the fruits of liberalisation were applied to all. No account was taken of the special needs of personality disordered patients; indeed, if anything this group benefited most in terms of reduced security and personal freedom. That these freedoms would be abused by some of this group should have been anticipated. Because it was not, the lives of many staff and patients have been blighted. (Home Office, 1999a: 2.0.16)

It is clear that Fallon placed the responsibility for the collapse of the PDU on a lack of foresight by those who established it and a lack of action when things went wrong (Home Office, 1999a: 2.13.23/ 2.14.5). Although Fallon clearly attributed some of the blame for the alleged breakdown of the PDU on the nature of the PDU patient, he rejected claims that they were solely or even mainly responsible. Although at times the report still appears to blame the patients:

> We can see no rational justification for keeping this very manipulative and troublesome sub-group in expensive therapeutic units providing management and treatment techniques from which they gain no benefit. (Home Office, 1999a: 6.10.11)

Fallon found that weak management on the PDU, particularly in terms of medical input (Home Office, 1999a: 2.13.23), and a lack of staff training (Home Office, 1999a: 4.2.14) were at the root of the problems. The report argued that although knowledge regarding the identification, diagnosis and treatment of PDU patients was still limited, common-sense should have dictated the necessity of providing a secure, controlled environment when dealing with a group assessed as demonstrating dangerous, violent or criminal propensities (Home Office 1999a: 2.14.5). Fallon concluded that the Patient Care Team (PCT) on Lawrence Ward showed a total lack of common-sense:

> The Ward policies were half-baked and poorly implemented; the staffing levels were inadequate. Yet staff were caring for a collection of highly dangerous individuals, some of whom had attained their privileged position by guile and manipulation. . . . We find it astonishing that within the context of a high security setting, a number of patients on Lawrence Ward were considered to be of low dependency. (Home Office, 1999a: 3.12.23)

The need to reassert control was 'almost universally accepted by staff and patients alike' (Home Office, 1999a: 4.2.12). Fallon and his investigatory team recognised the importance of the nursing staff on the PDU, highlighting how well they appeared to be doing in the face of adversity (Home Office, 1999a: 4.2.25). However, whilst acknowledging the progress made by the nursing staff Fallon chose to ignore their argument that they 'needed an opportunity to consolidate and develop a stable tradition' (Home Office, 1999a: 4.2.20). Instead the report recommended the closure of the PDU, finding it to be unsustainable in the long term owing to its size, the number and mix of the patient group and its lack of credible medical leadership (Home Office, 1999a: 4.2.33).

Fallon (1999a) went further assessing Ashworth as a whole:

> Ashworth Hospital's reputation is so badly damaged (and our Report will make it worse) that we see no realistic prospect of it ever recruiting and retaining sufficient numbers of high quality staff who can be proud of the place at which they work. The Hospital's negative, defensive and blame ridden culture is so deeply ingrained that we doubt that even the most talented management team would find it possible to turn it around. The scars and tensions left behind by the events of recent years will poison the therapeutic environment and hinder the development of sensitive multi-disciplinary working that is so crucial in the care of these patients. (Home Office, 1999a: 7.3.21)

The Report therefore recommended:

> Ashworth Hospital should close in its entirety at the earliest opportunity. (Home Office 1999a: rec.49: 7.3.23)

Fallon's (1999a) alternative suggestion is discussed in the following section 'making changes – the government's solution' in conjunction with the government's plans for Dangerous Severe Personality Disordered (DSPD) individuals (Home Office, 1999b).

In conclusion the problem which was first recognised in the large mental institutions of the early nineteenth century of ensuring security and control, and providing for the care and treatment of mental patients under one roof is still one which exists as the Special Hospital System enters the twenty-first century (Home Office, 1992, 1999a). Many of the difficulties faced by the early asylums were freely acknowledged to have been deliberately shifted to Broadmoor in 1863 and have reoccurred throughout the Special Hospital System ever since. Ashworth PDU is only the latest example of the challenging problems the Special Hospital System must attempt to resolve if it is to move forward.

However, although the Fallon Committee (1999a) concluded that Ashworth Hospital should be closed and the PDU was unworkable in its present state they did acknowledge that by the time their specialist team entered the PDU it appeared to be functioning efficiently, having recovered

from another crisis and inquiry successfully. The PDU was regarded as an experiment from its conceptualisation to make visible the particular problems of a troublesome and dangerous patient group (Willmott, 1997). To this extent the PDU has done its job and, in the words of the PDU staff, it is now time 'to consolidate and develop a stable tradition' (Home Office, 1999a: 4.2.20). These brief references in the Fallon Report (1999a) suggest that just maybe the PDU is working and could continue to work if given the opportunity in the future. This will be assessed throughout Part II of this thesis.

Making changes - the government's solution

The current government now face the political demons of needing to be seen to be doing something about psychopaths in the eyes of the public and a Special Hospital System which has been portrayed as being in crisis. The PDU patient is at the heart of both these problems.

The government is attempting to tackle these two problems together:

> The safety of the public is our prime concern. There's a very small group of very dangerous people who currently fall outside both the law and mental health provisions. We need to challenge this wholly unacceptable position and move beyond the rather artificial criteria of "treatability" in determining who should be detained. At the same time we must recognise that indefinite detention is a very serious step. We must ensure that the measures we propose have robust checks and balances to protect the rights of the individual and provide them with the best clinical support and care. (Straw in O'Brien, 30/8/99)

The current government proposal, which includes a solution to the placement of PDU patients and other individuals found to be dangerous and suffering from a severe personality disorder but rejected by psychiatry as untreatable, is set out in the policy document - 'Managing Dangerous People with Severe Personality Disorder' (Home Office, 1999b). This proposal has been incorporated into the White Paper: Reforming the Mental Health Act (2000) which will be reviewed following the 1999 proposal and subsequent responses.

The 1999 document focuses on the supposition that there are currently a small number of dangerous, severe personality disordered (DSPD) people who have to be released from prison or psychiatric care whilst still representing a risk to the public. The stated intention of the new proposal is to protect the public from DSPD individuals. It advocates the indefinite detention of dangerous people - namely those diagnosed as suffering from a severe personality disorder who may or may not have committed a criminal offence - in a secure institution which would be either a hospital or a prison or a third alternative. The predicted benefits are threefold:

> To eventually identify potentially DSPD individuals and hold them before they cause serious harm;
> To hold DSPD individuals until they no longer represent a serious risk;
> 'Managing them (DSPD individuals) in a way that provides better opportunities to deal with their disorder.' (Home Office, 1999b: 3)

The long term aim of the proposal is to reduce the number of DSPD individuals on the streets at any time by identifying potentially DSPD individuals at a younger age, before they have committed a serious offence. However, the identification of a severe personality disorder is very difficult before an act of extreme violence has occurred (Davison & Neale, 1987) and attempts to predict future dangerousness of young people, perceived as having a severe personality disorder, have led to dubious justice. A recently highlighted example was of a young man, left to fester in prison for twenty-one years, after being found to have a severe but untreatable personality disorder and judged to be dangerous following his arrest for burning a pair of curtains (Olden, 26/7/99).

Secondly, the primary aim of the proposal appears to be to hold those individuals identified as DSPD until they are no longer assessed as representing a serious risk to the public. This relies on the supposition that it is possible to test for risk. Even if it is possible to test for risk, it is likely to be difficult to assess it in the artificial and controlled environment of a hospital, prison or other specialist facility (Home Office, 1986).

The proposals have been criticised by the human rights organisation Liberty which described them as 'deeply problematic and quite shocking'. 'Proving you are not dangerous is almost impossible' (in Travis, 16/2/99) and by the Bar Council which argued: 'There are plenty of people who are potentially dangerous - do we lock them all up?' (in Travis, 16/2/99: 9).

The proposal identifies the areas of Human Rights Law which allow for the compulsory, indefinite detention of the individual found to be DSPD as articles 5.1(a) and 5.1(e). Individuals can only be detained if they can be shown to be of unsound mind by objective medical experts to the extent that it is necessary to warrant compulsory confinement and the disorder must persist throughout detention. There is no implied right to treatment. The law therefore allows flexibility to hold individuals on the grounds of dangerousness as long as it can be connected to a criminal offence or mental disorder.

Thirdly, the proposal argues for the need to manage DSPD individuals more effectively whilst they remain in detention. This is the area most directly related to this thesis and the management of the PDU patient.

The paper gives a number of reasons why PDU patients and their imprisoned contemporaries are not currently being managed in the most appropriate way:

> Staff in prison, probation, health, social services and independent sector agencies already undertake valuable work with some of these individuals. But this is within the context of services facing a range of operational pressures that make it difficult to deliver the kind of specialist provision these difficult and demanding people need. There are pockets of good and effective practice. But there is no co-ordinated system for managing dangerous severely personality disordered people and meeting their needs at all stages. Staff often feel cynical, frustrated or ambivalent because of the absence of therapeutic optimism and lack structures for linking services provided by different agencies.
>
> As a result, the relatively small numbers of the most dangerous and disordered individuals that this paper is concerned with present a disproportionate challenge to existing services. Most of these people are in prison but whether they are held there or in secure hospitals, keeping their disruptive potential in check absorbs high levels of resources and

> calls for careful and often intensive management. (Home Office, 1999b: 5-6)

The government paper identifies two broad sets of options to achieve its aims of managing DSPD individuals more effectively.

Option A maintains the current statutory framework and service structures. The intention is to strengthen existing legislation to stop the release of DSPD individuals, whilst they continue to be perceived as representing a risk to the public, and to improve penal and hospital provision for them. In the case of DSPD individuals found guilty of a criminal offence they will automatically be sent to prison although the power to transfer to hospital later will be retained. If the DSPD individual is required to be detained under civil proceedings it will no longer be necessary for them to be identified as treatable. In both situations the DSPD individual would be subject to an indefinite period of detention (Home Office, 1999b: 14-16).

Option B involves the implementation of a new legal framework and new services separate from existing mainstream prison and health service provision. It would provide powers for the indeterminate detention of DSPD individuals in criminal and civil proceedings under a new order - a DSPD direction. It could be attached to any court sentence if an offender was found to be suffering from a severe personality disorder and to present a serious risk to the public (Home Office, 1999b: 16).

Any sentenced prisoner could be considered for a DSPD order at any time during their sentence and as a consequence be removed to a specialist facility. Again the provision for offenders found to be suffering from a psychopathic disorder to be directed to hospital would be removed from the MHA 1983. The DSPD order could be awarded in civil proceedings following a period of compulsory assessment in a specialist facility to confirm the individual was suffering from a severe personality disorder as a consequence of which they represented a serious risk to the public. The DSPD order would allow for the future recall of any DSPD individual to a specialist facility for further assessment.

The new specialist 'third way' institutions would be governed by a public body separate from the NHS or the Prison Service - the DSPD service. However, the specialist facilities could be physically situated within existing prison or health service sites. DSPD individuals would be managed by a single service, regardless of whether they had been convicted of an offence - the hope being that a set of common standards and protocols would be developed and implemented specifically for the management of DSPD individuals.

The government proposal identified a three-fold approach to containing risk within the new institutions: physical security, procedural security checks and balances, and relational security. Relational security would be dependent on the knowledge of skilled staff to ascertain the moods of the DSPD individual and their ability to intervene to reduce dangerous behaviour.

The government proposal (1999b) made reference to the Fallon Report (1999a) and its recommendation that new units for PDU patients should be limited to fifty places with only eight to twelve beds on each ward. It also recognised that control problems were likely in institutions where DSPD individuals were held on indefinite sentences with little prospect of release and the need to make provision for similar control mechanisms to the prison system. However, the government proposal does not acknowledge Fallon's fears that a new third service would be vulnerable to the same pressures and fighting between the Home Office and Department of Health that the Special Hospitals had experienced and suffer from the same problems of isolation and uncertainty about its purpose. Equally the report concluded that any model that concentrated DSPD individuals could lead to a similar breakdown of control as had occurred on the PDU (Home Office, 1999a: 7.12).

Fallon's recommendations align to option A where new units would be delivered within the existing forensic network system retaining the option and flexibility, following assessment, for a personality disordered individual to be sent to a specialist regional facility within a hospital or prison (Home Office, 1999a: 7.2/ 7.9).

This latest government solution has been formulated before the results of the most recently government commissioned research have been collected and analysed. However, owing to the perceived immediacy of the problem of those now being labelled as DSPD individuals the government is planning to act first and adjust later.

> Decisions on the direction of policy development for managing this group cannot be delayed until the outcomes of the research are known. (Home Office, 1999b: 3)

Since the publication of the government's proposals, there have been two conflicting responses from the Home Affairs Committee (4/5/00) and the Health Committee (13/7/00).

The Home Affairs Committee supports the government proposals. Its only concern regarded the locking up of those who had not been found guilty of an offence, so it recommended

> that the proposals should be applied to individuals only when an assessment predicts it is almost certain that they will commit a very serious criminal offence. (Home Affairs Committee, 2000: s.36)

The difficulties of this proviso have been highlighted above and will be further discussed in conjunction with the medical viewpoint in Chapter II. The committee recommended option B as the best containment option (Home Affairs Committee, 2000: s.40).

The Health Committee (2000) examined the government's proposals on DSPD individuals in the context of the review of the mental health legislation (1999). The committee concluded:

> it is very difficult to predict dangerousness, other than on an individual's past offending history: thus the idea that individuals who have never offended might be identified before they could harm others was highly unrealistic. (Health Committee, 2000: s.154)

The government argued that the proposals were

> first and foremost a criminal justice measure and they should not be confused with the issue of mental health (in Health Committee, 2000: s.155).

The committee recommended if this was the case then they needed

> to make clear that they are concerned with offending behaviour and not mental disorder (Health Committee, 2000: s.156).

Secondly, the committee felt it was necessary for the government to make clear what it meant by interventions for untreatable individuals and how it was to measure success in the context of its new proposals. They stated:

> We feel that the whole debate around the care of those designated 'DSPD' has been fundamentally muddied by the various different meanings attached to the concept of 'treatability'. We welcome the recognition that services for people with personality disorder have in the past been very patchy, and we urge the Department to take positive action to develop more consistent services . . .
> We would also like the Home Office, as a matter of urgency, to clarify whether it sees the 'interventions' that it is developing for 'DSPD' individuals as being different in kind from the 'interventions' that are currently available, albeit patchily, in the NHS on the basis of mental health legislation. If, on the other hand, they can be distinguished from any 'treatment' that the NHS might provide, then we would argue that they should be made available in prisons, to convicted offenders, as part of the criminal justice system. (Health Committee, 1999: s.159/160)

The Committee felt the reviewable sentence, put forward in the Fallon Report, whereby after an initial prison term offenders who were still judged to be a risk to the public would have their sentence extended for a further two years and reviewed biannually, should be given greater consideration by the government (Health Committee, 1999: 7.). The government's response to this solution was that it

> does not enable us to develop the sort of services that we are very anxious to develop - Health and Prison Services together - around the

needs of people with severe personality disorder (in evidence to Health Committee, 1999: s.161).

They added that this approach would equally not allow the government to lock up the 'very, very small group of people' who had never committed an offence but were nevertheless perceived to be dangerous and exhibiting signs of SPD (in evidence to Health Committee, 1999: s.163). The committee's response was:

> As a health committee, we feel that there are others better qualified than ourselves to comment on an issue which is essentially one of preventative detention. However, we reiterate that if any of these individuals are suffering from a recognised mental disorder and treatment exists which might alleviate, in the broadest sense, that disorder, then they should be provided for in the NHS and not in the prison service. (Health Committee, 1999: s.163)

Finally, the committee received much evidence to suggest that a third service 'option B' would be right at the bottom of the league of popularity regarding staffing, below both the Special Hospitals and the prison service (Health Committee, 1999: s.164). The health committee concluded that they could not support either of the government's proposals believing existing services should, and could, be improved in the wake of new research on the treatment of anti-social personality disorder (Health Committee, 1999: s.165). They did support the Fallon Report advocating the replacement of the Special Hospitals with eight smaller regional units.

In the document 'Managing Dangerous People with Severe Personality Disorder: Taking Forward the Government's Proposals' (2000) the government reflected on the response to their 1999 proposal. The three main points they made were:

- of those who expressed a preference it was for option B;
- the main opposition was towards the detaining of civil cases;

- the main concern was the reliability of diagnosing personality disorder and assessing dangerousness.

The government explained that the final decision on option A or B would not be made until the results of pilot schemes in both the National Health Service and the Prison Service had been analysed. The first two of which are under way at HMP Whitemoor and Rampton Special Hospital. In response to fears about the detention of non-offenders the government argued

> in practice, it is highly unlikely that any individual without a long track record of increasingly serious offending will be affected by these new powers. (Home Office, 2000: 3-4)

Finally the government accepted there was a deficit of knowledge pertaining to dangerous and severe personality disorder and have pledged seventy million pounds over three years to progress understanding in this area (Home Office, 22/9/00).

Following the proposals for consultation of the Reform of the Mental Health Act 1983: Proposals for Consultation (1999) and the Managing of Dangerous People with Severe Personality Disorder (1999) the government produced a White Paper in December 2000: Reforming the Mental Health Act (2000). The White Paper came in two parts titled Part I: The Legal Framework and Part II: High Risk Patients.

In Part I it is argued that the last full review of mental health law took place over four decades ago and that

> the current laws have failed properly to protect the public, patients or staff. (Department of Health, 2000: 1).

The stated intention of the changes are to strengthen the current law and in so doing protect both the public and the patients (Department of Health, 2000: 2). The new law would keep the overarching description of mental disorder but not specify individual disorders (Department of Health, 2000 Part II: 3.2). This

would mean that the new compulsory powers for preliminary examination, formal assessment and initial treatment, including a care plan, and a new care and treatment order could be considered for all those diagnosed as suffering from a serious mental disorder. The main difference from the current MHA 1983 for the personality disordered is that the treatability clause would be removed for all mentally disordered individuals (Department of Health, 2000 Part II: 3.2).

A Care and Treatment Order and plan could be applied

> In cases where the use of compulsory powers arise primarily in the patient's own interests that plan must be anticipated to be of direct therapeutic benefit to the individual concerned. In cases where compulsory powers are sought primarily because of the risk that patient presents to others, the plan must be considered necessary directly to treat the underlying mental disorder and/ or to manage behaviours arising from the disorder. (Department of Health, 2000 Part I: 3.18)

The last half of the last sentence would allow those diagnosed as personality disordered but considered untreatable in conventional medical terms to be held on the grounds of their disorder so that there dangerous behaviour might be managed. This would be applicable to offenders and non-offenders alike. However, offenders could also receive one of the existing disposals, a life sentence or determinate prison sentence, a restriction order or a hospital and limitation direction (Department of Health, 2000 Part I: 4.10). The new act would also allow prisoners to be transferred to a specialist facility for assessment before a hospital transfer was decided upon (Department of Health, 2000 Part I: 4.11/12).

Part II of the White Paper (2000) concentrates on those individuals to which the government have applied the working definition 'dangerous people with severe personality disorder' (DSPD) and is closely linked to the government's 1999 proposal.

The definition of DSPD was outlined as including individuals who

> show a significant disorder of personality; present a significant risk of causing serious harm from which the victim would find it difficult or impossible to recover, e.g. homicide, rape, arson; and in whom, the risk presented appears to be functionally linked to the personality disorder. (Department of Health, 2000 Part II: 2.18)

Part II reiterates those issues of law discussed in Part I which specifically apply to DSPD individuals and outlines the government's promise to invest in and develop a system dedicated to dealing with DSPD individuals for the protection of the public, the patient and the carer. It starts from the premise that DSPD individuals cannot be held safely in mainstream, high security psychiatric wards but that they must be held in a therapeutic environment. It therefore has invested in a number of existing and newly built pilot sites within the NHS and HMPS to discover 'what works' with this group of individuals. It is envisaged these may form the core of any third service dealing exclusively with DSPD individuals. The government wants to work quickly in bringing in the powers and services outlined in this document but acknowledges that it will take time to incorporate the necessarily expanding knowledge base (Department of Health, 2000 Part II: 6.72).

Conclusion - No Change on the Ground

The government appears to be planning to implement far-reaching changes in an attempt 'to do something about' psychopaths - officially identified as DSPD individuals and allay the fears of the general population. The latest government White Paper on Reforming the Mental Health Act (2000) appears to offer a complete overhaul of existing mental health legislation and facilities. Part II of which exclusively deals with High Risk Patients and builds on the government's 1999 proposals on managing DSPD individuals.

The 1999 proposal and 2000 White Paper appear to attempt to deal with reducing public risk whilst attending to the needs of the personality disordered individual. Reviews by the Health Committee (2000) and the Home Affairs

Committee (2000) focus in the case of the former on the needs of the patients and in the case of the later on enabling the courts to indefinitely detain all offenders and non-offenders who they perceive to be too dangerous and have labelled DSPD to be free. The government's response to both these reviews quite clearly favours the views of the Home Affairs Committee (2000).

The government proposal (1999b) set out two 'new' options for the future containment and management of DSPD individuals. Option A entailed changes within existing mental health and criminal justice legislation and facilities. Option B, the third way proposal, arguably entails the development of a totally new system for the containment and management of DSPD individuals. However, the only difference between this proposal and existing facilities for the containment of DSPD individuals in Special Hospitals and prisons appears to be that they would be managed collectively under a new name - DSPD service. Fallon (1999a) and the Health Committee (2000) did not support Option B arguing that it would only lead to further isolation and stigmatisation of DSPD individuals and their carers.

It is therefore arguable how much the government's new proposals to do something about the psychopath would affect the existing situation on the ground in terms of the day to day management of those who have come to be labelled DSPD individuals. Although the proposal makes some reference to the every day management of DSPD individuals in security terms it does not expand on these issues or review the practical problems that any system set up to deal with dangerous patients would automatically face. It is part of the intention of this research that it will fill a gap in the existing knowledge base on the management of dangerous patients by discovering how the wards of the PDU work on a day to day basis.

However, the following chapter will demonstrate that the problem the government faces starts at a more fundamental, conceptual level.

CHAPTER 2

A Conceptual Problem: The Paradox of the PDU Patient

I would argue that the practical problems described in Chapter One concerning 'what should be done about' those who have come to be labelled as DSPD individuals by the government are rooted in the fundamental medical and legal paradox of the non-responsible or responsible dangerous patient. The medical diagnosis of those people who do not appear to fulfil the norms of society because they behave in inexplicable and dangerous ways but who also do not appear to be suffering from a loss of reasoning has created this contradiction. The creation and continuation of this problem will be reviewed below and this chapter will conclude with a discussion on how this fundamental paradox will inevitably effect PDU patients and staff on the wards.

Medical Dilemma

Officially patients are in the PDU because in medical terms they have been diagnosed by competent medical professionals to be suffering from a personality disorder for which they can and should be treated (MHA 1983).

It is necessary to review the complexities behind how and why a medical diagnosis of personality disorder is reached as personality disorder, from its conception as 'manie sans delire', has been plagued by controversy and ambiguity. Personality disorder has been and continues to be used to cover a multitude of inexplicable behaviours. Today there remains a wide diversity of medical opinion regarding the diagnosis, severity and dangerousness, and treatment and treatability of personality disordered individuals (Dolan & Coid, 1993; Home Office 1999a).

The intervention of psychiatry - medicalising the dangerous and inexplicable

People have long sought to explain what they fear as unpredictable, unexpected and inexplicable behaviour. An explanation was found by applying a medical

framework and insanity was defined as a lack of intellectual reasoning or understanding - a view which remains today regarding mental illness.

By the start of the nineteenth century with the rise of the professional body known as psychiatry to deal exclusively with the insane an exceptional group of individuals began to be identified. They did not fit the traditional perception of insanity as their reason appeared intact. However, on occasions they performed unreasonable, inexplicable acts through which they appeared to show a flagrant disregard for other people and the rule-governed culture in which they lived.

Ever since this time the psychiatric profession has been divided as to the origin (nature v nurture), identification and diagnosis (based on an assortment of emotions and behaviours inherently subjective in assessment), treatability and changeability of this exceptional group of individuals. From the start sections of the medical profession have attempted to reject this group as a non-medical problem believing them to be difficult to identify, untreatable and unmanageable in a medical setting. These issues raised in the historical development of what is today known as personality disorder remain central to the current medical debate.

Pinel (1801) a French physician first identified this new group of dangerous but not traditionally insane individuals and developed the concept of 'manie sans delire' to be applied to a 'violently insane person who showed no other symptoms of madness'.

By the mid 1830's in England Prichard the senior physician at Bristol Infirmary had expanded upon this explanation and developed the term 'moral insanity' to account for those individuals who abandoned all ethical and legal codes to such an extent that their behaviour had to be considered insane (Davison & Neale, 1987).

Prichard (1837) described moral insanity as follows:

> mental derangement in which the intellectual faculties appear to have sustained little or no injury, while the disorder is manifested principally or alone, in the state of the feelings, temper or habits. In cases of this

> description the moral and active principles of the mind are strangely perverted and depraved; the power of self-government is lost or greatly impaired; and the individual is found to be incapable, not of talking and reasoning upon any subject proposed to him, for this he will often do with great shrewdness and volubility, but of conducting himself with decency and propriety in the business of life (Prichard, 1837: 15).

Prichard's concept of moral insanity had little immediate impact on medical opinion as the profession had accepted his earlier assessment of Pinel's concept of 'manie sans delire' - there might be some underlying, albeit undiscovered, lack of understanding. However, even this weakened form of moral insanity was enough to blur the sharp distinctions between the sane and the insane.

At this time psychiatry became inextricably linked to the law as it had identified a sub-group of criminal individuals whose behaviour was thought to be so violent, perverted, depraved and out of control, they could be pronounced mad. This inevitably evoked a great deal of debate between psychiatry and the law. Before this time the medical profession had had little influence over or interest in the law. They had only been involved in a few capital punishment cases where they considered the offender to be suffering from a loss of understanding and therefore not deserving of the gallows.[2] As a result of Prichard's (1835, 1837) and Maudsley's (1874, 1885) concept of moral insanity or imbecility, at that time interchangeable, the psychiatric net was substantially widened.

Maudsley (1885) described the morally insane as having

> no capacity for true moral feeling - all his impulses and desires, to which he yields without check, are egoistic, his conduct appears to be governed by immoral motives, which are cherished and obliged without any evident desire to resist them (Maudsley, 1885: 171).

---

[2] 1800 Act - Parliament made provision for the special verdict of not guilty by reason of insanity following James Hadfield's attempt to kill King George III. (Kaye 1998: 27)

This definition seems to imply that all those who are habitually found guilty of delinquent acts can plead moral insanity and free themselves of moral and legal responsibility for a crime. Maudsley (1885) was aware of the controversial nature of his concept of moral insanity as a form of mental alienation which has so much the look of vice or crime that many people regard it as an unfounded medical invention (Maudsley, 1885: 170).

Unsurprisingly the concept was regarded as a serious threat to the legal and social framework of the country.

Around the 1860's the broad label 'moral disorder' was created to be applied to the two now distinct categories of moral insanity (a loss of feeling) and moral imbecility (where the individual never developed moral feeling). The diagnosis of the former relied on identifying a gross change in behaviour, whilst the diagnosis of the later relied on identifying a long-term pattern of rule-breaking behaviour. The diagnosis of both disorders was inevitably a retrospective process, only triggered by a clear display of an individual's inability to abide by the rules of society. Following this division in the meaning of moral insanity and moral imbecility, it is the category of moral imbecility which is most closely linked to the modern medical view of personality disorder as a long-term disorder.

By the mid 1860's the psychiatric profession was beginning to narrow Maudsley's broad boundaries of moral imbecility. Hayne's (1864) analysis of fifteen clinical cases provides an early characterisation of the modern psychopath (Hare, 1996; Roth, 1990). He referred to clear distinctions between moral imbeciles and normal persistent offenders, identifying a clear pattern of behaviour and emotion for the moral imbecile: bad behaviour starts by puberty, it persists despite punishment; behaviour can be both absurd and extreme and episodic; the individual seldom expresses regret or shame or the belief that the behaviour is wrong; the patient suffers from no delusions.

Koch (1889, 1891) was the first to label this longitudinal, morally defined pattern of disorder as a psychopathic personality. Kraeplin (1896) had doubts about the classification of this newly identified group and only included

a chapter on the psychopathic personalities in the eighth edition of his book on mental disorders. He listed seven types of psychopathic personality, all with antisocial overtones: excitable, unstable, eccentric, liars, swindlers, antisocial and quarrelsome. Schneider (1923) extended the list to include not only individuals who cause suffering to others but those who inflict suffering on themselves. This definition is not dissimilar to the modern concept of psychopathy or the current medical baseline for the broad category of personality disorder.

In the 1920's there was a bid to get rid of the category of moral imbecile, owing to confusion surrounding the diagnosis of the disorder, and redistribute members of the category into existing categories of mental disorder. However, in doing this there were always some residual members left who were then placed into the new category of psychopathic personality - a group with little in common apart from they did not fit anywhere else. Thus, the modern concept of psychopathic personality and its immediate consignment to a residual category or 'wastebasket diagnosis' (Davison & Neale, 1987: 260) was born. Hamblin-Smith (1922) an eminent psychiatrist of the time believed the disorder to be untreatable.

By the 1930's the focus changed from psychopathy (at this time interchangeable with psychopathic personality) being an innate disorder as identified by the European psychiatrists to one which was a product of society with its onset occurring in childhood. This led to the hope that if the condition was learned rather than inborn then early intervention might be successful. However, the difficulties of identification in the early phases of any disorder means that by the time individuals' anti-social tendencies are discovered it could be considered too late for them to unlearn all that has been imbued in them. Therefore, the psychiatrists of the mid-1940's agreed with Hamblin-Smith's earlier assertion that psychopaths were untreatable and feared that they were also unmanageable except possibly in a prison environment.

Henderson (1939) was the first British psychiatrist to outline a singular form of psychopathic personality which he identified as a predominantly

aggressive psychopathic state. He described psychopaths as not mentally subnormal people but as individuals

> who throughout their lives or from a comparatively early age, have exhibited disorders of conduct of an antisocial or asocial nature, usually of a recurrent or episodic type which in many instances have proved difficult to influence by methods of social, penal and medical care or for whom we have no adequate provision of a preventative or curative nature (Henderson, 1939: 18).

The 1969 edition of Henderson and Gillespie's Textbook of Psychiatry (10th ed.) gave a broad definition of individuals with psychopathic disorder as dangerous, emotionally stunted, social misfits:

> They constitute a rebellious, individualistic group who fail to fit in to their social *milieu*, and whose emotional instability is largely determined by a state of psychological immaturity which prevents them from adapting to reality and profiting from experience. They may be adult in years, but emotionally they are so slow and backward and uncontrolled that they behave like dangerous children. They lack judgement, foresight and ordinary prudence. It is the sheer stupidity of their conduct which is appalling . . . They are the misfits of society, the despair of parents, doctors, ministers, lawyers and social workers (Henderson & Gillespie, 1969: 307).

In the book the authors refer to the difficulty of early identification of psychopathic disorder prior to an act of extreme rule-breaking. They describe this as a nearly impossible task as

> there is no specific cause, no single traumatic event either of a psychological or physiological nature which need necessarily be present (Henderson & Gillespie, 1969: 310).

The 1960's saw psychiatry begin to view psychopathy not as a mental illness or mental deficiency but as a general category of personality disorder. Psychopathic personality was generally regarded as a severe form of personality disorder which at the milder end referred to odd individuals who

were perfectly capable of living in the community (Craft, 1962). Craft (1966) argued

> just as not all psychopaths are criminals, so all criminals are not psychopathic, but there is a substantial overlap between the two (Craft, 1966: 3).

He regarded an individual's rule-breaking to be an important tool through which their behavioural disorder could be identified:

> One cut-off point in behaviour disorders is available which is not in other clinical states, this being the mark of society disapproval of abnormal action shown by conviction (Craft, 1966: 3).

In 1962 a group of prison, general and special hospital doctors were asked to report on what they felt to be the salient features of psychopathy, apart from anti-social behaviour. The primary characteristics were considered to be a lack of feeling for others and a liability to act on impulse. The secondary traits were that in certain situations the above characteristics could lead to aggression possibly due to the individual's viciousness or desire to wish others harm. Equally, the individual was considered to be unable to profit from experience, appearing to lack shame, remorse or motivation. The negative aspects were identified as a lack of psychoses, a lack of pure intellectual inability and a lack of criminal motivation or planning.

It is not surprising that towards the end of the 1960's, psychopathic (personality) disorder was regarded by the majority of psychiatrists as a social problem on which medicine could make very little impression (Johnstone, 1996).

Historically therefore, although the origins (from innate to learned) and the label for the disorder ('manie sans delire' to a severe form of personality disorder) have altered, the issues surrounding the residual group first identified as not fitting the norms of insanity but insane by virtue of their inexplicable and dangerous behaviour have remained fundamentally the same. The disorder

could only be identified and diagnosed following an act of extreme anti-social behaviour and then assessed retrospectively through the discovery of the individuals underlying negative character traits and lack of mental illness. Ever since the initial identification of this group the medical profession have attempted to reduce it in size as a result of the unanswered and possibly unanswerable question about what can be done about these individuals.

The modern concept of personality disorder - a residual problem

Part of the brief of the Ashworth Committee of Inquiry (1997-1999) was to collect expert evidence on the modern concept of personality disorder and its relationship to offending behaviours. The information they received shows that the problems which recurred throughout the history of the development of the concept of what is today known as personality disorder and what is to be done about the individuals who are identified as suffering from the disorder remain.

> (I) Official Reports, many publications, statements from a majority of our witnesses and the replies of our expert witnesses in evidence confirm that there continues to be much scepticism, uncertainty and lack of agreement about the nature, diagnosis and the validity and reliability of existing classifications of personality disorder (Home Office, 1999a: 6.5.1).

The problems begin immediately with the labelling and describing of the problem:

> It is important to distinguish between psychopathic personality, psychopathic disorder and personality disorders. These terms are often used interchangeably in Britain but refer to different groups of problems and people (Blackburn in Home Office, 1999a: 3).

Psychopathic personality was originally the generic term for all personality disorders until it was adopted in America as representative of a:

> specific form of personality disorder defined by personality traits such as egocentricity, callousness, lack of empathy, and impulsivity. The Categories of anti-social PD in DSM III/IV and dissocial PD in ICD-10

are similar to (but not identical with) this concept (Blackburn in Home Office, 1999a: 3).

ICD-10 (The International Classification of Disease - 10: World Health Organisation, 1992) equates dissocial personality disorder with, amoral, anti-social, psychopathic and sociopathic personality disorder. It is defined as:

> A personality disorder, usually coming to attention because of a gross disparity between behaviour and the prevailing social norms, and is characterised by:
> (a) callous unconcern for the feelings of others;
> (b) gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations;
> (c) incapacity to maintain enduring relationships, though having no difficulty in establishing them;
> (d) very low tolerance to frustration and a low threshold for discharge of aggression, including violence;
> (e) incapacity to experience guilt or to profit from experience, particularly punishment;
> (f) marked proneness to blame others, or to offer plausible rationalisations, for the behaviour that has brought the patient into conflict with society (ICD-10, 1992: F60.2).

DSM-IV (The Diagnostic and Statistical Manual; American Psychiatric Association) places the personality disorders on Axis II of multi-axial model; of those identified anti-social personality disorder correlates most closely to psychopathy (Home Office, 1999a: 6.2.9). The diagnostic criteria is as follows:

> A: there is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:
> (1) failure to conform to social norms with respect to lawful behaviours as indicated by repeatedly performing acts that are grounds for arrest;
> (2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for profit or for pleasure;
> (3) impulsivity or failure to plan ahead:
> (4) irritability and aggressiveness, as indicated by repeated physical fights or assaults;
> (5) reckless disregard for safety of self or others;

(6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behaviour or honour financial obligations;
(7) lack of remorse as indicated by being different to or rationalizing having hurt, mistreated, or stolen from another,
B: The individual is at least age 18 years.
C: There is evidence of conduct disorder with onset before the age of 15 years.
D: The occurrence of anti-social behaviour is not exclusively during the course of a schizophrenic or a manic episode (DSM IV: 301.7).

Psychopathy and clinical psychopathy, when used by medical practitioners, are also accorded the above meaning.

Roth (1990) outlined a general consensual definition of psychopathy, as the following:

> It comprises forms of egotism, immaturity, aggressiveness, low frustration tolerance and inability to learn from experience that places the individual at high risk of clashing with any community that depends upon co-operation and individual responsibility of its members for its continued existence (Roth, 1990: 449).

This definition of psychopathy consists of a list of anti-social characteristics (similarly to DSM IV/ ICD-10), not one of which has been argued to be singularly indicative of psychopathy, which reflect an extreme inability to abide by the norms of society. The DSM IV diagnostic criteria in particular uses the offending behaviour of an individual as indicative of an underlying anti-social personality disorder. The implication is that the diagnosis of psychopathy is reliant on individuals showing themselves to be dangerous. Specifically the psychopath is found to be unable to co-operate or assume individual responsibility for themselves in any community. This suggests that the expectation is that these individuals will be dangerous in any setting.

The problems connected to the concept of personality disorder continue at the diagnosis stage. Alongside the diagnostic category of psychopath or dissocial/ anti-social personality disorder, there are a number of other distinct categories of personality disorder: paranoid, schizoid, schizotypal, borderline, histrionic, narcissistic, avoidant, dependent, obsessive-compulsive and passive-

aggressive. All the personality disorders have their separate diagnostic features, although all overlap to some extent. It is common for individuals in this area of mental disorder to be diagnosed as suffering from more than one type of personlity disorder (co-morbidity). Even if the above types of personality disorder could be shown to be a finite and clearly distinguishable group, there still remains a difficulty in diagnosing the different disorders. This is partially because there is not a standardised assessment mechanism or training manual for the identification of personality disorder.

Dolan and Coid (1993) referred to the array of diagnostic tools available to medical practitioners who operate within the Special Hospitals: ICD-10, DSM III/IV, PCL-R (Hare's Psychopathy CheckList Revised -1996), Blackburn's Typology derived from MMPI profiles (Minnesota Multiphasic Personality Inventory), SHAPS (Special Hospitals Assessment of Personality and Socialization), Psychodynamic Classifications.

The DSM takes a categorical approach to the diagnosis of personality disorder identifying clusters of behaviours or traits which cause significant social, occupational or subjective impairment or stress (Dolan & Coid, 1993: 15).

The ICD takes a trait approach to the identification of different personality disorders and looks at a variety of conditions to assess whether an individual's personal characteristics, inner experiences and behaviours deviate from what is considered culturally acceptable (Dolan & Coid, 1993: 13).

The PCL-R contains a list of twenty anti-social lifestyle behaviours and personality traits for which an individual is given a rating of 0-2 points. If an individual scores over thirty in total, they are regarded as psychopathic (Coid in Home Office, 1999a). It is regarded by some psychiatrists to be a particularly useful tool in research and in determining the severity of a patient's disorder (Home Office, 1999a: 6.2.11).

Blackburn's Typology is an empirical adaptation of the MMPI developed from research in psychiatric hospital and prison settings. It distinguishes four groups of personality characteristics and the traits which are representative of

them. Types 1 and 2 are considered to represent two sub-groupings of psychopaths (Type 1: primary or 4-9 type/ Type 2: secondary or neurotic). Types 3 and 4 are considered non-psychotic (Type 3: controlled/ Type 4: inhibited).

Blackburn later developed SHAPS (1997), a ten scale questionnaire, based on the MMPI, to identify primary and secondary psychopaths.

The Psychodynamic Classificatory technique is complex, requiring specialist training, and unlike the other systems which are based on personal traits and behaviours, it concentrates on the severity of the psychopathology of the individual (Coid in Home Office, 1999a).

Although a number of the diagnostic tools focus on the characteristics and psychopathology of the individual, as opposed to their behaviour, these can only be identified through the actions and verbalisations of the individual.

> Personality can only be judged from reliable accounts of past behaviour. (Gelder, Gath & Mayou, 1983: 105)

Case histories can be patchy and are often an amalgamation of earlier reports on the actions and words of individuals. Generally an individual, later diagnosed as having a personality disorder (particularly psychopathic, anti-social or dissocial - psychopathy), is first attended by a medical professional because of their offending behaviour and so it is inevitable this 'known' behaviour is of primary importance in their diagnosis. The Oxford Textbook of Psychiatry (1983) implies that this is the case:

> some personalities are obviously abnormal: for example those of violent and sadistic people who repeatedly harm others and show no remorse (Gelder, Gath & Mayou, 1983: 105).

It is questionable whether it is possible to make a definitive general or specific diagnostic test for the diagnosis of personality disorder when there is no one trait or behaviour which is indicative of the general group 'personality disorder' or of any one specific personality disorder. In the case of

psychopathy there is a tendency to focus on assessing whether an individual is dangerous. This is most likely to be confirmed with reference to individuals' offending behaviour. However, once individuals are removed from the rest of society it is arguably impossible for medical professionals to assess whether they continue to represent a risk to the society from which they have been removed.

The problems surrounding the labelling, identification and diagnoses of individuals medicalised as personality disordered automatically affect the prospect of developing effective treatment packages as they are clearly a heterogeneous group whose only clear link is their inexplicable and sometimes dangerous behaviour and their lack of psychoses. The issue of treatability is complex as with everything to do with personality disorder. It is important to take into account: the availability of known treatment and whether it has been tried and tested; the personal and social factors of the individual and whether they are amenable to treatment; availability of resources including staff and physical setting. The only point that all parties involved in the treatment of personality disorder including psychopathy appear to agree on is the need for further research. Dolan and Coid's (1993) comprehensive review of the research on the treatment of psychopathy so far for the Reed Committee (Home Office, 1994) concluded, as so many others had before them (Cleckley, 1941; Stafford-Clark *et al,* 1951; Scott, 1963; Cleckley, 1964; Carney, 1976; Blackburn, 1983; Frosch, 1983; Quality Assurance Project, 1991), that there was:

> insufficient evidence to determine whether or not those with psychopathic disorder could be successfully treated (Home Office, 1994: 4.4).

This finding was again reiterated in the evidence presented to the Fallon Committee of Inquiry (1999a). Blackburn (Home Office, 1999a) a researcher on personality disorder argued

> because research on the development of abnormal personality remains relatively undeveloped, there is no universally accepted treatment model. Different forms of PD may also require different methods (Blackburn in Home Office, 1999a: 5).

Coid (Home Office, 1999a) did conclude that the more severe the level of personality disorder, the less likely the individual is to be treatable. Dolan (Home Office, 1999a) pointed to the issue of treatability or untreatability being a reflection on the professionals, who either fail to find, or apply, the right treatment. A number of psychiatrists in their evidence to Fallon (1999a) made comparisons to deteriorative and terminal physical disorders which would still respond to ameliorative interventions in the same way that personality disorder patients might. It was agreed treatment and treatability were too often viewed in terms of reducing risk, rather than the equally important need to reduce personal distress. However, whilst PDU patients are being held primarily on the grounds of dangerousness, the risk factor they represent to staff and the public must remain at the top of the clinical agenda.

In conclusion, the modern concepts of personality disorder and in particular psychopathy remain in essence the same as Pinel's nineteenth century concept of 'manie sans delire'. Individuals continue to be identified as suffering from an asocial, anti-social or psychopathic personality on the grounds that their flagrant disregard for the norms of society is so inexplicable that they must be mentally disordered. As they do not appear to be suffering from any mental illness, in particular they are not delusional or hallucinatory, they are identified as personality disordered. The personality traits diagnostically attributed to these individuals, manipulative, aggressive, unable to experience remorse or benefit from punishment, unable to co-operate or be responsible for oneself in a communal setting infer that they are dangerous and unable to change or co-exist in a communal setting. The medical profession has yet to form any firm conclusions as to whether these individuals particularly those at the most severe end of the personality disorder scale can ever be treated and therefore be made fit to return to the public arena.

