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HMP Whatton Achieving Change

Treating the person not the prisoner:

How dynamic talking therapy interventions support Sex Offender Programmes and risk reduction at HMP Whatton

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Talking therapies help people to learn how to deal with negative thoughts and feelings and make positive changes in their lives. There are a wide variety of treatment types, each designed to deal with different sorts of problems, but they all have the potential to help those with mental illnesses or those distressed as a result of difficult life events. Talking therapies are known by a confusing mix of names depending on the theoretical approach they take to treatment. Some look at how thoughts and feelings affect behaviour, others assist people to increase understanding of how their personality and early life experiences influence current thoughts, feelings, relationships and behaviour.

Delivering talking therapy treatments in a setting exclusively devoted to the detention and rehabilitation of male sex offenders presents complex and diverse clinical challenges, as well as raising serious ethical issues. Yet individual and group psychological interventions of this type can offer valuable opportunities for increased self-reflection, development of empathy with others and emotional growth. Such personal growth can considerably enhance offenders' participation in, and co-operation with, the rehabilitation process and effectively contribute to reducing the risk of re-offending. In addition to the disturbing experience of incarceration, many prisoners arriving at HMP Whatton will have suffered some form of trauma or abuse at some stage in their lives, be it physical, mental, emotional or sexual. As Durcan[1] states:

> *Not only is prison itself a risk factor for emotional distress, but the prison population is comprised disproportionately of people from disadvantaged backgrounds with a history of trauma, loss and low resilience to distress.*

These people have frequently adopted unhelpful and unhealthy strategies over time to help them tolerate the intense residual psychological pain from their experiences. Such maladaptive coping strategies can include drugs and/or alcohol abuse, emotional detachment, denial, displacement of anger through high risk-taking or initiating violent confrontations, anti-social behaviour to reflect and support their damaged self-image, or behaviour emulating their abuser in order to gain a false sense of control over their experiences. Some will have fallen into patterns of learned helplessness and passive thinking that help to support and perpetuate offending behaviour by encouraging them to believe they cannot change.

The prospect of revisiting these emotionally distressing experiences as part of Sex Offender Treatment Programmes can lead to some individuals refusing to engage in treatment for fear of becoming re-traumatised or because they are unwilling to face the psychological pain involved. There are those who become defensively resistant to the point where they disengage part-way through a programme, severely disrupting the group dynamics and their own chances of progression. Others may have inflicted the same type of abuse they experienced on their victims, adding to the complexity of separating out their own abuse experiences from the role they played and the decisions they took in perpetrating their crimes. Some may be carrying burdens of post-traumatic stress, unresolved grief and loss, anxiety or phobias that prevent them effectively engaging in programmes work even though they desperately wish to do so. In more serious cases, individuals may be locked into repetitive cycles of emotional instability, suicidal or self-harming behaviour; or they may be suffering from clinical depression, obsessive compulsions, schizophrenia, bipolar disorder or other forms of mental illness, singly or in combination.

1. Durcan, G (2008) From the inside: Experiences of prison mental health care, London: Centre for Mental Health, cited in Appleby, L, May, P, Meiklejohn, C, Edgar, K and Cummins, I (2010) *Prison Mental Health: Vision and Reality*, London: Royal College of Nursing.

A significant proportion of prisoners will also have a personality disorder diagnosis, a type of illness which causes the person to think, perceive things, feel things or relate to others in ways that can be distressing. Studies suggest that personality disorders, which are a recognised form of mental disorder, are common among adult prisoners[2]. It is estimated that between 60 and 70 per cent of the UK prisoner population is affected by some form of personality disorder, the most common being the anti-social and borderline types[3], as defined by the Diagnostic and Statistical Manual of Mental Disorders[4].

It is against this background that the Counselling Psychology Service at HMP Whatton was launched in July 2006 to offer treatment to sex offenders suffering from a wide range of mental illnesses and psychological problems as they faced the challenge of programmes work to address their offending behaviour. Since its inception demand for the service has been consistently heavily over-subscribed, reflecting the widely acknowledged unmet high level of need for psychotherapeutic support across the prison estate, again, as stated by Durcan[5]:

> *The need for better mental health care in prisons has been evident for some time. Reports throughout the last two decades have shown that prisoners have dramatically higher rates of the whole range of mental health problems compared to the general population.*

More than 70 per cent of people in the UK prison population have two or more mental health disorders[6].

