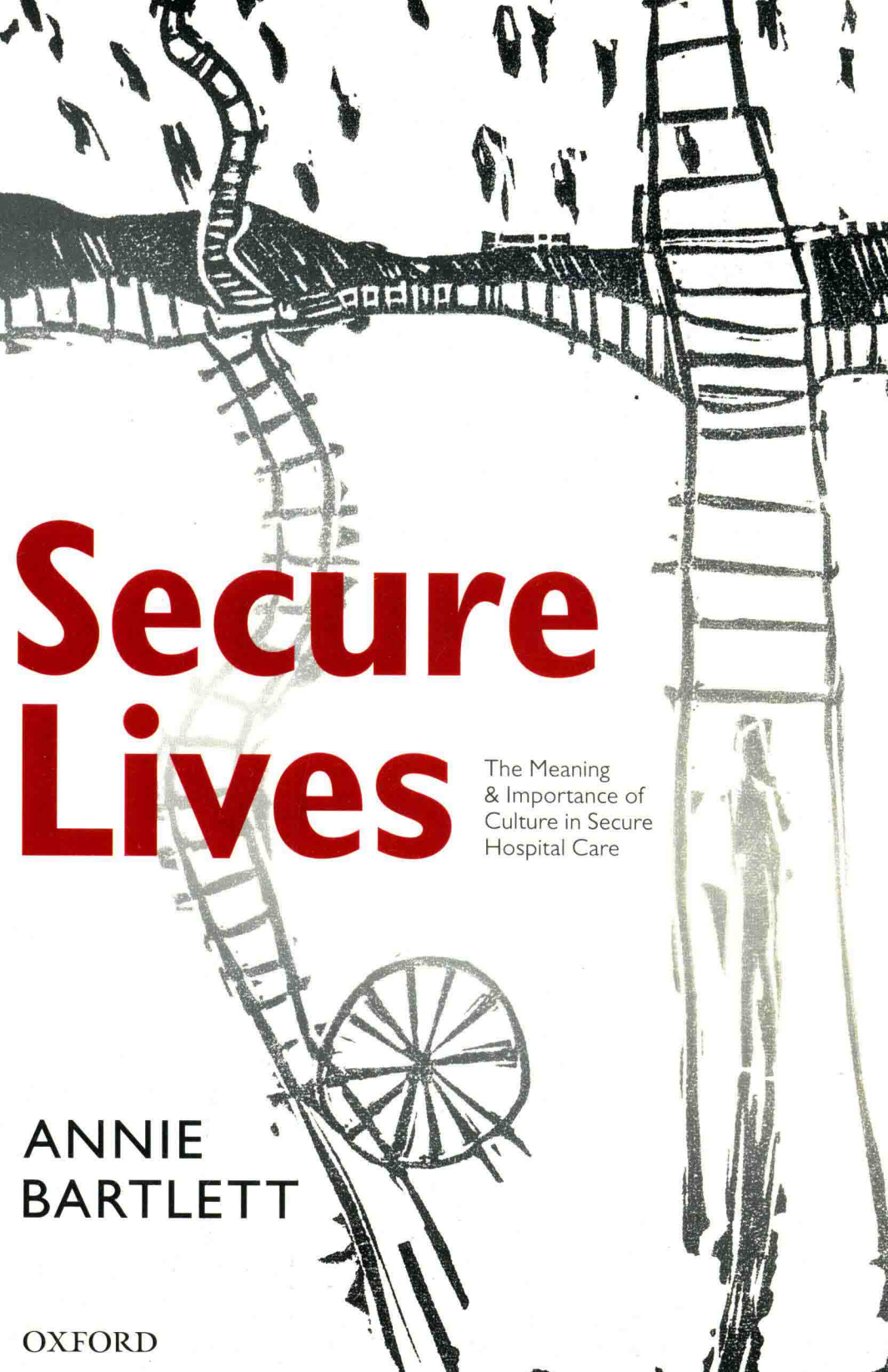

Secure Lives

The Meaning & Importance of Culture in Secure Hospital Care

ANNIE BARTLETT

OXFORD

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Foreword

To me as a psychiatrist who has been deeply concerned about the effects of psychiatric institutionalisation, Annie has indeed shared 'a glimpse into lives less lived than they might have been.' My own career rather dramatically changed direction after many years in general practice, followed by general psychiatric training, child psychiatry and psychotherapy. I rather belatedly discovered institutions and was convinced that the culture of these places was detrimental to the lives of the patients who had been thus set apart. This was in the early eighties when the 'ordinary life' movement was just beginning—it was a heady time. If I had known how long ideas about deinstitutionalisation would take effect in my own field of learning disability, perhaps I would have been less optimistic! This book is therefore of great interest dealing as it does with the nature of psychiatric institutions generally as well linking to current issues in non-institutional care.

Annie is very unusual as a psychiatrist who has also studied anthropology, in being able to frame questions about institutions, and to understand and describe so eloquently what happens inside one in particular, in ways that are of interest to clinicians, but also to social scientists and the general public as well as the people known as 'patients'.

Her writing brings to life people whose lives are unknown unless they are sensationalised in the media. The telling detail in the accounts of patients' lives reminds us of their individuality and builds a sense of their own agency and attempts to make sense of their lives, as well as their own difficulties in engaging fully with the culture of the place that they must now call home.

In using historical material she speaks to contemporary issues and reminds us that there are enduring and repeating themes in health care. We continue to think and at times to worry about how we look after vulnerable people. How we consider these questions and how we try and improve care will vary from generation to generation, but Annie

shows how much clinicians and managers can learn from other disciplines such as anthropology and social science. A narrower perspective will further diminish the lives of individuals who are dependent on the culture of a secure hospital for their own survival.