Legal Quandary

The majority of PDU patients have been convicted by the courts as 'dangerous offenders' and had there been no question of mental disorder their 'just desert' would be punishment by imprisonment. However, as dangerous offenders who have been diagnosed by the medical profession as suffering from a treatable 'psychopathic disorder' PDU patients must be sentenced to an indefinite period of hospitalisation (MHA 1983). This is not as simple as it first appears since the medical and legal professions have continually questioned and are questioned themselves by the politicians and the public about who should be considered responsible for the psychopathically disordered offender - the individual, the criminal justice system or the health service.

A new kind of insanity - who should be held responsible?

The history of madness shows that there has always been a great deal of confusion surrounding mentally disordered offenders in relation to the criminal justice system, as

> insanity is accepted as a medical concept provided it does not cause bad, violent or dangerous behaviour; if it does, then it becomes wickedness (Gunn, 1991: 21).

The law is informed by public, political and medical debates which have long established the need to incarcerate the mad and the bad for as long as they are perceived to be dangerous.

> Increasingly in the nineteenth and twentieth century penal practice and then penal theory will tend to make of the dangerous individual the principle target of punitive intervention. Increasingly, the nineteenth-century psychiatry will also tend to seek out pathological stigmata which may mark dangerous individuals: moral insanity (Foucault in Kritzman, 1988: 139-140).

The introduction of the concept of moral insanity in the nineteenth century led to a whole new relationship between psychiatry and the law. Ever since the

distinction between disorder of reason and disorder of morality was first made it has been debated whether those found guilty of a criminal offence and diagnosed as suffering from a moral disorder should be treated as patients or punished as offenders - whether they should be deemed responsible for their actions. The introduction of moral disorder as a pardonable excuse for the committing of an horrendous, inexplicable criminal act, created a paradox for the legal and medical professions:

> Is a psychopath criminally responsible? It is a moot point. For if a criminal is mentally ill, his symptoms can be tested independently of his crime. But a man is classified as a psychopath precisely because he has no symptoms. He is trapped in a circular definition: he is a psychopath because he has committed anti-social acts, but these are explained by his personality disorder. The more brutal and remorseless his crime, the more likely he is to be excused responsibility for it on medical grounds (Clark & Penycate, 1976: 6).

> The more psychologically determined an act is found to be, the more its author can be considered legally responsible. The more the act is, so to speak, gratuitous and undetermined, the more it will tend to be excused. A paradox then: the legal freedom of a subject is proven by the fact that his act is seen to be necessary determined; his lack of responsibility is proven by the fact his act is seen as unnecessary. With this untenable paradox of . . . the monstrous act, psychiatry and penal justice entered a phase of uncertainty from which they have yet to emerge; the play between penal responsibility and psychological determinism has become the cross of legal and medical thought (Foucault in Kritzman, 1988: 140).

This constant interplay between penal responsibility and psychological determinism has led to:

> the "lottery": the game of chance which determines whether or not an offender who is (*perceived to be*) suffering from a severe personality disorder ends up in prison (the vast majority) or hospital (Home Office, 1999a: 1.33.3) (Italics added).

> There are various elements of the lottery. First, whether an individual gets assessed at all. Second, if he is assessed, is he assessed by someone who is, crudely, "pro-treatment", or by someone who is more sceptical. Third, if he is regarded as "treatable", is there a bed available. Fourth, if

> there is a bed available, does the judge accept such a recommendation. Fifth, if one does get into hospital, particularly on a hospital order with restrictions without limit of time has that man won or lost? An individual diagnosed as suffering from a psychopathic disorder and committed to a hospital on a section 37/41 hospital order does not know when he will ever be regarded as safe to come out of hospital (Home Office, 1999a: 1.33.4).

At the end of the nineteenth and beginning of the twentieth century, the focus of concern for the law and psychiatry was shifting from the criminal act towards the criminal person and their potential for future dangerousness. As the crime was perceived as inexplicable, beyond normal understanding, it was impossible to direct the individual's sentence in terms of addressing the motives behind the criminal behaviour. The primary objective of the courts became how best to deal with the individual who had been demonstrated to be dangerous (Foucault in Kritzman, 1988).

The issue of dangerousness has always been explicit or implicit in the law pertaining to the criminal lunatic. The 1744, Vagrancy Act (5.20) instructed for the detention of

> those who by lunacy or otherwise are so far disordered in their Senses that they be too dangerous to be permitted to go abroad (in Scull, 1981: 40).

The Mental Deficiency Act 1913 provided for the certification and indefinite detention of moral imbeciles described as

> persons who from birth or from an early age display some permanent mental defect, coupled with strong vicious or criminal propensities, on which punishment has had little or no deterrent effect (Mental Deficiency Act, 1913, s 1(d)).

The Mental Health Act 1959 identified Special Hospitals as being for the confinement of the patient who requires

> treatment under conditions of special security on account of their dangerousness, violent or criminal propensities (MHA 1959).

The current Mental Health Act (1983) requires patients who are admitted to Special Hospitals to represent a 'grave and immediate danger', either to themselves or the public. Dangerousness is a legal requirement of all those who enter the Special Hospital but for the psychopathically disordered individual it is the key issue. This is because the medical diagnoses dissocial, anti-social or psychopathic personality disorder, which have become synonymous with the legal construct psychopathic disorder, are dependent on the individual exhibiting dangerous behaviour.

The majority of patients on the PDU have entered the hospital under the legal definition of psychopathic disorder (MHA, 1983). This definition identifies and defines the individual via their dangerous behaviour. There is no attempt to enlarge on what is meant by a persistent disorder or disability of mind, except it may produce an impairment of intelligence. As it is difficult to identify a psychopath who has not broken the law (Davison & Neale, 1990) it is this criminal act through which he was initially identified which is in reality used as proof of a disorder and the reason for continued detention (Robertson in Home Office, 1999a). This to a certain extent ignores the requirement of the act to find the individual to be suffering from a persistent disorder which can only be discovered following a prolonged period of assessment.

As stated above, the identification, diagnosis and treatment of a personality disorder, especially a psychopathic personality, is not clear cut. Further, the medical profession find little resemblance between the legal construct of psychopathic disorder and the medical concept of psychopathic personality (Dolan in Home Office, 1999a). If the legal construct, psychopathic disorder refers to psychopathy then it must encompass a broad range of behavioural traits which can be attributed to a number of clinical states (Home Office, 1991: 2.1(DSM Axis I & II)). Again the lack of any one behaviour which is indicative of psychopathy or any other personality disorder means that it is difficult to identify those to whom the legal construct of psychopathic

disorder should be applied. Therefore Butler's (1975) and Fallon's (1999a) recommendations of exchanging the term psychopathic disorder for personality disorder would be of little benefit as the problem is grounded in the medical concept of psychopathy, not the wording.

Legally the courts are left with a dilemma when dealing with those identified as psychopathically disordered, as it has almost become medical fact that they will remain

> untouched by therapeutic or rehabilitative interventions - two of the commonly accepted diagnostic criteria for psychopathic personality disorder being a failure to learn from experience and a failure to show remorse (Eastman & Peay, 1998: 94).

> Some, particularly severe personality disorders, are resistant to treatment or frankly untreatable (Home Office, 1999a: 6.10.5).

This leads to the inference that those who are sent to Special Hospitals under the legal construct of psychopathic disorder are not treatable and will remain dangerous. It is not that the courts do not face the same difficulties when dealing with the 'sane' criminal, but there has not been the same authoritative medical diagnosis of an inability to change placed on these individuals. If the courts are made aware that individuals will not change it is understandable that they will wish to avoid their release back into society. This problem is placed at the door of the psychiatrist. Legally, if the psychiatrist does not view the psychopath to be treatable, they cannot recommend hospitalisation. If a psychopath is not hospitalised, and their crime is one which does not warrant a life sentence, it is possible they will be back on the streets in a short length of time. Although not legally responsible the psychiatrist may appear morally responsible, for endangering the lives of the public, or even the offender, if they are not able to cope in prison or outside.

In recent years the law of 'just deserts' has been abandoned in the case of dangerous offenders where

> protective sentencing based on predictions of dangerousness has become the norm (Clarkson, 1997: 284).

The 1991 Criminal Justice Act established the need for the punishment to fit the crime, in no way lengthened as a deterrent or as a means of treatment, but in the case of the offender portrayed as dangerous, the law makes an exception - intent on interfering with what the person is, rather than what they did. Section 2(2)(b) makes provision for 'a longer than normal', or discretionary life sentence for the detention of those individuals who are deemed dangerous but not treatable under the 1983, Mental Health Act. This means that all those found guilty of a criminal offence and to be psychopathically disordered in the future are in danger of facing an indefinite or natural life sentence wherever they are contained.

Under the MHA 1983 dangerous, treatable psychopathically disordered offenders are entitled (via a number of routes) to be removed from the criminal justice system and placed in the care of a national health service Special Hospital. These are currently under review (Home Office, 2000) but at present these are the routes by which psychopathically disordered individuals can enter the Special Hospitals.

Section 37 of the MHA 1983, the Hospital Order, can be invoked in court when an offence is found to be punishable by imprisonment and two doctors find the individual to be suffering from a mental disorder. This order is awarded for six months and then renewed for another six months and then annually in a Mental Health Review Tribunal (MHRT).

Section 47 of the MHA 1983 can be used when a prisoner is found to be suffering from a mental disorder, either exacerbated or brought on by imprisonment, and it is felt they would benefit from hospitalisation. If a patient is transferred under section 47, there is always the possibility he may be returned to prison if he is considered to have recovered, to no longer be treatable, or not to be co-operating with the treatment programme. The majority of PDU patients in the last ten years have entered Ashworth Hospital under section 47 of the MHA 1983 (Home Office, 1999a: 1.33.1).

In the past, Section 47 has been invoked by the Secretary of State when an individual, still considered to be dangerous and identified as personality disordered, was nearing their earliest release date. Until the MHA 1959, it was not possible to detain patients beyond the expiry date of their sentence (Grounds, 1990). Now a Hospital Order (s.37), Prison Transfer (s.47), Restriction Order (s.41) and the new Hospital and Limitation Order (s.46) allow the Secretary of State to detain patients for an unspecified, unlimited length of time.

Section 48 of the MHA 1983 allows for the transfer of remand prisoners, suffering from a mental illness or severe mental impairment, who meet the 'urgent need' criterion, to be removed to hospital. Reed (1991) recommended this clause should incorporate all types of mental disorder but at present psychopathic disorder is not included.

Section 41 of the MHA 1983, the Restriction Order, allows those found to be psychopathically disordered and dangerous to be detained in a Special Hospital:

> for the protection of the public from serious harm (MHA 1983: s.41).

A person detained under this section can only be released at the behest of the Secretary of State. The Secretary of State will be advised by a MHRT which hears the report of the RMO on the predicted future behaviour of patients. Patients are therefore reliant on not undue caution from the RMO, the MHRT, and the Secretary of State, who is further influenced by public opinion.

The latest addition to the MHA 1983 for entry into the Special Hospital specifically concerns psychopathically disordered offenders. The Crime (Sentences) Act 1997 inserted two new sections into the MHA 1983 providing a new form of order - a Hospital and Limitation Order. This can be made if two medical practitioners are satisfied that the offender is suffering from the disorder and that hospital detainment and treatment 'is likely to alleviate or prevent a deterioration in his condition'. At the same time the offender would be given a sentence of imprisonment, to be completed following a successful

course of treatment. If the treatment is not successful the PDU patient will stay in hospital indefinitely, as before.

In consultation the Reed Committee (1994) voiced the obvious concern that any patient who had been successfully treated and was then returned to prison was at risk;

> prison may exacerbate underlying psychiatric conditions or precipitate breakdown in vulnerable individuals (Home Office, 1994: 1129).

Ironically, this is likely to be the reason a patient enters the Special Hospital under section 47 of the MHA, 1983.

Once detained in a special hospital psychopathically disordered patients become the medical and legal responsibility of their psychiatrist (Registered Medical Officer (RMO)). If psychiatrists assess patients to still be in need of treatment for a personality disorder and find that they continue to represent a psychological or physical danger to the public or themselves they will recommend that patients should continue to be detained. The assessment of patients is supposed to be based on their medical diagnosis. However, in reality as patients entry into the hospital was dependent on their offence so is any estimation of their continued dangerousness and detention (Home Office, 1999a: 6.8.13).

In their evidence to the Fallon Inquiry, Dr. Chiswick and Dr. Snowden explained the difficulties faced by the psychiatrist who is asked whether a personality disordered patient, whose behaviour has been found to be dangerous in the past, has changed and is ready for release based on their medical diagnosis:

> improvement of personality, improvement of mental health does not necessarily mean reduction of risk, because on these particularly difficult, very worrying individuals, the connection between their personality and their phenomenology and the offence is quite complex and it may be that the contribution from personality may not be the major factor. . . . So assessment of treatment and whether or not they would benefit from therapeutic intervention . . . does not necessarily mean that the patient . . .

> is going to be less risky . . . I am certainly suggesting that in this group their personality disorder probably contributed to their offending but it does not necessarily mean that wellness in terms of their personality disorder significantly reduces risk, or that it will significantly reduce risk enough to make them tolerable in the community (Snowden in Home Office, 1999a: 6.6.9).

At some point psychiatrists must place their faith and therefore their reputation in the words of psychopathically disordered individuals, two of whose key traits are manipulative and untrustworthy behaviour:

> In relation to offending by people with a personality disorder, what is one treating? If a person gets into relationship problems with someone else, male or female; acts violently perhaps in a sexual setting, perhaps not, or commits some other violent crime, in the absence of a mental illness what is it exactly that one can be confident about treating that is going to reduce the risk of reoffending? It is very likely that the person has a troubled background. So what? It is very likely that they might have abnormal sexual fantasies. So what? What do any of these things tell you about that particular offence? You are dependent on an account of that offence from that particular person, perhaps supplemented by other information. You are dependent on that person for an account of improvement, whatever that might mean, and you are trying to make decisions about their discharge to an environment which you cannot control. You cannot control the people they meet, the substances they take, or the lifestyle they lead, and that can make prediction virtually impossible. So the things that you might want to do in hospital which sound on a common sense basis worthwhile . . . They are probably a good use of time. Whether they actually reduce the likelihood of that particular person offending, nobody knows (Chiswick in Home Office, 1999a: 6.8.13).

This last sentence is of prime importance, whilst some studies have shown that previous violence is the best predictor of future violence (Walker, 1996) there is never any indication given as to which individual members of the former violent group will act violently in the future.

> It is relatively easy to group offenders into broad categories of relatively high or low risk, but for unusual individuals who have committed particularly nasty sex crimes the demand for certainty that they will never reoffend in a similar way is almost impossible to meet (West, 1996: 55).

This is the category many psychopathically disordered patients fall into which leaves them in the virtually impossible position of proving to those in power they have really changed and will never reoffend. It is apparent from the medical and legal discourse that they will face a long and frustrating task when attempting to convince others that they have changed. Particularly as

> professionals, like the public, overestimate risk, which, although real, contributes very little to general levels of violence (Bowden, 1996: 13).

and the medical profession is not immune to the wider views that mentally disordered offenders, especially psychopaths, are not only mad but bad (Prins, 1995).

> Basically we do not like people who offend and break the rules and cause trouble and are really frightening, dangerous, difficult, aggressive (Gunn in Home Office, 1999a: 227).

Conclusion: the paradox of the 'sick' and 'responsible' PDU patient

In conclusion as a result of the conflicting debates surrounding PDU patients - psychopath to the media, dangerous, severe personality disordered individuals to the government, anti-social, asocial or psychopathically personality disordered to the medical profession and psychopathically disordered and dangerous in law - their status on the wards of the PDU is likely to be confused. This can best be explained using Parsons (1953) concept of the 'sick' role.

As the PDU is situated in a hospital, the individuals who have been confined within it are automatically attributed the patient role. Parsons defined a 'role' as

> the organized system of participation of an individual in a social system with special reference to the organization of that social system as a collectivity (Parsons, 1965: 261).

> The essential criteria of a social role concern the attitudes both of the incumbent and of others with whom he interacts, in relation to a set of norms defining expectations of appropriate or proper behaviour for persons in that role (Parsons, 1953: 613).

For the patient, Parsons identified the 'sick role' as the norm, which places a number of expectations on the patient and the medical professional. The 'sick role' exempts the patient from normal social obligations and 'responsibility for his own state' (Parsons, 1953: 613). In turn the patient is expected to recover 'as expeditiously as possible' (Parsons, 1953: 613) and to voluntarily place himself in the care of, and co-operate with, appropriately qualified medical professionals. The medical professional is expected to reciprocate with the patient by having the knowledge and ability (professional competency) to help the patient, and restore him to health by way of the most effective and efficient route available.

The 'sick role' is problematic for all types of mental rather than physical disorders as patients may be unaware of their condition and therefore, unwilling to place themselves in the hands of medical professionals. Parsons (1953) explained this in terms of a further reduction in personal responsibility:

> The primary difference (compared with physical illness) would seem to center on the concept of responsibility and the mode and extent of its application. The insane person is, we may say, defined as being in a state where not only can he not be held responsible for getting out of his condition by an act of will but where he is held not responsible in his usual dealings with others and therefore not responsible for recognition of his own condition, its disabilities, and his need for help (Parsons, 1953: 614).

As patients are not able to identify their own disorders, diagnosis is left to medical professionals who are expected to be competent at identifying, diagnosing and treating patients. However, as all mental disorders are initially identified through behaviours, and as there is no one behaviour indicative of mental disorder, it is possible to question the competency of medical professionals' evaluations. In the case of Axis I (DSM) mental illnesses there is

physiological and neurological evidence available to medical professionals to confirm their diagnosis and direct their treatment. The personality disorders (Axis II DSM) are not so readily identified, diagnosed and treated as the mental illnesses, although current research is looking at biological factors (Mitchell & Blair, 2000). Medical professionals are reliant on patients' behaviours and self-reporting to identify and diagnose the disorder and there are no single, pharmacological, quick fix solutions available by way of treatment.

PDU patients do not fulfil the expectations of the 'sick role'. By the very nature of their disorder, PDU patients are unlikely to accept that their current state is undesirable or wish to place themselves in a position of dependency on others. It is assumed that a patient in the 'sick role'

> 'can't help it' but where scientific evidence is not available the tendency is to give the benefit of the doubt to the possibility that he can help it (Parsons, 1965: 284).

There is a lack of conclusive research in all areas of personality disorder (Dolan & Coid, 1993) and therefore the assumption must be that PDU patients can help it.

Personality disorder has been described by psychiatry as a disorder of morality not understanding and therefore not an illness for which PDU patients can deny responsibility. A behavioural manifestation of dissocial personality disorder (ICD10) has been identified as 'gross and persistent attitudes of irresponsibility' which appears to imply patients deliberately choose to disclaim all responsibility rather than they 'can't help it' (Parsons, 1965: 284). Equally, many patients on the PDU have also been found guilty of criminal offences for which others judge them to be wholly responsible. Paradoxically, as PDU patients are residents in a rule bound institution they are obligated to abide by the rules, to take responsibility for their behaviour and therefore their disorder.

This means that although PDU patients are resident in a hospital where the 'sick role' of patient and therefore the 'can't help it' principle should

automatically apply PDU patients are paradoxically held responsible for their crimes and their personality disorder and as such are expected to take responsibility for their recovery and behaviour within the institution. The status of patient should at least entitle PDU patients to treatment by medical professionals who are knowledgeable and competent in the treatment of their disorder. However, as yet the medical profession have failed to identify any one treatment that can effectively alleviate personality disorder and can therefore not fulfil their side of the bargain. As the guarantee of treatment has been removed so is that of recovery and the chances of transfer to a place of lesser security and eventual return to society.

The paradox of the sick patient who is in need of care and treatment and the dangerous individual who must be held in a secure and controlled environment therefore appears to present a complex problem to staff working on the ground who must 'deal with' PDU patients on a daily basis. The following chapter will therefore theorise whether and if so how it may be possible for staff and patients on the ground to work and live without being in a constant state of conflict.

CHAPTER 3

Addressing the Problem
A Complex Task for the Staff on the Ground

In Chapters One and Two I established when, why and by whom PDU patients were constructed as dangerous on the 'outside'. It is assumed by all those who deal with PDU patients that their dangerousness will continue in some form whether it be through a show of physical aggression or in more insidious ways whilst they remain in the Special Hospital. I further showed that there have always been both practical (e.g. who they are and where they should be contained) and conceptual (e.g. whether they are responsible for their actions as offenders or not responsible for their actions because they are sick) problems with 'how to deal with' PDU patients. The hospital policy-makers are concerned with providing adequate security and management for them and the hospital medical professionals with the provision of treatment.

I showed in Chapter One that the current government proposal (1999b) acknowledges some of the practical and conceptual difficulties of 'how to deal with' those whom they have chosen to call DSPD individuals but the issue of public safety continues to dominate their response. The proposal makes very limited reference as to how to address what the government and public inquiries (Home Office, 1992, 1999a) have portrayed as the fundamental problem of the Special Hospital System since its conception of the need to balance security and treatment, and care and control under one roof. Pilot projects are under way in both a prison and Special Hospital setting to help discover how the DSPD individual may best be managed but before this can be done I would argue it is necessary to evaluate whether and how staff on the ground can 'deal with' these dangerous individuals.

Whilst the official discourse as discussed in Chapter One has focused on the dichotomy of care or control or the problems of delivering both care and control, people who must work with dangerous individuals on the ground are

concerned with the immediate problem at hand of 'dealing with' dangerous individuals in terms of maintaining safety and keeping the peace. Therefore, it is more appropriate to talk in terms of how order is maintained. Moreover, order cannot be maintained where there is discord between staff and patients therefore the ways in which staff deal with patients must be or appear to be legitimate.

This chapter therefore discusses the concepts of order and legitimacy as a starting point for the analysis chapters in which I will seek to discover whether and if so how staff on the ground can establish their legitimacy in the eyes of the PDU patients and therefore maintain order on the wards of the PDU.

Unravelling the so-called dichotomy - the task of staff on the ground

It was made clear in Chapter One that those in charge of the Special Hospitals believe that they have failed to meet their defined purpose of providing care and control, and treatment and security. Their constant focusing on these ideals as so-called extremes of a pendulum swing has oversimplified what is a highly complex situation (Reiner, 1994) and has proven highly detrimental to the Special Hospital System (Home Office, 1992, 1999a). The issues of treatment and security have been discussed extensively in Chapters One and Two. I focus here on the concepts of care and control as the primary task of PDU staff is to care for patients as they are nursing staff working in a hospital and to control patients as they are also staff working in a secure institution for the containment of dangerous individuals. It is therefore the task of the staff on the ground to unravel how to deal with PDU patients on a day to day basis.

There is little research on the subject of how high security, psychiatric nurses actually perform their duties within institutions as nursing literature in this area has tended to focus on the specific clinical skills employed by the 'forensic' nurse (Morrison & Burnard, 1992, Robinson & Kettle, 2000). I have therefore looked to sociological and criminological studies on the ways in which police officers and prison officers have been found to perform their

duties on the ground to discover how PDU staff may chose to 'deal with' PDU patients.

Police literature in particular in recent years has focused on the complicated relationship which exists between the use of care and control and has shown that rather than these concepts being diametrically opposed that they are in fact closely interrelated (Bittner, 1974; Stephens & Becker, 1994; Walker, 1994). I would therefore argue that an unravelling of these so-called dichotomies may lead to a real possibility of finding a working compromise on the ground.

It is those on the ground who must deal with dangerous individuals on a day to day basis. The police are expected to maintain order on the streets in terms of keeping themselves and others safe and keeping the peace. In doing this the separate concepts of care and control become inter-linked and often interchangeable as the police go about their task of maintaining social order on the ground. I will argue that this is equally likely to be the case for PDU staff when dealing with PDU patients.

Stephens and Becker (1994) through their review of police work argued that

> Control is not pursued simply to control; often hidden behind the function of control is care and protection. (1994: 4)

The use of force can therefore if used appropriately and with good reason be perceived as appropriate (Stephens & Becker, 1994). This is similar to the argument Scull (1981) made regarding the early mad-doctors whose use of physical restraints was considered necessary for the protection of the patients at a time when madness was equated to having reverted back to a beast like state.

The police literature indicates that police officers do not make decisions on whether to use care or control in a specific situation but decide what action is most appropriate to that situation to avert an undesirable outcome (Bittner, 1974) and maintain social order which may provide the dual functions of control and care.

It is perhaps better therefore not to think in terms of care and control, or care or control but in terms of the most appropriate course of action. In terms of policing this has been described as whether to make the decision to use immediate physical force in an extreme situation or attempt to verbally negotiate with an individual (Walker, 1994). The literature on police work suggests this leaves the onus on the officers working on the ground to make the right decision. The decision as to what course of action to take in a particular situation can often only be taken at the moment in time when a situation occurs.

> There are theoretical and practical limits upon the extent to which the contextually appropriate course of action for operational officers attending a particular incident can be informed by prior guidelines or instructions. (Walker, 1994: 35)

Walker (1994) argued that police officers on the ground had considerable 'practical autonomy'. This exists in policing as it is only likely to be those officers who work on the ground who are able to consolidate through experience a considerable knowledge of their environment and those who live there, and because they are operating at a distance from the regulative organisation which they represent. However, even officers who have worked on the same 'beat' for many years can never become fully acquainted with every aspect of their territory or all those who may enter it in a free society.

In a secure institution the environment is set and there should be considerable records pertaining to those who are detained within it. Equally the administrators of the institution are normally a lot nearer to hand. This allows considerably more scope for administrators to provide clear policies and procedures and to oversee the application of the rules. However, it is still likely to be those staff who work intimately with the detained on a day to day basis who will be best informed about the current status of the environment and those detained within it.

Liebling and Price (1999) therefore found that the prison officer's job of peace-keeping similarly to the police officers was best performed through the

use of discretion rather than a strict adherence to the rules. A considerable knowledge of individual prisoners if used appropriately was found to be the best tool prison officers had for keeping the peace and managing prisoners. There is no reason why this should be any different on the PDU where perhaps staff could be considered to be at an even greater advantage as information on patients should be extensive and they may have spent many years in each others company.

I would therefore conclude that it is those on the ground who must attempt to disentangle or distance themselves from the external debates on security or treatment, and care or control and to get on with the job in hand of dealing with PDU patients in terms of maintaining order on the wards. This must clearly be done within the security and treatment constraints of the institution and under the supervision of their superiors but should not stop staff who have considerable knowledge of patients from choosing the most appropriate course of action whether it be seen in terms of care or control to avert a problematic situation and maintain order on the wards.

However, this is not the end of the task but only the beginning as any staff actions in a total institution whether they perceive them to be appropriate or not can still appear coercive and therefore illegitimate to others. These differing perceptions therefore could still mean that disorder could occur. I will discuss below whether it is possible for staff on the ground to make their actions appear legitimate to their patients.

The Aim of the Task - Conferring Ground Level Legitimacy

All systems of domination must be perceived to be legitimate before a lasting order can be achieved. This is therefore what all staff who work within such systems of domination must aim for including those on the PDU.

Beetham (1991) argued that a belief in the legal authority of power relationships was not sufficient in itself for legitimacy to be conferred. He found different groups of professionals could contribute to the concept of legitimacy at different levels. The lawyer finds legitimate power to be

dependent on legal validity. Moral and political philosophers go deeper to seek the justifiability of rules governing power in terms of normative principles (the values and beliefs of individuals in a given society). The social scientist finds evidence of consent through acts, identifying the empirical consequences that legitimacy has for the character of power relations in a social context. This is the point at which the empirical research for this thesis can be used to discover whether legitimacy can and is conferred through the actions of staff working on the wards of the PDU.

Beetham (1991) found therefore that there were three levels of legitimation: the legal rules, justification grounded in beliefs and evidence of consent through actions. Through this Beetham (1991) outlined three underlying structural constructs of legitimacy which need to be met before power can be said to be legitimate regardless of context:

1. it conforms to the established rules;
2. rules can be justified in terms of shared beliefs held by both the dominant and subordinate groups;
3. evidence of consent by those subordinate to the power relations. (Beetham, 1991: 16)

However, he argued that all systems of power relations are never fully successful in meeting the above constructs either because those in power fail to conform to their own rules and/ or because the power lacks the minimum justification in shared beliefs and/ or because the power fails to find legitimation through expressed consent (Beetham, 1991: 20). To assess legitimacy at any given time it is necessary to look at all three elements in context. The social scientist is afforded the task of

> assessing the degree of legitimacy-in-context of a given power relationship, as a necessary element in explaining, the behaviour of those involved in it. (Beetham, 1991: 23)

The data collected for this thesis therefore can be used to look at the degree of legitimacy which is available and can be conferred in the context of the PDU in

terms of staff chose of the most appropriate course of action for the maintenance of order on the PDU.

Beetham (1991) described how subordinates in a power relationship in which legitimacy had been conferred might choose to co-operate with and obey those in power despite their objection to particular rules:

> To consider first the behaviour of those subordinate within a power relationship its legitimacy provides them with moral grounds for co-operation and obedience. Legitimate power or authority has the right to expect obedience from subordinates even where they may disagree with the content of a particular law or instruction; and subordinates have a corresponding obligation to obey. This obligation is not absolute - hence the dilemmas that occur when people are required by a legitimate superior to do things that are morally objectionable to them, as opposed to inconvenient or merely stupid. (Beetham, 1991: 26)

This means that if PDU staff were able to convey legitimacy through their choice of actions then patients may be willing to co-operate and obey them despite disagreeing with their specific instructions. The chances of this are enhanced through the incentives and sanctions which staff have available to them (Beetham, 1991: 27).

Obedience is therefore to be explained by a complex of reasons, moral as well as

> prudential, normative as well as self-interested, that legitimate power provides for those who are subject to it. The complexity may make it difficult to determine the precise balance of reasons in any one situation; but it is important to distinguish them analytically, since each makes a very different kind of contribution to obedience. (Beetham, 1991: 27)

It is therefore clear that a useful analytical task for finding out if and how legitimacy was established on the PDU would be to discover that if it appeared that patients were obeying staff why this should be. Staff and patients' general choice of performance on the PDU will be reviewed in Chapters Six and Seven and their choice of actions in specific situations will be analysed in Chapter Eight.

The degree of legitimacy perceived by the subordinates in a power relationship affects the nature of the 'order, stability and effectiveness' of any system of power (Beetham, 1991: 33). Other factors which can also affect the 'order, stability and effectiveness' of a system of power are its organisational capacities and resources and/ or the degree of coercion they are able to apply. It is important to recognise that staff-patient power relationships on the PDU do not exist in a vacuum and all the issues described in Chapters One and Two can impress on them at any time.

There are certain pre-requisites which must be met before social order can be achieved in an institutional setting the importance of which will be shown below in the prison context. Order cannot exist without restraint - control of violence in a given setting, reciprocity or mutuality - as the conduct of individuals is not random but reciprocates or complements that of others, and predictability and consistency - as individuals must know what is expected of themselves and others and be assured that this will not suddenly change before they can attempt to fit in (Cohen, 1968). These are the pre-requisites which staff on the PDU must deliver if they are going to be able to maintain a stable order on the PDU through the legitimation of their actions.

Staff on the ground - the source of legitimacy and order in a high security setting

In this section I look to the prison literature on legitimacy and order (Cavadino & Dignan, 1992; Sparks, 1994; Sparks & Bottoms, 1995; Sparks, Bottoms and Hay, 1996; Liebling & Price, 1998, 1999) to discover whether legitimacy can be achieved within a high security setting between those who work and live on the ground. This is the point at which PDU staff through their choice of action may be able to confer legitimacy to their patients and thus maintain order on the PDU.

There are a number of important differences between prisons and secure hospitals: the main objective of the prison system is to ensure the safe custody of prisoners and whilst treatment or training is desirable it is not a pre-requisite

unlike in the Special Hospital System; generally speaking the prison population is young, male and active and not suffering from a recognisably treatable mental disorder unlike in the Special Hospitals where a mental disorder is a prerequisite, the age range is wide and physical disabilities are not uncommon; prisoners who cause disruption and break the prison rules will be subject to punishment whereas there is no disciplinary system as such in the Special Hospitals (Kinsley, 1998: 79). Although these differences are considerable and are likely to make the task of conferring legitimacy on the ground in a Special Hospital greater than that of achieving it within a prison the literature offers a useful conceptual framework in which to highlight any problems and solutions which can arise.

High security prisons and hospitals as total institutions (Goffman, 1961) and systems of domination are arguably in the greatest need of legitimation.

> The combination of an inherent legitimacy deficit with an unusually great disparity of power places a peculiar onus on prison (*Special Hospital*) authorities to attend to the legitimacy of their actions. (Sparks & Bottoms, 1995: 60) (italic words added)

The question of legitimacy touches all aspects of institutional life: internally in terms of the regime and social relations and externally there is the need to legitimate the conditions under which containment is imposed (Sparks, 1994).

As the research for this thesis was empirical and looked to explore everyday life on the wards of the PDU from the perspective of the staff and patients who work and live there it is hoped it will be possible to discover whether staff managed to establish internal legitimacy through their choice of actions and social relationships with patients as shown in reference to Beetham's (1991) concept of legitimacy. The regime and external conditions under which containment is imposed will necessarily be considered where they impact upon staff-patient social relations.

Cavadino and Dignan (1992) described a threefold crisis of legitimacy in the prison system:

> The penal system needs to legitimate itself with three groups of people: with the public (including politicians, commentators etc.), with penal staff (including prison staff and probation officers) and with penal subjects (prisoners, probationers and others who are subject to penal treatment). Failing to satisfy the sense of justice of these different audiences leads to the alarming visible 'symptoms' of the crisis: political problems, industrial relation problems, malaise among prison and probation staff, and disorder amongst prisoners. In saying that the crisis of legitimacy is central, we are saying that the penal crisis is in essence a *moral* crisis. (Cavadino & Dignan, 1992: 30)

Chapters One and Two clearly showed how those external to the PDU itself were struggling with the legitimacy of either the Special Hospital System as a whole, Ashworth Special Hospital, the Personality Disorder Unit at Ashworth Special Hospital, the concept of the dangerous, personality disordered individual held in a hospital setting or all four (Home Office, 1999a, 1999b). This lack of external legitimacy must inevitably effect those who live and work on the PDU. It would appear that at this time there is a lack of external legitimacy to support any order that might exist on the PDU. This will be discussed in relation to staff and patient choice of performance and actions in Part II.

However, while the government, the medical profession and the legal profession are concerned with the legitimacy of the Hospital or the PDU itself the staff and patients on the ground are necessarily more concerned with the legitimacy of their everyday affairs.

Although the perception of legitimacy of a system of containment is of equal importance to all three groups described by Cavadino and Dignan (1992) it is perhaps most relevant to the internal order of a system on which this thesis focuses that it is perceived to be legitimate by its subjects.

> Perhaps most importantly of all it is the legitimacy of the system with those who are its subjects. A penal system can only run with the acquiescence of offenders. No prison could run for long if not for the fact that most prisoners, most of the time, are prepared simply to co-operate with the staff and 'do their bird'. (Cavadino & Dignan, 1992: 22)

Although Woolf (1991) did not explicitly refer to the concept of legitimacy in his report into the Strangeways riot and a number of other riots throughout the prison system he did implicitly refer to a need for prison officers to establish legitimacy with those who had been imprisoned (Cavadino & Dignan, 1992; Sparks, 1994; Sparks & Bottoms, 1995; Sparks, Bottoms & Hay, 1996).

Woolf did not use the word 'legitimacy' in his report, but it is clearly the prison's lack of

> *legitimacy with inmates* which he saw as of central importance: 'It is not possible for the Inquiry to form any judgement on whether the specific grievances of these prisoners were not well-founded. What is clear is that the Prison Service has failed to *persuade* these prisoners that it is treating them fairly' (para. 9.25). (Cavadino & Dignan, 1992: 25)

It has long been recognised (Sykes, 1958; Cavadino & Dignan; 1992, CRC, 1984) that prisons cannot operate without the co-operation of their subjects and as such it is considered essential to the maintenance of order of the prison system that its legitimacy is established amongst its subjects. It is clear therefore that as the prison system is not in a constant state of disorder that legitimacy must be being established at one level and that legitimacy can be established in a high security setting where the subordinates to the system of power are being held against their will. This suggests that there is a chance that legitimacy could be established in the PDU setting and that order could prevail.

A prisoner's perception of the legitimacy of the prison system is most directly affected by staff-prisoner social relations on the ground (Sykes, 1958; Tyler, 1990; Cavadino & Dignan, 1992; Sparks & Bottoms, 1995; Sparks, Bottoms & Hay, 1996; Liebling & Price, 1998, 1999; Ahmad, 1996).

In his research in a maximum security prison Sykes (1958) found that the task of maintaining 'internal order' fell almost entirely to the prison officers on the ground. He argued that the absolute rules of the prison and the conditions of imprisonment - material deprivation and being forced to live in close proximity with others - were likely to provoke prisoners into acts of deviance and that the formal authority of the prison officers was largely seen as

illegitimate. He argued that whilst coercion could be and was used that it was not sufficient to sustain the smooth running of an institution where prisoners significantly outnumber staff. He therefore concluded that in this environment the prison officers could not have done their job without a certain degree of reciprocity from the prisoners. Implicit in his finding was that internal order could only be maintained if the prison officers were successful in establishing the legitimacy of the prison system in the eyes of the prisoners through their social relations based on a degree of reciprocity with the prisoners.

Sparks and Bottoms (1995) sought to discover if there were 'any conditions under which prison management could reliably call upon a recognition of legitimacy by prisoners' (Sparks & Bottoms, 1995: 54) using Beetham's criteria for legitimacy and Tyler's (1990) exploration of the shared expectations and criteria of justice.

Tyler's (1990) empirical research on policing showed that the two key criteria upon which subordinates accord legitimacy on those in authority are their perception of 'fairness' and 'respect'. This was apparent when individuals in their dealings with the police were more compliant and accepting of decisions when they perceived themselves to have been treated with respect and procedural fairness. These two concepts have been found to be important to the maintenance of order in prisons in terms of enhancing prison officers chances of their actions being perceived to be legitimate by prisoners (Sparks, Bottoms & Hay, 1996; Ahmad, 1996; Liebling & Price, 1999).

Sparks and Bottoms (1995) chose to look at 'routine encounters and interactions, on both procedural and interpersonal levels' (Sparks & Bottoms, 1995: 55) as their starting point for discovering the conditions upon which legitimacy might be established and therefore order achieved in the prison system. They identified four areas where legitimacy could be lost or gained within a prison setting: fairness of procedures, consistency of outcomes, quality of the behaviour of the officials and the basic regime of the system.

Sparks and Bottoms (1995) hypothesised that prisons may be able to meet some but not all of the above criteria thus always leaving the potential for

disorder. The criteria were applied to two dispersal prisons: one with a very restrictive regime, overt security and stringent control measures but where the staff were regarded as fair and the second with an apparently positive, relaxed regime and staff but where safety and procedural discretion were questionable. They found the first prison met three criteria for legitimacy: fair procedure, consistent procedure and good staff-prisoner relations. The second, whilst initially appearing to meet a high level of legitimacy, only offered a positive basic regime and staff relations. The only common criteria met by both prisons which is perhaps a reflection of its importance was the need for good staff-prisoner relations which enhanced the likelihood of prisoners perceiving staff to be taking the most appropriate course of action. They concluded

> it is important situationally controlling aspects of the prison environment be as unobtrusive as possible, and impede the normalization of its interior life to the least extent compatible with considerations of safe custody. But it is vital that the prison be made habitable in other ways. For considerations of fairness and respect are not just normatively desirable, they are central to the achievement and reproduction of social order itself. (Sparks & Bottoms, 1995: 59)

When questioned the prisoners made moral judgements assessing where they believed the prisons to be operating both positively and negatively. In their social relations with staff prisoners appeared to be implicitly aware that any far-fetched demands would not fall within a shared pattern of beliefs with staff and therefore would not be met. In turn the staff recognised that it was important to the prisoners that their citizenship and humanity were reflected in the way the staff chose to interact with them (Sparks & Bottoms, 1995: 59).

Liebling and Price (1999) similarly outlined the boundaries within which prison officers and prisoners negotiate their relationships and strive towards greater legitimacy.

> Relationships operated within fairly clear frameworks of expectation. Staff wanted compliance and acceptance of their authority. Prisoners wanted to experience themselves as agents, as, individuals, and to resist indifferent or overbearing coercion. The flow of power was negotiated in

> this space: only legitimate power generated the sort of consent prison officers required. (Liebling & Price, 1999: 20)

Sparks, Bottoms and Hay's (1996) work found that the social relationship between prison officers and prisoners was not static, predetermined or one-way but an ongoing negotiation between them in their everyday interactions:

> we take it as intrinsic that the members of an organisation (however unbalanced its power relations and however unwilling some of them are there) confront one another as actors in a dynamic play of conflict, compromise and mutual influence. (Sparks, Bottoms & Hay, 1996: 60)

It is clear therefore from the prison literature that the official sanctions and rules of a prison system in themselves are not sufficient to control against violence and ensure the maintenance of order. It has been shown that the compliance of prisoners is best achieved when they know what is expected of them and when those whom they must interact with on an everyday basis - the prison officers - treat them with fairness, respect and humanity and are aware that they cannot do their job without accepting the need for reciprocity with the prisoners. Sparks, Bottoms and Hay (1996) concluded that whilst a perfect normative fit between the prison authorities, the prison officers and the prisoners could never be achieved there is no reason why the different parties should not strive towards a greater legitimacy.

Prisons are in fact frequently rather keen to tailor their actions, demeanour, and

> demands in recognition of prisoners' customary expectations - and their capacity to resist. Equally, given the fact of their imprisonment, most prisoners have a quite precise sense of what they can and cannot legitimately expect. (Sparks, Bottoms & Hay, 1996: 303)

I would argue that whilst as outlined at the beginning of this section the prison system is significantly different from the Special Hospital System there is a fundamental similarity which allows comparison between the two which is the fact that on an everyday basis it is those who work and live on the ground who

are primarily concerned and involved in the maintenance of social order. The pre-requisites for social order and legitimacy are the same in any setting and it is likely their application will be similar in systems where there is a significant imbalance of power owing to the high security nature of the institution and the involuntary containment of its subordinates.

It is therefore possible to conclude that the maintenance of order on the wards of the PDU is likely to be primarily the task of ward staff but that it could not be achieved without a degree of reciprocity with patients. Equally, both staff and patients will be broadly aware of the perimeters of the arena in which they can legitimately negotiate with one another. The prison literature has shown that the social relationship between those who work and live on the ground is likely to be enhanced if those who work on the ground are able to appear to be consistent, predictable and fair in their choice of actions and to treat those who live there with respect and humanity.

Conclusion

In conclusion at this present time in the Special Hospital System it is the task of the staff who work on the ground to establish legitimacy through their choice of actions with the patients and ensure that order prevails on the wards. They must appear to do this within the demands of the Special Hospital System which requires that they support the security and treatment requirements of the hospital and provide for the care and control of patients. Although these concepts have often been described as extremes of the pendulum swing and as such diametrically opposed this is not the case as in practice the concepts are often interchangeable. Staff who work on the ground will always have a certain amount of discretionary power as to which approach to take when dealing with the patients. They must use their knowledge of the patients when attempting to chose the most appropriate course of action in any situation. This knowledge should have been enhanced through their social relations with the patients.

In order that the choice of action by staff appears legitimate to those patients whom they have power over staff must negotiate ongoing social

relationships with patients. In this way although patients may not agree with the reasons for their detention in the hospital or the rules of the hospital they may still choose to conform to those rules because the staff have been able to establish legitimacy through their actions at ground level. However, it must be remembered that there are likely to be other self-interest reasons why patients may choose to conform to the rules of the institution.

