Part I

Developments in Therapeutic Communities
Introduction

In September 2002 I was appointed Governor of Grendon, a prison I had long admired and yet had never anticipated having a part to play in its therapeutic tradition. However, in spite of my enthusiasm and the reassurances of many colleagues that I was well suited to the position, my early experiences were fraught with tension and conflict.

I have described elsewhere how I soon began to feel like an interloper sent to erode further Grendon’s therapeutic core (Bennett, 2007). My role quickly became one of a broker, straddling the two very different worlds of Grendon and the Prison Service, or the ‘system’ as many Grendonites referred to it (Bennett, 2006, pp. 137–138). On the one hand, the Governor was seen to represent the ‘system’ with its managerial culture of performance management, audits and cognitive skills programmes, while on the other hand, I was expected to support a therapeutic community regime, many of whose participants retained a deep sense of suspicion of the wider Service and some of whom believed that Grendon’s very survival as the only prison devoted entirely to therapy was at stake.

Conflicts were endemic and unhealthy, particularly those acted out between therapy and operations, between those who saw themselves primarily as being tasked with ensuring the security of a category B prison and those who sought to preserve a safe environment for the practice of therapy based on principles of openness, trust, challenge and individual
responsibility. Getting the balance right is crucial if Grendon is to be effective as a therapeutic community prison.

Looking back at my own part in this drama, I can see that the timing of my arrival was far from auspicious. Grendon was undergoing one of its periodic bouts of insecurity brought on by the new managerialism and popularity of cognitive skills programmes. Moreover, the escape of three prisoners a year earlier, with its inevitable traumatic aftermath, only served to exacerbate the mood of isolation, vulnerability and suspicion. It did not help that Grendon lacked clear strategic direction within the Service as a referral option for long-term offenders with complex needs.

I mention this low point in Grendon’s recent history because it provided reason for reflection and an impetus for moving forward. Along with senior therapists and operational managers, including Michael Brookes, the newly appointed Director of Therapeutic Communities, who was commissioned to undertake a Grendon Review, we set about reconciling destructive internal conflict. We also recognised the need to incorporate mainstream developments in risk assessment, public protection, offender management, audits and performance targets while yet preserving intact the traditional therapeutic core. I have no doubt that the widely acknowledged success of Grendon over recent years lies partly in its achievement of mainstream performance targets and partly in the accreditation of its therapeutic regime, the latter being decisive in reasserting its reputation as an official therapeutic intervention.

We also pursued vigorously the promotion of Grendon not only to attract those men who might derive greatest benefit from therapy, but also to demonstrate Grendon’s continuing and increasing relevance in a changing custodial world.

Like our predecessors, who had wrestled with similar issues, we were convinced that good research was essential in proving Grendon’s worth as a rehabilitative regime. Indeed, Grendon has a long and impressive body of research and the prison has no difficulty in attracting applicants. But from the outset, I have contested that the published research has been overly narrow in scope. For one thing, there is an urgent need for an overarching review of existing research in order to identify significant themes. For another, the available body of research is restricted; much is highly statistical and focuses primarily on reconviction outcomes. There are of course notable exceptions, including the excellent monograph by Genders and Player (1995); many of the issues covered by them have continuing resonance.

I am not suggesting that reconviction studies are unimportant; far from it, reconviction rates remain one of the most important measures of rehabilitation and we are bound to seek the best ways of achieving the best reconviction outcomes. But there is so much more to Grendon that is
relevant and positive in terms of reforming prisoners and prison reform that statistical reconviction studies fail sufficiently to encompass.

Grendon is a prison widely acknowledged for its excellent prisoner–staff relationships, for its low levels of violence, drug use and resort to the use of force. It has no segregation unit and for a prison holding many men labelled potentially difficult and disruptive, it has remarkably few serious incidents.

As might be expected in a therapeutic context where men are constantly challenged, emotions often run high. Nevertheless, the prison feels exceptionally safe. How Grendon works, how all these positive outcomes are achieved, deserve our serious attention and are legitimate areas of enquiry for a range of disciplines. It is precisely for these reasons that I commend the editors of this book for broadening the approach as well as the focus of research in order to present a comprehensive view of this unique prison.

I have explained the background to how and why this volume was conceived. But what of its wider relevance?