This book does not rush to judgement. Instead it is thought provoking about power and influence in hospital care and how they affect both clinical staff and patients, personally and locally.

That her work centres on a population held in secure hospital and deemed to be dangerous does not alter the fundamental questions about how institutional care is provided and maintained. Annie asks a very simple question that generally is hard to answer, which is to whom do we attribute responsibility—whether to systems or individuals in positions of authority. Anything that sheds light on what drives superficial and/or profound change and helps us identify real improvement is to be welcomed. This simple question will always be relevant to health care delivery as are so many of the issues in this imaginative, compassionate and insightful book.

My own research with Jane Hubert, a social anthropologist, involved an ethnographic study of a ward in a hospital for people with learning disabilities, now long closed. Some of the feelings described by this book's researchers about their fieldwork resonated strongly with me. The ethical issues involved in publishing our findings delayed publication for a while but the work has been widely cited. I wish Professor Bartlett the widest possible audience for her book too, focussing as it does on a different but equally complex population.

Professor Sheila the Baroness Hollins Emeritus
Professor of Psychiatry of Disability,
St George's University of London Past President,
Royal College of Psychiatrists Past President,
British Medical Association

Preface

This book is about two key ideas: culture and institutions. It is also about how those ideas can help us understand something that is important, i.e. how and when it is reasonable to lock up people who have mental disorders. All of this is made more digestible and more real by looking in detail at part of one institution, at one time. The institution is an extreme case, as it is a High Secure Hospital; to some people this may be a contradiction in terms. The fact that it is high secure and what that term means is part of the point of the book. It allows a glimpse into lives less lived than they might have been. It is therefore a book both about the function of a particular institution, or at least part of it, as well as how institutions, particularly other secure hospitals, can and do function. This is not to argue from one, single extreme case to unfortunate generalizations about care and secure care but to use the case of high security, as it was at the time of the study, to raise questions that apply, now, elsewhere as well.

