

The Complementary Medical Treatment Programme at HM Prison Coldingley: An Evaluation

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to HM Prison Service Planning Group on behalf of the Directorate of Operations (South)

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Preface

The Institute for the Study and Treatment of Delinquency

The Institute for the Study and Treatment of Delinquency (ISTD) is a non partisan, non campaigning body. The Institute aims to foster inter-agency and inter-disciplinary collaboration in the fields of education, training and research and in the administration of criminal justice. Both a charity and a company limited by guarantee, ISTD operates from a position of principled objectivity, based upon the findings of research.

Founded in 1931 as *The Institute for the Scientific Study of Delinquency* to 'initiate and promote scientific research into the causes and prevention of crime' the Institute set out to 'establish observation centres and clinics for the diagnosis and treatment of delinquency and crime'. Direct involvement in treating patients begun in 1933 with the opening of what later became the Portman Clinic, ceasing in 1948 when the NHS took over. Since then the Institute's educational role has taken on increasing prominence, becoming affiliated with King's College London in 1993.

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Summary

Complementary or alternative medicine is generally defined as those medical systems, practices, interventions and applications that are not currently part of the dominant or conventional medical systems. In May 1996, the Prison Service sponsored the introduction of a small pilot complementary medical treatment programme at HMP Coldingley, an adult male medium security prison in Surrey, in South-East England. The complementary medical programme is operated by an independent organisation called Complementary Medical Services for Prisoners (CMSP). This report describes the findings of an evaluation by the Institute for the Study and Treatment of Delinquency (ISTD) of the scope, operation, and perceived benefits received by both staff and inmates treated by CMSP. The study takes the form of a qualitative outcome evaluation. It was not intended to examine the clinical efficacy of complementary medical treatments.

Employing a mixture of participant-observation, statistical analysis, and literature reviews, the report examines the treatment modalities offered by CMSP, therapist training, the scope and scale of service delivery, patient demographics and the impact of complementary medicine on other areas of the prison. In addition, a questionnaire survey of 50 patients (35 inmates and 15 staff), representing half of those inmates and staff who had received complementary medicine and were still in the prison at January 1998, was carried out. The cohort was selected by proportional sampling of patients by the number of treatments received

Conclusions

The pilot complementary medical treatment programme is unique both in terms of the scope and scale of service delivery. It is a multi-faceted service offering both a holistic complementary medical alternative to the prison health care centre and a stand alone therapeutic treatment programme. One of the greatest problems with evaluating therapeutic interventions is the lack of consensus of the required level of proof of their efficacy and value. In terms of programme integrity, a number of themes identified by the 'what works' literature as being successful in changing offenders' attitudes and behaviour are present in the ICMTP. In terms of the efficacy of the programme, four-fifths of all patients interviewed believed they had 'benefitted' from treatment while over three-quarters expressed a positive sense of well being since completing treatment.

The study was extremely useful in clarifying the relationship between complementary and conventional medicine, suggesting that patients use CMSP as both complementary and alternative. This is supported by evidence that the introduction of complementary medicine does not appear to have significantly altered demand on the prison health care centre. This suggests that CMSP is meeting a demand not previously addressed by conventional medicine. Since it appears to address a slightly different client group from the health care centre it is unclear whether any savings could be made from conventional medical budgets to pay for complementary medicine.

The inconclusive findings from statistical analysis of treatment levels and associated behaviour make it difficult to conclude whether the impact of complementary medicine on order and control may be quantified. In the absence of such evidence the main benefits of complementary medicine on Coldingley are qualitative. Benefits include:

- pain relief
- increased self-confidence
- greater personal control
- increased sociability, in particular improved staff-inmate relations
- stress reduction
- improved general behaviour
- improved morale
- a more pleasant and constructive working environment

The importance of these benefits should not be underestimated since research has identified that a positive 'climate' is the most important factor in maintaining order in category C prisons (Marshall 1995,1997).

Four factors were identified as deserving attention if CMSP is to continue or expand service provision. These are:

- public relations
- patient monitoring
- complaints procedures
- continuity of care

While 50% of those questioned believed therapists should be paid, it is extremely unlikely that the Prison Service could afford to fully fund complementary medicine at CMSP's predicted treatment costs per prisoner. Possible methods of alternative funding, such as match funding are therefore recommended. Based upon the evidence from the research literature, expansion of complementary medicine throughout the Prison Service might target young offenders and female prisoners.

Sixteen recommendations for the possible improvement and expansion of treatment services are offered. These are summarised below:

- The creation of an advisory committee with responsibility for identifying existing complementary medical provision throughout the Prison Service as well as for disseminating examples of good practice
- The creation of a complementary medical advisory board at Coldingley to act as a regular forum between CMSP and interested parties in the prison
- Introduction of a formal independently adjudicated mechanism for dealing with complaints about treatment services
- Investigation of the mantras used during meditation
- Better advertisement around Coldingley of CMSP and services they offer
- Clarification of the referral process for inmates and staff
- Introduction of induction workshops for new staff and inmates explaining the nature,

broad application and perceived benefits of the various therapies offered

- The provision of regular staff only clinics
- Introduction of an additional local training course for new therapists dealing with prison culture
- A detailed audit of patient overlap between CMSP and the health care centre
- Re-examination of CMSP's mechanisms for recording and calculating monthly treatment returns
- Re-examination of the mechanism for the delivery of appointment cards to inmates on the wings
- Comparative evaluations of the work of CMSP at Feltham and Downview
- A longitudinal study of the impact of complementary medicine on offending behaviour
- Introduction of a pilot semi-residential intensive complementary medical treatment programme at Coldingley
- Re-examination of mechanisms for funding complementary medicine

In addition to these recommendations, guidelines for the formulation of a contract to provide complementary medicine are offered in appendix C.

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1 Introduction

1.1 Background

Alternative medicine is generally defined as those medical systems, practices, interventions and applications that are not currently part of the dominant or conventional medical systems (Ernst 1993, Chez and Jonas 1997). Such therapies are generically termed *natural* medicine. Where this *naturopathic* tradition differs fundamentally from conventional medicine, or the *allopathic* tradition, is in intent. Whereas conventional medicine aims to identify and treat symptoms of illness or disfunction (the *law of disease* or *disease model*) natural medicine sees symptoms as manifestations of underlying causes of illness or disfunction which if treated should remove the symptoms (the *law of cure* or *quality of life model*). The ultimate goal of natural medicine is therefore to restore health as opposed to simply providing cure from disease. The subtle differences between these two states is clarified by the World Health Organisation's constitution (1946) which states:

Health is a state of complete physical, mental and social well being and not merely the absence of disease and infirmity.

Alternative medicine has been practised for over 3,800 years. Even the most recent widely introduced treatment, homœopathy, dates back to the 1820s. Yet despite pre-dating modern medicine, the naturopathic tradition is usually defined by its relationship to the allopathic tradition. In the United States, where healthcare is overwhelmingly dominated by private practice, the term *alternative medicine* is most commonly used, whereas in the United Kingdom, where conventional medicine is centralised under the National Health Service (NHS), the term *complementary medicine* is preferred. Often whether a therapy is considered complementary, alternative or conventional will depend upon the practitioner. When spinal manipulation is used by a physician it is generally considered conventional medicine. However, if the same treatment is provided by a specialist on referral, such as a chiropractor, it is likely to be considered complementary, whereas if the practitioner is an independent osteopath it may be viewed as alternative therapy. The reasons for this lie in intent. Whilst the naturopathic tradition aims to treat the whole person *holistically* (i.e. both body and mind) it is possible for some complementary medical techniques, in particular manipulative therapies such as osteopathy, to be used non-holistically as a stand alone treatment modality.

The last 30 years has witnessed increasing public interest in complementary healthcare. Conservative estimates suggest that in the United Kingdom alone as many as 10 million people, equivalent to approximately one-fifth of the entire population, have used complementary medicine (Mills *et al.* 1997). This figure is comparable with similar estimates elsewhere which suggest that 20-30% of the Western World regularly visit a complementary therapist. Although patient interest continues to outweigh scientific interest (Ernst and Kaptchuk 1996), research suggests that conventional medicine is becoming more receptive (BMA 1993). A UK national survey of access to complementary healthcare through general practitioners (GPs), carried out

on behalf of the Department of Health, estimated that 45% of GPs have recommend or endorsed complementary therapy (Thomas *et al.* 1995). The report also found that 21% of GPs regularly refer patients to therapists which equates to approximately 750,000 complementary treatments a year. Figures are even higher in the South-West of England where 68% of GPs had been involved in complementary medicine, 55% had recommended it and 16% practised it themselves (White *et al.* 1997).

For all the apparent growing popularity of complementary medicine there has been no new major scientific evidence of its efficacy or safety (Ernst *et al.* 1995b, Hentschel 1996, Mills *et al.* 1997). The continuing skepticism of the majority of conventional practitioners and the public is based upon a number of factors: a general ignorance about complementary medicine, concern over the qualifications of therapists, lack of clarity about the potential dangers of various therapies, incomplete data about the costs involved and a fear that the patient will not receive the full care they need (Perkin *et al.* 1994, Ernst and Kaptchuk 1996). There is also concern over the definitions such as the difference between a 'therapy' and a 'technique' (Mills *et al.* 1997).

The need for more research and education about complementary medicine is therefore paramount if it is to gain wider formal acceptance and attract large scale funding (Lavalley and Verhoef 1995, Ernst and Kaptchuk 1996, Chez and Jonas 1997). However, traditional reductionist medical research methodologies are ineffectual in evaluating complementary medicine (Ernst 1993, Lavalley and Verhoef 1995). In particular there is a propensity to over-interpret findings (Ernst 1993, 1996). This is due to two main factors. First, and foremost, complementary medicine is drug free. It is not therefore easy or reliable to administer placebo treatments to a control group. Secondly, complementary medicine is 'person-centred' in approach - the treatment modality is matched to the individual by building up a life history - the same treatment may not therefore necessarily be given to patients with the same presenting symptoms, as the underlying causes may differ. This is not to suggest that research into complementary medicine is impossible as an impressive number of methodologically good trials have been carried out using techniques such as double blind trials (Ernst 1996). Research is not therefore impossible, but more sensitive techniques need to be developed for reliable medical trials. The most effective way to overcome these methodological flaws is by concentrating upon outcomes research (Lavalley and Verhoef 1995) or by examining harmful or useful practices (Chez and Jonas 1997).

1.2 Complementary Medicine in Prison

Conservative estimates suggest that different forms of complementary therapy have been, or are currently being, used in around 30 of the 135 prisons in England and Wales. This includes a representative cross-section of establishment types and prisoners ranging from sentenced adults to young offenders and remands. A variety of pilot initiatives have been implemented such as nutritional supplementation at Portland and Aylesbury YOIs and the use of acupuncture to support withdrawal from addiction at HMPs Bristol, Wandsworth and Hollesley Bay. In a recent much publicised and otherwise fairly damning inspection report of Dartmoor prison, the Chief Inspector, Sir David Ramsbotham, singled out for praise the introduction of acupuncture into a drug-free wing to help ease withdrawal problems, explaining 'Many state they found it enabled them to relax and cope with the penal environment' (HM Prison Inspectorate 1998). Such isolated incidents of positive public recognition are rare. In view of headlines such as 'Jail lullaby to help convicts fall asleep, prison plan angers victims' (The Express, January 27 1998) - written in response to alleged plans, supported by Sir David Ramsbotham, to expand a hypnotherapy

initiative for insomniac inmates at Littlehey prison in Cambridgeshire - the Prison Service has been understandably cautious about disclosing information about complementary or alternative therapy work in prison. Very little is therefore known about existing pilot work in this country and the benefits of previous complementary medical interventions. As a result the majority of prisons are unaware of existing models on which to base complementary medical service provision.

In common with the majority of regime evaluation work (Ditchfield 1990) the literature on complementary or alternative medical interventions, whilst by no means extensive, has been dominated by the United States. By far the most common therapy to be found in a criminal justice setting is acupuncture. The widespread use of acupuncture in the treatment of addiction dates back to the 1970s. An evaluation by the University of California at San Francisco of the 'Sisters In Sober Treatment Empowered in Recovery' (SISTER) drug rehabilitation programme at the female county jail, found a 7% reduction in recidivism of those who had taken part after one year. One of the programme elements identified as being most effective with the women was acupuncture. Of those not rearrested on release 93% had participated in the acupuncture scheme, run by 40 volunteers from Acupuncture and Recovery Treatment Services (ARTS) (McKinney and Campt 1996). Research suggest that acupuncture based diversion programmes are also highly effective (Moon and Latessa 1994). A court acupuncture diversion programme in Miami has reduced recidivism rates for addicts from 68% to around 1% (NADA 1990).

Evaluative penal research has also examined spiritual healing, meditation and yoga programmes focussing on improving self-awareness and self-esteem (e.g. Bunk 1979, Waldram 1993). An evaluation of a transcendental meditation programme (TM) at the maximum security Folsom State Prison, found that those who had taken part in the programme showed reduced anxiety, neuroticism, hostility and insomnia compared to a control group (Abrams and Siegel 1978). Gelderloos (1991) similarly found that TM programmes could not only provide immediate relief from distress but could also produce long-term improvements in well-being, self-esteem, personal empowerment, and other areas of psychophysiological health. Rhead and May (1986) found meditation was particularly effective used with inmates with psychosis. Evidence suggests such programmes also have a positive impact upon subsequent recidivism (Bleick and Abrams 1987).

Research in criminal justice settings has also found that inmates are more susceptible to therapeutic change than those in the community. Suggestive techniques, such as hypnotherapy and neuro linguistic programming, have been found to be particularly effective. Researchers have attributed this to the fact that inmates have generally poorer verbalisation skills (Curren 1995) and are subjected to greater sensory deprivation (Wickramasekera 1970, Deforest and Johnson 1981). Inmates are therefore particularly responsive to sensory therapies such as music therapy (Hoskyns 1998). Evidence would also seem to suggest that such therapies work particularly well with juvenile offenders (Kappes and Thompson 1985).

Overall the penal research literature demonstrates that a number of complementary therapies, in particular acupuncture and meditation, work exceptionally well with prisoners in treating addiction and psychoses. However, these projects have largely been confined to therapies being used in isolation as interventions in other regime programmes. No attempt has been made to integrate therapies on a unitary basis to provide a holistic alternative to traditional prison healthcare.

1.3 Complementary medicine at Coldingley

HM Prison Coldingley is a purpose-built male prison near Bisley, Surrey, in the South East of England. Built on the former site of a Shaftsbury Home for boys it opened in 1969 as a prototype 'industrial prison' providing a regime built around a 40 hour working week. It aimed to provide purposeful work through contract and pay wages comparable to those found in the community. Originally built for high-security prisoners (category B), Coldingley was down-graded to medium-security in 1993. It now serves as a category C training prison "with an industrial bias" (HM Prison Inspectorate 1996) for 294 male prisoners. All inmates at Coldingley must be fit for work, a condition of staying at the establishment set out in the compact signed by inmates on their arrival. Consequently, the healthcare centre will not therefore support long-term palliative care (long-term suppression of conditions with drugs) and will not therefore issue either opiates or ephadrines.

In May 1996, the Prison Service sponsored a pilot project to introduce a small amount of holistically-based complementary health treatments at Coldingley. The project was designed to treat both staff and inmates and is operated by Complementary Medical Services for Prisoners (CMSP), a charitable organisation based within the establishment.

1.4 Aims and objectives of the study

This report describes the findings of an evaluation by the Institute for the Study and Treatment of Delinquency (ISTD), on behalf of the Prison Service Directorate of Operations (South), of the complementary medical treatment programme at HM Prison Coldingley. The terms of reference were as follows:

The Directorate of Operations South wishes to evaluate how useful holistically-based complementary medical health treatments have been to staff and inmates. The Directorate wishes to be informed as to how the scheme actually operates, the qualifications and training of the specialist staff and prisoners and any evidence relating to effects on standard healthcare services.

It is not the intention that the researchers should physically screen prisoners or staff to assess any improvements in health or general fitness, but researchers might wish to consider questioning subjects in relation to reduction in stress levels or general well-being.

The evaluation is therefore more criminological in nature than medical; focussing not on the efficacy of complementary medicine but instead on a qualitative analysis of patient satisfaction. The specific aims of the study were as follows:

- i. To describe fully how the system works in practice, recording the numbers of clients involved in the project and the level of contact, with particular reference to any difficulties which have been encountered in the implementation of the scheme
- ii. To report on the qualifications and training of the therapists who provide the treatments and to describe what professional support is available to them

- iii. To identify the various alternative or complementary health treatments given to both staff and prisoners over the past twelve months
- iv. To establish whether these treatments on the whole have proved beneficial to individuals, in terms of perceived improvements to health, changes in lifestyle patterns, reductions in stress and general well-being
- v. To describe how the incorporation of the complementary health treatments have impinged on the usage of the normal healthcare services within the establishment
- vi. To compare the costs of provision of holistic treatment with traditional healthcare provision within the establishment
- vii. To make recommendations in regard to the value of the project and its continuation or expansion
- viii. To advise how a contract for the provision of complementary medicine could be constructed

The study timescale was four months, commencing in January 1998.

2 Treatment Programme

2.1 Complementary Medical Services for Prisoners

Complementary Medical Services for Prisoners (CMSP) was formally created in May 1996. It was founded as a result of the work carried out independently by its present director, Maureen Mulligan, a cranial resonance practitioner. Miss Mulligan is a member of the Council of the Cranial Osteopathic Association (CCOA) and a director of the European Institute of Cranial and Complementary Medical Practitioners working within Prisons (EICCOAP), a training and accreditation organisation for staff and complementary medical practitioners working within prison environments. CMSP was founded to build on 12 years of experience of working with prisoners by creating a formal programme of drug free holistic complementary medicine which could be used within any adult prison or young offenders institution in the UK. The programme aims to treat stress, trauma, addiction, abuse and patterns of control violence and offending behaviour.

In addition to its director, CMSP has a full-time deputy director (Julian Perry), an administrator and a finance director. CMSP has six trustees, representing interests both within and outside of the Prison Service, and three patrons:

- The Institute for Complementary Medicine
- Audrey Hallam OBE
- Swami Brahmarishi (Sanysain Yogi)

In January 1997, the Institute for Complementary Medicine offered to act as a host charity for CMSP until such time as independence is obtained through registration with the Charities Commission.

2.1.1. Aims and objectives of CMSP

CMSP's statement of purpose states that the organisation exists to:

Promote health, self-esteem and quality of life for people within the prison system through a professional Complementary Medical Service.

Undertake research, evaluation and full clinical trials where appropriate to demonstrate the efficacy of CMSP's treatment approach and to advance the role of complementary medicine in prisons and the wider community.

Its stated formal aims and objectives are:

- To provide an Integrated Complementary Treatment programme to address patterns

of control, violence and addiction and related psychoses

- To provide a range of complementary medical treatment practices to meet the needs of the client group
- To provide a professional structured training programme and to co-work with outside complementary medical programmes as appropriate
- To encourage recognition of the role of complementary medicine in addressing criminal behaviour
- To implement after care programmes to assist with on-going life skills after treatment
- To provide drug free treatment to prisoners and staff
- To promote services open to all regardless of race, disability, gender, colour, ethnic and national origin, religious belief, age, criminal record and HIV or Aids status
- To develop a training centre for complementary medicine practitioners and holistic counsellors who will receive training, education, supervision and support
- To undertake research and evaluation with appropriate ethical considerations, protocols and methodologies to demonstrate the efficiency of treatments

2.2 The Coldingley pilot project

The purpose of the creation of the unit at Coldingley was, 'to establish within prisons a structured integrated complementary medical treatment programme (ICMTP) to provide assessment within prisons and crisis intervention for those having drug, alcohol and other addictive and stress related disorders' (CMSP 1997). In doing so, CMSP aimed to:

- Reduce stress levels
- Assist in the removal of the addictive drive at its root
- Tackle behavioural disorders.

By addressing these issues CMSP aims to work towards giving patients the opportunity to regain self-esteem and dignity. In the spirit of holistic therapy the programme was offered to both staff and prisoners. This decision is based on the principle that each member of staff is responsible for a greater number of inmates, therefore treating a single member of staff is likely to have an indirect impact on a greater proportion of the prison than treating a single prisoner. Treating both groups in tandem should therefore have the greatest possible impact.

2.3 Treatment services

CMSP operates two treatment services: the integrated complementary medical treatment programme (ICMTP) and crisis intervention or pre-admission. The former is the core treatment

programme for patients who wish to work on themselves whilst the latter is a complementary alternative to an outpatient clinic providing emergency intervention and short term treatment. All treatment is approached from a *transpersonal perspective* which may broadly be described as 'detached attachment'. This approach teaches therapists to deal with patients as individuals whilst remaining professionally detached. It aims to encourage life histories to emerge naturally and be treated without personal prejudices interfering.

2.3.1 Crisis intervention (pre-admission)

The purpose of crisis intervention is to provide drug-free treatment for prisoners and staff with:

- Suicidal states
- Behavioural disorders
- Stress (including anxiety, insomnia, migraine, backache, digestive disorders and mood swings)
- Abuse (including physical, sexual, emotional and spiritual abuse, i.e. self-harm).

Treatments are tailored to the specific needs of the individual which may, or may not, include counselling. More typically, treatment consists of small courses of manipulative therapies such as osteopathy, reiki, stress management and acupuncture. This form of short-term intervention is often a pre-cursor to encouraging patients to go on to the intensive programme (ICMTP). For this reason it is also referred to as 'pre-admission'. If a patient is considered in a state of 'emergency crisis' they will be seen intensively everyday until such time that it is felt they have passed the worst. Patients on pre-admission to the ICMTP will generally receive 1-3 treatments per month.

2.3.2 The integrated complementary medical treatment programme (ICMTP)

The ICMTP is a comprehensive therapeutic treatment programme designed to address:

- patterns of control
- patterns of violence
- patterns of addiction
- related psychoses.

The ICMTP is a 12 week course consisting of an individually devised programme, formulated after an assessment process, alternating one-to-one 'transpersonal' counselling with appropriate manipulative therapies. In addition to individual sessions, patients on the ICMTP also participate in discussion groups with other patients on the programme. Alternation between mental and physical treatment modalities is employed as the former can bring powerful emotions (such as abuse, violence, loss etc) to the surface which if unchanelled would likely manifest themselves as aggression. Clearly, by itself, this state would not be acceptable in a prison setting. However, by balancing counselling sessions with courses of manipulative therapies, such as cranial osteopathy, osteopathy, reiki, acupuncture and holistic stress management (see under 'Therapies and Therapists' for definitions), this aggression can be managed and dissipated. Patients are therefore termed as being 'held' by the therapeutic process whilst they address their own issues

and focus their attention on strengthening their body's defence systems. Patients on the ICMTP receive, on average, 1-3 treatments per week. The number of places available on the ICMTP at any one time is limited owing to the increased demand the programme places upon therapist time.

Both treatment schemes aim to support and enhance detoxification whilst simultaneously reducing the demand for medication, providing the skills to address low self-esteem and to 'generally improve the mental, emotional, physical and spiritual health of the client group' (CMSP 1997). More specifically within a penal environment, the services aim to reduce the rate of offending and reduce stress related aggression towards staff and within the inmate population.

In addition to the two treatment schemes already operating, CMSP plans in the future to offer smoking withdrawal, behavioural management and detoxification programmes (the latter in conjunction with the health care centre).

2.4 The treatment process

The CMSP treatment model, demonstrating the integration of the two treatment modes, is shown in figure 2.1. The treatment process consists of distinct phases: referral, assessment, treatment and aftercare.

