

**MANAGING**

**TO BE A**

**CLINICALLY EFFECTIVE**

**THERAPEUTIC COMMUNITY**

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## **PREFACE**

My interest in choosing the theme of this dissertation arises from my previous experience of working in a Therapeutic Community. It also brings together my experience of clinical work with this challenging client group, experience as a manager developing a previous service and my current role of developing a new service replicating an existing model. As Lead Nurse I have had an integral role in the recruitment and development of staff in understanding communicating and implementing the Henderson Hospital model.

The intention of the dissertation is to enable me to understand the complexities of the model more clearly and share this knowledge with the staff team. This is intended to enable the service to develop more effectively with more comprehensive knowledge of the model in practice. Holding a clinical and managerial role I need to take a perspective that encapsulates both perspectives – utilising appropriate clinical experience and management styles which enable improvement of the clinical service. I have also drawn on my observations of the difficulties within the service and sought possible solutions through new knowledge of the model and management approaches to facilitate improvements. This is a critical approach rather than a criticism of staff who I believe have worked well in developing the service.

I would acknowledge and thank Henderson Hospital staff for their contribution and support in carrying out the study, the support from Craig Fees and the Planned Environment Trust and staff from the Therapeutic Community Service for inspirations and motivation.

## **ABSTRACT**

The Therapeutic Community Service is part of a national development of Therapeutic Communities within the NHS. Main House in Birmingham is a residential unit within the Service replicating the treatment model devised at Henderson Hospital over the last 50 years. Henderson Hospital (HH) is one of a number of Therapeutic Communities (TCs) with similar philosophies, treatment models, structures and potential treatment groups. The Therapeutic Community Service (TCS) is funded specifically to replicate the Henderson model and its initial funding is dependent on that verification through independent research.

This dissertation was an exploration to identify the key elements and aspects of the model in order to enable a more effective service at Main House (MH). The aims included understanding the model through the literature and key processes that were not described in literature. I also aimed to identify management approaches to facilitate effective change. These included leadership, organizational learning, change and motivation. This would support the replication of the model; increase staffs understanding of the model; enable understanding of the role of staff and residents in developing the culture; ensure clinical effectiveness within the developing TC and de-mystify the practice of TC working. In applying the learning to Main House the TC would be enabled to grow and ultimately secure the longer term funding of the service.

The study method involved searching the literature to describe the model and how it has evolved. This was supplemented by interviews with Key Informants and Groups to identify the unwritten aspects of the model. This sought to identify the subtleties of the therapeutic process that are harder to describe and the unchanging essence of the model irrespective of

changes to the clinical programme. The sample interviewed were long-standing and newer members of HH staff and the Replication group, which included senior staff from HH and Main House.

The analysis showed that the model had evolved through charismatic leaders who provided continuity as well as change. There was recognition its history and foundations and evolution and clarity of the model. The flattening of the traditional hierarchy was fundamental but leaders and staff did not give up their authority. Transformational processes of leadership, motivation learning and change were essential for individual and organisation development. Effective change must take account of power relationships within the team, understanding individual needs and utilise organisational ‘unfreezing’. HH staff has a shared aim and know they effectively hold the culture. HH staff also recognises that therapy is about residents having an experience of ‘being’; that staff take up to two years to understand their role, way of working, voice and skills and all with the help of their more experienced colleagues in a learning organisation.

Conclusions from the study include that Main House staff need to build on the development of the model by embracing the clarified model in practice. This means working more effectively as a team within a learning organisation. This includes sharing experience, accepting and working with conflict and having a common aim, understanding the implications of ‘being’ within the therapeutic approach, holding the culture and recognising the essence of socialisation to therapeutic change. The study showed that leaders must hold their responsibility within a flattened hierarchy. This enables staff to process difficult experiences and provides containment. Leaders must also define the organisational culture and work with the organisational and individual resistances to

learning and change. This will provide the environment to keep the organisation transforming its experience and creating a more effective Therapeutic Community.

## INTRODUCTION

The Therapeutic Community Service (TCS) within South Birmingham Mental Health Trust is funded directly from Department of Health (DoH) through their civil servants, the National Specialist Commissioning Advisory Group (NCSAG). New funding was made available to develop two new Therapeutic Communities and Outreach services based on the model developed within Henderson Hospital, now part of South West London and St George's NHS Trust. One of the new services is Main House, the residential Therapeutic Community (TC), where the research study is based. The key aspect of funding was to replicate the residential Therapeutic Community (TC). This dissertation examines the model and identifies key themes that will ensure an effective replication of the model.

### Henderson Hospital and its effectiveness

Henderson Hospital (HH) has a 50-year history of developing a psycho-social treatment for people with severe and enduring emotional, behavioural and relationship difficulties or more commonly labelled personality disorders (PD). TC treatment was seen as one of few effective ways of treating people with PD (Reed Report 1993). The therapeutic approach uses a 24-hour residential setting to encourage residents to engage in relationships, to learn about their maladaptive coping mechanisms and develop alternative strategies through feedback in the 'living-learning' environment. The group therapies and living together provides what was described as a 'crash course in living' (Whitley 1980). HH has research evidence demonstrating a clinically and cost effective therapy and service (Dolan and Coid, 1993; Copas et al, 1984; Dolan et al, 1996; Dolan et al, 1992). Funding for two new services was provided, initially for three years, to further research the model and evaluate the clinical and cost-effectiveness of the approach.

During the setting up of the new service and the training that was developed for the new staff team there are many clear indicators from HH about the structure and principles of the model. Some of the more subtle aspects of the model, however, have been difficult to be understood. Within the predominantly verbal model much of the dynamic processes have not been recorded and these are harder to transplant into the new services. Clearer understanding will enable staff to more closely replicate the dynamic processes of the model and culture.

### Expansion and Developing New services

The funding for the new services originated from the Reed Committee report (1994) which identified the need to expand services for those people with severe personality disorders. HH was identified in the report as one of a few effective services to treat this population.

Main House became operational in September 2000 after a significant period of staff and service development. The recruitment of staff brought together a clinical team with motivation to work within the principles of the model but with few staff with direct HH experience and a minority of newly recruited staff with TC experience. The Henderson Development Team (HDT), consisting of staff from HH and volunteers who have been residents of the Unit, provided information, support and supervision in the development of the new TCs. Each new staff member had a weeklong placement at HH to observe and experience the model and a training course developed with the support of an Educational Consultant and delivered by the HDT. The weeklong training course taught theories, principles and methods of the HH model (HDT, 1999).

The Replication group, consisting of the Clinical Directors and Lead Nurses from the three services, sought to understand what replication meant in principle and to actually replicate the model in the new services that were evolving.

#### The management issues being considered

NSCAG are seeking replication of the existing model that demonstrates a clear evidence base and outcomes of clinical effectiveness. Replication provides clarity of direction, assimilation of HH structures and cultures that are creative, innovative and experimental in a dynamic and constantly changing therapeutic environment. Replication would also assume that an effective model is in place. TCS needs to provide an effective psychological containment allowing for some self-harming or destructive behaviour to be acknowledged, while giving the therapeutic opportunity to think about and learn from them. The HH culture has this. The structures of the model can be presented, though much of the culture of the model is carried through the staff and is not defined or easy to define.

It has been challenging for a new staff team to work in a new organisation with a model that is unfamiliar to them. Unlike at HH, where a new staff member joins an experienced team and working model, TCS recruited a new workforce in a few months. Many of the highly motivated staff recruited had limited knowledge of the HH model and held competing and conflicting ideologies and interpretations of the model. The model was seen in an idealised or pure way often from a limited understanding of the model and with reluctance to accept knowledge and experience from within the service. This hindered the learning of the complexities of the model, individuals' roles, team working and philosophies that were necessary to be developed within a short timescale. The culture of

working together had to be developed over time without experienced peers to learn from. This was a significant change from how most staff had worked previously and how they needed to think and relate to the resident population.

The Main House (MH) staff team have made great efforts and been committed to developing the clinical service. However, while working clinically and managing in the service I have seen a number of behaviours and dynamics that have emerged which are different from the staff team at HH. The differing behaviours and issues observed by me within the staff team include:

- Staff seem to focus on a more pure psychotherapy approach rather than psychosocial therapy where the staff team are engaged in a more social way. The staff team seems to attempt to work in a 'blank screen' way and less willing to have close social engagement with residents.
- The staff team seem to believe that the model is held predominately by residents, despite residents having a maximum stay of twelve months. There seems to be some reluctance of staff to give information or explanation of the culture to residents, or follow the principles of the culture of enquiry.
- The staff team frequently question the meaning of the flattened hierarchy. They do not often appreciate management or leadership functions or roles. There seems to be a reluctance to understand, embrace and work within individual's own roles and to accept the roles and responsibilities of others, particularly management or leadership roles.

- The staff team often express feelings of being criticised, questioned or disempowered when their view is not immediately or fully acceded to. The staff team seems to become passive when working with decisions with which they don't agree. This impacts on the team's ability to be 'on task'.
- The staff team demonstrate some difficulty in working or connecting together and are reluctant to question or challenge each other. Unlike HH, there is relatively little conflict or difficulties verbalised within the wider staff team despite evidence of its presence. Instead, the conflict is often expressed in the form of staff challenging management decision-making or their role in managing the Service.

These issues seem to get in the way of the team focusing on the task of replication, understanding and implementing the model.

## **AIMS OF THE STUDY**

The aims of the study are:

- to gain awareness and information to clarify the model and understand key processes within the model. Clarifying the model will enhance implementation and practice.
- to explore the HH staff perceptions of the therapy processes, structures and/or culture that cannot, or have not, already been described.
- to utilise theories of leadership, change management, motivation and organisational behaviour to facilitate effective team working and development of the model.
- to provide a more detailed description of the model that can be more readily internalised by the team who need to understand and work within it. Utilising this knowledge or awareness will ensure that Main House can meet the criteria set out by NSCAG for continued functioning and funding.

## **STRUCTURE OF THE DISSERTATION**

The Introduction provided the context for the study. The structure and approach to the dissertation is to provide richer information and more detailed understanding of the model in practice. It is a descriptive approach aimed at increasing understanding rather than an objective analysis of what is necessarily a fluid and changing culture.

There are a number of sections within this dissertation. These include:

The **Ethical considerations** section discusses the conduct of the research and the safeguards for patients and staff confidentiality.

The **Literature reviews** seek to understand the Henderson model in more detail and provide useful management theories to utilise with TCS.

The **study method** describes the rationale for using Key Informant and Group Interviews and the considerations when utilising this method.

**The results** analyse the Key Informant and Group Interviews and provide a summary of the key findings.

The **Discussion** reflects on the findings from the study and literature reviews and draws themes together. It also reflects on the limitations of the study. Furthermore, it provides considerations for further study, exploration and evaluation.

**Summary and Conclusions** draw from the overall study and link the original questions that were posed and need to be understood. This includes the management issues and actions that need to be considered for the Service.

The study focussed specifically on the HH model and not an analysis of the wider TC movement. Wider reference was only provided if relevant or to provide the context for the HH model.

## **ETHICAL CONSIDERATIONS**

All research within the NHS must work within the guidelines of the ‘research governance framework for health and social care’ (2001), which I consulted. Ethical considerations within the guidance state that research must be ethical in terms of safeguarding the dignity, rights, safety and well being of participants within the study. The key principal was to ensure informed consent and the appropriate use and protection of data.