There are three High Secure Hospitals in the UK today and their names are well known: Broadmoor, Ashworth and Rampton. Enthusiasm for their existence has varied over the years. They have survived calls for their closure, as well as being full to bursting in the past. Today they are much smaller than they were ten years ago, or twenty or thirty years ago. They remain high-profile institutions. They have housed a small number of well-known people—Ronnie Kray and Graham Young—and continue to house others—Peter Sutcliffe, the 'Yorkshire Ripper', Ian Brady the 'Moors Murderer', the nurse Beverley Allitt, and Christopher Clunis, whose killing of Jonathan Zito prompted a radical overhaul of psychiatric community care. Apart from this handful of household names, most of the men and women sent there will be noteworthy only to a few people: their families and friends, their victims—if they still live—and their victims' families. People admitted to the High Secure Hospitals are thought, at the time of admission, both to be dangerous and to have serious mental health problems. From this, it follows that they are in need of inpatient psychiatric

hospital care but in a secure environment. Previously, they were called Special Hospitals, an interesting term in its own right. They were also meant to offer 'maximum' security until it was found they were really no more secure than a local prison. Yet, the historical term seems to conjure an image of an end point; nothing is higher than maximum. This is true. The High Secure Hospitals are end points, both in the sense that there is no higher level of security in hospital care and that the length of stay is years. It is difficult to leave. Many would argue that that is appropriate.

But it is not only those admitted as patients that have caused the three hospitals to be a focus of continuing interest. The people who work in these hospitals and what has happened in what were 'the Specials' have been as much a subject of interest as the patients themselves.

Few would doubt that there are people in England and Wales who need to be contained in order to safeguard the public. The moral, professional and ethical uncertainties so evident in the care, custody and treatment of the 'mad and bad' begin at that point. High Secure Hospitals are maintained by and for all of us. They take people whom society rejects, whose actions we abhor and who are often disowned by those who should be closest to them. In the name of the public, patients can be either vilified or pitied by the media. To imagine that there is no potential for these extremes of sentiment to be further played out when such individuals are concentrated in institutions is naive. Such individuals generate powerful and conflicting feelings in those around them. Just as many of the patients cannot see themselves or others as having good and bad characteristics, only one or the other, the High Secure Hospitals and their staff and patients have been sheared off from the 'good' parts of society. But, what happens within the walls does ultimately connect with all of us; to pretend otherwise is to reinforce the historical isolation of the High Secure Hospitals. In effect, it is to throw away the key.

This book is driven not simply by intellectual curiosity but also by the belief that what happens inside High Secure Hospitals and other secure institutional settings is important. This book includes a lot of information about part of one High Secure Hospital that we will call Smithtown. It looks at how people lived and worked in the hospital in the early 1990s and tries to report what they said and thought. The wards which took

part in the study are now different. Patients and staff have moved on. Ward environments are different. Ward philosophies change. The hospital itself is managed by a different organisation. But the questions the book addresses do not go away so easily.

The deinstitutionalization of mental health services continues, but different secure hospital units have been built in the last decade. As one set of institutions fades away, a new set has emerged. The new institutions are much closer to where most people now live, in cities.

The hospital under discussion has a physical reality; it is a series of buildings but it has a social reality too. This book is also about how the culture of the hospital is understood, who owns or acknowledges any of these understandings, how sure we can be that cultural norms exist and what constitutes culture anyway. Given the way in which so many understandings of culture exist—there is an anthropologist who counted and since then no doubt more meanings have appeared—there is a need to be precise. This is not just another sterile academic enterprise, on a par with angels on pinheads. It does matter what cultures are embodied in secure hospitals. There was a view that the culture of the Special Hospitals was a problem. It was said they were too rigid, too much like prisons and insufficiently therapeutic in their approach to patients. The managerial mandate of the then Special Hospital Service Authority was to change that.

So far, nothing much has been said about psychiatry. Smithtown is a psychiatric hospital.

So, the first part of the book is about the history of High Secure Hospitals, and what psychiatry says they are. This is sensible, as, at one level, they are simply hospitals for people with mental disorders. The truth is, they are also highly politicized. They sit in a political, not just a health context.

Part of understanding this in depth is to ask two questions. First, what is known about psychiatric hospitals? Second, what is known about prisons? Both psychiatric hospitals and prisons have been investigated, researched and much talked about by different kinds of people, including representatives of different academic disciplines. They are not the preserve of, respectively, psychiatry and the prison service. This is not a review of everything ever written on either psychiatric hospitals or prisons. It is selective. What has made it into the book it is, is there because it seemed

relevant to the two key concepts: culture and institutions. There are many arguments about how these different kinds of institutions should be properly understood. Broadly, psychiatrists and prison staff are on one side, and social scientists and historians are on the other but the devil is in the detail. Below the level of published debate is the impact on real lives caused by changes in public policy and psychiatric and penal practice.