2.4.1 Referrals

All clients are self-referrals, as the admission of having a problem is seen as the first step towards patients taking responsibility for their own health and recovery. Therapists are strictly discouraged from soliciting patients regardless of whether they feel individuals are in need of, or would benefit from treatment, unlike in the community. Under certain circumstances, CMSP will accept referrals from:

- The doctor or other health care personnel
- Wing liaison staff (such as members of the 'Safer Coldingley' drug strategy team)
- Inmates' personal officers

In exceptional circumstances, any member of staff may contact the unit if they are concerned about inmates. All approaches must be made to the treatment unit. Inmates approaching therapists outside of the unit are referred to the office to register for treatment. All patients are required to fill out a self-completion application form requiring them to list the symptoms they wish the therapists to look at. Regardless, therefore, of whether patients approach CMSP or are referred, participation remains by personal choice.

An important part of this process is referral back. CMSP will automatically refer patients for conventional medical intervention in the event of the discovery of a lump or if a serious cardiac condition is suspected. This is in keeping with the findings of the research literature which suggest that virtually all patients (both orthodox and complementary) generally prefer conventional medicine for serious disorders such as cardiac conditions, tumours and AIDS

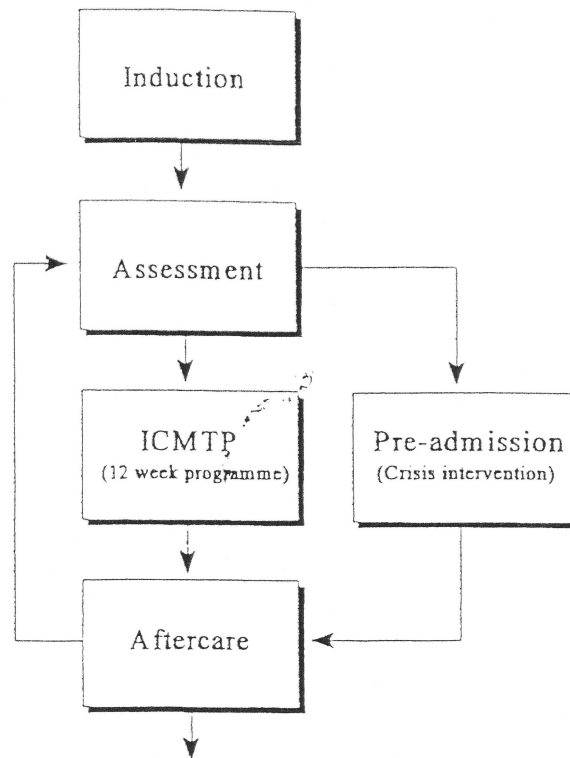


Figure 2.1 An overview of the CMSP complementary treatment model

(Hentschel *et al.* 1996). In this sense the service, whilst offering an alternative from the point of view of choice, remains complementary to the prison health care service.

2.4.2 Assessment

Under normal circumstances, all new patients will have an assessment of their needs prior to commencing treatment. Where urgent treatment is considered a priority as the patient is deemed to be in a state of crisis, assessment may be foregone until the patient is considered no longer critical. An assessment session typically lasts an hour and consists of one of the more experienced counsellors guiding patients through a *Treatment Survey* questionnaire. Separate questionnaires exist for staff and inmates. Patients are encouraged, where possible, to list up to 6 symptoms under the headings of mental, emotional, physical and spiritual and to score their severity. This serves both to compile the patient's life-history (holistic equivalent of a conventional medical patient history) and to qualify the extent of their illness or need by asking them to score the severity of their condition. In addition to providing valuable therapeutic information this symptomatic profile also supplies important baseline data for research assessment (patients are again asked to re-score their symptoms at the end of their treatment).

For many patients assessment is the first opportunity they have had to discuss personal issues with anyone and therefore the assessment process can be therapeutic in its own right. The assessment process is also used as an induction, describing the precise nature of the services CMSP offers together with the requirements of the patient such as the level of commitment expected. Patients

are then asked if they still wish to proceed.

2.4.3 Treatment

Following assessment, a group discussion takes place with other therapists and a suitable course of treatment is devised. The patient will then be referred to an individual practitioner for treatment. Appointments are allocated on an as soon as possible basis depending upon therapist availability and which treatment modality is most appropriate (i.e. ICMTP or crisis management). All appointments are logged on an appointment sheet and appointment cards are issued indicating the date, time and therapy. Treatment clinics take place four to six days a week, depending upon the availability of therapists, with a morning clinic from 8.30am until 12.00pm and an afternoon clinic from 2.00pm until around 4.00pm. Sessions vary in length according to the nature of the particular therapy and the working preference of the therapist, but typically treatments last between three-quarters of an hour to an hour. In so far as it is possible, appointment cards are distributed to inmates through the wings at least two days before the clinic. Staff are typically informed of appointments in person or by telephone as staff time is more limited and greater flexibility is required. At the end of each treatment the patient is required to sign a form to acknowledge they have been treated.

2.4.4 Aftercare

Upon completion of either treatment programme, patients will undergo a further assessment to decide whether continued treatment is merited. However, the precise role and influence of the patient in this decision is unclear. In the case of those undergoing crisis intervention re-assessment may result in them being placed on the ICMTP. Patients are free to reapply, effectively beginning the process from the start again, at any point after completion of treatment. In the case of inmates, aftercare will tend to focus on treatments with a view to developing their role in society, particularly after release.

2.5 Patient records

Each patient has an individual patient file and is allocated a 10 digit treatment case number. The file contains the individuals' application, their assessment and a *clinical record*. The clinical record form charts individual patients' ongoing treatment, providing a record of the actual treatment given at a particular session. Where possible, treatments are recorded in plain English, as opposed to using the professional terminology of the therapist involved. This is to ensure that the clinical record may be read and understood by any therapist as it forms a complete complementary medical treatment history. Therapists are asked only to record information about an individual that they would be happy for the patient to read in their presence. Therapists are also discouraged from recording any information that might, in the unlikely event that the file were seen by a third party, be able to be used against a patient, such as being abused as a child. Individual therapists may keep their own more detailed records (as required by their own professional body), if they wish, but must observe the same confidentiality required concerning all CMSP files.

The relationship between a CMSP therapist and patient is viewed with the same protocols as that

between a patient and a conventional medical practitioner. Staff and inmate files are kept separately in locked filing cabinets in the CMSP office which is locked at all times when a CMSP staff member is not present. Files are kept out of sight at all times when inmates or officers may be in the office. This includes the unit inmate orderly who is also excluded from being present during any case discussions. No files are removed from the office and clinical notes are not released to non CMSP staff.

If requested, under exceptional circumstances CMSP will prepare a *complementary health care report* outlining the treatment given and a professional assessment of an individual inmate's progress and current state. If requested, inmates are required to sign a release form. Inmates are discouraged from using these as evidence of accreditation for parole hearings thereby using completion of complementary therapy as a 'card stamping' exercise. Support for this position is reflected by the fact that in the two year period (April 1996- March 1998) only three such reports have been prepared.

At the end of each month therapists are asked to submit a *patient return* form. This records the names, case numbers and brief details of all patients they have seen. This enables calculation of the total number of patients seen, and the number of hours put in by therapists, per month.

2.6 Treatment location

The treatment programme is coordinated from the CMSP unit which is located in a former principal officer's office located on Alpha (A) Wing. Prior to January 1998, treatments took place in a variety of locations around the establishment making service provision heavily reliant upon vacancies and the good will of the chaplaincy, education and health care. A purpose built treatment centre was created in January 1998 providing a suite of two individual treatment rooms and a much larger group therapy room. The suite was created by the works department in liaison with CMSP by converting part of the dining room which links the four wings of Coldingley's Nucleated 'dog leg' design (Marshall 1995). Lighting, soundproofing and decoration have been maximised, within budgetary and security constraints, to provide a treatment facility quite alien from the normal prison environment.

3 Therapies and Therapists

3.2 Therapies offered by CMSP

It is suggested that there are in excess of 300 different therapies under the umbrella terms 'complementary' and 'alternative' which, in turn, may be further subdivided into seven major categories on the basis of philosophy, patient approach and orientation (Chez and Jonas 1997). In a report to the Department of Health, Mills *et al.* (1997) identified 14 major and discrete complementary disciplines in the United Kingdom. Since its creation (May 1996-March 1998) CMSP has offered 16 different complementary therapies. The therapies, together with a brief description, are as follows:

Acupuncture: Technique whereby needles are inserted into specific sites on the body surface, known as meridians, to improve the flow of energy around the body, thus preventing and treating disease, disability and dysfunction.

Acupressure: Technique similar to acupuncture except pressure applied to specific sites on the body surface as opposed to inserting needles.

Cranial Osteopathy: Non-intrusive meditative pressure applied to the bones of the cranium to affect musculature and body fluids encouraging the disturbed area to unwind and return to its normal state.

Cranial Resonance: A transpersonal treatment designed to address patterns of abuse, violence, addiction using meditative contact on the cerebro-spinal system. The treatment is administered by either an individual or group of practitioners working on a single patient.

Holistic Stress Management: The use of a variety of techniques (outlined above and below) designed to reduce stress and generate a positive impact on health and well being.

Homœopathy: A technique designed to match the totality of a patient's physical and mental symptoms to individualised herbal remedies administered in diluted microscopic doses.

Hypnotherapy: Technique designed to use the unconscious mind to change unwanted habits and conditions and to explore more helpful patterns of thought and behaviour

Meditation: The use of breathing techniques to relax and focus

Music Therapy: The use of music to assist the individual to focus their creativity and energy in a constructive manner. Helps to cultivate inner discipline, focus and harmony.

Nutritional Therapy: The use of supplements and individualised diet to address

deficiencies and chemical imbalance in order to assist in recovery and enhance the body's own defences and recuperative powers.

Osteopathy: The application of manipulative procedures to the musculo-skeletal system and soft tissues to address imbalances and stresses within the body and to enhance recovery from damage and dysfunction. Variation known as chiropractic.

Reflexology: The application of pressure and manipulation to areas of the feet which directly relate to other areas of the body, to improve the associated organs and systems.

Reiki: Non-invasive and non-intrusive healing designed to transmit energy between a therapist and patient positively stimulating the body and mind. Also known as healing.

Transpersonal Counselling: a person-centred holistic mode of counselling designed to encourage patients to develop a deeper awareness of their condition and to address undesirable patterns of behaviour and experiences.

Tai Chi: Movement and breathing designed to focus, calm and help the individual to take responsibility for their health and well being. Variations include moi tai.

Vibrational Medicine: A system delivering energies or vibrations, held in a liquid or solid matrix, to address physical imbalances and to transmute 'negative' traits of mind and emotion thereby stimulating recovery and allowing for greater receptivity to healing processes.

The availability of the various therapies is governed at any one time by the availability of the corresponding therapists.

3.2 CMSP therapists

There are two main categories of therapist working for CMSP: professionals and placement counsellors. With the exception of management staff (e.g. directors and unit managers who are salaried from core funding), all therapists work on a voluntary basis. For many of the professionals this means work for CMSP is carried out on an equivalent to *pro bono* work done by the legal profession and is therefore in addition to private practice. For placement counsellors, working for CMSP is a means of satisfying the practical requirement of their training qualification. The skill base and backgrounds of therapists therefore varies tremendously, as does their availability - ranging from full-time to one day a month.

Each therapist may be a practitioner of more than one therapy. Furthermore practitioners may practice their particular therapies in a variety of formats according to their training body and milieu - there are numerous possible counselling techniques just as there are many sub-categories of osteopathy and acupuncture. Appendix A contains a full list of therapists who have treated patients at Coldingley, together with their principal therapy, for the period May 1996-

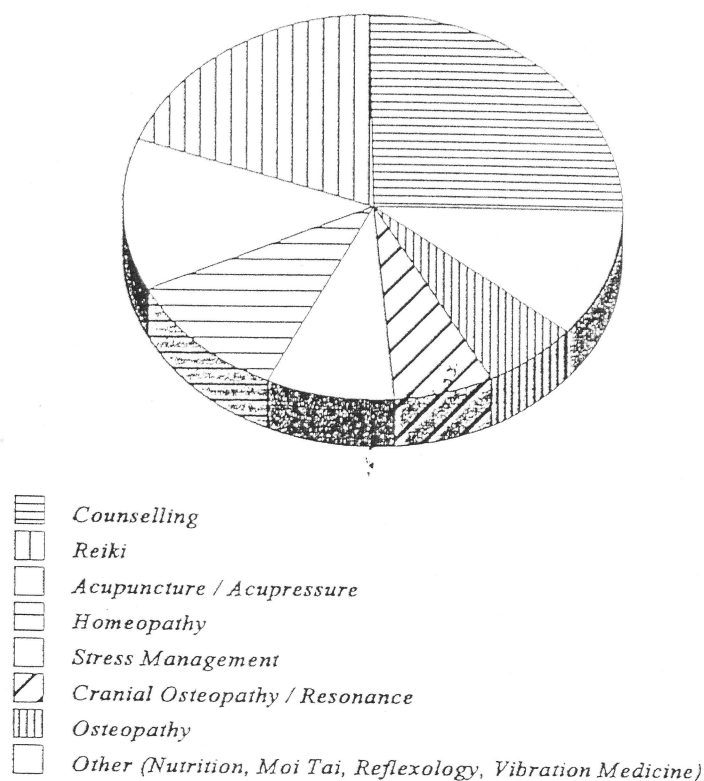


Figure 3.1 CMSP therapists at Coldingley by specialism

January 1998. Of those still registered with CMSP on January 21 1998, 47 therapists have treated patients at Coldingley on either a short or long term basis. Of these, two-thirds were female (66%) and one-third male (34%). Figure 3.1 shows a percentage breakdown of therapists at Coldingley by therapy type. As figure 3.1 demonstrates, each therapy is not equally represented in terms of the number of practitioners working with CMSP. Two specialisms, counselling and reiki, account for virtually half of all therapists, with counselling, reiki, acupuncture, homœopathy and holistic stress management accounting for over three-quarters of all therapists. Appendix A also provides details of each therapists' professional body or training organisation. However, given the complex nature and background of natural medicine, understanding of the importance of affiliations requires further qualification.

3.3 Regulating complementary medicine

In comparison with conventional medicine in the United Kingdom, which is governed by a single body (The British Medical Association), complementary medicine remains largely unregulated. Unlike the majority of other developed countries, United Kingdom law does not require that complementary therapists be registered with the state in order to practice (Stone and Mathews 1996). As a consequence, much of the public demand for natural medicine is being met by practitioners without statutory legislature, recognisable training qualifications, professional standards or insurance (Mills *et al.* 1997).

practitioners to raise standards and gain professional status. However, without formal obligation, virtually anyone may set up their own training programme and professional body without sanction, answerable only to their clients. For example, while homœopathy achieved formal recognition in the National Health Act (1950) and to date five NHS hospitals in Bristol, Glasgow, Liverpool, London and Tunbridge Wells have specialist homœopathic wards, the title was never protected by statute and therefore anyone can practice and call themselves a homœopath (Mills *et al.* 1997).

The Government has been relatively slow to call for the regulation of complementary medicine under a single cohesive umbrella organisation. At present the majority of training organisations are independent stand alone bodies with each therapy having a number of different associations and societies. For example, in the case of reflexology, membership of different organisations tends to reflect specific training and techniques used (Mills *et al.* 1997). Whilst many are professional bodies whose members include conventional practitioners, others are so small and *ad hoc* in nature as to negate the value of membership or certification. Similarly, while some disciplines now offer independent degree courses at, or validated by, universities others require as little as a single day to qualify. The majority of professional groups provide professional indemnity and public liability cover for their members. The cost of such cover is generally very low in comparison to conventional medical practitioners' insurance. While this means that virtually anyone may insure themselves as a complementary therapist it also reflects the lack of litigation, and therefore implied malpractice, in this area (Mills *et al.* 1997).

Self-regulation varies considerably by discipline. For example, virtually all healers recognise the Confederation of Healing Organisations (CHO) as their single governing body. Osteopathy and chiropractic have gone even further protecting their titles and providing external and internal regulation of their activities. The Osteopaths Act (1993) requires that from 1998 all practising osteopaths register with the General Osteopathic Council. It will therefore become a criminal act to practice unless registered and those found guilty of malpractice may be struck off. Table 3.1 shows the comparable national professional organisation of the main complementary disciplines offered by CMSP in order of size.

Table 3.1 National organisation of complementary medicine by discipline *

Discipline	Number of organisations			Date oldest organisation founded	Number of therapists		
	Complementary	Other	Total		Complementary	Other	Total
Reflexology	6	1	7	1952	5273	900	6173
Acupuncture	6	2	8	1960	1749	2085	3834
Hypnotherapy	11	0	11	1950	3006	-	3006
Osteopathy	4	3	7	1911	2325	88	2413
Homœopathy	3	2	5	1943	1497	507	2004
Healing	10	3	13	1884	1400	-	1400

(Source: Mills *et al.* 1997. Figures are based upon returns to a national survey and do not therefore necessarily include every organisation)

In the absence of statutory regulation, umbrella complementary organisations offer some degree of reassurance by encouraging developing standards and maintaining a list of recommended therapists. However, in the United Kingdom there are in excess of six umbrella organisations, the largest being: the British Complementary Medical Association (founded 1989), the Council for Complementary and Alternative Medicine (founded 1986), The Institute for Complementary Medicine (founded 1982), and the Research Council for Complementary Medicine (founded 1983) (see appendix B for a list of addresses). The ICM also administers the British Register of Complementary Practitioners and the British Council of Complementary Medicine. The situation is somewhat different in the United States where in response to concerns about safety, the National Institutes of Health (the medical research arm of the US Government) created a central Office of Alternative Medicine (OAM) which publishes a directory of alternative health care associations.

As a result of the professional state of complementary medicine, whilst CMSP demand evidence from volunteers of proof that they have a qualification to a level required to practice their chosen specialism, less weight is attached to formal qualifications than to practical experience, aptitude for working in a penal setting and credibility with the patient group. A great deal of importance is therefore placed by CMSP upon supervision and training.

3.4 CMSP therapist training

All therapists, regardless of whether fully qualified or on a placement, follow an identical induction and four stage training process. This consists of:

- i. *Introduction* - therapists are introduced to the aims and objectives of CMSP and the principles under which they work
- ii. *Security* - therapists are given an introduction to the dangers of working in a prison by a Prison Service uniformed security officer and advised on good practice. Therapists are also shown a video and given a talk on suicide awareness.
- iii. *Person-centred approach* - therapists are trained to work *transpersonally* and are taken through the treatment process themselves and asked to examine personal issues such as their own motives for wishing to work in a prison environment.
- iv. *Specialist training* - therapists are provided an opportunity, on retreat, to learn new skills and develop specialist training in their chosen treatment areas

Induction courses last a full day. Training modules 1 and 2 (introduction and security) together form another full day, as does module 3. Module 4 is a residential weekend. All therapists are required to complete modules 1 and 2 (a minimum of 2 days), before they are allowed to work in any capacity in one of the three treatment units. In addition, therapists are required to present physical evidence of qualifications from relevant governing bodies, in the form of original certificates, before being allowed to practice. As modules 3 and 4 represent a much deeper level of commitment, these training courses are optional. Therapists who demonstrate an aptitude for working in a prison environment and wish to become more involved in CMSP are invited to sign up for these courses when they feel ready. Therapists' relative strengths and weaknesses are

assessed during training and initial placement and they are then allocated to cases as appropriate. All core training takes place at Feltham Young Offenders Institution and is facilitated and licensed through the European Institute of Cranial and Complementary Medical Practitioners working within Prisons (EICCMPP).

Therapists on placements are governed by the same criteria as fully qualified therapists and are supervised both by CMSP and by an appointed fully-qualified therapist from their training or governing body. Such placements are normal practice for many disciplines (such as counselling) and are used to ensure newly qualified therapists, generally having undergone a number of years assessed theoretical and practical training, have a support network when they begin working in the field and not for teaching purposes *per se*.

On-going holistic support, education and supervision are compulsory for all CMSP staff and therapists ensuring skills and techniques are of a uniform standard and conform to the organisation's stated aims. Therapists therefore effectively remain under supervisory probation, for the duration of their time with CMSP. At present, the training schedule provides one introduction and one induction session per month. All therapists are required to have completed the first two stages of training before they are allowed to work in any capacity in the treatment unit. In addition to therapists, CMSP offers to train medical practitioners and prison staff who are interested in complementary medicine.

3.5 Professional support

In addition to CMSP's patrons and affiliated bodies, a number of holistically based complementary medical organisations have offered professional support. These include:

- The Cranial Osteopathic Association
- The British Acupuncture Council
- The London Academy of Oriental Medicine and Acupuncture
- The Centre for Counselling and Psychotherapy Education
- The Society of Homœopaths

CMSP are also actively encouraging the formulation of standards and codes of conduct by bringing together experts from the International Institute of Cranial and Complementary Medicine Practitioners (IICCMPP), based in Switzerland and the Council for Integrated Complementary Healthcare (CICH).

3.6 Code of care and confidentiality

The importance of establishing and maintaining clear boundaries between patients and therapists underpins all of CMSP's work. These cover such areas as security, therapeutic protocol and confidentiality. This is over and above the standard security checks (i.e. Criminal Records Office checks) required by the Home Office, and any required locally by the prison, for all staff working in an establishment.

Such boundaries aim to protect all four parties involved in treatment: the patient, the therapist,

the organisation and the host prison. For example, the penalty for breaching the security rules of the prison for a first offence will be the withdrawal of keys, a second or third offence will be met by termination of their services. Therapists are not permitted to work alone with an inmate in the treatment suite. Therapists are advised not to reveal any personal details or to give personal contacts to inmates or staff or offer to treat them outside of the prison. Similarly, all therapists are required to operate a professional dress code appropriate to their particular therapy. In particular, female therapists working with male inmates are required not to wear excessive make up or clothing that might be considered provocative. Therapists working with 'sharps' (such as acupuncturists) are required to verbally count needles in and out of a patient to ensure there are no losses, over and above standard medical hygiene requirements for such intrusive implements.

CMSP's *Code of Care* is founded on five principles. These are:

- All patients are treated with respect
- Within the 'therapeutic community' patients can communicate freely without interruption, verbal abuse or threat
- Information is stored in confidence
- Confidentiality of disclosure
- Grievances can be brought to the treatment management.

The therapeutic relationship is based upon trust and confidentiality, both of which are regarded as basic. The treatment unit is run as a *therapeutic community*. The nature of a therapeutic community is well described by Genders and Player in their 1995 book on Grendon:

The therapeutic community gives predominance to social learning over psychoanalytical methods...The community thus functions to provide both an experimental forum and a social context within which sociopathic disturbances can be expressed, confronted and explored

A therapeutic community emphasises self-help through peer support and by focussing on increasing individuals' responsibility and privilege creating role models out of those more advanced in the treatment process (Geiger 1993, Cullen 1998). The success of the therapeutic community at Grendon is well documented (Genders and Player 1985, Player and Martin 1996, Cullen *et al.* 1997, Cullen 1998). Patients are informed prior to treatment that although treatments will be carried out on a one-to-one basis, with the obvious exception of group sessions, therapists work collectively in the treatment process and therefore their case may be discussed. Such case discussions, termed *processing*, are an important part of the holistic process as it enables a better picture to be formed of the individual as well as providing an opportunity to draw on the experience and advice of others. Processing is also used to debrief therapists and to allow them to 'off-load' the burden of information patients place upon them without breaking the confidence of the therapeutic community.

The importance of following line-management (through the unit managers to the director or her deputy) is also strongly impressed upon therapists in training. All grievances, safety and security concerns are dealt with in this manner to ensure that correct Prison Service channels may be followed, such as the documentation required to initiate a suicide watch. CMSP are in the process of developing committee structures to cover: referrals, briefing, accreditation, insurance and disputes.