Ethical constraints and guidelines were considered and the decision was made not to seek ethical approval. Ethics Committee approval locally was not sought because there was no resident contact. Importantly, all staff gave informed consent in a number of ways. I presented my request to the staff team at HH and they agreed this in principle. They also received the questions that would be asked during the Interviews prior to my visits to HH. The Replication Group was informed and gave informed consent to the study, after being made aware of the questions that would be asked. Each individual gave informed consent immediately prior to the Interview.

Contributions from individual participants were anonymous. It was possible, however, given the small staff teams involved, to identify staff involved in the study and they were aware of this possibility. To minimise this further, responses from respondents are not individually attributed. Additionally, no specific information about respondents was identified within the Results. The roles of participants are only identified within Box 7 and not attributed to groups.

The analyses of comments were provided to participants for information and ensure the accuracy of participants’ perspectives. The contents of the Results were therefore accepted

as an accurate depiction of the Interviews. While staff had the opportunity to remove any aspect that they were unhappy with no requests were made.

HH works within an open culture of enquiry and the discussions held within the study were accepted as part of the thinking about the model that they work within. Nevertheless, all questions were considered to ensure that they were not invasive, breached boundaries of confidentiality, implied criticism of individuals or the model, or sought patient information.

## **LITERATURE REVIEWS**

### **IN SEARCH OF THE HENDERSON MODEL - THE LITERATURE**

This review identifies the evolution of the model from its beginnings, through its development, seeking to identify the key aspects of the model and how it has changed over time. This approach enables the developmental understanding of the model and creates a clearer description and visualisation of the model.

Literature about HH was gained from two main sources - the Planned Environment Trust archive (PET) and HH research department. PET has collected information about TCs for about 10 years and has original articles and books from a wide range of sources and authors including those referenced within this literature review. HH has also archived articles from its four Directors, researchers and other relevant authors. Repeated themes throughout the development of the model are also summarised in Box 3.

Ideas of, what would now be called, a TC has a history that goes back several centuries. These are outlined in Box 1. However, Maxwell Jones was the founding father of HH and its first Director. He developed his interest in understanding people during his school years after realising the beneficial impact of peer support. He started his psychiatric training at the Royal Edinburgh Hospital with David Henderson, who became the second Professor of Psychiatry in Britain, who had expertise in treating 'psychopaths' (Jones 1984). Because of this work and interest in somatic illness he was asked to lead a team in treating cardiac neurosis or Effort Syndrome at the evacuated Mill Hill public school (Jones 1968).

His treatment approach to Effort Syndrome was to identify the link between feelings and behaviour as well as the approach of empowering peers to support and educate each other

(Jones and Lewis, 1941) (See Box 2). The treatment at Mill Hill focused on group responsibility. This was to help patients realise their importance to each other in understanding individuals own problems. As well as discussion groups and work activities Jones utilised Psychodrama from 1942. He recognised that talking and non-talking therapies were important facilitators for behavioural and emotional change. Psychodrama has become an integral therapeutic medium within the model.

### **1700s**

1792 Moral Treatment developed by John Wesley provided kindly treatment, task sharing personal experience and socialisation between staff and patients. This reflected a TC approach. The local Quaker community founded its own asylum as became known as York Retreat after the death of a Quaker patient in a charity asylum (O'Sullivan, 1997)

### **1800s**

1837 A TC approach was developed in a penal colony in Norfolk Island under direction of Alexander Maconachie. He removed many authoritarian approaches for inmates to learn self-responsibility, tolerance of frustration, the co-operative sharing in group tasks and community roles prior to discharge (Whiteley, 1968).

### **1900s**

1938 Joseph Beirer appointed as first full time psychotherapist in a mental hospital in England. The principles he developed included self government and self determination by patients in group therapy and used psycho-dynamic therapy in several London Hospitals during the war and later.

1940s Jones developing the treatment of Effort Syndrome at Mill Hill.

‘Northfield experiments’ developing similar TC approaches.

1946 Main coined the term ‘Therapeutic Community’ from work at Northfield.

Jones working in Sutton with ex Prisoners of War.

1947 Jones invited to work at the Industrial Neurosis Unit within Belmont Hospital.

1960 Jones leaves Belmont Hospital.

The Unit becomes independent and re-named Henderson Hospital.

Taylor becomes Director of Henderson Hospital.

1967 Whiteley becomes Director of Henderson Hospital.

1970 onwards The population of Henderson Hospital reduced to provide space for activities.

1974 Henderson Hospital moved to new Unit when Belmont Hospital closes – to a former workhouse. It later moved to nurses accommodation after a fire.

1989 Norton becomes Director of Henderson hospital.

1994 Reed Committee report on the treatment of Severe PD published.

### **2000s**

2000 Main House operational as TC.

Adapted from Millard 1994.

## Box1 Timeline of development of TCs/ Historical developments of TC-type working

The war was a time of innovation and creative thinking. Dicks (1970) argued that the circumstances of the war required the development of ideas to deal with the unique

problems experienced by the military. There needed to be a shift of focus from the individual to the larger problems of human relations and organisation, the nature of hostility problems and of morale. Creative thinking was also being carried out at Hollymoor Military Hospital, later to be known as the ‘Northfield experiments’ (Dicks 1970). From this work Main devised the term ‘Therapeutic Community’ (Main 1946).

At the end of the war a number of experimental civil resettlement units for ex prisoners of war were set up to give an experience of community life and provide re-socialisation to their families and wider community. Jones was asked to take over a 300 bedded where he continued to develop his thinking about group working and democracy (Jones, 1984) (Box 2).

Date/ Director	Name of Hospital or Community	Key therapeutic approaches	No. of patients/ residents	Diagnosis	Treatment philosophy	Staffing
1940 Jones	Mill Hill Public School.	Discussion groups gradually less structured. Educational lectures. Daily routines. Men encouraged to suggest improvements, organise activities, raise criticisms. Nurses give reassuring responses and doctors facilitate groups with nurse support. Individual therapy. Psychodrama from 1942 - structured and planned initially and gradually developed into spontaneous group process. Workshop activities e.g. carpentry, gardening, handicraft.		War patients.  Effort syndrome.	Group responsibility.  Therapy groups of 25-30 patients.  Hospital treatment for about six weeks.  Democratic environment through individual responsibility.	
1945 Jones	Civil Resettlement Units.	Daily Community meetings. Educational psychotherapy groups. Individual therapy. Psychodrama – structured and planned Workshop activities.	300 in six group homes of 50 patients.	Former prisoners of war.  Difficulties with work, negative self image, lack social confidence. Fear of impotence.	Work rehabilitation.	

1947 Jones	Industrial Neurosis Unit within Belmont Hospital.  Later the Social Rehabilitation Unit.	Daily Community meetings. Educational psychotherapy groups evolving to dynamic groups. Individual therapy initially then stopped. Psychodrama – structured and planned moving to a dynamic approach. Daily work groups. Patient committees for new ideas, suggestions and problems; patient discharges; acting out behaviours and disciplinary actions; difficulties in staff-patient relationships; entertainment and planning social events; allocating beds to patients; messing committee for food; social amenities committee managing finance; catering and domestic cleaning; Liaison group consisting of representatives from the patients, nursing, administration to respond to suggestions and complaints of all Committees.	100 beds within a 400 bedded hospital.  18-60 years Men and women.	Chronically unemployed on fringes of society, involved with petty crime.	Work rehabilitation.  DROs seconded from the Ministry of Labour.  Skills learning and re-socialisation.  To develop safe and effective relationships through mutual understanding, tolerance and free expression.  Social organisation where patients learn to communicate freely.	4 psychiatrists 2 Social workers 2 Disability Resettlement Officers (DROs) 5 Workshop Instructors 3 nurses 11 Social Therapists
1960 Taylor	Renamed Henderson Hospital and an autonomous Unit.	Daily Community meetings. Psychotherapy groups. Psychodrama. Daily work groups. Structures introduced that are still integral include: Chair and 2 vice chairs co-ordinate activities and keep order throughout day and night akin to Top Three (or Resident Representatives in TCS); residents involved in Selection of new residents; Referred meeting to bring whole community together; Monthly elections for jobs with a hierarchy of roles.	100 beds 70 men and 30 women  Later 68 beds average or above average intelligence	Psycho-paths – ‘greedy, demanding and leading to arguments and violence...’ (Taylor 1966).  30% of admissions from courts raised from 20% under Jones.	Group analytic approach to treatment.  Work rehabilitation.  Social rehabilitation.	Some Social Therapist posts converted into nursing posts after moving to Henderson Hospital.
1968 Whiteley		As Taylor plus  Social skills training. A more rule bound culture. Jobs allocated to all residents on a rotational basis.	Initially 68 beds (1970) and gradually reduced to 30 patients  Usually	A treatment centre for psychopaths.  Diagnosis of personality disorder	Psychosocial therapy focusing on emotional and not just behaviour change, or work or social rehabilitation.	DRO and Psychiatric Social Worker help plan leaving (1970).  Social Therapist role changed to a

		Whiteley treatment process of: Interaction Exploration Experimentation	between 17 and 35 years  Average or above average intelligence  60% history of psychiatric admissions  50% history or criminal offences  Stay 6 –12 months		No psycho-tropic medication  Rappoport's four themes: Communalism Permissiveness Democratisation Reality Confrontation	healthy, non-professionalised group creating a healthy social environment.  A lack of stable competent trained specialists and impacts the profession as a whole.
1989 Norton		As Whiteley	30 and later 29 patients.  18-45 years.  Men and women.  Evidence base of having severe PD residents.  Evidence base of a clinically effective model.		As Whiteley plus:  People with severe and enduring emotional relationship and interpersonal difficulties.  Culture expressed as meaningful ritual; Engagement in therapy and residents having majority of votes.	Nurses and social therapists more training in psychodynamic therapies.

Box 2 The evolution of the Henderson model

### **The Maxwell Jones years of Henderson development**

Jones went to the Industrial Neurosis Unit (later renamed the Social Rehabilitation Unit and then HH) in 1947 to run a 100-bedded unit within the 400-bedded Sutton Emergency Hospital (later Belmont Hospital) to work with the chronically unemployed of London Jones (1949). He thought the normal working environment provided a more appropriate environment for learning skills and re-socialisation (Jones 1947). He was perhaps pessimistic believing that real understanding or emotional change was rare, although he saw the process of acting or verbalising feelings and attitudes helped to modify them. This seemed to support his view that rehabilitation was the effective treatment approach. Jones described the treatment in Belmont Hospital as changing social attitudes rather than

fundamental personality changes. For him, the essence of treatment was the distinctive way staff and patients overtly collaboratively. Patients became active participants of the therapy of other patients in contrast in a more passive recipient role in conventional treatment settings (Jones, 1953).

Jones saw the aim of the unit as providing a socialising experience, inviting changes in antisocial behaviour and developing satisfying and competent social relationships, in a non-punitive environment (Jones 1954). He recognised a tendency to cycles of destruction and more healthy behaviour by patients and a change in which ‘the threat of disintegration seemed to lead to a need for reintegration’ (Jones 1952,1959). This internal conflict was acted out in therapy.

Patients would be faced with the effects of their behaviour on others. They learned to question each other and accept that group viewpoints are as important as individual feelings. By feeding back to the community a patient learned that he/she was offering a service both to another patient and to the group (Jones and Tanner 1948). Individual relationships were considered to be a hostile act requiring understanding by the group (Jones 1954). All impulsive behaviour was brought to the community as a topic of discussion. These behaviours were brought into perspective by other patients and staff who emphasised their anxiety which such behaviour provoked in other people. Rule enforcement was frequently by discussion rather than by consequence. (Jones, Baker et al 1953)

Jones was that patients were receptive to their peers and would accept the authority of people like themselves more readily than an authoritarian figure (Jones 1954). Staff did

not place themselves in authoritarian roles, but encouraged the patient group to understand the inappropriate behaviour. Staffs' role was to think and act collectively and discuss events from all groups. Jones argued that the culture represented the attitudes, belief and behaviour patterns which gradually built up over time and needed to be established in the staff who were stable and permanent members of the community (Jones 1968).