Male prisoners are 14 times more likely to have multiple problems than men in the general population, while for females the ratio is 35 times more[7]. Furthermore, the suicide rate in prisons is almost 15 times higher than in the general population: in 2002 the rate was 143 per 100,000 compared with nine per 100,000 in the general population[8].

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Between 2007 and 2012, the six full years that the Counselling Psychology Service has been in operation at HMP Whatton, 1073 referrals were made by prison staff, all of which required explicit prisoner consent[9]. This represents an average of 21.3 per cent, or roughly a fifth, of the prison's population referred for individual or group interventions each year. During the same period 469 people received individual therapy and 197 undertook group therapy, an overall total of 666 people, or an average of 13.2 per cent of the prison population treated each year. The figures include 210 repeat referrals for further treatment — an average of 35 clients a year. These were people requiring repeat blocks of individual work to address more complex problems, or who wanted individual work after attending a therapy group, or those wishing to repeat group work. Some prisoners have multiple treatment needs and repeat interventions are often required in those cases. However, there is considerable practice-based evidence to suggest individuals with multiple presentations can benefit from repeated blocks of short-term intervention with experienced therapists.

The service currently employs two Counselling Psychologists, who are both HPC-registered and chartered by the British Psychological Society. As well as treating the full range of psychological problems and mental disorders, one practitioner is trained to deliver therapy in sign language for deaf clients.

They also supervise the work of two volunteer counsellors registered with the British Association of Counselling and Psychotherapy (BACP) delivering Transactional Analysis and Person-Centred Counselling on behalf of the service, and offer placement practice

2. Fazel, S. and Danesh, J. (2002) Serious mental disorder in 23,000 prisoners: A systematic review of 62 surveys, Lancet, 359, 545–550, cited in Howells, K, Krishnan, G, and Daffern, M (2007) Challenges in the treatment of dangerous and severe personality disorder, *Advances in Psychiatric Treatment*, vol. 13, 325–332 accessed at http://apt.rcpsych.org/
3. www.justice.gov.uk/...disordered.../working-with-personality-disordered-offenders.pdf -
4. American Psychiatric Association (2000) *Diagnostic and Statistical Manual of Mental Disorders* 4th ed., text revision, Washington DC: American Psychiatric Association.
5. See n.1
6. Social Exclusion Unit (2004) quoting *Psychiatric Morbidity Among Prisoners in England and Wales*, (1998), cited at http://www.mentalhealth.org.uk/help-information/mental-health-statistics/prisons/
7. Ibid.
8. The National Service Framework For Mental Health: Five Years On, Department of Health, (2004) citing *Samaritans Information Resource Pack* (2004) cited at http://www.mentalhealth.org.uk/help-information/mental-health-statistics/prisons/
9. Harper, R, and Franks D, (2013) *East Midlands Counselling Psychology Service Annual Report and Needs Analysis: A snapshot of the service taken on 31st December 2012*. East Midlands Counselling Psychology Service: HMP Whatton.

opportunities to Counselling Psychology doctoral students.

The service operates independently, but it works closely with Programmes and other departments to support the multi-agency approach to providing care for prisoners in crisis, or those with short and longer-term mental health needs. Consistent and regular feedback received since its inception demonstrates that the professionalism, efficiency and reliability of the service, and the quality and effectiveness of its treatments, are generally highly regarded by prisoners and operational and non-operational staff. The service is trusted and seen as a transparent, accessible and valuable resource for staff seeking information on psychological or mental health issues. Nevertheless, continuous efforts are made to build on this reputation by improving the quality and level of help it provides. Negotiations are currently being held with senior Healthcare staff at HMP Whatton to establish closer co-operation between the two services in order to help to ease waiting list pressures and maximise the efficient use of valuable and limited resources.

