European Court of Human Rights. In April last year, the court found that his care and treatment in prison amounted to inhuman and degrading treatment. In particular, prison and health staff had failed to keep proper notes of his care and did not take into account the effect on his mental state of subjecting him to disciplinary measures and segregation. A prison doctor, unqualified in psychiatry, had also changed his medication without reference to anyone else.

The court found that the Prison Service had failed to take into account the mental health status of Mr Keenan when deciding how to treat him while he was in their care. Actions which may have been standard practice for a prisoner without a severe mental illness, were found to be inhuman and degrading when applied to Mr Keenan, a person with a history of severe mental illness.

However, from our vantage point within mental health, it appears that a great deal more can be done to harness the knowledge and skills available from within the voluntary sector. We support the recommendations made in the HM Prison Report on working with the voluntary and community sector.[14]

For more information on schizophrenia, visit the Rethink severe mental illness website at: www.nsf.org.uk. For more information on the organisation and the services it has to offer, contact: Dick Frak, Director of Service Development, Rethink, 30 Tabernacle Street, London EC2A 4DD. Tel: 020 7330 9100. Fax: 020 7330 9132. Email: dickf@ops.nsf.org.uk.

14. *Getting it Right Together: working with the voluntary and community sector: A Strategic Framework*, HM Prison Service, December 2001.

Working Positively and Productively in a DSPD Unit

Len Bowers, *Professor of Psychiatric Nursing City University and* **Paola Carr-Walker**, *Research Assistant City University.*

People with personality disorder (PD), whether they crop up in our professional or personal lives, are notoriously difficult to like, care for, or manage. It is no exaggeration to say that overall, there are entrenched negative attitudes towards them within most psychiatric services and professions. In outpatient psychiatry this can often mean that the person with PD is discharged at the earliest opportunity, or held at arm's length and seen as infrequently as possible. Should they become inpatients in acute psychiatric wards, they may be ignored or avoided by staff. They are far from the most popular group of patients in forensic psychiatric services, although there are specialist wards within the High Security Hospitals for PD patients. In every psychiatric setting there are some who refuse to accept PD people into care on the grounds that they are not treatable.

Because of their PD, such individuals often come into conflict with the law and turn up in prison. Staff working in the Prison Service, in getting to know them over a period of time, can clearly recognise that they are not psychologically 'right'. Yet securing treatment for them can be difficult or impossible, especially when psychiatric services seek to keep them out at every turn, partly because of the feelings of helplessness they cause in carers. It is because PD offenders do not seem to fit anywhere, or get what they need in terms of treatment and management, that the new DSPD services are being created.

There are many reasons why PD prisoners are disliked and unpopular. They behave in the difficult ways that many prisoners do, only more intensively, frequently, and constantly. For example, they engage in bullying of other weaker prisoners or of staff. This can involve anything from constant nagging demands, through arguing to the point that black turns into white, to hectoring, threats, or actual physical violence perpetrated by themselves or others at their behest. Nor is such aggression always directed towards any sensible

goal. Instead it may confusingly be turned upon friends, allies, and those who have made the greatest efforts to help or assist. PD prisoners can be highly manipulative, arranging through careful lies to place staff in a bad light.

They will use alternative sources of power, such as official complaints procedures or the legal system to subvert the staffs' control over them, and they may use threats of doing this in order to try to intimidate staff. Alternatively, they may seek to build up a 'special' relationship with a member of staff, using flattery and the sharing of personal secrets, only to then seek to use that relationship as a lever to secure what they want. Finally, they are highly skilled at causing trouble and sowing dissension, both between other prisoners and between different members of the staff team, or between different professions, or between staff and their managers. In many respects they are a nightmare to treat and manage.

Yet some people cope with working with PD individuals, and cope well over long periods of time, whilst other staff do not enjoy the work at all, or become hostile and angry towards those in their care. In the first piece of research we carried out on this topic we tried to discover what made the difference between whether a person managed to maintain a positive attitude or not. In order to get an answer to that question, we sent a questionnaire to all the psychiatric nurses working in the High Security Psychiatric Hospitals asking about their feelings towards PD patients. From this we discovered that staff attitudes to PD had five components:

- enjoyment or loathing;
- a sense of security or vulnerability;
- acceptance or rejection;
- a sense of purpose or futility; and,
- feelings of enthusiasm or exhaustion.

We then interviewed 121 nurses, half of them working on specialist PD wards, about PD patients and their care. We rated those interviews as to how much they showed that the nurse concerned enjoyed working with PD patients was secure, accepting, etc. Then we inspected the interviews to find out how the more positive nurses thought or acted differently so as to maintain that positive attitude.

We found that several things had a relationship to overall attitude to PD patients. These included the organisational system (the operations of the complaints system, multi-disciplinary relationships, management methods etc.) and aspects of the individual nurse. For the nurse, what influenced attitude to PD was their:

- beliefs (for example, on the cause of PD);
- knowledge (for example, psychological understanding and models of PD behaviour);
- moral commitments (for example, to nursing professionalism, non-judgementalism, individualism);
- who they identified with (for example, patient or victim); and,
- the self management methods they use to contain their emotional reactions to patients.