Patients shared decisions with staff through patient committees and ward councils (Box 2). Sharing of serious responsibility was an effective way of overcoming residents' lack of confidence. No important decision affecting the Unit was taken without discussion with staff, and where relevant, patients. Jones was concerned that patients' were not given too much responsibility unaided and should be supervised by staff. (Jones 1968) He also seemed concerned that this approach caused conflict. Jones seemed to demonstrate a struggle between empowerment and protection. He was also clear that he was not handing ultimate responsibility to patients, which he thought was neither practicable nor desirable. 'What one wishes to do is to give patients a degree of responsibility, which is compatible with their composite at any one time.' He seemed to think that patients might take more responsibility over time.

While the structure of the therapy evolved over time (Box 2) the researcher Rappoport (1960) studied the approach. He saw the treatment ideology as 'ideas from a number of sources and added some of their own to integrate a nominally logical system for the active treatment of problems about which there is incomplete knowledge, considerable professional controversy, and few precedents or technical skills. After a formative period, their system of belief and action was presented as a unified group product shared by all

members of the Unit and as an effective approach to the problems in hand' (Rappoport, 1960). Ultimately he was quite complementary about the model.

The constant research published and written publications seemed to be aimed at convincing a sceptical audience. Additionally the constant risk of closure seemed to have an impact on how the organisation developed. The move from Belmont to HH, for example, was due to the difficulties and incompatibility with the wider Belmont hospital (Whiteley, 1980).

### **The Taylor years of Henderson development**

Jones left HH before the publication of the Rappoport study 'Community as Doctor' and the new Director, 'Fred' Taylor, was dismissive of the observations and recommendations of the research team. (see The Whiteley years below). HH was re-named and independent from Belmont hospital, was again under threat for its unorthodox approach and its charismatic Director, in the form of Jones, had left. Taylor, a former prison doctor and his deputy with an interest in this group of disorders moved to a more clearly 'delinquent' population. They also developed more rigid 'more realistic and less intuitively based style and a rather mechanistic network of interactions for subsequent commentary and exploration' (Whiteley, 1980). The culture moved to being more rule-bound. Additionally, a more formalised structure of patient committees was introduced that shared responsibility between residents and staff as well as a more tightly held structure to contain and work therapeutically. He also introduced patient involvement into the selection of new residents. There seemed to be a shift to a more democratic approach and also less leader-dependent.

Taylor (1966) described the Henderson TC as 'the first British unit developing an entirely patient-orientated approach to the voluntary treatment of psychopaths' (Taylor, 1966).

These patients were seen as challenging to treat. They were brought together ‘where they are in contact with each other for 24 hours each day...thus able to experience the effects of their behaviour on society by feeling the effects on themselves of similar behaviour on the part of others’ (Taylor, 1966). He believed that the community tasks enabled residents to face their personality weaknesses rather than acting out anti-social behaviour. They also learned to stop projecting their feelings of inadequacy, despair and persecution, which enabled them to see their environment as hostile and punitive. He held a more hopeful psychological change viewpoint than Jones.

Taylor (1966) saw the community as structured to give a patient a sense of belonging, be inclusive and enabling patients to start to make relationships. S/he learns that his/her efforts are as important as anything others do for them. Like Jones Taylor focused on patients helping to understand others so that he can give treatment as well as accept it. This enabled each patient to feel less of a failure and to feel less threatened in admitting to inner feelings of desperation. The atmosphere was permissive but did not mean, however, that anything was permissible. Antisocial behaviour was discouraged by social and community pressure.

Taylor introduced monthly elections of jobs and roles held on democratic lines and the committees were formed (Box 2). These seem precursors to many structures such as Top Three or Resident Representatives and Referred meetings (Taylor 1963, 1966). Taylor seemed to describe an increasingly rule-bound culture and a more clearly structured programme of roles and responsibilities in the running of the community.

The role of staff was to ‘be constantly on the alert to understand what the patient is trying to do to them. There may be constant attempts to provoke anger so as to justify the patient in his belief that the world is a hostile, punitive place... sometimes the approach is seductive and sexually provocative... staff must be able to respond with understanding and tolerance’ (Taylor 1966). Taylor saw the importance of daily meetings of staff. This would enable the staff team to tolerate working with patients who are constantly getting themselves into apparently hopeless situations, and ‘be able to maintain a sense of hope based on group processes rather than on their denial of their own despair’ (Taylor 1966). Learning to tolerate the projections of residents has been challenging to the new staff at MH.

Taylor left HH after seven years to develop a TC within John Connolly Hospital in Birmingham, which ran until 1984.

### **The Whiteley years of Henderson development**

Robert Rappoport and his team of researchers published a study of the model, ‘Community as Doctor’ in 1960. When re-issued it was re-considered at HH and helped to re-shape the model (Whiteley 1980). Rappoport examined the social interactions of the [then] ward. These included cycles of organisation and disorganisation within the resident and staff group; democratisation and authority (where leaders avoid enacting dependency and irresponsibility within the staff team, thus residents are witnessing this behaviour) and the role of leadership within a flattened hierarchy by facilitating staff to staff interaction. He questioned the permissiveness of ‘acting out ‘ behaviours and the impact on the staff and residents. He also identified the conflict between psychotherapeutic and rehabilitation aims of the staff team (Rappoport, 1960).

Rappoport had described four key characteristics or themes of the TC (1960) that became enormously influential as a way of seeing the model:

Communalism- living and being together in a close knit and intimate set of relationships (providing group acceptance within a quasi-family environment).

Democratisation- each resident and staff member having equal power in decision-making (increasing personal authority and participation with each person having equal voice).

Permissiveness- tolerating expression of feeling and behaviours to expose residents difficulties (fostering a more positive attitude towards authority, all of which are unfavourable for psychotherapy).

Reality confrontation- continual interpretations of residents behaviour and its impact on others.

Millard (1981) used Rappoport's themes to discuss the social context of therapy. He agreed that the TC provided opportunities to explore the social and internal experience of residents. By staff not responding residents are able to experiment socially and develop new or more appropriate social rules (democracy), share social performance (communalism), allow residents to try out stereotyped or familiar patterns of behaviour (permissiveness), explore the resources of residents to respond in particular circumstances (reality confrontation) (Millard, 1981).

Stuart Whiteley took up post as Director in 1967. His description of the model was of patients who were not only 'free to express his opinions but free to act, indeed to demonstrate by his day to day interaction with that model society, what a real problem is

between himself and society' (Whiteley, 1973). He argued that to resolve the conflict between the resident and society there must be meaningful interaction between them. He later quoted a patient who described treatment as a 'a crash course in living'. 'You will learn in six months what you should have learnt between the ages of six and ten...' and 'It's like real life speeded up... you meet in 24 hours situations you would not meet it 24 days on the outside' (Whiteley, 1985).

The model was now seen as highly ritualised and rigid, rule bound with resident roles and a busy timetable of groups (Box 3). However, he saw how the structures provided a three-stage treatment process (Whiteley, 1973)

- Interaction promoted by close living, an inward looking community somewhat cut off the outside world. All decisions and all problems are referred back to the community.
- Exploration of observed behaviour. Flexible group meetings punctuate the day's activities. These enable residents to comment on what has been seen and the effect it had on others. This provides abundant feedback.
- After close interaction and exploration within the group it is possible for the individual through Experimentation to try out new ways of coping. This might be as advice or to be more patient or less suspicious, but is largely mediated through the allocated roles of the patient's committee. These can vary from highly responsible posts such as the chairman of the community or foreman of the workshop down to canteen assistant.

Whiteley (1994) took the Main notion of the TC as a “culture of enquiry” further. He also saw a ‘culture of commentary’ and ‘culture of confrontation’, observing behaviours of individuals and others and to comment to invite comments about it. He argued that residents were frequently reminded of the therapeutic task and that the TC is artificially created for a therapeutic purpose – experiences are not a “for real” situation but an “as if” situation.

Whiteley believed psycho-dynamic interpretations were to be used carefully since ‘the therapist who hands interpretations at every opportunity will soon find the community waiting dependently on his next insight rather than themselves working as a community group on the task in hand (Whiteley, 1986). Interpretations were most potent when arising from the group or the community rather than the therapist. He wanted common sense interventions rather than “Nobel prize winning ideas”, clear and appropriate, not allowing misinterpretations or misunderstandings to arise. He disapproved of letting fantasies develop and argument that they were valuable for interpretation. Whiteley clearly set out the limits of psychodynamic interventions and emphasised the psychosocial communication.

Whiteley (1986) argued that the TC couldn’t be universally applied with constant results but evolved over years. Only at this time would staff become less dependent.

### **The Norton years of Henderson development**

This seemed to be a time of maintenance in and to the model. The focus seemed to be on maintenance of the structure as a representation of the model. This approach seemed helpful as a means of survival and ultimately its fruition into the national service. The

long-standing struggle with survival encouraged the frequent publication of descriptions of the model. This gave increasing clarity as well as highlighted the relationship between rigidity or tight structures and creativity or flexibility.

Norton (1992) identified some key characteristics when describing the Henderson model:

Engagement in therapy where residents and staff select new residents with the residents have the majority of votes.

Formal patient hierarchy- where residents are selected into roles but some roles cannot be taken until residing in the TC for 3 months.

Rigid timetable with rigid time boundaries.

Rules: breaking and enforcing where residents would have discharged themselves if they break a rule. They need to ask for permission to stay within the TC.

Community meeting- a daily formal meeting where all decisions are made that affect the whole community.

Culture expressed as meaningful ritual- ritualised activity helping containment and integration ‘ a form of imaginative creativity...’(Parera, 1988)

Response to serious incidents or distress with emergency meetings at any time decided on and facilitated by residents.

Norton (1992) commented that the HH TC approach involved no psychotropic medication. This lessened the potential for substitute dependence and, instead, fostered a ritual dependence on other people – initially in the form of fellow residents. The staff patient hierarchy is diminished and the emphasis is on a collaborative style of relationship rather than an authoritarian one. Norton (1992) saw the treatment goal as ‘to convert the actor

into a thinker and feeler' (Norton, 1992). For this to be achieved the patient with personality disorder needed to take responsibility for their actions rather than devolving this to professionals upon whom they often become overtly dependent.

Millard (1994) considered the effect of the rules on therapy. Clear rules and structures and social expectations enabled change to take place.

### **Defining the Henderson model as a 'model'**

The Concise Oxford Dictionary describes a model as 'a simplified description of a system etc., to assist calculations and predictions' (1980). Pidd described it as 'an external and explicit representation of part of reality as seen by the people who wish to use that model to understand, to change, to manage and to control that part of reality' (Pidd, 1996). Models provide structures for clarity and predictability. They define practice and enable a complex situation to be more readily understood. While simplified it provides 'safe and sure knowledge...' (Pidd, 1996) and provides boundaries to work being done. Although a model cannot answer all the questions posed by the complexity of reality it does provide predictors and some certainties for practice. It also enables a focus for considering areas that need to be understood more fully.

