bers react to retain the equilibrium, with a consequent greater wish to change things on the part of the adolescent, and so on, creating a vicious circle. Where the family equilibrium thus far has been based on pathological mechanisms this situation is unlikely to resolve itself and the disturbance of the adolescent who becomes the designated patient steadily increases.

IN A COMMUNITY

Adolescents who find their way into community homes and assessment centres have usually had an appallingly bad family background, suffered emotional deprivation, and experienced being unwanted most of their lives, and have a poor self-esteem. Simply moving such an adolescent from one place to another is sufficient to reproduce in him all the deepest emotionally painful experiences to which he has been subjected. He may react to this in various ways. If, however, his reaction is threatening to the staff in such places then natural reaction of the staff is to want to expel him fast. The adolescent who observes this reaction experiences yet another rejection and further evidence of his utter badness. He becomes more disturbed and angry, and expresses or suppresses these feelings as best he can. The staff who observe this reaction in the adolescent feel more threatened, and so on, again creating a vicious circle. Often the social worker is then asked to remove the youngster and is hard pressed to find a suitable place. The doctor, who is not under the same pressure as the social worker or the residential staff, tries to assess his real emotional needs and the possibility of working with him.

Already, then, there are three sets of adults with different aims and feelings surrounding the disturbed youngster—the residential staff who want him out; the social worker, under great pressure, who wants to find any place for him; and the doctor, who is trying to do something the adolescent does not even understand. His confusion, his feelings of helplessness, and his anger increase. If there are parents, they often think that their child is hard done by and see a great opportunity for projecting their guilt about having been bad parents on to the different agencies, so colluding with their child's anger with the helpers—which of course makes the situation worse for him. The youngster himself, who undoubtedly has experienced parental conflict, believes that he played a large part in creating this conflict, and has some sense of power as a result, often makes his own attempts to keep the different helping agencies apart and in conflict.

In these cases a meeting of all those helping the adolescent may help to create a single common aim and allow him to feel safer and calmer. The success or failure of such a manoeuvre would depend on the inclination of the helping agencies to get together and each of their abilities to grasp the importance of staying together.

This is the fourth of a series of six articles by Dr Perinpanayagam, the first of which appeared in the issue dated 4 February. The remaining two will be published over the next two weeks.

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Letter from . . . Chicago

Cold baths of Hercules

GEORGE DUNEA

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"O Hercules, how cold your bath is!" cried King Jugurtha on being cast naked into Rome's inhospitable Mamertine Prison—where some of the guards "tore off his clothes by force, and others, while they struggled for his golden earring, with it pulled off the tip of his ear," and where, "for six days struggling with hunger, and to the very last minute desirous of life, he was overtaken by the just reward of his villainies."[1]

Yet the times have not changed all that much, and with Illinois's penal population almost doubling in the past few years many of the State's prisons remain very cold—or very hot—filthy, overcrowded, and ridden with vermin and disease. Last year in Chicago's county jail a young inmate coughed and sweated and expectorated for several months before his ailment was diagnosed, but not before 71% of the inmates living on the same tier developed positive tests for tuberculosis.[2] Elsewhere in the State the penal institutions are equally overcrowded, with prisoners often having to sleep on the floor, or with three men crammed into one 50 sq ft cell for 20 hours a day. In many jails prisoners must contend with rats, cockroaches, non-functioning lavatories and contaminated food, assaults, gangs, guard brutality, extortion, and homosexual rapes. Several of these institutions were recently characterised in the press as jails unfit for humans and crimes against humanity.

Currently, some 400 000 persons are incarcerated at any one time in America's penal institutions. Of these, about half are serving long-term sentences in some 400 State or Federal penitentiaries, and an equal number are awaiting trial or serving short-term sentences, usually under one year, insome 4000 local jails. Most of the prisoners are poor, 95% are men, and two-thirds are under 30 years old. Blacks account for almost 40% of the penal population, with many shuttling to and fro between

Cook County Hospital, Chicago, Illinois
GEORGE DUNEA, MB, FRCPED, attending physician

the ghetto and the jail. Many prisoners are alcoholic or addicted to drugs; tuberculosis and epilepsy are several times as common as in the general population; and there is also much venereal disease, hepatitis, and hypertension. Yet medical services are often grossly deficient, and a 1972 survey conducted by the American Medical Association (AMA) described a shocking lack of manpower and services throughout the country, with 65% of all local jails having *only* first-aid facilities and coverage, and with 17% of jails having no medical facilities whatsoever. Some 31% had no arrangements by which a prisoner could see a doctor, and only 38% had a doctor available on a regular basis.

