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Working with people with personality disorder

From Management to Treatment:

Changing and Maintaining a Therapeutic Culture in a High Secure Prison

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Fallon's recommendations were for the creation of hybrid services as the culture of neither hospital nor prison was right for the psychopathology of people with severe personality disorder.[1] Four specialist services were established; two in hospital and two in prison. This paper describes our efforts to create and sustain a hybrid culture within a high secure prison.

Context

HMP Whitemoor's Fens Offenders with Personality Disorder Pathway Service was the first of the four inaugural Dangerous and Severe Personality Disorder (DSPD) developments to become operational, admitting its first prisoners onto an adapted prison wing in 2000.

National emphasis was on assessment and research with little thought to treatment. This resulted in several groups of patient/prisoners completing assessment but unable to access therapy. While clinicians provided assessment and consultancy, prison officers focused on developing relationships with prisoners and successfully delivered structured groups. Visiting senior clinicians offered tentative but often conflicting ideas about potential interventions, but made no effort to establish treatment. Only 'well-behaved' patient/prisoners were allowed to remain in the service, resulting in many being ejected for presenting with the very behaviours associated with their diagnoses.

In 2003 senior clinicial staff who were experienced in developing services for people with personality disorder were appointed to work solely within the service. The explicit challenge for these staff was to continue to assess patient/prisoners while developing a treatment model for a clinical population who were already in situ. The real challenge, which was implicit, was for this clinical model to be delivered within a high secure prison and for the clinical staff to find a way to work in partnership with operational staff without compromising either the security of the prison or the therapeutic integrity needed for effective treatment.

Difficulties in achieving and sustaining cultural change

Culture has been described as the 'personality' of an institution[2] or simply 'the learned and shared behaviour of a community of interacting human beings.'[3] Fox (2010) noted that HMP Whitemoor's culture at the inception of the Fens Service was still affected by the escape of six prisoners from its Special Secure Unit in 1994. In the aftermath, the prison was severely criticised for its failure to provide secure containment by adhering strictly to written security procedures and regulations. There were some merits in adopting this stance as *'HMP Whitemoor became an exemplary high security prison with a clear understanding of its primary task.'*[4] The opening of the Fens Service in 2000 was therefore extremely challenging as the staff were presented with a second imperative: to effectively treat prisoners with a diagnosable mental health problem. It was therefore inevitable that some cultural change would be demanded if a treatment service was to flourish within an environment preoccupied with security.

Organisational culture is notoriously resistant to change. Kim and Mauborgne (2004) identify four factors contributing to resistance to change; lack of understanding of why change is needed, recognition that change will involve a shift in resources or power, 'institutional politics' and lack of personal motivation for change.

Collective resistance to change within an organisation originates with lack of personal motivation to change which later mobilises into collective resistance.[5] Lack of personal motivation to change includes a number of factors: loss of

1. Fallon, P., Bluglass, R., Edwards, B., et al (1999) Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital (vol. 1) (Cm 4194, II). London: Stationery Office.
2. Kane-Urrabazo, C. (2006), Management's role in shaping organizational culture. *Journal of Nursing Management, 14: 188–194*.
3. Useem, J., & Useem, R. (1963). *Human Organizations*, 22(3) p. 169.
4. Fox, S., (2010) The Role of the Prison Officer (Dangerous and Severe Personality Disorder in the Prison System). In N.Murphy & D. McVey (Eds) *Treating Personality Disorder*. Routledge pp. 378-409.
5. Quinn, RE (1996) *Deep Change: Discovering the leader within*. San Francisco: Jossey Bass.

familiarity, fear of losing their job, learning new procedures, failing at the task or being mistrustful of the process.[6] Fox (2010) identifies further anxieties contributing to lack of motivation to change within prison officers; fear of deskilling, the perception that specialists will treat prisoners more favourably than they themselves are treated and that creating a treatment milieu will compromise security. When considering the survival or demise of specialist units within the prison service, Fox noted that these factors were significant both in terms of establishing a counter-culture and also in whether an alternative culture could become the dominant culture.[7]