The search for the model demonstrated that the HH approach developed clear structures that evolved in clarity. It became more clear over time, had a process of change and developed clear outcomes in terms of staff and resident expectations and roles. Jones described this as the 'framework' of his treatment, however (Jones 1948). The evolution of the model, though, showed that HH treatment approach is tightly structured and clearly defined. It helps decision-making by its clarity and provides a control or feedback system

with effective communications, within the rituals of the structure. It also helps work through the complexity of the therapeutic process with its relatively simple principles. All these indicate a model (Pidd 1996) rather than a framework.

<p><b>The Jones years</b></p> <p>The Community meeting Patient government The staff meeting or review Community treatment or socio-therapy Therapeutic culture Living-learning situations or confrontation Feedback within the social structure of a community. Maximum stay of a year (average stay 4-6 months. Norton years, 7 months) Voluntary patients Some admissions through the criminal justice system Unit Reception by existing patients for new residents on a weekly basis Community meeting of all staff and residents on a daily basis Workgroups There is constant development and change</p> <p><b>The Taylor years</b></p> <p>Rule-bound culture Monthly Elections of jobs and roles Clearly defined hierarchy or roles Group analytic principles of group work Selection of new residents involving current residents More severely disturbed population</p> <p><b>The Whiteley years</b></p> <p>Clearer theoretical background Emphasis on social psychotherapy Transformation of staffs roles and other disciplines</p> <p><b>The Norton years</b></p> <p>Consolidation of theoretical background Staff more widely trained in psychotherapy Clearer description of the model and the rationale for structures and the unique culture</p>
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**Box 3: The Henderson model (structures and processes) - contributions from the Directors**

The structure and ideology described throughout the evolution is identified. The model clearly had its foundations from the work at Mill Hill Hospital and Jones previous experiences. It has subsequently been claimed and developed by subsequent Directors into the social psychotherapy that is visible today. This is represented in Box 3. This review of the literature of the HH model provided a great deal of clarity about the structure and structural development of the model.

## **IN SEARCH OF MANAGEMENT UNDERSTANDING – THE LITERATURE**

From the review of the historical development of the HH model there are four key areas or themes related to management theory, concepts or perspectives that are relevant:

Leadership

The individual in the organisation in relation to motivation

Learning in the organisation

Organisational change and culture.

These areas need to be explored in order to aid the development of achieving the goal of understanding the model, improving organisational quality and achieving replication. The four areas are explored because references are made to them in some form throughout the literature review. They also relate closely to the constant learning or transformational TC style of working. It is also clear that the themes are related in respect of this Service and cannot be considered in isolation.

Key references were sought relating to the four themes and relatively recent articles were utilised for this literature review.

### Leadership

Leadership, the ‘flattened hierarchy’ or ‘multiple leadership’ and leadership styles have been an area of tension as the service has developed. This seems linked to different views of particular roles, staffs’ expectations and competing ideologies of the model. It may also relate to the highly demanding nature of the work and how a largely inexperienced staff

team feel supported and take support. Sometimes it still seems unbearably painful for staff to take support, knowledge or direction as modelling or containment from senior staff who they do not fully acknowledge as skilled or experienced. This is compounded when the current culture is not positive towards leaders in the service. Part of the role of transformational and transactional leadership is to manage staff into their roles and help to take appropriate responsibility. Understanding the model may help staffs' ability to be supported by the structures. They may also realise that conflict within the team is bearable which helps staff to develop and hold the culture.

Leadership has been defined as 'a process of influencing the activities of either an individual or a group in an effort to achieve goals in a given situation' (Hershey and Blanchard, 1993). Its focus is goal attainment and motivation of the whole service through her/his presence, modelling and vision. 'Management is usually viewed as getting things done through other people in order to achieve stated organisational objectives. Management or transactional leadership is regarded as relating to people working within a structured organisation along with prescribed roles' (Mullins 1996). Hershey and Blanchard saw management as a specific form of leadership that focussed on achieving organisational goals (Hershey and Blanchard 1993).

Transformational leadership is a process of influencing followers or staff by inspiring or moving them towards the leaders vision of a future state for the organisation. Leaders transform followers' energies to the development of the organisation while enhancing their expectations and abilities and willingness to take risks or innovate. Additionally transformational leadership moves the followers from being relatively passive recipients of

leadership processes to ones where they are perceived as ‘constituents’ of the leader. Bass described the components clearly (Bass ) (Box 5).

	<u>Transactional Leadership Management</u>	<u>Transformational Leadership Leadership</u>
Creating agenda	Planning and budgeting: Developing a plan – a detailed map of how to achieve the results.	Establishing direction: developing direction – a vision which describes a future state with a strategy.
Developing HR	Organising and staffing: Which individual best fits each job and what part of the plan fits each individual.	Aligning people: major communications challenge is getting people to understand and believe the vision.
Execution	Controlling and problem solving: Monitoring results; identifying deviations from the plan and solving ‘problems’.	Motivating and Inspiring: satisfying basic human needs for achievement, belonging, recognition, self-esteem, a sense of control.
Outcomes	Produces degree of predictability and order.	Produces changes – often to a dramatic degree.

Box 4: Kotter (1990) Transactional and Transformational leadership from ‘A Force for Change..

The role of the leader is to help the organisation move from thinking efficiently to thinking effectively. Leaders must recognise the behaviours or values that maintain unhelpful dynamics. They carry responsibility, particularly during organisational change. An important role of leaders is to create the appropriate culture within the organisation through

<p><u>Charisma</u> (or idealised influence) – leaders are role models that followers strive to emulate and join around a vision or common purpose.</p> <p><u>Inspiration</u> or motivation – providing meaning and optimism that the goal is achievable.</p> <p><u>Intellectual stimulation</u> – encouraging followers to question and challenge the way things are done, what is done and by whom even if it has been successful in the past. It is important to consider issues from new or unique perspectives.</p> <p><u>Individualised consideration</u> – this is an essential process of valuing, respecting and supporting the development of others. This is based on identifying the follower’s strengths and needs to develop their potential.</p>
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Box 5: Bass components of Transformational leadership:

his/her leadership style – facilitative, democratic, with staff who are empowered, effective, involved, creative and healthier (Alimo-Metcalfe, 2001). However, ‘Managers who can adopt both a transactional and a transformational style have staff who are more effective, more motivated and more satisfied’ (Alimo-Metcalfe,1996). Transformational leadership and competencies are not sufficient on their own. It is necessary to have a balance. The creativity the transformational leader is balanced by the structures, organisation and order provided by the transactional leader or manager. This is further explained in Box 4.

Millard clearly saw that maintaining the culture was the role of staff and defining that culture was the remit of the leader or Director. He reflected that Jones was quite authoritarian in his leadership style, but developed a democratic TC. He later developed this style of TC development at Dingleton Hospital (Millard, 1994). Jones was consistently clear that there is no sense of the staff or a doctor in charge relinquishing their authority, which really remained latent and could be evoked where necessary. He recognised it took flexibility, considerable experience and skill for latency wherever possible. (Jones, 1956) The treatment was still medical in its origin through expertise, knowledge, direction and leadership.

Jones saw Multiple Leadership (later called the flattened hierarchy) as a way to self-sufficiency of the organisation. The leader acted as facilitator or even from the outside as an occasional interventionist (Jones 1956). All team members had involvement in the running of the Unit through discussion and giving opinions. He believed, though, that there were problems with multiple leadership, not least with envy, rivalry and the avoidance of the responsibility on occasion. Multiple leadership and many of the issues discussed seem relevant to the whole Service and needs to be understood more fully by the staff team.

## The individual and the organisation

Kolb (1984) defined learning as ‘the process whereby knowledge is created through the transformation of experience’ (Kolb, 1984). He thought effective learning needed to relate to the individuals process of ‘maturation, self-fulfilment, perspective and self-determination’. It also needed to have some resonance with the thoughts, feelings, ideas and beliefs that adults brought to their learning. It is not a simple satisfaction of needs but ‘an acknowledgement of the goals, intentions, motivations and aspirations- however diverse, contradictory or confused – that informs someone’s decision to learn’. Linking this, motivation explains why individuals choose to work the way they do (Dawson 1986). Content theories consider staff focussing on what they want in terms of rewards (Figure 1) while levels of satisfaction is an alternative way of understanding motivation (Figure 2).

If Herzberg’s ‘motivation – hygiene’ factors are considered motivating factors – achievement, recognition, work itself, responsibility, advancement – may be adversely affected by all staff joining together, role blurring and lack of understanding of the model. The hygiene factors, which prevent dissatisfaction – policies and administration, supervision, inter-personal relations, money, status, security – were all affected by learning to be a new team in a new organisation and new way of working.

Motivation is essential to understand and address. Dell (1988) stated simply reasons why people did not get the job done or were not ‘on task’. They either did not know how to; something or someone kept them from doing it; or they did not want to. It was defined as ‘where the individual feels that work is sometimes good and sometimes bad, but that it is fulfilling, satisfying and capable of development in all ways’ (Rosenfeld & Wilson, 1999). Staff morale and the performance of an organisation were adversely affected during

change. This was due to disrupted relationships and communication patterns, increased stress from location, job or role change (McClenahan, 1999).

Both the organisation and individuals have factors that constrain, inhibit or are overtly against learning and change that are psychologically and organisationally complex. Dawson reflected that employees have expectations about rewards while managers focus on motivating staff to work more effectively and efficiently. He argued that problems with motivation are usually related to organisational structure or technological changes and not just the resistant staff (Dawson 1996). However, Bauman saw that organisations could induce suffering and ‘be at peace with itself’. This can include neglect of patients, repeated errors or working against the task of the service (Bauman, 1989).

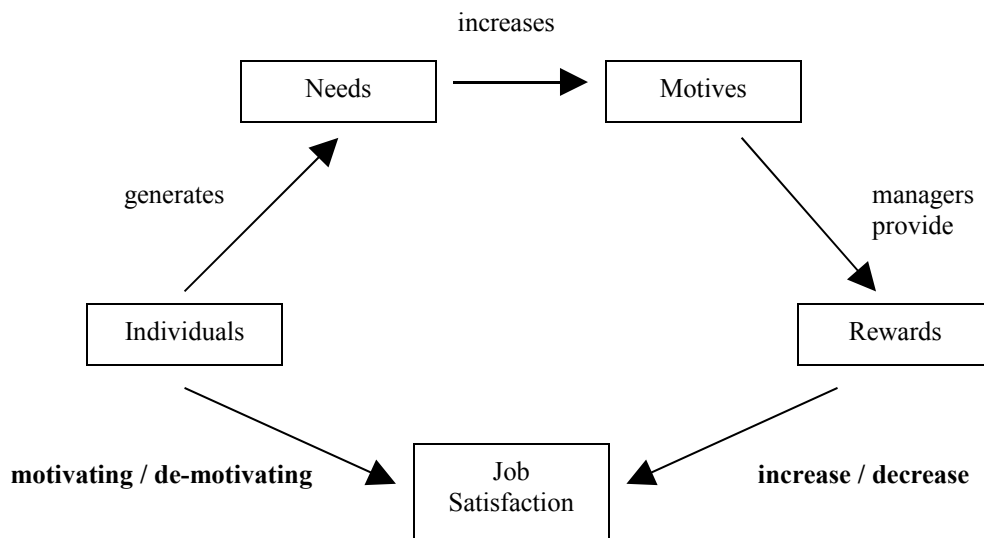


Figure 1: Assumptions which form the basis for content theory. From (Rosenfeld & Wilson, 1999)

As well as individual resistances to change and issues of motivation there are also blocks on learning. Lewin (1951) presented the idea of organisational ‘unfreezing’ - formal or

informal training that individuals need to reconsider or move away from to take on new learning, cultural roles or philosophy. There must be motivation to take on new skills and behaviours or there is less likelihood of sustained change. However, work organisations are particularly adept at obstructing individuals learning when major change is required through lack of information, responsibility or staff ownership (Butler 1992). Moreover, staff can develop a ‘skilled incompetence so they do not learn what they need to learn in order to make real change and progress. However, they tend to be unaware of their own responsibilities for the resulting maintenance of the status quo or resistance to change’ (Butler 1992).