One of the most frequently asked questions by visitors to Grendon is ‘why not more Grendons?’ If Grendon is an exceptionally safe and humane prison, which also happens to be highly effective in the rehabilitation of serious offenders, then surely it is worthy of replication? I have my stock answers. There are a few therapeutic communities in mainstream prisons, notably Dovegate in Staffordshire, originally described as the ‘Grendon of the North.’

Moreover, group therapy Grendon-style is not suitable for all offenders. Participation is voluntary and research suggests that therapy is more effective for those who have at least eighteen months to spend in a community.

But I am becoming increasingly confident that there are many more prisoners who could benefit from a Grendon-style regime, as indeed there are many aspects of the humane and rehabilitative regime at Grendon which could be transported to, or developed in, other prisons and which the research in this volume brings to the fore.

Peter Bennett

References

Chapter 1

Introducing Forensic Democratic Therapeutic Communities

Alisa Stevens

Introduction

Of the 140 prisons in England and Wales, just five currently offer a vision of ‘offender management’ based upon the principles and aims of the democratic therapeutic community (TC). Grendon – a category B (medium secure) establishment for up to 235 men – is the first, largest, and still the only dedicated TC prison, but has been joined in its penologically distinctive quest by TC units within the ‘mainstream’ men’s prisons of Gartree, Dovegate (both category B) and Blundeston (category C), and at Send, a closed women’s prison.

Democratic therapeutic communities, whether located in their traditional mental health, or more recently developed custodial, settings, offer a consciously designed, predominantly residential social environment and programme of treatment intended to help their members understand and, as far as possible, lessen or overcome their social, psychological, and emotional problems. It is the community as a collective and collaborative entity that is the primary therapeutic instrument (Roberts, 1997a), within which psychodynamic therapy – which emphasises the processes of change and personal development – is employed to unearth and ‘work through’ the (often unconscious) motivations and learned maladaptive protective
behaviours that result from formative experiences, particularly those acquired during a traumatic or abusive childhood (Malan, 1979). This potent combination of dynamic interaction between the individual, his peer community, and psychodynamic therapy encourages gradual accumulation of self-knowledge and insight which ultimately allows for profound and permanent personal change. Within prisons, this means that the community – the residents (the preferred TC term for inmates) and prison staff – work together to move from historical exploration and understanding towards a reduction in problematic behaviours and attitudes and hence ultimately, a non-offending future.

Psychiatric Origins

The origins of the TC treatment modality are generally attributed to the creation of specialist units – at Mill Hill, and more particularly, Northfield psychiatric military hospital – to treat traumatised World War II combat veterans presenting with acute dissociative and hysterical disorders. Keenly aware of the punitive and disabling mistreatment of Great War shell-shocked soldiers, and inspired by an emerging body of social scientific literature on small group processes and interpersonal relations (notably, Adler, 1924; Freud, 1922; and Mead, 1934), a handful of psychoanalytically-orientated psychiatrists considered the contemporary hegemonic ‘medical model’, as practised in secure psychiatric hospitals, to be systematically incapable of treating traumatised military personnel either effectively or humanely (Whiteley, 2004). In these ‘total institutions’, authoritarian, paternalistic professionals preoccupied themselves with the maintenance of control, hierarchy, and routine and slavish adherence to a myriad of, often bizarre, bureaucratic rules (Belknap, 1956; Caudill, 1958; Goffman, 1961; Stanton & Schwartz, 1954); whilst their deferential patients internalised an apathetic and pliant ‘sick role’ (Parsons, 1951) devoid of autonomy and individuality. By contrast, these TC pioneers hypothesised that this damaging and dependency-prone social environment only exacerbated in traumatised persons their tendency towards neurosis and personality disorder and that a more tolerant and empowering milieu might therefore relieve their symptoms of distress. Accordingly, they incrementally engineered a genuine revolution in psychiatric social relations by renouncing both the oppressive culture of the secure hospital and the traditional psychoanalytic dyad of ‘expert’ therapist and ‘grateful’ patient, in favour of a flexible, egalitarian organisational structure and collaborative, group-based interaction (Manning, 1976).
The initial, modest attempt at establishing a democratic TC occurred in the unlikely setting of a temporarily converted public school at Mill Hill, north London, to which psychiatric patients from the Maudsley Hospital were evacuated in 1940. In charge of a psychosomatic unit conducting physiological research into the aetiology of effort syndrome (or neurocirculatory asthenia, characterised by breathlessness, chest pain, giddiness, and persistent fatigue), the psychiatrist Maxwell Jones decided to share the research findings with his patients through regular didactic lectures. He soon realised, however, that the patients understood more, and their morale and self-esteem consequently improved, if he involved them in interactive group discussion by which each member contributed to the ‘social learning’ of the community. These small discussion groups began to affect the social structure of the ward, encouraging a flattened hierarchy and, in turn, greater sociological contextualising of the challenges treatment posed for both patients and staff (Jones, 1952, 1968; Whiteley, 2004).