A framework for achieving and sustaining cultural change

Instilling Belief

The clinical staff leading this service had a strong track record of developing successful services for the treatment of personality disorder. They knew that with the right interventions and a well-trained committed staff group successful treatment was possible. Part of the culture change would be to instill this belief in the broader staff group who were at best confused and at worst cynical about the potential success of therapy with this client group. The treatment model had to have a strong evidence base and be accessible to non-clinicians. Covey (1991) documents the importance of managers being seen as 'trustworthy'. Managers can be honest with their staff but need to also be deemed to be competent or they will not be considered trustworthy.[8] The level of trust in an organisation predicts its success because it is a crucial link to employee performance and commitment which is essential for culture change.[9]

Protecting Staff and Patients/Prisoners

Cultural change cannot be wrought from the top down by simple exhortation. Successful strategies need to take into account the needs, fears, and motivations of staff at all levels. Staff also faced significant challenges such as inadequate training and unrewarding but highly demanding clients who are difficult to see as vulnerable and who have the propensity to make the staff feel vulnerable or traumatised.[10] These dynamics can bring about hostility and/or collusive relationships and the risk of staff/patient boundary breeches is high. Thus attempts to influence key cultural dimensions had to achieve this through an assemblage of mutually reinforcing development activities, including training, supervision and the involvement of staff in all levels of the running of the service.

Providing a Safe Structure

Culture cannot be tackled in isolation from such issues as organisational structure, financial arrangements, lines of accountability, strategy formulation or human resource management.[11]

The team were also aware that services for people with personality disorder often drew controversy, were in conflict with host organisations, became isolated and were subject to public enquiries. It was therefore essential that governance structures supported effective inter- and intra-multiagency relationships and communication.

Changing From Management To Treatment

The prevailing culture was one of prisoner mangement. Prison officers manage prisoners with personality disorder very well.[12] There is however a dichotomy between treatment and management, with management often being mistaken for treatment. Managing patient/prisoners relies on containing the symptoms of their distress/disorder but does little to treat the underlying problems. Treatment requires staff to be able to treat the underlying causes of dysfunctional behaviour. Thus, one of the key aims was to distinguish between management of the prisoners' behaviours (which may bring about temporary inhibition of symptoms) and the treatment of the underlying psychopathology which addresses the need to engage in such behaviours and bring about more enduring change. It was however vital that the clinical team acknowledged the need for safe behavioural management if security was to be effectively maintained. The treatment model was therefore designed to provide treatment whilst allowing for occasions when management may take priority.

6. Oreg, S. (2006). Personality, context, and resistance to *organizational change. European Journal of Work and Organizational Psychology, 15*, 73-101.
7. See footnote 4.
8. Covey S.R. (1991) Principle-centred Leadership. Simon & Schuster, New York.
9. Laschinger H.K., Finegan J., Shamian J.A. & Casier S. (2000) Organizational trust and empowerment in restructured healthcare settings: effects on staff nurse commitment. *Journal of Nursing Administration 30 (9), 413–425*.
10. Murphy, N & McVey D (2010) The difficulties that staff experience in treating individuals with personality disorder. In N. Murphy & D. McVey (Eds) *Treating Personality Disorder.* Routledge p6-33.
11. Nutley, S. and Webb, J. (2000) Evidence and the Policy Process, in H. T. O. Davies, S. M. Nutley and P. Smith (eds.) *What Works? Evidence-Based Policy and Practice in Public Services. Bristol: Policy Press*.
12. Bowers, L. (2002) The right people for the job: Choosing staff that will adjust positively and productively to working in the new personality disorder services. *Feedback Report, November 2002*. London: City University (St Bartholomew School of Nursing and Midwifery). Bowers, L. (2006), On conflict, containment and the relationship between them. Nursing Inquiry, 13: 172–180.