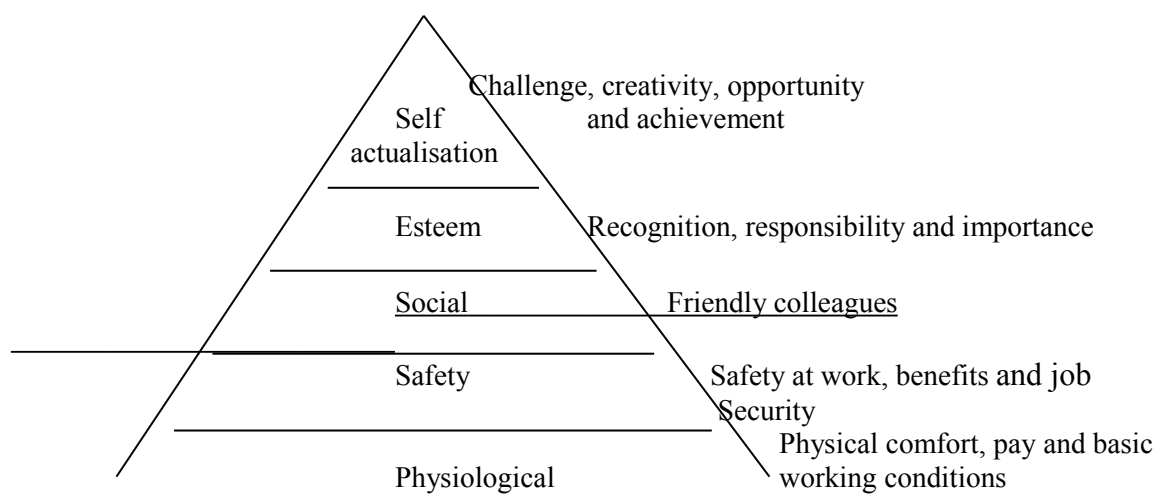


Figure 2: Maslow’s hierarchy of needs assumes that an individual is motivated to satisfying. From Rosenfeld & Wilson, 1999

Having appointed the majority of staff I have some awareness of their motivations for joining TCS. Understanding and responding to them is an important task for leaders and managers within TCS. This enables individuals and the organisation to focus on the task of replication and an effective clinical service. However, the relationship between job satisfaction and individual, and thus organisational, performance is not simple. There is

little empirical evidence for a link between motivation and increased performance. If it is linked the correlation is very small. However, Lawler & Porter believed that a low but consistent relationship existed (Lawler & Porter 1978). Improved motivation is only part of changing the organisational culture.

### Learning in the organisation

Learning is the process where knowledge is created through the transformation of experience. While it can occur ‘accidentally’ learning arises from the planned intention to learn and reflects on goals, intentions, motivations and aspirations of the individual or organisation. Organisational learning results from the inter-related tasks of development of the individual, the organisation and the larger social system.

TCS needs to learn and how the organisation learns is an important determinant of the way the organisation will innovate and develop. Peddler et al gave an indication of the way organisations can learn. They can facilitate ‘the learning of all its members and continuously transforms itself... everyone involved, without restrictions on thinking and innovation, a continuous process of change and adaptation, and focusing on learning about the change process itself’ (Peddler et al, 1991). This reflects much of the philosophy of the TC. Additionally, Senge thought learning resulted from the creative tension between developing a shared vision and making a full analysis of current realities and practices. This is also an important factor for change management. Learning must understand contexts and processes as well as tasks and outcomes (Senge 1991). These are important principles within the clinical work of TCS.

Pettigrew and Whipp argued that the way organisations learned was intricate and complex with vital skills and knowledge often being acquired in hidden and unnoticed ways. This reflected ‘accidental’ ways of learning. (Pettigrew & Whipp, 1991) This links to an important issue since HH learns through the culture, while TCS has some reticence and reluctance in learning needed. It still has to consider how this can happen through the culture to take in insights, skills and thinking.

Dale (1993) saw key principles for a learning culture included openness and reflective practice and where questioning and self-doubt are as important as certainty and control. This is absolutely essential in the development and maintenance of the learning organisation and the transformation of it. The learning organisation must have structural and cultural change, which is often radical and uncomfortable in its development.

Key for organisational learning is a transformational leader to recognise, challenge and defuse defensiveness, and avoiding premature conclusions to thinking. She/he must create shared ownership, nurture strategic thinking, facilitate the understanding of context and processes as well as tasks and outcomes. This is very important within the TC way of working if it is possible to implement.

### Organisational Culture and change

The organisational culture defines and encourages ‘established skills, habits and taken for granted ways of thinking and behaving’ (Hedberg, 1981). This makes managing an organisational culture difficult. While an observer sees a culture those who work in it see behaviours as obvious and automatic. ‘...organisations do not have brains, but they have

cognitive systems and memories ... members come and go, and leadership changes, but organisations memories preserve certain behaviours, mental maps, norm and values over time' (Hedberg 1981.) The memories are developed through the organisation via (Hedberg, 1981):

- its 'knowledge base''
- how it gains, presents and develops its unique knowledge.
- 'firm specific competencies'.
- the mechanisms for gaining and spreading distinctive skills and capabilities.
- 'Routines' for using skills and knowledge effectively - formal rules procedures, and strategies as well as less formal, sometimes contradictory, informal structures such as beliefs, frameworks, codes and cultures.

The WHO defines change as '...the process of planned transition from a present unsatisfactory situation in the organisation towards an improved future'. The process of change management must consider the individual and organisation as a whole adapt to the changing environment and strive for continued effectiveness and efficiency. There are considerations for the impact of change, however. The consequence of constant change is a lack of history and rootlessness. Additionally, change fatigue can create intolerance to 'yet another' change, as well as increased stress and losing sight of long term objectives. With a relatively young service change seems very challenging.

Kotter, Schlesinger and Sathe (1986) identified four common reasons for resistance to change:  
self-interest.

lack of trust or mis-understanding.

different views of the benefits of change.

having a low tolerance for change.

The possibility that staff resist change for one of those reasons is essential to understand from the perspective of the individual and the organisation. While staff express desire to work within the model staff need to appreciate the different way of working to that of their previous experience and from their understanding of the model. Moving from an idealised view of the model to working with the real model may be more difficult for staff and challenge their resistances to change. It would also provide closer replication.

There are four key principles for achieving effective organisational change:

- Understanding formal and informal power and performance within the team.
- A clear organisational structure.
- Primarily a facilitative management and leadership style.
- Understand the organisational history.

Main House seems to have a developing culture. It is thoughtful, but it does not quite seem to genuinely enquire about or challenge residents. Staff avoid conflict and struggle to verbalise fears and areas of weakness or vulnerability. Many of these issues have been verbalised within the team. However, the existing culture also seems to limit recognition in the value of leaders and works outside identified roles. This hampers the task of replication.

Management theories and perspectives give clear direction (summarised in Box 8) about developing the organisational culture within staff. They work to understand the needs, behaviours and expectations of individuals, staff roles, learning within the organisation and the dynamics of change. These need to be embraced by managers in order to understand, lead and facilitate and the staff team to work with leaders, developing a transformational learning culture to meet the organisation aim of more effective replication.

The literature reviews have enabled understanding of the model and managing within the HH model. Understanding of the processes within the staff team remains unclear, however, which holds unwritten information about the culture and ways of working.

## METHODS

The methods used in the research are qualitative. The TC is familiar with this approach, sociological research frequently uses qualitative method and this style was also used by Rappoport et al (1960) in a major study of HH, later used to develop the model. The data collection methods were:

Semi-structured Group Interviews with a combination of newer and less experienced staff. Jones seemed clear that the culture is transmitted through the staff team, rather than the residents. (Jones, 1968) More experienced staff hold more awareness of the rules, boundaries and philosophies of the model and how to act within the model. Additionally they have a clearer understanding of the essence of the model even when aspects of the structure change over time. I examined newer staffs' experience through the semi-structured interviews in understanding the model and explored how the culture was carried from a recipients (newer staff) perspective.

Group Interview with the Replication group. This group represents the evolved HH model as well as developing the cultures of the new services. This group Interview explored the development and replication in order to discuss and clarify the HH model.

Key Informant (individual) Interviews. Some staff had individual semi-structured interviews. Jankowicz identified this as a specific style because individuals could be chosen 'on the basis of their idiosyncratic, specialised knowledge ....' (Jankowicz, 2000). Jankowicz cited Tremblay (1992) about the value of the technique. He saw it could define essential characteristics by drawing on personal experiences and the understanding of the

people involved; identify the boundaries within which these definitions can apply; and increase knowledge (Jankowicz, 1999).

General issues about this method were considered. Bell recognised data collection was influenced by the amount of time available. She also stressed that despite the limitations of time, cross-checking findings was important. Therefore, more than one data collection method was valuable. 'Triangulation' was therefore utilised - 'cross checking the existence of certain phenomenon and the veracity of individual accounts by gathering data from a number of informants and a number of sources and consequently comparing and contrasting one account with another in order to produce as full and balanced study as possible' (Bell, 1999). Interviewing a number of groups and individuals provided opportunities for this. Differences of views or discrepancies would be noted in the study and commented upon.

Interviews can be adaptable and effective in enabling knowledge and information to be explored in depth (Bell, 1999). Bowling argued that 'interviewers could probe fully for responses and clarify any ambiguities; more complicated and detailed questions can be asked; more information, of greater depth, can be obtained; inconsistencies and misinterpretations can be checked ....' (Bowling, 1997). Cultural Interviews 'between members of a shared culture and evolve explorations of peoples experiences and the knowledge and values they pass on to the next generation' (Robson 1993) were essential. This study sought to understand how the verbal culture of HH was communicated through the staff over time. Additionally Bowling stated that this research method could be used in the evaluation of services as a 'guided conversation' (Bowling, 1997) with complex issues examined and clarification sought.

When considering this study I intended that the sample for the semi-structured interview would be a minimum of six and would include longer serving and less experienced staff. Bowling recognised the need for small sample size due to the amount of data received, its complexity, the amount of time taken to analyse information and because the information is aimed at understanding a social situation rather than provide statistical information (Bowling 1997). The length of employment for each staff member was recorded.

I recognised the possibility of interviewer bias. Bell recognised that this could not be avoided completely. To address this I endeavoured to be aware of my role in the study as interviewer and contain the impact of my presence by focusing on the questions without informal socialising (Bell, 1999).

The staff team could opt to participate and conveyed their willingness. On a positive note my role in the national service meant that I had spent time with some members of the HH staff team and the issue being explored was of interest to them. My understanding of the culture enabled the staff team to be at ease with the questions, enabling them to reflect on the questions posed. A researcher without this experience and knowledge of TCs may not be in the best position to ask the participants the ‘right’ questions, or to be able to understand the responses and interactions in the group and individual interviews.

Advanced letters outlining the rationale and questions were to provide clarity of the questions rather than minimising the risk of non-respondents. (Bowling, 1997). All respondents were made aware that the interviews were to be audio taped.