The ways in which staff perform the task of maintaining order on the wards will be discussed in Chapter Six. The ways in which patients respond and the reasons for their responses will be analysed in Chapter Seven. Finally, in Chapter Eight I will review whether order is achieved on the PDU and the reasons why staff choice of action in a specific situation may or may not lead to order. The following chapter will describe the research methodology and the situation on the PDU at the time of the research.

PART TWO

CHAPTER FOUR

Research Methodology
An Exploration of the PDU

The field work for this thesis took place on the five wards of the Personality Disorder Unit at Ashworth High Security Special Hospital. My doctoral research was funded by the High Security Psychiatric Service Commissioning Board (HSPSCB) as part of a two year project entitled 'Custody, Care, Control and Order in Ashworth High Security Special Psychiatric Hospital', for whom the grant-holders were Prof. Roy King and Dr. Catrin Smith. Access to the institution and the PDU was negotiated by the grant-holders who made a presentation to the hospital's ethics committee before the field work for the project and my thesis began.

The research team for the project consisted of myself, one other active field-researcher and a field-work co-ordinator. The same methods of data collection and the resulting data were used for both the project and my thesis. However, as the project and subsequent report were to be completed within a two year period it only incorporated data from three of the five PDU wards whilst the longer time limit on my doctoral project allowed for the use of data from all five of the PDU wards. Equally as the only full time member of the research team I collected data on all five wards whilst the other field-worker was limited to two of the wards to be included in the project.

I intend to show in this chapter the usefulness of employing social science research techniques to a high security mental health service setting. Within the field of criminology, social science techniques have been successfully adapted to the prison setting (King & Elliott, 1977; Liebling and Price, 1999) and sociology has seen a number of ethnographic studies in mental hospitals (Goffman, 1961). These studies have made a considerable contribution to the depth of knowledge of everday life within the walls of these institutions. It was therefore hoped that a similar approach would offer a new

and helpful perspective on the unique world of the PDU at Ashworth Special Hospital.

I utilised a Grounded Theory methodology (Glaser & Strauss, 1967) for this piece of research owing to my limited knowledge of the subject matter and the exploratory nature of the investigation. Although the project to which my studentship was attached had identified issues of 'social order and control' on the PDU as its main focus, this did not apply directly to my own investigations. My earlier studies in abnormal psychology, high security prisons and, indeed, my Master's dissertation which looked at the beginnings of the PDU had given me a broad overview on mental disorders, high security settings and some of the wider issues surrounding the PDU. However, this background offered no preparation or insight into 'what was going on' on the wards of the PDU and as such I was able to adopt the premise of the Grounded Theory researcher and begin a journey of discovery when I first entered the wards of the PDU (Glaser & Strauss, 1967: 97).

The application of Grounded Theory

The investigative approach used for this piece of research was qualitative and ethnographic because the general aim of the study was to be able to understand the environment and interactions which took place on the PDU from the perspective of the patients and staff who lived and worked on it. Such a micro understanding could never be attained through the impersonal quantitative research techniques of questionnaires, structured interviewing or statistical analysis.

Grounded Theory is an 'emergent research methodology' which allows for the discovery of theory from an ongoing comparative analysis of the data collected and as such was the obvious methodological choice for this piece of empirical research (Glaser & Strauss, 1967). It enables researchers to be reflexive to their research situation and data gathered, rather than to impose theories which may distort the data. The theory can therefore emerge directly

from the field work, data coding and analysis, and literature search which will be interrelated and continual processes throughout the field work and write up.

> Allowing substantive concepts and hypotheses to emerge first, on their own, enables the analyst to ascertain which, if any, existing formal theory may help him generate his substantive theories. He can then be more faithful to his data, rather than forcing it to fit a theory. (Glaser & Strauss, 1967: 34)

Grounded Theory methodology allows for a multi-method approach to be taken to the field of investigation so that different 'slices of data' (Glaser & Strauss, 1967: 57) gained in different ways can complement and support each other.

In field studies theoretical sampling usually requires reading documents, interviewing, and observing at the same time, since all slices of data are relevant (Glaser & Strauss, 1967: 75).

Denzin (1970, 1988) identified this as a triangulation approach to research methodology, arguing that such an approach allowed for the cross-checking of data. This in turn increases the researcher's and others confidence in the validity of the research findings (Robson, 1993).

For this piece of research I employed a number of research techniques in order to allow for the inclusion of the greatest number of staff and patient perspectives and behaviours to be represented in the study. The first half of the empirical research was exploratory and took an unstructured form whereby information was gathered informally through observation and conversations. This part of the research was supplemented by the gathering of ward and hospital documentation including copies of ward rules and philosophies where available. The research team also had access to the Hospital's Incident Reporting System database which detailed the numbers and types of incidents which occurred throughout the Hospital.

The second half of the investigation consisted of formal, one to one semi-structured interviews - through which emerging themes could be further probed in more directive and systematic questioning (Glaser & Strauss, 1967). As part of the ongoing research process I was also searching the literature to discover

whether there were existing theories which were applicable to the categories, hypotheses and theories which were emerging from the data collection.

Entering the field - a period of negotiation, observation and reflection

> It is presumptuous to assume that one begins to know the relevant categories and hypotheses until the 'first days in the field', at least are over. (Glaser & Strauss, 1967: 34)

My understanding of life on the PDU could only be developed once the fieldwork process had begun and so the starting point for the Grounded Theory approach was to enter the research situation and observe.

Once in the research setting, I and my co-researcher had to introduce ourselves to the ward staff and patients who were the subjects of the investigation, become familiarised with our surroundings and let the subjects of the study become accustomed to our presence. It was initially decided that myself as the main fieldworker would spend an average of one month on each of the five PDU wards becoming acquainted with the staff and patients, and their official philosophies, policies and practices.

The field work for this project took place at a time of great uncertainty and disruption on the PDU. When I entered the field there was a major public inquiry (Home Office, 1999a) in progress as well as both police and internal investigations on the PDU which were focusing on both staff and patients. These had understandably created an environment in which suspicion and paranoia were rife. It also became clear early on in the field work that both staff and patients felt that they had been 'ill-used' by previous researchers and there was an overall reluctance to answer any more questions.

This atmosphere meant that myself and the other field-worker had to tread very carefully when we first entered the PDU. Although ethical approval had been gained for the project this process had occurred away from the wards and as such counted for very little at ward level. Equally as the wards were in a state of flux and change with increased security requirements and new

philosophies and practices being drawn up, any notification of our arrival appeared to have been lost in the profusion of paperwork. This meant every time I entered a new ward or met with a new shift I had to introduce myself and the nature of our project anew. This was particularly difficult in a health setting where the emphasis in the past had been focused on specific quantitatively formulated hypotheses, questionnaires and interviews. As the Grounded Theory approach of sitting back and taking in the scenery was a foreign concept to ward staff and patients, I initially had to allay their suspicions that I was spying and that I did not have a clue what I was doing.

Much of the first phase of the field work was taken up with attempting to build a rapport with staff and patients on the wards of the PDU. I attended an induction course and became a key-holder so that I was 'free' to enter and leave the different wards and the hospital at any time. However, in an attempt to gain acceptance and 'fit' into ward life I found that entering and leaving the hospital at the same time as the ward staff changed shift was a helpful device for gaining the confidence of staff who became more relaxed outside the immediate environment of the wards. Key-holder status also had its own obstacles to overcome as many patients began with the idea that I was a new member of staff.

With key-holder status I became a supernumerary member of ward staff which meant that my intention to be a non-participant observer could at times become blurred. Owing to my need to gain the trust of those whom I wished to observe and later interview, I would more accurately describe myself as taking on the participant-as-observer role whereby I joined in with staff and patients' casual conversation and games on the wards (Robson, 1993). I also employed a demeanour described by Hammersley & Atkinson (1983) as an effective tool for the social researcher in the field by appearing as the socially acceptable 'incompetent' who is there to learn from others.

I was aware my presence on the wards would have an unavoidable impact upon life on the wards, but I hoped to keep this to a minimum and constantly questioned how it might be influencing matters. However, this was

an integral part of my use of the Grounded Theory research methodology. The field workers'

> firsthand immersion in a sphere of life and action - a social world - different from one's own yields important dividends. . . . his displays of understanding and sympathy for (the subjects) mode of life permits sufficient trust in him so that he is not cut off from seeing important events, hearing important conversations, and perhaps seeing important documents. *If that trust does not develop his analysis suffers.* (Glaser & Strauss, 1967: 226)

The most complex aspect of the fieldworker role was the need to constantly negotiate my relationship with those whom I wished to research. There was a need for extreme diplomacy when working simultaneously across wards, staff and patient groups. At the beginning of the research, possibly owing to my status as a young female, ward staff and patients often tried to 'rescue' me from various individuals and neither fully appreciated the fact that I was equally interested in both groups. However, my interest in all members of the PDU did help to avoid the possible pitfalls of 'going native' as I could never become fully immersed in either ward staff or patient life. Further, as an outsider with limited knowledge of clinical matters or policy issues, I was hopefully able to take a detached perspective and observe behaviours which were likely to be taken-for-granted by those who lived and worked in the field.

Although staff and patients were initially unsure of my presence on the wards and research approach, they clearly became less guarded with time and expressed their appreciation of our longitudinal methodological approach as they believed this showed a genuine interest in the 'reality' of ward life and their points of view.

From our viewpoint the rapport which evolved between ourselves and ward staff and patients at this time was likely to prove invaluable later when recruiting ward staff and patients for the next phase of the research - the one to one interviews. Equally some ward staff and patients who were very forthcoming in an informal situation were later unwilling to take part in formal interviews for various reasons. This meant any information gleaned in this

informal set-up was particularly important and hopefully went some way to preventing the quantitative research problem of having no information about non-respondents.

Although the research setting was limited to the perimeters of the separate wards it was still necessary to decide where and when to best position myself to capture the full complexities of ward life (Robson, 1993). I was aware that the validity of my data would be improved by being able to watch people over time and in different situations. As mentioned above, I found it useful to fit into the existing shift patterns of the ward staff and attended the wards for morning, afternoon and night shifts. The initial time I spent on each of the five wards was mainly shared across morning and afternoon shifts with each of the three staff teams employed by the wards. I also attempted to maintain contact with wards already visited throughout this period so that I did not lose the ground gained before the interview phase of the research.

The hospital's security requirements restricted the 'where' best to gather information on the wards as my movements were restricted beyond staff only areas and the main communal area of the wards. This was not a major difficulty because the main communal area appeared to be the focal point of the wards and therefore the best place to observe ward staff-patient interaction particularly before and after meals. Another fruitful position for information gathering was the night-station (the observation point for monitoring the two corridors along which patients' rooms were situated) as this was another area where ward staff-patient exchanges commonly took place.

All information gathered during the informal phase of data collection was written up in diary form at the end of each day. I did not make notes whilst on the wards as it was felt it would be too intrusive - further inhibiting the natural behaviour of the subjects. I also felt it would restrict my ability to interact with the subjects and develop a rapport.

The use of a Grounded Theory methodology meant that throughout this initial period of the field work I was already beginning to think about, code and analyse my data. At this early stage this was a matter of recording all the

details of the day on leaving the Hospital each evening and making brief notes in the margins. The narrative account consisted of a detailed portrait of life on the wards including: space - layout of the wards, subjects, activities, objects - physical aspects, acts - individual actions, events - occasions, time - sequence of events, goals - what the actors were attempting to accomplish, feelings - emotions in context (Spradley, 1980). The information built up quickly owing to the intensive nature of this first phase of data collection and coded categories outlining the nature of life on the wards soon began to add up.

> This constant comparison of the incidents very soon starts to generate theoretical properties of the category. The analyst starts thinking in terms of the full range of types or continua of the category, its dimensions, the conditions under which it is pronounced or minimised, its major consequences, its relations to other categories, and its other properties. (Glaser & Strauss, 1967: 106)

It was at this stage in the research that certain issues began to arise consistently - although the patients were considered dangerous, and their current status highly problematic, and ward staff had received little training, direction or support to deal with any problems related to this patient group there appeared to be little overt trouble.

I was then interested to find out whether, how and why the above was perceived to be the case. I developed the basic hypothesis that 'despite the actual and perceived (see Chapters One and Two) dangerousness of PDU patients, the wards on the PDU ran smoothly and order was maintained' (see Chapter Three).

This hypothesis appeared to 'fit' the data which had already been coded and corresponded with my reading on the problematic nature and dangerousness of PDU patients (discussed in Chapters One and Two) and the importance of social relations to conferring legitimacy in high security settings (discussed in Chapter Three). This then became the focus for the directed part of the information gathering process, namely, the semi-structured interviews.

Formal interviewing - questioning the emerging themes

For the more formal part of the fieldwork the research team decided to conduct semi-structured face-to-face interviews with as many ward staff and patients from the PDU as possible. These were to supplement the information already gathered and to cross-check the emergent themes of the research.

It was proposed that the interviews would take a semi-structured format because there was more than one interviewer and we wanted the flexibility to discover what the respondents knew, did and felt (Robson, 1993). The purpose of the semi-structured interview was to allow us the opportunity to question interviewees' subjective meanings and to check whether they understood the questions and we understood their responses. We developed a number of topic headings which were the same for both staff and patients, beginning with straight-forward warm-up questions followed by the main body of the interview and concluding with an open-ended question to allow the participants to add any further information they felt we had missed but believed to be important. The topic headings which were the same for both staff and patient interviews were as follows:

- Career history
- Nature of the ward
- Perceptions of patients/ staff
- Security & maintaining order
- 'Incidents'
- General

(A copy of the full interview schedule is reproduced in Appendix I).

We carried out a pilot study to test the interview schedule on a ward which both researchers had attended regularly and where the second researcher had spent the majority of her time. The pilot study was tested on ward staff only because of the issues of consent which had to be overcome before patients could be interviewed (A copy of the pilot interview schedule is reproduced in Appendix I). Questions were then altered better to fit the language of the

hospital and prompts were added where it was felt the questions were not eliciting the amount and kind of information required for the study. The main problem which arose was that ward staff appeared to be giving the official hospital line in response to certain questions rather than their personal standpoint on life on the wards. We were aware of the difference owing to the considerable length of time we had already spent on the wards.

Once the interview schedule was finalised we sent a letter out to each of the five wards explaining the next phase of the research and began to recruit ward staff for interview (A copy of the letter is reproduced in Appendix I). This was a long process owing to the number of ward staff, shifts and wards involved. The original suspicion which I had had to overcome when I first entered the wards returned at the idea of recorded interviews so that a compromise had to be reached in that interviews would be recorded in long hand rather than on tape. Confidentiality was a key concern for all interviewees and was reiterated at all stages of the recruitment and interview phase. It was very clear at this stage that if we had not taken the time at the beginning of the field work to develop a rapport with the subjects, very few would have been willing to be interviewed and their responses would have been official and therefore not as meaningful to the research. As social scientists we were not looking for respondents to supply us with a concrete truth but their perception of life on the wards of the PDU.

In order that we could interview patients it was necessary to gain the consent of the patients' Responsible Medical Officers (RMOs) as well as the patients themselves. A consent form was produced to confirm confidentiality which all three parties signed (A copy of the consent form is reproduced in Appendix I). On the two high dependency wards there were certain patients whom the Ward Managers felt it was not advisable to interview owing to their current mental state, and so these patients were not approached.

In total the research team interviewed fifty-four staff and thirty patients. The number of staff interviewed on each ward was: eleven on Ruskin Ward, eight on Newman Ward, fifteen on Owen Ward, nine on Lawrence Ward and

eleven on Macaulay Ward. There were a higher number of staff interviewed on Owen Ward because this is where the pilot study was carried out. The number of patients interviewed on each ward was: six on Ruskin Ward, five on Newman Ward, ten on Owen Ward, three on Lawrence Ward and six on Macaulay Ward. On average the ward staff interviews took one hour and took place at the times when the majority of patients were at work. The patient interviews could take anything between half an hour and four hours and were carried out at lunchtime or early evening.

The development of a substantive theory

The practical application of grounded sociological theory, whether substantive or formal, requires developing a theory with (at least) four highly interrelated properties. The first requisite property is that the theory *fit* the substantive area in which it will be used. Second it must be readily *understandable* by laymen concerned in this area. Third it must be sufficiently *general* to be applicable to a multitude of diverse daily situations within the substantive area, not to just a specific situation. Fourth, it must allow the user partial *control* over the structure and process of daily situations as they change through time. (Glaser & Strauss, 1967: 237) (In italics in original text)

The aim of the analysis was therefore to develop a substantive theory based on the data collected throughout the fieldwork to be able to explain the way in which the PDU worked from the perspective of those who lived and worked on it. The remainder of Part II of this thesis is an explanation of the substantive theory on whether, how and why order existed on the wards of the PDU, despite the problematic nature and, actual and perceived dangerousness of the patients, which developed throughout the fieldwork and analysis.

As the theory emerged directly from the data gathered rather than being forced into existing theories it is inextricably linked and can therefore lay claim to 'fitting' the substantive field of research. As the researchers directly asked those in the field about their perspective of life on the ward and the theory was built on their opinions and supported by respondents' quotes although the

typologies used in the analysis are abstract they should still be 'understandable' to those working in the field. This was particularly the case as the labels used for a number of the typologies were actually used on the wards of the PDU.

The typologies produced in Chapters Six and Seven of ward staff and patient performance are by their very nature general. These, in conjunction with Chapter Eight on maintaining order, should offer predictions and explanations of behaviours which are 'generalizable' to PDU wards, staff, patients and situations. The general concepts which have emerged should help to explain how situations may alter at specific times or for specific reasons and how to deal with these and possibly 'control' certain situations in practice. It is also hoped that the substantive theory that has emerged from this piece of work may be applicable to other environments where personality disordered individuals are held in places of high security either as patients or prisoners, and that this could be tested in the future.

In Part I of this thesis I have therefore theorised that it is ward staff who find a way of 'dealing with' dangerous patients on the ground by conferring legitimacy through their social relations with patients which allows the possibility that order can be maintained at ward level. I established:

(i) that PDU patients were actually (as the vast majority had been convicted of criminal offences) and were perceived to be (in terms of not fulfilling the expectations of social interaction, medical diagnosis and legal definition) dangerous (see Chapters One and Two).

(ii) that 'something must be done' (Eastman & Peay 1998) in terms of keeping the public safe from these dangerous individuals and managing them in secure environments which ensured the safety of those who lived and worked within those environments (see Chapter One).

(iii) that there was a fundamental paradox created for those who had to 'deal with' dangerous patients because as patients they were 'sick' (Parsons, 1953) and in need of care and treatment but as dangerous individuals they were required to be held securely and controlled (see Chapter Two).

(iv) that it was ward staff who had to deal with patients on a day to day basis and that could best be achieved not by thinking in terms of care and/ or control and, security and/ or treatment but in terms of the most appropriate choice of action based on staff knowledge of the circumstances and the individuals involved and, ultimately the maintenance of order (see Chapter Three).

(v) that the most appropriate choice of action can never be wholly directed by the general rules of an institution and that ward staff will have a degree of discretionary power (see Chapter Three).

(v) that order could only be maintained on the wards of the PDU if ward staff were able to confer legitimacy to their patients through an ongoing negotiation of social relations with them (see Chapter Three).

Part II of this thesis therefore realises the theoretical concept constructed in Part I through an analysis of the empirical data and describes how ward staff chose to deal with PDU patients. In order to do this Part II must accomplish the following:

(i) identify and examine if order appears to be maintained on the wards of the PDU in terms of observational evidence, ward staff and patients' perspectives and the Hospital's Incident Reporting System (IRS) (see Chapter Five).

(ii) identify and examine whether order on the wards appears to be a direct result of official Hospital and ward rules and philosophies (see Chapter Five).

(iii) identify and examine the level and amount of training ward staff appear to receive in how to deal with PDU patients (see Chapter Six).

(iv) identify and examine the reasons why and the ways in which ward staff appear to perceive PDU patients and choose to perform their duty of dealing with PDU patients (see Chapter Six).

(v) identify and examine the reasons why and the ways in which PDU patients appear to respond to ward staff and live out their lives on the PDU (see Chapter Seven).

(vi) identify and examine how order appears to be maintained on the PDU:

- examine the validity of the Hospital IRS;
- identify and examine specific situations which can create problems;
- identify and examine specific situations which have led to the recording of incidents;
- identify and examine how staff appear to be able to avert specific incidents and maintain order;
- identify and examine how staff appear to be able to confer legitimacy to their patients and maintain a stable order through their choice of action and social relations with them.

CHAPTER FIVE

Setting the Scene
The Nature of the PDU Wards

In this chapter I describe the nature of the five wards on which the current research was based, to provide the reader with an understanding of the environment in which ward staff and patients had to work and live on a daily basis. I will show the differences and similarities that existed between the five wards of the PDU in rhetoric and reality. In particular I will identify and examine the actual philosophies and rules which were in place at the time of my fieldwork. I also intend to identify whether the wards appeared to be running smoothly at this time and whether ward staff and patients perceived their wards to be running smoothly. I will further examine how these views were reflected in the Hospital's Incident Reporting System (IRS) database. In Chapters Six and Seven I will go on to analyse which styles of ward staff and PDU patient performance most closely 'fitted' each of the five PDU wards.

The empirical research for this thesis took place at a period of upheaval on the PDU consequent upon the internal review, police investigation and public inquiry which were in operation at the time. As a result it has not always been possible to confirm the official rhetoric for the current status of the wards. Their philosophies, policies and rules were under review and the management was understandably reluctant to volunteer ward literature that was potentially out-of-date. The main descriptive information about the wards, therefore, was gathered first hand through conversations and interviews with ward staff and patients. In this chapter I have therefore relied to a considerable extent on the words of both ward staff and patients to illustrate the ways in which the five PDU wards were operating at the time of my fieldwork. The five wards in this chapter will be identified by their initials R (Ruskin), N (Newman), O (Owen), L (Lawrence) and M (Macaulay), the staff by a capital S, followed by N if they were qualified and NA if they were not, and the

patients by a capital P. The number relates to the order of interview for individual staff and patients on separate wards.

Evolution of the PDU

The Personality Disorder Unit (PDU) came into existence in 1993 following the regionalization of Ashworth Special Hospital into separate clinical units. The Personality Disorder Unit and the women's services were to be managed under the Hospital's new Special Needs Directorate. The remaining patients were to be managed in two clinical units under a separate Mental Illness Directorate. Regionalization was a gradual process whereby many patients had to be moved around the Hospital and wards had to be re-designated to specific patient groups (Business Plan, 1994-95). The PDU was created as a clinical unit for patients who had a primary clinical diagnosis of personality disorder. At this time the PDU was described as "a work in progress", without an admissions ward or treatment model and where the requirements of ward staff and patients were under review (Business Plan, 1994-95) (see Chapter One).

The Fallon Report (1999a) included a description of the original plans for the PDU. It was to follow a dependency model which meant that patients were to be placed on wards as a result of their Patient Care Teams' (PCTs) perception of their treatment progress and their level of disruptive or difficult behaviour. Treatment progress was to be measured in terms of whether patients were fulfilling the requirements of their individual Patient Care Plans as set out by their PCTs. Disruptive and difficult behaviour was to be assessed in terms of the numbers and categories of incidents patients were involved in whilst they remained in the Hospital (see below and Chapter Eight). On entering the hospital, a patient was expected to be assessed on his personality disordered behaviour, including: levels of maturity, social functioning, risk of self harming, aggressive or abusive behaviour and other relevant indicators of the risk a patient might present in a hospital environment and to the social order of the wards.

The new PDU wards were to run at three levels of dependency - high, medium and low and deliver the corresponding level of structure. In addition to this the PDU was to have the use of the north site's Intensive Care Unit (ICU) - Tennyson ward.

The PDU was to be made up of six wards but by the time the fieldwork for this project began in November 1997 one of these wards - Shelley Ward was no longer part of the PDU. However, I include it in this description of the PDU as many of the staff and patients who worked and lived on Shelley Ward remained on the PDU at the time my fieldwork took place. Shelley was to be high dependency and admissions, Ruskin was to be medium to high dependency, Newman was to provide accommodation for younger psychopaths, Owen was to be medium dependency, and Lawrence and Macaulay were to be low dependency wards.

In 1996 the Hospital proposed the development of what came to be called 'the Wordsworth Project' as a means of relieving Shelley Ward of its most troublesome patients so that it could become a pure assessment and admissions centre. However, neither the Special Hospital Service Authority (SHSA) nor its replacement, the Commissioning Board supported the proposal, and the funds that had been made available were insufficient. In order that the Hospital would not lose its allocated capital allowance, it quickly came up with a revised Wordsworth Project, conceived as an attempt to help those patients at the 'softer' end of the system. It was still hoped that Shelley would be developed as an admissions ward (Willmott, 1997).

The new Wordsworth Project was designed to be a bridge between the Special Hospital and the Regional Secure Units (RSU), with the aim of resocialising PDU patients ready for their release to these places of lesser security. The intention was to aid the de-institutionalisation of patients by providing them with every-day living skills to equip them for a life outside the hospital. The Project was developed as a sixteen-bedded residential facility where patients could continue with their individual and group therapies but gain a greater sense of independence.

However, as there was no Responsible Medical Officer (RMO) attached to the Wordsworth Project at the time the fieldwork took place it was unable to provide twenty-four hour accommodation for PDU patients. This meant that patients were only able to attend the Project between one and three times a week. Further, the redesigned Wordsworth Project meant that there was still nowhere available for the removal of the recalcitrant population on Shelley Ward, and, when Shelley eventually closed down for 'refurbishment', the patients were in fact redistributed between the mental illness wards, the PDU and, where possible, the prison system. The PDU did not regain the use of Shelley Ward when it reopened as it was redesignated to the Mental Illness Directorate. Therefore, instead of the positive changes envisaged in the original proposal for the Wordsworth Project and Assessment Centre put forward by a former Chief Executive of Ashworth, the PDU, in fact, lost a ward.

The loss of Shelley Ward and the fact that the Wordsworth Project was not fully operational at the time of the fieldwork meant that the PDU was left without a new assessment centre or admission wards, and only a partly functioning quality of life and discharge centre. Equally, the promise of a progressive treatment programme running throughout the wards (Business Plan, 1994-95) was yet to be fulfilled and the Unit had been given no satisfactory means of dealing with its most recalcitrant patients.

Current State of the PDU

In the Fallon Report (1999a) Shelley, Owen and Ruskin had been re-classed as high security wards, Newman as a mixed high security but low dependency ward, Macaulay as a long term medium secure ward and Lawrence as a high and long-term medium secure ward (Home Office, 1999a: 1.24.1).

It was clear by the time the fieldwork began that security requirements had officially taken precedence over dependency models, and levels of security throughout the PDU had been increased.

At the time the fieldwork took place the PDU was attempting to move forward and shed its traditional dependency model. However, it was clear from constant references by both ward staff and PDU patients to the dependency levels of the different wards that the old dependency model would not be easy to shake off. Equally, the number of control problems recorded on the Hospital's Incident Reporting System (IRS) still tended to decrease in accordance with the wards' old dependency categories (Table I). (The IRS will be discussed in detail in Chapter Seven.)

The dependency model replacement was described as a structured living model. The structured living model was supposed to allow patients to develop more independence and a greater degree of autonomy within the constraints of the wards. This meant that patients progress should be marked by their movement from a highly structured, routinized ward to a parole or more community orientated ward. A number of ward staff and patients described the ward philosophies as nothing more than a paper exercise to appease the Mental Health Act (MHA 1983) Commissioners and the National Health Service (NHS) managers.

The PDU Patient

In this section I will outline the general characteristics of the patient population of the PDU in terms of their numbers, medical and legal status. These issues will be discussed in more detail below in relation to specific wards and in Chapter Seven in which I will analyse the influential factors effecting individual patient performance on the PDU.

As the number of patients on individual wards and throughout the PDU continually fluctuated I will give an average number of patients where necessary.

The Fallon Report (1999a) provides a useful snapshot of the 'official' PDU in terms of patient characteristics as it was on the 12th of February 1997, the same year in which the research for this project began. The statistical data

on patients included in the Fallon Report (1999a) is still highly relevant to this project as the majority of them continued to abide on the PDU.

The patient population of the PDU on the 12th of February 1997 numbered 112 (Home Office, 1999a: 1.24.1). Following the closure of Shelley Ward a small number of patients were transferred back to prison under s.47 of the MHA 1983 or to other clinical units within Ashworth Hospital so that by the time my research began in November 1997 the PDU patient population numbered 100. This meant that the PDU patient population made up about a quarter of the patient population of Ashworth Special Hospital.

As discussed in Chapters One and Two there are a number of different routes under the MHA 1983 by which patients can come to be on the PDU.

> Of the 112 patients, 41 (37%) had come from the prison system and 31 (28%) direct from the courts. Twenty-one (19%) had come from another Special Hospital. Only ten had come from Medium Secure Units. . . . There were also some civilly-committed patients (Home Office, 1999a: 1.24.2).

The majority of patients who had come from another Special Hospital had been transferred from Broadmoor Special Hospital some years previously when Park Lane Special Hospital had first opened (see Introduction).

Those patients who had come from Medium Secure Units were likely to have been making a return visit to the Hospital following their failure to adjust to the regimes or limited facilities made available to them in the Medium Secure Units compared with a Special Hospital.

The Fallon Report (1999a), like the PDU staff and patients themselves, also reflected on the difficult, slow and frustrating process through which PDU patients must go to attempt to attain a place in a Medium Secure Unit (see Chapter Eight). For this reason in particular the PDU population was described in comparison to the rest of the Hospital population by the Fallon Report as relatively static (Home Office, 1999a: 1.24.8). It was also found that the average length of stay of a PDU patient was a year longer than that of the Hospital population as a whole (nine years rather than eight).

This difficulty in transfer and longer than average length of stay is largely owing to the fact that the vast majority of PDU patients have come through the courts or prisons, are considered dangerous and are therefore held under restriction orders for an unspecified and unlimited length of time (Home Office, 1999a: 1.24.8, MHA, 1983, see Chapter Two). A particular problem on the PDU was that a substantial proportion of patients (around 80%) had committed sexual offences and were diagnosed with primarily psycho-sexual disorders (Home Office, 1999a: 4.2.3):

> 77 of the PDU's patient population were on section 37/41 orders, 19 on section 47/49 orders and one was on a section 46 order. 97 (87%) were therefore subject to restriction orders, or were treated as if restricted (Home Office, 1999a: 1.24.4).

As discussed in Chapter Two, over recent years the trend has been that patients enter Ashworth Hospital having first received a prison sentence. However, in the past s.47 has been used as a tool to stop the release of prisoners whom the authorities believe still to be dangerous by transferring them to a Special Hospital near the end of their prison tariff. Further, the nature of a restriction order means that even if a patient earns the chance of a fresh start outside, he must still obtain permission from the Secretary of State before he can be released and he may be recalled to the Hospital at any time.

The maximum occupancy on each of the PDU wards was 25. However, the average number of patients per ward at the time the fieldwork took place was 20 but this figure was variable owing to the regular movement of small numbers of patients between all five of the PDU wards. The movement of patients to different wards will be discussed below within the sections on individual wards.

The PDU Staff

In this section I will give a brief description of PDU staff in terms of numbers, training and gender. These issues will be discussed in more detail below and

in Chapter Six particularly in relation to the influence of training and qualifications on the adopted style of job performance of ward staff.

Again, as we saw with patients, the numbers of qualified or unqualified staff varied throughout my time on the PDU, and the numbers reported here were subject to change.

The Hospital operated a shift system for nursing staff whereby staff worked three days on and two days off. There were three shifts on each ward: the early shift started at 7.00am and finished at 2.30pm; the late shift began at 2.00pm and ended at 9.30pm; and the night shift lasted from 9.00pm until 7.30am. The shifts overlapped by half an hour in order that the new shift could be briefed on any events that had taken place since they were last on the ward.

PDU nursing staff were the only group of Hospital staff who had twenty-four hour contact with the patients. There were 149 ward-based nursing staff on the PDU in November 1997. This meant that there were an average of thirty nursing staff per ward. The level of qualification and training of the nursing staff is discussed in Chapter Six. Each ward had a Ward Manager who was expected to be on the ward every week day although their hours were often extended at times of unrest. All the Ward Managers at the time of the research were qualified Registered Mental Nurses, had been promoted in-house and were male.

The nursing staff were split into teams which consisted of five to six staff depending on the security level of the ward. This meant that there was an average of six nursing staff per team on Ruskin, Newman and Owen Wards and five on Lawrence and Macaulay. Each team was led by a teamleader who held the qualification of Registered Mental Nurse. At the time of the research, all the teamleaders, apart from one, were male and the vast majority had been promoted in-house. Overall, there was an emphasis on promotion within the Hospital and nursing assistants were generally encouraged to gain formal nursing qualifications. This was the opportunity for staff to take their forensic care diploma and nursing degrees at the Ashworth Centre.

The gender and level of training of staff on the wards varied according to the time of day, and the general and specific security requirements of the wards. In practice the ratio of qualified to unqualified and female to male staff below teamleader level varied from ward to ward and shift to shift. The preferred situation was for there to be only two untrained and two female staff on each team and therefore shift. This was for a number of reasons - only trained staff could dispense medication, the PDU was a male unit and about 80% of patients had been involved in sex-related crimes; and some of the patients were considered to be dangerous. The numbers of female staff on each team tended to increase the lower down the security level of the ward.

The majority of nursing staff were either members of the Prisoner Officers' Association (POA) or Royal College of Nursing (RCN) Unions. This was in part because the Special Hospital System did not have sufficient numbers to support a separate union. Although the unions, in particular the POA, had been considered quite active in the past, at the time of the research they were considered to be less active.

General PDU Regime

Each of the five wards on the PDU was of the same design with entry through double locked doors. Each ward comprised two patient bedroom corridors which radiated from a viewing area (the night-station) next to which was a patient bathroom. Leading down from the night-station along a corridor were a storeroom, seclusion room, Ward Manager's Office, interview room, the main entrance and the main ward office. This corridor also led into the main ward communal area attached to which was a second interview room, library, patients' kitchen and dining room, staff room and kitchen and a television room. Each ward also had its own enclosed garden. The variation in patient movement that was permitted between these areas will be discussed below.

The patients had keys to their rooms and to their lockers, which were located in the main communal area. Each patient room had its own toilet and

shower. Patients were allowed televisions and music systems in their rooms and until recently had been allowed computers.

There was a general regime in place on all wards in the Hospital whereby patients were expected to follow a daily timetable of off-ward structured activities between the hours of 9.30am and 12.30am and 2.00pm and 4.00pm. These activities included work, education and sport. Patients had breakfast before leaving the wards, returned the wards for lunch and then for dinner before sometimes pursuing off-ward recreational evening activities.

Attendance at all off-ward activities was dependent on a patient's Patient Care Team. Patients could be excluded from attending all off-ward activities if they were under Special (Close) Observation because of their perceived short term danger to themselves or others. Equally patients could be excluded from attending specific off-ward activities if they were considered to have a volatile relationship with another patient at that activity.

At the time the fieldwork took place the rehabilitation facilities in the Hospital were suffering from cutbacks which meant that workshops were being shut down and educational opportunities had been greatly reduced. The workshops that were open at the time of the fieldwork included upholstery, art, craft, electronics, cookery and joinery workshops. Attendance at workshops was very much encouraged on all five wards but was not compulsory. The levels of attendance at workshops and other off-ward activities tended to increase in accordance with an increase in the security level of the ward. This was in part owing to the fact that patient movement on Ruskin and Newman Wards was restricted to the main communal area during working hours. This meant that there was very little for them patients to do if they remained on the ward at these times.

An alternative to workshops was ward work, which involved general domestic and cleaning duties on the ward. Gardening, working on the patient magazine, in the canteen, library or Visitors' Centre provided further options for patients who had parole status within the Hospital. Parole status is

discussed in more detail in relation to Macaulay Ward the only remaining parole ward on the PDU at the time of the research.

Patients were also expected, in accordance with their individual Patient Care Plans (PCP) issued by their Patient Care Teams (PCTs) to attend therapy. At the time of the fieldwork a small number of patients from Owen and Macaulay Wards were involved in anger management and sex offender group therapy which took place off-ward but which nevertheless involved the participation of ward nursing staff. The Fallon Report (1999a) criticised the Hospital for focusing on social behaviour and administrative and risk issues in therapy to the detriment of seeking an underlying psychological understanding of PDU patients (Home Office, 1999: 4.2.27). There was a limited opportunity for individual therapy either with a patient's primary nurse or a hospital psychologist. There was very little contact between patients and the Hospital's psychiatrists who only attended the wards for Patient Care Team Meetings which occurred weekly (see Chapter Eight).

The attendance at therapeutic groups was voluntary although patients were expected to sign and honour contracts when they entered into a course of therapy, and failure to attend was considered detrimental to their progress. There was considerable resentment from both staff and patients that the increase in security following the introduction in December 1997 of the new Hospital-wide security manual meant that there was not sufficient staffing to allow some of the therapeutic group work to continue (see below and Chapter Eight). Furthermore, many patients believed there to be an insufficient number of psychologists assigned to the PDU.

Beyond the off-ward activities and therapeutic opportunities discussed above patients were very much left to their own devices and for those who chose not to leave the wards there was very little structure or direction to their day (see Chapters Seven and Eight). Following the setting up of the Fallon Inquiry the staff on all five wards were attempting to redress this problem by limiting patients access to their rooms and other communal areas to encourage more patient-patient and staff-patient interaction (see below). Many staff and

patients felt that such interaction had been lost following the introduction of twenty-four hour opening of the wards in the wake of the Blom-Cooper Report (1992).

Ruskin Ward

Ruskin and Shelley were the old high dependency wards and Ruskin continued to deal with the most intractable patients on the PDU. The official description of Ruskin adopted by ward staff was that it was a fifteen bedded, medium to high dependency ward or structured living ward. Its function was to control patients with chaotic and challenging behaviours within a security orientated environment. Unofficially it was referred to as the 'punishment' or 'naughty boys' ward by ward staff and patients which was, in part, inescapable owing to the fact that patients were sent there for 'cooling off' periods after displaying unsettled behaviour on other wards. Patients on Ruskin included admission patients and those who had failed to adjust to the reduced levels of structure on the old lower dependency wards. This was the same mix of patients which led to the original Wordsworth proposal and the requirement that these two difficult, contaminating and unpredictable groups be split up.

The Ward was transferred from the old Moss Side Special Hospital site to the Park Lane Special Hospital site at the time they merged to become the single institution that is Ashworth Special Hospital. Moss Side Special Hospital was historically a sanatorium which catered for mentally impaired patients and operated a disciplinary regime where staff wore uniforms and patients addressed them as 'sir' or 'boss'. Following the implementation of the much more liberal regime recommended in the Blom-Cooper Report (1992), Ruskin was described by ward staff as having suffered from a loss of control. Following the Lawrence incident and the start of the Fallon Inquiry in 1997 the Ward Manager and ward staff were instructed to 'regain control of the ward' (RS10:TL) (see Chapter One).

The philosophical and operational approaches on the Ward at the time of the fieldwork were developed 'as a reaction to how disturbed the Ward was'

(RS8:N). The changes were attributed to a strong ward manager bringing in ideas from the shop-floor, ward staff experience and knowledge of their environment and client group, patients need to feel safe, a return to the hospital's basic principles of health and security for all, and the need to have control of the day to day running of the ward. Ward staff stated that the philosophy of the ward was to look after the patients and meet their needs within a strict regime. More specifically it was to develop individual care plans in conjunction with the Patient Care Team (PCT), consisting of representatives from all the hospital's disciplines, focusing on patients' index offences which were described as having been neglected in the past.

The highly structured regime of the Ward included patients being woken up at specific times, patients being sent to work, therapy or other activities which had been prearranged, the sleeping quarter corridors being locked off during working hours and the night-stations being manned at all other times, patients being limited in the number of security items they were able to retain at all times and having very limited requested access to the kitchen and any culinary utensils. The majority of these rules were not exclusive to Ruskin and were in the new Hospital Security Manual which was introduced in anticipation of the Fallon Inquiry's recommendations. However, the interpretation and application of the rules in the new security manual were described by both ward staff and patients to be more stringent on Ruskin Ward than on the other PDU wards.

The Ward PCT had set a number of ward policies which were a result of their reactive approach to ward problems. This was very much a work in progress at the time of the research. An example of this approach is that patients were no longer allowed to take hot drinks down to their sleeping quarters because a member of staff claimed (although the patient in question denied the incident) a patient deliberately poured a drink over him at the night-station. It was intended that once all the policies had been approved by the PCT that they would be available to the patients in handbook form.

The Ward was viewed in a very positive light by the ward staff who described morale as high because safety was considered paramount unlike elsewhere in the hospital and outside (RS2:NA). Ward staff particularly praised the Ward Manager for providing firm support and leadership. Ward staff believed that the safety of themselves and their patients could only be maintained within the ward's highly restrictive regime. Ward staff views of the ward are summarised in the quote below:

> This is one of the most structured and supported wards now. I feel safer on here than on any other ward. It was out of control, frightening as patients took advantage of a lot of new staff. Lawrence was the catalyst to sort things out. The Ward Manager came in with ideas from the shop-floor. He reinvented the ward. (RS9:N)

Despite the degree of regimentation on the Ward, ward staff stressed the fact that the current state of the Ward had been built up through the development of positive staff-patient relationships and trust. (These issues are discussed in detail in Chapter Seven.) Ward staff also expressed the belief that

> privately most patients like structure and feel safer although they complain it's too restrictive (RS11:TL).

Although patients who were interviewed accepted the need for a ward with a highly structured regime within the PDU they equally expressed the view that they personally did not warrant the level of regimentation in operation on Ruskin.

> I can see that there are some patients who need a highly regimented regime - even more so than here. (RP:5)

However, this patient described his personal experience of the ward as entirely negative.

> Punishment in one word. I was moved here for punishment. It's a containment facility for the most unmanageable on the PDU so we're at

> the rock bottom of the Special Need's Directorate. It's contain, restrain and take away. (RP:5)

Patients expressed the view that many of the rules and regulations on Ruskin were 'petty',

> ludicrous policies - day-rooms locked off, can't use the cooker after 8.00pm, corridors locked off in the day, they take tobacco tins off you (RP:4),

and that patients were 'bullied' into submitting to the ward structure by overtly controlling staff. There were concerns expressed that fights and arguments occurred when patients were restricted from going to their rooms.

However, owing to the state of certain patients on Ruskin, I was restricted in the patients whom I was able to interview and it could be surmised that it was the patients who were deemed inappropriate for interview who required the high level of structure which existed on the ward.

The perception patients from other wards had of Ruskin was that it was extreme in its application of the rules. This was shown by one patient's comments:

> If a person was forced to go on one ward I would rather go to Tennyson (ICU) rather than go to Ruskin. Ruskin is over-structured. For example you can't take a cup of tea to your room. It is difficult to breathe on there I would imagine. (OP:5)

Considering the main aim of the Ward was to deal with the most difficult and disruptive patients on the PDU the Ward appeared to be and was described as running smoothly by both ward staff and patients.

> The ward is highly regarded. The facts speak for themselves - a highly assaultative patient has only struck one staff since he's been on here. (RS9:N)

The two most disruptive, high dependency wards on the mental illness and women's site had much higher numbers of recorded incidents than those of Ruskin. In 1997 Blake Ward in the Mental Illness Directorate had 128 Category A-C incidents and 644 Category D incidents, and Beeches Ward on the women's site had 117 Category A-C incidents and 351 Category D incidents. This was compared with the 16 Category A-C and 94 Category D incidents which were recorded on Ruskin Ward. (Possible reasons for the differences in the figures will be explored in detail in Chapter Seven) (see Table I).

Newman Ward

Newman Ward was originally an eighteen bedded ward for high to medium dependency patients. At the time of the fieldwork the intention was to change it to a challenging behaviour, therapy led regime within a structured living philosophy. The Ward Manager described this as an attempt to concentrate on patients' cognition in order to change their fundamental thinking patterns with the hope that this would permanently alter their behaviour. In conjunction with this ward staff would encourage patients to take ownership of their behaviour, learn to cope with their problems and improve their living skills.