Treatment Model

For staff to deliver a cohesive therapeutic experience it was essential that they operated within the same theoretical model. The treatment model was devised by the senior clinical staff and drew on the best available evidence regarding the treatment of personality disorder. This model was subject to the scrutiny of an international panel, expert in the field of personality disorder; thus lending it credibility.

The cognitive interpersonal model adopted explicity addressed the prominent domains of the disorder; maladaptive cognitions, affect processing, and interpersonal behaviour, as well as addressing both trauma and offending. The model was sufficiently complex and had sufficient 'face validity' to convince sceptical operational staff that the senior clinicans had the appropriate clinical expertise to act with authority in relation to treatment.

All staff on the unit received training that enabled them to understand the individual components and sequencing of treatment. Teaching staff the model enabled them to have an understanding of how human beings develop, and they were able to apply this model to themselves and enhance self-awareness. This meant the model had some personal relevance and was easier to understand and retain.

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Multiple interventions were offered within the treatment framework; one being schema-focused therapy. Prisoners each had their own schema plan[13] which was devised to support staff in managing the prisoner and their own response to the prisoner's more challenging presentations.

The role of non-psychologists in contributing to treatment was made explicit; thus operational staff learned that building relationships with prisoners in assessment was going to be crucial in containing these men in treatment. The operational staff who co-facillitated groups learned that their role was not solely safeguarding the physical security of the group but also the relational security that enabled them to make effective therapeutic interventions.

Reporting on Succeses

With these clients change is slow and often the focus is on negative rather than positive behaviours. Staff can become demoralised and belief in the therapy and the service managers can wane. Internal and external research is an integral part of the service and managers ensured that all results were communicated orally and in writing to all staff. As these were often positive this boosted staff morale as well as providing validation that the treatment was working.[14]

Also, as reseach can take time to complete, any positive comments or changes that were noted were communicated to staff. The most encouraging of these were from senior members of NOMS visiting the service who had previous experience of some of the most difficult patient/prisoners and who saw the positive changes that these men had already made.

Protecting staff and patients/prisoners

Therapeutic Milieu

In those with such severe psychopathology, every opportunity needs to be utilised to bring about real change. The majority of the prisoners' time is spent with the operational staff and each other. As Zimbardo's work has demonstrated situations where one group has power over another, without a healthy positive ideology, even good people can behave in punitive ways towards those perceived as subordinates.[15] Equally when one person is frightened of another collusive behaviours can develop to reduce the fear. Both these responses are highly likely when working with this client group; both are equally destructive to the therapeutic process.

Treatment had to be an ongoing process and not limited to interventions delivered in groups or in individual therapy; the aim was to develop a therapeutic milieu. It was therefore crucial that the operational staff were motivated and committed to the treatment model. It was essential to create the culture that was needed in addition to focusing on what to do, to communicate why it was important to do it that way. This was achieved through various strategies that worked synergistically; primarily teaching and training, supervision, individual and group, and developing a transdisciplinary approach.

Training

A significant amount of time was devoted to training the team, demonstrating how the treatment model would address the needs of the staff, patient/prisoners and the public. The teaching was

13. Murphy, N. & McVey, D (2001) Nursing personality disordered in-patients – a schema focused approach. Brit. J. of Forensic Practice, Vol 13, N4 pp8-15.
14. Saradjian,J., Murphy, N., & Casey H., (2010) Report on the first cohort of prisoners that completed treatment in the Fens Unit, Dangerous and Severe Personality Disorder Unit at HMP Whitemoor. *Prison Service Journal, 192, November 2010, pp.45-54*.
15. Haney, C., Banks, W. C., & Zimbardo, P. G. (1973) A study of prisoners and guards in a simulated prison. *Naval Research Review, 30,* 4-17.

delivered in a manner that allowed for discussion and did not leave operational staff believing that their professional identity was under threat. Clinical staff were trained in security issues by the operational team and at times both teams had joint training from external providers. These joint experiences of learning from each other enabled each to feel they had expertise to share. These processes were essential in bringing about a sense of shared purpose and in preserving personal value.