Wilfred Bion, meanwhile, was appointed director of the Training Wing of Birmingham’s Northfield military psychiatric hospital and charged with rehabilitating men who, although psychologically disturbed, were considered capable of returning to military service (Whiteley, 2004). Together with his colleague John Rickman, Bion decided to confront the patients’ unruly and disruptive behaviour by re-defining disciplinary problems, in suitably combative terms, as the ‘common enemy’. For six weeks in 1943, they introduced discussion groups and communal activities, designed to replace the fractured social bonds of war with the mutual support of a peer community and hence, ‘to treat socially the social elements of the patients’ neuroses’ (Roberts, 1997b). The insubordination and subversion of military discipline this represented, however, proved intolerable to their superiors and Bion and Rickman were dismissed from their posts. Undeterred, over the next three years Siegmund Foulkes and Harold Bridger, amongst others, implemented gradually (what has been retrospectively called) ‘the second Northfield experiment’ in creating an avowedly democratic and therapeutic milieu – but this time with the approval of senior personnel – which again advocated the use of group analysis, regular meetings, and social activities involving the whole community (Kennard & Roberts, 1983; Whiteley, 2004).

In 1945, Northfield acquired a new hospital director, Tom Main, who sought to incorporate techniques from both psychiatry and psychoanalysis to construct a psychodynamic and interpretative exploration of his patients’ objective difficulties through their subjectively experienced interpersonal frustrations and conflicts. In May 1946, Main published an article in which he argued that a neurotic, attachment disordered individual needed ‘a framework of social reality which can provide him with opportunities for
attaining fuller social insight and for expressing and modifying his emotional drives according to the demands of real life’ (Main, 1946). He rallied his colleagues to replace the hospital as ‘social refuge’ with an internal community, and the role of the ‘superintendent’ psychiatrist with a humble ‘technician’, whose daily task was to study and facilitate ‘the social pull and push’ of the community in order to mobilise its therapeutic potential (Main, 1946). Several commentators have since timed the appearance of this ‘stirring and inspirational’ paper as the ‘date of birth’ of the democratic therapeutic community (Kennard, 1996).

It was, however, the prolific stream of publications which emanated from Maxwell Jones (inter alia 1942, 1946, 1952, 1956, 1959, 1968); his 12-year leadership from 1947 of a social rehabilitation unit for the treatment of personality and psychopathic disorders; and his international evangelising of social psychiatry, which were to secure for him the reputation of the father of the TC movement (Manning, 1976). Thus, although Main and his Northfield colleagues can claim the creation of the TC philosophy, it was Jones at Mill Hill who devised the method (Whiteley, 2004).

**A ‘Living-Learning’ ‘Culture of Enquiry’**

Endorsement of Jones’s distinct vision was consolidated by three years of independent research at the Henderson Hospital, conducted (at Jones’s astute request) by a team of seven social anthropologists, led by Robert Rapoport. The resulting publication, *Community as Doctor* (Rapoport, 1960), identified four complementary and interdependent therapeutic community principles. These guiding tenets apply equally to staff and to residents, are intended to realise the inherent therapeutic and rehabilitative potential residing within the community, and are still widely used to define the TC ‘proper’ (Clark, 1965) – the ideal, power-sharing, therapeutic community whose social environment is the main therapeutic instrument.

The principle of ‘democratization’ exists to ensure that each member of the community can participate equally in therapeutic and administrative decision-making, with unfettered access to vertical and horizontal communication channels. This is achieved through regular whole community meetings, in which all matters relating to the running of the community – both the mundane and the substantial – are openly discussed and debated (Rapoport, 1960). Jones (1976) was acutely aware, however, that shared decision-making could encompass a wide variety of practices, ranging from the full involvement of every community member, to resigned acquiescence, managerial manipulation, or the most cursory show of hands. This
principle therefore further requires residents to develop an internal commitment to, and interconnectivity with, their community, in order that they experience a high degree of ownership of the democratic process and become willing to assume responsibility for its implementation and implications, regardless of whether this coincides with their personal preference.

