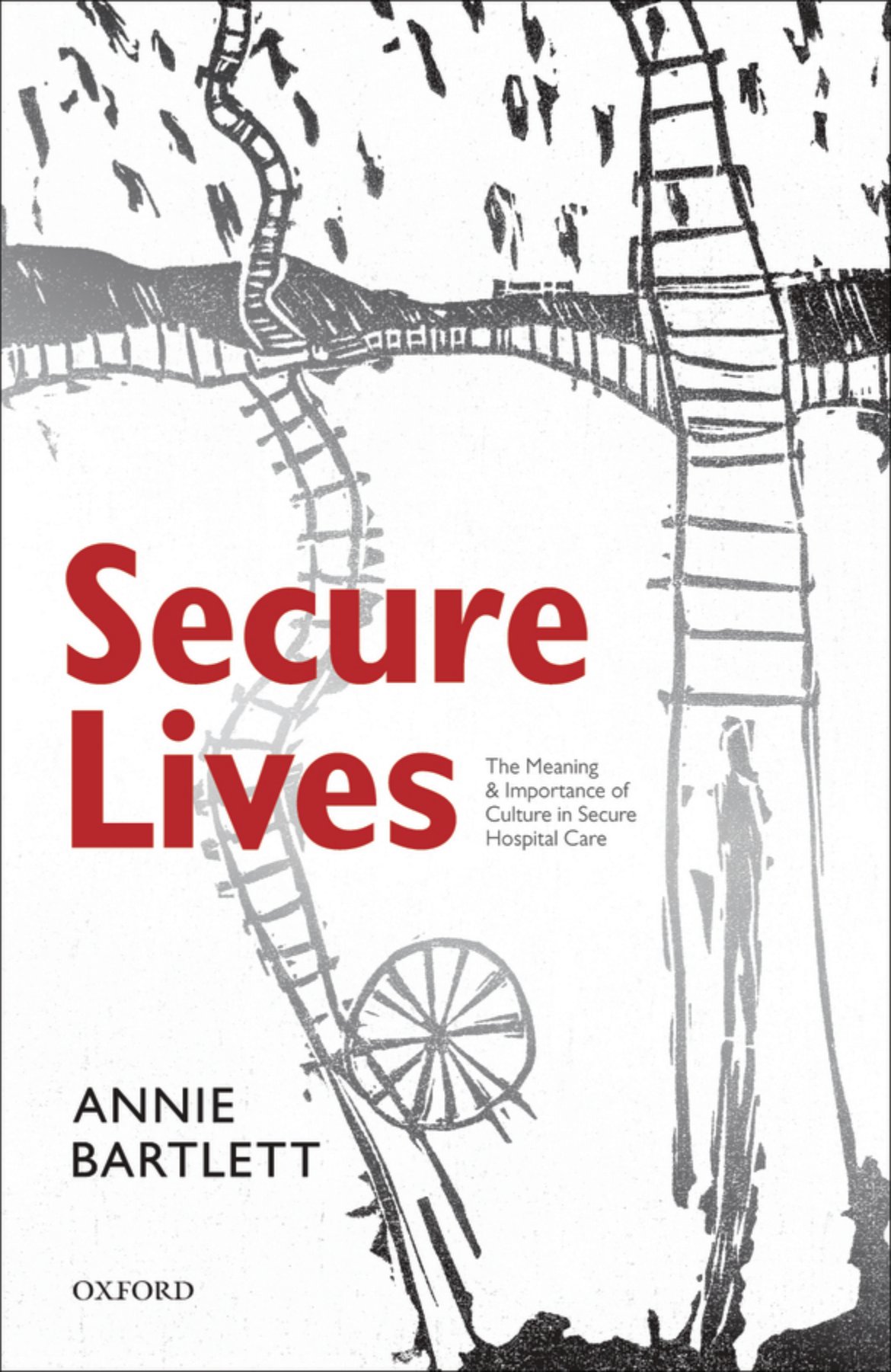

Secure Lives

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,

[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 fieldnote 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.