Unofficially, Newman Ward was described as the 'family' or 'naughty kiddies' ward with a high concentration of young, immature and dual diagnosis patients with both personality disorder and mental illness. The 'family' label resulted from the fact that many of the original ward staff and patients who were transferred from the Moss Side site still remained on the ward and had known each other for an extended period of time.

The Ward Manager was attempting to introduce the new philosophical and operational approaches described above at the time of the research, but the difficult patient mix, including highly disruptive ex-Shelley patients and dual diagnosis patients, meant that this task was being delayed in favour of crisis intervention management. The Ward Manager described the aim of the ward at the time of the fieldwork was simply to maintain its equilibrium, the

achievement being that the patients were not 'cutting up' or 'winding each other up' continuously. It was felt that the application of a challenging behaviour model to these particular patients would be unsuccessful as they did not have the capabilities to cope with their conduct being challenged. However, a patient booklet was presented to each patient on entering Newman Ward which described the Care Programme Approach, which the ward operated in conjunction with the patient's Care Team to cater to individual patient's needs.

The security and regime restrictions in operation on Newman Ward were the same as those described above for Ruskin Ward. Their patient booklet incorporated a list of 22 Newman House Rules which included such restrictions as:

> 4.At mealtimes when metal cutlery is being used, once patients have entered the dining room they must stay in the dining room until the cutlery has been counted and locked away. Patients' lockers are to remain locked during this period.
>
> 13.Snooker equipment may only be taken out between 12:15hrs and 13:30hrs and 16:30hrs to 21:00hrs.

Although a number of ward staff entered Newman Ward with reservations the view was expressed that their fears were not fulfilled.

> I was moved here and hated it because I thought it was a Moss Side ward. Now it's the best ward I've been on. (NS8:N)

Again the Ward Manager was held in esteem by ward staff and the general view was that, considering the number of volatile patients who were on the Ward, it ran well. This view remained despite a recent murder and attempted murder on the Ward.

> There's been a couple of dodgey things on the ward - a murder and an attempted murder but generally the ward runs well. (NS5:TL)

The Ward Manager expressed the view that although a strict adherence to the Hospital's security rules had an important part to play on the ward, the existing balance was a product of staff-patient relations and their use of humour (Discussed in Chapter Seven). I observed some very disturbed behaviour on the Ward but ward staff took it in their stride and kept the atmosphere surprisingly light. Again ward staff expressed the view that

> patients don't want to come to Newman but then they don't want to leave. (NS6:N)

Patients generally felt that there was a need for a challenging behaviour ward where patients are made to address their behaviour and beliefs as a result of constant questioning from staff and some felt that they had benefited from it in the past. They believed the level of structure at the present time was necessary, as some of the more volatile and disturbed 'patients would run amuck if given a chance' (NP:2). However, they no longer felt a personal need for the level of restriction and lack of individual freedom the Ward imposed. They resented the fact, to a certain extent, that they were associated with the 'kiddies ward' and the images that this label invoked to those from other wards. Patients objected to the rooms being locked off at certain times as not all felt that they were able to 'lock off mentally' in communal areas. It was observed that some ward staff deliberately 'torment and antagonise' patients. However, the wider view was that there was a definite bond between ward staff and patients which put patients at their ease.

The number of recorded incidents on Newman Ward as a high-medium dependency ward for immature and dual diagnosis patients compared favourably with similar wards outside the Unit. In 1997 they recorded 38 Category A-C incidents and 78 Category D incidents (Table I).

Owen Ward

Owen Ward was originally a medium dependency ward and was a direct descendent of the old Forster Ward for young psychopaths (aged 15 and 16)

which already existed on the Park Lane site. Park Lane Special Hospital was retrospectively perceived to have been a 'centre of excellence' particularly regarding its development of personality disordered patient care. At the time of the fieldwork Owen Ward was officially described as a twenty bedded,

> trust status ward, the flagship of the PDU, running along progressive quasi-therapeutic community lines. (OP: 5)

Owen Ward was also described as operating a cognitive-behavioural model which encouraged patients to use their positive skills.

Owen Ward was known throughout the wider Hospital and considered by the management to be the 'show ward' or 'centre of excellence' of the PDU. Although it was classed in the Fallon Report (1999a) as a high security ward, staff on the ward equated it to the old medium to low dependency wards. Its status with the Hospital management did allow it to a certain extent to hand pick the majority of its patients who were required to sign a contract on entering the Ward.

The Ward changed its name and location from Forster to Owen following a murder on Forster Ward. The intention at this time was to develop a ward specifically for personality disordered patients. However, Owen Ward was the site of the first PDU Ward failure which occurred in the Summer of 1994 and resulted in the Owen Incident (Home Office, 1999a).

> When Forster moved to Owen, it led up to the hostage situation. There were gang wars, corridor wars where one corridor was at war with the other, drugs, booze, porn and prostitution. (OP: 5)

The internal Inquiry following the hostage situation led to a security clamp-down on Owen. The Ward philosophy and practices at the time of the fieldwork were attributed as having

> developed out of the last breakdown of control, with the staff and Ward Manager working together to make the changes. (OS6:TL)

The official line for the Ward at the time of the fieldwork was that it

> has a high level of control, input and success. The ward is experimental trying out new interventions. The idea is to get closer to the patients' thinking which is linked to their behaviour and challenge it. Treatments are devised in a multi-disciplinary setting and they're proactive which means we get results unlike other wards which are custodially reactive. (OS2:TL)

The idea behind the quasi-therapeutic community approach on Owen was to give patients a greater sense of responsibility for their actions. This included patients being expected to get up, go to work and attend meals on their own initiative, although still with a certain amount of staff encouragement. Patients were expected to sign a contract to confirm they understood and would comply with the Ward's rules, policies and philosophy. The house rules on Owen Ward reflected their quasi-therapeutic and cognitive-behavioural philosophies and encouraged staff and patients to take joint responsibility on the ward. An example of these are given below:

> 1] Patients and staff should co-operate in the running of the ward. To keep at a reasonable standard, it is important that all patients maintain a high level of personal hygiene. Patients and staff to clean up after themselves.
>
> 2] Patients should display respect and consideration towards their colleagues and staff. Similarly, the staff should respect the rights and feelings of the patients in their charge.

The view of Owen Ward at the time of the fieldwork was very mixed from both staff and patients on the ward and those from other wards. Some ward staff had a positive view towards the therapeutic community approach.

> The ward offers good career opportunities. Initially the ward was difficult to adjust to after the firm boundaries instilled on the challenging behaviour wards. At first you don't feel safe. The ward is unique in its therapeutic community approach, offering patients as near normality as is possible so that we can assess how they can cope with some freedom of choice. (OS1:TL)

Other ward staff feared the therapeutic community approach, particularly as two earlier attempts to institute it on the PDU resulted in a total break down of control on Owen and Lawrence Wards (Home Office 1999a).

The Fallon Inquiry was having a considerable impact on the philosophy and operational practices of the ward and the morale of both ward staff and patients.

> The Inquiry means the ward remains in a state of flux. None of the wards are more or less safe. I came after the Owen Incident and I would say it is comparatively good now. The philosophy is aimed at the treatment of PD's but has been impinged by the Inquiry. (OS6:TL)

> We'd planned more on the ward but its slowed down as a result of the Inquiry and manning the night-station. I loved the ward pre-Inquiry but 5 hours on the night-station is not using your brain. The ward has been dragged down to the others level. The ward was more forward thinking, gave patients leeway. It was a steady environment but there are too many restrictions now and it's unfair as it only affects PD's. (OS7:NA)

Staff were aware of the negative light in which others viewed them.

> We're seen as a joke, a laughing stock by other wards, by staff not patients, because of the Ward Manager - he's the biggest psychopath going. (OS10:NA)

> Other wards hate us, talk of 'Owenism' or the 'Owen Academy' and that the staff flout the rules because we have a good Ward Manager who fights for the Ward and others just stick to the rules. They see us as a threat because our ideas work and we turn violent patients around. (OS8:N)

The patients mixed views were quite reflective of those of the ward staff referring to the impact of the Inquiry, and the positive and superficial sides of the therapeutic community philosophy.

> Compared with other wards within the PDU it is as good as it gets. . . . It's progressive thinking rather than action. Because of the Fallon Inquiry it cannot achieve anything. (OP: 5)

> I know lads want to come here because it's more relaxed and less restrictive than say Newman. I'd much rather be here. I feel sorry for the lads on there and they wonder why they kick off. (OP:6)

> I go to work because I don't want to stay on the ward but workshops keep closing. I moved here as a reward for good behaviour. It's heaven compared with Ruskin and offers better opportunities to get out. It's supposed to be therapeutic but it isn't. Officially it's a low to medium dependency TC ward but the reality is it's only low to medium dependency. It's only a holding ward offering quality of life for those in transition. The purpose of the ward is to sell patients to RSUs. Whilst you are here you have to avoid trouble and pretend to work. (OP:3)

In general terms the ward was perceived to be running smoothly by both ward staff and patients. Although Owen Ward had recently been recategorised as a high security ward its number of recorded incidents was at the same level as the two newly categorised medium secure wards of Lawrence and Macaulay (Table I).

Lawrence Ward

Lawrence Ward was one of the original parole wards on the Park Lane site (Parole status will be discussed in the section on Macaulay Ward as the only remaining Parole Ward on the PDU). It contained long stay patients and offered a higher quality of life than elsewhere in the hospital. Later it was given the status of a pre-discharge ward for patients who were close to release. Previously it had been considered to be the Ward to which patients were 'sent to die'. At the time of the research Lawrence Ward had been redesignated as a 'locked' ward for medium dependency and security patients, and for the reassessment of patients. Being the Ward at the centre of the Fallon Inquiry meant that its philosophical and operational approaches were under review and the ward had been placed in a state of limbo. Equally, it was still regarded by many patients as the 'paedo' ward.

Lawrence Ward, having lost its status as a parole ward and redesignated as a 'locked' ward, operated similar restrictive practices to those which existed

on Ruskin and Newman Wards and were outlined in the new Hospital Security Manual (1997). However, some Lawrence patients had retained their parole status and could still leave the Ward on request.

The pre-Inquiry Lawrence Ward was regarded as the 'flagship' ward of the PDU and ran along a therapeutic community model. It was considered to be running well at first but later

> the patients called themselves the elite and they were given a free licence. (OP: 5)

Clearly the way in which Lawrence Ward was being run at the time of the fieldwork was a direct reaction to the breakdown of control and subsequent Fallon Inquiry. The ward philosophy was on hold at the time of the fieldwork until the publication of the Fallon Report (1999a). However, staff did adopt a general positive philosophy of nursing.

> The Ward is very low to medium dependency. Patients are very long term and compliant with treatment. It's safe to live and work here as a result of the hospital's policies. Morale is quite good considering. There is no ward philosophy until the Inquiry's over. Just House Rules. I suppose it's to provide nursing care for PD's. (LS1:TL)

As on other wards, ward staff were working to turn the ward around. It was argued that this was despite a lack of support from senior management.

> The Ward is better now and the structures and boundaries are in place. Everyone knows the philosophy and the patients are happier as they know where they stand. It developed when the new Ward Manager and staff were brought in. We all had a meeting and decided how to run the ward and we stick to it as a team. Now each member of staff knows their role without going to the teamleader. (LS4:NA)

There were two possibilities being mooted for the future direction of Lawrence Ward. It was hoped that the new, more structured approach could be successful in taking the Ward forward towards a challenging behaviour regime or that Lawrence could become the main feeder ward for the Wordsworth

Project and concentrate on the resocialization of patients. However, at the time of the investigation there had been no clear decision made as to the future of the Ward. Following the onset of the Inquiry all ward patients were reassessed but after the completion of this exercise the Ward and patients were left in limbo awaiting the outcome of the Inquiry. It was felt that it was not possible to focus on the patients' needs arising from the reassessments until the Inquiry had put forward recommendations, which left many ward staff and patients feeling they had been left to stagnate for two years.

Despite the ongoing investigations, state of limbo and stigma which surrounded Lawrence Ward, both ward staff and patients were quite positive about the current state of the Ward.

> It's better than Ruskin, less structured. The best ward regarding staff and patients as there's no politics or the expectation to take sides. I feel that the wards quite progressive in that there's support there if you need it. They explain why they implement the rules. On other wards you only discover them when you break one. (LP:2)

Equally, despite the air of uncertainty and lack of treatment input, there were very few recorded incidents on Lawrence Ward (Table I).

Macaulay Ward

Macaulay Ward was also one of the three original parole wards on the Park Lane site and remains the only parole ward in the PDU (see explanation of parole status below). Although originally regarded as a low dependency ward, it was given a medium security categorisation in the Fallon Report (1999a). It was often referred to as the 'old men's' ward, although it had quite a mix of patients.

> There is an awkward mix of patients: either going somewhere with active treatment or not with quality of life but they still demand attention, also the very old and some who are predominantly MI. If it's a predischarge ward than patients would expect to move on but it's dangerous to have a ward of no hopers. (MS3:N)

The awkward mix of patients meant that there was some confusion as to what the current philosophical aims and operational practices should be on the Ward. As a parole ward, patients were given a certain amount of freedom of movement within the northsite enclosure of the Hospital between specific hours of day light. The parole status allowed some patients to go to work without needing a security escort, and to visit patients on other wards. However, since the new Security Manual had been introduced, parole patients' freedom of movement had been curtailed. They were no longer able to attend visits unescorted and their movement between work placements and other wards was a lot more closely monitored.

Parole status was expected to be earned by patients when they had displayed a level of trust and responsibility which was prescribed by their PCT. It was believed that, up until recently, patients simply expected to achieve parole status after spending a certain length of time in the hospital, or by manipulating their way into the position. The hope at the time of the fieldwork was that the Hospital had regained control over the awarding of parole status as an incentive and privilege to those patients who had earned it. The entitlement was meant to go to either patients who were on their way to lower security establishments, or to those who within a secure environment presented very few control problems.

The latest threat to patients on the PDU was that parole status would be revoked completely. This had heightened fears by ward staff and patients that there would be an increase in control problems as patients would have nothing to aspire to, particularly if they were expecting long term detainment, and felt they had nothing to lose. Although some Owen Ward patients had parole status and it was hoped they would take up the baton from Lawrence, they seemed to be making little headway with this proposal. It was already felt that the gaining of parole had lost much of its old status.

Again the Ward was seen as being without a clear philosophy by some ward staff.

> There should be a ward philosophy but there's not because the Ward has been upset with the Ward Manager and Acting Ward Manager. There has been so many changes that no-one's drawn up a ward philosophy. Changes in staff, ward guidelines, hospital rules which take up everyone's time and energy. (MS9:N)

The Acting Ward Manager claimed that the current plan was to deliver a structured therapeutic environment on the Ward. This would entail promoting a philosophy of co-operation to encourage patients to act at an adult level of functioning. The Ward would employ a 'normalisation model', expecting patients to attend work or other off ward activities and attend meals on their own initiative. Alternatively, patients were expected to do something constructive with their time and feed themselves if they did not choose to attend formal activities or meals. Patients were also charged with containing any problems they had until it was possible to raise them with ward staff.

The Ward was viewed in a very mixed light by those staff who worked on it. A member of staff who believed that the ward was running efficiently described it as safe with everyone pursuing the same goals.

> The ward is safe with a stable clientele and clear purpose but the hospital is a shambles. The ward offers a structured therapeutic environment for sex offenders. We rely on interpersonal relations more so than on other wards. It has developed because the new staff are committed to the same goals. (MS7:TL)

However, another staff member argued that the ward was divided and that it had little future to offer to the patients who lived on it.

> The problem now is that the ward has no direction, there is a lot of petty animosity between staff groups. Patients only end up here if they feel they've got nowhere else to go and as it's no different from other wards it's difficult to sell. (MS3:N)

The fear was voiced that those outside the ward regarded it as a neglected backwater populated by deadwood who were best forgotten (MS3:N).

> As a parole ward it's seen as far too relaxed and the regime is considered unsafe. It is associated with Lawrence as it was the other parole ward. I don't think the management cares what happens on this ward. Some patients have been forgotten. They were put in here years ago. Most are ready to move on and if they don't they'll all be forgotten. (MS9:N)

Overall, the views of the patients were perhaps the most negative on the PDU, as Macaulay was not seen to be fulfilling its promise as a parole ward or pre-discharge ward and the regime was perceived to be becoming more restrictive.

> Now there is little difference between this and other wards. The Ward is settled but there are problems now that the staff are being stopped doing what they want to do. I hear that this ward isn't run right, it shouldn't be parole and certain patients shouldn't be on here. The only good thing left is the doors are open. (MP:1)

> The Ward is OK but I'm more interested in getting out. With the rooms open at least there's some independence. The Ward is very restrictive and strict, you have to go to work like in prison. Discharge doesn't come into it although it's a parole ward, there aren't many groups (therapy groups). We're here for life. (MP:2)

Again, despite the apparent level of discord and disillusionment on the ward, in most cases this only manifested itself in ward staff and patient grumbling and moaning. Generally, the atmosphere on the ward was relaxed and friendly, and the recorded incident level was low (Table I).

Table I

Total Numbers of Category A-C and D Incidents per Ward in Ashworth Special Hospital in 1997

(**Bold** PDU wards and *italics* wards with high incident numbers throughout Ashworth)

Directorate	Ward	Total Numbers of Cat. A-C Incidents	Total Numbers of Cat. D Incidents
Mental Illness	Arnold	37	76
	Carlyle	33	128
	Dickens	9	44
	Eliot	2	7
	Forster	38	42
	Tennyson	67	47
	Blake	*128*	*644*
	Finches	12	10
	Gibbon	21	56
	Hazlitt	32	38
	Johnson	25	53
	Keats	6	19
Unit Total		410	1164
Special Needs			
PDU	**Newman**	**38**	**78**
	Owen	**6**	**19**
	Lawrence	**2**	**21**
	Macaulay	**5**	**15**
	Ruskin	**16**	**94**
Unit Total		**67**	**227**
Other Special Needs	Acacias	43	160
	Beeches	*117*	*351*
	Cedars	*76*	*278*
	Amber	9	37
	Elms	52	68
	Hawthorns	18	129
	Jade	4	41
Unit Total		319	1064

Table II

Summary of Nature of the Wards on the PDU

PDU Wards	Official Description			Unofficial Description		
	Original Dependency Model / Level	Official Security Level	Current Approach	PDU Label	Staff Perception	Patients' Perception
Ruskin	Medium to high dependency	High security	Highly structured & restrictive	Punishment or Naughty Boys Ward	Well run ward & supportive Ward Manager	Too restrictive personally but others needed structure
Newman	Accommodati-on for younger psychopaths	Mixed high security but low dependency	Structured Living & Challenging Behaviour	Family or Kiddies Ward	Well run ward, supportive Manager. Friendly	Too restrictive but good staff-patient relations.
Owen	Medium dependency	High security	Quasi-therapeutic Community & Cognitive-Behavioural	Flagship or Show Ward	Mixed. Forward-looking & treatment orientated. Isolated & potential for trouble	Mixed. Good relations & treatment prospects. Unfair, no community & lack of treatment.
Lawrence	Low dependency	High and long term medium secure	Reassessment Ward	Paedo. & Limbo Ward	In control but unsure about future & lack of outside support.	Good staff-patient relations but fearful of lack of progress.
Macaulay	Low dependency	Long term medium secure	Parole & Quality of Life	Old Man's Ward	Mixed. Positive therapy & quality of life. Backwater offering no hope.	Disillusioned. Only positive aspect doors being open. No progression in sight.

Conclusion

It is clear from my description and examination of the five wards on the PDU at the time of the fieldwork that they appeared to be running relatively smoothly to myself as an external observer and that they were perceived to be running smoothly by those who lived and worked on the PDU. Equally, the official Hospital IRS showed there to be relatively few incidents occurring on the PDU compared to wards throughout the rest of the Hospital with similar dependency levels (An examination of the relevance of this finding will take place in Chapter Eight).

However, it is clear from the description of the PDU wards that although, individually, they appeared to be running smoothly, they were fighting their own separate battles. As one patient described:

> Each ward becomes an oasis in a desert and each one is trying to survive. (OP: 6)

Each ward was attempting to find its niche and develop a positive philosophy and clear therapeutic practices in accordance with it. However, this was occurring at a grass roots level on the initiative of individual Ward Managers and ward staff and there appeared to be little communication or unity across the Unit. This meant there remained

> no yardstick for moving onto the wards or for parole or for discharge. (OP:5)

Many believed that, whilst there were significant differences in the way the wards worked in the past, these had been diminished and obscured with the introduction of the recent hospital wide security requirements (1997).

In conclusion, although the individual wards were attempting to deliver a high standard of patient care and an array of therapeutic interventions within a structured and secure environment in which both ward staff and patients could feel safe, the long term aims of the PDU to progress patients towards transfer or release did not appear to be being fulfilled.

In conjunction with this thesis the lack of unity and clarity regarding the philosophies and rules in place on the wards of the PDU and diminished hope for patient progress at the time of the fieldwork will be taken into consideration as obstacles which ward staff and patients had to contend with when striving towards order. The ward staff and patient typologies described in Chapters Six and Seven reflect some of the difficulties discussed above. I intend to show how different ward staff and patient typologies were more prevalent on certain wards because of the nature of the wards described above (see Tables IV and VI).

CHAPTER SIX

Working on the PDU
Ward Staff Performance

> One thing we do know about the treatment of (PD) patients . . . in Special Hospitals is that the cornerstone of the therapeutic endeavour is the quality of your nursing staff and the support they give to the therapeutic endeavours, and if that is not in place you can do very little. In Ashworth it is in place. (Grounds in Home Office, 1999: 4.2.25)

In earlier chapters I have examined the changing ways in which the PDU patient has been constructed in law and medicine, and reviewed the history of Ashworth Hospital and its PDU, in terms of the cyclical swing of the pendulum between treatment and security considerations. In the light of this, and the different management styles which prevail in the five wards considered in the previous chapter, it would be hardly surprising that ward staff experienced some difficulty in knowing how to comport themselves in dealing with PDU patients in terms of their daily management.

In this and the following two chapters I intend to show that it is not the management philosophies of the five wards *per se* but the way in which ward staff interpret and perform their job as either nurse or nursing assistant which has the greater impact on PDU patient behaviour and the running of the PDU. In this chapter I will set out the context within which and identify and examine the ways in which ward staff characterise and perform their job.

Limited instruction in dealing with PDU patients

Firstly, I will identify and examine the level and degree of training ward staff appeared to have received in how to deal with PDU patients.

Recent nursing literature on those who are coming to be labelled as 'forensic' psychiatric nurses shows that there is very little empirical evidence or information available, and therefore very limited training and education, in this field (Morrison & Burnard, 1992, Robinson & Kettles, 2000).

> Forensic nursing is a specialist branch of psychiatric nursing. Because the field is so new and because it is expanding rapidly, little research has been done in the field. . . . One thing is certain: a great deal of research needs to be done to lift the cloud of confusion that currently hovers over the field of forensic psychiatric nursing. Not least is the need to clarify the role of the forensic psychiatric nurse and, in particular, the specialist skills needed to fulfil the role effectively. (Morrison & Burnard, 1992: 1)

The job specification of ward staff is both to police and care for the PDU patient twenty-four hours a day (Home Office, 1999a: 4.1.6/ 4.7.6). They are selected for this function on the basis of the PDU core person specification (see below) and formally socialised into this position through training and managerial supervision. I will show that these formal socialisation processes deal primarily with specific clinical and security procedures but fail to offer adequate guidance on the general management of the PDU patients in their daily lives.

The 'Core Person Specification - All PDU Staff' (Ashworth Special Hospital, Core Persons Specification Leaflet: unpub.) is that: physically, they display socially appropriate appearance and interactions; mentally they are able to articulate their views and feelings, are self-aware, able to reflect on their own experiences and can be assertive but not aggressive. The only statutory qualification for the post is that applicants must have a clear criminal record for all major offences. Applicants are also expected to have an interest in the care of personality disordered patients, be oriented towards people, have a mature outlook, be of a positive not a cynical disposition and show empathy and warmth. A number of these qualities would be difficult to detect before an individual actually started work on the wards and all are open to interpretation. Very few ward staff said that they had volunteered to work on the PDU because they had not felt qualified or experienced enough to deal with PDU patients.

All PDU ward staff may also be reviewed on their core competencies (professional nursing skills). These should include: self-awareness; a therapeutic perception of their role; the ability to communicate, to negotiate

relationship boundaries, to operate reality based risk taking and to motivate; a sense of humour; a willingness to seek support (adapted for PDU from Spencer 1983: Soft Skill Competencies in 1994 by Moran, Owen & Richards). It will be shown below that although this list may appear promising, limits on training and supervision have meant that the active development of these skills is unsupported. Again these nursing core competencies are inevitably highly subjective as, for example, not everybody shares the same sense of humour.

The skills required of the PDU ward staff vary somewhat according to their rank in the nursing hierarchy but largely focus on clinical practices (Applied Psychiatric - Mental Health Nursing Standards in Clinical Practice - Kreb & Larson 1988). At the top of the ward hierarchy are ward managers who must have the professional qualification of registered mental nurse (RMN) and must also be trained managerially. Next come team leaders who are also required to be RMN qualified and preferably have received management training. The third rank, Staff Nurses, are similarly required to have the RMN qualification but not training in management. Enrolled nurses (EN), who have received two years academic training, come next in the hierarchy. As qualified nursing staff all the above are able to administer drugs and deliver specific therapeutic interventions. Finally, there are Nursing Assistants who have basic national vocational qualifications (NVQ). Since ward managers and team leaders have managerial or supervisory functions, it is the final three categories of nursing staff - Staff Nurses, Enrolled Nurses and Nursing Assistants - who have the most direct contact with the patients.

All those who have trained as psychiatric nurses will have been instructed in many areas of patient care including producing patient care plans, the administration of medicine, developing professional nurse-patient relationships, managing violence, and supervising other staff (Ritter 1989). However, none of the essential qualifications or the corresponding nursing instruction required for staff to work on the PDU (the majority of the patients are also offenders) is Special Hospital or personality disorder specific.

All Special Hospital staff are required to complete a two week induction course before they start work on the hospital wards. This course focuses on the dangerousness of the Special Hospital patient and details the specific security & safety requirements of the hospital. The trainee staff are presented with a leaflet on security 'dos and don'ts' and the prevention of patient violence. The security mission statement is: 'Security should be minimally obtrusive and must respect the rights & dignity of the patient.' (Ashworth Special Hospital, Induction Leaflet: unpub.) Finally, the ward staff are trained in self-defence. The induction is an essential requirement for all Special Hospital employees although one interviewee stated that he had only completed the full course after working on the wards for eighteen months.

Ward staff who are appointed to the PDU are expected to have attended a core competency course on personality disorder. The course was described by ward staff as focusing on the symptomology of personality disorder rather than the skills needed to manage PDU patients. Memories as to the length and availability of the course were conflicting as different staff remembered it to have lasted one day, one week or two weeks or not to have been running at all. In response to a direct question as to the value and availability of PDU specific training only twelve of the fifty-three ward staff interviewed reported it to have been beneficial preparation for working with PD patients and twenty-three ward staff claimed they had no knowledge of a PD specific training course at the Hospital.

The last process of formal socialisation for ward staff is effected through the supervision provided by the Hospital's administrative and clinical management personnel. However, as Fallon (1999) reported, the administrative management of the Hospital appears to have been in a permanent state of flux (Home Office, 1999a: 1.28.2). Both ward staff and patients stated that management presence on the PDU was very rare, that managerial instruction was often confused, and clarification hard to find. The fact that the main Hospital administrative block was outside the confines of the

security perimeter seemed to emphasize the distance between life on the wards and management.

The presence of senior clinical staff on the wards of the PDU was also regarded by most ward staff and patients to be so infrequent that wards might be best characterized by the absence of clinical staff. Non-ward staff, including psychiatrists, psychologists, social workers, rehabilitation and security staff, generally only attended the wards for the weekly Patient Care Team Meetings, where patients' progress were reviewed. In addition psychologists sometimes visited the wards for one to one therapy sessions; or on-call (usually junior) psychiatrists would have to attend wards if patients had been placed in seclusion. There was therefore rather little evidence of external support, control or direction from senior management on the PDU.

To a certain extent, to this observer at least, the wards appeared to run themselves. In this vacuum the nursing staff on the PDU had a certain amount of freedom as to how they interpreted and performed their job.

I do not, of course, call into question the way in which ward staff carried out the clinical and technical tasks assigned to them. This did not form part of the research remit - although as far as I could tell staff applied themselves efficiently and effectively to these matters in accordance with their professional training. However so much of what goes on in the ward is not 'clinical' or 'technical' at all - or at least not in ways that are covered by professional training. Rather, much of the day of ward staff is spent in the overt or covert supervision and management of patients. It is these processes which form the subject matter of this thesis.

I should also say straight away that in what follows I do not intend to call into question the sincerity, or the motives, of ward staff in any way. I start from the assumption that all ward staff honourably attempted to do their job as they saw it and to the best of their ability. My task is simply to try to understand, in the absence of clear and specific guidelines, how, why and to what effect ward staff interpreted and performed their job in the daily management of patients.

There may be many factors, of course, which influenced ward staff in their job of managing PDU patients. As a result of my analysis of the interview and observational data gathered in the fieldwork for this thesis, I have focused on the personal biographies of the ward staff and the cultural influences of the Hospital as the main determinants of staff job interpretation and performance. By personal biography I mean the common sense understanding, general knowledge and life experience a member of staff brings with them to the ward from the outside world. When referring to the cultural influences of the Hospital I include the way in which ward staff learn from significant others who are already employed on the wards. I intend to show below that it is these two informal processes of socialization - personal biography of the ward staff and cultural influences of the Hospital - which are the key to understanding how and why staff interpreted and performed their job.

Staff Style of Performance

I use the term 'style of performance', in the context of my research, as an analytical tool to describe the general characteristics which ward staff and patients displayed towards each other in their work and life on the wards of the PDU. As the research focused on what actually happened on the PDU, the observable behaviour, adopted styles of performance seemed the most appropriate descriptive term to apply to the separate typologies of ward staff and patients.

Particular styles of performance were negotiated in the course of on-going daily interaction between ward staff and patients on the PDU. Some styles of performances adopted by staff may be subject to change and forced renegotiation during one-off encounters with significant others on the wards. (The conflict produced by the different styles of staff performance will be analysed in detail, following a review of patient styles of performance, in Chapter Eight.)

Following an analysis of the current research data I have identified six styles of negotiated ward staff job performance on the PDU which I have labelled - *custodian*, *clinician*, *carer*, *fatalist*, *adult* and *screw* (For ease of recognition, and to avoid confusion in the meaning of terms, styles of performances will be referred to in *italics*). They seem to be a joint product of the formal and informal processes of socialisation undergone by ward staff and the social exchange and bargaining between ward staff and patients on the PDU (Goffman, 1961). It must be recognised that these six styles of job performance are typifications; developed essentially for analytical purposes. In the real world ward staff styles of job performances may not always be found in their pure form. In any case they are dynamic and may change in the course of a career, perhaps even in the course of a day or an interaction. It is for these reasons I have only been able to offer a tentative order of frequency for the six pure forms of ward staff performance in this study.

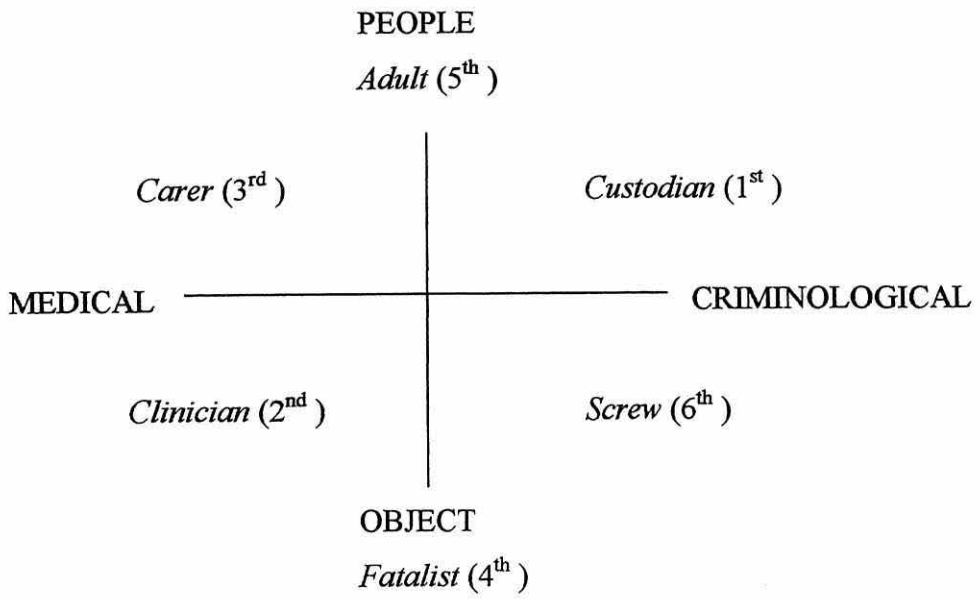
In Diagram I, I set out the dimensions along which the six typifications of ward staff performance can be presented. The horizontal axis concerns the extent to which ward staff perceive the patient to constitute a medical or criminological problem. It represents the central dilemma of the Special Hospital, in particular the PDU, and feeds directly into the formal processes of ward staff socialisation which are both medical and security orientated to deal with the PDU patient who is both sick and dangerous. The vertical axis concerns the extent to which patients are seen as multi-dimensional people, with individual characteristics, or objects - devoid of distinction beyond their legal or medical classifications. It cuts across the horizontal axis to represent how the ward staff respond to 'people work' (Goffman, 1961) - the daily management of the PDU patient, and possibly reflects the personal biographies of ward staff and the everyday attitudes and dispositions they bring with them into the hospital.

The positioning of the styles of ward staff performances will be discussed in detail below where I will take each style of performance in order of the frequency with which I encountered it. I will describe the characteristics of

each style of ward staff performance, the response of others towards it, and the background of ward staff who adopt it.

Diagram I

(Brackets indicate the rank order of frequency with which role identity found at time of research)



As the primary data were qualitative I shall use direct quotations from staff and patients in the text to illustrate the analysis. In what follows the five wards are identified by the initials A, B, C, D or E; the staff by a capital S, followed by N if they were qualified and NA if they were not, and the patients by a capital P. The number relates to the order of interview for individual staff and patients on separate wards.

Custodian style of ward staff performance

What I shall call the *custodian* style of performance seemed to be the modal performance adopted by ward staff on the PDU. In its pure form it can be located at the criminological end of the medical-criminological dimension and the people end of the people-object continuum (see Diagram I). Ward staff who I characterise in this way appeared to identify themselves as focusing on the security aspects of the job, and the criminal nature of the patients. They

nevertheless tried to interact with patients as individuals and had quite well developed people-work skills.

Ward staff who adopted the *custodian* style of performance chose to focus on non-clinical aspects of their job, concentrating on general patient care and security tasks:

> To 'ensure a good quality of life for patients within a normalised, caring & supportive setting.' And ensure 'Avoidance of risk to the general public is paramount.' (Business Plan, 1996-97: 1.7)

These staff operated a 'firm but fair' (ES10:TL) approach to patient care. They instinctively employed many of the people skills specified in Moran, Owen & Richards (1994) soft core competency skill list (see previous section). They also exhibited many of the characteristics Liebling and Price (1999) found to be important in a good prison officer.

> Prisoners wanted staff to care about 'doing right by them'. A good officer was 'a listener', with a (controlled) 'sense of humour', was 'careful', was 'motivated', was 'someone you could talk to', someone 'who will keep an eye on you . . . who'll make sure everything's OK with you'. A good officer was 'capable of being able to use authority'. Their qualities were 'intelligence', 'compassion', 'maturity' and 'understanding'. (Liebling & Price, 1999: 57-58) (see also Chapters Three and Eight)

Custodians expressed a willingness to 'sit with patients, laugh and joke, (play) team games, (offer a) shoulder to cry on' (DS3:N) and above all they demonstrated 'compassion' (DS8:WM) - acknowledging the pains of confinement (Sykes, 1958) and the frustrations of hospitalisation (Morrison, 1994).

They prioritised security but recognised the hospital's principles of keeping overt measures to a minimum. They believed that a keen knowledge and understanding of the individual patients in their care was the key to security and that this was best gained by spending time with patients in the communal areas of the wards in one to one dialogue and unobtrusive observation (see Chapters Three and Eight). They performed essential security

tasks in a consistent way that caused minimum disturbance and distress to the patients. These ward staff believed that by operating clearly structured regimes and eliminating 'grey areas' (CS1:TL) they were helping both staff and patients in facilitating the work of others who wished to carry out specific treatment programmes with patients. Kinsley (1998) reflected that security was of key importance to ensuring that treatment could take place in the Special Hospitals.

All qualified ward staff, including *custodians*, must face the 'horrendous crimes' (BS7:N) of many of the PDU patients. This could be particularly difficult when patients were found to be continuing their deviant behaviour in hospital:

> I think I'm more fortunate than staff with families as I can switch off to patients' IO. I detached from the patients a long time ago. I'm more concerned with incidents they've been involved with inside, for example 'grooming teenage girls in letters' (ES9:N).

Staff could also lose their distance when patients graphically described their offending behaviour - 'how he used to prey on vulnerable children on holiday' (BS9:TL). Finally, as the earlier quote suggests, staff with families may have a particular difficulty disconnecting from patients' offences:

> There have been two or three occasions when patients have got to me. I've had to withdraw because of my kids. (DS8:WM)

Custodians typically dealt with their natural aversion to the index offences of the patients by accepting it and 'consciously try(ing) not to let (it) affect' (DS2:N,3) their attitude towards the patients. They learned to 'switch off' (AS2:N) to the patients' crimes as they had taken place 'a long time ago' (BS9:TL) and the 'offences (did) not personally affect (their) life' (AS6:NA). They could then use their knowledge of patients' index offences as a further aid to Hospital security - an indicator of a patient's capacity to be 'a security threat' (CP:5) or 'a danger to females' (BS2:NA) or 'to be (a) potential murderer . . . and (the staff to be their) potential victim' (CS15:N). In this way

custodians used their knowledge of patients' index offences to further the safety of those in their care and others.

Ward staff who adopted the *custodian* style of job performance were most universally viewed by both staff and patients in a positive light. Although they represented the criminological end of the medical-criminological dimension in the Hospital their fair approach to security (Tyler, 1990; Ahmad, 1996) and people-work skills were considered by both staff and patients to be invaluable to the smooth-running of the wards (see Chapter Eight). *Custodians* therefore appear to have been most successful in establishing legitimacy in the eyes of their patients and colleagues through their choice of actions and social relations with patients (see Chapter Three and Eight).

One PDU patient registered his appreciation of staff who adopted the *custodian* style of performance:

> The better practising staff are those that have the skilling of life experience and academic skilling. . . . They don't treat people according to clinical models but as people. But all the skills that they have they apply in a holistic manner. But they do it very subtly. . . . For example, in the Park Lane days, security was always very tight but it was only semi-visible to the patient. . . . These kinds of staff treat you as a human being. (CP: 8)

Patients welcomed the structure and consistency of *custodians* - they 'knew where they stood' (DP:3). They deeply appreciated the non-intrusive and considerate nature of *custodians* who performed the essential security tasks such as checks and searches without appearing to relish them. Patients returned the respect shown by the custodians by shaking the hand of a ward staff member who 'd(id)n't appear to enjoy room searches' (CS4:NA). Many patients were aware that the ward staff focused on their crimes above their disorder but valued the fact they were dealt with as fellow human beings and not in a 'childish' (AP:3) way where their voice remained unheard because of their medical diagnosis.

Ward staff who were most likely to adopt the *custodian* style of job performance were those who had been formally trained in psychiatric nursing.

It is not surprising that this should be such a common role performance because formal psychiatric nurse training emphasises the observation and supervision, and the prevention and management of violence (Ritter 1989) which correspond with the duties of prison officers (see Sykes 1958; Liebling and Price, 1998). Similarly to the job of prison officer the formal socialisation process at Ashworth trained staff to focus on dangerousness and risk reduction (Business Plan, 1996/97: 1.4). The induction process served constantly to remind trainees that the majority of patients were in the Hospital because they had committed crimes.

For those ward staff who had either qualified as nurses at Ashworth or who entered the employment of the Hospital immediately after receiving their qualifications a focus on patient dangerousness and hospital security is highly likely. Staff who adopted the *custodian* style of performance believed that PDU patients were not treatable. This was as a result of their common sense and media informed understanding of psychopaths (see Chapter One) which was compounded by their on-the-job experience and a lack of PD specific training to contradict this view. Staff would therefore chose to concentrate their efforts on the non-treatment aspects of the PDU nurse role. This was possible on the PDU as very few patients were on full time medication and the majority of therapy sessions were off ward and outside the sphere of the PDU nurse remit.

It was also perfectly possible for untrained nursing staff to act out a *custodian* style of job performance on the wards. In this case it seemed that this probably derived from their biographical experiences outside the hospital. Personality disorder has had such a high profile in the media that they could hardly be immune from the debates around mad or bad (see Chapter One). Some who brought with them views in which criminological issues predominated, could easily have found support in the staff culture on the wards, and role models to follow amongst the trained staff. The formal socialisation of nursing assistants was also highly security-orientated as they

were not qualified or encouraged to be involved in the formal treatment of the patients:

> As an NA I'm just here to serve their meals and observe them. . . They see me as a laugh; shake my hand as I don't appear to enjoy room searches. (CS4: NA)

Clinician style of ward staff performance

I have called the second most frequently displayed style of performance on the PDU the *clinician* performance. In its pure form it can be found at the medical end of the medical-criminological dimension and the object end of the people-object dimension (see Diagram I). Ward staff whom I have characterised in this way tended to focus on the treatment aspects of their job and attempted to objectify their relationship with patients by viewing them in terms of the sum of their diagnostic symptoms - individuals to be restored to health and then removed. They believed themselves to be experts on PDU patients both in respect of their abilities to administer long-term therapeutic interventions and the daily management of patients.

Ward staff who adopted the *clinician* style of performance could most readily be equated to the emerging branch of psychiatric nursing which has been labelled 'forensic' nursing whereby the current literature focuses on the need to develop a specialist branch of nursing for dealing with patients in secure settings (Morrison & Burnard, 1992; Robinson & Kettles, 2000). However, whilst the management of people with personality disorders has been recognised as a prime focus for forensic nursing, as yet the lack of training and education, and empirical research in this area offers those who are currently dealing with this group little practical direction (Morrison & Burnard, 1992; Robinson & Kettles, 2000).

Therefore, ward staff who adopted the *clinician* style of performance could be viewed as the current experts in the field and often promoted themselves as such. On the PDU they chose to focus on the clinical aspects of their job. They perceived that it was their duty 'to be proactive in helping the

patients overcome their PD (personality disorder); . . . . attempting to treat not just confine' (ES9:N). They had adapted their professional nursing skills, including patient assessment, production of patient care plans, involvement in therapeutic group work and individual interventions and the development of professional nurse-patient relationships (Ritter, 1989) to work specifically with PDU patients.

The rigid enforcement of professional nurse-patient boundaries, whereby staff did not impart any personal information to the patients but expected the patients to openly discuss their life experiences with them in the name of therapy, showed the intention of these staff to maintain strictly clinical, impersonal relationships with patients. This tended to mean that *clinicians* appeared not to care for patients, ignoring their emotional needs, as they believed this fed their disorder - 'I'm here not to care but to offer therapy, instil social values' (BS3:N3).

Clinicians typically viewed patients' index offences as a symptom of their underlying personality disorder. They dealt with the patients' index offences by regularly referring to them in the course of their daily interaction with them considering this to be the most effective way to ensure that the patients addressed and took responsibility for their offending behaviours.