The most straightforward principle, communalism, requires that facilities and domestic arrangements are shared. Involvement in communal tasks – and the helpful realisation this frequently entails that one’s seemingly unique problems are, in fact, shared by fellow residents – is intended to increase a fragile member’s self-esteem and lessen his isolation and helplessness, whilst simultaneously reinforcing the community’s espoused moral values of social responsibility and altruism and promoting the development of trusting, reciprocal relationships (Rapoport, 1960; Yalom, 1980). The simplicity of communalism, however, conceals the complexity of its application: people may be united in their problems but have no propensity to co-exist harmoniously, and to do so without adopting a naïve conception of community as ‘phoney sharing’ (Morrice, 1979) often requires a substantial and sustained effort.

Although now possessed of rather unfortunate pejorative connotations, in Rapoport’s (1960) original designation permissiveness simply meant that residents tolerate in each other behaviours and speech that might normatively be perceived as deviant. Within the psychodynamic tradition all behaviour is meaningful, so all the individual’s conscious and unconscious cognitions, emotions, motivations, and interpersonal dynamics are considered diagnostically and therapeutically informative (Yalom, 1980). This behaviour, however, will not be available for analysis if, in order to gain approval or avoid censure, one feels compelled to modify or disguise one’s behaviour provisionally and instrumentally. The permissiveness principle therefore allows a TC resident to behave as he typically would – expressing and enacting habitual difficulties, secure in the knowledge of his continuing membership of an accepting environment – and this in turn facilitates the provision of plentiful ‘living-learning’ opportunities (Jones, 1968).

Crucially, however, this empathetic analysis is balanced by reality confrontation – the principle that although problematic behaviour is tolerated, it does not pass unnoticed or without criticism. Predominantly through the intimate forum of small therapy groups (typically of up to eight residents), members – as auxiliary therapists and role models – relate the effects such behaviour has upon them. This circumvents the universal tendency to deny, minimise, or rationalise one’s less admirable characteristics and their objectionable consequences (Rapoport, 1960) – or, in the criminologists Sykes and Matza’s (1957) memorable phrase, the...
deployment of ‘techniques of neutralisation’. Even seemingly trivial incidents and interactions are therefore analysed within this ‘culture of enquiry’ (Main, 1946) in order to excavate their ‘true’ meaning and purpose, and to encourage members to offer support, advice, and feedback in a collaborative and pro-social manner.

This dialectical relationship between the individual and the ‘miniature social universe’ (Yalom, 1980) of the group additionally expedites the ability of the TC member to confront the discordance between self-image and the figurative mirror presented by one’s peers, and so incrementally to acquire insight into the pervasiveness of maladaptive beliefs and behaviours. Indeed, Jones, who came to prefer the terms ‘social learning’ and ‘facilitator’ to ‘treatment’ and ‘therapist’ (1976), described social learning simply as ‘two way communication of content and feeling, listening, interaction, and problem solving, leading to learning’ (1980), and ultimately, personal change. (However, Jones did not explicitly accord social learning the status of an underpinning theory of TC treatment, nor does his use of the term properly correspond with social learning theory, as familiar to criminologists and psychologists.) Accordingly, the reality confrontation principle best embodies Main’s (1946) exhortation that a genuine therapeutic milieu must prepare the resident for a return to ‘a real role in the real world’.

Forty years after Rapoport, and as befits TCs’ continually evolving and dynamic nature, Haigh (1999) updated and adapted the original principles as ‘five universal qualities’ of therapeutic environments, presenting them as a developmental sequence which reflects the therapeutic journey of the TC resident. The first quality, attachment, utilises attachment theory (Ainsworth, 1967; Bowlby, 1969, 1973, 1980) to show the importance of sensitive joining (and leaving) procedures, so that residents develop a sense of belonging to, and of valuing and being valued by, their community (Haigh, 1999). The resident then learns that the TC’s culture of safety and containment (extending permissiveness) sets, and holds, appropriate boundaries within which they can experience their emotions; of necessity because ‘it is more fundamental for a place to feel safe than for anything to be allowed’ (Haigh, 1999). Only once these two elements are in place can residents confidently commit to clear, open, and honest communication (communalism) between and amongst staff and residents, and with the external world (Haigh, 1999). Greater involvement with, participation in, and responsibility for the community (reality confrontation) can then occur, so that residents become not only mindful of each other’s needs and problems and how to negotiate their place within the community, but of the ultimate interdependence of all members of society (Haigh, 1999). Finally, ‘a deep recognition of the power of each individual’ (Haigh, 1999)
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(Extending democracy) promotes residents’ sense of agency, empowerment and self-efficacy.