These self management methods were of particular interest, and included: appeal to a higher morality (for example, prevention, illness, humanism); reminding oneself of the patient's abuse history; ideology of individualised care; using clinical supervision for ventilation; and others. We also discovered that nurses with a negative attitude tended to be badly affected by the work, which harmed them psychologically and socially; whereas those with a positive attitude tended to make gains in self-awareness, self-confidence and assertiveness[1].

A special unit for Dangerous and Severely Personality Disordered (DSPD) was opened at HMP Whitemoor two years ago, and another purpose-built DSPD unit at HMP Frankland is under development. Since September 2001, we have been trying to find out whether it is possible to predict in advance who will be able to adjust well to working with DSPD prisoners, and who will experience difficulties. In order to establish this, we have interviewed and given questionnaires to everyone working in the Whitemoor unit, and will now be following those individuals up for the next 18 months to see how their attitudes to prisoners, and interactions with them, develop and change. We will be comparing this with the measures we took at the outset to see whether they can be used in the future selection of staff to work on DSPD units. We are anticipating that there will be some positive and some negative effects on staff attitudes over the 18 months of the study, and we will also look into how these compare to results from staff at the High Security Psychiatric Hospitals described above.

So far, we have interviewed prison staff and used questionnaires to learn about their attitudes towards PD prisoners. We used the Staff Attitude to Personality Disorder Interview (SAPDI) which measures overall attitude to PD as well as the beliefs, knowledge, moral commitments, cognitive self-management methods and skills underlying that attitude. The Attitude to Personality Disorder Questionnaire (APDQ) was used with the prison staff as a co-measure of overall attitude to personality disorder. Both the SAPDI and APDQ were developed and used in the study described above conducted in High Security Psychiatric Hospitals. We found that prison officers and nurses had a great deal

1. Findings of the research is given in *Dangerous and Severe Personality Disorder: Response and Role of the Psychiatric Team* by Len Bowers, Routledge, London (2000).

in common in the ways in which they thought about such things as the crimes of those they cared for, or the challenging behaviours of PD people. There were also differences, with prison officers sometimes mentioning things that nurses in the previous study had not, and vice versa.

We also measured staff's general well-being and personality characteristics. The first set of results has found that collectively the prison staff expressed enjoyment, a sense of security, acceptance, purpose and enthusiasm when working with prisoners on the DSPD unit. Generally, these components were felt more strongly with prison staff than with the nurses in the High Security Psychiatric hospitals. The results showed the trend of prison staff whose personality profile indicated they were more open to different experiences was to express more feelings of enjoyment and have a more positive attitude when working with PD prisoners. We also found that those staff members with better feelings of general well-being had a more positive attitude to prisoners with PD.

On our recent visits, taking place between six and nine months after the initial start of our study, we are looking for changes in attitudes towards PD prisoners; carrying out observations of the prison staff when in association with prisoners; measuring staff perception: of management style; and asking staff to rate themselves on behaviour traits that are deemed characteristic of prison officers. The DSPD unit prison staff have participated enthusiastically in this study and with interest.

Our feedback to the staff is keenly anticipated for the next stage and findings so far have been well received. We very much appreciate all the help and kindness that the DSPD unit staff have shown us over the past few months during our time spent at HMP Whitemoor.

Staff Development in Personality Disorder Services

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The issue of Personality Disorder is one that has been the subject of much media interest and scrutiny over the last few years; much of this focused on Ashworth Hospital where a judicial inquiry (The Fallon Report) into the management of the PD service was undertaken. Although people with a Personality Disorder are only a small proportion of the population of prisons and high secure mental health services they do attract a disproportionate level of scrutiny.

The report into the PD service at Ashworth identified that

'About ten per cent of the population have a personality disorder but they do not necessarily become offenders or find themselves in psychiatric care, although they often suffer from illness, alcohol or drug problems, and often visit family doctors. It is also reported that two to three per cent of the general population have an anti-social personality disorder and they are more likely to be found in prison populations and before the courts'

(DoH 1999: The Fallon Report).

High profile cases such as the Michael Stone case also raised media and political interest which has resulted in proposals to develop strategies and services to manage dangerous people with severe personality disorder (Home Office 1999, 2000). One of the main outcomes of the strategy was the provision of 320 new specialist secure places for people with DSPD, 140 places in the NHS in new high secure accommodation and 180 places in refurbished or new provision in the Prison Service.

The strategy is being developed and implemented through a number of projects. The projects are joint initiatives between the Home Office, the Prison Service and the Department of Health. There are nine projects currently working towards a target of development and implementation by 2004:

One of these projects is Human Resources and Training, which attempts to address the needs of staff working with this group. The Human Resource and Training Advisory Group was been established to:

- identify the HR and Training requirements for the DSPD assessment and treatment pilots;