Some of the disagreements in the literature are because people asked different kinds of questions and had different ways of answering those that they thought were important. So, the next section looks at what was a tension throughout the study on which this book is based. This has also been a personal tension throughout much of my adult life, between how psychiatry looks at the world and how anthropology does. Donald Rumsfeld talked about the 'known unknown'; this is more about unknown knowns. Each discipline can silence the other by ignoring its existence. Both claim to be eclectic, both are new kids on the block—psychiatry new in medicine and anthropology new in social science. This book is in the space between and speaks in two directions. This is both uncomfortable and intriguing.

The legitimacy of an anthropological approach to High Secure Hospitals and a debate about the nature of its questions, as opposed to those asked by psychiatric research, are explicitly considered in the study. Social anthropology's reflexive approach to an understanding of the social world, in particular how it frames the understanding of research during the fieldwork described in the book, became apparent. My professional identity is that of psychiatrist, the study approach was anthropological. This made it crucial to consider how the researchers' intentions were understood, what people in the hospital thought about us and the status of our observations, as well as how findings might be translated into writing. This led to some sound ideas on the nature of social relations in Smithtown and who was in charge of what.

Ethnographic material from the empirical study answers a series of basic questions about daily life in High Security.[1] In this specific context,

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[1] Generous funding was obtained from the Wellcome Trust. They recognized the difficulty and potential impact of the project topic. The Wellcome Trust had the advantage of being independent of all government agencies and had no expressed position on the future of the Special Hospitals.

not previously studied in this way, the meaning of culture became critical. Anthropology, the investigative tool of the study, is preoccupied with culture, a word that is notoriously difficult to define. The construct of culture in atomized or divided societies is very relevant to discussion of ward life, as previous authors thought that patients living together had no shared culture. This part of the book describes and contrasts beliefs, attitudes and social practices in Smithtown with various understandings of culture and cultural knowledge. The managerial identification of a 'cultural problem' among the clinical staff of the Special Hospitals resulted in this being an obvious area of interest.

The recent Francis Report, following deficiencies in the care of the elderly in North Staffordshire, reminds us that problems of clinical and managerial culture are not confined to the care of the dangerously mad. The recent Winterbourne Report reminds us that the care of vulnerable adults in locked units can go badly wrong when a culture of cruelty goes unsuspected.

The wider NHS has been told repeatedly that it must change, and the reasons for this are less to do with care quality than a need to deal with rising demands for health care. Most recently, the financial constraints imposed on the health service have made change imperative. To many health professionals, calls for change have seemed no more than a rhetorical device common to successive governments, signifying little. To others, they have seemed to be a way to channel the creative energy of clinicians who strive for excellence and improvement on behalf of patients whose care might otherwise be tinged with complacency. Many of us who work in the NHS today accept a paradoxical state of permanent change, with or without the impetus of the recent Francis or Winterbourne reports.

So, the last part of this book takes us back into the wider world to explore the relevance of the ideas on both culture and cultural change, emerging from what is, after all, a single case study. There are several reasons why something so particular and, to be frank, so odd, as a High Secure Hospital matters.

Secure hospitals will carry on locking people up. While the last decade has seen investment in this area outstrip that of the rest of mental health

services, these high-cost low-volume services are under scrutiny. It is no longer good enough to say clinicians know best and so another bed must be found. In straightened, economic times, better value for money is demanded. How we want Secure Hospital care to work is both a parochial issue for clinicians and managers, as well as patients and relatives but is also important for society more generally. It has been said that the test of a society is how it runs its prisons. How we run our Secure Hospitals is also a good test. The culture of our secure institutions and their reach tell us about ourselves, as much as describing those who do not fit easily into general society. The ethos they express speaks beyond the walls and mesh fences of now regulation height. How and why we lock people up and what it feels like when we do are practical clinical questions but also moral and political ones. For people who think execution is best, this book is not for them. For people who think long-term detention in the name of care and therapy is never justified, this is probably not for them either. For those who want to know a little of what it really can be like in high-security hospital care, it might be. And, in being written, it is there for all of us to consider.