CMSP have few conditions of treatment other than that the individual should be prepared to work on themselves and assist in their own recovery. From this stems the need for commitment. CMSP is unwilling to treat inmates who consistently fail to attend therapy sessions without prior notice or subsequent valid explanation (such as having a visit). A first offence is met by a warning. If patients continue to miss sessions they are removed from the programme and must re-apply and go through assessment again if they wish to continue.

The organisation is in the process of developing a unit handbook to cover complementary medical practices, protocols and ethics to be adhered to within the treatment unit. Once completed, this handbook will be made available to prison and healthcare personnel who request it.

Standardisation and uniformity in practice are underlying principles in all of CMSP's work. CMSP's aim is to train every interested therapist equally in the management process to ensure that all therapists are capable of running the therapeutic unit. Not only does this standardise practice across the organisation but it also serves to ensure that the treatment process is prioritised above individuals by making all managers effectively interchangeable. This is particularly important since in addition to the unit at Coldingley, CMSP have also established treatment units in two other prisons. The second unit opened at HMP Downview, an adult prison near Banstead in Surrey in August 1997. The third unit opened at Feltham Young Offenders Institution in Middlesex in October 1997. Since opening, Feltham has become CMSP's central office. It has been suggested that a further 11 prisons have approached CMSP with a view to setting up treatment units. In addition a number of establishments have approached CMSP with a view to training existing health care staff.

4 Service Delivery

4.1 Treatment statistics

Mills *et al.* (1997) estimate that nationally, each complementary therapist sees approximately 80 individuals per year. With an estimated 43,567 complementary therapists practising in the UK this equates to nearly 3 million patients per annum. CMSP began treating patients in May 1996. The total number of complementary medical treatments for the financial year 1997/8 was 3,074, the monthly mean being 256. This equates to 0.9 treatments per inmate for the entire prison. Over the same period, 854 individuals were treated, an average of 71 per month. This included 248 new patients, with an average of 21 new patients per month.

In the six month period to March 1998, an average of 61 inmates and 8 members of staff were treated per month. On average there were 17 patients per month on the ICMTP and 235 on Pre-Admission or receiving Crisis Intervention. In the same six month period the number of therapists grew from 31 to 47 an increase of almost 50%.

Figure 4.1 shows a comparison of the mean inmate population with both the number of individuals treated and the total number of treatments for the two year period 1996/7-1997/8. The total number of treatments since the unit was created in May 1996 is 4,575 with an average of 199 treatments per month. As figure 4.1 shows, service provision has virtually doubled per month in CMSP's second year of operation compared to their first. Detailed records of the numbers of individuals treated are only available from September 1996. The total number of individuals treated between then and March 1998 is 1186 with an average of 62 patients per month. In May 1997 alone, CMSP treated almost one-third of all inmates in the prison. In both July 1997 and March 1998 the total number of treatments given exceeded the establishment population.

CMSP figures greatly exceed those for comparable large scale complementary services. The S.I.S.T.E.R drug rehabilitation programme in California estimates to treat 300 clients per year with up to 40 voluntary acupuncturists working five days per week (Geiger 1993). Whilst this does not take into account the scope and scale of therapy received by individual CMSP patients, it is remarkable for a single treatment unit.

The treatment unit is also remarkable in another manner. Although individuals may choose to forego further treatment, because of the combination of CMSP's minimal criteria for being treated and the fact that therapy is self-referral, the percentage of patients considered unsuitable for treatment is virtually zero. CMSP estimate that the percentage who approach the unit but then do not go beyond the assessment is between 1-3%. In these cases, it is usually the patient's choice not to proceed as they are not prepared to make the necessary level of commitment that CMSP require, namely to play an active role in their healing process. Initial evidence suggests that many drop outs reapproach CMSP at a later date, although more detailed analysis is probably warranted. This is markedly different from figures for therapeutic communities

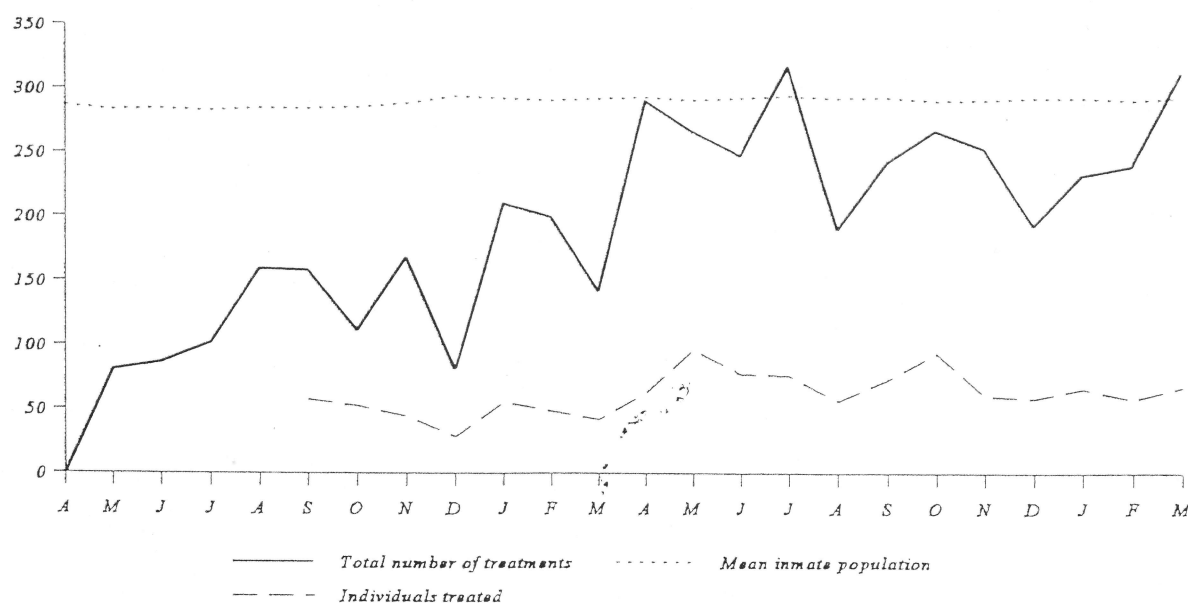


Figure 4.1 Mean inmate population, number of individuals treated and total number of treatments 1996/7 - 1997/8

generally, which typically report drop out rates of up to 20% due to unsuitability for treatment (Cullen 1998). The need to clarify the precise number of patients who drop out of treatment and their reasons for doing so is an important part of programme evaluation and research. Further attention clearly needs to be directed to this matter in future as accurate data may be able to demonstrate significant findings.

4.2 Service constraints

CMSP identify a number of factors which have served to constrain service delivery. These are:

- Availability of therapists and therapeutic specialisms
- Treatment location and conditions
- Delivery of appointment cards
- Access to inmates

Comparing the number of treatments per therapy for the year to March 1998 (figure 4.2) with the number of therapists per specialism for March 1998 (figure 4.3), it may be seen that three therapies (counselling, acupuncture and stress management) account for almost three-quarters (73%) and almost two-thirds (62%) of all therapists. Given the importance of counselling in the ICMTP, its predominance is not unexpected. However, in other instances it may be seen that treatment numbers are disproportionate to the number of therapists. For example, osteopathy is the fourth most common therapy yet is ranked seventh in terms of the number of practising therapists.

Rather than reflecting supply and demand, figures 4.2 and 4.3 suggest that the provision of a

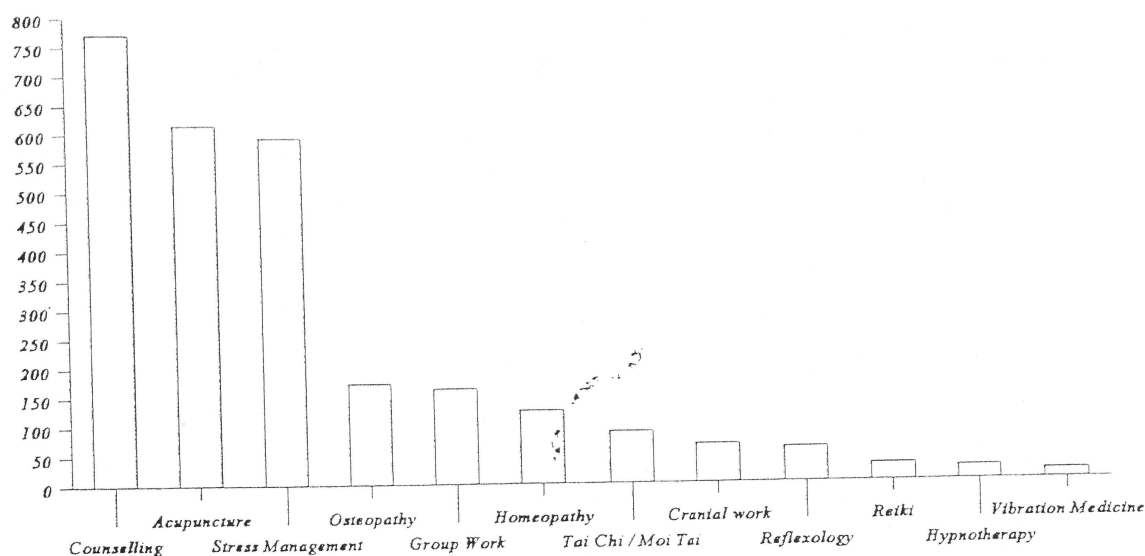


Figure 4.2 Total number of treatments by therapy (April 1997-March 1998)

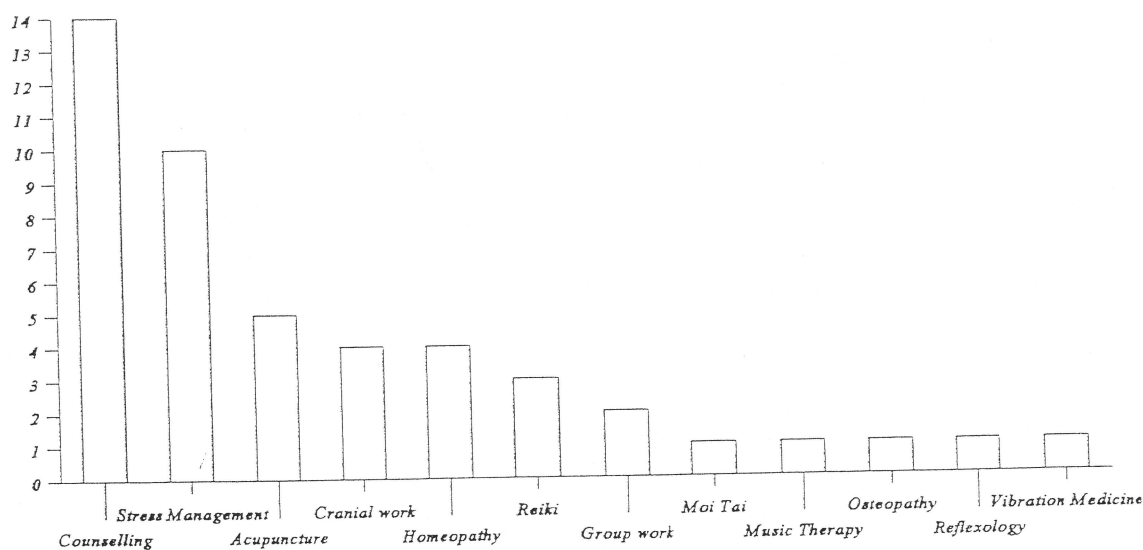


Figure 4.3 Number of therapists by therapy (March 1998)

particular therapy is wholly dependent upon the availability of the relevant therapists and the time that those therapists, as volunteers, can give. On average therapists give 10.8 hours per month. This figure is higher for counsellors who work a mean of 15.6 hours per month. Other types of therapists generally work between 2 and 10 hours per month, the average being 5.6 hours. It should, however, be noted that inherently some therapists can treat a greater number of patients than others, either simultaneously or consecutively, in the same time period. For example, while a music therapist is able to see ten patients in one hour, a meditation practitioner is able to make 5 treatments and a counsellor only one.

The precise course of treatment an individual receives is therefore constrained by supply and not demand. The likelihood that a treatment programme will be able to match the optimum therapy for the individual's needs is, therefore, considerably reduced. In the case of the ICMTP this problem may be alleviated by the fact that any number of physical therapies may dissipate aggression brought up through counselling. However, for those seeking complementary therapy as a form of crisis intervention (i.e. for a bad back) a substitute therapy may negate some of complementary medicine's potential effectiveness.

Treatment location and conditions are another area of concern. Whilst others have been extremely generous in facilitating the use of free space by CMSP, in particular the Healthcare Centre, reliance upon coalition for accommodation elsewhere in the prison often resulted in rooms being double booked or unavailable at the last minute. Available spaces, such as association and television rooms, the church hall and dentists room, were often far from ideal for intimate treatment offering little privacy. In addition, such environments often also carry strong associations for inmates conflicting with CMSP's independence from the Prison Service, conventional medicine or formal religion. Whilst this problem has been largely removed following the opening of the dedicated treatment suite, a number of occasions still arise where treatment numbers are limited by space as opposed to therapists.

Whilst the appointment system used by CMSP generally works well, it is subject to the constraints of working in a busy industrial prison environment. Some concern was expressed by therapists and inmates that a small number of wing staff were not passing on appointment cards until the evening or day after appointments were scheduled. Whilst there was no evidence that such delays were malicious in intent, the issue had been raised with the Governor and appeared to have been addressed. This was reflected by a sharp decline in the number of such complaints. Nevertheless, delivery of appointment cards would appear to remain a logistical problem.

All inmates at Coldingley are required to work or take part in full-time education. As a result inmates are therefore widely dispersed around the establishment during the working day. Although there is a high degree of freedom of movement around Coldingley, the establishment is heavily zoned (fenced off into locked functional areas). With the exception of those in education, inmates are therefore unable to make their own way to appointments. For security reasons sets of prison keys are strictly limited in supply and are therefore at a premium. Initially this created considerable problems as a shortage meant that it fell to the unit manager to fetch and return all inmates for their appointments, in addition to escorting therapists to and from the prison gate, leaving little time to carry out administrative or therapeutic duties. This problem becomes more acute as the numbers of patients and therapists continue to rise. The situation has, however, been greatly alleviated by security allocating more keys for therapists on a shared tally basis.

Another area where CMSP has been made acutely aware of the difficulties of running a treatment service within an industrial prison regime is in getting inmates released from work to attend therapy sessions. Coldingley's workshops operate commercial contracts and are therefore under pressure to meet deadlines and performance targets. In accordance with performance related pay, it is establishment policy to deduct from the wages of inmates payment for the length of time that they are absent from the industrial complex. Inmates therefore choose to lose money in order to attend complementary medical appointments. This suggests a certain degree of commitment and rebukes some suggestions that inmates use therapy as a strategy for work avoidance.

Inmates have complained to therapists that industrial staff have been unwilling to release them for appointments. Instructors have expressed concern over what they see as large numbers of inmates regularly being taken out of the industrial complex often, they claim, without prior notice and without inmates being returned. Staff shortages mean that instructors must be taken out of other duties in order to properly search inmates before they leave. Attempts have been made to ensure that daily lists of inmates with appointments are circulated to all wing and industrial workshops. In addition inmates with early morning and afternoon appointments are asked to stay on the wing and are escorted to work after their treatment. In practice such problems appear to be minimal but may be placed under greater pressure following the privatisation of the industrial complex.

4.3 CMSP internal pilot study

CMSP has an ongoing policy of research and evaluation to validate the work being undertaken. In September 1997 an internal pilot study was carried out looking at the Integrated Complementary Medical Treatment Programme (IMTP) and Crisis Intervention to assess the benefits to inmates and staff (Perry 1997). The CMSP study reported that a cohort of 21 patients (20 inmates and one member of staff) were 'chosen' that had each received 3 or more treatments over the previous 8 weeks. 62% of the cohort were either on the intensive programme or had completed the main phase of the programme. The remaining 38% had received individually tailored 'crisis intervention' treatments.

Data was collected over a five week period using a confidential 12 question questionnaire (Form 3). Patients were asked to score perceived changes in symptoms, interest in treatment, perceived effectiveness and overall satisfaction. In addition a number of open ended questions dealt with numbers of treatments, treatment facilities, overall health and the quality of treatment provided.

Four questions lent themselves to quantitative analysis by comparing pre- and post - treatment changes in scores. 85% of the cohort recorded a perceived improvement in their symptoms. Almost three-quarters (67%) of all patients recorded above average scores for overall condition with many selecting maximum scores, suggesting general satisfaction with treatment. 60% of the sample recorded an active interest in the treatment and complementary medicine with approximately 15% expressing an interest in training in a therapeutic discipline at some point in the future. The majority of the sample (70%) believed their treatments to have been effective for them although what is meant by the term 'effective' is not qualified. In terms of overall satisfaction, all patients recorded scores above average (mean score 6.8). Qualitative analysis suggested that inmates were generally positive about the quality of treatment and valued the work of CMSP with many suggesting it should be expanded. Patients were, however, critical of the environment in which the treatments took place although this has subsequently changed following the opening of the treatment suite in the converted dining hall.

The report concludes that, 'the data provided here gives ample cause to suggest that holistic drug-free health care has a vital role to play in the health of those in a prison environment. Further that there is good cause to initiate other pilot studies and more detailed research projects in examination of the benefit and cost effectiveness of CMSP's role within prisons. Further research and evaluation work is therefore justified for the future investment and development of Complementary Medical Services for Prisoners' (Perry 1997).

Whilst the pilot study raises a number of interesting issues and does suggest that further study is merited, the research also raises a number of problems. No attempt is made to relate overall satisfaction to the number of treatments given or length of time treated, despite the information being recorded on the questionnaire. Similarly, whilst the study reports that a high percentage of the sample developed an interest in the treatment process, it neglects to mention that an equal percentage indicated they had received no benefit and 5% recorded a negative score. Again no attempt is made to define what is meant by 'effective'. This is not to diminish the value of personal testament as this can be a very effective qualitative measure but only if the representativeness of that person is taken into account as well as predisposition to complementary therapy. Overall, the sample size is too small for percentage scores to be meaningful without indication of their representativeness of the remaining patient group or indeed the establishment. Shifts in scores do not take any account of whether patients were initially sceptical or were supportive of complementary medicine or other extraneous factors, such as parallel participation in other programmes. Furthermore only a single member of staff was included.

For such an evaluation to be reliable, it must demonstrate the representativeness of the sample in relation to both the patient group and the prison from which the patients are drawn. The precise nature and duration of treatment also needs to be recorded. Moreover, background demographical information is required to assess possible pre-disposition to complementary medicine.

5 Patient Demographics

5.1 Demographical research

In order to assess the representativeness of patients using the complementary medical service at Coldingley, it is useful to examine briefly the literature on complementary patient demographics for the outside community. Research suggests that whilst no demographical group is particularly non-disposed to complementary medicine (Ernst *et al.* 1995a), it is more likely to appeal to women and to the young (Ernst *et al.* 1995b, Furnham and Kirkaldy 1996). The literature also suggests that those who choose to use complementary medicine in the community are likely to differ socio-demographically, psychologically and in lifestyle from conventional medical patients; they are more likely to have a healthy lifestyle, have a higher level of education, and are less likely to smoke or drink (Hentschel *et al.* 1996).

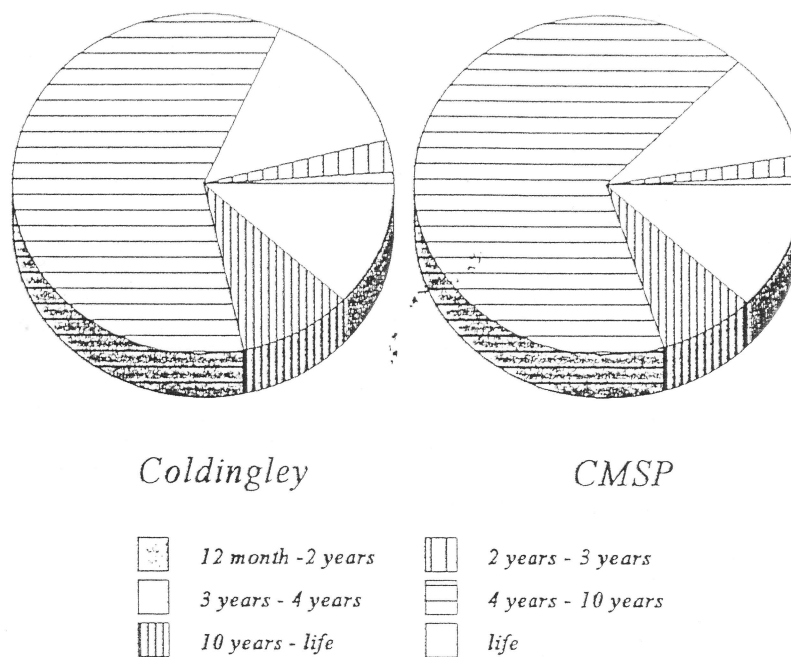
Research suggests that dissatisfaction with orthodox medicine is not the principal reason for seeking complementary medicine (Ernst *et al.* 1995a, Furnham and Kirkaldy 1996) and instead suggests that whilst the reasons people choose complementary medicine are complex, choice is generally based on a belief that it works (Furnham and Kirkaldy 1996). In a study of 250 patients in three complementary medical practices, Vincent and Furnham (1996) found that whilst the reasons for selecting complementary medicine varied according to the nature of the therapy used, five common factors could be identified. In order of importance these were: a belief in complementary medicine; the ineffectiveness of orthodox treatment for their complaint, concern about adverse effects from orthodox medicine, lack of communication from doctors and the availability of complementary medicine.

Empirical evidence of problems or difficulties arising from complementary medicine is slight. In a study of primary care physicians in the South-West of England, 38% of respondents reported adverse effects from treatment most commonly after manipulation (White *et al.* 1997). This statistic is sufficiently high to warrant investigation of difficulties encountered following treatments amongst CMSP patients.

5.2 Inmate patient demographics for Coldingley

Coldingley has certified normal accommodation (CNA) for 294 inmates. The mean population for 1997/8 was 295. Treatment data for the period May 1996 to December 1997 was compared with the inmate roll for January 1998 in order to identify the number of inmates still at Coldingley who have received complementary treatment. At the time of survey, 101 current and former patients remained in the establishment, representing just over one-third (34%) of the total population. Information about sentence length, main offence, age, ethnic group and religion for both the patient sample and the general population at Coldingley were extracted from the Local Inmate Database System (LIDS). General data was obtained from pre-formatted LIDS queries whilst patient sample data was obtained from individual inmate records.

5.2.1 Sentence length



Sentence Length	Population		CMSP Patients	
	(%)	(N)	(%)	(N)
12 month - 2 years	1.36	4	1.01	1
2 years - 3 years	3.06	9	2.02	2
3 years - 4 years	13.9	41	10	10
4 years - 10 years	60.2	177	66	66
10 years - life	9.9	28	8.1	8
life	11.9	35	12	12

Figure 5.1 Coldingley population and CMSP patient sample by sentence length

The average sentence length for adult sentenced males in England and Wales is 16.1 months (Home Office 1997). As would be expected in a category C training prison, the population of Coldingley is primarily made up of inmates serving medium and long-term sentences. 95% of inmates are serving sentences over three years and 82% sentences over four years. The percentage of prisoners serving life in both the patient sample and in Coldingley as a whole is double the national statistic of 6% (Home Office 1997).

Comparing the CMSP patient sample with the rest of the Coldingley population (figure 5.1) it can be seen that the sample is proportionately representative. This is supported statistically (Chi-sq=3.6, 5df, $p=.61$). It may, therefore, be concluded that CMSP patients are unlikely to differ from other prisoners at Coldingley in terms of sentence length.