Access to care in most of the larger prisons is by means of sick-call, where one doctor might typically see 100 people in two hours. In one institution a mesh screen separates the doctor and pharmacist from the prisoners, so that examinations are impossible. The interviews tend to be brief and authoritarian, with no privacy or continuity or indeed medical records, and with many prisoners merely receiving aspirins, diazepam, or antacids for their symptoms. In many cases access to sick-call is denied by the guards, often as a form of punishment or even extortion. The inmates tend to be manipulative or hostile, there is ever-present potential conflict between the doctor and the guards, and most doctors, even if initially dedicated, soon give up in the face of an endless stream of people for whom they can do very little. Treatment of emergencies and serious illness is equally unsatisfactory, and patients have died from lack of attention, from delays in having operations, or merely from failure of having intravenous therapy, dressings, or food.

Rights under the eighth amendment

For many years this unsatisfactory state of affairs remained uncorrected. In the past decade, however, prisoners began taking their cases to the Federal courts, claiming that their constitutional right were being violated, and seeking redress under the Eighth Amendment of the Federal Constitution—which guarantees that cruel and unusual punishment shall not be inflicted. Hundreds of suits have been filed, and litigation has become so common that at least one correctional system retains a full-time lawyer on its staff and maintains a courtroom within the prison complex. Traditionally reluctant to intervene, the courts have increasingly come round to the view that the Government has an obligation to provide adequate medical care. And of the many court cases the most important and precedent-setting was that of Newman *v* Alabama (1972), where prisoners brought suits under the provisions of the Eighth Amendment, citing grossly inadequate medical care and numerous examples of gross neglect, some resulting in the deaths of prisoners. The court ruled that the State had wilfully and intentionally violated the inmates' constitutional right by failing to provide sufficient medical facilities and staff—and ordered that the facilities should be upgraded. Later, on the State failing to make any changes, the courts intervened again—threatening to close all of Alabama's prisons unless improvements were made.

Since that time several other courts have delivered similar verdicts, and in 1976 the US Supreme Court ruled that it was the Government's obligation to provide medical care for those whom it is punishing by incarceration and who are totally dependent for their needs on prison authorities. Other courts have amplified this principle by ruling that prisoners have a right to basic hygienic conditions, a reasonably safe environment, and to medical care that is adequate under the circumstances, though not necessarily optimal.[3] Thus, while mere negligence in giving or failing to supply medical treatment would be a matter to be adjudicated in the civil courts, a complaint qualifying under the provisions of the Eighth Amendment must suggest "deliberate indifference," "wanton infliction of unnecessary pain and suffering," "a barbarous act," or "conduct that shocks the conscience."[3] On the basis of these principles the courts and the Federal Government have intervened several times and forced local authorities to make improvements or face the closure of their jails. Several penal systems have complied with the courts and upgraded their medical facilities—and criteria have been developed for maintaining adequate standards of care to include initial and periodic physical examinations, use of nurses and physician assistants, availability of consultants and back-up facilities, improved hospital dispensaries, contracting-out services, and affiliations with universities and medical centres. Progress has been hampered, however, by a growing disenchantment with the results of rehabilitation, a reluctance to increase local taxes, and a desire on the part of the public for a tougher attitude on crime. Faced with rising penal populations, prison officials are often caught between the Federal courts on one hand and the lack of public funds and sympathy for criminals on the other. Yet in the long run the public stands to gain from adopting a more enlightened attitude, since most convicted prisoners eventually return to society and barbarous prison conditions perpetuate a vicious circle of further violence and crime.

Television violence

Meanwhile there has been growing concern about television violence and its effect on the young and on individuals with criminal tendencies. In a recent AMA survey 94% of responding doctors thought there was too much violence on TV, as did 70% of Americans surveyed by the National Parent-Teacher Association. It has been said that "never before has so much violence been shown so graphically to so many"; and since the late 1960s several studies have shown that television is an important, though not the only, cause of violence in society. More recently, in an AMA survey, it was found that over half of the doctors thought or suspected that some of their patients' behavioural problems were related to TV violence—and some reported increased aggression or anxiety in children, nightmares, injuries sustained while re-enacting their favourite programmes, or outright acts of violence. In San Francisco a little girl was raped by four teenagers three days after the showing of a similar incident on TV. In Chicago two youths recently burnt a wooden cross on the front lawn of a black family half an hour after watching "The FBI versus the Ku Klux Klan." At a Michigan prison nine out of 10 criminals said they learnt new tricks and improved their criminal skills by watching TV, and four out of 10 admitted attempting crimes they had seen on TV. In Miami a 15-year-old youth convicted of first-degree murder claimed he was innocent because prolonged subliminal intoxication with television had produced a temporary state of insanity in which he felt he was playing out a TV drama. And, after receiving more than 1500 letters from concerned readers of the *New England Journal of Medicine*, Feingold and Johnson concluded that "the burden of proof that television violence does no harm lies with those who introduce such a potent force into the societal brew."[4]