Individual therapy varies according to the type of problem requiring treatment, but in each case the primary focus is on the working alliance between therapist and prisoner, and that person's preferred mode of working. This integrated-relational, client-led approach to therapy often requires a dynamic mix of treatments using cognitive-behavioural, systemic, psychodynamic and humanistic theoretical approaches. As a result, the therapists' skills base incorporates elements including Cognitive Behavioural Therapies (CBT), Eye Movement Desensitisation and Reprocessing (EMDR), Brief Solution-Focused Therapy, Transactional Analysis, Systemic Therapy, Schema Therapy, Object Relations Therapy, Personal Construct Therapy, Self Psychology, Attachment work and Mindfulness.

The service's group work also incorporates many of these different therapeutic approaches. The two main treatment groups currently offered to prisoners at HMP Whatton are COPE (Coping with Problem Emotions), which is a 14-session group developed to help people learn how to manage powerful emotions appropriately, and an eight-session Self-Harm Group, which helps people to break their cycle of self-harm and find safer and more positive ways to communicate and process their negative feelings and thoughts. In addition to these groups, the service provides occasional Bereavement and Loss groups for those who are struggling to come to terms with powerful emotions connected with grief and loss. A treatment group for those prisoners suffering from low to moderate depression has also been developed by the service and was launched last year.

The service provided just over 794 hours of clinical contact with prisoners in 2012[10], involving delivery of six groups and completion of 60 individual cases. A Clinical Outcome Routine Evaluation (CORE) questionnaire is used before and after treatments to evaluate the effectiveness of the intervention work. The CORE is a popular general measure of change with widely recognised validity. It looks at four broad areas: general well-being, problems and symptoms, life and social functioning, and risk of harm to self or others.

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Over the six years since the launch of the Counselling Psychology Service CORE averages for people receiving individual treatments have consistently shown significant improvements across all sectors. In the well-being category, which relates to individuals' sense of positivity, hopes and aspirations, an average 43.3 per cent improvement has been recorded. Meanwhile, an average reduction of 42.4 per cent has been indicated in problems and symptoms, consisting of elements including panic, anxiety and somatisation (psychological distress experienced as real physical pain), intrusive or irrational thoughts, insomnia, flashbacks, and obsessive behaviour.

Clients reported on average a 40.9 per cent improvement in functioning, related to the ability to problem-solve, communicate concerns to others, feel warmth towards others, build relationships, cope with criticism, acknowledge achievements and develop an appropriate level of self-esteem. But most significantly, a reduction of 60.6 per cent on average was recorded in individuals' risk of causing harm or injury to self or others.

These improvements were achieved with an average block of only eight standard 50-minute therapy sessions per individual, extended at the therapist's discretion to ten sessions in some instances to obtain effective closure. Data from the CORE returns showed a

10. Ibid.

general improvement of 43.2 per cent, suggesting those people completing a single individual course of treatment were generally left more emotionally resilient, more self-reliant and more stable psychologically as a result of the experience.

Group CORE results mirrored the individual therapy results, with CORE averages for people engaging in groups also consistently showing significant improvements across all sectors. This was demonstrated for all groups, particularly the COPE and Self-Harm groups.

Research suggests some humanistic and psychodynamic talking therapy interventions have been effective in helping to reduce anger[11], an intense emotional response which frequently features in and influences offender behaviour. However, much of the research in this area has tended to come from the cognitive behavioural therapy (CBT) perspective. The Whatton COPE Group model takes a more integrative and holistic approach to treatment, looking at both the origins and focus of anger, as well as helping people identify triggers to their behaviour and manage responses in a more effective way. Deffenbacher et al. suggest anger management treatment outcomes should take into account general life functioning[12].

The Whatton COPE Group model takes a more integrative and holistic approach to treatment, looking at both the origins and focus of anger, as well as helping people identify triggers to their behaviour and manage responses in a more effective way.

CORE returns for the two COPE groups completed since 2011 showed an average 46 per cent improvement in wellbeing after the 14 sessions. Symptoms reduced by an average 47.5 per cent, general functioning was enhanced by 52.2 per cent and risk of harm to self and others lowered by an average of 69.7 per cent.