Supervision

Supervision has served several roles, including supporting the growth of the team, protecting it from the interpersonal risks associated with this population and exposing it to the experience of the treatment model.[16] Thus the supervision model reflects the treatment approach and is delivered both in the group and individually. Initially it was difficult for operational staff to see clinical supervision as supportive rather than as a means of assessing their performance, so clinical supervision was initially resisted by many. Several strategies were employed to change that perception. Initially, a series of experiential training sessions in being a supervisor and supervisee were organised. This was followed by training experienced officers who were knowledgeable about the theoretical model as supervisors.

The same integrity was applied to supervision as to delivering therapy; thus staff could depend upon receiving supervision (on the whole) at the identical time, in the same room and with the same frequency. Every member of staff, including the most experienced senior staff received supervision. Frequently officers would find themselves in group supervision alongside a senior clinican. Supervision often focused on an individual's internal world and how they could be acting out their own issues. As the senior team member was open about such issues, this was one of the most powerful ways to change the attitude of operational staff to supervision. After two or three years operational staff began to see supervision as an essential component of the work and not as an 'added extra'.

Reviewing Critical Incidents

When incidents occurred, an inquisitorial rather than adversarial analysis was undertaken and any lessons that could be learned were communicated and implemented. This enabled both patients/prisoners and staff to be honest and believe that their managers would and could keep them safe.

Providing a safe structure

Developing a Transdisciplianary Approach: The Key to Culture Change in The Fens Service

NHS guidance is unequivical about the importance of teamworking when treating people with personality disorder but it is less specific about how such teams should work effectively together. The management therefore decided that the most effective way to achieve and sustain cultural change was to use a transdisciplinary rather than a multidisciplinary approach.[17]

A transdisciplinary approach to teamwork involves each discipline having a clear role and its own unique contribution towards treatment but with integrated aims, objectives and philosophy. A transdisciplinary team is one in which members come together from the beginning to jointly communicate, exchange ideas and work together to generate solutions to problems. A multidisciplinary team uses their individual expertise to work autonomously to formulate a solution and where each expert makes its distinct contribution. A transdisciplinary team allows members to contribute their own knowledge and expertise, and to share ideas from the beginning to create a total care plan within a consistent shared theoretical model.[18]

Every aspect of the service other than basic prison duties and individual therapy is designed to be carried out jointly by clinical and operational staff. Clinical staff are made aware of the importance of security and their role in maintaining a safe environment and officers are prominent figures in the referral, assessment and treatment of prisoners. Officers are co-facillitators in group work and part of Care Programme Approach (CPA) Planning and Review meetings, and clinical staff spend time supporting prisoners on the landings outside of formal clinical settings.

Clinical staff are required to attend all debriefs following shifts in which they hand over the themes of their sessions, particularly any areas which need to be followed up by other staff. Operational staff share their observation and interactions with patients/prisoners, including contributing to CPA documentation. Significant effort is devoted by managers of the service to synthesising the contributions made by two very different staff groups. Operational staff learn that their interactions with prisoners have real potency and that their inclusion in treatment is not tokenistic. Over time briefings have evolved to include specific reference to 'offence paralleling' including sexualised or flirtatious interactions

16. Sneath, E., (2010) Issues and Challenges for the Clinical Professional. In N.Murphy & D. McVey (Eds) *Treating Personality Disorder. Routledge. P. 468-498*.
17. Murphy, N.,(2010) Effective Transdisciplinary Teamworking. In N.Murphy & D. McVey (Eds) Treating Personality Disorder. Routledge. P.264-304.
18. Choi B.C, Pak, A.W. (2006) Multidisciplinarity, interdisciplinarity and transdisciplinarity in health research, services, education and policy: 1. Definitions, objectives, and evidence of effectiveness. Clin Invest Med. 29(6):351-64.

or behaviour that may be reminiscent of addictive behaviour. Clinicians have offices on the wing and as such are ever present. Thus all staff; clinical and operational have the opportunity to develop through role modelling.