Already in 1976, in the same journal, Dr Franz Ingelfinger had called TV violence an unchecked environmental hazard and called for a boycott of products associated with the offending programmes.[5] Also joining in the antiviolence was the AMA, with resolutions deploring excessive violence, calling on the industry to recognise its social responsibilities, and also asking 10 major corporations to review their advertising policies. Since then the crusade has assumed further momentum. The national convention of the United Church of Christ accused the television industry of debasing American culture, degrading people, exploiting sex and violence, and falsifying human reality and values. The Southern Baptist convention developed for its members a viewing log and a rating sheet with a pre-addressed "immediate reaction" postcard—as part of a campaign to "confront television's moral challenge" and make heard "the anguished cry of the American people." And the 6·5 million member National Parent-Teacher Association decided to get tough by giving the networks an ultimatum and threatening boycotts of violent programmes and of products thus advertised,

as well as petitions, law suits, and attempts to deny renewal of licenses to certain television stations.

So far the crusade appears to have been effective and the networks are clearly becoming concerned. In August five television producers expressed the view that "the industry is slowing violence to a degree that is dangerous," and that "we are going to be faced with a plastic television that is going to breed a plastic society." It was also suggested that the pendulum may be swinging too far in the other direction, that we may see a return of censorship, and that even *Hamlet* and *Roots* will be banned for being too violent. So far, however, these fears remain unfounded. And, while there has been some reduction in the number of violent programmes, we are as yet in no danger of becoming a plastic society, and indeed it appears that the networks are replacing hate with lust and crime with sex.[6]

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Occasional Review

Regional secure units and interim security for psychiatric patients*

ROBERT BLUGLASS

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Patients who need an element of security as part of their care and management are referred to psychiatrists from the general population as well as from courts, penal institutions, and legal agencies. If mentally abnormal offenders are defined simply as those who are put on hospital orders they are a small proportion of all offenders. Using this definition the Butler Report[1] indicated that in 1973 psychiatric disposals accounted for less than 0·5% of the 736 860 convictions occurring in one year (excluding motoring offences). Less than 1% of admissions to all hospitals receiving mentally disordered patients were from courts or penal establishments (on hospital orders). These figures, however, give a distorted view of the problem. The statistics exclude those who were refused admission to psychiatric hospitals from the courts and do not take account of a sizeable group of mentally disordered individuals who are from time to time offenders and who do not qualify for hospital orders. There are also many people in the community who have not offended but need secure care from time to time.

Background

The special hospitals (in England Broadmoor, Rampton, Moss Side, and Park Lane) admit patients on compulsory orders who need treatment and management under conditions of special security because of their dangerous, violent, or criminal propensities. Before 1959, however, most mental hospitals had locked wards. Thus offender patients and difficult non-offender patients who were a problem of management and needed some degree of security (but not as much as the special hospitals provide) were easily accommodated. The nursing and medical staffs had a long tradition of caring for them and had acquired considerable skill, and they found few patients too violent, threatening, or dangerous to cope with. The policy of unlocking doors and dispensing with restrictive methods of care developed during the 'fifties with the introduction of a new range of psychiatric drugs, a new approach to occupational and industrial therapy, the concept of community care, greatly improved staffing, and other measures.

This movement was encouraged by the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency and by the eventual provisions of the 1959 Mental Health Act. In 1961 a Ministry of Health report[2] welcomed the open-door principle, but was convinced that security arrangements should continue to be provided in some regional NHS psychiatric hospitals (although not necessarily all) and that regional health authorities should provide various types of unit, including some secure units, so that patients could be transferred between them as necessary. It also recommended special diagnostic centres that would admit patients presenting specially difficult problems for assessment, treatment, and research. These recommendations were accepted by the Government.[3] In fact only one centre materialised, at the Northgate Clinic in Hendon (in 1968), and this soon became a specialised adolescent unit.

During the 'sixties and on into the 'seventies the open-door policy was adopted by psychiatric hospitals throughout the country, and with the results predicted by the 1961 working party. NHS hospitals were increasingly reluctant to admit patients from the courts on the grounds that security was not provided and its reintroduction would adversely affect the vast majority of patients who did not need it (86% of whom were admitted to hospital informally). Many of these patients from the courts did not in fact need secure arrangements but despite this they were increasingly unwelcome. The problem was eventually made worse by the development of district general hospital psychiatric units, which many psychiatrists find unsuitable for difficult or unpredictable patients and for offenders (though not all agree). No provision had been made in them for the care of chronic patients or those needing security, and they did not therefore replace the mental illness hospitals.

Consequently, offender patients, including those who do not necessarily require conditions of special security, have been increasingly admitted to the special hospitals. In order to obtain admission their dangerousness tends to be exaggerated. The special hospitals in turn have found it more and more difficult to discharge their recovering patients to NHS hospitals (even though they have ceased to be

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Midland Centre for Forensic Psychiatry, All Saints' Hospital, Birmingham
ROBERT BLUGLASS, MD, FRCPSYCH, consultant forensic psychiatrist (also senior clinical lecturer in forensic psychiatry, University of Birmingham)