Contents

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

Part 1

Some abstract nouns: institutions, culture, crime and madness

Chapter 1

Institutions, culture and the culture of institutions

'There's nothing wrong with him medically.'
'Medically?'
'He's just very unpleasant. And therefore incurable.
I'm sorry.'
(Kane 2002: 6)

To invite you, the reader, into an abstract discussion of institutions, culture and the culture of institutions with only the flimsy argument that these are important concepts, might send you off in the direction of detective fiction. So, this chapter tries to make these key concepts both absurdly simple and also very difficult, the latter by refusing to allow the ideas to be thoroughly pinned down, as if in a butterfly collection. Shared understanding of concepts like these, even if achieved, is fleeting. Abstract nouns move on and change meaning. That is the real history of both 'culture' and 'institution' as words. However, if this chapter works, it will provide a context for the discussion carried on through the book and provide enough of a common framework for consideration beyond the pages here.

What is an institution?

This is the question I should have asked myself a long time ago. It is easy to produce a list of types of institution. Having compiled a list, the easy escape from the difficult task of definition, is to suggest that the members of the list are so different from each other that no definition would be adequate. Thus, banks (financial institutions), the Booker Prize (a literary institution), the University of Cambridge (an academic institution)

and the Institute of the Blessed Virgin Mary (IBVM, a religious institution) would look similar to each other while being equally, if not more, different from each other.

The class of institutions is a big class. The pupils are different sizes and shapes. They might prove unruly, preferring their own rules to everybody else's, including the teacher's. These things on the list above are institutions but that does not tell us what an institution is. Using the 'without which not' style of definition beloved of the ancients might suggest that rules are necessary to them. Institutions are not anarchic; in fact, this is precisely the feature they share. More than that, they have rules that apply, at least to some extent, to them and not to other things. Their character is a preference for order, not chaos. They do the same things repeatedly. The institutions in my list, respectively, send out your bank statement each month; award, after due process, a literary prize each year; teach, set examinations and award degrees; or admit novices to a religious order to live in accordance with the rules of the order and, should they and the order wish, become nuns in due course. So each institution in the random list has processes in line with their purpose. Their purpose may vary but there may be similarities in their approach at a crude, broad brush-stroke level.

Many institutions are old, like the bank of Monte Paschi di Siena or the University of Cambridge; some, like the Booker Prize and the IBVM, are newer. If they have survived many centuries in changing circumstances they might be thought to be different from when they started out in life. The University of Cambridge has evolved to admit women but it has not changed its fundamental identity. The bank of Monte Paschi di Siena has digital banking; this was not the case in 1472 when the bank was founded. So, some have a capacity for change without loss of identity or erosion of purpose. UBS, a Swiss bank, spent much of the 1990s taking over a number of other financial institutions. These takeovers included Barings Bank. UBS continues but its name no longer reflects all of its acquisitions. Its name makes no mention of Barings, an institution that has gone to the wall. So institutions have lives; some change and some die. Spotting change in institutions is hard. If it were not hard, we would all have predicted the banking crisis of 2008, as we would have been clear

that there was something rotten in the mortgage market in the US. We, the public, did not, nor did more than a tiny handful of economic experts or even bankers themselves. This single series of events, on its own, suggests that the assessment of change within institutions might be difficult. This was true even though the organizations in question were both open to a significant level of routine public scrutiny and run by clever people.

Are institutions a good idea?

The financial crisis of 2008 that afflicted the world economy has also called into question the value of banks. A lot of people neither like nor trust them and despise what they do. Some would argue that it has undermined the idea that banks are a good idea. In truth, it is hard to imagine a world without them, for all their recent character defects. Managing personal finance would be reduced to personal transaction, personal and enterprise credits and loans would be shrunk. Economies would be stifled but the bankers would not get their bonuses. Banks, as institutions, are currently a mixed blessing.

They are only one kind of institution. What about other kinds of institution? Institutions go in and out of fashion. Thomas Cromwell did not much like monasteries and his patron Cardinal Wolsey liked universities more, so took money from one kind of institution to give to another (see Mantel 2009, 2012 for these issues brought to life). Universities are easy to defend. However, the two that Wolsey and his king, Henry VIII, did so much to improve are both now accused of elitism. So what might have seemed an acceptable institution at one time might be viewed differently later.

Why concentration camps differ from Butlins

This is not a question. This is to point out something that Goffman, the guru of thought about institutions, did not make entirely clear. Goffman (1961: 23–72) accepts few, if any, of the distinctions between institutions; psychiatric hospitals are boarding schools are prisons and shockingly, concentration camps.[1] He is more convinced of similarity in

[1] Townsend (1962) conducted a major study of Old People's Homes. He shares Goffman's view that different kinds of institutions are similar rather than different.

day-to-day function than he is concerned with difference of purpose. Yet, at one level, this is obscene. To compare educational institutions with fine pedigrees and outstanding pupils and teachers to institutions designed for forced labour and murder is inappropriate. Butlins were holiday camps with rules about what time everyone got out of bed. They were enjoyed by thousands of people in their heyday and commercially successful. Concentration camps are different. Even if some boarding schools are sometimes authoritarian or control bullying badly, they do not set out to kill people. Nor do hospitals. Differences of purpose must, at times, be more important than any similarities.