As previously stated, an estimated 60 to 70 per cent of the UK prisoner population have a personality disorder[13], and statistics also suggest 70 to 80 per cent of people who suffer from a Borderline Personality Disorder self-harm[14]. Because anti-social and borderline personality disorders are the most common types seen in custodial settings, acts of self-injury are a frequent occurrence in prisons.

Self-harm can be described as the urge to inflict physical wounds on your own body, motivated by a need to cope with unbearable psychological distress or regain a sense of emotional balance. The act is usually carried out without suicidal or sexual intent. Some people use self-harm as a way of stepping back from suicide, others as a trade-off, swapping physical pain they can tolerate for emotional pain they cannot. Some use it to express feelings in the only way they know how. So self-harm can be seen as having three general functions: coping, control and validation[15]. Such behaviour can be extremely debilitating and damaging to the self-harming individuals, but also distressing and stressful for prison and other staff who have to deal with them.

Ten self-harm groups have been run at HMP Whatton since 2009, with 76 potential clients being assessed and 65 people actively engaging in the eight-session treatment plan.

Of those people, ten were on an ACCT document at the start of the group and 24 had self-harmed in the month prior to the group starting. In total, 40 people had engaged in self-harming behaviour within the three months prior to starting a group. There was a significant drop-out rate, with some people withdrawing and others choosing to switch to individual therapy, so only 45 people completed the groups. Of those who completed the course, only five reported actively self-harming at closure, but at minor levels. The figure was the same at the review session a month later. It should be noted that these figures include one individual who attended two groups.

Averaged CORE returns for the eight-session self-harm groups run since 2009 report a 23.5 per cent improvement in well-being, a general reduction in symptoms of 32.4 per cent, functioning enhanced by 32 per cent and risk of harm to self and others reduced by an average of 46.5 per cent. Overall CORE scores

11. Deffenbacher, J, Oetting, E, and DiGuiseppe, R, (2002) Principles of Empirically Supported Interventions Applied to Anger Management, *The Counselling Psychologist*, Vol. 30, No. 2, 262-280
12. Ibid.
13. Fazel and Danesh (2002) see n.2.
14. Ministry of Justice (2011) *Working with Personality Disordered Offenders — A Practitioners Guide*, www.justice.gov.uk/guidance/docs/working-with-personality-disordered-offenders.pdf
15. Adams, J, Rodham, K and Gavin, J (2005) Investigating the 'Self' in Deliberate Self-Harm, *Qualitative Health Research*, Vol. 15, No. 10, 1293-1309.

showed a general overall improvement of 32 per cent in mental state based on the criteria listed.

Practice-based evidence from working with repeat-referral clients suggest these individual and group treatment outcomes have positive implications not only for general offender management, but also for prisoners' potential engagement in offender treatment programmes and possible progress on release, as illustrated by the reduction in risk factors and symptoms of psychological distress recorded. For longer and indeterminate sentence prisoners, where multiple repeat referrals are possible, the opportunity for extended assimilation and extension of psychological insight and self-reflection is frequently reported by inmates as being valued and life-enhancing.

General reflections and observations obtained in feedback from prisoners after their therapy experiences often share the theme that much earlier access to therapeutic support or intervention could have put them on a more positive life path or even played a role in preventing their offending.

Other common observations indicate that prisoners feel they have enhanced their learning from Sex Offender Programmes, or they have been able to make better sense of their experiences in them, as a result of undergoing personal therapy processing either before or after programmes work.

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It is clearly acknowledged that these types of statements may be seen as grooming or compliance strategies designed to ingratiate or influence parole or sentence planning outcomes. However, referrals to the Counselling Psychology Service are made with the explicit agreement of the individual, in the full knowledge that the work has no influence on parole or offender management reports. Throughout the process it is stressed to prisoners that therapy treatments are in no way directly concerned with assessing or reducing risk of reoffending because this is the remit of the forensic psychology department. Prisoners do not have to engage, they choose to engage knowing there are no potential benefits or losses in terms of influencing parole. Therefore it can be argued that the feedback obtained is not as influenced by pressure or expectancy to 'say the right things' or please the therapist as it may be in other intervention settings or environments.