These ward staff attended to the everyday management of patients by dealing with them as if they were nothing more than the sum of the behavioural traits and characteristics associated with their medical diagnosis of personality disorder. The 'true', 'pure' or 'classic' psychopath was attributed with characteristics such as being 'highly manipulative, charming, intelligent (and) cunning' (CP:7). *Clinicians* prided themselves in their ability to play the patients at their own games:

> The ward manager is the biggest psychopath going. He takes that as a compliment because he's a clever mind game player. To be honest he does have a vision. He likes to take patients who're described as untreatable and unmanageable and I don't know how it happens but they change. The ward manager is the foundation of the ward - he likes the power. (CS10:NA)

Perceptions of ward staff who adopted the *clinician* style of performance varied significantly amongst other ward staff and patients. The above quote indicates that other staff could perceive *clinicians* to be overly obsessed with mimicking psychopathic traits but impressed when they appeared to get results.

One highly articulate patient expressed his complicated double-edged view of staff who adopted the *clinician* style of performance:

> One group come in with wonderful ideas . . . mostly they are qualified staff . . . they believe that they can change the world. . . . Some of them are tenacious and dedicated and vocationally motivated. (CP: 8)

However, their:

> well-meaning approach is one that is very structured. These staff have a picture of you and your expectations and your treatment and nothing else matters. There is no flexibility. This can be very patronising and anti-therapeutic. (CP: 8)

The majority of patients tended to hold with either the first or the second half of the above patient's views perceiving those with an enthusiasm for 'treatment' as either their saviours or their persecutors.

It is not in dispute that ward staff who adopted the *clinician* style of performance were highly motivated and dedicated and had become skilled in dealing with PDU patients. However their claim to expert status and their unbending use of medical terminology to explain all ward staff and patient actions could and did lead to patient frustration and resentment (see Chapter Eight).

Ward staff who adopted other styles of performance observed how *clinicians* tended to expect all patients to be 'manipulative, demanding, childish, aggressive' (ES11:TL), 'immature, selfish, self-centred, misfits, loners, (unable to) make friends easily and lack(ing in) social skills.' *Clinicians* were described as looking for 'hidden agendas' (AS11: N) behind all patient actions - for example, one patient who displayed distress at the death of

his father was suspected of only mimicking an emotional response to further his transfer chances. Patients complained that the dismissing and recording of all their negative responses to confinement as representative of their underlying disorder, whether intentional or not, was both unjust and underhand. If patients believed that staff who pursued this approach had stifled their progress through the Hospital they could respond with aggression (see Chapter Eight). It has been shown in the nursing literature that nurses' response to patients venting their emotions can often be viewed as a form of punishment by patients (Topping-Morris, 1992: 3).

Fellow staff and patients also criticised *clinicians* for being 'office boys' because they were perceived as spending an excessive amount of time hiding in non-patient areas - completing administrative tasks rather than interacting with patients.

Further, colleagues of *clinicians* observed that they could become overly possessive of the patients who they were treating as one reported, they 'believe they own their patient and won't share their knowledge' (CS1:TL). They considered this attitude to be dangerous as the exchange of information on patients is felt to be central to the security of the wards (see Chapter Eight).

Equally, both ward staff and patients voiced their anger that *clinicians* used patients as a stepping stone for furthering their own careers by claiming a unique expertise in being able to deal with PDU patients (CP:2).

Clearly, as yet, ward staff who adopted the *clinician* style of performance have been unable to confer legitimacy to a number of ward staff and patients. Whilst their professional and consistent approach to their work appeared to have helped their claim to legitimacy (Liebling & Price, 1999) their underdeveloped social relations with patients appeared to have confounded their ability to legitimate their choice of actions which at times could appear unfair to patients (Sparks & Bottoms, 1995; Ahmad, 1996) (see Chapters Three and Eight).

Ward staff who were most likely to adopt the *clinician* style of performance were professionally qualified psychiatric nurses who had spent

their nursing careers in one of the three Special Hospitals. They were likely to have volunteered to work with PDU patients as a result of their experience, interest and sometimes further training in this area of mental health work.

Many *clinicians* had trained at Park Lane Special Hospital and refined their skills on the PDU in specific response to the PDU patient. At Park Lane Special Hospital ward staff learnt to operate structured, treatment led regimes as opposed to the primarily security orientated regime of Moss Side Special Hospital.

Unqualified nursing assistants could also attempt to act out the *clinician* style of performance. This appeared to be mostly dependent on the attitude of their colleagues and Ward Manager - whether they encouraged nursing assistants to become involved with patients' therapeutic input. However, their lack of formal training could lead to problems as exemplified by one nursing assistant whose attempts to prove one patient was lying about being abused as a child, including interviewing his parents, almost appeared to be a witch hunt.

Carer style of ward staff performance

The style of performance which I have described as *carer* was much less frequently apparent than the previous two styles of performance but still had a significant impact on the PDU. In its undiluted form it can be found at the medical end of the medical-criminological dimension and the people end of the people-object continuum (see Diagram I). Ward staff whom I identified in this way appeared to view themselves as wholly responsible for the patients as they perceived the patients to be sick people who were not capable of taking responsibility for themselves, their disorder or ultimate recovery (Parsons, 1953). But whilst these ward staff appeared to focus on the patients' sickness they still attempted to pay heed to the individual wishes of the patients.

Staff who adopted the *carer* style of performance perceived the PDU patients to be deserving of their help and attempted to offer them twenty-four hour care. This took the form of physical and medical, and emotional and practical support - combining their formally learnt nursing skills with their

socially determined people skills. The nursing literature indicates the emphasis placed on this 'holistic' approach in nursing and patient care.

> Nurses are constantly reminded of the importance of 'holistic' and 'individualized' care. . . . Holistic care means that carers try to take account of the physical, psychological and social aspects of the patient's life while the patient is hospitalized and dependent to some degree on professional help. (Morrison, 1994: 107)

However, PDU staff were very limited in the medical and physical nursing duties they could perform to assist PDU patients, such as administering drugs or helping them bathe. Many patients were not on medication and were capable, where permitted, of looking after themselves. Where needed *carers* would pursue such varied duties as serving meals and taking care of dying patients (Ritter, 1989) in a professional but understanding way.

As *carers* were restricted in the number of medical and physical ways in which they could help PDU patients they endeavoured to offer alternative forms of social support - both practical and emotional:

> I see myself as a 'house mother' - because of my maturity patients will take things from me which they won't from younger staff - for example banter - telling them what to do. Patients do know that I care and see me in the same way. Also I am an advocate as there is so much that patients can't do for themselves so they need me to liase with other departments. If they are in the right I will argue for them. (AS9:N)

As indicated above, in practical terms, *carers* attempted to safe-guard patients' welfare (Ritter 1989) by keeping them informed and assisting them in the resolution of their everyday living problems (AS11:N) (Department of Health: Patients' Charter 1996). They made themselves available to help patients discover why their clinical queries were being ignored or helped find out why off-ward staff or external visitors had failed to attend meetings with patients. *Carers* were not afraid to aid patients in making formal complaints (Ritter 1989) against other staff.

In the Special Hospital setting patients' freedom of movement and activity are severely curtailed on the grounds of security which means they are unable to carry out many daily living tasks without the consent or assistance of the nursing staff. *Carers* were the most actively helpful at facilitating patients' requests to unlock doors, in order that patients could get a drink of water in the middle of the night, or to supervise telephone calls or to escort patients to visits or workshops. Equally, these staff would attempt to avoid involvement in the more overt of the hospital's security measures such as person and room searches and carried out the tasks which they were instructed to do with the minimum of disturbance. If staff do not show patients due consideration and respond promptly to their legitimate requests it can greatly exacerbate their experience of confinement (Sykes, 1958; Morrison, 1994) (see Chapter Eight).

Emotional support was another method through which *carers* could act out their chosen style of performance. This service could be viewed as medical, in therapeutic terms, as it could occur between a *carer* who was an official case manager for a particular patient. A patient was assigned up to three members of staff, a case manager and two case workers, whose function it was to offer the patient individual therapeutic support whilst he was on the ward. However, *carers* could be described as giving a more universal, emotional support - an ever ready shoulder to cry on - to all those patients who required it on their ward. One patient described how a *carer* was accepted as someone who 'you c(ould) talk to . . . for unofficial therapy.' (CP:2) As shown in full above a member of staff described herself as a 'house mother' (AS9:N) to the ward owing to her willingness to listen and try to understand the patients' situations.

Carers were not blind to patients' offences but regarded them as not being capable of taking responsibility for their behaviour whilst they were sick.

The desire of ward staff who adopted the *carer* style of performance, to care for and help PDU patients, did not sit easily with the traditional staff cultures of Moss Side and Park Lane hospitals. It could be argued that they still dominated the current Ashworth Hospital, including the PDU, where

issues of security and control were considered paramount. *Carers* could face considerable derision from other ward staff who perceived them to be blind to the criminal and clinical risks which PDU patients represented.

Further, the staff culture of the hospital socialised staff into 'sticking together', 'maintaining a united front', and 'not overstepping staff-patient boundaries' (Conversational quotes). This issue was repeatedly referred to by patients, as one observed - (there is) 'a lot of . . . pressure from colleagues. . . . not to overstep the divide to the evil side' (EP:3). The 'underlying staff strategy is to stand together, due to security.' (DP:2) The widespread, 'them and us' staff culture isolated and over-stretched *carers* who were willing to step outside staff-patient lines and who attempted to respond to all the patients' needs:

> One or two patients have recurring problems, dependency on medication, but they're not hard work - but their requests wear you down. You have to deal with the same problems with the same patients over and over. (AS11:N)

Patients could respond positively to *carers* as they appreciated that these staff recognised and attempted to minimise the everyday difficulties of living on the PDU. In particular they regarded *carers* as refreshingly approachable, as one patient said: 'staff who care are the easiest to get on with so you ask them to do things for you' (AP:6). They also welcomed the opportunity to be able to talk about their problems, medical or not, at any time. This style of performance seemed, in particular, to be valued by long stay patients who were keen to establish a reasonable quality of life.

However, patients could reject the attentive nature of *carers* as they did not regard themselves as being in need of emotional support and resented *carers'* attempts to proffer help as an invasion of their privacy (Goffman, 1961). *Carers'* attempts to involve patients who chose to 'isolate themselves' and 'drag them out' (AS9:N), in the name of therapeutic intervention, could be interpreted as coercive by patients who did not want to be helped (see Chapter Three).

It is clear therefore that whilst *carers* appeared to be able to confer legitimacy to some members of the patient population of the PDU others regarded their attempts to develop social relations as overly intrusive. Further, the small numbers of *carers* and their apparent lack of support for the staff culture and security requirements of the Hospital left them unable to confer legitimacy to many of their colleagues.

The socialization process by which ward staff developed the *carer* style of performance was likely to have begun before they entered the PDU or Hospital. *Carers* were most likely to be qualified psychiatric nurses who had worked in facilities outside the secure sector and with patients who were diagnosed as mentally ill or mentally impaired. They attempted to bring the philosophy and practices they had learnt in these settings with them into the PDU environment.

However, it was difficult to adapt their formal training to the PDU as staff had to deal with the security and control directives of the Hospital and the personality disorder diagnosis of the patients. As illustrated above those who wished to continue in the *carer* style of performance had to mix their people skills with their nursing skills to deal with the PDU situation. It is perhaps unsurprising that there were a limited number of ward staff who adopted the *carer* style of performance on the PDU as they were viewed as the antithesis of what was required in the post-Fallon (1999a) security-control swing of the Special Hospital pendulum.

Fatalist style of ward staff performance

Ward staff whom I characterise as adopting the *fatalist* style of performance were on the increase at the time of the research and were becoming a significant group within the PDU workforce. In its extreme form it can be located at the object end of the people-object continuum (see Diagram I). These ward staff appeared to reject any pretension to people work - whether it be directed at dealing with the sick or the criminal and as such do not fit easily into the medical-criminological continuum. However, as they appeared to

perceive the patients to be dangerous and untreatable they fit most closely at the criminological end of this continuum. Perhaps for the sake of self-preservation, they deliberately distanced themselves both emotionally and physically from the patients whom they recognised as a volatile commodity which they must service in order to receive payment.

Fatalists performed the absolute minimum required of them as ward staff, 'I cope by not working to my max' (AS2:N), where possible retreating into routine and administrative work, such as sitting at the night-station or behind a computer, in a bid to ensure minimal patient contact. They acted as if they did not care about patients and believed that by shunning interaction with patients and leaving them to their own devices they would reduce their work load. As one patient observed: 'some staff are lazy - they stay in the office, staffroom or nightstation - they find excuses to be busy' (DP:5). *Fatalists'* perceived patients to be untreatable and potentially dangerous but believed that avoidance rather than security was the safest tactic.

In a similar way to that of prison officers in a 'secondary comfort indulgence' adaptation (King & Elliott, 1977) *fatalists* attempted to make the best of what they perceived to be a bad job. They enjoyed the slow pace of life on some of the wards: spend the morning reading free newspapers, catching up on the gossip, dawdling over long mealtimes in the staff room and generally pottering through their shift in the expectation of a higher than average wage packet. Some of these staff were literally 'marking time' (King & Elliott, 1977) as they actively sought new posts. The more highly qualified ward staff appeared, at the time of research, to be successful in their search whilst less qualified ward staff were trapped by their mortgages, reliant on the extra pay they accrued through overtime and working in a high security establishment.

Other ward staff appeared to accept the resignation of staff who adopted the *fatalist* style of performance as understandable. It only created resentment and frustration if it led to an increase in the workload of other ward staff or if they felt their approach to security was lax and left them at risk.

PDU patients also expressed an awareness of why some ward staff became despondent and apathetic towards their work. They viewed this style of job performance to be both positive and negative:

> There are the just for the job staff. Here to earn their money - not too bad. Can't be bothered to do checks - walk down the corridors or to search your room. They sound as if they are a bad kind of staff but in fact they can be quite good. I think the times when they are a bad kind of staff is when they can't be bothered to do things that they are supposed to do - when they can't be bothered to serve lunch. (CP:5)

Patients' appreciated the non-intrusive nature of *fatalists* as a side-product of their patient avoidance and reluctance to become engaged in staff-patient interaction was that the patients regained some personal space. However, the negative side to the indolence of these ward staff was that they were adept at finding 'excuses to be (too) busy' to help patients (DP:5) and complaining about performing even the most basic ward duties; they 'moan if you ask (them) to do the phone' (CP:1). One patient also reported:

> The bad ones out of this group bring some form of baggage with them - domestic problems or financial problems . . . These staff can be bad tempered with patients although this is not necessarily their intention (CP:8)

It is therefore apparent that ward staff who adopted the *fatalist* style of performance appeared to fail to confer legitimacy through their social relations with others. However, an understanding of their viewpoint by both other ward staff and patients, and the fact that their choice of action or more accurately inaction did not appear to cause disruption to others showed that many did perceive their style of job performance to be legitimate under the circumstances.

Ward staff were unlikely to enter the hospital and immediately adopt the *fatalist* style of job performance. They would go through a process of alienation before they chose to reject other more formal and people-orientated styles of performance. *Fatalists* were more likely to be trained than untrained

ward staff and tended to have viewed nursing as their vocation, not just a job, when they entered the Hospital. However, their on-the-job experience of working on the PDU had left them feeling alienated from their original nursing values as identified in the earlier *clinician* and *carer* styles of job performance.

Unsurprisingly, in the unsupported and unstable climate in which the research took place, where internal, police and public inquiries were all underway, the number of *fatalists* was on the increase as staff began to experience acute feelings of isolation and paranoia. The increase in security, a direct result of the inquiries, had led many *carers* and *clinicians* to despair at the disruption this created in their therapeutic endeavours and treatment plans with patients. The rapid increase in security was beginning to lead to staff 'losing what faith they had in notions of treatment, training and rehabilitation' (King & Elliott 1977: 318).

As indicated in the earlier section *carers* could face considerable derision from staff who were located at the criminological end of the medical-criminological dimension and in time become worn down. Equally, *carers* and *clinicians* may only have a finite resilience to patients' constant rejection of their attempts to help them. *Carers* also become 'burnt out' as a result of their kindness towards patients which made them a constant target for requests because 'the more patients who like you, the more work you have.' (ES7:N)

Finally, the problem remained that *carers* and *clinicians* who enter the PDU with a spirit of optimism may not have been able to cope with the apparent hopelessness which they faced when working with PDU patients who were regarded by many to be dangerous and untreatable. They could adopt the fatalistic view that there was nothing they can do to help PDU patients. Particularly, as one patient identified, when their best efforts were constantly thwarted:

> Sometimes one of the saddest pictures is where staff come in and they are well meaning and they apply their ideas but once they have put a package together for that person and got them ready to move on. That patient hits the bottleneck. They can't get out of the hospital. After this happens several times, most of them can only tick over (CP: 8)

Ward staff therefore become demoralized by their lack of power to further the patients' progress:

> Should the patient be fortunate enough to progress sufficiently so as to demonstrate to doctors and other staff that they could and should leave the institution, they may find that carers remain powerless to arrange such a discharge until others co-operate. (Topping-Morris, 1992: 3)

Adult style of ward staff performance

Although not that common in its pure form on the PDU I include the *adult* style of ward staff performance in this analysis because it appeared to be particularly important to the PDU patients. In its pure form it is positioned at the people end of the people-object spectrum (see Diagram I). Ward staff who adopted this style of performance acted out the first principle of people work and focused on the immediate needs of the whole person rejecting the need to focus on their medical disorder or offending behaviour.

Ward staff who adopted the *adult* style of performance operated within the constraints of the hospital rules but they did not concur with the hospital or ward philosophies which ostensibly clumped all patients together under their medical diagnosis. They chose to try to respect patients as responsible, self-determining adults with individual personalities - some of whom they would prefer to be more involved with than others. This meant their responses to patients were dependent on their personal, first hand knowledge of them rather than on their medical diagnosis or index offence. They attempted to be friendly towards all patients but their individualized approach meant that they formed strong bonds with specific patients if they had known them a long time or shared a common interest, like supporting the same football team, as on the outside.

These staff displayed similar people skills to *custodians* and *carers*. They showed a particular empathy towards the difficulties of 'life *en masse*' (Sykes, 1958: 4) and the pressures of confinement which they perceived in general were not connected to the patients' medical diagnoses or index

offences. They took the view that most patient 'problems are based on daily living, . . . (the) same as (the) staff' (ES6:TL), observing 'patients get on no different from twenty men anywhere; (they) have their jealousies, dislikes (but) considering the length of time they spend together they do very well' (CS7:NA). They credited the patients with the insight that 'if they behave inappropriately they'll lose out but it's human nature to rebel if you don't want to be somewhere' (ES9:N) (see Chapter Three). Similarly to *custodians* and *carers,* they attempted to ease the patients' problems but focused specifically on their everyday living problems to the exclusion of all medical and criminological issues.

One *adult* outlined his general philosophy towards PDU patients:

> I don't read their case histories as their offences happened fifteen years ago. I form opinions from the people I meet now. Some are good and others I wouldn't get on with outside. They might have done terrible things when their heads weren't right - who am I to judge. Some are more demanding - I'm told it's because they're PD but it's their nature anyway. I think I get on OK with the patients - I have as much to offer them from life experience as the qualifieds. Some don't like me because I'm an extrovert. They think of me as caring, out going - someone they can have a laugh with, cry with. (CS7:NA)

As reflected above ward staff who adopted the *adult* style of performance had a unique attitude towards patients' index offences which separated them from *custodians* and *carers*. They were philosophical about patients' index offences, taking a non-medical and non-criminological viewpoint, reflecting 'there but for the grace of God' (CS8:N). *Adults* made their own assessment of patients as they would any other adult, as shown by the comments of one interviewee:

> The most serious offenders cause the least trouble, a lot have quite attractive personalities, where as the annoying ones may be the least dangerous; for example: the two most unpopular patients are both arsonists who set fire to derelict buildings. (AS11:N)

Ward staff who adopted alternative styles of performance, particularly non-people orientated ones, may not approve of the attitude of those who adopted the *adult* style of performance had towards the patients. They could be accused of naivete and unprofessional behaviour for failing to protect, and potentially undermining, staff-patient boundaries which they believed to be essential for both medical and security reasons.

The subjective response of *adults* to patients' merits and faults could lead to patient accusations of favouritism. However, many patients valued their refreshingly human approach, incorporating both life experience and general knowledge, of *adults*:

> One NA, who has worked outside, just treats us like someone off the streets. (CP:1)

It is therefore clear that staff who adopted the *adult* style of role performance could be perceived to confer legitimacy through their negotiation of respectful, adult social relations with some patients. However, their lack of consistency and dismissive attitude towards the values of the institution could undermine the level of legitimacy they were able to confer.

Staff who were most likely to adopt the *adult* style of performance were untrained, older nursing assistants on their second career. They were strong-minded individuals who brought with them firmly held life philosophies and well developed people skills, based on considerable life experience, which could withstand the dominant Hospital culture. As nursing assistants they remained largely unscathed by the formal socialization processes in the hospital.

> As an NA they (the patients) see you as a sympathetic ear, someone to moan to and vent their frustrations. Also you're there to do basic tasks. As an NA you have a different relationship with them than the qualifieds. You're told to get to know the patients first, in training and by other ward staff, so that their index offence doesn't colour your relations. I tend to forget what they've done. (AS6:NA)

Nursing assistants do not have to read patients' case notes which leaves them free to 'form opinions from the people (they) meet' (CS7:NA). It was not surprising that there were only a small number of staff who could be recognised as adopting this style of performance in its pure form as it could be described as a rejection of the medical and criminological culture of the Hospital and PDU. This style of performance was therefore most apparent on the more disparate wards.

Screw style of ward staff performance

It was rare for PDU staff to adopt the *screw* style of performance in its pure form. However, it is included here because when staff did operate within this style of performance the consequences for other ward staff and patients were great. In its extreme form it can be located at the criminological end of the medical-criminological spectrum and the object end of the people-object continuum. Staff who I characterise in this way appeared to consider it their duty to punish patients for their crimes.

Screws appeared to reject the medical philosophy of the hospital and believed the patients were untreatable and 'should be in prison' (CS12:NA). They assumed all PDU patients were categorically dangerous and must be controlled at all cost. This perception of patients translated into an overtly rigorous approach to room and patient searches, patient supervision and interventions in patient altercations: 'there are the *screws,* they are one type of staff - check movement, all checks properly, . . . they enjoy it too' (CP:5). Similarly to the group described by King and Elliott (1977) as the 'heavy mob', in their prison research, the PDU *screws* 'regarded themselves as key men should trouble arise' (King & Elliott, 1977: 267).

Screws quite clearly focused on the patient's index offences to the exclusion of all other patient characteristics. They felt strongly that the 'patients are . . . detained for horrendous crimes and (that) it's . . . (their) job (to be) punitive' (CS2:TL). Unlike *custodians* these staff believed patients should be punished for their crimes.

In the post Blom-Cooper (1992) era staff have had to find non-physical ways to punish patients. One method was to use the extensive catalogue of hospital rules as tools to exaggerate the discomforts of incarceration and emphasize a patient's criminality. This was done by refusing to show patients a basic level of respect; 'instead of knocking on our doors in the morning some of the staff will shout down the corridors 'locking off' as if we're in prison' (EP:1) or they can force a 'patient (to) take his shoes off for a rub down because they d(o)n't like him' (CP:7).

Ultimately staff who adopted the *screw* style of performance were able to document their interpretation of a patient's behaviour in their permanent records; 'if you argue with them they'll walk away with a pen in their hand, so you can't lose you temper' (CP:1). This meant the punishment was ongoing as it was reconsidered every time a patient's case was reviewed. This was made worse as *screws* were likely to perceive all patient responses as criminal: 'they hate the word 'no'; that's why they're rapists' (CS11:NA). Further, *screws* justified their non-response to patients as a social learning technique:

> The patients need social skills and I don't think staff answering to their beck and call is helping them. (CS11:NA)

Screws could be perceived as deliberately

> provocative; (they) do things (that) they know will annoy people. . . . to gain a response . . . It suits them as then they can restrain. (It) makes them feel like they are doing a good job (EP:5).

Patients' observed that staff deliberately 'wind you up' (AP:4/5) to alleviate their boredom or justify their existence. Dealing with control problems was an opportunity for *screws* to show their worth (Galting, 1961).

The *screw* style of performance was one often attributed to ward staff by patients and occasionally by other ward staff who represented the medical and people styles of performance.

Patients viewed *screws* as 'bigoted' (CP:1), 'regimented and authoritarian' (BP:1). Although at times all patients could get frustrated with ward staff and call them *screws* in general the majority of patients felt 'there are only a few bad eggs' (CP: 8). They described this small number of ward staff as promoting an 'entirely negative, degrading, dismissive (and) abusive environment' (EP:5) in order 'to make it difficult for patients' (EP:6).

Patients felt that the mental abuse inflicted on them by today's *screws* was worse than the old physical abuse. Some appreciated the old Moss Side practices of *screws* who let them fight their own battles: 'on the old Moss Side they gave us boxing gloves and let us settle our differences there and then and didn't write us up' (EP:1). However, this option was lost in the patient reforms which followed the amalgamation of Ashworth and the Blom-Cooper Report (1992).

It is clear that those ward staff who adopted the *screw* style of performance did not establish legitimacy in the eyes of the patients or other ward staff as they did not attempt to develop social relations and their choices of action were deemed inappropriate.

Both trained and untrained ward staff were found to adopt the *screw* style of performance. Both ward staff and patients believed it to have developed from the 'boot-boy' culture of Moss Side Special Hospital where a number of ward staff had army and prison backgrounds. These ward staff were described as being particularly 'brutal' and 'controlling' (CP:3) when dealing with PD patients who 'a lot of staff used to get rid of their aggression and get their adrenalin going on' (CS10:NA). As shown in Chapter Five many ex-Moss Side ward staff worked on the PDU and a small number could be perceived to be adopting the *screw* style of performance. This style of performance was therefore evident to new recruits who could be attracted by the forceful personalities of this small but significant group. The current political and post-Inquiry (1999a,b) climate had led to a resurgence of emphasis on the dangerousness and criminality of the PDU patient and the one style of performance which best fits this position is the *screw*.

Table III Summary of Styles of Ward Staff Performances

Style of Staff Performance	Attitude to Patients	Management of Patients	Response of Other Staff & Patients
Custodian	View as criminals but able to socialize positively with them	Sophisticated people-work skills - show respect when carrying out security duties	Universally viewed in a positive light as both consistent & fair
Clinician	View as personality disordered who must be treated	Focus on clinical work - medicalize all patient responses	Appreciated for progressing patients through the system but patients may resent all their actions being pre-judged in terms of their disorder
Carer	View as sick and in need of help	Focus on offering physical & emotional support to patients	Staff appreciate as it reduces their workload. Patients see them as approachable & understanding but can find them too intrusive
Fatalist	View as a dangerous commodity to be avoided	Focus on making the most of a bad job and avoiding patients	Staff & patients understand demoralisation but staff resent increased work load & patients are frustrated when their requests are dismissed
Adult	View as individual humans with both positive & negative attributes	Focus on getting to know the patients and assisting where possible	Both staff & patients are suspicious but when trust is established patients' appreciate
Screw	View as criminals who should be punished	Focus on security and controlling patients in punitive ways	Viewed negatively

Table IV Analysis of Distribution of Style of Ward Staff Performances on the PDU

(*Italics* highlights the most significant style of ward staff performance on each ward)

Style of Staff Performance	Ruskin	Newman	Owen	Lawrence	Macaulay
Custodian	*Most common as the concentration is on security and criminal behaviour.*	Most common as focus remains disruptive behaviour.	Only 2nd most frequent as the concentration is on medical issues.	*Main identity since the ward has become security orientated.*	*Although a parole ward there remained a large number of staff who felt most secure adopting this identity.*
Clinician	Few as staff who adopt this approach face some derision as medical matters are only considered of secondary importance.	Very few clinicians as not many of the patients fit the care they can offer.	*Most frequent identity as the focus is on treatment.*	Few as treatment was suspended on the ward during the period of research.	Few as the focus is on long term care rather than treatment.
Carer	Very unlikely to continue here as staff do not believe the patients warrant sympathy.	*Number of carers quite high owing to the family nature of the ward & number of co-morbidity patients.*	Few carers as the focus is placed on personality disordered behaviour.	A few staff remain who try to mother the patients.	*Most frequent for carers owing to the number of long stay & high co-morbidity patients.*
Alienation	Not in evidence as strong sense of camaraderie.	Small number leaving but the family atmosphere maintained morale.	*Increasing numbers as security meant treatment groups were being cancelled.*	*Highest number as a result of ongoing investigation by the Inquiry team, hospital & police.*	Small number owing to the stagnant patient population in what was supposed to be a parole ward.
Involvement	Very few as personal relationships are actively discouraged between staff & patients.	*Significant number as staff & patients may have spent many years together.*	Few as staff-patient boundaries are considered important medical practice.	Very few as the Inquiry has denigrated trust & morale on the ward.	Small number owing to long stay nature of the ward.
Screw	*Small but significant number who believe the patients should be punished.*	Not evident owing to the long term bonds between staff & patients.	*A small number who expressed disgust but used medical terminology.*	A few owing to the nature of the paedophile allegations of Inquiry.	A small number felt that the patients were simply biding their time & that they would be better off in prison.

In conclusion the highly problematic nature of where the PDU patient should be placed and who he is has led to several very different styles of ward staff job performance. I have shown in this chapter through the identification of six typologies of ward staff performance that there were a number of factors beyond the limited training and education staff had received which influenced the ways in which they chose to deal with PDU patients. An examination of other ward staff and patients' perceptions of ward staff who adopted the various styles of performance has shown that it was those ward staff who have been identified as adopting the *custodian* style of performance who were able to establish the greatest degree of legitimacy at ground level on the wards. It was only ward staff who were identified as adopting the *screw* style of performance who appeared to be unable to establish any degree of legitimacy on the ground.

However, it is clear that there was no single style of ward staff job performance which was regarded as ideal from the joint perspective of ward staff, patients or management. The most effective aspects of each, with regards dealing with patients in terms of patient management, will be assessed following a review of patients adopted styles of performance in the following chapter and an analysis of how the styles of performance affected the smooth running of the wards in Chapter Eight.

CHAPTER SEVEN

Living on the PDU

The PDU Patient

> Institutional life will determine who the patient will live with, what privacy they will have, if any; whether they will be at risk from assault from others around them; who will be allowed to visit them and how frequently; and how, if at all, they are able to express their own individuality and sexuality. They will fast become aware that information is being gathered about them, by others and without the surety that the content will be accurate in detail. The patient may discover that some types of behaviour, non-co-operation with treatment schedules, aggressive displays of anger or frustration, maybe even leading to an assault, or an intense or suicidal mood will cause staff to separate them from other clients and they come to interpret this as a punishment for letting their feelings get out of control. This patient is likely to realise there will be little opportunity to vent these feelings without attracting some sort of sanction. (Topping-Morris, 1992: 2-3)

This is a description of the way in which mentally disordered offenders are likely to be dealt with in a secure psychiatric Hospital setting. In this chapter I will identify and analyse the ways in which and the reasons why PDU patients appear to choose to respond to this environment and the ward staff who deal with them on a twenty-four basis.

Influential factors in the special case of patient performance on the PDU

In Part I, I discussed how historical and current medical and criminological views of PDU patients have affected their image and placement over the last one hundred years (see Chapters One and Two). Whilst the cultural debate about who a PDU patient is and where he should be placed continue, the PDU patient himself must try to adjust to his immediate position on the PDU.

Unlike PDU staff, who can go home at the end of their shift, PDU patients are at home. Their home is a hospital; so they are officially patients and whatever their diagnosis the essence of being a patient is to be sick. But they do not strictly fit into the sick role of non-responsible patient as they are

also personality disordered and dangerous (and in the majority of cases offenders) and as such are considered responsible for their behaviour (see Chapter Two). It is in the light of this paradox, and the different management styles of the wards and individual staff discussed in the previous two chapters, that PDU patients must go about their lives. In this chapter I will set out the ways in which patients deal with these uncertainties, and characterise and perform what amounts to their life role.

The PDU patient is expected to play an active part in his recovery by committing to a treatment plan, attending therapy sessions, and developing work and social skills. It was not part of the remit of this study to assess the effectiveness of these therapeutic interventions, as this is best left to those better qualified (Dolan & Coid, 1993), (although I may make reference to limited opportunities for patients in these areas). However, as with the ward staff day, much of the patients' time, particularly that which is spent in the wards, is not occupied with programmed activities. It is how patients conduct themselves on the wards which is the focus of this thesis. This arguably has considerable impact on a patient's overall recovery as hospital environment and social relationships have been tentatively identified as important factors for patient response to treatment (Dolan & Coid, 1993). It is hoped the analysis in this chapter and the subsequent chapter will be a helpful addition to understanding in this subject.

Perhaps the key factor used to assess whether patients are making progress towards recovery is their ability to stay out of trouble. In total institutions, where individuals are confined indefinitely in close living conditions, Goffman (1961) found 'staying out of trouble is likely to require persistent conscious effort' (Goffman, 1961: 43). Although the Patients' Charter (1996) requires that patients be kept informed the majority of patients claimed to be unaware of the rules of the institution. Therefore, it could be argued, that patients received even less official guidance about how they should conduct themselves on the wards than do ward staff. But, unlike ward staff, a patient's choice of performance on the PDU may affect their whole life.

Patient conduct may be influenced by any number of variables, in addition to their personality disorder. In my analysis of the interview and observational data collected for this thesis, I have concentrated on the non-clinical personal biographies of the patients and the cultural influences of the hospital in an attempt to throw light on how and why patients adopt certain styles of performance. As shown in Chapter Three PDU patients are likely to make their chosen responses to institutional life and ward staff for a complexity of reasons (Beetham, 1991).

As I shall show the patients' responses to life on the PDU provided a reasonable resemblance to ward staff responses - a near, but by no means perfect, mirror image. This is not surprising because if ward staff and patient styles of performance are adapted through a process of negotiation between all those on the wards, they are likely to fall along the same medical-criminological and people-object continuums.

Just as I argued that ward staff styles of performance were unlikely to be found in pure form, and should not necessarily be regarded as permanent strait-jackets, so patient styles of performance may be similarly fluid. In fact there tended to be more variation in the styles of performance adopted by patients perhaps in response to the uncertainties surrounding their lives and hospital careers. There was a significant likelihood of change or forced re-negotiation of a patient's style of performance in an encounter with a member of ward staff who was generally regarded to be the main power-wielder. It was for this reason my order of frequency for patient styles of performance was rather more tentative than the one given for staff styles of performance.

Following an analysis of the present research data I have identified six negotiated styles of PDU patient performance - *personality disordered*, *offender*, *sick*, *loner*, *adult* and *psychopath* - which, as with the ward staff, seemed to be a product of formal and informal processes of socialisation undergone by PDU patients and the social exchange and bargaining between ward staff and patients on the PDU. However, maybe as a result of their personality disorder, or the uncertainty in their lives, or because it is their

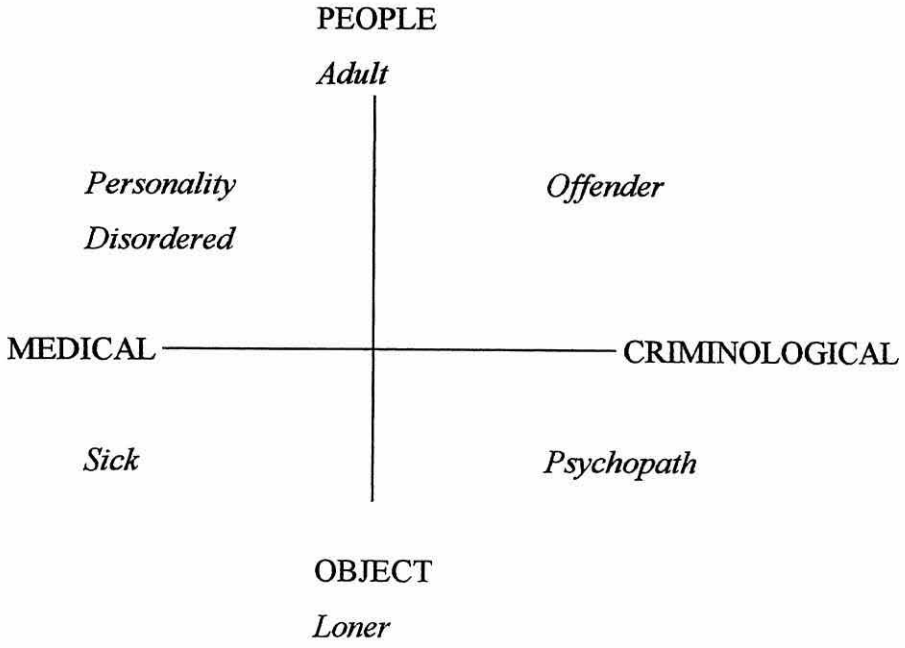
whole life, or because of some other unknown variable, some patients tended to show considerable determination to resist any change in the style of performance they originally devised for themselves.

It is important to remember that patients may have seen themselves in these terms - sometimes in deference to, sometimes in opposition to - the way they were viewed by ward staff and others. It is accepted that this list can never be finite as not all variables and behaviours can be detected by an outsider.

In Diagram II, I attempt to set out the dimensions along which the six typifications of patient styles of performance can be presented. The horizontal axis concerns the extent to which patients perceived themselves in medical or criminological terms as non-responsible and sick, or responsible criminals. The vertical axis concerns the extent to which patients viewed themselves as being treated as people or objects. It cuts across the horizontal axis to represent how patients' responded to ward staff behaviour towards them, and possibly reflects their personal biographies.

I will now discuss the content and order of frequency of patients adopted styles of performance below.

Diagram II



Personality disordered style of patient performance

What I shall call the *personality disordered* style of patient performance seemed to be the modal style of performance adopted by patients on the PDU. In its pure form it can be located at the medical end of the medical-criminological dimension and people end of the people-object continuum (see Diagram II). Patients whom I characterise in this way appeared to identify themselves as personality disordered and as such expected to receive treatment, on successful completion of which they expected to be released. They believed it to be the duty of PDU staff to facilitate their treatment and progress through the hospital but they expected this to be carried out at a person to person level and not to impinge unnecessarily on their adult male autonomy.

Patients who adopted the *personality disordered* style of performance appeared to believe that they should be in hospital; 'the ward and the hospital are the best place for me as in the last three years I have been getting treatment, making progress' (BP:2). However, this only applied if the patients perceived that they were receiving satisfactory levels of clinical input; as one patient commented 'I'm happy when I'm getting treatment, otherwise I would rather be outside' (DP:3). At the time of the fieldwork the majority of patients who adopted this style of performance felt they were receiving inadequate clinical input in terms of both quantity and quality. But they rarely expressed the view that this was the responsibility of the ward staff whom they believed to be at the mercy of management and wider policy changes. They did, however, believe that they should only receive treatment interventions from those who were properly qualified to administer them - either trained nurses or off ward staff (preferably psychologists).

These patients were aware of the medical and criminological debates surrounding their position but remained convinced that if they received the appropriate treatment they - 'can be cured' (BP:3). Some of them displayed great tenacity, during my time on the wards, apparently able to remain optimistic in the face of repeated rebuffs from MHRT panels and RSU doctors.

Patients who adopted the *personality disordered* style of performance used medical terminology to describe their needs and problems. Within therapy they recognised the need for their offending behaviour to be addressed but believed their position in the Hospital signified that they were unable to help their actions at the time.

They tended to expect the ward staff to implement clinical staff-patient boundaries and record their behaviour as they hoped this would help them. There was some complaint amongst this group that there was 'a lack of monitoring' and recording (CP:3). However, they believed that more emphasis should be placed on recording positive activities and where negative encounters did occur they required that their opinion of the situation be included in any report.

Like some ward staff who adopted the *clinician* style of job performance some patients who adopted the *personality disordered* style of performance took pride in the psychopath mythology of being able to engage in mind games and operate as 'highly manipulative, charming, intelligent and cunning' (CP:7) people. It was suggested this was learnt on the wards but the same patient argued - 'if psychopaths were as charming, clever and manipulative as people say we are I wouldn't be here' (CP:7). It did offer these patients a chance to engage with staff on an apparently more equal level.

In more general behavioural matters these patients would comply with the rules of the hospital if they believed it was in their best interests to do so but they resented what they described as childish rules, such as being unable to cook their own meals or being sent to bed, as they believed these indignities undermined their adult autonomy (Goffman, 1961) . Whilst relinquishing responsibility for their crimes they still expected to be treated as responsible and intelligent adults, and to be allowed to take care of themselves when they were not directly taking part in therapeutic sessions.

Perhaps the key response to those who adopted the *personality disordered* style of performance was distrust, particularly from ward staff who operated at the criminological end of the medical-criminological continuum.

Even those who acknowledged the existence of personality disorder and believed that patients could change may still question whether patients were genuinely trying to change or simply performing for the system. One patient summarised the difficulty faced by all PDU patients: 'as a PD I am wrong which ever way I go' (CP:7).

The sweeping distrust of many ward staff was highlighted in one staff statement: 'all PD's test boundaries, the quietest are most worrying as you don't know what they're thinking' (ES9:N). The institutional culture taught staff to suspect patients of manipulation, distortions and fabrications when dealing with a psychopath. This could mean that patients who did change and were ready to move on were left frustrated;

> for the first four years I needed to be here, getting intensive therapy, but now it's detrimental and no one's willing to take responsibility to move us on (AP:4).

The *personality disordered* style of patient performance was learnt on the PDU. These patients appeared to be fully conversant with their legal and medical position. They were aware that their only chance of leaving the hospital was to co-operate with their treatment plans and stay out of trouble. This was a relatively new approach in the Special Hospital setting where before the Park Lane era patients could earn release on the strength of their good behaviour and the length of their stay relative to their crime (Dell & Robertson, 1988). Post Blom-Cooper (1992) patients were made aware of their legal right to treatment and given new avenues to actively pursue that right. Freshly armed with this information and power a proactive *personality disordered* patient emerged who demanded treatment or release.

Patients who I have identified as adopting the *personality disordered* style of performance appeared to be most likely to perceive the *clinician* style of staff performance to be legitimate. However, this would be dependent on whether they perceived these individuals to be providing them with adequate medical care. Equally, as these patients believed that they should be respected

as adults they may also perceive the *custodian* and *adult* styles of staff performance to be legitimate (see Chapter Three).

Offender style of patient performance

Patients whom I characterise as adopting the *offender* style of performance were on the increase at the time of the fieldwork owing to the negativity surrounding the treatment of personality disorder. In its pure form the *offender* style of patient performance can be situated at the criminological end of the medical-criminological continuum and the people end of the people-object dimension (see Diagram II). These patients appeared to believe they arrived at their current position as a result of their criminal activities and as such remained uninterested in ward staff attempts to treat them for any underlying personality disorder. They accepted responsibility for their crimes and in turn expected to be respected as responsible adults and to be allowed to serve, what they perceived to be the appropriate tariff for their offence, in peace.

Patients who adopted the *offender* style of performance seemed to regard themselves primarily as prisoners. They only viewed the hospital as offering slightly more comfortable accommodation and, in the post Blom-Cooper (1992) era, a more relaxed regime than most high security prisons.

> In here there is a veneer of friendship but they won't hesitate to search you but obviously prison is harder and there's no pretence at friendship (CP:5).

But this particular perception was rapidly altering at the time of the fieldwork as the full impact of the security clamp-down came into force. Despite the less severe environment of the Special Hospital these patients generally felt that they would have been better off serving their time in prison. A view clearly expressed by one patient:

> I don't know why I came here. I would have preferred prison, it's easier to understand that you're being secluded from society as a punishment but here they claim they're trying to treat you but you don't see it (EP:5).