Do institutions fulfil their purpose?

The example of concentrations camps allows a question, not of the goodness or badness of particular kinds of institution, since the atrocities committed there are not in doubt, but of whether they are run in accordance with their purpose. Some are, sometimes, but maybe not forever. Some never are.

Nazi concentration camps, within their remit, were, in fact, only partially effective. They did succeed in killing people and disposing of bodies. The technology of mass killing was improved as the Second World War progressed. The camps were less good as a reliable source of labour, their original intent. The conditions in which the Nazis kept people created illness and starvation, and, even without gas chambers, resulted in many deaths. The camps and the ideology they embodied thankfully failed in their intention to eradicate Jews from Europe, although the Jewish population decreased throughout Europe, particularly in the East (Hoffman 2010; Mazower 2009).

Thomas Cromwell was able to take advantage of the monasteries' and nunneries' failure to keep to their purpose. Where their administration was corrupt and their priests alcoholic and sexually active, it was easy and reasonable to suggest that they did not deserve their wealth. They were not godly institutions full of god-fearing, pious men and women. Echoes of the same arguments have emerged in discussion of the Catholic Church, as it has struggled with allegations of corrupt banking and a failure to tackle sex abuse by priests (BBC 1982, 2013).

Do institutions always live in buildings?

So far, there has been a physical reality to most of the institutions discussed. The exception is the Booker Prize. It may be decided upon somewhere, when the judges meet. It will be awarded somewhere, a large dining room perhaps, but it does not have a continuous physical presence in which institutional life occurs on a daily basis. So, it does not always live in a building, and it can be called into being when required. It is not characterized by a particular order to the day, the regular rhythms of life. It is held together by an idea and the people who are signed up to it. The idea has modest administrative underpinning that makes sure the judging is done properly, and which guarantees the dinner and a prize winner at the end who will briefly claim the media attention. The idea is literary excellence. Behind that, it is a device to boost the value of literature in the public's mind so it can do battle with the X-Factor, help authors survive and keep publishing houses in business.

Perhaps it is an extreme case. There are also institutions which embody ideas, have buildings and rules but rely less on a building than a prison or a concentration camp. An example is the Royal College of Physicians. It has a building in a prestigious location, Regent's Park. It is for senior physicians and promotes competence in a medical discipline. It spreads knowledge about its area of expertise. However, the College is really its membership, without which it could not afford its building. But its membership is scattered. It would not normally meet en masse. Small groups of members will come together for a variety of professional purposes, maybe in the building, maybe not. Members decide, just as in a golf club, who can join; there are rules about membership but not about daily life. Without passing the relevant examinations, membership is impossible.

How virtual is real?

Then there is the institution, a bank, without offices. No branch buildings but an existence in hyperspace. Egg Bank must have had a big computer and a headquarters somewhere but when it was launched it had a novelty value. It was a virtual institution in a field, banking, characterized at the time by a slower approach.

So, to come back to the original question of definition, institutions are many things. They share, to some extent, routines, rules and order and distinct identities but little else. They have varied purpose, embody different values and do what they are supposed to do well or badly. They may or may not have a physical location in which their way of doing things is evident. They have varied lifespans. This is an unsatisfactory definition but a starting point. The alternative to definition is to hide behind the multiple uses of the word 'institution'. This relies upon the assumption of shared understanding which, as what follows makes clear, is far from the case.

What is culture?

If culture is always a word, and an English word at that, and an idea, although contested, would it matter if it were replaced with another, sausages, perhaps? This is not a flippant question. In fact, it is an important one. It addresses the vagueness, the specificity and the cultural particularity of the English word culture, all in one go.

If culture, the word, had been sausages, its multiple meanings and associations would, with their ambiguity, have been lost. People are clear about what is or is not a sausage. The current society-wide preoccupation with all things cultural, from opera and T S Eliot, old-fashioned elitist, high culture to culture as in multicultural education or culture as cultures, contributes to the reader's understanding of culture in this book. To use sausages instead would be to define more precisely, and certainly more concretely, but would absolve the reader of an opportunity to deal with contested meaning, without losing their sense of direction.