‘A Penal Institution of a Special Kind’

It will be immediately apparent that the therapeutic principles and qualities described by Rapoport and Haigh are not normally associated with the experience of mainstream imprisonment. Yet, the search for a different approach to rehabilitation had begun in 1931, nine years before the innovative work of Jones and his colleagues, when the Home Office appointed a departmental committee to inquire into existing methods of dealing with persistent offenders. Its resulting report argued that ‘a certain amount of persistent crime … is due to abnormal mental factors’ and thus ‘certain delinquents may be amenable to psychological treatment’ (Home Office, 1932). Given the paucity of scientific knowledge about crime, criminals, and effective treatment, however, both the Committee, and separately, the Medical Commissioner and Committee member, Sir Norwood East (1932), recommended that an experiment be instituted with ‘willing’ offenders by which the longitudinal value of psychological treatment could be assessed (Home Office, 1932).

This experiment was duly conducted between 1934 and 1938 with selected inmates at Wormwood Scrubs, under the auspices of a medical psychologist and psychotherapist, William Hubert (Faulk, 1990), and subsequently formed the basis of Drs East and Hubert’s *The Psychological Treatment of Crime* (1939). Although they did not attempt to establish whether, in fact, levels of recidivism had been reduced, based upon their clinical judgements of behavioural improvement, they unequivocally concluded that ‘the most satisfactory method of dealing with abnormal and unusual types of criminal would be by the creation of a penal institution of a special kind’ (East & Hubert, 1939).

Although East and Hubert’s recommendation was welcomed, the outbreak of World War II and prolonged bureaucratic procrastination ensured that two decades passed before building work actually commenced on the envisaged ‘experimental psychiatric prison’ – HMP Grendon, near Aylesbury in Buckinghamshire. When it finally opened in September 1962, during the height of penal welfarism (Garland, 1985), Grendon was tasked with caring for up to 250 men, 25 women (never, in fact, admitted), and 50 ‘borstal boys’ who, whilst they failed to satisfy the legal criteria for insanity and were not suffering from a psychosis, were nevertheless deemed to require psychiatric treatment and management (Commissioners of Prisons,
1963). Its explicit psychiatric orientation was confirmed by the employment, as recommended by East and Hubert (1939), of a forensic psychiatrist, Dr William Gray, as governor and medical superintendent, independent of the traditional Prison Service management structure; as well as psychiatrists, psychologists, and welfare officers, and the liberal prescription of psychotropic medication (Gray, 1973; Newell & Healey, 2007).

The ‘patients’, then, were perceived as troubled people who happened to be offenders – predominantly the less serious, though often recidivist, criminals who typically committed acquisitive rather than violent offences. In 1973, for example, 57 per cent of Grendon residents were imprisoned for property offences – compared to 17 per cent for violence, 8 per cent for robbery or its attempt, and 7 per cent for sexual offences (Cullen, 1997). Grendon’s humane and civilised regime perceived rehabilitation as a holistic endeavour and accordingly,

... therapy at Grendon [was] not primarily directed to the prevention of crime ... the principal undertaking of therapy [was] to facilitate and promote the welfare of each individual inmate. By so doing, it may succeed in enabling some inmates to avoid reoffending after their release, but this [was] a secondary or consequent effect ... (Genders & Player, 1995, emphasis preserved).

By the mid 1980s, however, Grendon was forcefully and frequently criticised from within the Prison Service for being aloof, inflexible, and overly selective in its clientele, too often unresponsive to the needs of mainstream prisons struggling to manage the increasing numbers of ‘heavy end’ and ‘control problem’ prisoners (Cullen, 1998). Moreover, as political support for the ambitious rehabilitative ideal declined (Allen, 1981) – the May Committee, for example, starkly concluded that ‘the rhetoric of “treatment and training” has had its day and should be replaced’ (May, 1979, para 4.27) with a more limited, legalistic notion of ‘positive custody’ (May, 1979, para 4.46) – so the pressure on the Prison Service’s ‘jewel in the crown’ (Genders & Player, 1995) to demonstrate its continued relevance and ‘special purpose’ increased.