### Developing interview questions

A number of factors influenced the development of the questions. Essentially, I wanted to understand the staff experience and understanding of the model they work with. Furthermore, I worked to understand the model and culture was carried through generations of staff while providing a stable effective service. I wanted to hear this from the perspective of more and less experienced staff. I therefore needed to consider Triangulation of questions. Additionally, from my role in the Replication group there seemed to be unanswered questions about the model that were located in the close working relationship of the staff team. I thought it essential to illicit these for the MH staff team who could then further understand their roles and relationships.

The literature review raised more questions about the model in practice and how management approaches or theories were understood in the Service. I believed there was still only partial knowledge of the model. Therefore, clarifying questions about the model were included, seeking to unify differing interpretations of the model. Intuitive questions were included using my previous discussions and experience within the Service.

### Questions asked

Box 6 identifies the questions within the study. Each study Interview comprised a list of questions. A profile of the questions asked in each interview is provided within Appendix C. (Letters sent to HH explaining the proposed questions are Appendix A and B)

1. What is the essence of the model
2. What has been learned about the model and culture through the replication process
3. Are we any clearer about the uniqueness of the model
4. What is the function of leader/leadership in the TC
5. What is the leadership style needed for the TC
6. How is multiple leadership or the flattened hierarchy experienced
7. How does the model use structures to 'contain' and be 'creative'
8. Who holds the culture of the TC
9. How has the culture changed
10. What is the culture in the staff and how is it conveyed and understood
11. What is the unwritten culture and how is it conveyed
12. How are you signed up to the model
13. How does the shared aim get conveyed
14. What holds the staff team together
15. What is the role of staff
16. What's it like being new
17. How is conflict in the team managed
18. Is there a Henderson way of working and, if so, how do you learn what it is and how to do it

Box 6: Questions asked within the study Interviews

Analysis of questions

Responses to questions were analysed using ideas from content analysis (Holloway, 1997).

Utilising some of Colaizzi's steps of phenomenological analysis in a more practical way 'extracting significant statements' occurred from each question asked. The 'formulation of meanings' by identifying or interpreting significant statements preceded 'clustering of themes' within each question (Holloway, 1997).

The Colaizzi analysis is similar in style to Inductive Content Analysis – dividing themes and constructs and then searching for general patterns and generating working hypotheses of interpretations from the available data.

## MAIN FINDINGS AND ANALYSIS

### Participant characteristics

Two staff team group Interviews, The Replication Group Interview and three Key Informant Interviews were carried out. In total 13 staff participated in interviews from a number of professional backgrounds. A profile of staff is provided within Box 7.

#### **STAFF PROFILES**

##### **Staff involved by training/professional background**

Art Therapist  
Social Worker  
Medical Doctor  
3 nurses  
Social Therapist  
3 Consultant Psychotherapists  
Researcher

##### **Staff and Interviewed groups involved by length of stay**

###### **Replication group**

5 staff Interview average 6 years

###### **Key Informant Interviews**

3 staff Interviewed average 8 years

###### **Semi-structured Interviews**

2 staff Interview average 18 months  
3 staff Interview average 4 years 5 months

###### **Shortest time in HH**

3 months

###### **Longest stay in HH**

12 years

#### Box 7: profile of participants

## **INTERVIEW RESULTS**

### Participants responses

There were four themes that emerged from the study:

The essential model in terms of principles structures and culture

Leadership and hierarchy.

The shared aim.

Learning to work together within the model.

Linking the questions and responses to questions developed the themes. Individual questions seemed to partly answer each one or gave little new information. Linked together they provided greater clarity. Some questions were asked to only one group and could not provide Triangulation of response without linking up questions that merged together through the discussions. While addressing some of the themes separately they were also highly inter-related in respondents thinking and for the model to be effective.

The key essences were consistently reported throughout the questions. There was little disagreement and highly consistent messages about:

the essences of the model.

the value of structures and how they contain and provide creativity.

how the culture is carried over time.

Staff wanted to hold the idea that residents held the culture and agree that this was not the reality. While, at its best residents, hold many aspects of the culture such as enforcing structures and rules, ultimately the culture in the residents was to attack the ideology as a part of their therapeutic process.

**The key essences are:**

The collaboration between residents and staff, power sharing and empowering residents that outnumber staff. Residents, and staff work together to manage the events, risks and difficulties within the community.

The key therapeutic change process at the core of the model is the mixture of groups providing ordinary socialisation with residents encountering different people and groupings, different roles and authorities - the transforming experience.

Psychotherapy groups help understanding and the socialisation provides space for experimentation, psychological risk-taking and change. The structures of groups and rules for containment and effective working are essential. The culture of enquiry is the genuine non-judgmental curiosity of residents' behaviour and feelings.

Therapy is paradoxically about 'being' or having and taking in the experience of a situation rather than actions and seeking solutions. The 'doing' part of therapy should not get in the way of the experience because residents have histories of 'doing' to hide anxieties about who they are. They tend not to have a sense of identity and the therapy is to find the individual inside themselves, their needs and finding ways of getting those needs met in non-destructive ways.

Living together enables learning of how each person affects others in the group, learning to have healthy relationships, receiving from feedback and sharing experience.

This enables the trying out different roles and parts of themselves within the group and the development of a sense of themselves.

Resident' empowerment was developed by staff working with residents in a flattened way. This includes the roles residents have, responsibilities taken, voting with residents votes out-numbering staff and taking on support roles that staff would normally have. A residents stay in therapy is dependent on the feedback they receive from their peers and themselves.

Containment and creativity are not opposites but work together. Clear structures provide containment inviting exploration of the residents' inner world - a safe boundary for permissiveness to take place. The creative thinking comes from how structures are used, working within them and meeting their needs within the structure of the structured and unstructured time.

The culture of enquiry is not critical or moralistic, but making genuine enquiries to understand a residents motivation for doing something. The culture is a benign approach. Residents' attack this and seek to be condoned or condemned in ways that are familiar to them and justifies their acting out behaviour.

The culture is carried by the presence of different roles and functions. Senior staff and leaders hold the culture largely. Duty staff also holds the culture, which is powerful but subtler in its impact. It provides important but more low profile containment.

A less clearly defined hierarchy between staff and residents and between staff enables role blurring and flattening of the hierarchy. This recognises actual and potential contributions as individuals within both the resident and staff groups.

Staff need to learn and integrate the way of working and to experience the dynamic process of establishing themselves in the team. Getting a sense of their role is a challenging process. It can take eighteen months to two years to find a way of 'being' in the TC - finding a role and voice with the residents and the staff. Staff need to be older than all the residents to have authority i.e. be a staff member for more than a year.

The therapeutic process provides both nurturing and criticism (or maternal and paternal responses) though much is delegated to the resident group. Nurturing needs to come from several places and to be taken in by this resident group within the model.

There isn't a strict parallel between residents and staff. It does provide a useful notion when there are difficult dynamics in the community. Staff can explore whether a dynamic is in the staff group and not in the residents or vice versa. Knowing that some paralleling is likely to be occurring is useful to apply to the clinical material.

Leaders, either in the form of the Director or staff in a managerial role and wider staff had different emphases. Managers focused on the functions of a leader while the wider staff participants related their wants of a leader and, in particular, reassurance. These linked significantly and the roles and expectations were complimentary.

**Key issues for leadership and hierarchy includes:**

The leader allows the staff group to regress and express difficult negative counter-transference. There is regression with staff acting out or on their feelings and then working through of issues and difficulties. Leaders must be robust to take projections and enable staff to process their difficult experiences.

Leadership is about managing the anxiety of the staff, external world and residents. The leader keeps the whole in mind and works to preserve the model. They are available for the staff team, holding the culture, holding staff and the internal and external reality. The leader provides security. It is also important for some idealisation of the leader who contains and protects.

Leaders must be flexible and aware of the needs of the situation. They must provide a compatible style, avoiding extremes even when being pushed by the dynamics to taking authority. The style focuses on keeping the thinking in the staff team alive and keeping the message simple and succinct. Leaders need to be consistent with staff and residents giving guidance, though not necessarily knowing everything.

Leadership is a shared responsibility and those in leadership positions must keep people on task and working within their role. All staff have some leadership role taking on parts of what the leader does or their philosophies. Leaders, though have specific responsibilities.

The flattened hierarchy relates to the authority of the group and supporting each individual. Every team member has a voice although other dynamics are involved including length of time served, individual personalities and traits. This gives a more influential voice and more time to speak to some staff, while others could feel marginalised, disempowered and de-skilled.

The shared aim was represented in the commonality of beliefs throughout the questions and similarity of responses. There seemed a high level of clarity of shared purpose.

**The shared aim issues were:**

There is an underlying commonality of the philosophy, remit and in the way of working. Staff attune to this 'fabric' and enable the maintenance of the culture. While staff bring new ideas into the culture there is a general attunement that keeps the model generally the same.

All staff share the experience of doing a difficult job. There is also a shared strong commonality of optimism in the model and belief in its potential.

Staff consistently present how structures and culture enable the staff to work together. Staff need to be active in learning but the relationship between new and old staff is important in learning the model and finding ways to work within it. This came consistently from the wider staff team and represented both older and younger staff. The expression of conflict was seen as able to resolve tensions within the staff team and helps understand the therapeutic process. It was seen as but as undesirable as inevitable.

### **Learning to work together in the model included:**

The culture is conveyed through staff structures such as aftergroups, supervision, academic training, new staff training and informal time with staff. This promotes learning of the model, togetherness as a team and the culture of supporting each other. Staff use these processes to learn to sustain feelings without acting upon them and to find a voice in the Community.

Staff need to bear the openness and sharing of experience which is essential. They need to understand the roles of team members; the subtleties of working in the model and the roles that are demonstrated by older staff. It takes time and much is not consciously taught. Staff learn the culture from doing things and being together. Working in different situations over time develops skills in managing anxiety-provoking situations, containing strong feelings in the community and being able to think clearly.

Staff are open to share feelings and experiences as well as supporting each other however difficult they may be. Staff can make mistakes and not be criticised unduly. This support enables the staff team to talk freely and learn from situations. If this does not happen it is difficult to work effectively together and the model gets compromised. The potential for destructiveness in the therapeutic environment is high if staff do not work together.

Conflict is inevitable when working together and with this population. Staff need to work with the conflict constructively. Any conflict is important to resolve since whenever it is in staff team there is an impact on residents.

Its uncomfortable being new but this may enhance learning. New staff must adapt and fit into the existing culture and find a voice. This can feel inflexible.

New staff and new residents initially think the rules and structures are paramount and gradually realise that they only provide the conduit for effective therapy.

Older staff provides modelling of the philosophy of working, effective therapeutic work, clarity about the structures and understanding of how boundaries may be being attacked. They also have more authority to challenge residents. New staff take in this clarity and experience.

The study interviews provided valuable insights about a number of areas that were not previously understood or as easily understood. This has provided significant clarity about the unspoken or less visible implementation of the model that Main House staff may be able to utilise.

Box 8 highlights the key themes from the three sources of the study.