All organised service meetings consist of both operational and clinical staff, and whenever possible managers have empowered staff by the involvement of all staff in in high status activities such as teaching, training, presentations to visitors and at conferences and by being fair about the assignment of such tasks. This joint approach reflects the importance of achieving a balance between security and therapy when working with these clients.

Governance

Governance is the act of affecting and monitoring (through policy) the long-term strategy and direction of a service. It comprises the processes that determine how power is exercised, how those involved are given a voice and how decisions are made. Part of this is to manage relationships between the various partner agencies at all levels effectively and with integrity, to enhance performance. That performance needs to be effectively assessed, monitored and measured and the findings used to influence the strategy and future direction of the service.

This requires an infrastructure that sustains successful service-wide transformation. Thus all decisions that impact on any aspect of the functioning of the service must be made within the meeting structure and process. Decisions made outside of meetings will result in chaos, poor leadership, negativity and a sense of disempowerment in staff. It is also essential that the service has strongly defined agreements with host and partner agencies that will protect it against the vicissitudes of changing managers within the service or these agencies.

From the outset of the development of The Fens Service the managers have made a concerted effort to develop a solid governance framework that has enabled involvement of and communication with all staff. The structure of The Fens Service Governance is detailed in Figure 1.

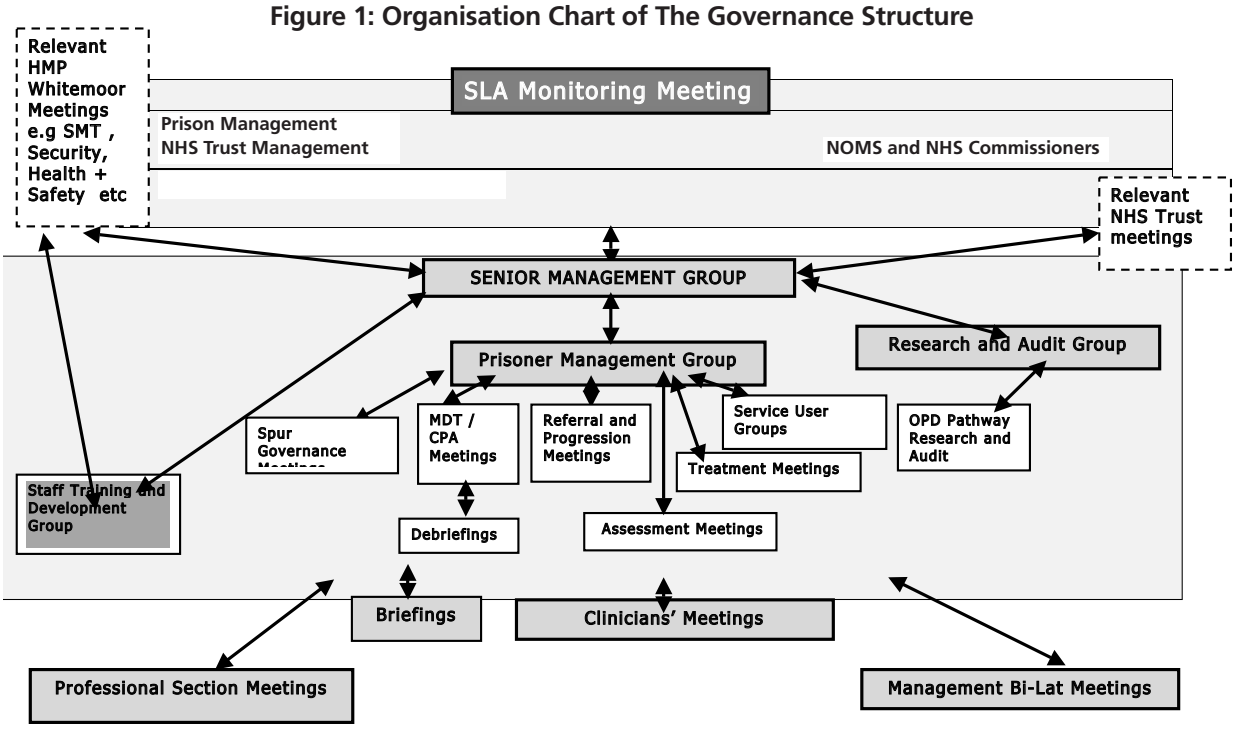
Operational Policy

The operational model for a service is a written agreed outline of every aspect of the service's functioning which directs the reader to the policies and other documents that govern the service. This document is issued on induction to every member of the staff team *(Figure 1 below)*.