This was the potentially hazardous context in which the Home Secretary decided to establish an Advisory Committee on the Therapeutic Regime at Grendon (ACTRAG) in order to review the prison’s future orientation. The resulting report (Home Office, 1985) contained no fewer than 29 recommendations, fundamentally and irrevocably changing its referral and management practices. Grendon was henceforth to focus upon providing therapeutic community treatment for three categories of offenders: socio-
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paths – a term little used by British psychiatrists, but descriptively interchangeable with the clinical constructs of psychopathy and antisocial personality disorder, and associated with a constellation of malign interpersonal and behavioural characteristics (American Psychiatric Association, 1994); sexually-motivated offenders; and the long-term (and particularly, life-sentenced) prison population. It was, in short, to stop recruiting recidivist property offenders and replace them instead with serious violent and sexual offenders (Faulk, 1990). A 28-bed psychiatric rescue unit for those suffering acute mental breakdown or prison-induced crisis, however, was created, thus preserving some continuity with Grendon’s original objectives. Exceptionally, this unit was ‘governed’ by a psychiatrist, offered individual psychotherapy and (the otherwise now discontinued practice of prescribing) psychotropic medication (Selby, 1991]. (Its gradual corruption, however, into a chronic long-stay unit with a high proportion of suicidal residents resulted in its 1993 closure.) Finally, and critically, ACTRAG replaced the post of medical superintendent with the conventional (non-medically qualified) ‘governing governor’ (Cullen, 1998), thereby ushering Grendon firmly into the Prison Service fold.

Implementation of ACTRAG’s recommendations, and the emergence of persuasive empirical evidence of Grendon’s rehabilitative success in the early 1990s (detailed in chapter 18), proved decisive in reviving the prison’s flagging fortunes. As Darwin might have predicted, by evolving, Grendon survived. In the years that followed ACTRAG, Grendon successfully repositioned itself as a national resource and centre of excellence for the TC treatment of the most serious offenders, measurably more ‘damaged, disturbed and dangerous’ (Shine & Newton, 2000) than the ‘average’ inmate. Approximately three-quarters of Grendon’s contemporary population are serving an indeterminate sentence, with more than 90 per cent imprisoned for murder, other violent crime, sexual offences, or robbery (Kennedy, 2008).

Diagnostically, Birtchnell and Shine (2000) found, from assessing 107 newly-arrived inmates, that 86 per cent met the criteria for at least one personality disorder, most commonly antisocial (69 per cent), paranoid (65 per cent), and borderline (60 per cent) personality disorders. Furthermore, the mean number of disorders per prisoner was 4.02. The incidence of psychopathy among Grendon residents has proven more difficult to state definitively. Only around a third of current Grendon residents have been assessed for psychopathy, either prior to admission or during their time at Grendon, using the standard measurement tool, Hare’s (1991, 1993) Psychopathy Checklist (Revised) (PCL-R). However, three fairly recent studies are instructive. During 1995, Hobson and Shine (1998)
administered the PCL-R to 104 inmate receptions, comprising 73 per cent of receptions that year. Of this sample, 26 per cent obtained a PCL-R score (out of 40) of 30 or above, indicative of prototypical psychopathy. Shine and Newton’s sample of Grendon men, resident between 1995 and 2000, scored a mean PCL-R score of 24, surpassing that (at 22) of high-security prisoners (Clark, 1998, cited in Shine & Newton, 2000). Gray et al. (2002) assessed 78 newly-admitted residents (59 per cent of all admissions) over a 15-month period between 2000 and 2001. Using the lower cut-off score of 25 then recommended for British offenders as metrically equivalent to a score of 30 in North America (Cooke & Michie, 1999) – they found 47 per cent of these receptions to be psychopathic. The scores ranged from 5 to 39, with a mean of 22 (Gray et al., 2002, p. 10).

**Grendon and Beyond: TC Units**

As a case study in successfully negotiating ‘volatile and contradictory’ (O’Malley, 1999) political penological policy, Grendon epitomises how, by adept re-branding of its ‘unique selling point’ to a new and more punitive penal marketplace, and by re-defining its optimum target population, it was able not only to thrive whilst other equally experimental penal initiatives floundered, but, moreover, to inspire the development of wholly or semi-contained TC units within mainstream prisons. The longest surviving of these units, at HMP Gartree in Leicestershire, has offered treatment for 23 men drawn from within Gartree’s life-sentenced population since 1993.