LITERATURE REVIEW OF HH MODEL	LITERATURE REVIEW OF MANAGEMENT THEMES	KEY THEMES FROM INTERVIEWS
<p>The model developed by Jones is very different to the HH model in terms of philosophy. The model has moved from work rehabilitation to social psychotherapy perspective.</p> <p>The constant theme has been survival through research, publication and alignment with others.</p> <p>The writing have moved from describing the philosophy to</p>	<p>Leadership provides vision, motivation, modelling and achieving organisational goals. Transformational and Transactional leadership are essential functions.</p> <p>Leaders develop the organisational culture - facilitative, democratic, empowering. Authoritarian leadership can create democratic organisations.</p>	<p>Collaboration between staff and residents and being in situations together is essential.</p> <p>Staff sign up to the model by having a shared aim and commonality of team working and resident empowerment.</p> <p>The culture of enquiry is a benign approach - not condoning or criticising – but a genuine attempt to understand motivations to do something.</p>

<p>describing the key principles of therapy. The HH model has developed from a loose framework and experimentation to develop the model to a model with clear structures. Experimentation is within the therapy process.</p> <p>Four charismatic leaders have all taken the HH model forward.</p> <p>The history of the model has provided continuity and enabled incremental and transformational change. The history is essential to its present.</p> <p>The flattened hierarchy is a fundamental underpinning. Leaders and staff do not give up their ultimate authorities.</p> <p>Staff need to be effective in working with projections and transference's of residents. It is important for effective team working with this population to utilise staff structures of supervision and sensitivity.</p> <p>The structures and rules enable the therapy to work effectively and safely.</p> <p>There is a consistent view of the change process -community tasks and socialisation or living together to help face internal conflicts rather than act on them.</p> <p>The TC is an 'as if experience rather than a 'for real' experience.</p>	<p>There are fundamental differences in motivations for staff and managers – staff seek rewards while managers seek effective working.</p> <p>Organisations can inhibit motivation and learning by rigid structures, lack of information and reducing staff ownership and responsibility.</p> <p>Individuals resistances include the fear of change, self interest, unmet rewards, needs or many 'hygiene factors', and 'skilled incompetence'. Staff, therefore, do not acquire the skills to change or develop.</p> <p>'Organisational unfreezing' can help staff change by teaching ways to move away from what is not needed so they can take in new skills and knowledge.</p> <p>Understanding power relationships in the team, having a clear organisational structure, being facilitative and understanding the organisational history provides effective change.</p> <p>The learning organisation is an apt description of the way TCs work focussed on the process of learning, risk -taking, reflecting.</p> <p>Transformational process of leadership, motivation, learning and change is essential for individual and organisational development.</p>	<p>Leaders help staff work through difficult feelings and idealising is important for the wider staff team. All staff have leadership roles. The flattened hierarchy enables support for the whole staff team.</p> <p>Leaders, senior staff and duty staff all have a role on holding the culture.</p> <p>There is an investment in the Lead Nurse and Director that is important to present.</p> <p>Structures and rules provide a safe space for creativity and experimentation.</p> <p>Therapy is about having the experience of 'being' rather than 'doing'.</p> <p>Therapeutic structures keep the culture alive enabling residents to work effectively.</p> <p>The experience of being de-skilled is part of the process of learning in the TC. It takes 18 months to two years to establish a role, voice, skills and authority. The process of gaining credibility is important for being able to work in this challenging way.</p> <p>The culture is predominantly held within the staff team.</p>
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**Box 8: Integrating information from three sources/ Summary of study**

The search of the literature has demonstrated how clearly the model can be described and defined. There is also value in understanding the development of the model from a historical perspective to clarify how the model has developed. Additionally the explanation of management theories has emphasised the importance of leadership within

organisations, the value of understanding individual motivation to change as well as the organisational dynamics of change.

The dynamic processes of the model can be more clearly verbalised. These are provided through the experience of working within the environment as well as formal and informal teaching. The complex hierarchical system provides a challenging learning environment for new staff and very clear transmission of the culture. This enables perpetuity of the model as well as questioning of it.

## **DISCUSSION**

The study has provided valuable information about the structure of the model. It has given insights about the unwritten culture of HH and provided clarity about management theories and perspectives that can be utilised when working with the staff team. These are summarised in Box 8. From the study it is easier to recognise areas for further development towards the HH model. While recognising the strides taken by the staff team over the last two years this section focuses on identifying areas for improvement and ways of achieving that.

TCS staff<sup>7</sup> have worked well to develop the model with the support of the HDT. However, there has been a sense of learning on the job. It was inevitable that there were still areas for improvement in the service after the unique way of starting a residential psychotherapeutic service. Staff<sup>7</sup> have undoubtedly worked to adapt to the culture. However, they have had to learn the culture and develop it at the same time. The experience of newness has been anxiety provoking for staff due to the lack of foundations or rootlessness, the feeling of not enough time, knowledge or skills. This anxiety is still evident albeit in a less overt or verbalised form. This may have contributed to the relative lack of taking in modelling and sense of having no one who understands the model or HH way of working.

There has been little significant hierarchy relating to time spent working within the service except managers with TC experience. New staff seemed reluctant to accept this and while there are other forms of hierarchy due to personal power and some roles, there were few experienced staff steeped in the culture of this model. The hierarchical model of roles, experience and length of stay as being important for the containment of the model has not been recognised as possible for TCS. Staff<sup>7</sup> have an experience of feeling de-skilled,

working to find a voice and a role within the team and within the service. One of the impacts of not having accepted or peer role models to pass on ways of working and feeling de-skilled seems to be decreased motivation, reluctance to change and not taking in leadership. Understanding the four key principles of change seems an essential reference in enabling the organisation to develop.

The study has provided new information that means a significant change in thinking. The notion of “being” and residents taking in experience is a radically different way of seeing the model in practice. MH staff’ focus primarily on ‘doing’ the structures and particularly psychotherapy. It is essential to understand what this new information means. The model already supports the residents finding a new way of ‘being’. The challenge for staff is to understand their role in creating the space for this and know when they as staff are stepping out of it creatively. This includes how the team uses the culture of enquiry and how staff’ model themselves as ‘being’. This modelling will enable residents to develop different facets of themselves. This can be done in a range of groups where staff may be modelling different aspects of themselves. This is a key struggle within and for the staff team.

MH staff can re-focus or adapt aspects of the therapeutic processes to provide a more effective therapeutic containment and a more contained, robust and confident staff team. The MH emphasis is different from HH and the literature in a number of areas. These include:

- The emphasis of psychotherapy rather than socialisation and living together as the key change process. The value of therapy groups, though, is of holding and restating the

culture. This provides the structures and dynamics for residents to understand themselves in relationships and make changes more fully.

- HH show that staff<sup>7</sup> hold the culture actively through verbalisation and modelling. Residents grasp ebbs and flows depending on factors in the resident population at any one time. Staff<sup>7</sup> ultimately hold the culture and support residents when there is an area or issue they have not experienced or considered. HH recognise that senior staff and leaders hold the culture and duty staff<sup>7</sup> are important in holding the culture. Staff<sup>7</sup> need to accept their role and the roles of others in carrying the culture. This will provide more effective containment.
- The culture of enquiry needs be fostered more actively and within the spirit of genuine curiosity rather than implied criticism that currently happens.
- Conflict is not desirable but inevitable. The essential part is the expression and resolution of it.
- The study showed the essential role of team working. Sharing feelings enables learning to occur for the whole team, learning to manage difficult situation and feelings, making the work more bearable and enables thinking. It is destructive if staff<sup>7</sup> do not work together in this way and MH staff need to use the staff structures more effectively.
- There are also different and conflicting views about empowering of residents. Jones and others have been clear about the processes of empowerment such as voting and decision-making, residents' roles and supporting their peers. The limits provide clarity

for residents who are in therapy. It also contains the underlying potential for destructiveness.

- Tight boundaries and rules provide a safe boundary for residents to take therapeutic risks for change. New residents and staff seem to think that rules and structures are a means in themselves rather than a conduit for change. The containment provides creativity and must be maintained more actively by staff.
- There seems to be no shared aim within TCS. Staff still focuses on differences rather than commonalities. The shared aims and understanding needs to be within the culture and all staff working with it.

While there are a number of management tools available a key approach is organisational ‘unfreezing’, enabling staff to move away from old thinking and philosophies and having the capacity to adopt more accurate HH model way of working and ‘being’.

The leadership role within MH holds a great deal of the staff regression and negative counter-transference. There is little sense of staff accepting the role as manager in the Service. They do not seem to value having people with leadership qualities or roles, who keep the team or individuals in mind or providing security. Generally there is a denigration rather than idealisation of the leader and the leadership role. There is competition about roles and authority within the “flattened hierarchy”. While the staff team seem to hold the ideal of everyone being the same, HH staff appreciate containment of the leader, varying levels of accountability and other forms of formal and informal hierarchy within the staff team.

It is important to understand the resistance of staff to the leadership role and the staff role both from an individual motivation and an organisational behaviour change perspective. While the vision of the leader may be present followship must ensue. Re-considering Bass (1966) ideas of Intellectual Stimulation and Individual Consideration (Box4) it seems important to understand the resistances to seeing the leader as holding something good. The boundaries (predictability, order, controlling) and qualities of the transactional leader also seem valuable.

The flattened hierarchy or multiple leadership is a fundamental underpinning within the model. However, Jones was clear that multiple leadership invited all staff to express their opinion and the medical and senior staff still needed to take their authority and make decisions on behalf of the Service. It is important that this is embraced.

The leadership role is complex within the TC. The leader needs to be both transformational and transactional in orientation and robust enough to receive the negative counter-transferences from staff and residents. There is a demand for consistency and even-handedness in approach across the staff team and resident population. The idealisation of the leader seems to be the compensation for the leader providing security and holding the culture of the TC. This relates to (Alimo-Metcalfe 2001) who described the leader defining the culture of the organisation.

Main House staff still have some reticence in making mistakes. The culture is apprehensive and they fear residents' hostility if they challenge them. The culture of enquiring seems to be in staff aftergroups rather than questioning and modelling with residents. There is also limited openness. However, HH staff recognise the essential nature to both staff managing

the emotional demands of the work and therapeutic potency of sharing experiences. They take therapeutic risks and, where necessary, reflect on the impact and how it could have been better when in staff structures. HH recognise the conflictual process that is only occasionally expressed within MH is inevitable and can be valuable. Taylor (1966) also recognised its value. The lack of expression has an impact on relationship building, staffs' ability to find a voice, role in the team and on the flattened hierarchy. It reduces the ability to establishing one's self within the team and for the team to work effectively.

MH needs to develop the strong, shared commonality of aim and purpose. Without this strong commonality the staff team feels more fragile, have a much weaker sense of shared sense of being a team and less invested in the therapeutic approach. This may have a contributory affect on current high sickness levels for example.

The organisation needs to be united by shared openness and understanding of the challenging job that they deal with. Staff can, in fact, make mistakes and learn and grow from the experiences that they have. TCS staff are still developing the awareness of the need to work like this.

Since learning comes from the transformation of experience it is essential to create the environment for staff to take risks in sharing that enables thinking, reflecting and innovation. It also seems important to understand the individual and organisational resistances to learning and change such as 'skilled incompetence' or organisational 'unfreezing'. This approach leads to staff learning robustness through the experience and sharing of experiences in an open way.

The interviews posited the idea that staff were working within their vision or fantasy of the model rather than the reality of it. Staff are highly motivated to work within their fantasy of the model. It is important to understand the disillusionment and impacts of the realisation when faced with the reality of the model. This may be difficult within MH with its current staff culture. This may be a contributory factor in resisting change - misunderstanding the model, self-interest (preserving from something painful) or unconscious awareness of maintaining the status quo. Transformational learning - challenging and defusing defensiveness, shared ownership and nurturing thinking – will help facilitate the uptake of a healthier vision of the culture and reduce the risk of harbouring frustration and resentment and resistance to change.

TCS staff have seemed reluctant to accept their role and focus on the organisational tasks. The study identifies some of the organisational task – communality of the shared aim, understanding and accepting roles within the flattened hierarchy, sharing experience of working together. Managers can understand the individuals needs for rewards or satisfying (Figures 1&2), and aware of the impact of such organisational change. They also need to understand resistances to change and blocks on learning from the individual and organisational perspective. Transformational change can only occur with managers and staff working and sharing together and staying focused ‘on-task’.