Culture has a home in the academic discipline of social anthropology; this operates in relation to wider discourse not independent of it. Similarly, the diffuse meaning of culture in wider academe and society is not independent of the historical efforts of anthropology to elucidate a concept that, like the world, was changing as it was described. So the contested meaning within anthropology is a genuine reflection of diversity on micro and macro levels. It is testament to the validity of anthropological method, rather than cause for breast beating by anxious

anthropologists worried that in saying anything at all, they have said something someone will dispute.

Culture, like other big words such as 'self' and 'society', are often discussed in what has been termed antithesis (Kuper 1999; Peel 1996), the antithesis being to other key concepts such as 'civilization', 'biology', the 'individual' or 'nature' (Geertz 2000: 48; Ortner 1974). The importance of the term can be read from such juxtapositions. Ingold's comment (1996: 57) on society could as well be applied to culture: 'No term is more pivotal to the identity of social anthropology than that of "society" itself, yet none is more contestable.'

Kuper (1999) notes that in Kroeber and Kluckhohn (1952), 164 definitions of culture were classified into two groups, of which 157, most generated by anthropologists, had appeared between 1920 and 1950. The message was unmistakable. Anthropologists were saying this is our 'stuff', even if they were not sure what the 'stuff' was.[2] Such a lack of agreement might have more to do with the differences between the subjects of anthropology than the anthropologists, of course.

Keesing (1981: 68) notes continuing inconsistencies. He helpfully emphasizes the distinction, often lost, between 'observable' culture, as he puts it 'things and events out there in the world', and 'the organised system of knowledge and belief whereby a people structure their experience and perceptions, formulate acts, and choose between alternatives'. Natural science prides itself on its precision. Its words, its 'ohms', 'electrons' and 'Higgs boson', are necessary to its methods and key to its inaccessibility. Writing the last of these I wondered if it was 'Hick's' and 'bison'. Social scientists who strive, it would appear, at times for a similar immunity to informed criticism by the wilful use of words such as 'alterity' or 'personalistic' are losing sight of their natural advantage, that of describing the world in the everyday terms of those who inhabit it. The disputes raging in anthropology can remain accessible to the informed lay reader. Culture is just one of those disputes. Geertz may be right to

[2] Kuper (1999) suggests that the enthusiasm for claiming this territory subsequent to 1952 was prompted by the turf war instigated by Talcott Parsons. He writes engagingly on the politics which led to the clarification of disciplinary interests in the 1950s.

point out that when seen from outside, anthropology might be 'a powerful regenerative force in social and humane studies' and that this may be 'closer to the mark than the Insider view that the passage from South Sea obscurity to worldly celebrity is simply exposing anthropology's lack of internal coherence, its methodological softness, . . . its political hypocrisy, . . . its practical irrelevance' (2000: 96).

In this book about one institution and its values and practices, culture is a vehicle. It can carry other ideas, while itself being ideational. This applies whoever you are. Specifically, culture can carry ideas about social relations and what constitutes daily life, in this book, within the walls of a High Secure Hospital.

Is culture a thing?

Culture is only one 'thing'. Academic disciplines are full of them, none more so than psychiatry (depression, schizophrenia). Words can break free of their original moorings and sail off into uncharted waters. Perhaps this characteristic of academic abstractions is both evident in, and a product of, styles of writing, where such abstractions are linked with active verbs, e.g. 'post-modern critique wants to address' (Marcus 1998: 218). Academics have a perverse interest in maintaining such entities as well as in shifting their meaning, since to do so is simultaneously both to reinforce the significance of the specific topic and to highlight their own individual contributions. Discrediting topics as obsolete or to attack their usage within disciplines is but a subtle variation on this practice.

Despite such cynicism, the status of the abstractions of disciplines is of historical and contemporary interest. As long ago as 1981, Keesing worried about culture acquiring a life of its own, being a thing that might 'do' things as if separate from the social conditions in which it is discernible.[3] This concern was also echoed by Strathern (1996: 83), in response to a question on the possible obsolescence of the term culture. She would

[3] This criticism, applied to society, comprised much of the 1989 debate: 'The concept of society is theoretically obsolete', see Ingold (1996). One observation on this debate was the difficulty participants had in discussing society without mentioning the word culture, which slipped in largely unremarked and undefined.

see the utility of the term waning once 'we begin to manipulate it as an imaginary entity'. It is all too easy to see that discussions of culture in anthropology might arrive at a dead end.