Further replication of the TC regime was advanced by two important surveys of unmet psychiatric need amongst sentenced prisoners. Forensic psychiatrists from the Institute of Psychiatry in London analysed the prison files of, and conducted semi-structured interviews with, a 5 per cent cross-sectional random sample of sentenced male adult and young offenders (Gunn et al., 1991), and then additionally 25 per cent of women inmates (Maden et al., 1994), from 16 prisons in England and Wales. They assessed for any psychiatric disorder and determined, from five options, the most appropriate treatment modality. The authors concluded that 5 per cent of male, and 8 per cent of female, prisoners would benefit from therapeutic community treatment; 47 per cent of whom were diagnosed with a personality disorder. They suggested that this provided a rough guide to the level of need nationally and justified the development of an additional TC prison, a recommendation strengthened the same year by the Prison Service Directorate of Health Care Task Force’s estimate that TC treatment
would be advantageous for at least 2392 prisoners by 2001 (Genders, 2003).

Together, then, these findings provided the impetus for the 2001 inauguration of a 200-bed, entirely separate TC unit for adult males within a private sector prison, Dovegate in Staffordshire (see further chapter 3). In 2003, a 40-bed unit for adult males opened at HMP Blundeston in Suffolk. The same year, the therapeutic needs of women were belatedly addressed by the provision of a TC unit at Winchester West Hill prison. Within a year, however, this prison reverted to the male estate, requiring the TC to transfer to Surrey’s HMP Send, with predictably disruptive consequences for the nascent community (Stewart & Parker, 2007). Regrettably, and notwithstanding its uniqueness within the female estate, the staff’s concerted marketing efforts, and the identification by HM Chief Inspector of Prisons (2006) of ‘a need for national action and responsibility to encourage and enable suitable women to be identified for the TC and take advantage of its opportunities’, Send TC has yet to fulfil its maximum potential occupancy of 40 places.

There have also been some prominent TC unit ‘failures’. Three separate facilities for young offenders have closed, at HMYOIs Glen Parva (1979 to 1996); Feltham (1989 to 1997); and Aylesbury (1997 to 2006). Additionally, the Max Glatt Centre at HMP Wormwood Scrubs operated from 1975 to 2002, during which time, like Grendon, it successfully transformed its target clientele to reflect its evolving remit, from adult male prisoners with addictive and compulsive behaviours to violent and personality-disordered offenders (Jones, 1997). Maintaining programme integrity and dedicated staffing levels, however, proved persistently challenging (Woodward, 1999). Ultimately, the host prison could no longer reconcile the TC’s need for a stable and committed community with the exigencies of a large, overcrowded, local prison with rapid inmate ‘turnover’, which, at the time of its mooted closure, was beset by ‘dysfunctional’ management and a ‘corrosive situation’ following serious allegations of widespread staff brutality (HM Chief Inspector of Prisons, 2001). As Lewis (1997) rather graphically, yet presciently, warned, ‘A small unit can be likened to a foreign body, or transplant, in the human body, and is subject to the same process of “rejection”’.

Most (in)famously, the Barlinnie Special Unit (BSU) in Glasgow achieved astonishing rehabilitative success with some of the most disruptive and dangerous men in the Scottish prison system (Cooke, 1989, 1991). Part of a long Scottish tradition of small units, the 10-bed BSU opened in February 1973 for the treatment of long-term and known or potentially violent inmates (Scottish Home and Health Department, 1971). Although the BSU never formally identified itself as a democratic therapeutic community, its
‘social community’ (Whatmore, 1990) and therapeutic regime was supported by TC principles and practices (Cooke, 1997). This semantic differentiation is perhaps explained by its specific purpose to contain and manage ‘difficult’ prisoners, and by residents’ desire to avoid any imputation of an overtly psychiatric orientation, given that the BSU invariably represented a last resort alternative to indefinite detention in Carstairs state mental hospital or isolation in Scotland’s then notorious – and evidently counterproductive – ‘cages’ and ‘diggers’ (segregation units, colloquially referred to in English and Welsh prisons as ‘the block’).