There is good reason to avoid including talking therapy treatments in sentence plans. Individuals need to be ready and able to engage in psychological therapy. This is not simply related to the individual's desire to do the work, but to the scale and extent of the problems to be dealt with, and that person's current capacity to engage openly and non-defensively with the process. There is no point in asking someone to confront a repressed trauma or dismantle a psychological defence mechanism if he simply does not have the resilience or capacity to do so at the time of asking, or is not in a place where he feels secure and strong enough to face the challenge. In this regard talking therapies are not an off-the-shelf, one-size-fits-all cure for prisoners' psychological and behavioural distress. The process is as unpredictable and varied as the individuals who come for treatment.

One common factor for a positive outcome is that people tend to get out of the process what they put in, so the better they are able to engage the more they are likely to benefit. The second and more important factor is the strength of the working relationship — the therapeutic alliance — between therapist and client. Given these two factors, talking therapies can have powerful influences on individuals' perception of self and their patterns of interaction, and be an agent for change through a variety of psychological mechanisms.

There is some evidence that lack of security in childhood attachment patterns has a significance in the development of sex offending behaviour[16]. For a child, attachment to a consistent and effective caregiver establishes a sense of security, safety and well-being that enables the healthy development of individual identity in a predictable and secure environment. The absence of this security can be influential in the development of personality disorders, particularly borderline personality disorder[17].

16. Bogaerts, S, Vanheule, S, and Desmet, M (2006) Personality Disorders and Romantic Adult Attachment: A Comparison of Secure and Insecure Attached Child Molesters, *International Journal of Offender Therapy and Comparative Criminology*, Vol.50, No.2, 139-147.
17. Fonagy, P (2000) Attachment and Borderline Personality Disorder, *Journal of the American Psychoanalytic Association,* Vol. 48, No. 4, 1129-1146.

It has been argued that custodial sentences have a negative impact on prisoners' development of sense of self[18]. Talking therapies depend on the establishment of a strong working attachment between therapist and client. Providing a positive attachment experience for the individual, possibly for the first time in his life, and activating the client's ability to find meaning in their own and other people's behaviour[19], offers pro-social modelling with an added bonus of giving the individual a positive experience interacting with a psychologist. As stated by Bogaerts et al[20]:

> *By experiencing an inter-subjective relationship with a therapist, a patient can be enabled to develop a deeper understanding of his or her own attachment and abusive history.*

Mann suggests the majority of sex offenders feel psychologists should deliver Sex Offender Treatment Programmes, but that many do not trust psychologists[21]. Providing a positive attachment alliance with a psychologist in a relaxed and supportive talking therapy setting, where the client is encouraged to be in control at all times without the pressure of having to progress through a programme that has an influence on his release date, can encourage prisoners to develop that trust. It can also help to redress the negative influence of rumour and inmate disinformation that generates distrust and resistance to engagement in programmes. As Mann argues:[22]

> *Sexual offenders in prison are heavily influenced by the attitudes of those around them about the efficacy of treatment. They are influenced by non-treatment staff, by other prisoners, and by their families and friends.*

So to improve and encourage engagement in Sex Offender Treatment Programmes we must acknowledge the tensions between prisoners and their view of psychologists, and work to alleviate them by improving the context in which treatment is delivered and trying to change prisoners' adversarial perceptions of the prison environment[23]. As part of this process it is important to provide pro-social modelling and a supportive environment for those being treated, which is where ethical dilemmas can often manifest for the therapist.

Talking therapies depend on the establishment of a strong working attachment between therapist and client.

Therapeutic treatments need to be holistic and take account of human rights, ethical practice and the well-being of those undergoing treatment[24].

In a prison environment such as HMP Whatton this means the Counselling Psychology Service must balance duty of care to those being treated with the ethical demands of professional governing bodies, including the Health Professions Council and British Psychological Society. It must also meet the expectations of the National Offender Management Service (NOMS) as service provider, the judicial system and the wider public. Holding clear and firm boundaries is essential to avoid this balancing act distorting or negatively influencing the relationship between therapist and client. One way of achieving this is through openness and transparency of the treatment process and explicit acknowledgment of the limitations that each service partner imposes on the service. The strict confidentiality boundaries of therapy inevitably can cause tension between therapist and client, but in a prison they can also create problems because of expectations about sharing information.