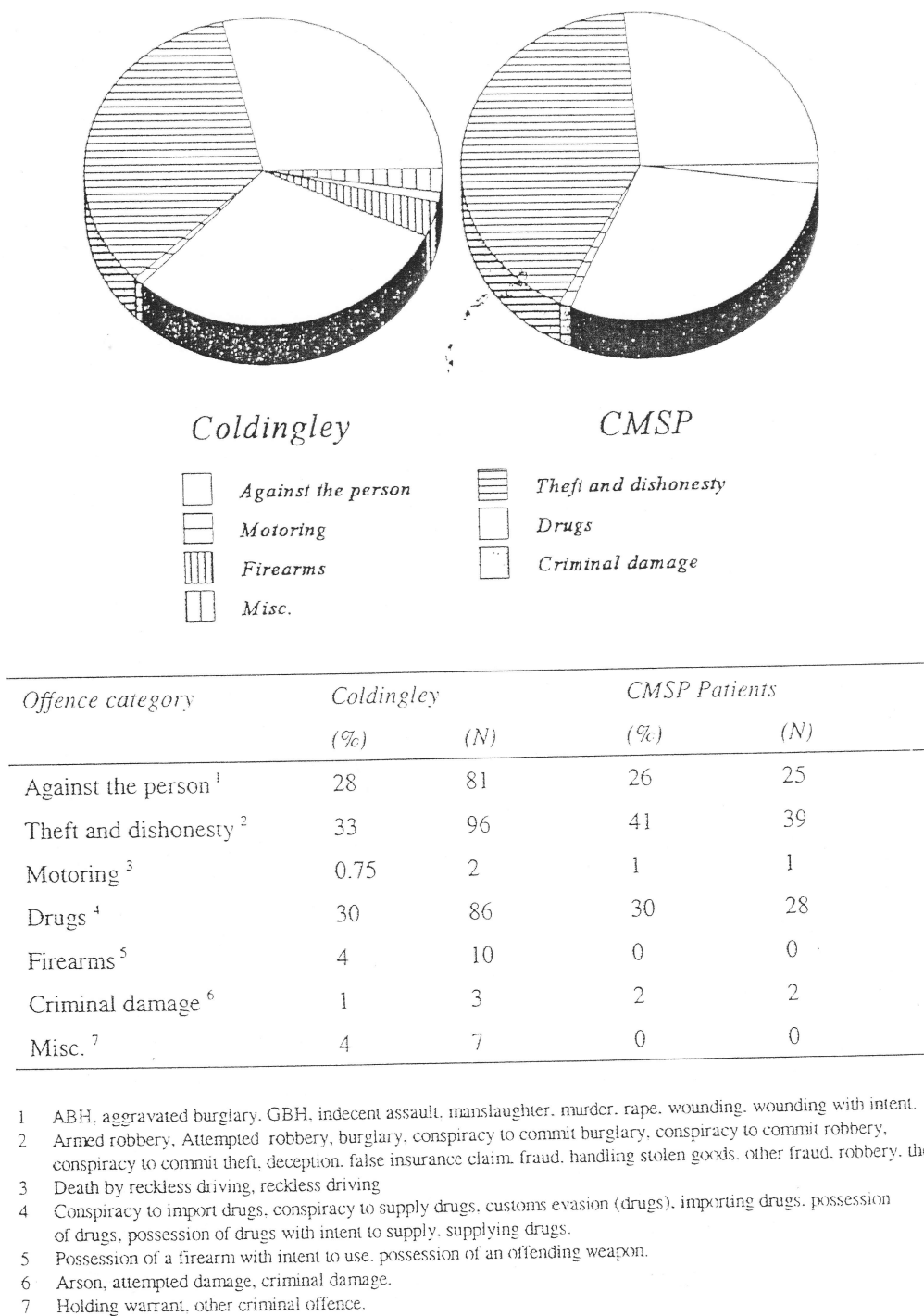


Figure 5.2 Coldingley and CMSP patient sample by main offence

5.2.2 Main offence

Figure 5.2 shows a comparison of the CMSP patient sample with the total inmate population by category of main offence. In both groups three main categories of offence each account for approximately one-third of the population. Offences of theft and dishonesty constitute the largest

group (33% for Coldingley and 41% for CMSP patients), followed by drug offences (30% for both Coldingley and CMSP patients) and offences against the person (28% and 26% respectively). There is a notable lack of sexual offences from both the sample and Coldingley as a whole. The sample is statistically representative of the prison ($\text{Chi-sq}=6.4$, 3df, $p=.09$) from which it may be concluded that CMSP patients are unlikely to differ from other prisoners at Coldingley in terms of offence.

This offence profile is not representative of the entire prison population of England and Wales. Nationally, violence against the person accounts for only 25% of offences for adult sentenced males, followed by 27% for theft and robbery and 15% for drugs (Home Office 1997). Drug related offences are overly represented at Coldingley at twice the national average.

5.2.3 Age

The average age of prisoners at Coldingley is approximately 34 compared to 33 for the CMSP patient sample. This is directly comparable to Grendon where the mean age is around 32 (Cullen 1998). As figure 5.3 shows, both groups are demographically similar with the majority of prisoners falling between the age 21-42. Again, the patient sample is statistically representative of the Coldingley population ($\text{Chi-sq}=15.6$, 19df, $p=0.68$) from which it may be concluded that CMSP patients are unlikely to differ from other prisoners at Coldingley in terms of age.

5.2.4 Ethnic group

Ethnic minority prisoners, in particular black prisoners, are over represented at Coldingley. White prisoners account for 61% of the population, followed by 32% black and 5% Asian. The comparable figures for England and Wales are 82% white, 12% black and 3% Asian (Home Office 1997). This is probably the result of Coldingley's location as there is only one other training prison closer to London. Comparing the ethnicity of the CMSP patient sample and the Coldingley population (figure 5.4) it may be seen that the patient group appears representative. However, more detailed analysis shows that black Caribbeans, as a sub-group, are over-represented in the complementary therapy group by 7% whilst black Africans are under represented by almost 5%. This would seem to suggest that there may be a cultural predisposition amongst black Caribbeans towards complementary therapy. However, given the relatively small number of cases involved, one must be careful not to over interpret. Over representation might equally be attributed to the dynamics of the groups involved and the neighbourhood effect (i.e. positive feedback from one member of a group encourages the others to attend). Such caution is borne out by the statistical analysis which found no marked difference between the patient group and the rest of the inmate population of Coldingley ($\text{Chi-sq}=1.1$, 3df, $p=.77$). It may therefore be concluded that no ethnic group is any more or less likely to use complementary medicine in Coldingley.

This finding is extremely significant. Research on therapeutic interventions in prison has found that prisoners of African-Caribbean origin demonstrate lower take-up rates than inmates from every other ethnic group (Genders and Player 1995, Player and Martin 1996, Cullen 1998). Player and Martin, in their evaluation of the ADT drug programme at Downview prison,

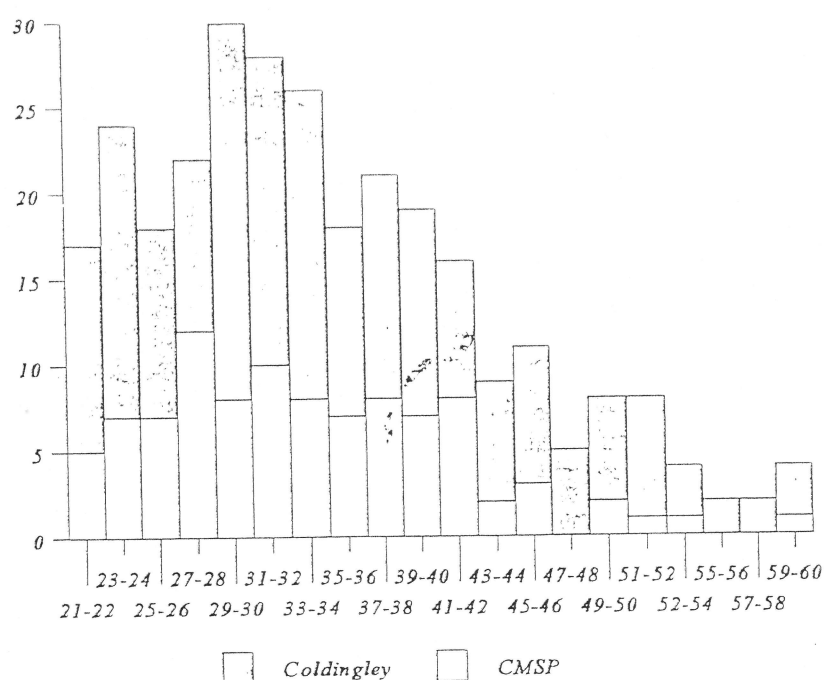


Figure 5.3 Coldingley and CMSP patient sample by age

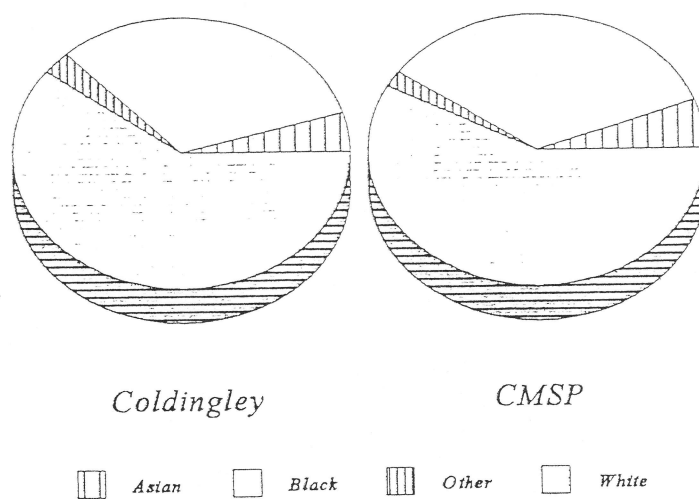


Figure 5.4 Coldingley and CMSP patient sample by ethnic group

attribute this to greater suspicion of the merits of such programmes and the greater need for first hand information. Cullen similarly concluded that the low numbers of ethnic minority prisoners at Grendon is the result of 'a powerful antipathy for the psychiatric image of the institution'. The over-representation of black inmates in the CMSP patient sample, in particular black Caribbeans, might therefore be interpreted as suggesting that feedback about complementary therapy within the establishment is largely positive.

5.2.5 Religion

There are 20 recognised religious denominations at Coldingley. This number rises to 21 if Rastafarianism is included although the Prison Service does not recognise this as a religion. However, while three religions account for almost two-thirds of the population of Coldingley (Church of England 35%, Roman Catholic 19% and Muslim 14%) nearly one-fifth of the prison (19%) do not belong to any religion. Comparing patient sample with the rest of the Coldingley population (figure 5.5) suggests no religious group is any more or less likely to use complementary medicine. This is once more supported statistically which found that there was no marked difference between the CMSP sample and the rest of the inmate population ($\chi^2=2.17$, 4df, $p=.7$). Again, whilst the number of cases involved are small, it is interesting to note that half of all the Hindus, Jehovah's Witnesses, Rastafarians and Sikhs in the prison have sought complementary medicine.

5.3 Staff patient demographics for Coldingley

Coldingley has a total staffing complement of 182 of whom 173 are full-time and 9 part-time. In terms of gender, 149 (86%) are male and 33 (14%) female. Although staff information is recorded in each prison on a computerised personnel system, demographic data is still less readily available than inmate data using LIDS. It is not, therefore, possible to give as thorough a breakdown for staff patients as for inmates.

5.3.1 Gender

At the time of survey, 17% of the staff at Coldingley (30) had received, or were receiving, complementary therapy. Of these, 57% were male (17) and 43% female (13). Figure 5.6 shows a gender comparison of staff seeking complementary therapy against the total staffing complement. Statistical analysis suggests that the patient sample is not representative of the entire staff ($\chi^2=9.6$, 1df, $p=.001$) from which it may be concluded that female prison staff are more likely to seek complementary medicine than their male counterparts. This would appear to support similar findings from the literature for the general population (e.g. Ernst *et al.* 1995; Furnham and Kirkaldy 1996). The reasons for this may be numerous, such as greater health consciousness and openness in discussing personal problems. In addition, increased stress for female staff working in a predominantly male environment, thereby having to gain acceptance as 'one of the boys', is widely recognised (HM Prison Inspectorate 1997a,b). Female staff also have a tendency to be concentrated in positions within the prison that are stereotypically seen as female, such as education and operational support (*ibid*). Higher number of female staff seeking complementary therapy may, therefore, be the result of a 'neighbourhood effect' with

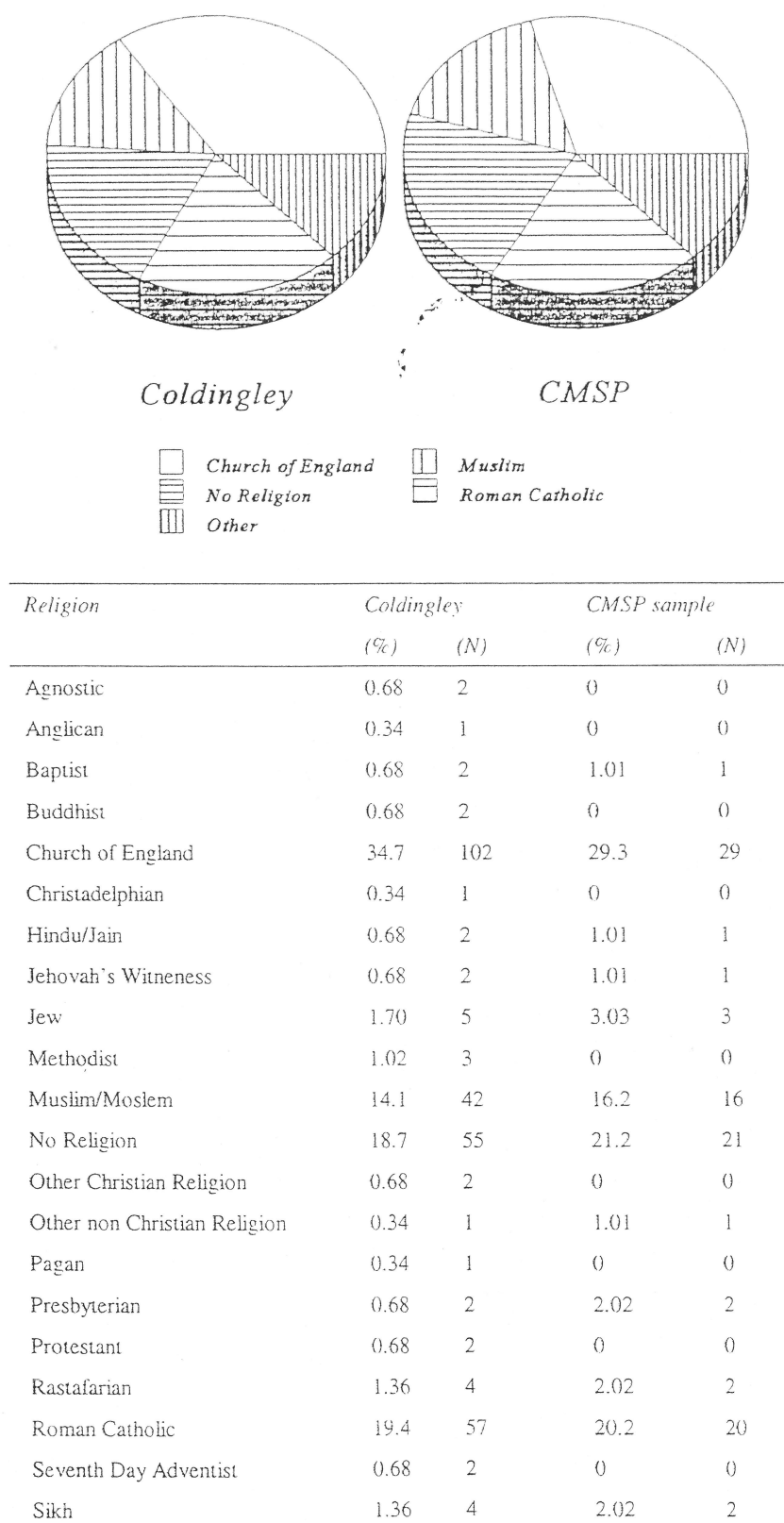


Figure 5.5 Coldingley and CMSP patient sample by religion

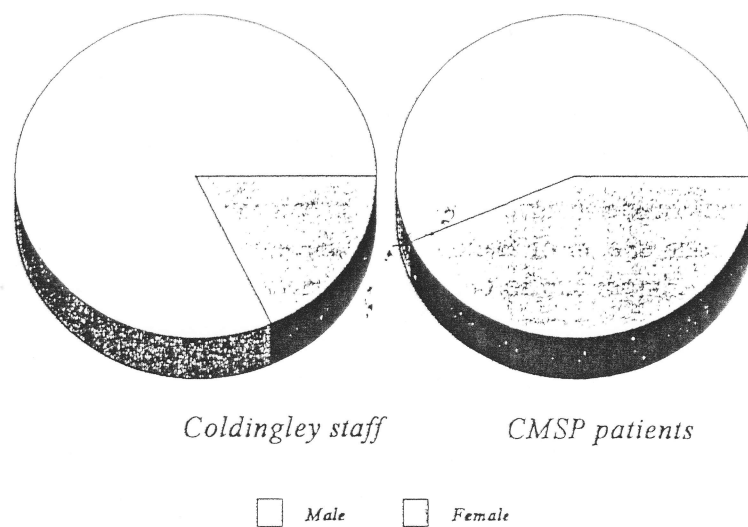


Figure 5.6 Coldingley staff and CMSP staff patients by gender

close colleagues recommending therapy to each other.

6 User Survey

6.1 Methodology

Accepting the problems with using control groups or clinical trials in researching the efficacy of complementary medicine, it was decided a mix of participant-observation and face-to face interviews would illicit the most representative responses from, and about, therapists and the client group. Therapists were shadowed for a period of one month, during which time the operational treatment model and structure of the programme were observed. Individual treatments were not observed as this was deemed too intrusive and likely to break patient-therapist confidentiality. Current and former CMSP patients were interviewed in order to assess qualitatively service delivery and perceived outcomes from treatment. Separate questionnaires were designed for both staff and inmates employing a combination of structured and semi-structured questions.

In order to demonstrate sensitivity to the holistic nature of the treatment programmes the questionnaires were designed to collect data on patients' religious and conventional medical history in addition to asking about the specific course of treatment undertaken and the perceived benefits. With the exception of sections dealing with personal and background details and an additional set of questions for staff in their professional capacity, the structure and questions of both staff and inmate questionnaires were identical.

Questions were worded in a neutral fashion using plain English and were formulated deliberately to illicit an 'open' or 'closed' response. In this manner, every effort was taken to present equal opportunities for interviewees to express positive or negative opinions according to the individual's treatment experience.

All interviews were conducted by the same researcher with as much informality as possible. A standard brief introduction was used explaining the purpose of the research, the interviewer's background and the study's prospective audience. The independence of the interviewer from both the Prison Service and CMSP was also stressed. Confidentiality was assured by anonymity. Questionnaires were only identifiable by a reference number consisting of the interview number and date. Questions were read out verbatim to ensure uniformity and minimise the likelihood of the interviewer leading the interviewee's responses. Where questions were asked to be repeated they were again done so verbatim and where called for, a standard example was given in each case. In light of the intimate nature of the enquiry, interviewees were reminded that they were free to leave and return to, or to not answer, any questions they felt uncomfortable about, although in practice no such instances occurred. Subjects were also reminded that they were free to leave at any time during the interview.

Interviews were conducted on a one-to-one basis in private. All interviewees were approached individually and asked in person if they would be prepared to take part in the study. Where it was not deemed appropriate to take part in the study there and then, an appointment was made for the

interview to be rescheduled. Whilst the majority of interviews took place in the CMSP treatment suite, when vacant, interviews were also conducted in wing offices, the kitchen, gymnasium, education block, works department and industrial workshops; where possible, inmates were not removed from the industrial complex (zone). A surprising number of inmates, while enthusiastic to take part in the study, were reluctant to leave work and therefore interviews were scheduled for free association time. This was testament both to the work ethos of the establishment and the realistic bonuses that could be earned through hard work.

Staff interviews were deliberately conducted prior to those with inmates in order to introduce the research and interviewer to relevant staff before seeking permission to approach inmates in their charge. All staff approached were extremely helpful in facilitating approaching inmates for the study.

6.2 Sampling frame and sample size

At the time of formulating the sampling frame, 30 members of staff and 100 of the 101 inmates previously identified as having received some degree of treatment and remained. A target sample of half of each patient group was set (50 inmates and 15 staff) resulting in a total of 75 interviews. A combination of random and proportional sampling was employed. At the outset of the study a request was made to have no contact with individual CMSP treatment files in order to reduce the likelihood that selection could not be biased by prior knowledge. The cohort was selected without consultation with either CMSP or establishment staff. Interviewees were identified by alphabetically listing all those still in the establishment in descending order of the number of treatments received. Every second name was then selected for possible inclusion. Where individuals were not available, the name above or below was substituted. The sample list was compared with a list of inmates' earliest dates of release (EDR). Those due to leave the prison during the sampling period were identified and approached first. Any individuals who were felt to have some prior knowledge of the study or were familiar to the interviewer as a result of time spent shadowing therapists were left until last so as to limit potential bias of rest of the sample.

In practice, the sample size proved to be unrealistic for several reasons. First, Coldingley is a busy training prison with a constant turnover. In the course of the main survey, conducted during March 1998, 12 of the target sample were transferred or discharged reducing the sample from 100 to 83. Secondly, the initial refusal rate was surprisingly low given the intimate nature of the study and its sponsor with only three outright refusals. However, in the latter stages of the survey, when dealing with those inmates who had received two treatments or less, the refusal rate began to rise rapidly. A difference in perception between individuals and CMSP as to precisely what constituted a treatment resulted in a proportionately significant number of inmates declining to take part in the study as they did not consider their attendance at open group sessions held in the church as equating to receiving treatment. Once the total number of refusals reached in excess of 10 and were almost becoming consecutive, it was decided to exclude those who had received fewer than two treatments. This further reduced the sample to 67. Finally, a sample of 50 were identified, representing half of all those eligible, 15 staff and 35 prisoners.

6.3 Pilot study

A small pilot study was undertaken in the last week of February to assess the feasibility of the data collection methodology and to obtain feedback on the design of the questionnaires (N=6). Following the pilot the wording of a small number of questions was revised to further clarify meaning. One question was removed and three additional questions were inserted to further qualify perceived benefit. The final questionnaires consisted of 67 questions for staff, taking approximately 30 minutes to complete, and 74 questions for inmates taking between 45 and 60 minutes to complete.

6.4 Results

The 50 questionnaires were coded and analysed using the Statistical Package for the Social Sciences (SPSS). The results are presented under six headings, corresponding to the section headings of the questionnaires, these were: patient background, disciplinary history, therapeutic history, spiritual background, medical background and complementary medical treatment. Analysis of associations between patients' responses (correlation analysis) was also carried out. However, despite revealing a number of statistically significant relationships, given the representativeness of the sample patients (outlined below) it was not felt that these findings would greatly enhance the substantive findings that follow. This analysis has not therefore been included.

6.4.1 Patient background

Personal details, such as age, gender, nationality, and ethnicity in addition to information about professional and criminal histories, were gathered for the purpose of identifying the demographical nature of the patient group and the representativeness of the survey sample.