The BSU is now remembered by criminologists almost as much for its controversial end as for the imaginative and enlightened penological approach it pioneered. Opinions still differ as to whether its closure, in January 1995, was inevitable after becoming ‘stagnant and fossilised’ (Scottish Prison Service, 1994), with radical practices made routine, negative behaviour ignored, and non-involvement normalised (Cooke, 1997); or whether the – perhaps only temporary – problems it was experiencing were merely an expedient excuse to close a unit whose empathetic and tolerant treatment philosophy had become a ‘political embarrassment’ (Collins, 1997, cited in Sim, 2007). Certainly, it is difficult to reconcile the overwhelmingly supportive evaluation by Bottomley, Liebling and Sparks (1994) – who anticipated the correction of the problems they observed and confidently dismissed the option to close the unit (Bottomley et al., 1994) – with the catastrophic ‘regime slippage’ highlighted by the Scottish Prison Service (1994) in its internal working party’s report, partly informed by the findings of Bottomley et al. Tellingly, then, in his subsequent and exquisitely poignant memorial to the BSU, Richard Sparks (2002) writes of ‘the abiding sense of unease’ he still feels from ‘having been implicated unwar-ily in someone else’s arcane and somewhat ruthless stratagem’.

More positively, recently instituted procedures to audit and accredit penal TCs, and the development of a set of detailed manuals and guidelines for the delivery and management of prison TCs (discussed in chapter 2), should eradicate the re-occurrence of the sort of gradual community dis-engagement and regime ossification which proved so fatal to the BSU, and may help defend host-dependent units from the operational intrusions Wormwood Scrubs endured.

Furthermore, prison-based democratic therapeutic communities have provided the model for the development of ideologically and operationally similar socio-therapeutic prisons in several European countries. Most notably, Germany opened its first socio-therapeutic prison, Asperg, in 1969, seven years after Grendon (Lösel & Egg, 1997). Having consistently enjoyed political and judicial support, this type of regime is now available in approximately 30 German prisons, originally as institutions wholly inde-
dependent of the rest of the prison system, or, more recently, as ‘departments’ within mainstream prisons (Lösel & Egg, 1997; Smartt, 2001). This independence has ensured that the inter-disciplinary staff – including (often Rogerian, client-centred) psychotherapists, (cognitive-behavioural) psychologists, and social workers – enjoy considerable latitude to shape the delivery of ‘a colourful variety’ of social therapy to reflect their diverse competencies and interests, within their particular institution. Accordingly, ‘a uniform and systematic concept of the social-therapeutic institution does not exist’ (Lösel & Egg, 1997) in Germany. This therefore directly contrasts with English prison-based TCs which, as chapter 2 elucidates, must now adhere to a Core Model and which are, in some important respects, subject to, and arguably adversely restricted by, ‘top down’, centralised, homogeneity-encouraging Prison Service direction. A further significant distinction is that, since 2003, social therapy is mandated by the German courts for violent and sexual offenders serving more than two years (Wößner, 2008).

Conclusion

Prison-based democratic therapeutic communities have therefore evolved, from their unlikely wartime psychiatric antecedents, into a well-established, internationally respected, alternative model of imprisonment and treatment. They have doggedly survived ‘nothing works’, an increased emphasis upon security and control, new public managerialism, and a now seemingly perpetual ‘crisis’ of penal resources and penal legitimacy (Cavadino & Dignan, 1992). Notwithstanding the estimates of need from the Institute of Psychiatry and the Prison Service Directorate of Health Care, however, TCs in England and Wales still only operate on the periphery of the prison estate, providing treatment for just 538 men and women – and this in a prison population which is projected to reach as high as 90,200 by June 2012 (Ministry of Justice 2009:2). To radical criminologists and neo-abolitionists, TCs’ marginal status is a direct and deliberate reflection of the political and ideological marginalisation of penal welfarism and humanistic, holistic rehabilitation, in favour of a ‘tough’ law and order discourse and reductionist, deficits-focused risk management. Yet, when one ponders the fundamental incongruity of conjoining democratic therapeutic communities with coercive institutions of retributive punishment, even this numerically limited engagement with TC ideals represents an extraordinary achievement, whose ‘special purpose’ continues to be much admired by penologists, and much valued by those residents for whom it
enables meaningful, pro-social change (Stevens, 2008). The celebration of this achievement, realistically tempered by concern for the challenges that remain, begins in the chapters that now follow.

References


Compilation of Grendon Research (pp. 23–35). Leyhill Press. Available from Psychology Unit, HMP Grendon, Grendon Underwood, Aylesbury, HP18 OTL.