Struggles

It would be misleading to imply that this process has not come at a cost. Operational staff in the service have had to suffer taunts from colleagues elsewhere in the prison such as being called 'care bears'. They have struggled with role conflict 'are they officers or therapists?' Many had personal crises recognising that the trauma of prisoners reflected their own; this issue was also pertinent for clinical staff. Some clinical staff struggled with sharing clinical information with operational staff. Some also found it difficult being based on the wing and having no escape from the

Figure 1: Organisation Chart of The Governance Structure



therapy environment. Senior managers spent an inordinate amount of time over and above standard hours with staff and prisoners, including coming in weekends when serious events occurred. Staff were highly appreciate of these efforts and responded with increased performance.

Protecting the culture

Kane-Urrabazo (2006)[19] highlights four factors pertinent to managers which are significant in maintaining culture: trust and trustworthiness; empowerment and delegation; consistency and mentorship. Managers at all levels need to be aware of their roles in upholding positive workplace cultures and increasing employee satisfaction, as dissatisfaction is a major cause of staff turnover and damage to therapeutic relationships. Managers need to be aware that they are always under scrutiny by subordinates. In a service such as The Fens where the managers are in constant connection with the broader staff team, the responsibility is even greater. It is vital therefore that they are honest, open and demonstrate their competence but also that they own up to the mistakes that they will inevitably make.

The Fens Service empowers staff of all disciplines by ensuring they are included in decision making processes, valuing them and always being prepared to acknowledge both formally and informally their good work and support those who have had a stressful experience. Clinical and operational managers will often stay if there is an incident, not to necessarily intervene but to support and value the staff. Staff who are supported have a greater sense of self worth and are more able to adhere to therapeutic strategies and support the patient/prisoners.

Adhering to a shared theoretical model, shared governance and operational policy ensures consistency. In The Fens attention has been given to maintaining the integrity of these processes, presented as senior staff 'policing' the broader staff group. McCormack (1984) argues that responsive management guarantees greater consistency, though consistency does not preclude flexibility. Flexibility is needed when it is clear that a policy is not fit for purpose and may need revision.[20]

In addition to managers and systems, the key carrier of the culture is the broader staff group. An integral contribution towards maintaining the culture is played by mentoring. The Fens Service has both a staff mentoring policy and a patient/prisoner mentoring/support scheme. New staff members and patient/prisoners are inducted into the service and then supported by their mentors. Warren (2005) suggests that mentoring helps to generate loyalty and establish emotional ties to the service.[21] The quality of the mentors however is crucial in the success of this strategy and its efficacy in maintaining a positive culture.

The Future

Since the nascent stages of the government's 'DSPD' initiative and their push to develop treatment services for this population, completed research has indicated the need for a strategic review. Commissioners agreed that the most effective way forward was to de-commission the hospital sites and invest in services delivered jointly by NHS and NOMS. This has resulted in the commissioning of the Offender Personality Disorder Pathway. The implications for the Fens Service is that it will continue to provide assessment and treatment to prisoners with this complex disorder. The Fens service is not a finished product and continues to face the challenges of maintaining and developing a therapeutic service within a high secure prison.

19. See footnote 2.
20. McCormack M.H. (1984) What they Don't Teach you at Harvard Business School: Notes from a Street-smart Executive. Bantam Books, New York, USA.
21. Warren C. (2005) Mentor me this. American Way 28, 30–31.