### Strengths and Weaknesses of the Study

Carrying out the study in three parts - the literature review of the model, the literature review of management theories and the interviews - was an important strength. It enabled me to understand the model and managing the service to be more effective in a highly

structured and logical way. Each of the three aspects provided clear information and direction that can be readily utilised by managers and staff within MH. However, the interviews reveal most information that would be of value to the staff team to develop the culture. The historical perspective does also provide important foundations and insights.

The literature of the model was very systematic. It had two key sources that provided comprehensive information. The approach to this literature review was also linear. While taking the historical perspective may have been indulgent it also provided a history of the model to the new staff team who may not fully grasp it. It provided some demystification for the model and its origins. Taking a broader perspective about TCs would have diluted understanding the HH model. It seemed important to maintain the focus of this model' in particular, so that the staff gained a tool to understand the structure and internalise it more fully. It also has the built-in history that is essential for both foundation and change.

The management theories focused on transformational processes. This seemed important given the model of treatment being developed. This was not taken in the more linear systematic approach, although it provided a breath of thinking. Additionally the source material was usually comprehensive and provided some breath of information.

The interview questions were thoughtfully considered. Given previous experience of HH these seemed key questions to be asked and understood. Additionally these were the questions being asked in the staff team. However, several of the questions did not seem to extract clear answers or merged into others by being only partially answered. There was no test validity of the questions and seemed to have questions that were ill defined or hard to answer. Some answers seemed to over-lap with each other.

A fuller picture came when linking themes from several questions together. Additionally several questions were asked to only one interview group, which gave a limited response. Therefore several questions gave answers that did not provide much clarity. Using Triangulation and drawing themes together gave more complete pictures of the model and important insights.

In hindsight, larger groups being asked fewer questions would probably have gleaned more information that would have been of more value.

While there would have been ethical issues another perspective would have been to interview the residents to have their perspective of the model. This would have also helped inform the residents of MH who also had no role models. Residents were trying to develop their role in the community as well. With additional time available I would have probably utilised longer interviews of larger staff bodies and interviewed residents to provide a much clearer picture of the process of the model from the two perspectives.

### Achieving the study aims

From the literature reviews and the study interviews I have gained valuable awareness and information of the model. I have also more insights into the key staff processes that have not been hitherto been described in literature. Management theories and approaches have helped provide a framework for change and development of the staff team and organisation. I believe that this dissertation has enabled me to help facilitate a more effective replication of the model with a more confident and competent staff team. While it

may take time to integrate new learning, thinking and practice into TCS this is needed to maintain the agenda set out by NSCAG.

Further work is needed, however. The work to develop TCS model needs to be evaluated. Understanding the impact of new knowledge is essential to ensure organisational transformation. Additionally more detailed interviews or discussion involving HH and MH staff would be helpful as 'peers' would be exchanging thoughts and subtle ways of learning. More detailed capsulation of the unwritten model would help staff understand the process, by taking in some the HH experience of transformational learning.

## SUMMARY AND CONCLUSIONS

The aims of the dissertation were gain awareness of the HH model, understanding how the structures and culture had evolved and gain insights into staff processes to help enable MH to develop closer replication. The study also acknowledged development of the model to date. Management approaches would inform to facilitate team working, leadership, effective change and development towards the model. Staff may acknowledge the issues raised and still feel criticised and disempowered even though the intention is to provide clear ways forward. Criticising the staff team would also be a criticism of myself given my role in developing the service. However, TCS passed its second anniversary while HH is 55 years old and we have some learning to do to reach their maturity.

Whiteley said that TCs were not uniform or with constant universal results. The study demonstrated differences in emphasis between HH and MH. A key change of emphasis arose from a key emphasis in therapy as ‘being’ or having an experience rather than ‘doing’ or focussing on tasks or problems. The study also highlighted other key areas to adapt that will improve clinical effectiveness:

- Being ‘on task’ – understanding the organisational goals, individuals roles and carrying them out.
- Developing and maintaining the shared aim and commonality or working and sharing together. This facilitates a learning culture and focuses the staff team on the joint tasks and experiences.
- Embracing the culture of enquiry in its truest sense.

The learning organisation transforms experience. The shared verbalisation of the challenging work and the expression of feelings and conflict (and a more hopeful pain – particularly when leaders consistent and facilitate) develops the whole organisation. Within roles staff can act on feelings while leaders respond to expressed or unexpressed need. This transformational approach empowers staff to reflect, take risks innovate and is motivational.

To work more effectively with the model the organisation needs to work together with the leader to accept and maintain the vision of the culture. Those in leadership roles need to consider the organisational and individuals needs. Transformational processes understanding the organisation and those within it, of leadership, learning and change does this. Additionally leaders must consider the organisational constraints for effective team working. These include lack of responsibility as well as the individual motivations such as rewards, satisfying ‘hygiene’ needs and resistances to change such as the four common reasons for resistance to change (Cotter, Schlesinger and Sathe 1986). However, the whole organisation can embrace effective change principles. There is now a history, a clearer understanding of the value of roles, power and authority and a culture that supports verbalising staff with a predominantly, though not exclusively, transformational leadership style.

Belbin, when examining team roles, saw that teams have a reciprocal part to play and are dynamically engaged with each other. Sudden transformations of companies seldom worked in practice. They need to grow from out of the old like a snake shedding its skin in a gradual way (Belbin 1993). Therefore transactional influences as well as transformational

leadership must provide history and containment. However, TCS is a transforming and transformational experience with a transactional foundation at its base.

It seems important to reflect on Rappoport's observation of the model. He described cycles of organisation and disorganisation within the staff and residents groups, and democratisation and authority where leaders avoided enacting dependency and irresponsibility within the staff team (thus keeping it out of the resident group). He saw the valuable role of leadership within the flattened hierarchy by facilitating staff to staff interaction. This seems to summarise the philosophy of the therapeutic model, the essential importance of a working together and the key roles of staff and leadership in managing and maintaining the culture.

The dissertation has provided stronger roots, from which the model, culture and staff team can grow and develop. It has been a very helpful challenging experience that I have benefited from. I hope that TCS can also gain from this work.

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## APPENDIX A

### Replication Group Interview

As part of my MBA I would like to conduct a Group Interview to explore key aspects of the Henderson model of TC. I am looking at how the culture of the model is developed and carried over time. My particular focus is on the areas that are not clearly written about, are within the verbal culture or need to be 'metabolised by staff' as part of being and working within the TC.

Because the study is from a management perspective I have to show how the study will help the management of, and improve the quality of the service. Due to this my focus will be to consider the impact of leadership, power and authority, organisational behaviour, staff roles and gaining clearer understanding of the essence of the model to improve the quality of clinical treatment. I shall happily explain more to set the scene before the Interview.

The key questions I shall be asking are:

- What is the essence of leadership in the TC
- What is the function of leadership in the TC
- How is leadership carried through the culture over time
- How does your leadership style affect the TC over time
- What is the leadership style needed for the TC
- What is the essence of the therapy
- How does the staff team support and create the environment for this to grow
- What is the impact of the residents on the staff and how is this managed
- How does the model use structures to 'contain'(rules, boundaries, consequences)
- How does the model use structures to be 'creative' (thinking, flexibility)
- What is the culture of the TC
- Who holds the culture of the TC
- What is the culture in the staff and how is this conveyed and understood
- What is the role of staff
- What has been learned about the model and culture through the replication process
- How has the model been understood
- How has the model been impacted/changed
- How has the culture been understood

I would intend to record the Interview for analysis as well as make notes during the Interview.

Thank you for your co-operation and hope we have a fruitful discussion.

Michael

## **APPENDIX B**

### **Staff Team Group Interview**

As part of my MBA I would like to conduct a Group Interview to explore key aspects of the Henderson model of TC. I am looking at how the culture of the model is developed and carried over time. My particular focus is on the areas that are not clearly written about, are within the verbal culture or need to be ‘metabolised by staff’ as part of being and working within the TC.

Because the study is from a management perspective I have to show how the study will help the management of, and improve the quality of the service. Due to this my focus will be to consider the impact of leadership, power and authority, organisational behaviour, staff roles and gaining clearer understanding of the essence of the model to improve the quality of clinical treatment. I shall happily explain more to set the scene before the Interview.

The key areas for further understanding are outlined below though I shall pick and choose questions to explore these areas:

How is multiple leadership or the ‘flattened hierarchy’ experienced  
How does the leader give up and keep the leadership role  
What is the impact of the leader on the model  
What is the leadership style needed for the TC  
Can the model as opposed to the structures be described or can it only be experienced  
What is the essence of the therapy  
How does the staff team support and create the environment for this to grow  
What is the impact of the residents on the staff and how is this managed  
How is conflict in the staff team managed  
How does the model use structures to ‘contain’ and be ‘creative’  
How does the model change structurally and stay the same  
Who holds the culture of the TC  
What is the culture in the staff and how is this conveyed and understood  
What is the unwritten culture and how it is conveyed  
Is there a Henderson way of working and, if so, how do you learn what it is and how to do it  
Is the Henderson model unique and, if so, in what ways  
What is the role of staff

I would intend to record the Interview for analysis as well as make notes during the Interview.

Thank you for your co-operation and hope we have a fruitful discussion.

Michael

## APPENDIX C

The questions were asked in the order shown

### Questions asked to Replication group 11/12/01

What has been learned through the model and culture through the replication process?  
Are we any clearer about the uniqueness of the model?  
What is the function of leader/ leadership in the TC?  
What is the leadership style needed for the TC?  
How compatible is leadership with the flattened hierarchy/multiple leadership?  
What is the essence of the model?

### Questions asked to Key Informant 1 16/12/01

What is the essence of the model?  
Who holds the culture of the TC?  
Is there a Henderson Hospital way of working and, if so, how do you learn what it is and how to do it?  
How is the model and culture conveyed?  
Who are the culture carriers?  
Are there parallel processes between staff and residents?  
Is the model paternal or maternal?

### Questions asked to Key Informant 2 22/1/02

What is the essence of the model?  
What is the function of leader/ leadership in the TC?  
How does the model use structures to 'contain' and be 'creative'?  
Who holds the culture of the TC?  
What is the unwritten culture and how is it conveyed?  
Is there a Henderson Hospital way of working and, if so, how do you learn what it is and how to do it?  
What is the culture in the staff and how is it conveyed and understood?  
How is conflict in the staff team managed?  
How are you signed up to the model?  
How has the model changed?

**Questions asked to Key Informant 3 23/1/02**

What is the essence of the model?  
What is the function of leader/ leadership in the TC?  
How is multiple leadership or the flattened hierarchy experienced?  
Who holds the culture of the TC?  
What is the role of staff?  
What is the culture in the staff and how is it conveyed and understood?  
Is there a Henderson Hospital way of working and, if so, how do you learn what it is and how to do it?  
How are you signed up to the model?  
What holds the staff team together?

**Questions asked to Semi-structured Interview (2 staff) 16/12/01**

What is the function of leader/ leadership in the TC?  
How does the model use structures to 'contain' and be 'creative'?  
Who holds the culture of the TC?  
Whats it like being new?

**Questions asked to Semi-structured Interview (3 staff) 16/12/01**

What is the essence of the model?  
What is the role of staff?  
What is the staffs experience of the model?  
What is in the staff team?  
What holds the staff team together?  
What do you take in and give up when you come to Henderson?  
How does the model use structures to 'contain' and be 'creative'?  
Who holds the culture of the TC?