Reports and Pamphlets

Report on the Work of the Prison Department 1978. HMSO London Cmnd. 7619 £3.25.

Throughout my professional lifetime prisons seem to have lurched from one crisis to the next, a characteristic which perhaps they share with the mental health services. 1979 follows the familiar pattern, the current issues being overcrowding, industrial relations, and the awaited report of the Committee of Inquiry under the chairmanship of Mr Justice May. This inquiry has very wide terms of reference under the broad umbrella of 'the state of the prison services in the United Kingdom'. Recommendations are expected upon resources, organization and management, structure of the prison services, the remuneration and conditions of service of staff, shift systems, and industrial relations machinery. In his foreword to the present Annual Report the Director General of Prisons promises a separate publication of the Government's evidence to the Inquiry at a later date.

Perhaps there is a clue to the official view of the problems in the introductory chapter. We are told that 'as generally acknowledged, the service's difficulties mainly stem from the challenge of a large and increasingly difficult prison population; inadequate premises; severe overcrowding throughout the system; and a serious shortage of essential staff'. These are very familiar heart-cries, but solid statistical evidence is given to support them. The average daily population in 1978 was 41,796, the highest ever recorded, and it peaked at 42,370 only slightly below the all-time high of 42,419 in 1976. What is more, the number of females in custody is steadily climbing and reached a new peak of 1,468 in November 1978.

The Prison Department presumably feels it cannot comment upon the reasons for this heavy burden, and it will be interesting to see whether the Government evidence to the May Committee has made any proposals about substantially easing it. Clearly, however, the roots of such difficulties have nothing to do with prisons and are to be found in social attitudes. It is still a remarkable fact that Britain is locking up a higher proportion of its population than most European countries find it necessary to do. Mr Justice May and his colleagues will not be able to make many comments about these wider social issues, but if real remedies for our chronic prison problems are to be forthcoming at some stage someone, somewhere, will have to tackle them.

Another indication of the underlying difficulties which led to the May Committee is the inclusion of a new chapter in this year's Report called 'Industrial Relations'. All society's institutions are eventually affected by widespread social change, such as the growth of worker control. Those of us who work in the National Health Service are increasingly aware that decision-making is now profoundly influenced by the views of employees, which are often expressed through the trade union structure. Much to the amazement of many members of the judiciary, similar patterns are now beginning to occur within the prison service, and it may not be too long before consultation with staff will be necessary before the admission of a prisoner to prison in the same way that they are currently necessary before the admission of a patient to a hospital. 1978 saw a sharp increase in the number of episodes of industrial action taken by different branches of the Prison Officers' Association. The figures speak for themselves:

Year	*No. of occasions on which branches took action*	*No. of branches involved*
1975	*19*	*13*
1976	*34*	*23*
1977	*42*	*21*
1978	*119*	*63*

The Report draws attention to two consequences of industrial action, in spite of the fact that most incidents were restricted to a minority of establishments. First, staff relationships between prison officers and other staff are adversely affected; second, important work such as the building programme, maintenance and the general improvements from which staff and inmates alike will benefit have been held up significantly, and prison industries have become unprofitable.

One slight relief from the pressure on prisons is perhaps evidenced by the increasing number of bail hostels which are now opening. Eleven more were opened during 1978, and there are now approximately 210 bail hostel places available for courts.

In contrast to earlier years, the chapter on health and medical services is not preoccupied with the failure of the NHS to deal adequately with mentally abnormal offenders. This may be in part because the pressure on the prison psychiatric services has fallen to some extent.

Psychiatric referrals to visiting psychiatrists and NHS consultants have increased from 7,472 in 1977 to 9,818 in 1978, presumably relieving full-time medical officers of some psychiatric work. In addition to this, consultant psychiatrists visited establishments on 3,118 occasions (an increase of 15 per cent) to examine and prepare reports at the request of inmates' solicitors. The biggest change, however, is in the continuing fall in the number of persons remanded in custody or on bail for the purpose of obtaining a psychiatric report from a prison doctor. In 1978, 8,962 were remanded for psychiatric investigation—the

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corresponding figure for 1977 was 10,190. The number of hospital orders also fell, no doubt partly as a result of the reduced number of psychiatric referrals. However, the Report is at pains to point out that it is not possible to deduce from the bare figures whether more or fewer offenders suffering from mental disorder warranting detention in hospital are now being received into prison at the sentencing stage. A small point of interest to College members may be that during 1978 24 inmates were offered and accepted ECT.

No mention is made in the Report of the difficulties with recruitment of medical staff, although it is possible to discern the problem from looking at the bare figures. The prison medical service has now 100 full-time and 114 part-time medical officers; this leaves vacancies for 22 full-time and 33 part-time medical officers.

A final point of medical interest is that a working group was set up during the course of 1978 to review the operation of Grendon prison, which provides a unique community therapy service for male prisoners, both adults and youngsters, who have neurotic disorders and personality problems. I have myself researched this establishment for some three or four years and recommended that it should continue with its important work, even although many criminologists are frustrated by it because it is making no more and no less impact on reconviction rates than any other prison. So I was gratified to see that the Prison Board has endorsed the working group's preliminary conclusion that the establishment should continue in its present rôle.

This Report, then, has a slight air of expectancy and uncertainty about it and all attention will be focussed on the May Committee Report which should have appeared by the time these comments are in print.

JOHN GUNN

Correspondence

Criteria for Consultant Posts

DEAR SIR,

I should like to comment on the Appendix (Criteria for Consultant Posts in Psychiatry) to the article 'Appointment of Consultant Locums' (*Bulletin,* October p. 149).

In Paragraph 1, despite exceptions, the main emphasis is on the essential nature of the MRC Psych qualification for a candidate. Although it is in any candidate's interest to have extra qualifications with which to impress interviewing committees, there is no evidence to support the view that the possession of the MRC Psych qualification makes a candidate any more fit to occupy a consultant post than another candidate without such a possession but with similar experience.

Whereas Paragraph 3 contains important desirable qualities for a consultant in its attention to previous experience, including that of teaching, there is no mention of the depth or quality of the experience. I realize that it is difficult to objectify the quality and easy to list the breadth of an experience, But I do not think this should be an excuse to emphasize one above the other.

I also think it about time that the emphasis on research experience is looked at critically. I feel this is included because of the research orientation of the majority of those responsible for formulating College policy. Is it really such a desirable quality for a consultant working in the National Health Service? Time spent in research normally means time spent away from clinical experience, and surely this is the situation in which most consultants should work most of the time. The special emphasis on research 'worthy of publication' seems ambiguous since journals vary so much in the quality of work accepted.

It is interesting that when one looks at Paragraph 4 practically, one realizes that the eligibility for consultant posts in different specialties varies. A minimum of 5 years' psychiatric experience, with 2 years as senior registrar, is required for General Psychiatry. Child and Adolescent, Forensic and Psychotherapy posts all require 3 years senior registrar training. In these fields a senior registrar post is unlikely to be obtained before 3 years in other posts, making a minimum of 6 years' experience the basic requirement. Although in Subnormality 3 years' experience as senior registrar is again required, these senior registrar jobs are often filled by less experienced doctors. My point here is that these recommendations seem to be authorizing the growing trend towards superior and inferior branches of psychiatry, just when psychiatry is beginning to be seen itself as an equal to other branches of medicine.

I hope this letter may provoke other correspondence from psychiatrists like myself who have reservations about some of the present trends in psychiatric training reflected in the 'finished sketch', the 'Candidate for a Consultant Post in Psychiatry.'

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