Anthropological accounts often rely on salient detail to bring them to life. In this case, there are still paramount issues of confidentiality, for staff and patients. The reader may be left wanting to know more about given individuals who feature in the study. Both patients and staff in the Special Hospitals have suffered from prurient curiosity and sensationalist writing. Care was taken at all stages of the study on which this book relies to minimize the likelihood of any individual being identifiable.[2] The reader may be surprised to discover that all the staff and patients in an English Special Hospital are French, and that the wards carry the names of French towns and cities. So be it.

[2] Empirical data could not always be cited in its entirety; this is indicated in the text. All field-note material is in italics in the text.

Acknowledgements

My thanks go to the people and organizations that have made this book possible. It has had a long gestation period and I hope they will think it was worth the wait.

Nigel Eastman and Gilbert Lewis helped germinate the idea, one night in South London: both gave very practical support. Nigel Eastman continued to look on kindly from a distance and persuaded Hubert Lacey and Deji Oyebode to give me time to complete the doctorate that informs the book. The Wellcome Trust and notably David Gordon had the imagination to fund me with a Wellcome Trust Health Services Fellowship, at a time when no one in a medical school undertook qualitative inquiry. Esther Goody was always an enthusiastic Doctoral supervisor and, unlike me, did not doubt my capacity to complete the original study. The Department of Social Anthropology at the University of Cambridge taught me whatever I know about social anthropology, and my fellow students offered ideas and encouragement. Marilyn Strathern provided thoughtful and pragmatic advice. Sally Beckwith, Marie Clack, Anne Gatenby, Mary Healey Scully and Joan Stevenson, all of whom have been unfortunate enough to be my secretaries, helped with different stages of what is finally a book. Caroline Dacey kindly helped with proofreading.

Smithtown Hospital allowed me access to their staff and patients who were generous enough to talk to me and to my two research assistants. That the project happened was in itself remarkable. I hope those to whom we spoke will feel that I have listened and looked carefully, although the difficulties of doing justice to the experiences of staff and patients' lives and the complexity of the hospital's purpose, in no small measure, account for the delay in publishing this book. Anne Backhouse and Matthew Fiander were my ears and eyes on two wards in Smithtown. Like me, they found the work exciting but demanding. I owe them an immeasurable debt for their conscientious fieldwork but also for their common sense, sensitivity, humour and integrity. I was very lucky to find them.

In their various ways, Ruth Evans, Gill Mezey, Diana Souhami and my anonymous Smithtown reader all helped. Pat Lawton's sensible medical advice allayed some last-minute anxieties. Henrietta Moore's commanding understanding of her subject meant I received detailed anthropological advice at a critical point. Martin Baum was brave enough to commission a work that probably does not fit neatly into his brief with OUP, and Peter Stevenson and Lauren Dunn have cajoled and guided me to publication.

Sandra and Fred were just there, which, it goes without saying, was and is invaluable.

List of abbreviations

CMHT	Community Mental Health Team
CNWL FT	Central and North West London NHS Foundation Trust
CTO	Community Treatment Order
DSPD	Dangerous and Severe Personality Disorder
HAS	Health Advisory Service
HMIP	Her Majesty's Inspectorate of Prisons
IBVM	Institute of the Blessed Virgin Mary
IPP	Indefinite Sentences for Public Protection
MAPP	Multi-Agency Public Protection
MDO	mentally disordered offender
MIND	National Association for Mental Health
MSFT	Mid Staffordshire NHS Foundation Trust
NAs	nursing auxiliaries
NCCL	National Council for Civil Liberties
NOMS	National Offender Management System
POA	Prison Officers' Association
RCN	Royal College of Nursing
RMO	Responsible Medical Officer
SHSA	Special Hospitals Service Authority

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