The therapeutic challenge

David Jones looks at the treatment of personality disorders in prison and health.

Ten years ago the Dangerous and Severe Personality Disorder Programme (DSPD) was launched. There were initial human rights concerns about forcibly detaining and treating offenders before they had committed offences. Many of the key issues have been well described elsewhere (Seddon, 2008).

Now, according to press reports, it is all over (Davies, 2010). The D in DSPD will be discarded, funding is to be drastically reduced or withdrawn. The programmes that have been developed vary considerably in both therapeutic approach and in setting. I have had the opportunity of working in two different settings, the therapeutic communities (TC) at HMP Grendon and one of the DSPD pilot projects in a medium secure National Health Service setting (Health). I argue that there are strengths and weaknesses in both cultures and give preliminary consideration to how far the expectations of the DSPD project have been met.

The key founding principles of the DSPD project were:

To work with patients who pose a serious physical or psychological risk to others and to focus on the 'treatment or management of:
- *social functioning*
- *mental health issues*
- *offending behaviour*
- *risk'*

(Department of Health, 2003)

The intent was to bring together the criminogenic and risk-oriented approach primarily developed by forensic psychologists with the patient-focused, 'wellbeing' approach of psychiatry. Historically there had been tensions and conflicts between these two fields and the DSPD project foresaw a shift from the traditional professional hierarchies towards effective multidisciplinary teams with leadership according to skill.

Bearing this in mind I have identified four key areas of comparison between HMP Grendon and Health. These are culture, staffing, therapeutic activity, and cost.

Culture

The prison system has its roots in the Penitentiary Act of 1799, a system intended to be sparse, requiring work and encouraging the prisoner towards silent reflection upon his transgressions. Prison regimes remain broadly similar with limited facilities, few choices, and the ability to lock men up in their cells. These restrictions make it easier for prison officers to manage men, many of whom have severe personality disorders and who, sometimes individually but certainly as a group, have an extraordinary capacity to push and breach boundaries. It is just what they do, so having a regime that is clear, certain, and minimal makes it safer and easier for staff. There are disadvantages to this bland regime not least that the opportunities for rehabilitation, reducing the risk of reoffending, are diminished because of the absence of meaningful contact between staff and prisoner.

Grendon was always intended to be different, with maximum unlock time, first name terms between staff and prisoner, and therapeutic activities that involved everybody. This produces a safe establishment with a friendly and creative atmosphere that has been repeatedly noted in reports.

Nevertheless the prison is very secure. There is a high fence surrounding the buildings and each one of five therapeutic communities is locked in its own wing. The prisoners are locked in individual cells overnight and for periods during the day. The familiarity between staff and prisoner can look strange to somebody with a security model in mind. When the balance between security and therapy tilts something will happen; either a serious breach or an erosion of the therapeutic alliance if security becomes too oppressive (Jones, 2006). This relationship between security and therapy is crucial: it must be open, direct, and firm.

The health service has a totally different culture. A patient is traditionally understood to be someone who receives treatment. Health facilities are comfortable with large en suite rooms and reasonable food. Rules and procedures are designed to protect seriously disabled mentally ill patients. So offenders, personality disordered patients, who have been transferred from prison or high security hospital, can be highly motivated to stay in relatively comfortable conditions but not necessarily to do therapy. And in contrast to Grendon it is the external agents, solicitors, advocates, and senior managers who can be experienced as allies while therapeutic staff are characterised as persecutors.

Staffing

In both the prison service and Health I have worked with colleagues who are extraordinarily committed. I have met many people whose intelligence, sensitivity, and capacity to work therapeutically often belied their age, educational achievements, or status within the organisation. However, neither core profession, nursing nor prison officer, train their staff for the therapeutic work required with personality disordered patients. There are significant differences in the orientation of the staff teams, in the power structures and in the constitution of the multidisciplinary teams. Generally speaking, health staff are trained to be responsive to needs and compliant with the requests of patients while prison staff are equipped to maintain security.

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Thus it is a major and continual task to introduce something of the other to each group so that nursing staff become more robust and questioning and prison officers more reflective and attentive to the position of the patient/prisoner.

The wider multidisciplinary teams differ greatly. A Grendon community of 40 prisoners may have a lead therapist, psychologist, perhaps an additional therapist, and a part-time art therapist and a psychodramatist. The Health unit has clinical and forensic psychologists, several social workers and occupational therapists, an art therapist, consultant psychotherapist, and five psychiatrists. The luxury of all these staff is not without its problems. These include an increased dependency in the patient group, a deskilling of core nursing and other staff, and unresolved issues of power and authority and leadership.

The Grendon staff group place great emphasis on working as a multidisciplinary team particularly with regard to decision making. It would be very unusual for the lead therapist, for example, to act counter to team consensus (Morris, 2004). This position is reinforced by the parole board system whereby all disciplines submit reports and the board makes decisions about release or movement to lower security. In Health such important decisions as discharge or community leave may be made by one person alone, the responsible clinician who is, at present, invariably a psychiatrist. This traditional medical authority is not easily or willingly relinquished and many things which are not medical at all – psychological, social, or security issues for example – become redefined such as to fall within the authority of the medic.

Therapeutic activity

The practice of the prison therapeutic communities is well documented through treatment, management and training manuals and performance is audited in detail by a joint Royal College of Psychiatrists and prison service team. Therapy consists of two large community meetings and three small therapy groups a week. The emphasis is upon group work and on prisoners taking responsibility for their own therapy and that of their colleagues. Individual work is discouraged and every member of staff within the community is required to participate. Grendon is a therapy site on an industrial scale. On a therapy morning there will be 25 small groups taking place, the prison will be silent because everyone is in a small group. However, apart from some education classes, sports, and limited vocation training this is all there is. Psychiatric input is very limited, a notable change from the first 40 years of the prison's existence.

While all the DSPD units are different my experience is within one which offers a TC model which is supplemented by a range of other activities related to substance misuse or anger management and individual work is 'prescribed' according to individual need. It is a very full therapeutic programme. But there are other differences which may be equally significant. The Grendon model requires men to care for their environment, to do work, and be held responsible for it and to regard everything that happens, or that they think and feel, as material for therapy. That has been hard to reproduce in the Health setting and the rigorous culture of Grendon has proved hard to replicate in the current climate of healthcare.

Cost

Medical facilities are costly and we would want them to provide the best treatment at an efficient cost. A feature of the DSPD project was to provide a large amount of money in order to develop creative treatment settings. One of the products should have been to produce a model or template for treatment which was demonstrably effective and cheap enough to be reproduced in other financially-challenged districts. The current annual costs per patient/prisoner are roughly £200,000 in Health and £40,000 in Grendon.

Finally

Health has developed a model which is comprehensive and able to focus upon complex individual need and the therapeutic community has shown itself able to contain difficult clients and produce a safe space for therapy to take place.

Several issues remain problematic. The cost disparity between Grendon and Health is difficult to justify even though there is a substantial difference in intensity and quality. This is somewhat undermined by the highly protective health service culture which can be manipulated by men with such challenging personalities.

It would seem that the intent to create a synergy of practice from different perspective has made some progress but still has a way to go. ■

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