This was essentially because they believed they would have served a determinate sentence of much shorter duration in prison than most had already spent in the hospital. Beyond the determinacy of prison sentences patients who adopted the *offender* style of performance most valued the adult way in which they believed offenders were dealt with in prison. As one patient said:

> The main difference compared with prison is here we've got no creditability, everything is dissected, analysed, rejected - very negative (EP:3).

They felt that in return for prisoners taking responsibility for their offences and behaviour they were able to earn the respect of those who managed them. These patients were generally prepared to be punished for their rule-breaking in the hospital if they felt that the punishment was fair and immediate. But they felt that the recording of such incidents was often unnecessary and the repercussions too great. One argued:

> If a patient does something wrong it should be dealt with there and then, shouldn't judge us on past or possibilities in the future. They can't expect 100% good behaviour, we do get angry and upset, do silly things but regret it later (DP: 3)

Many expressed the view that they never knew where they stood in the hospital and resented the interference and patronising manner of ward staff who represented the medical end of the medical-criminological spectrum. They disliked the way these ward staff constantly tried to engage them in therapy, in particular the way they included recreational and work activities in their treatment plans: ' I resent staff trying to package attendance of workshops up as treatment, so I'm seen as refusing treatment' (BP:2) (as the patient was not going to work). They seemed to be happy to have social intercourse with staff - playing cards, having a joke or taking part in sports - as long as it was regarded as non-medical. These patients tended to try to make the best of their surroundings, utilising any apparently non-medical options, and earn as great

an independence as possible, aiming at gaining parole and trusted job status, within the secure environment. One member of staff described such a patient:

> with some you don't have to do anything - for example one patient who does gardening goes out early in the morning, comes in for lunch, goes out and comes back late. The only stuff we have to do for him is stuff the hospital won't allow him to do for himself (AS11:N).

Patients who adopted the *offender* style of performance also felt that the clear and rigid rules of the prison system and Moss Side Special Hospital offered them greater guidance and protection than today's mission statements and theoretical philosophies which were too open to interpretation. They perceived there to be some benefit to the new security manual which was seen as providing a more consistent set of security procedures.

These patients tended to accept some responsibility for their offending behaviour although they were still likely to refer to any mitigating circumstances. They appeared to prefer the status of criminal to that of madman; trying to normalise their own crimes and distance themselves from patients who they believed to have committed 'real' acts of madness and perversion. One patient, when referring to his transfer onto a new ward, explained:

> I was told I was moving here when the paedos' (paedophiles) left the rooms vacant. I didn't like it at first due to it's sex offender credentials. Describe the ward as having some of the bad cases, child molesters and rapists. It sickens me (BP:3).

They would only engage in therapeutic interventions which appeared to be directly related to their index offences - such as rehabilitation schemes for drug and alcohol abuse or anger management.

Patients who adopted the *offender* style of performance were regarded by both ward staff and patients, at the criminological end of the medical-criminological continuum, to represent the least trouble of all PDU patients as they were able to take care of themselves, where possible, and tended to try to

play the system. In return these patients appreciated the fact that they can have a joke with the *custodians* and occasionally let off steam, verbalising their frustration with a string of profanities, without automatically being recorded.

However, ward staff who were characterised as adopting the medical end of the medical-criminological dimension believed that although a number of these patients had been in the system for twenty or more years they could be considered no nearer release than a new admission.

> Patients been here ten to fifteen years, kept their noses' clean and thought they were getting out. Now they're refusing treatment which is frustrating (DS8:WM)

Ward staff expressed the view that whilst in the past patients might have been able to keep their head down and gain release (Dell & Robertson, 1988) this was no longer possible, and that now patients had to be willing to actively participate in all aspects of their treatment plan. Patients who adopted the *offender* style of performance were still considered to be dangerous by both ward staff and patients as one patient observed:

> the parole ward here is full of psychopaths, just means they're no longer getting caught at what they did before they got parole (EP:1).

Patients who adopted the *offender* style of performance were likely to have experienced a long career in secure institutions beginning in an approved school or prison, and progressing to Broadmoor or Moss Side Special Hospitals. In all of these establishments the regimes were highly regimented and the emphasis firmly placed on security, discipline and control. They all promoted the 'mentality, keep your head down and get out' (DS8:WM). Patients who adopted the *offender* style of performance continued to believe that the unofficial tariff (Dell & Robertson, 1988) which was in operation in the past continued today and their attitude could influence new patients coming into the system.

> The problem is with patients who think they've done their time and shouldn't be here. They'll do the courses but won't take it in. New patients can learn this pattern of behaviour (CS3:N).

There has also been a policy instructed increase in the number of prison transfers, encouraged by the Reed Committee (1994) and hospital medics, as this allows patients to be returned to prison if treatment fails. It is probable that a significant percentage of patients will continue to perceive themselves primarily as prisoners on their transfer to the Hospital. The *offender* style of performance has clear similarities to the prisoner adaptations, 'doing your own bird' and 'opportunism', identified in King and Elliott's (1977) prison study.

Patients who could be characterised as adopting the *offender* style of performance could often be found waxing lyrical about the good old days in prison or Broadmoor, rarely Moss Side, where they recalled: being left alone; being treated like adults; receiving fair judgements from ward staff they had reciprocal respect for. Although, there did not appear to be a strong inmate culture running throughout the Hospital or even on individual wards, 'not a community - a lot of people doing time - trying to get through' (EP:3), patients' shared history could at times create a transitory camaraderie when they sat round after meals swapping tales.

Patients who I have identified as adopting the *offender* style of performance appeared to be most likely to perceive the *custodian* style of staff performance to be legitimate. In particular owing to the respect, consistency and fairness these staff tended to develop in their social relations with patients (see Chapter Three).

Sick style of patient performance

Patients whom I identify as adopting the *sick* style of patient performance were a small but long term group with a high co-morbidity rating. In its pure form it can be found at the medical end of the medical-criminological dimension and the object end of the people-object continuum (see Diagram II). These patients

tended to closely fit Parson's (1953) sick role - they perceived themselves to be ill and as such incapable of self repair or taking responsibility for their actions.

Patients who adopted the *sick* style of performance believed that the symptoms of their illness could be treated most effectively in a hospital. However, they were unlikely to regard the PDU to be the best place for them. They considered that their high co-morbidity rating meant that their mental illness diagnosis should take priority over their personality disorder diagnosis. To this end they would constantly refer to themselves as mentally ill, restating any earlier diagnosis of mental illness or fixating on the mental illness part of their dual diagnosis.

In part this was because these patients perceived that their chances of release would increase if they were primarily seen as mentally ill, and hopefully treatable, rather than personality disordered. These patients would bargain to be seen as *sick* because they wanted to be moved out of the PDU and onto one of the mental illness wards which they believed to be less autocratic and safer than the PDU. Relocation to the Mental Illness Unit (MIU) tended to be seen as desirable to these patients, whether they wished to be released or not. In some cases patients did not want to leave the safety of the Hospital but simply felt they would have a more comfortable life on the MIU. One patient who was constantly remonstrating for a change of location, within the hospital, maintained:

> I shouldn't be here as I'm mental illness not PD. . . . It's quite daunting on here with some patients scheming 24hrs a day (EP:1).

Patients considered that if they could be successfully accepted as *sick* it would improve their quality of life in the Hospital as they believed ward staff treated patients whom they perceived to be mentally ill with more compassion and forbearance than those they perceived to be personality disordered. To be accepted as *sick* was viewed as infinitely preferable to being viewed as personality disordered. Those who adopted the *sick* style of patient performance, in the same way as patients who adopted the *offender* style of

performance, wished to repudiate any association with personality disorder, or more exactly psychopathy, and all its negative connotations (see Chapter One). Parsons (1965) found that those who cared for the sick were expected to suspend all personal disapproval and, 'within wide limits, not to be shaken by what the patient does' (Parsons, 1965: 615) or has done in the past. One patient outlined the difference in ward staff attitudes towards patients with mental illness and personality disorder diagnoses:

> MI treated like human beings. PD treated like caged animals. . . .for MI patients if they kick off it's part of their illness, if you are PD then it's considered part of your supposed character. (EP:3)

Patients, therefore, adopted the *sick* style of performance because they felt it absolved them of responsibility for their behaviour. This was because a diagnosis of mental illness could be attributed to some underlying chemical or genetic malfunction, 'forces beyond their control' (Parsons 1978: 21), rather than a personality trait. These patients believed that adopting the *sick* style of performance enabled them to distance themselves from their crimes. They could claim their crimes were committed as a result of their illness and advance the possibility, if they could show they had recovered, of release. This meant that they would refuse to take part in any therapeutic interventions which they considered to be directly related to their crimes.

Ward staff who operated at the criminological end of the medical-criminological continuum regarded patients who adopted the *sick* style of performance to be merely using it as a way of denying their criminality. Whilst *clinicians* tended to reject patients adoption of the *sick* style of performance as nothing more than an attempt to manipulate the system. Therefore, although an inability to take responsibility for one's actions is considered to be a basic trait of personality disorder (see Chapter Two), ward staff were reluctant to allow PDU patients to negotiate a *sick* style of performance. This was because Parson's sick role presumed a patient 'can't help it' but 'where scientific evidence is not available the tendency is to give the benefit of the doubt to the

possibility that he can help it' (Parsons 1965: 284) (see Chapter Two). As the evidence surrounding personality disorder remains inconclusive and all the patients on the PDU had a primary diagnosis of personality disorder it was highly unlikely that they would be accepted as *sick* by the ward staff.

Where ward staff did recognise that patients were showing signs of mental illness on the PDU the reality appeared to be that they were treated and spoken about in highly dismissive terms as 'inadequate, dual diagnosis, rather than classic PD' (DS4:N). It was observed, that when ward staff had more demanding PDU patients to deal with, those who adopted the *sick* style of patient performance, often older, infirm and low intelligence patients, were likely to get ignored.

The biographic history of those who adopted the *sick* style of patient performance appeared to be one of long term residential care. As long term residents of total institutions, where their autonomy was likely to have been greatly restricted (Goffman, 1961), the patients had become dependent on others as they have been given few opportunities to learn 'to take responsibility for themselves or make their own decisions' (AS9:N). As a result of this these patients had perhaps gone through a process of 'learnt helplessness' (Seligman, 1975) whereby it had possibly become easiest for them to adopt the non-responsible *sick* style of patient performance. It was also clear that the perceived way in which patients with a mental illness diagnosis were treated better, and had a greater opportunity of release, than patients with a personality disorder diagnosis meant that if patients believed themselves to be, at least in part, mentally ill they may attempt to be accepted as such.

Patients who I identified as adopting the *sick* style of performance appeared to be most likely to perceive the carer style of staff performance to be legitimate. This was because this style of performance best supported the patients' belief in their status as 'sick' (Parsons, 1953) (see Chapter Three).

Loner style of patient performance

Patients whom I characterise as adopting the *loner* style of performance were increasing in number at the time of the research as patients began to lose hope in the Special Hospital System. In its extreme form it can be located at the object end of the people-object continuum (see Diagram II). Such patients appeared to reject their existence within the Hospital as meaningless and would try to isolate themselves from, what they perceived to be, the harsh reality of everyday hospital life and shun interaction with others.

Patients who adopted the *loner* style of performance were extremely asocial and where possible would shy away from human contact by remaining in their rooms and performing lone activities, such as playing computer games, watching television, listening to music or drawing, in an attempt to kill time. In effect they opted out of hospital life, regarding the changing philosophies and regimes as farcical, literally suspending their day to day existence, an adaptation Goffman (1961) called 'situational withdrawal', through the unconsciousness of continual sleep or daydream. They believed that treatment would be of no benefit to them, either medically or in terms of release, and resented ward staff attempts to make them face the devastating reality of their situation. This also meant that these patients were unlikely to attend a work placement. Any relationships they did form with other patients tended to be focused on the negative aspects of their personalities.

This style of performance was considered fruitless by staff who operated at the medical end of the medical-criminological continuum but many staff at the criminological end appreciated the fact these patients tended not to bother them with requests. However, as these patients were difficult to monitor, staff remained highly suspicious of them.

Patients who adopted the *loner* style of performance might have entered the Special Hospital with a sense of personal alienation from the outside world and see their placement in the Hospital as confirmation of this. They did not believe they should be in the hospital and therefore automatically rejected all aspects of the Hospital.

However, the majority of patients whom adopted this style of performance were likely to have entered the hospital with the expectation that they would receive help and on completion of treatment that they would be released. They may have originally adopted a medical style of patient performance but because they felt they had received little or no treatment, or because they were constantly told by ward staff and the outside world that there was no hope for them (see Chapter One), they had relinquished their medical style of performance and adopted an *loner* style of patient performance. Equally, patients who cherished their adult status may have surrendered to the constant attacks on their self and retreated into themselves (Goffman, 1961). Finally, patients might have been spurned by ward staff and patients because of their index offence. It may have been easier for these patients to isolate themselves rather than deal with the constant rejection of others.

Patients who I have identified as adopting the *loner* style of performance appeared to be unlikely to perceive any of the staff styles of performance to be legitimate as they rejected the system and beliefs the staff represented and shunned all social relations with them (see Chapter Three).

Adult style of patient performance

Patients who adopted the *adult* style of performance were likely to adopt it in conjunction with another style of performance - namely the *offender* or *personality disordered* styles of performance. In its pure form it is positioned at the people end of the people-object spectrum (see Diagram II). Patients who adopted this style of performance focused on keeping their independence as adults and maintaining the social status they perceived themselves to have obtained before they entered the Hospital rather than a medical or criminological status.

Patients who adopted the *adult* style of performance attempted to behave within the rule-bound and social constraints of the wards. They were aware that if they wished to be allowed to adopt the *adult* style of patient performance

they must first earn the respect of ward staff by displaying a knowledge and awareness of the rules of conduct of the institution (Goffman, 1967). Equally, they did not want to forfeit their chances of release by being perceived to be operating outside the principles of the Hospital. Within these boundaries they attempted to reject the contamination and mortification of the self, a product of the 'economy of action' inherent in the total institution, which Goffman (1961) found could weaken natural adult autonomy and masculinity.

These patients attempted to refute the process of institutionalization which could destroy their self image and place unrealistic expectations on them to curtail all emotional responses in a bid to appear to tow the line. In plain terms these patients objected to being handled like children; as one patient said, 'only the odd staff treat you like a grown up' (AP: 1). These patients did not like their actions to be automatically medicalised and reported:

> I get enough interaction as I'll talk to any one but you know if you argue they'll walk away with a pen in their hand, so you can't lose your temper. Problem here is there's not enough to allow normality. (CP:1).

However, patients who adopted the *adult* style of performance were prepared to negotiate for their position, refraining from open displays of frustration and anger, in order to gain privileges and retain their overall separateness.

Where ever possible these patients would attempt to act independently and take responsibility for performing basic living tasks. This was most easily achieved if the patient had parole status and lived on a low dependency ward. This could mean that the patient was able to go to work without escort or continuous observation throughout the day. Equally parole patients lived on wards with minimum structure which meant they were left to get up and go to bed on their own and to cook their own meals (see Chapter Five). These may sound like small concessions but in a total institution where everything is routinized these mundanities take on a greater importance in restoring a sense of dignity and quality of life to patients (Sykes, 1958; Goffman, 1961).

These patients did not shy away from social interaction with both ward staff and patients who they felt shared similar interests, such as sporting or musical, to themselves.

Patients who adopted the *adult* style of performance were most likely to be accepted by other patients often being looked upon for support. They were also likely to relate well to ward staff who adopted the equivalent staff *adult* style of performance. This was because these ward staff accepted the patients as individuals, dealing with them on a personal level, without prejudging them on the basis of their index offences. Any problems between such ward staff and patients were considered to be an everyday clash of personality and where they found mutual interests bonds of friendship could be formed. Equally these patients were likely to respond well to *custodians* who offered them a certain level of respect and independence.

> Patients are quite amenable but outspoken. Those who think they're highly educated can be subversive but if you talk to them and don't get ratty they'll listen. (CS5:NA)

However, staff who operated at the medical end of the medical-criminological continuum objected to patients adopting an *adult* style of performance. They expected patients to relinquish their self identity before they could be considered to be fully participating in any treatment plan (Stockwell, 1984).

Patients who were most likely to adopt the *adult* style of performance entered the hospital with a well established sense of self which they attempted to maintain by keeping up their contacts with the outside world. They were likely to have entered the hospital later in life than other patients. A number were in the prison system previously and refused to adopt a medical style of performance, as with patients who adopted the *offender* style of performance, because they believed it diminished their status as independent adults.

> It's all about toleration and respect. It is important to be able to take on the perspective of other persons. You have to respect personal space and maintain self-esteem and dignity. (CP: 8)

Patients who I have identified as adopting the *adult* style of performance appeared to be most likely to perceive the *adult* and *custodian* styles of staff performance to be most legitimate. This was because these styles of staff performance invited patients to negotiate individual and adult respectful relationships with staff at a 'social' level (see Chapter Three).

Psychopath style of patient performance

What I shall call the *psychopath* style of patient performance, although at the time of the fieldwork the most uncommon of the patient styles of performance, had the greatest impact on day to day life on the PDU. In its pure form it can be located at the criminological end of the medical-criminological continuum and the object end of the people-object dimension (see Diagram II). These patients were openly asocial in their rejection of their position as patients and the Hospital as a whole.

The *psychopath* style of performance was adopted by patients who rejected their need for treatment as patients and, unlike those who adopted the *offender* style of patient performance, tended to object to being punished for their crimes. They tended to reject all ward staff interaction, whether it be clinical, offence-led or social, and tried to challenge the system, and the ward staff as representatives of the system, at every turn. This style of patient performance was similar to that described by Goffman (1961) as the 'intransigent line' adaptation.

Specific situations in which those who adopted the *psychopath* style of patient performance demonstrated asocial behaviour will be discussed in Chapter Eight but it is necessary to identify the more general ways to demonstrate the *psychopath* style of performance. The most common form of asocial behaviour was verbal abuse and threats which were likely to result from ward staff failing to respond to patients' requests immediately. Ward staff performing security tasks, especially room and person searches, were a particular focus for patient hostility.

The highly volatile, younger patients who adopted the *psychopath* style of performance were most likely to express their displeasure through aggressive physical outbursts which could be directed at inanimate objects or people. They could also carry out minor acts of sabotage which would lead to a great deal of ward disruption; when a patient removed a ward lighter all areas had to be searched before it was recovered which was both time-consuming for ward staff and upsetting for other patients.

The older, more intelligent *psychopaths* were likely to employ official channels to make their objections known. They tended to use the hospital complaints system, mentally noting ward staff infractions of the rules, to revenge themselves against particular ward staff. One younger member of ward staff voiced his concern that the patients were

> constantly watching you, storing up verbal complaints until you refuse them something - so I always wash my hands in front of them before serving meals (CS4:NA).

When patients no longer felt that the Hospital complaints system was representing their viewpoint they could start legal litigation against individual ward staff or the Hospital. This approach was favoured by a few long stay patients who appeared to relish the opportunity to 'challenge the system' (CS3: N). Some patients employed a number of solicitors for this purpose. The main focus of complaint being that they were no longer receiving treatment and should therefore be released. These forms of non-physical disruption and challenge tended to be considered most common to the PDU as one patient observed:

> physical trouble is rare here - (patients are) intelligent although (they're) PD. I call them white collar lunatics. (BP:3)

Patients who adopted the *psychopath* style of performance were highly unlikely to be received positively by either ward staff or patients on the PDU. The vast majority of ward staff and patients considered that these patients were both a

short-term physical and long-term psychological danger, 'those in your face and those working behind the scenes' (AS1:TL), to them.

However, as long as their behaviour did not directly effect particular ward staff or patients some expressed the view that short lived outbursts of anger relieved the monotony of ward life. *Screws* relished such opportunities to get their adrenalin going and to respond with physical restraining techniques.

Ward staff viewed the *psychopath* style of patient performance as inevitable and blamed patients' disruptive behaviour on their disorder because this made them 'manipulative - unable to cope with pressure or accept their problems' (ES2:NA). They were also seen as 'immature, selfish, self-centred, misfits, loners - don't make friends easily and lack social skills' (AS8:NA).

Both ward staff and patients disliked the long term insidious behaviour of the *psychopath*. Staff were fearful that patients who adopted the *psychopath* style of performance held the balance of power:

> patients . . have the upper hand and could lose you your job tomorrow for doing nothing. We are guilty until proven innocent. The patients are dangerous if you do not give in to them (CS11:NA).

Both ward staff and patients were fearful of the subversive nature of those who adopted the *psychopath* style of patient performance. This was because many of their illicit activities remained undetected until the damage was already done. These patients were generally disliked as ward staff considered them to be very time-consuming and patients believed that 'if something happens on another ward we get punished; so then we're all the same - all dangerous' (AP:7).

Patients who adopted the *psychopath* style of performance appeared to show a deep loathing of the Special Hospital System and all those who represented it. This may have developed at different times in their Special Hospital career.

Some patients would react as soon as they entered the hospital in an immediate rejection of confinement and all that it entailed. To a certain extent

these patients were simply not prepared to constantly strain to the institutional line. Goffman (1961) identified this as the 'intransigent line' adaptation and argued at some point in the future patients' fury would burn out and their self deception would abate. It certainly appeared, from the reports of ward staff and patients, that a number of PDU patients fitted into this category. However, a small number of patients were cited as having sustained this style of performance for many years. They were likely to have been moved around the hospital significantly more often than the average patient, in particular these were patients with a dual diagnosis who could be transferred between mental illness and personality disorder unit wards, occasionally touching base in the joint intensive care unit.

Patients may have entered the Hospital with hopes of treatment and rehabilitation but have come to the realisation that they were highly unlikely to be released because of the suspicion, whether founded or unfounded, surrounding their commitment to change and fears about their future risk (Prins, 1999). One patient expressed his hatred of the system:

> I loath the ward, staff and patients. It's almost entirely negative, degrading, dismissive, abusive environment. Nobody understands PDs., how to deal with them, that's the root of the problem (EP:5).

Patients were left with little incentive to behave with the promise of freedom removed. Ward staff and patients believed internal incentives to be diminishing, at the time of the fieldwork, as increased security restrictions were reducing any real distinctions between the admission wards and parole wards. As one patient remarked:

> what normal people would stay locked up for twenty-seven years without trying to escape or attacking someone? . . Recently we've realised the carrots aren't there any more and discontent will lead to violence (CP:7).

The obvious revulsion and forceful nature of some ward staff, particularly *screws*, could also help push some patients towards the *psychopath* style of performance.

In the current climate this style of performance appeared to be adopted by very few patients, although many ward staff believed it to be only because patients were becoming more cunning. It is only necessary to look at the recent history of Owen and Lawrence Wards (Fallon Report, 1999) to see how easily those who adopt the *psychopath* style of patient performance can take a dominant position on a ward.

Patients who I have identified as adopting the *psychopath* style of performance were likely to perceive all styles of staff performance to be illegitimate in the same way as those who adopted the *loner* style of performance are likely to do. Again, this was because they objected to the reasons for their confinement, the Hospital itself and were unwilling to negotiate social relations with the representatives of the system of confinement (see Chapter Three).

Table V: Summary of styles of patient performance

Style of Patient Performance	Attitude to Self	Attitude towards ward life & staff	Response of staff & other patients
Personality Disordered	View as Personality Disordered but wish to be given responsibility & respect of adults.	Participate fully in treatment which they expect staff to deliver.	Viewed positively by Medical staff & patients although suspicion surrounding their sincerity.
Offender	View as Criminal & reject medical diagnosis. Wish to be regarded as responsible adults, receive punishment & leave.	Only participate in offending related therapy, interact socially with staff & pursue non-treatment activities to pass the time.	Considered least trouble by Criminological staff but frustrate Medical staff. Interact well with other patients.
Sick	Focus on mental illness part of diagnosis and take no responsibility for offence.	Reject PDU & expect most assistance from staff. Believe they can be treated.	A lot of work for all staff. Patients & staff view them as annoying and childish.
Loner	View themselves as existing in limbo & refuse to acknowledge disorder or offending behaviour.	Shun interaction with vast majority as futile. Attempt to isolate themselves from the everyday reality of ward life.	Other staff & patients understand their attitude & appreciate the fact they appear to cause no trouble. Although they arouse suspicion as an unknown quantity.
Adult	View themselves as adults who are capable of taking care of themselves. Willing to try to earn respect & responsibility as adults.	Participate fully in social interaction & work activities but only participate in treatment programmes at a superficial level.	Criminological & People staff respond well to this group & trust & friendships can be formed but Medical staff perceive them to be unco-operative.
Psychopath	View selves at odds with the system & all who represent it. Do not accept in need of treatment or punishment.	Disrupt the ward with verbal abuse, acts of sabotage & complaints & legal litigation against both staff & Hospital.	Universally rejected although some staff & patients believed that at least minor disruptions relieved the monotony.

Table VI: Analysis of distribution of styles of patient performance on the PDU

(*Italics* highlights the most significant styles of patient performance on each ward)

Styles of Staff Performance	Ruskin	Newman	Owen	Lawrence	Macaulay
Personality Disordered	Small number as most have not come to terms with their disorder.	Small number as number of co-morbidity & long term patients.	*Most common as ward focuses on treatment participation.*	Few as patients were being reassessed & restarted at the beginning of the treatment process.	Small number as number of co-morbidity & long term patients.
Offender	A small number but most do not accept need for punishment.	Small number owing to co-morbidity & tolerant atmosphere.	Few as expected to acknowledge need for treatment.	A number as patients were not receiving treatment.	Small number as patients felt they were ill & not responsible.
Sick	Few who were co-morbidity & highly disruptive.	*A number who were considered co-morbidity & supported as such by staff.*	Not detectable as expected to acknowledge primary personality disorder.	Not detectable owing to lack of sympathy & reassessment process.	*Quite common as a number of long stay who have moved around hospital & receive support.*
Loner	Small number who have been sent here because they rejected treatment.	Not detectable owing to inclusive approach.	Small number who feel the ward is not fulfilling its promise.	*Most common owing to the Inquiry, lack of treatment & progress.*	Small number who believe they have been forgotten about.
Adult	Not detectable as it is difficult to earn the respect of staff.	Few who take on responsibility for other patients.	Very few who have built relationships with some staff but not encouraged.	Not detectable as trust broken down in wake of Inquiry.	Very few who take responsibility for other patients.
Psychopath	*Most common as the ward for actively disruptive patients.*	Very few as staff allow patients to vent their frustrations.	Very few openly disruptive but some complain against the system they believe has failed them.	Very few owing to the current apathy on the wards.	Very few openly as freedom & indulgence but some complain about failing to make progress.

In conclusion the above identification and examination of the reasons why and the ways in which PDU patients responded to the uncertainties and difficulties surrounding their institutional life, future and ward staff on PDU has shown that like the staff there were significant differences in patients' choice of performance. A small number of PDU patients appeared to reject outright their containment in the Hospital thus seriously diminishing any chance staff had to establish legitimacy and negotiate social relations with this group. However, it would appear that the vast majority of patients for a variety of reasons, at the time of the research, were open to the possibility of negotiating social relationships with and responding positively to those ward staff who they perceived to be legitimate in their style of job performance. In general terms it appears that it would be those ward staff who adopted the *custodian* style of job performance who would be most successful in negotiating social relationships with the greatest number of PDU patients.

CHAPTER EIGHT

Order on the Wards

Introduction

In Part II I have described and analysed the ways in which the wards on the PDU operated, the number and types of official incidents which occurred on each ward (see Chapter Five), the styles of performance ward staff developed to manage PDU patients (see Chapter Six), and patients' responses both to their position on the PDU and to ward staff (see Chapter Seven). I will now show, by interpreting staff-patient interaction, how and why everyday life on the PDU is affected by these different variables in terms of order and disorder.

In this way I intend to show that although the public and political perception of PDU patients is that their behaviour will be both dangerous and bizarre (see Chapter One) that for much of the time their behaviour was both 'normal' and predictable. External pressures have resulted in the hospital management focusing their attention and resources on the PDU but paradoxically the hospital's incident database showed that the majority of incidents at Ashworth occurred on the mental illness and women's side of the Hospital.

I do not, of course, claim to be fully conversant with all, or even the majority, of acts of rule breaking that occurred on the PDU, as by their very nature *sub rosa* activities and psychological abuse are very difficult to detect. However, where possible I will take these into consideration.

I will demonstrate that at an everyday ward level, despite the air of negativity surrounding it, that the PDU appeared to be working because the vast majority of ward staff and patients did not want to work and live in a state of disorder and chose to strive towards order. A common observation of ward staff was:

> Patients get on no different from twenty men anywhere. They have their jealousies, dislikes but considering the length of time they spend together they do very well. (CS7: NA)

Many patients were equally aware of the situation:

> A lot of people in here could do terrible things if they wanted to, but they choose not to. (CP:7)

The aim of this chapter therefore is to demonstrate how and why ward staff could avert potentially disruptive situations on the PDU through the most appropriate choice of action under the circumstances based on their knowledge of the situation and the patients involved (see Chapter Three). Finally, I intend to show how and why ward staff appeared to be able to maintain a stable order on the PDU through their negotiation of 'right' social relations with patients (Liebling & Price, 1999) (see Chapter Three). This has been found to be key to improving patients' experiences of hospitalisation in the nursing literature (Morrison, 1994) and prisoners' perceptions of imprisonment in the criminological literature (see Chapter Three).

Potential, opportunity and motivation to 'do terrible things'

The PDU is populated by a group of men who have been found to be dangerous (MHA 1983) and are currently regarded by many psychiatrists to be immune to the effects of either treatment or punishment (Home Office, 1999a) (see Chapters One and Two). A large percentage of PDU patients have been found guilty of gratuitous acts of physical and sexual violence (see Chapter Two). Although the search for a treatment or treatments for personality disorder is still very much an ongoing process (Mitchell & Blair, 2000) these individuals have been involuntarily and indefinitely confined in a high security institution. In the current political climate PDU patients have a very limited prospect of release (Home Office, 1999b) (see Chapter One). This may be expected to create problems of control and management within the institution, just as the 'ill-judged decisions' of the then Home Secretary Leon Brittain,

whereby he introduced a minimum tariff of twenty years for some lifers of twenty years, created considerable problems within the prison system (King & McDermott, 1995).

The common-sense expectation is that if a number of people who are perceived to be, have been shown to be, and have been told that they are dangerous and mentally unstable, are placed together against their will for an extended and indefinite period of time that there is the potential for considerable disorder. The likelihood of disorder is increased by virtue of the fact there was little real long term motivation left for PDU patients to behave.

The fieldwork for this piece of research took place during the Fallon Inquiry (1997-8) when the PDU was in a state of flux. It is arguable that it is precisely at a time when new policies and procedures are being introduced and the incarcerated population are being faced with uncertainty and a lack of predictability that unrest and rule-breaking were likely to occurred (Home Office, 1991). Both ward staff and patients expressed the belief that the hospital management was expecting violence since all the windows of the wards had recently been reinforced.

As a result of his perceived dangerousness and by the nature of his confinement in a total institution, the PDU patient is subjected to considerable material deprivation and severe restriction on his adult autonomy (Goffman, 1961). In such circumstances frustration, irritation, emotional, verbal or violent outbursts could be considered highly probable for all but the most tolerant and so-called sane, sociable person. Sykes (1958) found that incarceration made the likelihood of crime highly probable:

Subjected to prolonged material deprivation, lacking heterosexual relationships, and rubbed raw by the irritants of life, the inmate population is pushed in the direction of deviation from, rather than adherence to, the legal norms. (Sykes, 1958: 22)

New security restrictions, introduced in the wake of the Fallon Inquiry (1997-98), and new Health and Safety requirements themselves a product of NHS reform were having a significant effect on patients' lives: On higher

dependency wards patients had to request to be let into the kitchen to get a cup of water. A restriction was placed on the use of the telephone which required patients to ask ward staff if they could make a telephone call, which could only take place if staff were available for the whole duration of the call. The 'treat' of an occasional take away meal was diminished by the fact that they could no longer be reheated. Patients were expected greatly to reduce the amount of personal property they kept in their rooms because of the fire risk and to enable effective room searches. Goffman (1961) found that such indignities could be perceived to be highly brutalising, degrading and humiliating to patients.

However, despite the restrictive nature of the PDU, its position in a National Health Service hospital meant patients did have a certain amount of freedom of movement and activity within the ward environment. This 'creates a situation in which crimes among inmates are possible' (Sykes, 1958: 17). On the lowest dependency ward patients had some access to each other's bedrooms and free twenty-four hour movement in some of the communal areas. On the highest dependency ward patients were permitted to be in their rooms outside work and meal times and in the side-rooms of the communal area outside work hours and in the evenings. This meant patients could spend a significant amount of time whilst on the wards in the company of fellow patients unobserved by staff. During this period, apart from the occasional therapy session or if patients were carrying out ward work, patients had no official occupation on the wards and as Dunbar (1985) found an 'idle prisoner is a dangerous prisoner' (Dunbar, 1985: 22-23).

Therefore, PDU patients if they should wish to do so have the time, the space and the opportunity to break the rules.

PDU staff as nurses working in a hospital had limited recourse to official mechanisms of control. Ward staff did not have the power to impose many of the official sanctions without referral to the Patient Care Team (PCT). They therefore remained relatively powerless on a day to day basis. Patient Care Teams, rarely appearing on the wards, did not offer them sufficient support,

and staff expressed the view that their decisions were often lenient and left them in a difficult position.

The PDU rhetoric suggested that if patients worked hard they could earn a privileged place on a low dependency parole ward or independent structured living ward (see Chapter Five). However, many staff and patients feared that the new hospital-wide security requirements had eliminated the main distinctions between the wards, the only remaining differences being in-house rules and the zeal with which the staff applied security measures (see Chapter Five). A patient on a lower dependency ward commented on the unrest which had already been created by the blanket security restrictions:

> The ward is not smooth running now because of the new rules which are too strong for a parole ward. It's upset the atmosphere between staff and patients - now they've stopped certain activities and security items - as a result of the non-justifiable management rulings. Now the patients are fighting to get off the ward. (AP:1)

Finally, as patients on the PDU were being held for an indefinite period of time the ultimate prison sanction of loss of remission could not be used as a means of control.

It is clear from this review of the current position of PDU patients that they had the potential, the opportunity and perhaps the motivation to behave in asocial and disorderly ways.

Officially Ordered

Recording of Interactions as Quantifiable Incidents

A review of the official hospital statistics on incidents on the five PDU wards in Chapter Five showed that when order was assessed in terms of quantifiable incidents, the PDU had the appearance of being the most smooth-running unit in the hospital. This finding was corroborated by the testimony of staff and patients on the PDU at the time of the research, in particular those who had experienced life in other parts of the hospital (see Chapter Five). This is the first level at which it is possible to show that despite external and management

beliefs that disorder was most likely to occur on the PDU that this did not actually appear to be the reality of the situation.

It is important to look at the way in which potential incidents were assessed and recorded before the quantitative data can be said to show in fact that disorder appeared to be least likely on the PDU.

All the incidents which appeared on the hospital's incident database, having been entered into its computerised Incident Reporting System (IRS), would also have been recorded in the ward Day Report (DR) and individual patient's clinical notes. However, not all information which was entered into the DR or patient's clinical notes appeared in the official hospital statistics.

Incidents which are logged into the IRS are those which qualified ward staff believed needed to be officially recorded. The decision to record an event as a category A-D incident was likely to be dependent on a number of variables, including the staff member's understanding of the IRS, their perception of the incident and the events surrounding it, the nature of the ward on which the incident occurred, their adopted style of performance and their perception of the patient involved.

The IRS identified the four incident categories as A, B, C or D. Level D incidents are the least serious and include minor assaults, verbal altercations between patients, verbal abuse against staff, minor accidents involving a patient, minor property damage. The worst level incident was Category A which included any unexpected deaths, however caused. Category B incidents comprised any life threatening activity whatever the intention, severe assault, particularly with a weapon or involving strangulation, escape from a secure area or absconding from an escort, an escape plot, rooftop incidents which lasted longer than fifteen minutes, accidents involving any patient resulting in a major injury or conditions as outlined in the accident reporting procedure, serious sexual assault, serious fire. Category C comprised serious assault, significant destruction of property, drug/ alcohol abuse, sexual assault, all incidents involving the use of C & R techniques or locks, accidents involving any patients resulting in a significant injury as outlined in accident reporting

procedure, fire, an impulsive attempt to run away.

The different categories of incidents were considered by some ward staff to be easily distinguishable, but others felt that there was overlap between the different levels of incident categories. An example given was that there was 'some difficulty deciding between Cat B and C for assaultative behaviour' (ES4:N). Although the system included descriptions of the different types of incidents for each category level it was felt there was room for further clarification.

The belief that the IRS was difficult, cumbersome and time-consuming to use by a number of ward staff meant that they would avoid logging incidents or reduce their severity. This was because the higher the category of incident the more information had to be put into the computer and a greater number of people had to be informed.

> The IRS is flawed so not all possible Cat D's are logged. It does give incidents more importance but it can take three quarters of an hour to log a Cat D and anything higher means contacting a number of people which is difficult at weekends. It should be done by administration staff as it takes staff away from the problem. (AS1:TL)

> In the daytime I record as accurately as I can but at night it's different - depending on the severity I will class it down one. This is because, depending on the severity of the incident, you have to tell everyone from the chief exec. downwards and they don't want a phone call in the middle of the night saying someone's tried to kill themselves. It is not clear in the incident reporting system what a serious attempt on a life is. (CS8:N)

The member of ward staff quoted above described, during an informal conversation, how a female patient had seven ligatures round her neck but the incident was not recorded as a serious attempt on life to avoid the bureaucratic consequences.

One member of ward staff wryly observed:

> I believe they computerised the incident reporting system so incidents never got recorded - making the place look good. (AS9:N)

Subjective nature of quantitative incidents

The recording of incidents onto the IRS was inescapably subjective. This was of great concern to patients because the IRS was a key tool for off ward clinical staff in their assessment of patients' behavioural and mental status which affected their whole future.

The number of incidents recorded on different wards was partly a matter of logistics. On the PDU there were six staff per shift on higher dependency wards and only four on the low dependency wards which meant there were more staff available to observe problematic patient behaviour on higher dependency wards. A *custodian* from a higher dependency ward observed:

> There are few incidents considering the type of patient - ninety-nine percent are Cat D which other wards may not log. (ES11:TL)

Ward staff who had worked outside the PDU in other parts of the hospital, particularly on the women's side, felt that minor incidents were more likely to be recorded on the PDU because the number of incidents were so low. On some female and mental illness wards ward staff considered that there was not enough time to record all of the large numbers of potentially recordable incidents. However, the view was also expressed that disruptive behaviour by PDU patients was 'more subtle rather than violent' (ES9:N) and therefore less observable than the obviously violent behaviour which occurred on wards outside the PDU, and this accounted for the differences in recorded incidents.

In terms of their ward background, those ward staff who worked on highly security-orientated wards and who focused on disruptive behaviour and those ward staff who worked on treatment-orientated wards and who concentrated on personality disordered behaviour tended to be most likely actually to record incidents. In the first instance this was seen as a form of discipline or control, and in the second it was considered to be important for assessing treatment progress and patient risk. In terms of the PDU this meant

that incidents were most likely to be recorded on Ruskin and Owen wards. A *clinician* described his motivation behind recording incidents:

> Patients only see incidents being recorded as something that will upset their MHRT. An incident may be out of character, recording is to help the patients, it's vital - for example patients being pestered for sexual favours. Sometimes you have to involve security, the PCT or the police. The situation could happen again and someone could get hurt. Recording is a mechanism to get other people involved. My focus isn't security. If you were using recording punitively then you wouldn't bother to find out why patients were behaving in that way - we do. For example someone who is pestered for sexual favours may commit suicide or mutilate themselves so it needs to be recorded so we can help him. (CS9:N)

The recording of incidents was also dependent on the amount of time staff had worked on the ward in question. The number of incidents ward staff regarded as recordable reduced as they spent more time on a ward and learnt which behaviours were viewed as acceptable.

> When reporting incidents I may give patients the benefit of the doubt if I know they're having a hard time and apologise afterwards. I only report if they're malicious but some staff won't even report them to avoid the security label. When you first come on this ward you give Cat Ds all the time but it changes. (ES2:NA)

Whether an event was recorded as an incident and the level at which it was recorded was perhaps most dependent on the adopted style of performance of the ward staff who witnessed and recorded it. The main reason given for recording incidents was on the grounds of therapy and as such it was clearly *clinicians* who were most likely to record incidents. Because the recording of incidents could be perceived as punitive by patients, thus potentially hindering their progress towards release, it was also favoured by *screws*. *Carers* and *Custodians* were least likely to record potential incidents in a bid to maintain

good staff-patient relations and because they appreciated the difficulties of institutional life. [3]

Those staff who adopted the *clinician* and *custodian* styles of performance - more professionally trained and thus perhaps less easily influenced - were most likely to be consistent in their recording of incidents. The extreme relationships which could occur between *screws* and patients could lead to a greater likelihood of bias with incident recording. [4]

Some staff do play up the antecedents for patients they think are troublesome. (CS8:N)

One way to understand the decision making process by ward staff in the recording of incidents is in reference to the use of swearing on the wards. In many everyday contexts swearing is an acceptable form of adult expression and as such tends to be accepted as the norm by *custodians*.[5] Swearing was seen as an integral part of the playful banter which took place between ward staff and patients in communal areas of the wards. However, when ward staff judged the swearing as being linked to abusive or threatening behaviour they tended to no longer regard it as acceptable.

> It's difficult as we all swear jokingly - for some patients you should record but for others it would be six times a day and you know they don't mean it. It depends if it's threatening. (DS2:N)

Ward staff assessed the nature and context of an incident of swearing according to their perception and knowledge of the patient involved, the individual situation and any extenuating circumstances which they perceived to be

---

[3] Staff who adopted the *adult* style of performance were perhaps the least likely of all to record incidents.

[4] Staff who adopted the *adult* style of performance were perhaps equally likely to fall into the trap of bias when choosing to record or not to record incidents.

[5] Staff who adopted the *adult* style of performance were also likely to accept swearing as the norm.

relevant. Firstly, as indicated above, if swearing was viewed as a normal part of a patient's speech pattern, which was most likely in the case of those patients who adopted the *offender* or *adult* styles of performance, then it was unlikely that staff would make a record of it. But if it was considered out of character for a patient to swear then it might be recorded as an important indication of the patient's mental health. Secondly, ward staff said that it was not so much the actual words used by patients but whether the emotion they conveyed appeared playful or malicious - 'is it a threat to kill or a joke' (DS4:N). If staff perceived patients to be *adults* they were likely to opt for the former and if they regarded them to be *psychopaths* they would opt for the latter. Thirdly, if patients were considered to be under a lot of stress, perhaps as a result of family problems or an impending mental health review tribunal (MHRT), their language might be assessed, particularly by *custodians*, as excusable.[6] Patients were most likely to be given the benefit of the doubt if they behaved in a respectful and adult manner towards ward staff, behaviour typical of *offender* and *adult* patients and if they later apologise for their actions.

> I would include behaviour which is out of keeping but must look at the context. Some staff are trigger happy. Some patients just say 'fuck off' five times a day. I won't log immediately, see why and if they apologise. (DS5:TL)

Patients' response to the recording of incidents depended both on their perception of events and on the ward staff involved in the recording procedure. A lack of uniformity in the use of procedures could lead to feelings of injustice and thus delegitimate a system of power (Tyler, 1991). The majority of PDU patients expected and accepted that their rule-breaking behaviour would be recorded - 'if I'm verbally abusive I expect to be Class D'ed' (BP:2) - but were unhappy about the inconsistent nature with which events were interpreted and recorded. They also resented their lack of input into the process.

---

[6] Staff who adopted the *adult* style of performance were equally likely to accept such difficult circumstances as an understandable reason for swearing.