In fact, culture has been taken up again by other academic disciplines, the media and management consultants to name but a few, who are interested in helping culture avoid an unwarranted early death (Kuper 1999; Weiner 1995). Wright (1994: 2) helpfully indicates how this applies in organizational studies, of which this book is one example. She argues that culture has appeared in four different guises in organizational studies. These are national cultures to which multinationals relate, the multiethnic work force of a company, the 'concepts, attitudes and values' of the workforce and the 'company culture' of formal managerial values and practices.

This version of culture has immediate appeal, except for the fact that it has no place for the patients of our High Secure Hospital.

Culture: does everyone have one?

This may be easier to answer if the question is put the other way around. Is it possible to be human and not to share to some extent attitudes, views, behaviours, customs, practices and aspects of the material world with other people? If the answer is no, then arguably everyone has a cultural group whether or not they would see it that way. We are social animals with a remarkable capacity to communicate and to generate material culture from natural material, to communicate linguistically and symbolically and to divide ourselves into tribes.

The reason this is important is that it has been said that patients, in contrast to prisoners, lack culture. What seems to be meant by this is that they lack a set of attitudes in common rather than shared practices. Prisoners define themselves in opposition, more or less fiercely expressed, to the order of the prison institution. Patients, by operating with staff, deny themselves that possibility of coherent opposition. This is therefore a critical issue for High Secure Hospital care where there is a conjunction of high security and a patient population with histories of violence.

Culture: can you see it move?

It is a matter of historical fact that societies change and that both cultural values and cultural practices change. That is not the question. The question is whether it is possible to detect change as it is happening.

The French Revolution of 1789 marked a sea change in social attitudes and behaviour leading to the seemingly permanent loss of the monarchy from France and an espousal and articulation of values that persist to this day. No one doubted something momentous was happening at the time. In North London today, already a multicultural community, like other areas of the capital, there is a small but definite French invasion happening now. This has led to the designation of North London as part of a French election, the establishment of a new French school and a remarkably successful French bread stall at a local market where, on Saturdays, as much French as English can be heard. This last point is only a slight exaggeration. Is this a cultural change in North London society? Are these reasonable markers of change, and is that enough of a change to be significant?

Culture and institutions

Having thought a little about both culture and institutions, we can now think about them in the same sentence. We can turn to what might be known about institutional culture, as embodied in mental health and penal institutions.

The potential literature is large. It could be reviewed by academic discipline, by chronology, by location or by theme. To keep a focus,[4] we look first at what we know about psychiatric hospitals and then what we know about prisons. We are principally concerned with these types of institution as repositories and incarnations of particular ideologies, and

[4] The literature cited is drawn from an original hand search in 1992 and a subsequent electronic database search derived from ASSIA, IBSS, Psychlit. PsychINFO, Medline, supplemented by further hand-searching of the Haddon and Institute of Criminology Libraries, Cambridge.

their relationship to the wider social world.[5] This leads on to a section on how crime and madness fit together as concepts. We then consider how secure hospital care, i.e. institutions designed to help people who are both mentally disordered and law breakers, are organized and how that relates to the fit between madness and crime.

What do we know about psychiatric hospitals?

When were they invented?

The nineteenth century saw the development and firm establishment of the psychiatric industry (Jones 1993; Scull 1979, 1989). This had three components. First, was the building of psychiatric institutions, asylums, subsequently renamed hospitals. Second, came the emergence of increasingly specialized workers, initially called alienists, subsequently deemed psychiatrists and other mental health workers. The third was the development of a body of specific psychiatric knowledge, a technology of practice for which training was required. As time has gone on, this body of knowledge has shown considerable loyalty to biomedical models of illness and treatment, despite the scepticism of the other medical specialities, many patients, the general public and academic commentators.

Starting history in the nineteenth century is, it has to be confessed, a little arbitrary. What makes it defensible is the radical overhaul of the care of the mad at this time (Allderidge 1979). How this society has coped with madness has been described as an 'academic minefield' (Jones 1993: 4). What marks out the nineteenth century is a new and explicit focus on the warehousing of the mad, notably of 'pauper lunatics', and the scale of the physical building programme that accompanied it.