The mean age of the inmates in the survey sample was 35. The sample is statistically representative of CMSP inmate patient group as a whole (chi-sq 7.4, 4df, $p=.19$). The mean age for staff by comparison was 46 (range 29-61). Examining ethnicity and nationality, 61% of inmates were white, 28% black and 11% Asian. 81% of the inmate sample were British. Foreign nationals constituted 19% of the sample, the largest group being Irish (6%) followed by Iranian (3%) and Turkish (3%). Figure 5.1 compares the ethnicity of the inmate survey sample with the total patient group. Again, the sample is statistically representative of all inmate patients (chi-sq=2.3, 3df, $p=.5$).

Examining inmates' main offence, 33% of the sample had committed 'crimes against the person', 30% 'theft and dishonesty', 30% drugs and 3% motoring offences. Figure 6.1 compares the survey sample against the overall patient group. Once more, the sample is statistically representative (chi-sq=5.5, 4df, $p=.24$). If we break down the sample by sentence length, 8% were serving sentences of 3 years or less, 25% less than four years, and over 60% were serving more than 5 years. 12% of the sample were serving life. While the number of lifers is high compared to the national average, it is representative of Coldingley. Figure 6.1 shows the survey sample and total patient group by sentence length. Again the survey is representative of all CMSP patients (chi-sq=7.4, 5df, $p=.19$).

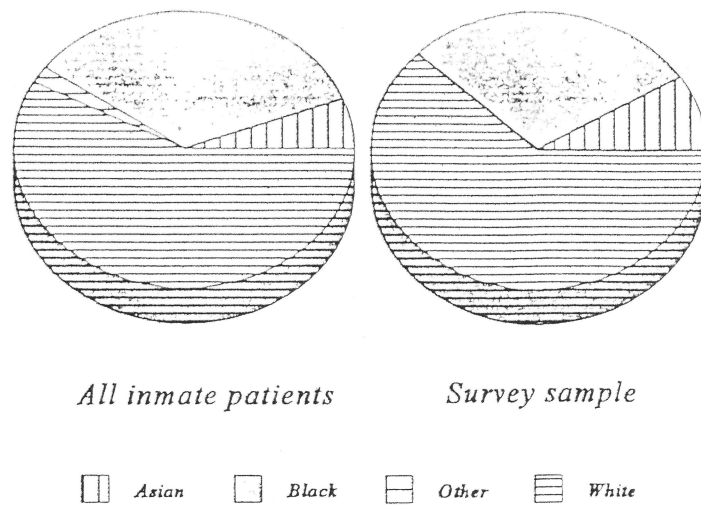


Figure 6.1 CMSP patients and survey sample by ethnic group (inmates)

Over three-quarters (78%) of inmates questioned have had previous convictions. The number of convictions ranged between 1 and 32, the mean being 7. The mean age of inmates at first conviction was approximately 22, the oldest being 43. Almost half (45%) were first convicted before they were 20 and 9% were aged only 10. Over half (55%) had served previous custodial sentences (ranging from 1 to 10), the mean number of previous sentences being 2.8. Almost one-third (29%) had spent time in care. Length of time at Coldingley varied from 4 months to six and a half years. The average stay at Coldingley was approximately 1.5 years. One-third had less than a year to serve and 50% less than two years. 11% had over four years left to serve.

In contrast to the inmate sample, all of the staff interviewed were white. 60% of the staff sample were male (N=9) and 40% female (N=6). Again, this is representative of the gender balance of the number of staff having therapy overall (57% male, 43% female). 47% were uniformed grades, 46% civilian staff (e.g. education staff) and 7% other (instruction officer, probation officer). 20% worked on the wings, 47% in the education department, 13% in operations, 27% in the industries and 13% in the works department. Service experience ranged from 10 months to 21 years, with the mean length of service being 8 years. Only 27% had worked at other prisons with over three-quarters having been at Coldingley more than 3 years, the average being 6 years.

Those seeking complementary therapy are broadly typical of the Coldingley population at large. The criminal histories of the sample suggest that those seeking complementary therapy represent one of the most damaged, and damaging, groups in society. The breadth and intensity of problems requiring attention are therefore unlikely to be typical of those experienced by complementary therapists working in the community.

6.4.2 Disciplinary background

Inmates were asked about their prison disciplinary record. One-third of those questioned had

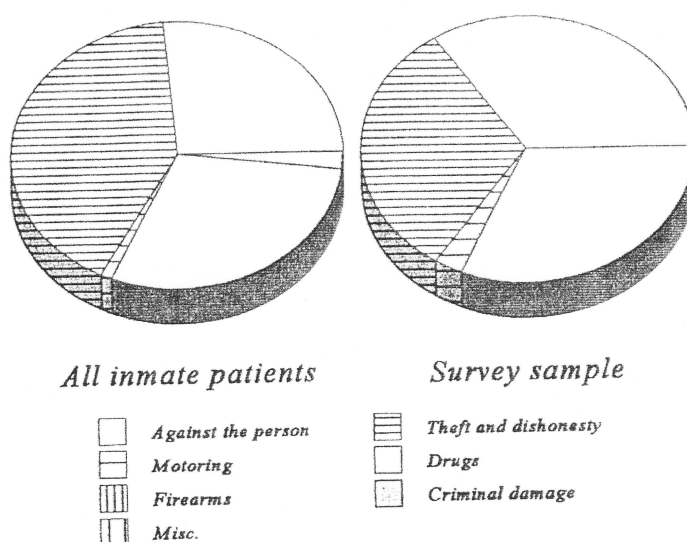


Figure 6.2 CMSP patients and survey sample by offence type

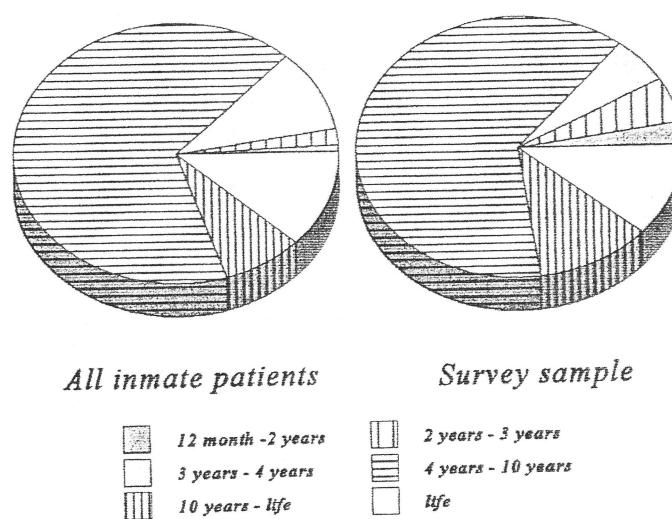


Figure 6.3 CMSP patients and survey sample by sentence length

not had any adjudications on their current sentence. The remaining two-thirds had between 1-31 adjudications, with 4.8 being the mean. Half of those asked had adjudications at Coldingley, the average being 2. One inmate had 14 adjudications at Coldingley alone. The most common reasons given for adjudications were for disobeying an officer and other behavioural offences. Almost two-thirds (61%) said that they had had an adjudication since starting complementary therapy.

In order to assess likely levels of addiction amongst the sample, inmates were asked whether they had ever had a positive urine test. 41% admitted they had tested positive in a mandatory

testing (MDT). One-quarter said they had only tested positive once; 20% had four positive tests or more. Fifteen inmates explained their drug histories; 11 had tested positive for cannabis, 2 for opiates alone, and two for a mixture of cannabis and opiates.

6.4.3 Spiritual background

Almost three-quarters of the total sample (70%) considered themselves to be either religious or spiritual, in whatever way they wished to define either term. The figure was marginally higher for inmates (72%) than for staff (60%). Asked if they belonged to a particular religion, 47% of inmates and 75% of staff said yes. Of those who belonged to a religion, 60% were Church of England, 20% Catholic, 13% Muslim and 6% belonged to other religions. Once again, the inmate sample is statistically representative of all CMSP patients ($\chi^2=8.5$, 4df, $p=.07$).

Patients were asked how important religion or spirituality was to them personally. 41% of inmates and 13% of staff said it was 'very important', 35% and 47% respectively, claimed it was 'fairly important', 9% and 20% felt it was 'not very important' and 15% and 20% believed religion or spirituality was 'not at all important'. Finally, patients were asked if they had ever tried meditation before. While almost one-third (31%) of inmates had meditated before, none of the staff questioned had.

These findings suggest that inmates seeking complementary medicine are more likely to be interested in spirituality than in formalised religion whereas staff are more likely to belong to a formal religion. They also suggest that spirituality is more likely to be important to inmates and they are more likely to be open minded about spiritual matters. This is consistent with findings that inmates are more open to stimuli as a result of sensual deprivation (Wickramasekera 1970, Deforest and Johnson 1981). These findings might also possibly be a reflection on the organisation of religion within prison.

6.4.4 Medical background

Patients were asked whether they had had long-term or serious medical problems. 46% of inmates, compared to only 27% of staff, said they had. Of those, whilst all of the staff had received treatment for the condition or problem, only 76% of inmates said their problem had ever been treated.

A third of the total sample had received some form of counselling before, with the figure being slightly higher for staff (37%) than inmates (27%). The most common form of counselling for both groups was for relationships followed by a prison psychologist for inmates.

As a measure of openness, patients were asked whether they would generally discuss personal or health issues with others. 63% of inmates said they would not discuss issues with staff while a surprising 53% of staff said they would not discuss personal issues with colleagues. In contrast, over half of inmates asked (57%) said that they would discuss personal issues with at least one other inmate.

In order to determine whether patients chose complementary medicine as an true alternative or

to supplement conventional medicine, they were asked whether they had used orthodox medicine at the same time as they were being seen by CMSP. While 40% of staff said they had, only 23% of inmates had used both. This might be interpreted as demonstrating inmates' greater confidence in complementary medicine. 40% of inmates and 20% of staff said that they were dissatisfied with the orthodox medical treatment they had received in the past. Many said that this was the result of a dislike of the drug dependency that they believed conventional medicine condoned. However, it is equally likely that it is a reflection of the dissatisfaction expressed by prisoners about the prison medical service, and the health care centre at Coldingley in particular, since inmates have less choice over their medical options than staff.

Patients were asked whether they had heard of complementary medicine prior to going to Coldingley. Almost three-quarters (70%) of the total sample had heard of complementary medicine before. Unsurprisingly the figure was far higher for staff (80%) than for inmates (46%). Similarly while 40% of staff said they had tried complementary medicine before, only 28% of inmates had. Table 5.1 shows the therapies that patients had tried prior to treatment by CMSP at Coldingley. Osteopathy was the most common treatment for staff, typically to deal with industrial or sporting injuries, whilst the most common treatment for inmates was acupuncture, usually in the treatment of an addiction such as smoking.

Table 6.1 Therapies tried by patient sample prior to treatment at Coldingley

<i>Therapy</i>	<i>Staff (%)</i>	<i>Inmates (%)</i>	<i>All patients (%)</i>
Osteopathy	50	10	38
Acupuncture	13	40	31
Homœopathy	33	30	31
Tai Chi	-	10	6
Healing	-	10	6

6.4.5 Therapeutic background

CMSP is not the only intervention programme run at Coldingley. In common with findings from other studies (Player and Martin 1996) the majority of inmates had some experience of other therapeutic programmes before trying complementary medicine. The ACORN Trust runs a drug and alcohol education programme, the Rehabilitation of Addicted Prisoners Trust (RAPt) offer a 12 step drug treatment programme and the probation and education departments operate a cognitive skills based offending behaviour programme. Inmates were asked about which of these therapeutic interventions they had taken part in whilst at Coldingley. ACORN was the most common with 48%, followed by offending behaviour with 34% and RAPt with 31%. The majority of inmates had taken part in more than one programme. This is consistent with Player and Martin's (1996) findings for participants in the RAPt programme (formerly ADT) at Downview. Interestingly, while only 20% did not complete the ACORN course, 23% had not completed the offending behaviour programme and 46% had not completed RAPt. For the majority of cases the figure for RAPt was so high owing to the number of inmates asked to leave the course for failing

to abstain from drug taking.

Inmates were asked to identify the most positive and negative aspects of each intervention they had taken part in. ACORN came in for particular praise. In particular inmates liked the one-to-one counselling and found the course relaxed, informative and down to earth. The ACORN counsellor was singled out for specific praise and was clearly viewed with a great deal of affection and respect by the majority of those questioned, many of whom had not even taken part in the ACORN programme. A number of inmates were also extremely positive about the RAPt programme, although it was noticeable that many were currently on the programme. In particular, inmates appreciated the way it had made them look at, and work on, themselves, describing it as 'powerful'. One inmate went so far as to say that it 'teaches you how to live'.

Of those who were critical of the RAPt programme, most felt that it was hypocritical. Several inmates described how they felt they had been unfairly expelled from the programme for confessing to having used drugs whilst 'everyone' was aware that others in the group were using and dealing on the wings. Others said that they had 'faked' a drug or alcohol habit purely in order to take part in the programme as they had been advised it would improve their parole chances. The only criticism of ACORN, in contrast, was that the 'open door' policy often meant that you could be interrupted during a personal discussion. ACORN, however, offers an informal, non-judgemental, drop-in counselling centre with an emphasis on harm-reduction and education. RAPt, by contrast, expects full-time attendance on the programme which can last for between 3 and 5 months and demands total abstinence from drug taking which is enforced through regular in-house urine testing.

By far the greatest criticism, bordering on vitriol, was reserved for the offending behaviour programme. Inmates resented being 'forced' to do it, describing it as 'boring', 'childish', 'superficial', 'rigid', and 'impersonal'. Furthermore the majority felt that attendance was purely about numbers and making the Prison Service, and Coldingley in particular, look good regardless of whether it was actually helpful. It was widely described as 'a card stamping exercise for parole'. While the Prison Service's Key Performance Indicator 7 for 1997/8 does indeed set numeric targets for inmates completing offending behaviour courses (Home Office 1998), it is useful to place criticism into perspective. The offending behaviour programme is the only intervention at Coldingley run by the Prison Service, the others are operated by independent organisations. Similarly, it is the only programme which is effectively compulsory if the inmate's offence warrants it and the individual wishes to apply for parole. Furthermore, the 'what works' literature, upon which the national offending behaviour programme was based, has been empirically demonstrated to be the most effective form of intervention in reducing recidivism (McGuire 1995, Vennard *et al.* 1997).

In addition to the programmes at Coldingley, almost one-half of inmates questioned (46%) had taken part in a variety of programmes at other prisons. The most common were anger management (57%) and offending behaviour (29%), the remainder consisting of victim and drug awareness (14%). Interestingly, only 13% of staff interviewed had been involved in the running of a therapeutic programme or been involved in peer or inmate counselling. One might therefore conclude that while there is a climate of familiarity with, and therefore predisposition towards, therapeutic interventions, staff are unlikely to have any prior experience of self-analytical programmes.

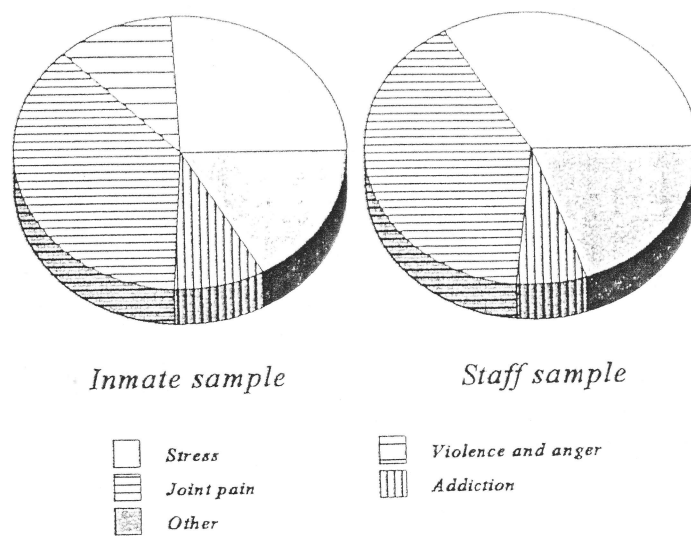


Figure 6.4 Condition for which complementary medicine was sought

CMSP as an alternative to conventional medicine was provided by the fact that while 67% of staff *had* previously sought conventional medical help for their principal complaint, 61% of inmates had *not* sought conventional help. This pattern is consistent with the findings of national research which suggests that the overwhelming majority of patients seen by complementary therapists have not previously seen a doctor (Mills *et al.* 1997).

Treatments received

The number of treatments received varied considerably for staff and inmates. While almost three-quarters (73%) of staff had received less than 10 treatments, more than half of inmates questioned had received over 10 treatments with almost one-quarter having received over 25 treatments. 14% of inmates had received over 30 treatments and 3% had received over 50. The mean number of treatments for inmates was 17 and 2 for staff. This difference between staff and inmates is largely explained by their treatment modality. 93% of staff had received crisis intervention while 40% of inmates questioned had been on the ICMTP.

Figure 6.5 shows the number of treatments received for the whole sample (staff and inmates) compared to all CMSP patients (again both staff and inmates). Despite a lower proportion of patients who received less than five treatments (owing to the exclusion of inmates who had only received one treatment in the sampling frame), the sample is statistically representative of the whole patient group (chi-sq 28.5, 11 df, $p=.003$). At the time of the survey, just over one-third of inmates (37%) and approximately one-quarter of staff (27%) were still being treated. The length of time since patients had begun treatment ranged from a month to two years for inmates and six to 18 months for staff. The mean length of time, however, was almost identical across the sample being 9 months for inmates and 11 months for staff.

First impressions of CMSP and the programme varied considerably. While the majority of

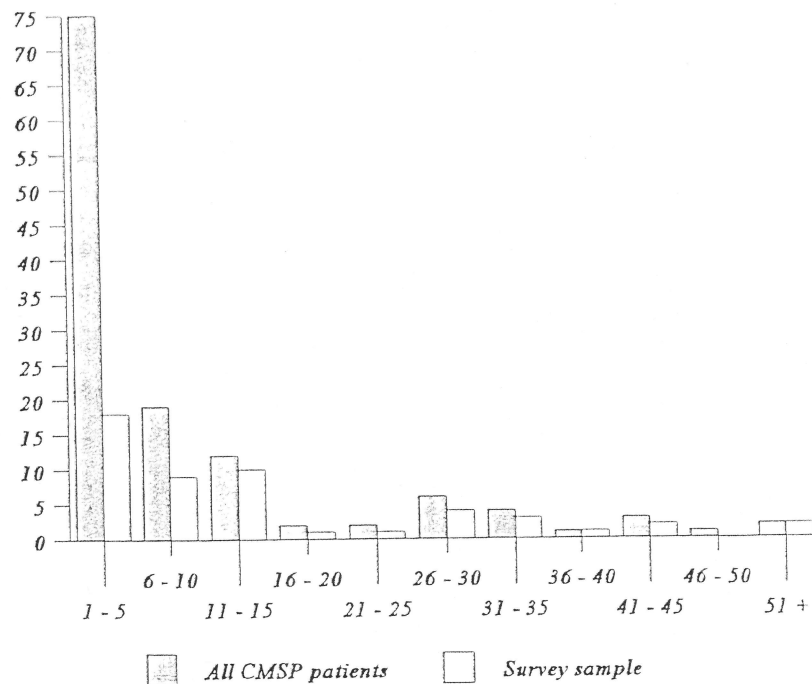


Figure 6.5 CMSP patients and survey sample by number of treatments received

inmates' impressions were positive (54% positive, 26% negative and 20% neutral), first impressions from staff were positive and negative in almost equal proportions (47% positive and 40% negative with only 13% neutral). Staff responses ranged from 'brilliant', 'good', 'kind' and 'very positively surprised' to 'wacky', 'strange', and 'not listening to what I wanted'. Inmates in turn described their first impressions as ranging from 'deep', 'heavy', 'gobsmacked' and 'spiritual' to 'a skive', 'bullshit', 'bit of a drama' and 'a bit twilight zone'. The most common remark made by inmates was that therapists were sincere, non-judgemental and treated them as individuals. One long-term inmate commented that it was the first time he could recall anyone, aside from another inmate, addressing him by his first name and not as a number. This suggests that while inmates are more likely to be initially cautious in making up their minds about complementary medicine, staff are more likely to be sceptical and less open minded.

As would be expected from a programme which matches treatment to individual needs, the treatment experience varied considerably. Again reflecting the different treatment modalities (i.e. crisis intervention and ICMTP), three-quarters of staff had received up to three different therapies whilst three-quarters of inmates had experienced up to five. The highest number of different therapies received by staff was seven whilst 7% of inmates had experienced over 10 different therapies. One inmate had tried all but one of the therapies CMSP offer. Table 5.2 details the percentage of patients who have received each therapy. The therapies experienced by staff clearly reflect the principal reason for going for treatment, namely stress, being dominated by the manipulative therapies (acupuncture 87%, reiki 80%, osteopathy 40%, reflexology 20%). It is further interesting to note that numbers were the same for counselling as stress management (27%). For inmates, the treatments received reflect the more varied reasons for attending, with almost half receiving counselling (46%) and a far greater spread across the other therapies offered.

Table 6.2 Therapies received by survey sample *

<i>Therapy</i>	<i>Staff (%)</i>	<i>Inmates (%)</i>	<i>All patients (%)</i>
Acupuncture	87	77	80
Reiki	80	51	60
Homœopathy	20	52	42
Counselling	27	46	40
Osteopathy	40	37	38
Reflexology	20	31	28
Meditation	13	29	24
Stress management	27	17	20
Music therapy	6	20	16
Tai chi/ moi tai	0	23	16
Cranial osteopathy	6	17	14
Hypnotherapy	0	9	6
Louise Hay +	0	6	4
Vibration medicine	0	6	4

* Each patient may receive more than one therapy hence percentages do not total

+ Self-help group work based around the best selling book by Louise Hay

Individuals were asked which of the therapies they had received they had liked the most and which they had liked the least. The results are compared in table 6.3.

Table 6.3 Most and least popular therapies *

<i>Most popular therapy</i>	<i>Staff (%)</i>	<i>Inmates (%)</i>	<i>All (%)</i>	<i>Least popular therapy</i>	<i>Staff (%)</i>	<i>Inmates (%)</i>	<i>All (%)</i>
Acupuncture	42	29	37	Acupuncture	18	38	48
Reiki	21	34	30	Reflexology	54	-	25
Counselling	27	17	16	Counselling	9	15	13
Osteopathy	29	-	9	Reiki	18	-	8
Reflexology	14	3	7	Moi tai /tai chi	-	15	8
Homœopathy	-	3	2	Music therapy	-	15	8
Stress management	-	3	2	Louise Hay	-	8	4
				Meditation	-	8	4

* Patients could select up to two therapies in each category

The most striking finding from table 6.3 is that while one-third of inmates, and half of the staff, listed acupuncture as their most liked therapy, almost half of the sample said that they had disliked acupuncture the most. This finding supports CMSP's ethos that matching therapy to the individual is vital and that although several treatments may achieve the same ultimate goal, not all of them will appeal equally. This was the reason why so many therapies were offered. Reiki was the most popular therapy with inmates (34%). When asked why, virtually all responded by saying that although they could not even start to explain how reiki worked, they could feel it generating heat whilst being treated and felt extremely relaxed immediately afterwards. Both staff and inmate advocates reported feeling so relaxed while it was being carried out that they could have fallen asleep there and then. Reflexology was both the least popular, and fourth most popular treatment with staff, but was barely mentioned by inmates. Reasons given by inmates for the unpopularity of acupuncture focussed upon pain from needles and, in the case of group auricular acupuncture, lack of privacy. Not all dissatisfaction with therapies was therefore related to the therapy itself. A number mentioned the different impact that individual therapists made when administering the same treatment.