> Recording is necessary so that doctors are aware of any improvements but there's a problem with bias and shortening a report can make things sound worse, such as writing torrent of abuse. (BP:1)

Perhaps surprisingly there were a number of patients who believed that there was insufficient recording of incidents on the PDU:

> Everything should be recorded. I'm here to have my behaviour monitored but they miss things out - for example when I'm sullen or I miss a meal. They only pick up on extremely anti-social behaviour. Does that mean I'm an angel the rest of the time? They should do a page for each patient but the hospital's not geared up for that. (CP:3)

Patients were most likely to accept decisions made by the ward staff whom they perceived to be *custodians* because they believed these ward staff worked most consistently within the rules of the hospital and tried to be as fair as possible (see Chapter Three - Beetham, 1990).

In conclusion whilst the hospital IRS is a useful starting point to assess life on the wards of the PDU it must be noted that the official hospital statistics were compiled from the subjective judgements of individual ward staff and that the IRS was used inconsistently. Although the PDU appeared to be the most smooth-running unit in the Hospital it is necessary to be cautious in coming to this conclusion. In terms of physically harmful incidents, either self-inflicted or caused by others, it did appear to be safer than the rest of the Hospital. However, the Fallon Report (1999a) has shown that the 'dangerousness' of the PDU patient should not be underestimated when assessing whether a ward is running smoothly below the surface. As a number of ward staff, particular *clinicians*, warned 'the danger is when patients insidiously wear down boundaries' (AS2:N).

It is also possible to conclude that in official terms there was order on the wards of the PDU at the time of the research. In the hospital overall the PDU had both the lowest recorded, and arguably the lowest actual number of overtly aggressive and violent incidents. This finding is at odds with the external

perceptions of the PDU patient discussed in Chapter One of this thesis. If people are described as dangerous they are perceived to represent a serious risk of harm to others. These individuals have shown themselves to be capable of harming others in the past and their diagnosis implies this behaviour could re-occur in the future (see Chapter Two). However, at the time of the research there was very little official evidence of overtly dangerous behaviour on the PDU. Below I shall review why PDU patients' potential to behave dangerously and disrupt order on the PDU was not fulfilled.

Origins of Incidents

In this section I will describe how and why incidents occurred on the PDU. It is important to look at incidents to discover exactly what ward staff did to achieve their goal of maintaining order (Sparks & Bottoms, 1995). An examination of the origins of incidents on the PDU will show that the most serious incidents tended to be generated outside the PDU and that some problems were created as a direct result of the political response to PDU patients (see Chapter One). Incidents which had their origins inside the PDU tended to be more numerous but primarily mundane resulting from everyday staff-patient interactions. They tended to occur when ward staff and patients failed to recognise the everyday living problems that arose as a direct result of being in a total institution (Sykes, 1958; Goffman, 1961), rather than being a product of the extreme asocial tendencies of patients:

> I think they (patients) get on very well considering it's fifteen to twenty-five patients living in a small community. Most problems are based on daily living so we try to get them to sort them out, the same as staff. (ES6:TL) (*custodian*)

Below I intend to show that many of the incidents which occurred could be averted or reduced in seriousness if ward staff had used their discretionary powers and first-hand knowledge of the wards and patients to choose the most appropriate course of action under the circumstances.

External origins of incidents

External decisions on the future career of PDU patients could effect behaviour on the wards. This was most apparent when patients were under review for transfer from Mental Health Review Tribunals (MHRT) or RSU doctors. All patients were entitled to an annual independent MHRT (MHA 1983) to assess whether their detention should be prolonged on the grounds of their continued mental disorder and/or dangerousness. These decisions were not made in a vacuum and were therefore clearly influenced by the current political agenda and media commentary (see Chapter One). Risk was only assessed when patients were being held under a restriction order (s.37) and their future was decided in the final analysis by the Home Secretary.

The MHRT committee is chaired by a legally qualified president and completed by a medically qualified member and a lay representative who has a semi-professional knowledge of mentally disordered offenders. Tribunals follow quasi-judicial procedures, including the rights of the parties involved to obtain and present evidence, to challenge others' evidence, to have legal representation in the case of restricted patients and to be given the reasons for the tribunal's final decision. The Hospital representatives have the right to withhold evidence from the patient if they can provide sufficient reason; for example the possible risk it might present to those who gave evidence.

The tribunal can discharge unrestricted patients and make recommendations to the Secretary of State for the future of restricted patients but the Home Secretary has the final decision. He can refer to the Advisory Board which was set up for the purpose of assessing patient risk and whose judgements are based on wider information than that which is available to the MHRT. This means the Home Secretary is more likely to follow their advice on the future of a patient than the recommendations of the MHRT.

In practice the main function of the MHRT for PDU patients was to recommend whether they should be transferred to a lower security establishment if it was assessed that they no longer warranted the level of security provided by the Special Hospital.

The transfer of patients, however, depended on whether suitable lower security placements could be found. This in turn hinged upon the willingness of regional security units (RSU) to take PDU patients. The view was expressed by the majority of ward staff and patients that RSUs were unwilling to take PDU patients:

> Patients can wait years for RSUs and then the place turns round and says they are not the right sort of patient. (AS8:NA)

The tribunal process invited PCT staff to express their opinion on patients' progress. The main respondents were patients' Responsible Medical Officers (RMO) but tribunal teams could choose to ignore their recommendations. There was always much speculation, amongst the PCT, ward staff and patients, as to which decision a tribunal would make and opinions could vary dramatically so that the final outcome sometimes came as a surprise to at least one party.

Patients awaiting an assessment or decision from a MHRT or RSU doctor, unsurprisingly, could become very tense and this could result in minor incidents of verbal abuse or physical damage. Whether this was recorded as an IRS level incident was dependent on the ward staff who observed the behaviour. *Clinicians* were particularly likely to record incidents on the IRS, tending to pre-judge all patient behaviour in terms of their underlying personality disorder:

> You must always record incidents. I only record the facts but if the precipitating reason is unknown then you must form an impression from your knowledge of the patient. Patients are aware we record. They may be upset if they're due for an assessment from an RSU doctor but the pressure could have been the trigger. *PD's can't handle pressure.* (CS6:N) (*clinician*)

By contrast, *custodians* often chose to empathise with patients feeling that they were under pressure:

> How I record depends on individual clients and events. For example a patient throws his plate, a normal reaction when I discuss it with him and find out he's under pressure. If he cleans up I'll include it in the DR, as there are witnesses, but not computerise. I let him know I'm recording, allow him to read it and include a statement that it was out of character. It depends on your perceived danger but you mainly record to let your colleagues know. (CS3:N) (*custodians*)

Patients were most likely to get a 'knock back' from a MHRT or an application for transfer to an RSU. Patients' reactions to negative responses were dependent on a number of factors.

Patients who adopted the *personality disordered* style of performance and perceived their 'knock back' to be based on decisions made externally to the Hospital tended to respond by pursuing legal action.

Sick patients could react in a much more immediate manner. One such patient, who was detained as a young teenager for a minor offence, had the full backing of his PCT to be moved to a place of lower security. But the Home Secretary ignored the advice of the MHRT who supported the PCT and the patient attempted suicide. The staff involved in his case was also significantly demoralised and retreated into a *fatalist* style of performance.

Alternatively, problems could be created if *sick* patients were recommended for transfer. One such patient, who wished to remain in the security of the Hospital, was placed on a transfer list for a RSU by his former RMO. The patient's new PCT attempted to enrol him into the hospital's pre-discharge scheme. Ward staff protested that the patient was fundamentally gate-shy with an organic brain disorder which affected his understanding. The patient became highly abusive and threatening towards ward staff when he saw his transfer was imminent. This behaviour was only abated when the transfer process was halted and the patient told that he would not be moved in the foreseeable future.

The situation could be very difficult if patients believed their position to be a result of negative reporting from their PCT. In these circumstances they were likely to show their frustrations at ward level or against the off-ward staff whom they believed to be responsible. One patient, understandably, described

how his chances of release were diminished because of the infrequency with which he saw his RMO:

> I've only seen my RMO once before a tribunal and he said he didn't know me so he couldn't make any recommendations. (EP:4)

Patients' solicitors could create problems if they advised their clients not to conform to treatment, employing the MHA 1983, in a bid to claim that if the patient was no longer receiving treatment he should be released. Solicitors could also encourage patients to litigate rather than use the hospital's internal complaints and advocacy systems:

> On this ward patients go straight to their solicitors as they don't trust the hospital system. (BS3:N)

Clearly solicitors took instruction from their clients and some patients, particularly those who I have chosen to call *personality disordered*, needed no encouragement to engage their services in minor ward disputes. One *personality disordered* patient explained how using the courts rather than the hospital's internal systems was a way of occupying his time:

> I like challenging the ward rules and regulations through the courts as it keeps me going. Because of me they have to go through RMOs if patients refuse to have their rooms searched. I know I do it too much. (CP:4)

A common cause of upset to patients was the failure of legal representatives, off ward staff and outside visitors to keep appointments. This could be compounded if: visitors failed to inform ward staff in advance; did not give reasons for their absence; if ward staff neglected to pass messages on to patients; if patients had stayed on the ward to receive the visit. A *personality disordered* patient observed how staff showed a lack of respect for the routine of his life when they failed to inform him about appointments:

> There is a lack of communication between staff and patients which reflects a lack of consideration for the patients. For example going to work and then being sent back to the medical centre for an appointment. Not telling you about appointments and then sending you to work. I don't like being messed about because the staff don't care. (CP:7)

The failure of friends and family to attend visits was of greatest salience to *adult* patients as confirmation of this style of performance tended to be reliant on maintaining strong bonds with the outside world. Insufficient or undelivered news from the outside world could weaken their adult status. A *screw's* failure to inform an *adult* about a telephone call led to a Category D incident:

> A patient's girlfriend rang whilst he was at workshop and forgot to pass on the message. She phoned again and told him about the earlier call. He stormed at me pointing his finger and said I'd have lost my 'effing' job if this was outside and I said he'd be in prison if it wasn't for me. Everything was recorded in his notes. (CS12:NA)

Another cause of complaint was when off-ward staff failed to communicate their plans to ward staff or patients; made decisions which were opposed to the views of ward staff or patients; or were slow in delivering their promises. The off-ward staff included psychiatrists, psychologists, social workers, management, security, advocacy, workshop staff, therapy staff and education staff. A *custodian* outlined such an incident: 'a patient attempted to throw hot tea over me after receiving mixed messages from his RMO. This led to seclusion' (AS1:TL).

The infamous Owen Incident (Home Office, 1999a) occurred as a result of a patient's RMO reversing his earlier decision to allow a patient to receive a female visitor on the actual day of the visit after the patient had made preparations for the occasion and been made aware that the visitor was at the hospital. The problems began when all patients were locked in their rooms without explanation. Patients were later let out of their rooms whilst ward staff proceeded to systematically search all of the rooms. Patients were eventually returned to their rooms but were given no information as to why they had been locked in or whether it would happen again. The next day the patient's visit

was cancelled by his RMO and the situation culminated with the patient taking a psychologist and patient hostage at knifepoint.

A lack of information was considered to be the source of most stress in the hospital to some patients (CP:6) and this could amplify their reaction to events. This was an important factor which led to the Owen mass search escalating into the subsequent incident; patients were locked in their rooms without any warning whilst their property was searched (Home Office, 1999a).

Hospital services and personnel external to the PDU could disrupt the wards when they failed to perform their functions efficiently. This could, and often did during my time at the hospital, include cancellation of workshops owing to under staffing. *Offenders* and *adult* patients tended to take their work placements very seriously, as it gave their life meaning and routine, as in the outside world, so workshop closures could create considerable tension on the wards:

> When management close down a workshop we're left with some very angry patients who want to go to work. (AS10:NA) (*custodian*)

> There's problems if there is a change in the structure of their day. If groups are closed it's a big issue - maybe it is - it is their life. (BS7:N) (*custodian*)

This was compounded by the fact that if workshops were cancelled patients, apart from those with parole status, must remain on the wards all day with little to occupy their time. Those patients who I have chosen to call *adult* and *offender* patients, particularly, could consider that the area of 'most stress is being grounded on the ward' (DP:3). The chance of trouble occurring could and was reduced on some wards by opening up patients' rooms to avoid them milling around the communal areas voicing their frustrations loudly.

Mealtimes could be affected when services external to the PDU failed to provide the food requested. However it was whether ward staff attempted to resolve any mix ups which could either abate or provoke a situation:

> Catering is a major issue - for example if something is missing from the food trolley which they've requested they start shouting and complaining. We have to sit them down and start phoning around to see what's happened. We are representatives of the hospital so they have a go at us but it's not personal most the time. (AS11:N) (*carer*)

The failure of hospital personnel to perform administrative duties on request could have far reaching repercussions at ward level.

> For example I almost had a riot at Christmas, patients were promised a chippy meal but someone in purchasing forgot to sign the forms. Little things can make a big difference. (DS8:N) (*custodian*)

In this case the Ward Manager, a *custodian*, used his own money to ensure the promise was kept and he kept control of the ward.

Incidents on other wards could lead to widespread disruption. This could leave wards under staffed as their members could be called upon to answer alarm calls which could create excitement on their own wards. Patients wanted to know what was happening and who was involved. They also wanted to know whether it would have any future implications for them. A fear was that 'if someone 'cocks up' everyone's punished' (CP:7). The extreme cases being the Owen incident and the Lawrence affair (Home Office, 1999a) which led to a mass review of security and increased restrictions throughout the hospital. The Fallon Inquiry focused on allegations made by an ex-PDU patient that there was paedophile activity, trading in pornographic material and fraudulent practices prevalent amongst the patients on Lawrence Ward. In the case of some patients the effects of the Inquiry has arguably led to an extension of their time in the hospital:

> Because of the Inquiry I have lost two years - had no treatment, just security - and it will take another two years for me to regain my position with the new PCT. They've put our lives on hold while they've sorted themselves out. (BP:1) (*loner*)

It was expected that off ward therapy sessions would upset patients as they would be made to focus on their index offences and their whole way of thinking and behaving could be challenged. When patients returned to the wards they could be in a state of agitation so that an innocent joke could trigger a violent reaction. However, a sensitive handling of patients when they returned to the wards could help alleviate their tension but this could only take place if ward staff were kept fully informed about the patient's current state of mind. Hospital policy directed clinical staff to record the details of the therapy sessions in the ward's DR. But staff could be left ill-equipped to deal with patients when clinical staff were too busy, had forgotten or refused to report the nature of therapy sessions on the grounds of patient confidentiality.

Inconsistency and a lack of information regarding hospital rules could originate off-ward but the demeanour of ward staff could either placate or provoke disgruntled patients. In general nursing a lack of information has been found to be a key source of patient complaints (Audit Commission, 1993). Below is an example of an *offender* who was frustrated in his attempts to find out what he was allowed to have in his room:

> There is a great deal of inconsistency in the rules applied and how they apply them. There is no fixed set of rules to which the patients have access. Ward policy means you're given eight to ten pages of nothing. Hospital and Unit policies - not always made aware of them. For example - room searches - one member of staff confiscated a marker pen three times and the ward manager had said it was OK. Now the new ward manager has asked security and they decided I couldn't have it. I've never seen any policy containing a list of what's permitted in our rooms. I've asked for one but none's been issued. It depends who does the room search. It's mainly a management problem that policies aren't publicised. Rules are open to interpretation - some staff are relaxed and trusting, others aren't. (EP:5)

A *custodian* observed that the majority of patients would accept hospital rules as long as staff kept them informed in advance and presented the reasons for any changes:

> The ward is smooth because of the structure which everyone knows about - the rooms are locked off, incidents will be recorded. They'll accept policies as long as they are given notice; for example if they know the water regulators have been locked off because a patient was constantly jamming them. (BS8:N)

Internal origins of incidents

The most common incidents on the PDU occurred as a direct result of interactions between ward staff and patients on the PDU. As patients had to address ward staff before they could perform many basic functions, including entering the communal side-rooms, making telephone calls, collecting their mail, ward staff and patients were frequently in contact with one and other and there was considerable scope for disagreement and misinterpretation between them.

Outside influences remain

Ward security procedures, particularly body and room searches, could be a key source of friction on the PDU. These increased in the wake of the Fallon Inquiry (Home Office 1999a) and were therefore another example of how external politics could cause upset on the PDU.

A Category D incident was recorded when the new telephone checks had been implemented and the patient did not wish the ward staff observing him to see the number he was dialling:

> A patient attempted to speed dial. I tried to stop him, the patient refused and became physically threatening. I reported him. (ES2:NA)

This example shows how an *offender* resented being newly subordinated to the demands of security and how changes in the rules could create friction.

Room searches could provoke a strong reaction if patients were found with a banned item. One patient received a Category D incident after his 'room was searched and he became verbally abusive after we (staff) found valium' (ES1:NA).

Another occasion where a room search ended in an incident was reported by a patient:

> During a room search I was accused of having two items I shouldn't have had but I'd had them for five years - a tankard and plate. Staff claimed other patients could use them as weapons. I wanted to put it before the PCT but they wouldn't let me. I walked out of the office and slammed the door. Staff got me on the floor and placed me in seclusion. I thought I was speaking my mind but they said I was being threatening. (DP:3)

In this example the *offender* was frustrated about the unclear procedures on personal items allowed, the inconsistency with which staff upheld the rules and that his solution of resolving the problem by asking the PCT was rejected immediately. On this occasion it appears the ward staff involved overreacted to his display of annoyance and performed as *screws* by applying C & R on the patient and placing him in seclusion.

Certain patients, particularly those who I have called *loners*, could react very badly to being searched as they perceive it be a gross intrusion of their privacy (Goffman, 1961).

> I'm worried about being searched. I hate it. I can't get out of room searches but I can get out of searches when I return from work. Nine people go out on movement and staff never pick on the first or the last back. They won't pick the last one just in case someone comes back early and they have to nominate before and picking the first one, it won't seem random and it will hold up the rest of the group. I can't deal with the stress. I just have to make the situation not arise. (CP:5)

Random drugs testing could provoke strong reactions if not handled carefully. An *offender*, who was occupied watching the television, was asked to produce a urine sample by a *clinician*. Below are two eye-witness accounts of the ensuing events which led to a Category C incident being recorded:

> An example of a minor incident that led to a major incident was Mark (patient name changed). He was asked to give a urine sample and he said he'd give it later. He wasn't refusing. The staff said OK and Mark forgot about it. Later he was called into the office and told by staff that they

> thought he was on drugs. A row ensued. Mark stormed off down to his room and three staff followed. That's threatening and intimidating so Mark stormed up here. The staff are jumping and they put him in seclusion. I heard him say 'if you hit me again I'll punch you'. Now he's been moved and is refusing to come back because he won't sign a contract. (CP:7)

> Mark. Heard him and Ted (staff name changed) shouting and threatening each other. Mark went down to his room and Ted followed with two henchmen to carry on the argument. They should have left until both of them calmed down. The worst thing that would have happened is he'd have smashed up his room but wouldn't have hurt anyone. Unfortunately Ted has to have the last word and be in your face. Mark keeps on so the bells get pressed and he gets put in seclusion. Then Ted goes in to search him. I'd have sent an outsider who wasn't involved. So he gets hit. They should have given each other breathing space. (CP:6)

The technique of challenging the patient, a method encouraged on the ward, was justified by the *clinician* on the grounds that the patient was exhibiting personality disordered behaviour. However, events may have been averted if the clinician had not appeared to accuse the patient of drug taking, if he had allowed the patient time to calm down and finally if he had allowed a neutral party to attend the patient in isolation.

'Little' things are very important (Sykes, 1958; Morrison, 1994)

The close proximity in which patients are forced to live with people whom they would not choose can create problems:

> Living with each other twenty-four hours a day can create tensions. Most of us spend time in our rooms. If we can't it leads to fights and arguments. Generally try to get on the best we can with each other. (EP:6) (*offender*)

Small matters can flair up into incident situations as patients could only suppress their frustrations for so long: 'a lot of repressed anger can lead to squabbles over newspapers' (CP:3); 'older patients don't like the noise' (AS3:N) level on the wards; the choice of television channel can become a test of wills:

> Patients almost came to blows over the choice of T.V. channel. They were separated and then we discussed the situation. I told them to stop being stupid. (ES1:N) (*custodian*)

The restrictive routines of the wards, where patients are told when to eat, sleep and work, are regarded as necessary, by both ward staff and patients, for *sick*, *psychopathic* and arguably *personality disordered* patients, but *offenders* and *adult* patients perceived them to be an unnecessary infringement on their adult autonomy. One member of staff observed how certain patients could be 'abusive when we get them out of bed' (DS6:N). It can also be a source of distress for *loners* as one explained the 'most stress is being denied access to my room' (BP:1). 'Mealtimes can be an emotional minefield' (BP:1), particularly for *loners*, as all patients were forced together in one small room. Minor issues took on much greater importance so that a patient received a Category D record when he became 'verbally abusive owing to a meal mix up' (BS5:TL1).

In more general terms *offenders* and *adults*, and to a lesser extent *personality disordered* patients, were frustrated by the lack of 'normality' and trust that they had to contend with on the wards of the PDU.

> I get enough interaction as I'll talk to anyone but you know if you get angry they'll walk away with a pen in their hand so you can't lose your temper. The problem here is there's not enough trust to allow normality. There's no way of getting your aggression out. (CP:1)

The fact that patients were highly reliant on staff to pursue 'normal' activities could create problems if staff did not respond immediately or respond negatively (see Morrison, 1994).

> The three most important things to patients are: mail, visits and earning money but staff take two hours to get the mail and you have to wait for people to take you across to visits. The staff think it's immaterial but that's what keeps you going; they say things like 'you're not going anyway so what does it matter?' When you have a go at them about it they just say 'we're only human and we forget'. (AP:6) (*offender*)

As demonstrated above contact with the outside world and being able to work were of key importance to *adults* and *offenders*. Equally *personality disordered* and *psychopathic* patients expected ward staff to address all their needs immediately. However, *clinicians* and *screws* tended to believe that patients should sometimes be made to wait either as a learning experience or because they did not feel they should have to run after patients.

> Some groups feel they should not give in to patients and they make patients wait for requests as a sign of control. To me this is just staff showing their authority. If a patient gets narked by this it can aggravate a situation rather than calming it down. Egos come into it. (AS8:NA)

> If you want to make a phone-call it's 'hang on a minute, I'm going to have my tea' and then you find him in the T.V. room. For example one night I wanted to make a phone-call before I ate my tea so then the staff made me eat it cold because of health and safety. (AP:7)

In this example the patient was on the receiving end of a combination of the *screw* mentality and hospital bureaucracy. If patients reacted aggressively to ward staff abuses of power *clinicians* and *screws* tended to blame it on their psychopathic tendencies and their inability to accept the word 'no'. This could further frustrate patients to the extent that the making of a minor request can escalate to the point where the patient is placed in seclusion (Goffman, 1961; Morrison, 1994).

Misunderstandings between patients and ward staff could be a source of incidents. The example below occurred because an *offender* attempted to bend a rule which he believed impinged on his personal privacy and autonomy. The staff involved perceived the patient's behaviour to be threatening but the patient claimed he had not realised it would be interpreted as such.

> Category D: Patient threatened to throw tea over a member of staff. There is a rule that patients must keep their doors open when they visit each others rooms and his was closed so the teamleader went down to tell them to open it. The patient thought he was being victimised but the teamleader thought they were involved in sexual activities. The patient followed the teamleader into the corridor and said don't threaten me

> while I've got a cup in my hand. He said he didn't realise it sounded like a threat. (AS11: N)

Ward staff could provoke incidents by making negative personal comments about patients and becoming embroiled in arguments with patients.

> The staff cause minor incidents, they only happen when certain staff are on. If the staff didn't get involved in arguments there wouldn't be one. (CP:5)

> I have to make an effort for staff interaction. Staff can make comments when sat at the night-station or at mealtimes - personal snipes. (BP:1)

I observed an example of this behaviour when I was sat at the night-station with a member of ward staff. A patient came along the corridor, introduced himself to me and as he was walking off a *screw* whispered loudly to me that there was no way the patient was getting out. The patient half heard the comment and came back so that the ward staff had to quickly back track.

Misunderstandings between patients could easily lead to incident situations when they lived in such a confined space. Transactions between patients must be officially sanctioned but a certain amount of *sub rosa* activity is inescapable in a total institution and trades, involving pornography, alcohol, drugs or personal belongings, could remain hidden until a dispute occurs.

An example of a simple transaction between two patients leading to a physical fight and Category D booking occurred over a cassette player:

> Two patients got into a physical fight so I restrained one. Sat them down, cleaned them up and spoke to them individually. One was aggrieved as he had not been paid for repairing a cassette player. The other patient thought the repair had been a favour. I explained that there were other ways to sort the problem out. Also other patients had been winding them up and they only found out when they were sat talking to each other. They shook hands. (CS13:TL) (*custodian*)

Incidents on the same ward can trigger further problems:

> If an incident's due to an individual patient's problems the others don't care but if it's a strategy for a patient to make a name it can affect the rest of the ward - either goes very quiet or they'll self harm. (DS8:N)
>
> Incidents can make the patients angry or hostile towards the person who caused the incident. (DP:4)

I have shown in this section that there were many potential external and internal sources of incidents on the PDU - although clearly the examples given above do not exhaust the possibilities.

I further hope I have illustrated that many of the incidents which did occur, particularly those which originated within the PDU, might have been averted if the ward staff involved had used their discretionary powers to choose the most appropriate route of action based on their knowledge of the situation and the patients involved. Indeed, in certain situations, I hope to have shown that the most appropriate choice of action by ward staff averted the escalation of potentially highly damaging situations. It is clear that many of the incidents were 'normal' and therefore predictable under the circumstances. These issues will be discussed in the following section.

A Negotiated Order on the Wards

How can we make sense of the incidents discussed in the previous section? We know that 'negotiated order' is the best way to maintain stability (Shapiro & Navon, 1985) and facilitate the most effective and efficient management of the PDU (see Chapter Three). So how do ward staff and patients manage to negotiate order on the PDU? Prison research has shown that there is a need to establish 'right relationships' (Liebling & Price, 1999) between those who live and work in institutions. These have been found to be the most effective 'instruments of legitimacy' (Liebling & Price, 1999: 89). To discover how 'right relationships' can be formed it is necessary to assess the 'specific skills' ward staff employed to establish them and how patients responded to ward staff. Ward staff were not always able to articulate exactly what they did beyond

attributing it to 'common sense' so it was therefore necessary to review their practical application of these skills.

Starting Point: Predictable, Normal and Understandable 'under the circumstances'

It was generally acknowledged by both staff and patients on the wards that, in the vast majority of cases, PDU patient behaviour was predictable and therefore the majority of potential incident situations could be averted if ward staff chose the most appropriate course of action.

One patient compared the situation on the PDU to that of the rest of the hospital:

> It's different from mental illness as the patients are not inverted from the norm. It's better. On the mental illness wards there's a liability of being attacked. On the personality disorder wards people think before they act so it's safer. . . . *You see the warning signs first.* (EP: 3)

It was only possible to spot the warning signs and choose the most appropriate course of action if ward staff were willing to accept that patient responses to adverse situations were both understandable and 'normal' considering the abnormal environment in which they must live (Sykes, 1958). As we have seen there were many areas of patient life in which they were placed under stress and that many of these were inescapable considering the closed environment in which they lived and the fact that most patients desired to be released.

It was therefore the duty of both ward staff and other patients to be aware of these factors and alert to the possible problems which could occur. This was only possible when ward staff had gained considerable knowledge of the individual patients with whom they worked (see Chapter Three). In their work in prisons Liebling and Price (1999) emphasised the power 'knowledge' gave prison officers when attempting to maintain order. Knowledge could be achieved when staff had developed good observational and communication skills which enabled a gathering of information from both their colleagues and patients. One *custodian* argued how communication with, and observation of,

patients was most effective when staff spent their time interacting with patients rather than remaining in staff only areas and waiting for patients to report any problems.

> *Communication is the essence - it allows early intervention.* Allows the patients to air their views in a more acceptable manner. *Communication is physical observation of patients by staff.* On other wards patients just sit there with no interaction with the staff. If there is no interaction you don't know what's going on in their heads and things are just left to bubble. On here we allow them to release pressure so there's not the tension like on other wards. (CS15:N)

The predilection of *clinicians* and *screws* to dismiss all patient behaviour in terms of their underlying disorder and anti-social tendencies could be detrimental to the process of communicating with patients and gathering knowledge. In the case of *screws* and *fatalists* their desire to avoid patient contact could further compound the problem. The more open approaches of *custodians, adults* and *carers* could aid this process.

A *custodian* observed:

> *Awareness is the key; knowing the patients allows you to almost predict what will happen.* Ninety per cent of incidents can be averted and if they're not we've failed. You must observe how a patient is first thing in the morning - a ten minute conversation then may avert a seclusion later. There's always a problem at the root of a patient's actions. They're easier than mental illness patients as they go through the normal processes. (ES6: TL,1)

This approach was confirmed as important by an *offender's* comment:

> I kicked a window because I got out of bed the wrong side. I got secluded for one hour. Not told if I was Class D'ed but it's a joke - big deal! (DP:5)

The ward staff and patients quoted above were agreed that real knowledge of patients must be gained through first hand observation of, and interaction with, patients. This was an ongoing process and could not be gained through simply reading patient's notes - although clearly this could assist staff in developing an

understanding of individual patients. A *clinician* emphasised the need for extensive knowledge of individual patients:

> I need a vast knowledge of the patients' histories - the time of their IO; the affect of Christmas; times they feel guilty to highlight the possibility of suicide or depression and to allow me to judge their dangerousness. (BS6:N)

It is therefore clear that ward staff could only make the most appropriate choice of action in potentially disruptive situations if they had first acquired an extensive knowledge of daily life on the PDU, an understanding of the difficulties and complexities which existed there in and an individual knowledge of those patients who lived on their ward.

The level of awareness and knowledge necessary to be able to predict and allay potential incident situations could best be acquired by combining the shop-floor observational, communication and interactional skills of the *custodian* with the thoroughness and interest of the *clinician* (see Chapters Three and Six).

How order is negotiated on the PDU

In this section I intend to show how and why staff were able to maintain a stable order on the PDU at the time of my fieldwork through the ongoing negotiation of staff-patient social relationships which enabled staff to establish legitimacy in the eyes of the PDU patients.

We know, in broad terms, that the emphasis on security, at the expense of treatment, and the emphasis on treatment at the expense of security, does not work (see Chapter One and Three). Getting the balance right is not just a matter of philosophical approach. It has to be translated into practice on the ground where inherently conflicting positions have to be resolved:

> Owing to the Hospital's quest to balance security and therapy, which is impossible, staff always sway to one side. (BS5:TL)

The task therefore falls to the ward staff to attempt to resolve the conflicting interests of the hospital management and wider political agenda and maintain order on the wards of the PDU through their social relations with PDU patients (see Chapter Three).

In an attempt to discover how this task is achieved on the ground I have identified ward staff who appeared to have and were reported as having 'right relationships' (Liebling & Price, 1999) with patients and considered the skills they employed in their negotiation of staff-patient relationships. I refer here to the work of Liebling and Price (1998, 1999) and Ahmad (1996), although it was located in the prison sector, as it assessed the importance of human, relational factors to establishing legitimacy on and therefore maintaining order in the prison system as a whole. Nursing literature also shows a need for nursing staff to negotiate their relationship with patients in order to improve patients' experience of hospitalisation (Morrison, 1991, 1994) but there is not the same need to establish legitimacy in a general hospital setting as in the Special Hospital System as the vast majority of hospital patients are unlikely to be in a position to or desire to cause disorder.

I argue therefore that 'right' staff-patient relationships (Liebling & Price, 1999), negotiated through ongoing positive interaction, were the key to stable order on the wards of the PDU.

Research into prisons has shown that prison staff employ a wide range of skills in the management of prisoners which are developed on the job rather than through training. These skills include: respecting prisoners as individuals and human beings (Lombardo, 1981; Genders & Player, 1995; James et al, 1997; Liebling & Price, 1999), displaying honesty, consistency and fairness (Ahmad, 1996; James et al, 1997; Liebling & Price, 1999), 'appropriate use of authority' (Liebling & Price, 1999), balancing flexibility and maintaining boundaries (Sparks et al, 1996; Liebling & Price, 1999), 'human relation skills' (Liebling & Price, 1999), developing trust and offering emotional support (Lombardo, 1981; Hay & Sparks, 1991; Genders & Player, 1995), good 'verbal

skills' (Liebling & Price 1999) and displaying a sense of humour (Hay & Sparks, 1991).

Similar, issues have been identified in the nursing literature on nurse-patient relationships. Morrison's (1991) study identified a range of 'attitudinal characteristics' which he found to be of key importance - commitment, kindness, genuineness, treat people as individuals, show sensitivity, listen to people, have time for people and consistency.

Sykes (1958) described prison officers as having a 'difficult tightrope to walk' (Sykes, 1958: 119). This is perhaps even more the case for PDU ward staff who must develop their skills in specific response to the practical and conceptual problems surrounding PDU patients and the conflicting demands of the Special Hospital System (see Chapters One and Two).

It is clear from Chapter Six that staff who I identified as *clinicians* and *custodians* were most likely to foster good professional relationships with patients in terms of clinical assistance and adherence to the rules of the institution.

A number of incidents occurred as a direct result of patients becoming frustrated at the lack of consistency and fairness in the application of hospital rules. Inconsistency was a key source of frustration to patients on the PDU. Below a *custodian* identifies a number of reasons why inconsistency was a problem on the PDU:

> There are double standards for staff and patients alike. Some people can do one thing and get away with it whilst others are pulled up. Things could be resolved without resorting to this. There is inconsistency between groups on the ward. A lot is down to personalities, some to gender, inexperience. Some qualifieds have not been here long and have positions of authority and handle things differently to those staff who have been here for years. The way a woman deals with something is opposite to a man, men are more macho, aggressive. If it is not important they should just let it go. (AS8:NA)

It appears that individual staff personalities, group approaches, gender, position and experience could all effect the way in which staff delt with patients.

Problems were most likely to occur when staff who performed as *screws*, and perhaps to a lesser extent *carers*, were dealing with patients. *Custodians* on the other hand, seemed to have a greater awareness of the possibility of inconsistencies arising, and this helped to alleviate the problem.

It was apparent that patients' perceived there to be a lack of clarity with regards to what was expected of them. This meant there was also a need for openness and honesty when dealing with patients. Although PDU patients were considered unable to follow rules, owing to their disorder (see Chapter Two), custodians believed:

If patients are given a clear and honest reason for a 'no' they'll usually accept it. (CS6:TL)

A carer observed that patients needed to be kept informed of the rules so that they knew what is expected of them:

> This ward is probably smooth, going on what other wards are like. Everyone knows what the structural timetable is. There's only a problem when someone throws something unusual in, everyone gets confused. For example a patient thought we were wrong to search him before he went on the bus to the east site because they don't on other wards. We checked and we were right. *Patients keep order if they know what is expected of them*. They need the structure and regime of the ward to follow - to cope. It takes the responsibility away. (AS9:N)

A *custodian* explained how by being honest, open and consistent he felt he had earned the trust of at least some of the patients on his ward:

> Patients see me as approachable, consistent, open and honest. They come to me with personal problems which shows trust. I can't interact with all patients on the same level, I must know their limits and mine. (ES11:TL)

It was clear that patients needed to perceive the staff to be honest, consistent, clear and open before they could develop the level of trust necessary for them to be able to approach staff with their problems, rather than 'acting out' their frustrations and disrupting the ward. The final quote was from a custodian whom both ward staff and patients credited as a 'role model' (Liebling & Price,

1999) for professionalism and as having developed the right relationships with both ward staff and patients.

In terms of furthering their progression through the system patients were most likely to look to those staff whom they perceived to be *clinicians*. Clearly patients who I call *personality disordered* in style of performance expected these ward staff to support their treatment efforts and those staff whose patients were closest to release were regarded as 'good' professionals in this context.

Ward staff must also be willing to establish good social relationships with patients if they want to gain patient trust. Whilst professional boundaries are important there is also a need for ward staff to show that they are human by responding to patient humour, interacting on a non-clinical basis and respecting the patients as fellow adults and humans. Ward staff could only do this by spending time interacting socially with patients in communal areas of the ward.

A *custodian* described the importance of spending time with patients, in conjunction with being fair, when it came to building a good rapport and gaining patients' acceptance.

> Rarely have any problems with the patients; day to day their index offences don't enter my head or it would affect my rapport with them. They feel I'm fair as they will accept the word 'no' from me. *I don't spend my time in the office like other teamleaders.* (DS5:TL)

The building of rapport between ward staff and patients tended to be focused around finding interests which ward staff and patients had in common which were neither medical or criminological. Topics which ward staff and patients discussed included sport, cooking and gardening as these were activities which both groups could actually be involved in. Again it was necessary for boundaries to be maintained and ward staff were expected to avoid discussing their personal lives in front of the patients. *Custodians* and *carers* appeared to be most effective at maintaining this balance and were most likely to be found having a game of cards or snooker with patients. Ward staff whom I have called *adults* were particularly likely to form close bonds with individual patients but other ward staff were fearful that there was the potential for them

to lose sight of the boundaries. *Screws, fatalists* and *clinicians* distrusted patients' motivations for talking to them believing it to be a guise to erode staff-patient boundaries and as such they were less likely to be in a situation where they could form social relationships with patients.

A *custodian* emphasised the importance of humour and ward staff showing their human side in developing staff-patient social relations but added the note of caution that boundaries should sometimes be imposed. This demonstrates the fine balance ward staff needed to maintain between their professional and social relationships with patients:

> *Humour is useful, you need to use your own personality, not just show you're professional but human.* They can't learn if we don't communicate and act as role models. It's not natural if we don't react to their humour. It can make problems too - if you have a problem and show you're upset and they can see you're human they may encourage you to do it again - then you have to take steps to stop it. (CS15:N)

The quotes below show how *custodians* perceived humour to be both important as a professional and social tool, in averting potentially disruptive situations and forming relationships with patients, and how its use needed to be enjoined with a knowledge of individual patients and situations:

> Some staff like to have fun with patients, others use force but it depends on the situation. Best thing is the bond between staff and patients, put them at their ease - on an even keel by acting daft. (DP:2)

> There's a lot of banter - a bit of fun which you need. You call it lightening the load. Banter works but you have to know where the perimeters are - something could appear rude but it's OK if you know the person. (CP:7)

Humour could also be used in a detrimental way by some ward staff to humiliate patients. Although some ward staff who I have identified as *clinicians* referred to 'hangman humour' as a useful tool for helping patients face up to their index offences it was unlikely to be viewed in a positive light by patients. I witnessed an example where a *clinician* joked about how much

an *offender* would enjoy working at the Visitors' Centre with children and although he did not physically react he was clearly offended by the implication and fearful that other patients might have heard the comment. *Screws* did not appear to need an excuse to openly taunt the patients about their offences.

Custodians and *adult* staff recognised the need to show patients respect as adult human beings and individuals by not always prioritising their professional guard and by accepting that patients were capable of taking responsibility for their actions:

> These men know they've done terrible things and have to do a punishment and get on with it. They're not so bitter and twisted as the women. They just want to be treated like human beings while they're here. You can build relationships and develop respect for each other. You don't have to be on your guard so much. (CS8:N)

An *offender* explained how he further perceived staff respect when they talked to him as an equal and acknowledged that owing to the Hospital restrictions he may sometimes need assistance to do things which he was not permitted to do for himself. When this occurred he reciprocated the respect of staff by dropping his guard:

> With some staff it takes a long time to get them to do things for you which you can't do for yourself. The easier ones *I can drop my guard* with allow them to get to know me - they have home trips with me. They don't talk down to you either like some do but you have to put up with it or you'd be at each other all the time. Staff don't see the same things as important - for example phonecalls. *Respect works both ways.* (CP:6)

This quote shows how when patients perceived themselves to have a good social relationship with ward staff they began to trust them and drop their guard. A *custodian* explained that trust could only develop between ward staff and patients when staff credited and respected patients as adults:

> Some staff forget they're adults and don't credit them when they act like adults. They have to learn about trust. (CS10:NA)

Ward staff needed also to be willing to offer patients emotional support in terms of showing them sensitivity and empathy. This could be displayed by again respecting the patients' adult autonomy and by having the ability to listen to patients' concerns and frustrations. This skill was most apparent in staff who adopted the *carer*, *adult* and *custodian* styles of performance. The examples of the problems created by the bad news often received following MHRT and RSU assessments given in the previous section showed that there was a need for staff to show sensitivity and empathise with the enormity of the upset this might cause patients. On an everyday level this sensitivity was displayed when staff showed a willingness to chase up the reasons for why workshops were cancelled or mail had gone astray.

Again staff who I have identified as *screws*, *clinicians* and *fatalists* tended to dismiss patients' need for everyday support. A *clinician* indicated suspicion when a patient appeared to be upset by the death of his father viewing it as an attempt by the patient to further his progress towards release by demonstrating his ability to show emotion.

'Right' professional, social and emotional relationships on the wards of the PDU tended to be most readily formed by ward staff who I have identified as adopting a *custodian* style of performance. Wards staff and patients perceived these individuals to be able to employ a balance of skills which included: being consistent, fair, open, clear and honest about the application of hospital rules which meant that patients were willing to approach them when inconsistencies inevitably arose; the ability to drop their guard and interact with patients at a social level, gaining the respect and trust of patients by showing their human side and individualism but maintaining the necessary distance with their personal lives; showing a sense of humour and appreciating that of the patients but being aware there was a line which the jokes should not cross; offering emotional support which included showing a sensitivity towards the fact 'little' things mattered when patients had minimum control over their lives and listening to the patients' concerns.

'Right' relationships increase the knowledge base on which negotiated order is grounded

'Right' professional, social and emotional relationships enhanced staff-patient trust and therefore ward staff legitimacy which in turn led to patients being more willing to co-operate and share information with ward staff. If patients felt able to talk to ward staff and not hide their problems it allowed them to increase their knowledge base of patients and avert potentially disruptive situations through the most appropriate choice of action and thus consolidate a stable order on the wards:

> All interaction is worthwhile - this job is about relationships. So if you know a patient you can stop them killing a member of staff. (CS9:N)

A *personality disordered* patient who had his leave of absence (LOA) application refused by the PCT, although his behaviour had been exemplary, was aware that a *psychopath* patient had been accepted for an LOA by the PCT. The first patient felt able to go and talk to his Ward Manager, a *custodian*. This gave the Ward Manager the opportunity to explain that he would not have allowed either patient the LOA but under the circumstances he could not retract the other patient's LOA. The patients willingness to talk to his Ward Manager helped avert an incident; as another member of staff observed:

> It is important that they (patients) feel confident to come to me. Even minor problems can escalate if they've got no-one to talk to. (ES6: TL)

The situation was further helped by the Ward Manager's honest explanation that a mistake had been made. This *custodian* was another recognised 'role model' whose understanding of the importance of 'little' things to patients and sensitive handling of the takeaway meal incident given in the section on 'external origins of incidents' above averted a potential riot. Another patient expressed his appreciation of ward staff who 'tell it like it is' (AP:5).