As the century wore on, critics noted that treatment was failing most patients; they did not often leave hospital. Whatever the strength of the argument, it went largely unheard. Legislative authority had backed a system of categorization of madness still substantially in use today.

[5] By implication the study of the individual as one of an aggregate, whether psychiatrically disordered or not, is neglected in this review. Such material is only cited where it addresses the issue of the social.

Categories of madness had previously existed (Berrios and Porter 1995) but in the nineteenth and early twentieth centuries they saw institutional expression on a massive scale. In this country and in America increasingly large numbers of people were detained within psychiatric institutions. In 1827 in England and Wales there had been nine public asylums. In 1930 there were ninety-eight (see Jones 1993: 116). The patient population peaked in the UK in 1955 and fell by more than half in the next four decades (Raftery 1992).

This was a wholesale change in social policy. It was led by politicians and academics, some of whom were disenchanted psychiatrists and some of whom were social scientists. They argued theoretically and practically for a change in the model of care; institutionalization was followed by deinstitutionalization and care in the community. The sheer volume of writing is testament to the seriousness of the attempt to address the inner workings of that embodiment of psychiatric practice, the psychiatric hospital and the social relations of those who lived and worked there.

How do psychiatric hospitals work?

The heyday of social science accounts of psychiatric institutions and the social relations of staff and patients was in the 1950s and 1960s (e.g. Belknap 1956; Caudill 1958; Goffman 1961; Greenblatt et al. 1955). This work was American and often described very large mental hospitals.[6] Subsequent and less radical contributions came from the UK and elsewhere but the important ideas are rooted in this era. It is no accident that these studies emerged at this point of transition between institutional and community care for those with mental health problems.

These empirical approaches were characterized by a reluctance to engage with macroeconomic or political forces. The projects primarily examined the world inside the institution, this focus also being a crucial component of an analysis which emphasized isolation and separation.

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[6] Rapaport's (1960) anthropological study of the twelve-bedded Henderson Hospital is an exception. The unit's ethos was and is a therapeutic community and the study offers a stark contrast to the finding of work on a large scale. Permissiveness, reality confrontation, democratization and community characterized life in the Henderson.

It is sensible to divide most work on psychiatric institutions into those that 'buy into' psychiatric ideology and those that 'opt out', i.e. where psychiatric discourse is either reframed or problematized as just one of a number of interpretations of the same social phenomena. The main theme in this work is the nature of social relations between staff and patients and understandings of modalities of power within such institutions.

Opting out

The dominant strand of writing about the psychiatric enterprise documents hierarchically differentiated institutions whose social organization is indifferent to the size of the institution or the psychiatric descriptions of the patients (Goffman 1961; Greenblatt et al. 1955; King et al. 1971). These are custodial institutions. Life within them is heavily regulated (Goffman 1961; Morris 1969;[7] Perucci 1974). Staff rule. Some staff rule more than others (Perucci 1974; Segal 1962). Those high up in the formal hierarchy are unaware of individual requests or complaints (Scheff 1961), or communication is only top-down (Greenblatt et al. 1955). Patients entering such institutions lose autonomy (Goffman 1961). Their status plummets, as they are formally designated a patient, their rights are removed and their individuality becomes irrelevant. Their difficulties are seen as a consequence of the institutional processes to which they are now subject rather than intrinsic to them and/or linked to the rationale for incarceration in the first place. Their only room for manoeuvre is to adopt a social role within the institution which enables survival of a sort. Their role, in a fragmented patient community, is often defined by its relationship to staff, and this may provide a mechanism to exit the institution (Perucci 1974). Such an exit bears no discernible relationship to psychiatric or psychological models of mental health.

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[7] Morris is writing about mental handicap institutions. This term has fallen out of favour in psychiatric circles. It referred to people with significant intellectual and other impairments present from birth but not usually including mental illness. Institutions in the UK followed the US model after 1924, and were explicitly classificatory in intent and deliberately, as opposed to inadvertently highly regimented. She concluded such institutions had only a tenuous claim to the title hospital, as they should be providing social rather than medical care.