The issue of consent to referral for treatment and disclosure of information is complex in a prison setting because of the inevitable power imbalance between prisoners and staff. This places an onus on Counselling Psychologists to make appropriate challenges and monitor the issue on their clients' behalf, but requires careful management to avoid generating conflict between the various interest groups involved.

It is clear from the experience of the Counselling Psychology Service at HMP Whatton that talking

18. Greve. W, Enzmann, D, and Hosser, D (2001) The Stablization of Self-Esteem Among Incarcerated Adolescents: Accommodative and Immunizing Processes, *International Journal of Offender Therapy and Comparative Criminology*, Vol. 45, No. 6, 749-768.
19. Ibid.
20. See n.16.
21. Mann, R (2009) Getting the context right for sex offender treatment, in Prescott, D (ed) *Building Motivation for Change in Sexual Offenders*, Brandon, VA, US, Safer Society Press.
22. Ibid.
23. Ibid.
24. Mandikate, P, and Akerman, G (2012) Can Convicted Offenders Be Classed as 'Volunteering' for Therapy? Working with Men Who Have Committed Sexual Offences and Volunteered for Treatment in a Prison-based Therapeutic Community, *Sexual Offender Treatment*, Vol. 7, No. 2.

therapies have a valuable and special role to play in establishing a structured and integrated approach to the psychological engagement and treatment of offenders. This places a demand on service providers to ensure they adapt to meet the needs of treatment through the continuous review of services and consistent investment in the clinical development of practitioners, in order to implement the most modern and effective therapeutic interventions available.

An example of this is the growing reputation of Eye Movement Desensitisation and Reprocessing (EMDR) for treatment of post-traumatic stress disorder, phobias and anxiety. The Whatton service already has a growing practice evidence base for the effectiveness of this technique for a variety of clinical problems. But there are also interesting, albeit limited research studies that highlight the potential of EMDR to effectively treat people with personality disorders[25] and sexual abusers of children who have themselves been abuse victims[26].

More generally it has been widely recognised that there is:

> *A lack of adequate expertise and resources in prisons in the treatment of primary mental health problems, especially in relation to counselling and psychological therapies[27].*

Therapy and counselling services in our prisons are currently provided on an ad hoc basis by means of a number of disparate organisations, some, but not all, of which are linked to various charities and quasi-professional bodies. Services are not standardised or co-ordinated. Treatments are often delivered without any structured approach to the effective co-ordination of interventions with psychology or healthcare departments. Treatment provision varies widely, as do the skills base of practitioners and the level of supervision.

The Whatton Counselling Psychology Service model demonstrates how talking therapy services can be provided effectively and safely in prisons, employing a combination of qualified mental health practitioners such as Counselling Psychologists and Counsellors.

The co-ordinated structure provides a broad range of treatments and sets appropriate standards of care and intervention. It also provides effective, high-quality supervision and support for practitioners in a very challenging environment. Applied to other general and specialist establishments on a wider basis, such a model offers a number of advantages. These include providing a coherent link between psychological offender treatment programmes and the clinical needs of prisoners, and putting talking therapy interventions across the prison estate onto a more ethical, standardised and properly supervised footing. Such a model has the potential to contribute significantly to the ultimate goal of the prison regime, to help prisoners become more effective citizens and break repeat patterns of offending behaviour for good.

25. Brown, S, and Shapiro, F (2006) EMDR in the Treatment of Borderline Personality Disorder, *Clinical Case Studies*, Vol. 5, No. 5, 403-420.
26. Ricci, R, Clayton, C, and Shapiro, F (2006) Some effects of EMDR on previously abused child molesters: Theoretical reviews and preliminary findings, *The Journal of Forensic Psychiatry and Psychology*, Vol. 17, No. 4, 538-562.
27. Nottinghamshire Healthcare NHS Trust, Offender Health Directorate *Primary Mental Healthcare Service Model*, October 2012.