Confidence in the therapists

Confidence in the therapists was generally high. 87% of staff and 88% of inmates said that therapists always explained exactly what they were doing. 97% of inmates and 87% of staff trusted the confidentiality of the therapists. This trust was further reflected by 87% of staff and 94% of inmates who said that they felt they were completely open with therapists. Inmates' trust in the confidentiality of other prisoners being treated by CMSP was less strong (58%). This reflects a broader trend of distrust of other inmates that dominates prison culture. A number of staff were concerned at being treated in possible earshot of inmates. Concern was also raised about the possibility of the CMSP inmate orderly having access to their files. Observation of CMSP routine, in particular the strict enforcement of security, confidentiality and boundaries, suggests that such concern is largely unfounded. Furthermore, a number of inmates suggested that it was the early involvement of certain inmates, such as the orderly, who were considered influential (the '*faces*') in the prison that provided the social acceptance for others to go. Observation of the running of the unit suggests that the respect amongst inmates for the orderly is one of the principal factors in the smooth day-to-day operation of CMSP. Recognising the potential difficulties for the unit when this prisoner leaves Coldingley, CMSP is in the process of encouraging inmates on the ICMTP to become more involved with the administration.

Difficulties encountered

Almost three-quarters of the sample (73% staff and 69% of inmates) said they had experienced no difficulties with their treatments. This is more encouraging than the findings from the survey by White *et al.* (1997) which found 38% of patients reported adverse effects after treatment. However almost half (47% staff and 43% of inmates) said that some part of their treatments had made them feel uncomfortable. The most common complaint for both groups was that they had experienced physical discomfort from acupuncture. Other common complaints was the lack of privacy and intimacy afforded by group sessions. Many felt that the minority who were not committed to working on themselves could easily '*sabotage*' group sessions for those who were. A number of inmates spoke of '*feeling fragile*' after counselling or were made to feel

uncomfortable by counselling as they felt therapists were 'prying'. One of the most common remarks made by both groups, was the mental and emotional difficulty of going straight from treatments back to the prison environment. Many said they continued to feel vulnerable for periods after treatment and found the stressful surroundings of the wings and workshops difficult to deal with. As one inmate remarked, '*you get all de-stressed only to have to go straight back to the stressful environment that drove you to therapy in the first place*'.

A significant number of inmates questioned (12%) said that the introduction of a male reiki practitioner had made them feel deeply uncomfortable. The gender of the therapists raised a number of interesting issues. Several inmates claimed that one of the many reasons they sought therapy was the opportunity for female company, in particular female conversation. All dismissed the cynical response that their intent was sexually motivated. Many highlighted the 'normalising' effect of escaping, however briefly, from the all male environment of the prison. One inmate said that this brief contact was one of the few things that made him still feel human. The importance of a gender balance in creating a 'normalised' prison environment and preparing prisoners for release into society is stressed in the Prison Service's own guidelines for designing establishments (HM Prison Service 1989).

Almost one-third of inmates said they considered giving up at some point in their treatment. The comparable figure for staff was lower at 13%. Issues brought up by counselling were the most common reason cited, although outside factors such as changing jobs within the prison were also offered as factors in contemplating dropping out. Only two inmates from the sample (5%) actually gave up. However, even they were able to look beyond their own experience and said they would still try treatment again if they had other problems and had still recommended it to others. This is a strong testament to the level of belief in complementary therapy.

Almost half of the staff and a fifth of inmates suggested that going for treatment created practical difficulties. Inmates highlighted difficulties in getting released, or collected, from work as well as delays in receiving appointment cards from wing staff. Staff expressed problems in attending treatments around work schedules. A number felt that the appointment system was poor and did not provide sufficient warning of appointments or their cancellation. Several spoke of travelling in especially, only to be told that their appointment had been cancelled. Many staff said that they would have liked to continued their treatment but CMSP had never offered them any further appointments. This appears to be the result of a lack of understanding of CMSP's ethos of self-empowerment over health. All patients, whether staff or inmates, are expected to ask for further appointments. Therapists do not send out reminders or appointments in the same way that conventional medical clinics might.

Perceived benefits

Belief in the efficacy of treatment appears high. 82% of the sample (86% of inmates and 73% of staff) believed they had benefitted from treatment. This compares well with the findings of CMSP's own evaluation which reported a similar figure of 85% (Perry 1997). 7% of staff and 3% of inmates felt it was '*hard to say*' whether they had benefitted as they were still being treated or would not be able to practice the life-skills they had learnt until after they were released. Asked to quantify how much they had benefitted on a five point scale, 57% of inmates and 64% of staff said they had benefitted '*a lot*'. 18% of staff and 17% of inmates claimed to have

benefitted 'enormously'. Some qualified this further, by explaining they had experienced almost total relief from muscular or joint pains.

CMSP claims to work with the physical, mental (or emotional), social and spiritual aspects of life. 67% of staff and 75% of inmates said they had benefitted physically from treatment. 60% of staff and 72% of inmates believed they had benefitted emotionally. Fewer suggested they had gained improved socialisation since having treatment (40% of staff and 55% of inmates) although a fifth of staff said they were unsure. Finally, 53% of staff and 50% of inmates said they had gained 'spiritually' from treatment while 13% of staff were again uncertain. The majority did not equate spiritual benefit with religion but instead suggested they had gained greater insight, and were more confident, of themselves.

Three-quarters of the sample (73% of staff and 77% of inmates) had noticed positive changes in themselves since having treatment. Asked how they had changed, 40% said they were more relaxed, while 20% cited health improvements: '*it has opened doors that were not open before*' and '*I have got rid of my siege mentality*'. One inmate said he knew he *had* changed but could not describe *how* or *why*. One-third (31%) of inmates suggested their attitude towards staff had improved since having complementary therapy. A similar proportion recognised that their relationships with other prisoners (37%) and family and friends (34%) had improved. Many attributed this change to being more self-confident and less easily upset by the actions of others. These findings are consistent with a number of studies of therapeutic interventions which have found reductions in hostility to staff (Player and Martin 1996, Cullen *et al.* 1997, Cullen 1998).

To further qualify perceived benefit, patients were asked to describe the single most important thing they had gained from having treatment. 22% said they had found '*pain relief*', a further 22% cited personal development such as '*greater self-confidence*' and '*maturity*' as being most important, 20% said they had gained insight into complementary medicine and now knew they had '*a choice*' and '*alternatives*' and 16% had benefitted from learning stress reduction techniques.

Two other 'quality of life' questions were posed. First, patients were asked summarise, in one or two words, their current state of mind. 74% of inmates and 61% of staff described feeling generally positive (e.g. '*confident*', '*focussed*', '*contented*' and '*on the right track*'). 18% of inmates and 15% of staff were unsettled, describing their mental state as '*stable*'. Almost one-quarter of staff (23%), but only 8% of inmates, said they felt '*stressed*' or had '*low morale*'. Patients were then asked to describe how they felt more generally about themselves since having treatment. 77% of inmates and 60% of staff were broadly positive. 20% of staff and only 8% were unsettled, while 20% of staff and 14% of inmates were unhappy. A number of responses from inmates reflected extremely well on CMSP. Such responses included: '*I am less worried, less frustrated and more contented*'; '*I like myself a lot more than I did 6 months ago*'; '*I am more in control of my emotions than I was when I came in*'; '*I can't wait until I get out and prove myself to the doubters*'; '*I am more positive about the future, I care and I feel I have a choice*' and '*I feel good about myself and I didn't feel that way when I came in*'. Negative emotions were generally related to stress and continuing physical pain.

Support for the treatment programme

Engagement with the underlying ethos of complementary medicine appears high. Approximately

half of the sample (53% of staff and 43% of inmates) believed that their problems were purely physical before they started treatment. However, 82% of the sample (80% of staff and 88% inmates) came to believe that there were other issues to address with hindsight. The most common insight gained was a greater understanding of the ways in which psychological or emotional conditions, such as stress or anger, could manifest themselves physically in terms of bad backs, migraine, and insomnia etc. Poor diet, negative attitude and lack of self confidence were also identified as being underlying causes of conditions.

Over half of inmates (55%) said that there was nothing about the treatment programme that they would wish to see changed. Of those who did wish changes, *'less group work'*, *'more consistency and aftercare'*, and *'greater choice and involvement in the treatment process'* were the most common suggestions made. A number of inmates had been forced to stop treatment as a result of going on the RAPt programme. For these inmates the most common request was the ability to carry on with therapy in tandem. The precise reasons for RAPt inmates being asked to stop having complementary therapy is unclear.

A third of inmates did not feel that staff were supportive of CMSP; a further 31% said that staff were divided; 6% of prisoners were uncertain. They cited the nicknames staff used to describe therapists, such as *'the Witches of Eastwick'* and *'complementary terrorists'*, as evidence of a lack of support. 60% of staff reluctantly acknowledged that their colleagues were probably not very supportive of CMSP. Staff were asked what reputation they thought complementary medicine had amongst their colleagues. One-third thought complementary medicine had a good reputation while 27% believe colleagues held mixed views. The remainder suggested other staff felt therapy was a *'luxury'* and therefore *'wasted on inmate'* who *'already got too much'*. Despite the staff belief that prison culture mitigated against inmates being openly supportive of complementary medicine, staff generally thought it had a good reputation amongst the majority of inmates. As one member of staff suggested, *'they see it as a bit cissyish until they try it and then they rave on about it'*. Staff did, however, question some inmates' motives for having treatment. While they acknowledged many went because *'they were not getting conventional medical help'* others, they suggested, were simply *'playing along'* or going purely to *'get close to women'* or *'get touched by women'*.

Much of the staff attitude towards CMSP is the result of lack of understanding and communication. Asked their professional view, as opposed to that of patient, three-quarters of staff did not feel that the staff as a whole were sufficiently informed about CMSP and the services they offer. Many drew attention to the fact they had to learn from inmates that CMSP also treated staff. One-third of those questioned felt that the CMSP unit created problems for staff. Amongst those problems listed, *'timetabling'* and *'taking inmates without warning'* were most commonly cited. 20% felt that the fact the unit was run by *'outsiders'* created problems. In particular they felt therapists' lacked a general appreciation of prison culture. Others suggested therapists' attitudes towards staff sometimes failed to appreciate that they were only visitors to the prison and failed to take account of staff's point of view. Several suggested therapists needed more security awareness and a better grounding in prison sub-culture. CMSP's incident record does not, however, uphold this view.

In support of CMSP, the majority of staff (60%) did not believe that complementary medicine could be provided as effectively by trained staff through the prison healthcare centre suggesting *'prison politics would get in the way'* and that *'it would be the first thing to be cut back'* in

expenditure cuts. It was also suggested that by practising in the community, independent therapists would be more likely to bring in new techniques and that independence was vital to complementary therapy's acceptance by prisoners. This was further supported by inmates who felt that the majority of the health care staff were Prison Service first and physicians second.

Staff were asked how communication and understanding with CMSP might be improved. Over half of those questioned (55%), suggested therapists should provide an introductory talk and induction session to brief them about the treatment process and introduce them to the services offered. One-third (37%) suggested CMSP's services could be better advertised around the prison, while 18% suggested that CMSP should offer staff only clinics out of work hours.

Support for complementary medicine

Asked for their general impression of complementary medicine as a whole, 86% of inmates and 93% of staff expressed a positive belief. One inmate questioned, suggested *'everyone should have some'*. The majority of staff believed complementary medicine *'has a place'* in modern health care with many suggesting *'it should be available on the NHS'*. 80% of inmates believed that complementary medicine had a positive impact on the prison. A further 17% were uncertain what the impact had been. Asked to qualify their answer, prisoners suggested *'it has had a big impact'*, *'there is less trouble and fighting'*, *'less people are stressed'* and that *'people that use it are calming down'*. One inmate suggested, *'it has helped people, which prison is not here to do'*. Staff were less certain of complementary medicine's impact. While 57% believed it had *'reduced overall tensions'* and had a *'calming effect'*, 29% were not sure but generally perceived a benefit. 7% thought complementary medicine had been *'disruptive'* by causing *'resentment amongst staff who did not know about its introduction'*.

All patients in the sample were unanimous in saying that they would recommend complementary medicine to others. Asked to explain how they would recommend it given that little is generally understood about complementary medicine, both staff and inmates said they would draw on their own experience, several suggesting doubters should not *'knock it until they have tried it'*, while one inmate succinctly said *'its the business, its natural, it works'*. Over half of staff (57%) said that they had personally recommended an inmate approach CMSP. Staff were again unanimous in saying that they would have tried complementary medicine if it had been made available earlier or at other prisons in which they had worked and 94% of inmates said that they, too, might have tried it sooner. All staff and 97% of prisoners questioned said they would like to see programmes offering complementary medicine made available throughout the Prison Service, although many qualified this statement with a need for high standards, integrity and accountability.

Funding complementary medicine

A third of staff (who had themselves been treated by CMSP) were unaware that the therapists were volunteers and not paid. However, only 14% of inmates did not know therapists worked on a voluntary basis. Asked if they felt this was important, 33% of staff felt it demonstrated commitment and welfare concern. One-fifth felt it was not important to the patient. 40% of staff and 51% of inmates believed that therapists should get paid or, at the very least, be reimbursed for costs. One inmate argued, *'better pay might attract better therapists'* while another suggested, *'pay might attract more therapists'*. One member of staff suggested that staff and

those inmates who were on the enhanced regime could easily afford to contribute something. Another inmate argued *'they can afford to ship people around the system for bad behaviour at enormous cost, why not use some of that money to treat them?'*. The majority of staff believed that the prison would not have complementary medicine if they had to pay for it as it would be a low priority in the current adverse financial climate.

Impact of complementary medicine on offending

Finally, inmates were asked to assess whether complementary therapy would have any effect on their offending. Only 40% of those questioned suggested that the treatment programme had addressed the issue of their offending. However, in those cases all said that their offence, and sentencing in general, had arisen naturally in conversation and did not therefore feel that therapists had an ulterior agenda. This percentage also reflects the fact that inmates on crisis intervention do not necessarily have a counsellor. Inmates suggested treatment had *'made me think about the victims'* and *'changed my ideas about responsibility'*. The fact that CMSP's programme is not overtly about offending behaviour, though may in due process address the causes of offending, appears important. The great majority of both staff (80%) and inmates (88%) did not feel that complementary medicine would work if referral was formalised in the sentence plan. Inmates cited the example of the level of willing participation in the offending behaviour programme as a reason why compulsory referral would not work. In its defence, however, a number of inmates questioned suggested that CMSP's policy on non-solicitation may sometimes miss those who need and might benefit from treatment the most.

Over two-thirds of those prisoners questioned believed that complementary medicine would help them after release. This was either as a result of new life-skills and attitudes they will take with them from Coldingley or because they now know they could seek complementary medicine in the community as an effective means of dealing with problems. This would seem to lend strong support to CMSP's goal of establishing 'aftercare' units in the community to help ex-offenders and their families. Of those asked, almost half (45%) said that it was 'not very likely' they would reoffend on release. The 14% who claimed that it was 'fairly likely' they would reoffend blamed this on their nature, circumstance and the failure of the state to offer a realistic alternative to what they could earn from crime. 41% of inmates in the sample said they would not reoffend. The reasons given ranged from *'length of sentence'* to *'age'*, and *'maturity'*. *'Changed priorities'* was another common response, in particular the fact that their children were growing up or their parents were becoming frail. It is unclear from inmates' comments precisely what role complementary medicine, and CMSP in particular, have played in these decisions.

7 Impact on the Prison

7.1 Programme interaction

The complementary medical treatment programme at Coldingley does not operate within a vacuum. This final section looks at the impact the programme's operation has had on various aspects of the prison in the two years since its inception. In particular, the influence of complementary medicine on order and control, the health care centre, the chaplaincy, and other programmes are examined.

7.2 Impact of complementary medicine on order and control

One of CMSP's principal goals is to encourage recognition of the role of complementary medicine in addressing criminal behaviour. To this end, the ICMTP aims to reduce the rate of offending and reduce stress related aggression towards staff and within the inmate population (CMSP 1997). In a report to the Director of Operations South (Prison Service), the Governor of Coldingley, quoted by Perry (1997), reported that since CMSP started delivering '*significant numbers of treatments*' in May 1996, there had been a significant drop in prison disciplinary hearings (adjudications). The report, dated September 8 1997, demonstrated that between January-March 1996 and June to August 1997 the number of adjudications had virtually halved (from 339 to 188). More specifically, those resulting from violence, aggression and non-compliance had more than halved (from 143 to 56). The report concluded that, '*this constitutes good evidence that there has been substantial improvement in the level of behaviour of prisoners at Coldingley over the last 18 months*'. Without refuting these statistics, temporal association is not sufficiently reliable grounds to assume a 'cause and effect' relationship. For example, since CMSP began treating prisoners at Coldingley the number of reported drug related incidents has risen, yet this circumstantial evidence by itself is not enough to suggest that complementary medicine is responsible.

To examine whether it is possible to quantify the impact of CMSP's work at Coldingley against improvements in inmate behaviour and staff sickness levels, monthly report rates were calculated by dividing the number of adjudications per month by the monthly inmate population. Research on control in category C prisons has found that the report rate is one of the most meaningful indices of order (Cookson *et al.* 1994; Marshall 1995, 1997). Figure 6.1 shows the number of monthly treatments against monthly report rates and working days lost per month through staff sickness for the period 1996/7-1997/8. The mean report rate for 1997/8 was 0.09 adjudications per person, while 7.73 working days were lost per member of staff. As figure 7.1 demonstrates there does not appear to be an obvious relationship between treatment levels and either order or staff sickness over this period. Statistical analysis (Pearson's product moment correlation) found two significant relationships. During 1996/7 staff sickness dropped as the number of treatments increased ($r=-.7$ $p=.001$). Over the same period, the report rate similarly improved as the number of treatments rose ($r=-.6$ $p=.001$). These findings would appear to

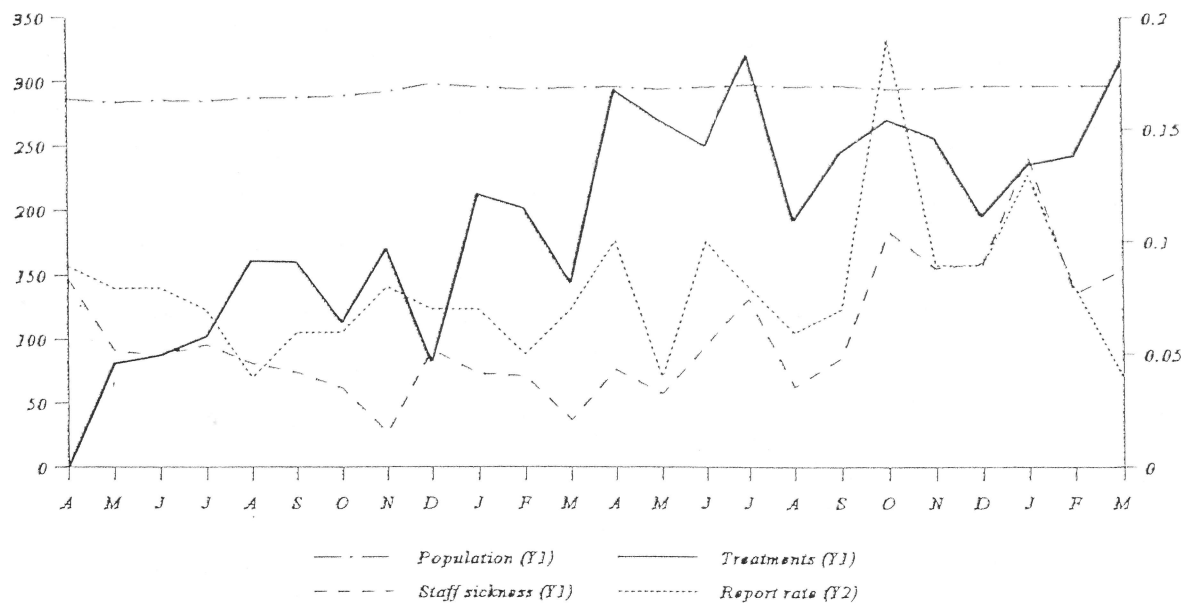


Figure 7.1 Impact of complementary medicine on order and staff sickness (1996/7-1997/8)

confirm the Governor's circumstantial findings. However, analysis failed to demonstrate any statistically significant relationship between treatment and either order or sickness for following year (1997/8). This, therefore, throws some doubt upon the reliability of the findings for the first year as any 'treatment effect' ought to be broadly consistent over the period.

One explanation for this inconsistency may be the calculation of the measures used. The mean report rate has risen steadily over the past three years, rising from 0.05 in 1995/6 to 0.07 in 1996/7 and again to 0.09 for 1997/8, suggesting an overall decline in order. However, the report rate is an imperfect measure of control since the definition of what constitutes a disciplinary offence alters over time as does the disciplinary focus. A number of legislative changes have been implemented since CMSP began treating patients in May 1996, including mandatory drug testing (MDT) and volumetric control of possessions resulting in greater numbers of incidents related to drugs and property.

Figure 7.2 shows the number of treatments against a breakdown of adjudications by three categories of offence: violence (i.e. fighting or assault), behaviour (i.e. bad behaviour, disobeying rules, absent without permission, denying access, good order and discipline, idleness, and disobeying an officer) and drugs (i.e. possession of drugs). Statistical analysis again found two significant relationships. In 1996/7, the number of adjudications for property related offences declined as the number of complementary medical treatments increased ($r=.7$, $p=.001$). During 1997/8, staff sickness rose with an increase in the number of adjudications for bad behaviour ($r=.8$, $p=.001$). Once more, however, these relationships were not supported by evidence from other years. In the absence of more longitudinal data any relationships observed must be treated with some caution. Nevertheless, they do suggest that it may be possible to demonstrate that complementary medicine has a quantifiable impact upon order in the prison.

Finally, treatment data (number of treatments received and whether or not individuals were on the ICMT) and behavioural data (number of adjudications both during the current sentence and

and public holidays). The centre operates a dispensary although as a matter of policy will not issue opiates or ephadrines. It cannot therefore support long term palliative care such as prescribing methadone for drug addicts. The centre operates on the same principle of self efficacy as the rest of the establishment. Patients are required to take some responsibility for their own health and seek medical help when they feel it is necessary.

The last inspection of Coldingley by HM Prison Inspectorate was somewhat critical of health care provision (HM Prison Inspectorate 1996). The report criticised a lack of an in-patient facility (in-patients being transferred to Bullingdon some 50 miles away) and the limited surgery hours. The two medical officers were also criticised for not seeing all new receptions within 24 hours of arrival. The health care centre was also criticised as having an '*air of neglect*' as many fittings were worn and '*floor coverings were heavily stained*' (paras 3.28-3.30). The report recommended a programme of redecoration and more effective cleaning. Although the inspection report is some years old and health care provision at Coldingley has expanded and undoubtedly been improved, it was in the climate reported by the Inspectorate that CMSP was established. In light of remarks made, the potential demand for an alternative or complement to the health care centre would appear to have been extremely favourable.

Figure 7.3 shows the number of patients treated annually by conventional and complementary medicine (1990/1-1997/8). As figure 6.3 demonstrates, the numbers treated by conventional medicine have declined steadily from 1990 to 1993 after which it has remained fairly constant at around 5,000 patients per annum, dipping slightly in 1996/7.