Goffman (1961: 11–22), who is still frequently cited, generated a highly determinist but satisfyingly complete model of the 'total institution'. This arose from participant observation in a large US asylum.[8] In his analysis the individual's sense of self is affected by situational factors that are part and parcel of institutional existence; the patient is seen very largely as a passive victim of the process. The inmate world contains two 'constructed categories of person': staff and patients. His understanding of the staff world is limited but his descriptions of the experience of the inmate world constitute a powerful polemic. He argues that the existence of mortification processes, reorganizing influences and limited lines of response for inmates constitute the 'mental patient career'. The mortifying experiences include the destruction of the individual self-image, the intrusive presence of a hierarchical relationship between staff and patients, and the indignities of communal living. He outlines strategies available for the inmates. These consist of paying lip service to the regime, embodied by staff. He assumes that people never want to enter institutions. As he starts inside the institution, he can disregard grossly abnormal behaviour in the community of a kind likely to be seen and labelled as mad by members of that community. Recently, I saw a man sitting on a bench in my local high street wearing only a striped dressing gown. Chatting to friends who had also seen him, they had come to the same conclusion as me that something was mentally wrong with him. They worried for him and about him. Goffman's bleak account[9] of what was designed to be a therapeutic institution suggests the young man in the dressing gown was lucky to escape it, being 50 years too young.

Buying into

There are less dismissive approaches to the concept of madness in this older literature. This school of thought accepts that the institutionalized

[8] Even if he was a sociologist.

[9] Martin (1984) reviews inquiries into UK psychiatric hospitals conducted between 1969 and 1980. Almost all were critical. Although the inquiries themselves identified isolation, poor funding and administration as key problems, Martin's own conclusions echo the social science critique where the intention to alleviate suffering is less important than the smooth running of the hospital.

individual has previously failed to cope in the community. It follows that there may be value, if only humanitarian value, in describing this as illness (as opposed to witchcraft or evil or wilful inertia) (Alaszewski 1986; Stanton and Schwartz 1954). The advent of contemporary ideas about witchcraft, linked at times to exorcism, including that of children should remind us that to be labelled as other by your community can still be both humiliating and dangerous. Exorcism does not cure schizophrenia.

Hospitalization as a response to the identification of madness is based on a philosophy of care. The therapeutic potential of this philosophy may be undermined by scarce resources, the limited independence of subordinate staff (Belknap 1956), unhelpful shift patterns (King et al. 1971) or constant changes of staff (Alaszewski 1986). Individuals' treatment needs are assessed and treatment is arranged to target those needs. Within this framework, it is then legitimate, as a temporary measure, to remove, from the patients, aspects of their non-institutional self, e.g. the right to vote. The temporary nature of patient identity is not a convenient fiction but a reality; the work of staff is to equip those disabled by an illness to return to and remain in the community (Barratt 1988a, b; Belknap 1956; Caudill 1952). The institutional practices which underpin this are uniquely clinical and therefore different from other kinds of institution. Hospitals are not banks, religious orders or boarding schools. The departure of patients is linked with improvement discernible within an illness model but is also affected by levels of social support offered by family and friends outside the hospital (Spillius 1990).

Stanton and Schwartz (1954) exemplify this less critical approach in the historical literature. They conducted a two-year study of a fifteen-bedded disturbed women's ward in a US private hospital. Their ethnography is concerned with whether or not the institution meets its own goals; to do this they used a psychiatrist as an anthropologist.

They suggest convincingly that the real-life interactions between patients and staff are complex and paradoxical. In a disturbed ward, where custody must have been a central issue, they place emphasis on the staff, encouraging change and active therapy as well as being involved in administration. They fail to identify significant areas of inmate culture and stress the importance of the staff–patient dynamic

to the life of the unit. Patient information is negatively distorted by omission and selection when staff describe patient activities. They listen to how patients are talked about; the linguistic representation of the patient is invariably passive. The study as a whole is imbued with the psychiatric values of the day and is a long way from today's Recovery model. This new model has generated a tension between the processes resulting in a positive outcome in its own terms (Leamy et al. 2011), conspicuously: 'connectedness; hope and optimism about the future; identity; meaning in life; and empowerment' and the discourse of chronic illness (Lester and Gask 2006). Service User-led services, e.g. the SUN project at Springfield Hospital and Borderline UK, two initiatives, one in a mainstream mental health trust and one a charity, concretize this radically different discourse on life after mental health problems and how the patient or service user or expert by experience is active in determining their destiny, not a passive service or care recipient. The views of service users are now valued as part of the architecture of care quality and their take on ward climate and satisfaction with services eagerly sought.[10]

The concept of psychiatric hospital culture

Accounts of psychiatric institutional life illustrate the confusion present in academe and elsewhere about the term 'culture'. In most cases but not all (Alaszewski 1986) authors have avoided the term, which is interesting in itself. Society, social interaction, roles, strategies and social structure have all found a place. Given the stability of the psychiatric institutions described, it is perhaps surprising that culture is not more often addressed. This is intriguing when the isolation (be it an artefact of method or a social reality) of such institutions (Goffman 1961; Martin 1984) might predispose them to developing distinctive cultures. But the emphasis on staff–patient interaction acknowledged by Goffman (1961: 106) and echoed by other authors undermines any claim to a full understanding of a psychiatric institution.