A *clinician* who had developed positive professional relationships with a number of patients but recognised the importance of maintaining boundaries

observed how useful the relationships could be in gaining information and learning how to deal with individual patients:

> On the whole I have a good relationship with the patients, don't get on with the same ones as the other staff, sense one or two trust me, not necessarily a good thing but it could be useful. Means that I can get information out of them that other staff can't to get a picture of their life. But one patient if I show him warmth and understanding he latches on to you so you have to be assertive and lay down boundaries when you speak to him - stating for how long. (AS11:N)

Over time ward staff may be able to foster a level of trust with patients which means that patients will reciprocate by being honest with staff:

> I'm someone they can trust, been here a long time, and they'll give me a straight answer. Plenty of contact. (DS6:N) (*custodian*)

Equally if patients felt that they could trust ward staff they were more likely to report to them if there was anything amiss on a ward. This again improved ward safety and reduced the chance of incidents:

> Often on here a patient will tell the staff if something's going on. For example an incident where a patient took a piece of metal from the laundry room. They won't tackle each other so they told staff who sorted it out. It was innocent as the patient wanted to use it to mend his bird cage. The patient told the staff for self preservation - it could have been used as a weapon. They do look after each other's interests - for example one patient picks up anything harmful round the grounds, glass or tin, and hands it in. (AS8:NA) (*custodian*) (1st ex. *sick* patient/ 2nd ex. *offender* patient)

As in all total institutions staff are 'reliant on patient co-operation' (BS5:TL) (see Chapter Three):

> The ward is smooth due to interpersonal relationships; patients knowing where they stand - even on this group patients wouldn't like it if we barked orders. *We can only remain safe with the good will of the patients as there's more of them than there is of us - either they want a quiet life*

> *or to meet rehab. goals.* Patients deal with minor problems using peer pressure so we don't see. (AS7:TL)

Patient co-operation was enhanced by good patient-patient relationships which were most likely amongst patients who adopted the *adult*, *offender* or *personality disordered* style of role performance. Staff observed that generally patient-patient relationships were good:

> Patients have quite friendly relations considering they're with each other twenty- four hours a day. They respect each others personal space. (BS1:TL)

> Patients get on amazingly well for fifteen people with their problems. They're experts at being in institutions and learning tolerance. I wouldn't feel safe sleeping with a dozen of the most dangerous people in the country. (ES9:N2)

Conclusion

In conclusion an analysis of recorded incidents and reported and observed potential incident situations on the PDU has illustrated that there is a kind of order on the PDU. This order manifests itself in an absence of violent or aggressive incidents on the PDU. However, it is clear that within a large institution and particularly among PDU patients there remains the potential for insidious, manipulative behaviour. It is questionable whether this behaviour can ever be controlled but an awareness of patients' potential for dangerous and disorderly behaviour and the development of a sound knowledge base of individual patients and their likely responses to different situations can arguably reduce the likelihood of such behaviours.

Ward staff negotiated order on the wards through an ongoing development of 'right' relationships with patients. Staff-patient relationships were enhanced through the development of specific skills which were beyond the scope of their professional training. Although all ward staff, with the exception of the *screw*, at times could appear to employ these skills it is those staff who I have identified as adopting a *custodian* style of performance who appeared to employ them most consistently and effectively and whom the

patients responded to most positively. *Custodians'* use of these skills appeared to foster internal legitimacy on the wards of the PDU and thus created a situation in which patients were willing to award staff the degree of trust and co-operation necessary to keep them informed enough to maintain a stable order on the wards.

CONCLUSION

Theoretical Implications

In taking a Grounded Theory approach to this research I have been able to develop a model of the way in which the Personality Disorder Unit works at Ashworth Hospital. In theoretical terms I have laid out a framework which is intended to enhance our understanding of how ward staff and patients respond to each other on an everyday, and situation by situation, basis. The framework involved the plotting of adopted styles of staff job performance and patient response on a simple grid using two dimensions, namely medical-criminological and people-object. Useful though this has been for analyzing the ways in which ward staff and patients avoid or avert potential trouble situations and strive towards order, it requires further testing in new situations on the basis of which refinements might be made.

One obvious way forward would be to test the efficacy of this framework in other environments where personality disordered individuals are held in conditions of high security. Ideally, this would be done before decisions were taken about the future shape of services for DSPD persons, but in the nature of these things this may not be how things turn out. Policy developments may yet create a new laboratory for further research. Any new facilities established would thus provide important opportunities for exploring the development of appropriate relationships between staff and DSPD persons, and the underpinnings of a negotiated good order. One cannot come to the conclusion of a study such as this without being aware of its limitations. Future research would have to take on board some of the many other potential factors which have a bearing on the well ordered institutional environment. These may range from the physical layout of the plant, to the social structure of the ward; and from the operational policies and procedures to the personal biographies of those by whom, and for whom, they are put into practice.

Practical Implications

The residual group of individuals, currently labelled in their most extreme manifestation as Dangerous Severe Personality Disordered, were first identified as not fitting the norms of insanity but nevertheless deemed insane by virtue of their inexplicable and dangerous behaviour, two hundred years ago. Ever since then medical and legal professionals as well as politicians have been trying to decide what best to do about them in terms of appropriate medical treatment, rightful punishment and the proper protection of the public. This group includes those patients who are currently detained in the PDU at Ashworth Special Hospital.

The only matter that all those involved in the debate agree upon is that for so long as these persons remain dangerous they must be contained in places of adequate security out of harms way. The proper place of confinement is currently under review following frequent inquiries into the Special Hospital System ever since Broadmoor opened in 1863.

The current government, at first glance, appears to be planning to implement far-reaching changes in an attempt 'to do something about' DSPD individuals. The White Paper on Reforming the Mental Health Act (2000) seems to offer a complete overhaul of existing mental health legislation and facilities. Part II of the White Paper deals exclusively with High Risk Patients and builds on the government's 1999 proposal - 'Managing Dangerous People with Severe Personality Disorder' (Home Office, 1999b). This document set out two 'new' options for the future containment of DSPD persons. Option A entailed changes within existing mental health and criminal justice legislation and facilities. Option B, the third way proposal, arguably entails the development of a totally new system for the containment of DSPD individuals. The main difference between these two options appears to be whether DSPD people should be collectively contained in new facilities or continue to be distributed throughout existing health service and prison establishments.

Both the government documents (Home Office 1999b, 2000) discussed above contained very limited reference to what should happen to DSPD

individuals once placed within a secure facility. However, it was proposed in the White Paper on Reforming the Mental Health Act (2000) that the 'treatability clause' should be removed from the Mental Health Act in relation to 'psychopathically disordered' people (the existing legal term for DSPD individuals). Furthermore, the policy document (1999b) on DSPD persons, as indicated in the title, focused on the 'management' rather than the 'treatment' of this group. It appears therefore that the greatest change, implicit in the government's current plans for DSPD individuals, is that the requirement to treat this particular group is being replaced by, or at the very least subordinated to, the need to manage them.

If management rather than treatment is to be the way forward, then it could be argued that Special Hospitals are no longer the best place for persons defined as DSPD and that they might be better managed in a penal setting. This argument is supported to a considerable extent by many medical professionals who believe that this particular group of the mentally disordered are not treatable. However, since the government proposal requires the inclusion of at least a small number of DSPD individuals who have not committed criminal offences it is likely that the need to provide both penal and health service provision will remain.

I would argue, however, that this does not mean that the rhetorical debates on where the pendulum should be positioned to balance security and therapy, and care and control need to continue. It is clear that such rhetoric has, if anything, been detrimental to the management of the Special Hospitals in the past. The paradox of the sick patient who is in need of care and treatment and the dangerous individual who must be held in a secure and controlled environment will endure for so long as there remains a medical diagnosis for individuals who do not fit the norms of insanity but who nevertheless are deemed insane by virtue of their inexplicable and dangerous behaviour. The existence of this paradox should be acknowledged but it should not be allowed to have a detrimental impact upon the everyday running of the Special Hospital System.

Drawing firm conclusions from an exploratory study such as this is perhaps hazardous. Nevertheless it is worthwhile considering, however tentatively, some of the implications of the data.

It is clearly staff on the ground in the Special Hospital System who bear the brunt of the daily management of DSPD persons. It will be the staff on the ground who will have to do this job in whatever system is developed in the future. I have shown in this thesis that the Personality Disorder Unit at Ashworth Special Hospital is, or was at the time of the research, being managed relatively successfully if that success is to be judged in terms of the maintenance of order on the wards rather than the balancing of security and treatment, care and control.

I would therefore argue that perhaps the Fallon Report (1999a) was too quick to condemn the PDU and that ward staff do indeed need to be given the chance to consolidate their hard work. If the government is indeed now focusing primarily on the management of DSPD individuals in secure facilities, then I would argue that the best way for them to proceed is to think in terms of the maintenance of order.

If this were to be the case then it would be useful for those in charge of the new government initiated projects at Rampton Special Hospital and HMP Whitemoor to look to the Personality Disorder Unit at Ashworth Hospital to see what lessons could be drawn on how best to manage DSPD individuals.

At the time of the fieldwork ward staff were receiving very little, if any, training specific to dealing with personality disordered patients. Equally, there was a lack of unity and clarity regarding the philosophies and rules in place on the five wards of the PDU. There was also diminished hope for patient transfers to places of lower security. Despite these manifest problems I found, as an observer, that the five wards on the PDU appeared to be running relatively smoothly and, indeed they were perceived as such by those who lived and worked on the PDU. Furthermore, this order is actually reflected both in the low level of serious incidents of violence and aggression as they are

recorded and reported in the Hospital, and in my own observation of potential incident situations.

On the basis of the evidence provided in this thesis it is clear that many ward staff have become highly skilled at managing PD patients. I would also argue that, despite the dangerous nature of the PDU patients, and the high degrees of negativity surrounding them, the vast majority of the patients on the PDU at the time of the research were open to the possibility of negotiating social relationships with, and responding positively to, those ward staff.

I have shown that different ward staff adopted very different styles of job performance when attempting to deal with PDU patients. There was evidence to indicate that it was the ward staff whom I identified as adopting the *custodian* style of job performance who were most successful in their ability to avert potential incidents and negotiate right staff-patient relationships. It seemed that this was primarily because patients saw that style of job performance as having a high degree of legitimacy.

Ward staff whom I identified as adopting a *custodian* style of job performance employed a sophisticated balance of people-work skills which included: being consistent, fair, clear and honest about the application of hospital rules which meant that patients were willing to approach them when inconsistencies inevitably arose. They had the ability to drop their guard and interact with patients at a social level, gaining the respect and trust of patients by showing their human side and individualism whilst still maintaining the necessary distance with their personal lives. They managed to show a sense of humour, and to appreciate the humour of the patients, but remained aware that there was a line which the jokes should not cross. They offered emotional support, which included showing a sensitivity towards the fact that 'little' things mattered when patients had minimum control over their lives, and a willingness to listen to patients' concerns.

All ward staff, with the exception of those I identified as *screws*, could and did employ these skills for at least some of the time and towards some of the patients, but it was the *custodians* who appeared to employ them most

consistently and effectively, and to whom the patients responded most positively. Their use of these skills created a situation on the PDU in which patients were willing to award staff the degree of trust and co-operation necessary to maintain a stable order on the wards.

Although many of the skills outlined above appear to be common sense, and some are incorporated into nurse training, there is in my view a need to place a greater emphasis on the importance of these skills in future training programmes. I would argue that this needs to be taken into consideration regardless of the government's final decision on where DSPD individuals should be placed.

Appendix I

Letter of request to interview for staff

28 April 1998

I write on behalf of myself and my colleagues Kate Smith and Lucy Willmott from the University of Wales, Bangor.

As you may be aware, we are presently involved in a research project within the hospital which looks at the ways in which order is maintained on the wards of the Personality Disorder Unit.

We have spent the previous few months in getting to know both staff and patients and in becoming familiar with the daily routines and procedures that constitute day to day life on these wards.

We now wish to move on to the next stage of our research which involves talking to members of staff individually. Through the use of a semi-structured questionnnaire, we intend to further our understanding of the reasons that disorder occurs on the wards and the ways in which it is dealt with.

We are writing to all members of staff who are currently working on the wards of the Personality Disorder Unit in order to ascertain whether they would be interested in taking part in this research.

We wish to emphasise that we are independent researchers employed by the University of Wales, Bangor. Any information that you provide will remain completely confidential and will not be passed on to any other person or authority. Should you require any further information do not hesitate to contact myself or Dr. Kate Smith at the address given above.

If you wish to take part in the research project please will you fill in the attached slip and return it to your ward manager as soon as possible.

Yours sincerely,

Hillary Bradshaw

I wish to take part in the research project on Maintaining Social Order in the Personality Disorder Unit currently being carried out by the University of Wales, Bangor.

NAME..... DATE.....

Letter informing patients of interviews

FOR THE ATTENTION OF ALL PATIENTS - PDU

I write to you on behalf of myself and my colleague, Lucy Willmott from the University of Wales, Bangor. As you may be aware, we are currently involved in a research project within the Hospital which looks at the ways in which order is maintained on the wards of the Personality Disorder Unit. We have already spent some time in getting to know both staff and patients and in becoming familiar with the daily routines and procedures that constitute day-to-day life on the wards.

We now wish to move on to the next stage of our research which involves talking to patients. Through the use of a semi-structured interview, we hope to further our understanding of the ways in which staff and patients keep order on the wards and, if disorder should occur, the ways in which it is dealt with. The more people who participate the better the picture we will be able to build up. We hope that you will be able to help us in our work by agreeing to talk to us to let us have your views.

We wish to emphasis that we are independent researchers employed by the University of Wales, Bangor. Any information that you provide will remain completely confidential and no information will be traceable back to any individual.

My colleague and I will always be ready to answer any questions you may have about the research and, should you require further information, do not hesitate to contact either myself or Lucy.

I very much hope that you will be able to participate.

Yours sincerely,

Hillary Bradshaw

Patient research consent form

Part 1	should be signed and data by patient
Part 2a	should be signed and dated by the Responsible Medical Officer
Part 2b	should be signed and dated by the Responsible Medical Officer
Part 3	should be signed by the researcher(s)
Parts 1 & 2	should be held on the researcher's file
Part 3	should be kept by the patients

Part 1

I ..... agree to be involved in the study carried out by.....I am satisfied that the purpose and procedures of the study have been fully explained to me by.....

I have also received a written explanation of the study. I understand that my involvement in the study will be confidential and without prejudice to me, and that I can withdraw at any time.

Signed.....Date.....

Part 2 - Section A

I.....Responsible Medical Officer to.....hereby give my approval to the involvement of the above-named patient in the research project conducted by.....I have received a written explanation of the study.

Signed.....Date.....

Part - Section B

I.....Responsible Medical Officer

to.....am satisfied that the patient is capable of giving consent to his/her involvement in the proposed research project.

Signed.....Date.....

Research Consent Form 2

ASHWORTH HOSPITAL

Part 3 - To be retained by the patient

I.....

confirm to.....

that all the information relating to him/ her in the study will be confidential without prejudice to him/ her.

Signed.....Date.....

Signed.....Date.....

Signed.....Date.....

Pilot Interview Schedule: Staff

(9:5:98)

Introductory Statement

- Purpose of the research
- Not associated with Ashworth or any inquiry etc. Researchers from Bangor University
- Confidentiality
- Talk in as much detail as like
- May be some overlap of questions
- Tell us if we've missed something that's important
- Time at the end for questions about research

Career history

1) What is your job/ position on the ward?
2) How long have you worked at Ashworth?
3) How long have you been on this ward?
4) Where else have you worked?
5) What kind of training have you had? (*Probe*: type, value etc.)
6) Have you attended any courses since being on the ward?
7) How does this ward compare with elsewhere (in hospital and outside)?

   Probe: Did you choose to come on this ward? If so, why?

   How do you feel about being here?

   Differences in terms of safety, patients, staff, morale etc.

Nature of the ward

1) Describe the ward, what's it all about?
2) Tell me about the approach taken.
3) Do you think that there is a ward philosophy, a particular way of working?

   Probe: How has this developed (reactive/ proactive?)

   Does this vary by shift?

Do all staff share this view?

How do you work with someone who has a different philosophy or way of working?

4) Are there any times when staff get the opportunity to meet or get together?

Probe: How do you feel about staff change-overs?

Value of community meetings?

'Team-work' (ie do you feel part of a team?)

5) How do you think this ward is seen by the rest of the hospital (other wards, management etc)?

Perceptions of patients

1) Tell me about the kinds of patients on this ward (not really interested in diagnoses)?
2) Are there any kinds of patients who cause you a lot of work?
3) How do you get on with the patients? How do you relate to them?
4) How do the patients get on with each other? How do they relate to each other?
5) How do you think the patients see you?

Security and maintaining order

1) Do you think that this ward runs smoothly? (*Probe*: egs. Day-to-day strategies for maintaining order)
2) What might disrupt the smooth-running? (*Probe*: egs. Internal/ ward-based and external factors)
3) What do you think about the level of security? (*Probe*: new measures)

'Incidents'

1) What sorts of actions can you take when situations arise (that threaten the smooth-running in any way)? (*Probe*: minor/ major)
2) What might influence your decision about a course of action? (*Probe*: egs. Different patients etc.)

3) What might influence your decision whether or not to record an occurrence? (*Probe* egs.)
4) How do you decide on which category to record an occurrence as an incident? (*Probe*: Cat.ABC or D, egs)
5) Have you ever been in a position where you have not recorded something or not recorded it fully? (*Probe*: egs)
6) Conversely, have you ever recorded something although you didn't really want to? (*Probe*: egs)
7) What happens once an occurrence is recorded? What happens next?
8) What do you feel about the whole process?
9) What recourse is there for patients if they feel they've been treated unfairly?

   Probe: Complaints, patients rights etc.

   What's your opinion on this?

10) What recourse is there for staff if they feel they've been treated unfairly? (By patient, ward management, hospital).
11) Do you have many 'incidents' on this ward (Probe: A,B,C or D)?

How does this compare with other wards?

How might you explain the differences?

[we need to get some information or an example of a situation where they felt that they dealt with something well/ badly. Probe this: did they feel adequately trained to deal with it. How have they changed their approach etc..)

General

1) You are working in an environment which is clearly difficult. What support is there for staff?

   Probe: within/outwith the hospital Counselling services.

6) How do you deal with the stress?
7) Is there anything about the job you'd like to see changed?
8) Has the job changed at all over the time you've been working here?

9) Is there anything else you'd like to add about your experiences of working here?

10) Is there anything you'd like to ask me about the research?

Thank you for your time and comments

Revised Interview Schedule: Staff

(11:6:98)

Introductory statement

- Purpose of the research
- Not associated with Ashworth or any inquiry etc. Researchers from Bangor University
- Confidentiality
- Talk in as much detail as like
- May be some overlaps of questions
- Tell us if we've missed something that's important
- Time at the end for questions about the research
- Duration of interview: approximately one hour

Career history

1) What is you job/ position on the ward?

What is you Group Number?

2) How long have you worked at Ashworth?
3) How long have you been on this ward?
4) Where else have you worked?
   - pre-Ashworth
   - within Ashworth
5) What kind of training have you had? (Probe: type, value etc)
   - during time at Ashworth
   - PD-specific
6) Has the hospital offered support for further training?
   - e.g. financial/ time off for study
7) How did you come to be working on this ward?
   - did you choose to come on this ward?
   - How do you feel about being here?
8) How does this ward compare with elsewhere (in hospital and outside)?

- differences in terms of safety, patients, staff, moral etc.

Nature of the ward

1) Could you describe the kind of ward this is?
2) Do you think that there is a ward philosophy, a particular way of working?
   - how has this developed?
   - does this vary by shift?
   - How do you work with someone who has a different philosophy or way of working?
3) Do you feel that you are part of a team?
4) Are there opportunities when staff can meet to discuss work?
   - in work (e.g. staff handovers)
   - how useful are these meetings?
   - ouside work (e.g. socially)
5) How do you think this ward is seen by the rest of the hospital (other wards, management etc)?

Perceptions of patients

1) Describe the kinds of patients on this ward.
2) Are there any kinds of patients that cause you a lot of work?
   - difficult to deal with/ easy to deal with?
3) How would you describe your role in relation to the patients?
   - is your relationship with a patient affected by knowledge of their index offence
4) How do the patients get on with each other? How do they relate to each other?
   - value of community meetings?
5) How do you think the patients see you?
   - friend/ goaler etc?
   - do you feel that you have sufficient interaction with the patients?

6) Do you think this is the best environment for these kind of patients/ offenders?

Security and maintaining order

1) Do you think that this ward runs smoothly?
   - egs day-to-day strategies for maintaining order
   - do patients keep order?
2) What might disrupt the smooth-running?
   - i.e. precipitating factors? (internal problems: staff/ staff, staff/ patient, patient/ patient)
   - (external: management changes, RMOs, security, visitors, family problems)
3) What do you think about the level of security? (*Probe*: new measures)

'Incidents'

1) What are the means of dealing with situations which could disrupt the smooth running of the ward [OTHER than recording them as incidents?] Give examples?
2) What kinds of things might you record in the Daily Report?
3) What kinds of things might be recorded on the computerised Incident Reporting System?
   - what are the benefits/ drawbacks of each system?
   - what might influence your decisions?
   - How do you decide on the classification of an incident?
4) Can you describe a Cat D incident you have dealt with/ been involved in, either on this ward or on another PDU ward.
5) What is the most serious incident you have dealt with/ been involved in, either on this ward or on another PDU ward?
   - what happened to you afterwards (support)?
6) Do you feel adequately trained to deal with the sorts of incidents you have described?

- egs of time you dealt with something well/ badly.
- Is there any opportunity for staff to [debrief] discusse events following an incident?

7) Does the recording/ reporting on incidents affect the atmosphere on the ward?
   - affect relationships?
8) What do you feel about the recording/ reporting process?
9) Do you have many 'incidents' on this ward?
   - how does this compare with other wards?
   - how might you explain the differences?
10) What do you think about the procedures for patients who feel that they have been treated unfairly?
11) What recourse is there for staff if they feel they've been treated unfairly? (By patient, ward management, hospital - including informal mechanisms).

General

1) You are working in an environment that is clearly difficult. What support is there for staff?
   - within/ outwith the hospital
   - counselling services
2) How do you deal with stress?
   - switch off from job?
3) Is there anything about the job you'd like to see changed?
4) Has the job changed at all over the time you've been working here?
5) Is there anything else you'd like to add about your experiences of working here?
6) Is there anything you'd like to ask me about the research?

Thank you for your time and comments

Interview Schedule: Patients

(11:8:98)

Introductory statement

- Purpose of the research
- Not associated with Ashworth or any inquiry etc. Researchers from Bangor University
- Confidentiality
- Talk in as much detail as like
- May be some overlap of questions
- Tell us if we've missed something that's important
- Time at the end for questions about the research
- Duration of interview: approximately one hour

Career history

1) How long have you been a patient in Ashworth?
2) How long have you been on this ward?
3) Have you been in any other institutions before you came to Ashworth? (prison/ special hospitals/ secure units?)
4) Have you been on any other wards within Ashworth?
5) What kind of work do you do? (if any)
   Workshops/ ward work?
   Useful?
6) How did you come to be on this ward?
   How do you feel about being here?
7) How does this ward compare with elsewhere? (differences in terms of safety? Staff/ patient population/ morale? Etc.)
   Outside the hospital?
   Within the hospital?

Nature of the ward

1) Could you describe the kind of ward that this is?
2) Do you think that this ward has a particular philosophy, a particular way of working?
   - does this vary by shift? (do staff on each shift have different approaches/ ways of working?/ do individual staff have different approaches/ ways of working?)
3) Do you feel that you are part of a community on this ward? (have a stake in the ward?)

   Value of community meetings?
4) How do you, as patients, get on with each other?
5) How do you think this ward is seen by the rest of the hospital (other wards, management etc)?
6) What is the best thing about this ward?
7) What is the worst thing about this ward?

Perceptions of staff

1) Describe the kinds of staff on this ward.
2) Are there any kinds of staff you find difficult to deal with/ easy to deal with?
3) Do you think that your relationship with members of staff is affected by knowledge of you index offence?
4) How do staff get on with each other?
5) How do you think the staff see you?
   - prisoner/ patient etc.?
   - do you feel that you have sufficient interaction with staff?
6) Do you think this is the best environment for you?

Security and maintaining order

1) Do you think that this ward runs smoothly?

   If so, why?

2) Do you think that the patients keep order?
3) What might disrupt the smooth-running?
   - ie. Precipitating factors? (internal problems: staff/ staff, staff/ patient, patient/ patient) (external: management changes, RMOs, security, visitors, family problems)
4) What do you think about the level of security? (*Probe*: new measures)
   Hospital security?
   Ward security?

'Incidents'

1) Can you describe a verbal or minor incident been involved in or witnessed (either on this ward or on another PDU ward)?
2) What is the most serious incident you have been involved in or witnessed (either on this ward or on another PDU ward)?
   - what happened to you afterwards (support)?
3) Do you feel that the ward staff are adequately trained to deal with the sorts of incidents you have described?
   Do you feel that they deal with incidents well/ badly etc.?
   Is there an opportunity for staff to [debrief] discuss events following an incident?
4) Does an incident affect the atmosphere on the ward?
   - affect relationships? - patient/ patient, staff/ patient, staff/ staff?
5) What do you feel about incidents being recorded? (in clinical notes/ daily report/ computer)
6) Do you have many 'incidents' on this ward?
   - how does this compare with other wards?
   - how might you explain the differences?
7) What do you think about the procedures for patients who feel they've been treated unfairly?
8) What recourse if there for staff who feel they've been treated unfairly? (by patient, ward management, hospital - including informal mechanisms).

General

1) What contacts do you have with people outside the hospital?
   - family, legal advisers etc?
   - visits?
2) What causes you the most stress on this ward?
3) How do you deal with the stress?
4) Is there anything about the ward/ hospital that you'd like to see changed?
5) Have things changed at all over the time you've been a patient here?
6) Is there anything else you'd like to add about your experience of being a patient here?
7) Is there anything you'd like to ask me about the research?

Thank you for your time and comments

BIBLIOGRAPHY

Ahmad, S. (1996) *Fairness in Prisons*. University of Cambridge Ph.D. Thesis.

Ashworth Hospital Authority (unpub). Newman 'Ward Rules' in Patient Booklet.

Ashworth Hospital Authority (unpub). Owen 'Ward Rules'.

Ashworth Hospital Authority (unpub). 'Core Person Specifications - All PDU Staff'.

Ashworth Hospital Authority (unpub). 'Induction Leaflet'.

Ashworth Hospital Authority (unpub). 'Business Plan: 1994-1995'.

Ashworth Hospital Authority (unpub). 'Business Plan: 1996-1997'.

Ashworth Hospital Authority (1997) Incident Recording System (IRS) Category A-C, and Category D Incidents.

Ashworth Hospital Authority (1997) Hosiptal Security Manual.

Audit Commission (1993) *What Seems to be the Matter: Communication between hospitals and patients*. London: HMSO.

Batchelor, I. R. C. (1969) (ed). *Henderson and Gillespie Textbook of Psychiatry* (10th edn). London: Oxford University Press.

Beetham, D. (1991) *The Legitimation of Power*. London: Macmillan.

Berger, P.L. and Luckmann, T. (1967) *The Social Construction of Reality: a Treatise in the Sociology of Knowledge*. London: Penguin.

Bittner, E. (1974) 'Florence Nightingale in Pursuit of Willie Sutton: A Theory of the Police' in Jacob, H. (ed). *The Potential for Reform of Criminal Justice*. Beverly Hills: Sage.

Blackburn, R. (1983) 'Are Personality Disorders Treatable?' in *Issues in Criminology and Legal Psychology*. Vol 4 pp23-26.

Bowden, P. (1996) 'Violence and Mental Disorder' in Walker, N. (ed). *Dangerous People*. London: Blackstone Press.

Brindle (4/11/97) 'Secure Hospital 'Out of Control'' in *The Guardian*, pp4.

Busfield, J. (1996) *Men, Women and Madness: Understanding Gender and Mental Disorder*. Basingstoke: Macmillan.

Bynum, W. F. Jr. (1981) 'Rationales for Therapy in British Psychiatry, 1780-1835' in Scull (ed). *Madhouses, Mad-doctors and Madmen: The Social History of Psychiatry in the Victorian Era*. London: Athelone Press.

Carney, F. L. (1976) 'Treatment of Aggressive Patients' in Madden (ed). *Rage, Hate, Assault and Other Forms of Violence*. New York: Spectrum Publications.

Cavadino, M. and Dignan, J. (1992) *The Penal System: An Introduction*. London: Sage.

Clark, T. and Penycate, J. (1976) *Psychopath: The Case of Patrick MacKay*. London, Henley and Boston: Routledge and Kegan Paul.

Clarkson, C. M. V. (1997) 'Beyond Just Deserts: Sentencing Violent and Sexual Offenders' in *The Howard Journal*, Vol 36, 3, pp 284-292.

Cleckley, H. (1941) *The Mask of Insanity* (1st edn). St Louis: C.V. Mosby Co..

Cleckley, H. (1964) *The Mask of Insanity* (4th edn). St Louis: C.V. Mosby Co..

Cohen, P. (1968) 'Stability and function in society' in Open University (ed). (1970) *Understanding Society*. London and Basingstoke: Macmillan and Co. Ltd..

Cooper, G. (8/2/97) 'Paedophile Inquiry at Mental Hospital' in *The Independent*, pp 1.

Craft, M. (1962) 'The Treatment of Adolescents with Personality Disorders' in *The Howard Journal*, Vol 11, 1, pp 47-57.

Craft, M. (1966) (ed). *Psychopathic Disorders and their Assessment*. Oxford: Pergamon Press.

Davison, G. C. and Neale, J. M. (1987) *Abnormal Psychology*. New York: Wiley.

Davison, G. C. and Neale, J. M. (1990) *Abnormal Psychology*. (5th edn). New York: J Wiley and Sons.

Dell, S. and Robertson, G. (1988) *Sentenced to Hospital: Offenders in Broadmoor*. New York: Oxford University Press.

Denzin, N.K. (1970) *The Research Act*. Chicago: Aldine.

Denzin, N.K. (1988) *The Research Act: a theoretical introduction to sociological methods*, 3rd edn. Englewood Cliffs, NJ: Prentice-Hall.

Department of Health and Home Office (1991) *Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services*. London: Department of Health and Home Office.

Department of Health (1996) *Patient's Charter*. HMSO: London.

Department of Health (1999) *Reform of the Mental Health Act 1983*. Proposals for Consultation.

Department of Health (2000) *Reforming the Mental Health Act*. Cm5016, The Stationery Office.

Dolan, B. and Coid, J. (1993) *Psychopathic and Antisocial Personality Disorders: Treatment and Research Issues*. London: Gaskell.

Dunbar (1985) *A Sense of Direction*. London: Home Office.

Dworkin, R. (1977) *Taking Right Seriously*. Cambridge, MA: Harvard University Press.

Eastman, N. and Peay, J. (1998) 'Sentencing Psychopaths - Is the 'Hospital and Limitation Direction an Ill-considered Hybrid?' *Criminal Law Review*, pp 93-108.

Foucault, M. (1988) 'Politics, Philosophy, Culture: Interviews and Other Writings 1977-1984' in Kritzman (ed). New York and London: Routledge.

Frosch, J. P. (1983) 'The Treatment of Anti-social and Borderline Personality Disorders' in *Hospital Community Psychiatry*, Vol 34, pp 243-248.

Galting, J. (1961) 'Prison: the organization of dilemma' in Cressey, D.R. (ed). *The Prison: Studies in Institutional Organization and Change*. New York: Holt, Rinehart and Winston.

Garfinkel, H. (1967) *Studies in Ethnomethodology*. New Jersey: Prentice-Hall, Inc..

Gelder, M., Gath, D. and Mayou, R. (1983) *The Oxford Textbook of Psychiatry*. New York: Oxford University Press.

Genders, E. and Players, E. (1995) *Grendon: A Study of a Therapeutic Prison*. Oxford: Clarendon Press.

Glaser, B. and Strauss, A. (1967) *The Discovery of Grounded Theory. Strategies for Qualitative Research*. Chicago: Aldine Atherton.

Goffman, E. (1961) *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. New York: Anchor Books.

Goffman, E. (1967) *Interaction Ritual: Essays on Face-to-Face Behaviour*. Garden City, New York: Anchor Books: Doubleday and Company, Inc..

Goode, E. (1996) (ed). *Social Deviance*. Boston: Allyn and Bacon.

Grounds, A. (1990) 'Transfers of Sentenced Prisoners to Hospital' in Criminal Law Review, pp 474-478.

Gunn, J. (1991) *Mentally Disordered Prisoners*. London: Home Office.

Hamblin-Smith, M. (1922) *The Psychology of the Criminal*. London: Methuen.

Hammersley, M. and Atkinson, P. (1983) *Ethnography Principles in Practice*. London: Tavistock.

Harding, L. (17/2/97) 'Prison or Hospital?' in *The Guardian*, pp 2.

Hare, R. D. (1996) *The Hare Psychopathy Checklist - Revised*. Toronto: Multi Health Systems.

Hay, W. and Sparks, R. (1991) 'What is a Prison Officer?' in *Prison Service Journal*, Spring, 2-7.

Haynes, S. (1864) 'Clinical Cases Illustrative of Moral Imbecility and Insanity' in *Journal of Mental Science*, Vol 10, pp 533-549.

Health Committee (2000) Reporting on White Paper - Managing Dangerous People with Severe Personality Disorder: Proposals for Policy and Development. London: Health Committee.

Henderson, D. (1939) *Psychopathic States*. New York: Norton.

Home Affairs Committee (2000) *Third Special Report: Government Reply to the First*

Report of the Home Affairs Committee. London: Home Affairs Committee Publications.

Home Office (1975) *Report of the Committee on Mentally Abnormal Offenders*. Cm6244. London: HMSO.

Home Office (1984) *Managing the Long-Term Prison System: The Report of the Control Review Committee*. London: HMSO.

Home Office (1986) *Psychopathic Disorder: The Need for Reform*. Consultation Paper.

Home Office (1990) *Prison Disturbances, April 1990*. Cm1456, London: HMSO.

Home Office (1992) *Report of the Committee of Inquiry into Complaints about Ashworth Hospital*. Cm2028-1, London: HMSO.

Home Office and Department of Health (1994) *Report by the Working Group on Psychopathic Disorder*. Cm2088, London: HMSO.

Home Office and Department of Health (1999a) *The Report of the Committee of Inquiry into Ashworth Special Hospital*. Cm4194-II, London: The Stationery Office.

Home Office and Department of Health (1999b) *Managing Dangerous People with Severe Personality Disorder: Proposals for policy and development*. London: The Stationery Office.

Home Office, HMPS and Department of Health (1999c) *Managing Dangerous People with Severe Personality Disorder: Taking forward the government's proposal*. London: The Stationery Office.

James, A.L., Bottomley, A.K., Liebling, A. *et al.* (1997) *Privatizing Prisons: Rhetoric and Reality*. London: Sage.

Johnstone, G. (1996) *Medical Concepts and Penal Policy*. London: Cavendish Pub..

Kennedy, D., Laurence, J. and Jenkins, R. (8/2/97) 'Sex and Drugs Ring in High Security Wards' in *The Times*, pp 1.

King, R. D. and Elliott, K. W. (1977) *Albany: Birth of a Prison - End of an Era*. Henley and Boston: Routledge and Kegan Paul.

King, R.D. and McDermott, K. (1995) The State of Our Prisons. Oxford: Clarendon Press.

Kinsley, J. (1998) 'Security and Therapy' in Kaye, C. and Franey, A. (eds). *Managing High Security Psychiatric Care*. London and Philadelphia: Jessica Kingsley Publishers.

Koch, J. L. A. (1889) *Kurzgefabter Leitfaden Der Psychiatrie*. (2nd edn). Ravensburg: Domischen Buchhandlung.

Koch, J. L. A. (1891-1893) *Die Psychopathischen Minderwertigkeiten*. Ravensburg: Maier.

Kraeplin, E. (1896) *Psychiatrie, En Lehrbuch Fur Studierende Und Aerzte*. Reprinted in (1976) Classics in Psychiatry. New York: Arno Press.

Krebs, M. and Larson, K. (1988) *Applied Psychiatric-Mental Health Nursing Standards in Clinical Practice*. New York: John Wiley and Sons.

Liebling, A. and Price, D. (1999) *An Exploration of Staff-Prisoner Relationships at HMP Whitemoor*. Prison Service Research Report, No 6: HMPS.

Lombardo, L. (1981) *Guards Imprisoned: Correctional Officers at Work*. New York.

Maudsley, H. (1874) *Responsibility in Mental Disease*. London: King and Co..

Maudsley, H. (1885) *Responsibility in Mental Disease*. London: King and Co..

Mitchell, D. and Blair, J. (2000) 'State of the Art Psychopathy' in *The Psychologist*, Vol 13, 7, pp 356-360.

Moran, Owen and Richards (1994) 'Soft Skill Competencies' adapted from Spencer (1983) (leaflet unpub)

Morrison, P. (1991) 'The caring attitude in nursing practice: a repertory grid study of trained nurses' perceptions' in *Nurse Education Today*, 11, pp 3-12.

Morrison, P. and Burnard, P. (ed). (1992) *Aspects of Forensic Nursing*. Aldershot: Avebury.

Morrison, P. (1994) *Understanding Patients*. London: Bailliere Tindall.

News of the World (23/7/00)

O'Brien, D. (30/8/99) 'Should We Lock Them Up?' *Womans Own*.

Olden, M. (26/7/99) 'The One That Got Away' *The Big Issue*.

Parry-Jones, E. (1981) *From Workhouse to Hospital - A Story of H M Stanley Hospital, St. Asaph 1840-1980*. Clywd Area Health Authority.

Parsons, T. (1953) *Personality in Nature, Society and Culture*. Kluckhohn, C. A. and Murray, H. A. (ed). New York: Alfred A Krupal.

Parsons, T. (1965) *Social Structure and Personality*. New York: Free Press of Glencoe.

Parsons, T. (1978) *Action Theory and the Human Condition*. New York: Free Press of Glencoe.

Pinel, P. (1801) *Traite Medic-Philosophique Sur L'Alienation Mentale, Ou La Manie*.

Paris. Davis, D. D. (1806) (trans). A Treatise on Insanity. Sheffield: Cadell and Davils.

Powell, D. (4/11/97) 'Ashworth Inmate Ran a Holiday Firm' in North West, Merseyside and Wirral: *Daily Post*, pp1.

Powell, D. (4/11/97) 'How Sex Fiend Fled on Shopping Trip' in North West, Merseyside and Wirral: *Daily Post*, pp10.

Price, D. and Liebling, A. (1998) *Staff-Prisoner Relationships: A Review of the Literature*. Institute of Criminology, University of Cambridge.

Prichard, J. C. (1835) *A Treatise on Insanity*. London: Sherwood, Gilbert and Poper.

Prichard, J. C. (1837) *A Treatise on Insanity and Other Disorders Affecting the Mind*. Philadelphia: Haswell. (Reprinted in 1973 by Arno Press: New York)

Prins, H. (1995) *Offenders, Deviants or Patients?* Routledge: London.

Quality Assurance Project (1991) 'Treatment Outlines for Antisocial Personality Disorder' in *Australian and New Zealand Journal of Psychiatry*, Vol 25, pp 541-547.

Reiner, R. (1994) 'Policing and the Police' in Maguire, M., Morgan R. and Reiner, R. (eds). *The Oxford Handbook of Criminology*. Oxford: Clarendon Press.

Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency. (1957) Cm169, London: HMSO.

Ritter, S. (1989) *Bethlem Royal and Maudsley Hospital Manual of Clinical Psychiatric Nursing Principles and Procedures.* London: Harper Row.

Robinson, D. and Kettles, A. (eds). (2000) *Forensic Nursing & Multidisciplinary Care of the Mentally Disordered Offender.* London and Philadelphia: Jessica Kingsley Publishers.

Robinson, K. (1966) 'Law and Practice of Psychopathic Disorder in England and Wales' in Craft, M. (ed). *Psychopathic Disorders and their Assessment.* Oxford: Pergamon Press.

Robson, C. (1993) *Real World of Social Research.* Oxford: Blackwell.

Roth, M. (1990) 'Psychopathic (Sociopathic) Personality' in Bluglass, R. and Bowden, P. (eds). *Principles and Practices in Forensic Psychiatry.* Edinburgh; New York: Churchill Livingstone.

Schneider, K. (1923) *Die Psychopathischen Personlichkeiten.* Leipzig: Thieme. (trans). In (1950) Psychopathic Personalities. London: MW Hamilton Cassell.

Scott, P. D. (1963) 'Psychopathy' in *Postgraduate Medical Journal,* Vol 39, pp 1-7.

Scull, A. (1979) *Museums of Madness: The Social Organization of Insanity in Nineteenth-century England.* London: Allen Lane.

Scull, A. (ed). (1981) *Madhouses, Mad-doctors and Madmen: The Social History of Psychiatry in the Victorian Era.* London: Athelone Press.

Seligman, M.E.P. (1975) *Helplessness on Depression, Development, and Death.* New York: Freeman.

Simmons, J. and McCall, G. (1966) *Identities and Interactions.* New York: Free Press.

Shapira, R. and Navon, D. (1985) 'Staff-Inmate Co-operation in Israeli Prisons: Towards a Non-functionalist Theory of Total Institutions' in *Journal of Criminal Justice,* Vol 19, pp 151-163.

Sparks, R. (1994) 'Can Prisons be Legitimate? Penal politics, privatization and the timeliness of an old idea' in *British Journal of Criminology*, Vol 34, pp14-28

Sparks, J. R. and Bottoms, A. E. (1995) 'Legitimacy and Order in Prisons' in *British Journal of Sociology*, Vol 46, 1, pp 45-62.

Sparks, R., Bottoms, A. E. and Hay, W. (1996) *Prisons and the Problems of Order*. Oxford: Clarendon Press.

Spradley, J.P. (1980) *Participant Observation*. New York: Holt, Rinehart and Winston.

Stafford-Clark, D., Pond, D. and Doust, J. W. L. (1951) 'The Psychopath in Prison: A Preliminary Report of a Co-operative Research' in *British Journal of Delinquency*, Vol 2, pp 117-129.

Stephens, M. and Becker, S. (eds). (1994) *Police Force, Police Service: Care and Control in Britain*. Basingstoke: Macmillan.

Stockwell, F. (1984) *The Unpopular Patient*. Guildford: Biddles.

Sykes, G. (1958) *The Society of Captives*. Princeton: Princeton University Press.

The Diagnostic and Statistical Manual of Mental Disorders (4th edn). Washington D.C.: American Health Organisation.

Thomas, D. A. (1998) 'The Crime (Sentences) Act 1997' in *Criminal Law Review*, pp 83-92.

Topping-Morris, B. (1992) 'An Historical and Personal View of Forensic Nursing Service' in Morrison, P. and Burnard, P. (eds). *Aspects of Forensic Psychiatry*. Aldershot: Averbury Press.

Travis, A. (16/2/99) 'Psychopaths to be Denied Liberty' in *The Guardian*, pp 9.

Tyler, T. R. (1990) *Why People Obey the Law*. New Haven: Yale Press.

Vagrancy Act (1744) in Scull, A. (ed). *Madhouses, Mad-doctors and Madmen: The Social History of Psychiatry in the Victorian Era*. London: Athelone Press.

Walker, N. (1994) 'Care and control in the police organisation' in Stephens, M. and Becker, S. (eds). *Police Force, Police Service: Care and Control in Britain*. Basingstoke: Macmillan.

Walker, N. (1996) (ed). *Dangerous People*. London: Blackstone Press.

Walker, N. and McCabe, S. (1973) *Crime and Insanity in England II: New Solutions and Problems*. Edinburgh: Edinburgh University Press.

Weber, M. (1968) *Economy and Society*. Berkeley, California: University of California Press.

West, D. (1996) 'Sexual Molesters' in Walker, N. (ed). *Dangerous People*. London: Blackstone Press.

Willmott, L. (1997) 'Research into the Development of Facilities for Personality Disorder Patients at Ashworth Special Hospital' in University of Wales, Bangor: Masters Thesis.

World Health Organisation (1992) *The Tenth Revision of The International Classification of Disease and Related Health Problems* (ICD-10) Geneva: WHO.

Statute

Mental Deficiency Act 1913

Mental Health Act 1959

Mental Health Act 1983

Criminal Justice Act 1991

The Crime (Sentences) Act 1997