A number of significant administrative and policy changes have taken place since 1990. Foremost amongst these changes was the recategorisation of the prison from category B to category C in April 1993, considerably altering the inmate population. The mean sentence length has dropped and health and fitness of those being allocated is generally better. The introduction of a compact requiring all prisoners to be fit for work has further altered allocation criteria to the prison. In addition, levels of employment at Coldingley have risen in conjunction with greatly increased pay incentives. The number of inmates using the prison doctor in order to avoid work has therefore dramatically declined. The health care centre staff have also instigated a number of policy changes during this period. In particular, staff now insist that inmates attend set appointments on time. Those who register sick and do not turn up for appointments are now charged with a disciplinary offence. These initiatives have been introduced to try and 'normalise' the prison to comparable levels for the community. Self-reported sickness rates amongst the prison workforce are almost three times greater than those in the community.

Between April 1997 and March 1998, 2,226 patients were seen by the doctor while health care centre staff saw 2,786 patients. This total of 5,012 conventional patients compares with 854 patients seen by CMSP, a ratio of approximately 6:1. While this compares favourably to a ratio of approximately 12:1 for the previous year, complementary medicine does not appear to be taking significantly numbers of patients away from the health care centre. Two possible conclusions may be drawn from this finding: either patients using complementary medicine do so in tandem with conventional medicine or complementary medicine appeals to a different inmate demographic from conventional medicine. Given that, on average, HCC staff make approximately 6 referrals to CMSP per month, the truth is probably a combination of these two

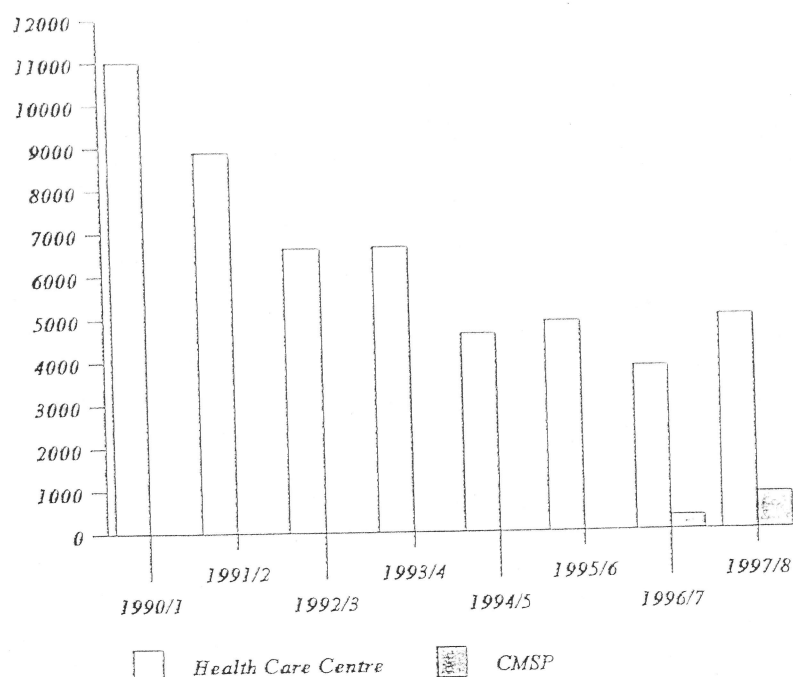


Figure 7.3 Patients treated by conventional and complementary medicine (1990/1-1997/8)

possibilities. This suggests that CMSP has identified a niche and is satisfying a demand which was not previously addressed by the health care centre. In this sense CMSP is providing a true *complementary* medical service.

Cost comparisons between complementary and conventional medicine at Coldingley are made difficult by the differing nature of funding. Coldingley pays CMSP a flat monthly rate of £10,000 (£120,000 per annum) to cover general administration (e.g. postage and photocopying) and equipment costs, against a forecast cost of approximately £115,000 per annum for conventional medicine (including the HCC, dental practice and optician costs). An internal cost analysis by Prison Service Headquarters of prison health care costs for the category C estate, found that even taking account of core funding for CMSP, Coldingley's health care costs per prisoner has decreased by 7% since 1995/6 to £161 for 1997/8. This compared to a best performer of -19% (Whatton) and +41% for the worst (Erlestoke). The average cost per prisoner for type 1 health care facilities (such as Coldingley) was £186. The gap between Coldingley's health care costs and the rest of type 1 facilities has continued to widen in the past three years going from 3% higher in 1995/6 to 11% less in 1997/8. At present Coldingley's health care costs are 21% less than the average for all Category C establishments.

By comparison, an hour session of complementary medicine in the community costs around £35. Taking an average of 45 minutes per treatment, the approximate true market value of the service provided by CMSP in 1997/98 is £60,070. This equates to around £70 per patient per annum. On this basis, the approximate market value of treatments since the unit started is £90,070. However, these figures do not include operational overheads, salary or travel. Based on estimates for a fully-functional treatment unit, CMSP have estimated that the total cost of treatment per prisoner per annum would be around £250 (CMSP 1997). At current prices, the

would therefore be around £89 more for complementary medical patients than for conventional medical patients. However, this figure does not reflect the potential reduction in medium- and long-term palliative care, both in terms of reduced pressure on treatment staff and reduced drug dependency and demand. For example, a number of inmates in the survey sample suggested they were long-term migraine sufferers and regularly used the health care centre dispensary for paracetamol. The majority of these sufferers reported a considerable reduction, and in some cases a total absence, of migraine attacks since completing complementary therapy. It is very difficult, therefore, to fully estimate the 'value added' costs of complementary medicine compared to conventional medical costs.

The relationship between the conventional medical practitioners and complementary therapists at Coldingley is exceptionally good. The health care centre has been extremely supportive of the complementary medical service on the understanding that it remains precisely that and does not jeopardise patient's best interests. The centre hosted CMSP until it acquired its own treatment facility, providing 2-3 treatment rooms 2-3 times per week from May 1996. Therapists were also provided with a separate pass key to avoid being seen as being too dependent upon conventional staff. Since the CMSP treatment suite opened, HCC treatment rooms are still occasionally used at peak times. In line with much of the medical literature, HCC staff acknowledge the apparent effectiveness of complementary medicine in working with certain conditions, in particular neurosis and addictive disorders. While staff recognised that complementary medicine had reduced some pressure on the HCC they suggested that this was in part because unlike the HCC, inmates saw CMSP as independent of the Prison Service. Staff could only recall 2 referrals from CMSP since they began treating patients. These related to suspected heart conditions. Overall staff did not feel that the majority of staff or prisoners were abusing CMSP.

7.3 Relationship between CMSP and the prison chaplaincy

Another area of prison life that complementary medicine might be seen to infringe upon is spirituality. Spirituality can form an important dimension to the treatment programme, in particular through meditation. However, a distinction should be drawn between spirituality (i.e. that which relates to the human spirit) and formal denominational religion. CMSP does not claim to endorse or reject any particular religion in order that the treatment services do not discriminate against anyone on the grounds of religious belief. This ambiguity towards religion might be misinterpreted as being anti-religious. For example, CMSP's office contains a number of icons representing a variety of religious faiths, including Buddhism, Hinduism and Christianity. This has led some individuals to the assumption that effective complementary treatment is reliant upon patients adopting a particular belief system. Observation of the operation of the unit does not support this view. Similarly, the user survey failed to identify any patients, staff or inmate, who felt that complementary medicine conflicted with their religious beliefs. Individuals are encouraged to interpret spirituality, if it should arise, in whatever manner they feel comfortable with and understand it.

Coldingley operates a multi-faith religious centre, run by a chaplaincy team. The prison chaplain has been largely supportive of the work CMSP aims to do, facilitating group treatments through the loan of the church hall. However, staff, inmates and visitors to the prison have approached the chaplain expressing concerns about a number of specific areas of CMSPs work. In particular, concern has been voiced regarding some of the mantras used during meditation sessions. The use

of mantras (repetitive chants) are not confined purely to meditation or Eastern culture and in fact are regularly used in the Christian faith in what is termed 'the practice of the presence'. Concern in the case of CMSP, centred on the specific language used which, it was suggested, was 'provocative' and appeared to produce agitation amongst inmates. It was also suggested that the mantras could be construed as being anti-authoritarian. Whilst there was no specific evidence to support the idea that meditation sessions were deliberately subversive, this had caused the chaplaincy concern.

Other concerns raised with the chaplaincy related to the role of outside agencies in the prison more generally. The chaplain suggested that while staff appreciated that the atmosphere in the prison had clearly improved in recent years and that outside agencies, such as CMSP, had undoubtedly played a considerable role in that transformation, many were concerned at the 'closed door culture' which had increasingly developed. Staff were often made to feel as if they were trespassing and as a result were becoming increasingly socially excluded from those areas of the prison where outside agencies operated. As a result, staff were left to judge therapists and programmes by their conduct around the rest of the prison. Many staff also felt that their security concerns were also seen as largely unwanted influences by outside agencies. Some staff felt rejected by therapists, despite many already performing a welfare role, which becomes reflected in the language used. The chaplain suggested that if staff felt complementary medicine was 'not a piece of the jigsaw' and therefore did not 'contribute to the whole', then they would naturally begin to question the value of the service and as a consequence would be unlikely to support it fully.

7.4 The 'Safer Coldingley' scheme

One of the criticisms of other service providers at Coldingley was that they were unclear about precisely what CMSP offered. Concern was also raised about the referral process. Other agencies sometimes felt unsure what they were referring inmates to. Individuals also felt that while they regularly suggested inmates approach CMSP, there were very few instances where CMSP had referred inmates to them.

One way in which the relationship between both CMSP and the prison and CMSP and the other agencies working in the prison is being developed, is the 'Safer Coldingley' drug strategy. The scheme, started in January 1998, brings together representatives of CMSP, ACORN, RAPt, the health care centre and wing staff to offer a 'holistic' support network for inmates with serious addiction problems. Individuals who give cause for concern are presented as a case history and discussed with members from each of the agencies present in order to identify the treatment options at Coldingley. A coordinated strategy for dealing with the individual is then prepared, circulated and implemented accordingly, with members jointly monitoring progress. The group serves the additional purpose of alerting members to the services and treatment methodologies of the various agencies. In this way, the scheme helps to breakdown perceived barriers between different agencies and staff. By focussing on an agenda related, though not necessarily analogous, to the individual members' aims and objectives, the 'Safer Coldingley' scheme alerts agencies, such as CMSP, to the wider prison agenda and in doing so, may help them to identify how the services they offer contributes 'a piece in the larger jigsaw'.

8 Conclusions and discussion

8.1 The value of the complementary medical treatment programme

In so far as evidence from published literature suggests, the pilot complementary medical treatment programme at HM Prison Coldingley is unique, and therefore, from a research perspective, extremely valuable. The scope of treatment modalities and therapeutic options available, together with the scale of service delivery, is quite unlike any other complementary medical intervention in prison, either in the United Kingdom or in the United States. CMSP provides a multi-faceted service. By offering both a holistic complementary medical alternative to the prison health care service and a stand alone therapeutic treatment programme, CMSP provides both a medical service and a hybrid therapeutic regime intervention. As such, its potential benefits extend to many areas of prison life.

As Cullen (1998) notes, one of the greatest problems with research on therapeutic interventions in prison is the lack of consensus of the required level of proof of their efficacy and value. In this sense, the debate about the efficacy of complementary medicine has a number of parallels with the debate about the purpose of prison. Practitioners and commentators are equally divided over what is the fundamental purpose of each and by which criteria efficacy can be judged. Many commentators draw attention to the continued existence of the prison, after centuries of alternative and competing punishments, as evidence of its value. Complementary medical practitioners might justifiably do the same.

Meta-analysis of offender treatment programmes has resulted in an important body of research literature on 'what works' in therapeutic interventions, based on empirical evidence. Research has identified a number of factors common to programmes which were successful in changing offenders' attitude and behaviour (McGuire 1995, Venard *et al.* 1997). These were:

- a 'cognitive-behavioural' approach
- training in social skills and problem solving
- targeting high risk offenders
- focussing on criminogenic problems
- active participatory learning styles
- adhering to stated aims and procedures.

It is clear that a number of these factors are present in the integrated complementary medical treatment programme (ICMTP) offered by CMSP. In particular, the ICMTP aims to address patterns of control and offending by encouraging patients to recognise that their actions and thought's define them and that they alone are responsible for their actions. By helping inmates understand their motives, CMSP encourage them to develop strategies for coping with criminogenic situations. While the selection process for the ICMTP does not specifically target 'high risk' offenders, it does target those in greatest need which may ultimately equate to the same thing. All patients are, however, required to take responsibility for their own health as a basic

criterion for continued treatment. The treatment model may therefore be seen to have a strong degree of integrity in its design.

In the absence of clinical evidence of the efficacy of complementary medicine, the value of *affidavit* testament of patient's perceptions of treatment is generally recognised by conventional practitioners as a valid measure. Four-fifths of all patients interviewed in this study believed they had 'benefitted' from treatment and over three-quarters expressed a positive sense of well being since completing treatment. The representativeness of the sample, together with the findings of CMSP's own study (Perry 1997) suggests that a 'success' rate of around 80% might therefore be expected for all complementary medical patients at Coldingley. With the possible exception of concern over some of the mantras used in meditation, neither observation nor the patient survey revealed any evidence to suggest individual's health is being placed at risk by therapists. Similarly there is no evidence of complementary medicine posing any serious threat to order, security or control.

8.2 Benefits of complementary medicine in prison

The potential benefits of introducing complementary medicine into prisons are broadly two fold: medical benefit and improvement in order and control. In turn specific benefits may relate to either fiscal savings and or improvements in the quality of life.

8.2.1 Health care benefits

The closed nature of the prison environment provides a unique opportunity to clarify the relationship between complementary and conventional medicine, since both treatment ideologies are competing for the same patient body. The study suggests that staff and inmates use CMSP as a mixture of both alternative and conventional medicine dependent upon the nature of their complaint. Where conventional medicine does not appear to offer a treatment option, such as in the treatment of a bad back or stress, staff and inmates appear to regard CMSP as an alternative to traditional medicine. However, where conventional medicine does offer treatment options, patients appear to use complementary medicine to augment and complement traditional health care. This relationship is supported by evidence that the introduction of complementary medicine has not significantly altered the number of patients treated by the health care centre. Given that this suggests CMSP is indeed providing a *complementary* medical service, it is unlikely that cost savings could be made in conventional medical health care to pay for the further development of complementary health care. Benefit therefore needs to be demonstrated in improvements in the quality of life for staff and inmates. The survey showed that for many, the most important contribution of CMSP's work at Coldingley has been the introduction of patient choice. That Coldingley's regime is based upon the principle of self-efficacy, may account for some of the treatment programmes' success.

8.2.3. Improvements in order and control.

Statistical analysis of treatment levels and associated behaviour within the prison were unable to demonstrate conclusively that complementary medicine has a quantitative impact upon order and control. These findings suggest that longitudinal data is needed to take proper account of policy

fluctuations in adjudications. In the absence of quantitative evidence, the main identifiable benefits of complementary medicine are therefore qualitative. Benefits for the patient are likely to include:

- pain relief
- increased self confidence
- better understanding and greater control over emotions
- increased sociability
- greater personal health awareness
- stress reduction
- increased awareness and skills to address offending behaviour.

A number of staff and inmates spoke of the 'domino effect' complementary medicine had on the prison population. This is testament to CMSP's ethos of treating the prison 'holistically'. By treating staff and a significant number of disruptive prisoners or 'faces' in the prison, any benefits enjoyed by the individual are likely to permeate throughout the establishment generally. These benefits are likely to include:

- improved general behaviour
- improved staff-inmate relations
- improved morale amongst both staff and prisoners
- a more pleasant and constructive working environment.

Without diminishing the value of the services that the individual therapists offer, it should be recognised that a major factor in the apparent success of the treatment programme, or for that matter the majority of therapeutic interventions in prison, is time. The survey, supported by the research literature, demonstrates inmates have a greater pre-disposition to therapy than people in the community. This is because they represent a largely disenfranchised group subjected to abnormal sensory deprivation. In an environment that is acknowledged to brutalise and desensitise people, it is important to recognise the significance of the 'placebo effect' gained simply by treating prisoners as individuals and affording them time, personal attention and space. If a conventional medical nurse could afford to sit and talk with patients for an hour this would also undoubtedly produce a perceived reduction in stress. Any regime intervention, such as CMSP, that recognises and builds upon this fact will clearly have a significantly beneficial impact on the atmosphere of a prison. The importance of this should not be underestimated. Research has found that a positive regime 'climate' was the most important factor in establishing and maintaining order in category C prisons (Marshall 1995, 1997).

8.3 The future of complementary medicine in prison

The study has been important in identifying the demographical profile of those who seek complementary therapy in prison. While the age, religious beliefs, offence, sentence length and ethnic origin of inmates using complementary medicine do not differ from the overall demographics of the whole prison population, female members of staff are more likely to seek complementary medicine than their male colleagues. The high level of ethnic minority prisoners, in particular black prisoners of African-Caribbean origin, participating in the treatment programme distinguishes CMSPs programme from many other therapeutic interventions in prison. Accepting

the apparent efficacy of service provision to date, the potential demand for complementary medicine in prison is therefore considerable.

Preliminary evidence from CMSP's expansion into Feltham YOI suggests that complementary medicine has an even more profound and immediate effect working with young offenders. This supports the findings from the research literature which suggests that complementary medicine appeals to both the young and women more than adult males (e.g. Ernst *et al.* 1995; Furnham and Kirkaldy 1996). This would suggest that if complementary medicine in prison is to be expanded, then it should perhaps be directed towards young offenders and women prisoners. Not only would both of these minority groups be more likely to be receptive to complementary medicine, but these categories of prisoner are widely recognised as have some of the most underdeveloped and impoverished regimes in the Prison Service (HM Prison Inspectorate 1997a,b).

The study has also identified a number of problems which should be addressed if CMSP is to continue to expand the scope and scale of its service delivery. These are:

- *Public Relations* - Although independence from the Prison Service is fundamentally important to CMSP's integrity and relationship with inmates, this should not be at the expense of their hosts. One of the greatest requests from staff, the survey revealed, was for better education about CMSP and the services they offer. A request echoed by other agencies working in Coldingley. One of the most important future tasks for CMSP should therefore be to fulfill their stated aim of advocating the benefits of complementary medicine by greater inter-agency education.
- *Patient monitoring* - Ambiguities over the precise definition of what constitutes a treatment was one of the problems to emerge from the user survey. This has clear implications for accurately recording treatment numbers. Similarly, in common with other therapeutic programmes, CMSP does not keep clear records of 'drop outs' from the treatment programme (Vennard *et al.* 1997). While the highly individualistic nature of treatment regimes makes precise definitions of drop outs difficult, these are key statistics if the treatment programme is to withstand the external scrutiny necessary to satisfy service purchasers.
- *Mechanisms for redress* - The role of a number of individuals in the creation of the treatment programme at Coldingley has been paramount. This is not unique to CMSP. In his study of Grendon, Cullen (1998) highlighted the importance of the influence consecutive governors in facilitating the aims and objectives of the therapeutic community. However, if service provision at Coldingley (and elsewhere) is to be expanded, service delivery cannot risk being largely dependent upon individual personalities (staff and prisoners alike). While CMSP's current training process is already geared towards ensuring that all therapists and unit managers are interchangeable, CMSP's line management is still very reliant upon a single director. Whilst strong management is important, as the organisation grows a far greater amount of decision making and responsibility must be devolved to lower management. Mills *et al.* (1997) stress the importance of protecting both therapists and patients by providing formal channels of redress independent of service providers. Existing plans to introduce a detailed sub-committee structure should therefore be implemented as

a priority. The appointment of an external advisory or watchdog committee should also be considered.

- *Continuity of care* - A number of staff and inmates in the user survey felt that they had been denied treatment or that their wishes were ignored. Several complained of counsellors being changed without any notice. While evidence suggests in many cases this is a misunderstanding over responsibility for making appointments, continuity of care must be an important part of the service provision and therefore protocols need to be clarified. The question of continuity of patient-therapist relationships is to some extent beyond the control of CMSP. For as long as the organisation is reliant upon voluntary therapists, service is constrained by supply and not demand. Attention should therefore be given towards a revised funding process to ensure CMSP can retain a core team of professional dedicated therapists.

8.4 Funding complementary medicine in prison

Over 50% of patients questioned, suggested therapists should be paid in order to recognise the value of the service provided. Payment, it was suggested, might also enable the quality and quantity of therapists to improve. At present, CMSP is core funded by the Prison Service and finds additional funding from patrons and other outside sources. Taking CMSP's estimated treatment cost of £250 per patient per annum and multiplying this for the number of patients treated during 1997/8, a fully funded service would have cost the Prison Service approximately £214,000 last year alone. This figure represents somewhere in the region of a 70% increase on present core funding of CMSP and is £85,000 over forecast expenditure on conventional healthcare. It is unlikely that additional funding of this order could be found from internal budgets. In particular, since complementary medicine does not appear to have reduced demand for conventional medicine it is unlikely that additional money could be found from cost savings made in the health care centre.

The national survey of complementary healthcare (Thomas *et al.* 1995) found 17.4% of therapy was paid for entirely or in part by the patients themselves. Payment varied considerably in relation to the therapy being provided. For example, while patients were usually required to pay for manipulative therapies (e.g. osteopathy, massage, chiropractic) homœopathic treatments were generally available free on the NHS. This was largely since manipulative therapists were more likely to be independent therapists working with NHS referrals. A number of members of staff and inmates questioned for the user survey, suggested that in view of the high wages paid to inmates at Coldingley, patients might be prepared to contribute to the cost of their treatments. It was certainly felt that this might deter time wasters. However, this would effectively privatise the service and might deter those who may benefit the most. Furthermore, many patients placed a great deal of importance on the voluntary status of therapists as it was believed this reflected a level of welfare concern which was clearly not motivated by financial reward.

8.5 Formulating contracts for the provision of complementary medicine in prison

As Rees (1996) notes in her evaluation of complementary therapy on the NHS, one of the main purposes of undertaking research on complementary medicine is to inform purchasing decisions.

However, as she also stresses, one of the greatest problems facing researchers is that potential purchasers are rarely explicit about the sorts of service provision or evidence of efficacy they require. In part this is a reflection of how little is generally understood by potential purchasers about complementary medicine and therefore what criteria service tenders ought to be compared against. Acknowledging this, the Research Council for Complementary Medicine (see appendix B for address) publishes a guide entitled *Purchasing Complementary Medicine* which looks at various approaches and recommendations, including those of the BMA. However, this does not take account of the additional environmental considerations and constraints placed on service providers by operating in a prison environment. In particular, formal qualifications do not necessarily prepare complementary therapists for working in a carceral environment, nor do they indicate aptitude.

One of the difficulties in constructing a contract for complementary service provision in prison, is the lack of existing alternative models against which to compare tenders. Outside of the three prisons in which CMSP currently operates (Coldingley, Downview and Feltham) HMP Wandsworth would appear to be the only other prison which has attempted to implement a holistic complementary treatment programme. A 12 week pilot project ran as part of the prison's drug strategy between February and April 1998 at a total cost of £9,856. Six therapists offered 12 inmates a holistic programme of acupuncture, chiropractic, homœopathy and counselling. The inmates were identified and chosen by the therapists from those involved in the existing drug strategy as those most likely to benefit from treatment.

The decision to introduce complementary therapy as part of an integrated programme was identified in drawing up Wandsworth's drug strategy two years ago with funding coming from a direct bid to the Directorate of Healthcare. The providers were identified by recommendation and invited to submit a proposal. The background of the therapists, who came from the College of Healing, was investigated by seeking references and the opinion of third parties. A service level agreement (SLA) was then drawn up in conjunction with the senior health care officer (SHCO); a research evaluation was costed as part of the SLA. Preliminary feedback suggests that in common with the experience at Coldingley, therapists were able to achieve more working with inmates one day a week than they could achieve over a whole week with clients drawn from outside. The Wandsworth programme, together with the experience of Coldingley identify a number of criteria which might be included in a contract to supply complementary medicine in prisons. These are listed in appendix C.