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[10] Most early ethnographies of psychiatric hospitals ignored social change. Menzies' (1960) study of a general hospital provided a rare psychodynamic analysis of resistance to change.

Two factors may be more telling. First, to suggest that there is culture, is, on the whole, a positive remark but the tone of much of this writing is negative. Second, Goffman (1961: 23) refers to a process of 'disculturation' that occurs to the patient on admission. This preadmission identity of the patient—who they were before they were a patient—is largely neglected in the study of the psychiatric patient but features strongly in the equivalent prison literature. Staff in institutions have extra-institutional identities which come to work with them, and, unlike most patients most days, leave with them as well. The net effect of these different kinds of partial presence and identity, and the arbitrary collecting and housing of people called patients, may be to undermine a notion of culture within psychiatric institutions. Culture implies similarity rather than difference, and similarities may be hard to find. At best, the difficulty of adequate description is elucidated.

Who lives in psychiatric institutions?

The answer to this question depends partly on whether or not any credence is given to the idea of madness and its particular refinement in mental health services. It also depends on the historical period in question. Two points remain true across time and place: to enter a psychiatric institution you are thought to be suffering from some version of madness (and in all probability a doctor has said which kind) and you are unlikely to want to go there of your own volition.

What is the matter with you?

Descriptions of madness have changed over time. Psychiatric categorization per se has been taken to task for its very existence (Foucault 1967), for its inappropriateness as a metaphor for deviant behaviour (Scheff 1966), for its lack of a biological basis (Szasz 1961), for its discriminatory application to the poor (Scull 1989), to women (Ripa 1990; Showalter 1987) and specific subcultures (Gamwell and Tomes 1995; King and Bartlett 1999; Littlewood and Lipsedge 1988), for the unreliability of its application (Rosenhan 1973, 1981) and the way it legitimized a stigmatizing social process (Scheff 1981). These critical contributions are united by a focus on both social process and cultural groups.

Remarkably, the classificatory systems of psychiatry which focus on individual psychopathology go from strength to strength (APA 1994, 2013; WHO 1992). Indeed, we await, with eager anticipation, the imminent arrival of ICD-11. DSM-5, the latest American contribution to psychiatric classification, provoked controversy as it was developed. Significant criticism related to its lack of scientific validity (Allen 2013). Equally strong voices pointed out that 68% of the task force members had links to the pharmaceutical industry. This, allied to non-disclosure clauses signed by these individuals, created an impression that DSM-5 was created in unhealthy secrecy (Cosgrove et al. 2009). The number and range of disorders has expanded over time, leading to what has been described as 'diagnostic inflation' (Allen 2009: 221). This has left the profession open to ridicule, exemplified by a hoax that suggested taking 'selfies' was actually a psychiatric disorder endorsed by the American Psychiatric Association (Vincent 2014). Although not true, the fact that it was taken at all seriously, suggested that psychiatric classification might be heading in the wrong direction. More importantly, the net effect of more diagnoses may well be more, perhaps unnecessary, treatment.

Psychiatric categories, however flawed, can be said to have a standalone quality, independent of the social conditions in which they are generated. This positivist approach is the one that would strike the reader of any psychiatric textbook forcibly, and informs much mental health teaching and practice. It is also compatible with certain kinds of social criticism, i.e. there is nothing wrong with the categories but there is something wrong with the way they are applied. In the UK this has spawned a debate on the possible racism of British mental health practitioners (Lewis et al. 1990; Minnis et al. 2001), the value of terms such as race, ethnicity and culture in mental health practice (McKenzie and Crowcroft 1996) and the way in which services may have failed particular elements of the UK population (Cooper et al. 2010; Ramon 1996; Singh et al. 2007).[11]

[11] There is an unresolved debate about the overrepresentation of Afro-Caribbeans in locked psychiatric beds (McGovern and Cope 1987).