The experience of Wandsworth again highlights the lack of a coordinated approach by the Prison Service with regard to the provision of complementary medicine. Local budget centres and prospective service purchasers are ill informed about existing experience of complementary therapists working in UK prisons. The pilot work at Coldingley, and elsewhere, places the Prison Service at the forefront of institutional complementary medical service purchasers. If the Service is to capitalise on the innovative and beneficial work being done in its own prisons then a national mapping exercise is badly needed. Otherwise, pilot work such as CMSP's at Coldingley, and evaluations such as this, will likely continue to be unnecessarily replicated and the examples of good practice sadly overlooked. In light of the general revolution in alternative healthcare, both nationally and in the Western world as a whole, complementary medicine looks set to stay an important part of therapeutic interventions in prisons. What form this takes, and how effective such interventions are, will remain largely dependent upon whether the Prison Service seizes its own initiative.

9 Recommendations

- 9.1 Consideration should be given to creating an *advisory committee on the provision of complementary medicine in prisons in England and Wales* under the auspices of the Directorate of Health Care. The committee would have responsibility for identifying existing complementary medical provision throughout the Prison Service as well as for disseminating examples of good practice and treatment models to inform local purchasers of options available to them. The committee should also have responsibility for drawing up national codes of conduct to protect both patient and service providers' interests.
- 9.2 Consideration should be given to creating a *complementary medical advisory board* at Coldingley to act as a regular forum between CMSP and interested parties in the prison. Members of the board should include representatives of CMSP, wing staff, instructors, education staff, the chaplaincy, senior management and if considered appropriate, inmate representation. The board should be chaired by an independent party such as a member of Coldingley's Board of Visitors. The board would serve to improve communication and understanding about treatment goals and methodologies between therapists and prison staff.
- 9.3 A formal independently adjudicated mechanism for dealing with complaints about treatment services should be introduced.
- 9.4 The mantras used during meditation groups should be examined to confirm or deny suspicions that they may unknowingly contain unhelpful suggestions.
- 9.5 CMSP should advertise the treatment modalities and services they offer more widely around the prison.
- 9.6 The referral process for inmates and staff should be clarified and widely advertised around the establishment.
- 9.7 CMSP should provide a detailed induction process and regular workshops for new staff and inmates explaining the nature, broad application and perceived benefits of the various therapies offered.
- 9.8 Consideration should be given to providing regular clinics just for staff. These should be held on either a weekly or fortnightly basis out of normal working hours with administrative costs met by staff attending the clinics. In addition to increasing the opportunity for staff to receive treatment, such clinics would also help increase understanding and support of CMSP's work with prisoners.
- 9.9 Therapists' training should involve an additional element dealing with 'jail craft' to enhance understanding of prison culture and inmate sub-culture. This should take place at the host

establishment.

- 9.10 A detailed audit of patient overlap between CMSP and the health care centre should be carried out with a view to formalising referrals.
- 9.11 CMSP's mechanism for recording and calculating monthly treatment returns should be re-examined to ensure treatment figures are an accurate reflection of recognised service delivery and will withstand external scrutiny.
- 9.12 The logistical problems of delivering appointment cards to inmates on the wings should be re-examined with a view to possibly finding a more workable solution.
- 9.13 Evaluations of the work of CMSP at Feltham and Downview should be evaluated after a year of operation and the results compared with the findings for Coldingley.
- 9.14 Consideration should be given to carrying out a longitudinal study of the impact of complementary medicine on offending behaviour. The study might also examine whether former patients continue to seek complementary medicine in the community.
- 9.15 The possibility of establishing a pilot semi-residential intensive complementary medical treatment programme at Coldingley should be investigated. Participants on the ICMTP would be assigned to CMSP in the same way that inmates are current assigned to either ACORN or RAPt. The pilot should be evaluated after 6 months and the results compared to a control group based on current ICMTP provision.
- 9.16 Funding mechanisms for complementary medicine should be re-examined. The possibility of match funding should be investigated with a view to additional expenditure being offset by increased efficiency, the provision of additional specific clinics for staff and continuity of both care and therapeutic treatment options.

Appendix A

CMSP therapists and their relevant training bodies

Therapists listed below have treated patients at Coldingley on either a short- or long-term basis during the period May 1996 - January 1998 and were still active on 26.1.98.

<i>Name</i>	<i>Principal therapy</i>	<i>Training organisation or officiating college</i>
Alder, Maria	Nutrition	Institute for Optimum Nutrition
Allan, Wendy	Reiki	Shambala Healing Centre
Allen, Rosemary	Cranial Osteopathy	College of Osteopathy
Bennis, Jackie	Counselling	Centre for Counselling and Psychotherapy Education
Blyth, Simon	Acupuncture	College of Integrated Chinese Medicine
Brown, Pat	Stress Management	National Federation of Spiritual Healers
Byrne, Sandra	Reiki	London College of Clinical Hypnosis
Cassell, Rosemay	Counselling	Surrey University
Cheneour, Paul	Music Therapy	The Guildhall School of Music and Drama
Day, Laurie	Counselling	Metanoia Institute, London
De Gale, Maria	Osteopathy	Guild of Osteopaths, BRCP
Demick, Marilyn	Reiki	Usui College of Reiki
Dennis, Thom	Reiki	Phoenix Obsidian College
Eedy, Chris	Osteopathy	College of Osteopathy
Faulkner, Theresa	Stress Management	National Federation of Spiritual Healers
Fox, Nick	Reiki	Usui College of Reiki
Gamlin, Roger	Counselling	Centre for Counselling and Psychotherapy Education
Haines, Tim	Acupuncture	London Academy of Oriental Medicine
Hartzel, Michael	Stress Management	National Federation of Spiritual Healers
Harvey, Angela	Counselling	Centre for Counselling and Psychotherapy Education
Higginson, Marilyn	Counselling	Surrey University
Holman, Pam	Homoeopathy	The College of Homoeopathy
Horsburgh, Penny	Homoeopathy.	London College of Homoeopathy, BRCP
Hutchings, Michael	Acupuncture	British Acupuncture Council
Ingham, Nida	Counselling	Surrey University, UK Council for Psychotherapy
Janes, Kathy	Homoeopathy	College of Homoeopathy

<i>Name</i>	<i>Principal therapy</i>	<i>Training organisation or officiating college</i>
Jerming- Havill, Ulla	Acupuncture	London Academy of Oriental Medicine
Jurdon, Caroline	Homoeopathy	London College of Classical Homoeopathy
MacKenzie, Judy	Reiki	Usui College of Reiki
Mannah, Agnes	Reiki	Usui College of Reiki
Mulligan, Maureen	Cranial Resonance	BRCP, Institute for Complementary Medicine
Murray, Roger	Acupuncture	British Acupuncture Council
Patterson, June	Acupuncture	The College of Traditional Acupuncture
Pearce-Gan, Kathy	Reflexology	Guild of Complementary Practitioners
Perfitt, Coral	Homoeopathy	The College of Traditional Acupuncture
Perry, Julian	Vibrational Medicine	College of Vibrational Medicine
Phillip, Abraham	Moi Tai	Centre for Counselling and Psychotherapy Education
Plimmer, David	Osteopathy	Allied School of Therapeutic Massage
Sharman, John	Counselling	Not yet supplied
Siame, Doreen	Counselling	Surrey University
Slater, Gay	Holistic Stress Man.	Association of Reflexologists
Sprackling, Margaret	Counselling	Centre for Counselling and Psychotherapy Education
Stone, Barbara	Counselling	Samaritans
Stratton-Woodward, Edward	Counselling	Centre for Counselling and Psychotherapy Education
Sweeney, Allan	Reiki	Usui College of Reiki, World Federation of Healers
Taylor, Carole	Reiki	Institute for Optimum Nutrition
Williamson, Tamara	Cranial Osteopathy	College of Osteopathy

Appendix B

UK complementary medicine umbrella organisations

The following general organisations provide information about various therapies as well as maintaining lists of registered practitioners:

Institute for Complementary Medicine
P.O. Box 194
London
SE16 1QZ

British Complementary Medical Association
29 Fosse Road
Leicester
LE3 1AE

Research Council for Complementary Medicine
60 Great Ormond Street
London
WC1N 3JF

Council for Complementary and Alternative Medicine
Suit D
Park House
206-208 Latimer Road
London
W10 6RE

Appendix C

Guidelines for the formulation of a contract to provide complementary medicine in prison

The evaluation of the services operated by CMSP, together with the experience of service purchasers at HMP Wandsworth, identified a number of factors which would appear to be desirable in drawing up a contract or service level agreement (SLA) to provide complementary medicine in prison, these are:

- treatment offered should form a structured holistic programme as opposed to individual treatments by independent therapists
- therapists should be registered to recognised bodies governing their respective therapies
- therapists should have independent insurance cover to practice
- therapists should be required to commit to a minimum level of contact (e.g. patient hours) appropriate to the type of programme being offered (e.g. 'per inmate' in the case of a finite programme such as the Wandsworth model, or 'in total' in the case of an ongoing programme such as the CMSP model)
- therapists should be required to undergo a 'prison awareness' induction programme (covering such issues as security, suicide awareness, and prison culture) *specific* to the establishment in which they will work
- within the boundaries of theoretical differences and patient confidentiality, therapists should be required to formally liaise with existing health care services and therapeutic programmes within the establishment setting out clear guidelines for referrals
- therapists should provide a detailed induction process and regular workshops for new staff and inmates explaining the nature, broad application and perceived benefits of the various therapies offered
- therapists should provide separate clinics for both staff and inmates at regular times with clear appointment systems

- in addition to their own detailed confidential patient records, therapists should be required to keep complete records of patients seen and treatments administered and be prepared to make these available to management and appropriate independent organisations
- therapists should agree to provide a formal independently adjudicated mechanism for dealing with complaints about treatment services
- treatment programmes should provide for an ongoing research assessment

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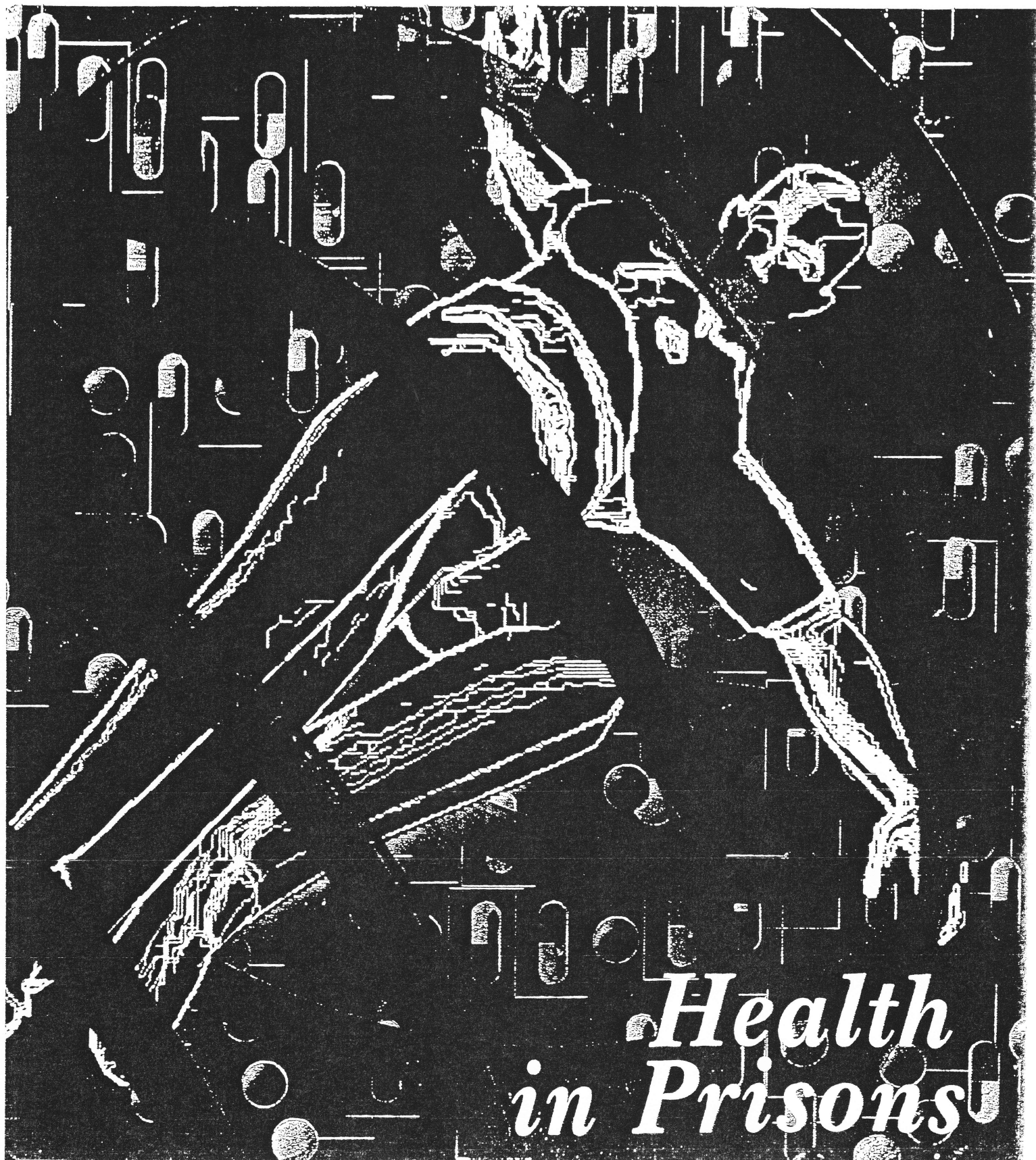
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*Health
in Prisons*

Drug-free Health Care for Prisoners

Maureen Mulligan is the Director of Complementary Medical Services for Prisoners.

Complementary Medical Services for Prisoners (CMSP) provides a range of services in a number of Prison Service establishments. This article provides a brief introduction to the philosophy behind this distinctive treatment approach, and after describing the work that we are currently doing for the Prison Service, outlines some of our future development plans.

Treatment Philosophy

We work to promote health, self-esteem and quality of life for people in prison. Our therapeutic principles promote the patient's responsibility to himself, and are based on the Law of Cure. We believe that conventional (or allopathic) drugs, which are used to manipulate a patient's chemistry, control and suppress behavioural patterns, create dependency and leave the problem of violence frozen in time. By contrast, natural medicines co-work with the patient's life force and activate the defence system which permits the restoration of health.

Treatment Programmes

It is our aim to improve the mental, emotional, physical and spiritual health of our clients. We work to reduce the demand for medication, the rate of re-offending, and levels of stress-related aggression towards staff and between prisoners. We also seek to provide prisoners with the skills to address low self-esteem.

We have been working in prisons for 12 years. We began at HMP Wormwood Scrubs, working with lifers and remand prisoners. Here we were able to spend three years focusing on prisoners with addictive behaviours. We have now developed treatment programmes at HMP Coldingley and HMYOI Feltham.

We currently offer three distinct treatment programmes. The Integrated Complementary Medical Treatment Programme (ICMTP) is a comprehensive 12 week programme aimed at

addressing patterns of control, violence and addiction. It includes regular complementary medical treatment, including cranial resonance and osteopathy (the application of non-intrusive pressure to the bones of the cranium), acupuncture and vibrational medicine. This is supplemented with one-to-one counselling, group therapy, Tai Chi Cihuan, meditation and art and music therapy.

A Crisis Intervention programme aims to provide drug-free treatment to prisoners with behaviour disorders, stress states and those at risk of suicide and self-harm. It is also helpful for those suffering from anxiety, insomnia, migraine, backache, digestive disorders and mood swings. It relies on many of the same treatment methods as the ICMTP.

The Addiction programme involves teamwork between conventional medical practitioners and CMSP. Allopathic drugs are gradually replaced by natural remedies over a period of a week, in order to stabilise the patient and address chemical imbalances, sleep disturbances, stress and associated emotional and mental states. The addictive tendencies are treated with the use of cranial resonance, vibrational medicine, acupuncture and reflexology.

Does it work?

CMSP operates an ongoing research and evaluation programme. We engage in internal clinical audit, as well as specific clinical trials. Our initial results were discussed at a recent conference at the Royal Society of Medicine, opened by Sir David Ramsbotham, HM Chief Inspector of Prisons.

Staff Training

In addition to providing treatment for prisoners, we provide training for prison staff who are interested in working in this area. The training includes complementary medical techniques such as auricular acupuncture and holistic stress management. It is

person-centred, and as well as training in a new skill, it offers the opportunity for personal growth and development. The courses are licensed by the European Institute of Cranial and Complementary Medical Practitioners working within Prisons, and successful students will be eligible to join the CMSP register.

The Future

We are developing a treatment and training centre at Feltham. This will enable practitioners, conventional medical staff, prison staff and prisoners to discover more about

complementary medicine. It will also provide a centre of excellence for visits from the growing number of overseas groups and governments interested in our drug-free method of tackling offending.

In 1999 we are hoping to organise an international conference for complementary medicine practitioners working in prisons.

Anybody wishing to know more about our work or to take up the opportunities for staff training outlined above should contact me or one of my colleagues at Coldingley or Feltham ■

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Faculty of Health Care & Social Work Studies

Integrated Complementary Medicine for Communities

A One Day National Conference at
The Royal Society of Medicine,
London on 30 November 1999

Presented by
the University of Salford
& CMSP

Conference Aims

The conference will focus on a number of areas:-

- An introduction to the work of Complementary Medical Services for Prisoners and a review of the work done so far.
- Problems facing communities and how they can be helped by complementary medicine.
- Relevance of complementary medicine to drug and alcohol problems.
- Role of Higher Education in supporting complementary medicine.
- Training and services which will be available through the University of Salford.
- Research underpinning complementary medicine practice.



on 12 years of experience working with prisoners by creating a formal drug-free, holistic complementary medicine service which could be used within prisons or young offenders institutions in the UK. CMSP aims to treat stress, trauma, abuse and patterns of control, violence, self-harm and offending behaviour and to promote health, self esteem and quality of life in prisons.

Programme Objectives

The CMSP programme has been developed to meet the special and demanding needs of inmates and staff within the prison system. The programme is directly applicable to similar needs presented by many hospitals, mental and secure institutions.

The purpose of the programme is to address patterns of control, violence, addiction, manipulation disorders, sexual maliciousness, self-harm and related disturbances as experienced by large numbers prisoners, to reduce recidivism and serve as a protection for the civilian community. The therapeutic process is a multi-disciplinary and multi-dimensional one operating on deep holistic principles and based upon the 'law of cure'. Complementary medical interventions are applied to support the patient while they address their deepest patterns and dysfunctions through counselling and other deep active modalities.

The programme is cranial based and develops self-observation allowing the patient the opportunity to dissolve deep seated trauma, illusions and control patterns held within the causal, mental, emotional and musculo-skeletal systems.

Client Administration

CMSP has developed a stand alone therapeutic administration and infra-structure but which co-works with conventional medical practice where appropriate. The programme has a strict policy of client confidentiality, record keeping and informed consent as well as detailed baseline and follow on data for both clinical and research purposes.

Training and Supervision of Practitioners

Practitioners involved in the programme receive person-centred training which is licensed by the European Cranial and Complementary Medical Association. Supervision is provided on site by trained staff and unit co-ordinators. CMSP has also developed links with the Faculty of Health Care and Social Work Studies at the University of Salford and the Mental Health Authority.

Treatment programmes and modalities

CMSP offers two treatment modalities for both staff and inmates, these are: Crisis Intervention Treatment (pre-admission) for suicidal states, behavioural disorders, stress and abuse.

The Integrated Complementary Medical Treatment programme (ICMTP) which lasts 12 weeks treats patterns of control, violence, addiction and related psychoses.

Individual treatment interventions that have been employed are: Acupuncture, Aromatherapy, Cranial Resonance, Cranial Osteopathy, Counselling, Art and Music Therapies, Energy Healing (Reiki, Seichem, Spiritual Healing & Polarity Therapy), Herbal Medicine, Homoeopathy, Manipulative Therapies (Osteopathy, Physiotherapy, Therapeutic Massage & Shiatsu), Meditation, Movement Therapies (Tai Chi and Moi Tai), Nutrition, Psychotherapy, Reflexology, Vibrational Medicine and Yoga.

During the programme the patient is supported by a range of safe and effective drug-free procedures that facilitate recovery and rebalancing within all levels of the individual. The unique requirements of each patient necessitates access to a wide range of treatment modalities that have proved both safe, effective and appropriate within the prison environment.

Relevance to drug and alcohol problems

The large scale problem of drug and alcohol use in prisons necessitates regimes that are capable of accessing the causal roots of the problem and not merely its physical manifestation. With drug use there is nearly always deep seated trauma, pain and long-standing damage that needs to be addressed. In view of the Prison Service's aim to reduce corporate medication, employing such treatment programmes which operate at these deep levels, is essential if the drug and alcohol problem is to be reduced and the cost to the prison service and public reduced.

Research

Research into the integrated CMSP programme has been undertaken by the Institute for the Study and Treatment of Delinquency (ISTD), now the Centre for Crime and Justice Studies and CMSP. Findings show that CMSP's regime was unique in both the UK and US and that there was clearly identifiable benefit to the majority of inmates who received treatment programmes. The constitutional,

integrated, drug-free treatment programme employs methods which are beneficial to inmates and staff presenting patterns of control, violence, addiction, malice and related disturbances.

The benefits of complementary medicine include pain relief, increased self confidence, greater personal control, increased sociability, improved staff-inmate relations, stress reduction, improved general behaviour and improved morale and a more pleasant and constructive working environment.

The research report also identified a number of factors common to the treatment programme which were successful in changing offender attitudes and behaviour.

These were:

- * A cognitive behavioural approach training in social skills and problem solving
- * Targeting high risk offenders
- * Focusing on criminogenic problems
- * Active participatory learning styles

In terms of the efficacy of the programme 80% of all patients interviewed believed they had benefited from treatment while more than 75% expressed a positive sense of well being since completing treatment. All staff and 93% of prisoners who received treatment would like to see the programme offering complementary medicine made available throughout the Prison Service.

Evidence suggested that the programme meets a demand not previously addressed by conventional medicine and is therefore providing a truly complementary service.

The number of patients withdrawing from treatment was between 1-3 % which is significantly lower than the 20% non completion rate for conventional treatments.

Implications for the wider community

Maureen Mulligan and her team is currently working with the University of Salford to develop an integrated complementary medicine programme for inner city communities to address problems such as stress, trauma, abuse, addictions, control and violence and improve health and quality of life.

Treatment programmes are also available for staff who have experienced violence and abuse in the work place and the effects of operating in a stressful environment. Training is available for conventional medical practitioners and also for staff from a variety of professional activities and institutions including education and social service.

Masters in Complementary Medicine

The University of Salford currently offers an undergraduate programme in Complementary Medicine Practice. In February 2000 the University of Salford will commence its new masters programme which aims to enable practitioners to explore energy based complementary medicine practices and to critically evaluate their own practices. Salford is unique in developing teaching to this level in energy based practice. The course involves supervised clinical practice in specialist areas of care.

Maureen Mulligan:

Cranial Resonance Integrated practitioner.

Director of CMSP

Maureen is a member of the Executive Council of the International Cranial Association (formerly the Cranial Osteopathic Association), a director of the European Cranial and Complementary Medical Association and independently established and developed a formal programme of integrated, constitutional, drug-free medicine which has been implemented for use within adult prisons and young offenders institutions in the UK. Maureen is the co-ordinator of the first MSc in Integrated, Constitutional Medicine at Salford University.