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Special Edition

Working with people with personality disorder

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Editorial Comment

Personality disorder in offenders then and now

Monica Lloyd *and* ***Dr Rachel Bell****.*

In the early days forensic psychologists in prisons taught social skills to offenders or set up encounter groups with staff in the belief that interaction with pro-social models would automatically render them less anti-social. Of these naïve beginnings, the best that can be said is that it taught us what we did not know, part of which concerned the prevalence of personality disorder amongst offenders and the treatment challenge this embodied. In fact very little was known of the psychiatric profile of offenders; forensic psychologists did not use clinical diagnostic models and the definitive psychiatric morbidity study that established that almost two thirds of the offender population had some form of personality disorder was not undertaken until 1997.[1] But this revelation alone changed little because at that time personality disorder was a 'diagnosis of exclusion' across the NHS. There were no services in place and personality disordered patients were largely deemed to be untreatable.

It took a series of events for this to change. Firstly the 1990 riots in Manchester's Strangeways prison exposed the lack of treatment for sex offenders in custody and their vulnerability when order and discipline broke down. This proved to be a catalyst for the development of treatment programmes for sex offenders, followed soon after for violent offenders, informed by the new 'what works' literature and developed to a standard that could be accredited by an international panel of experts. Secondly, 1996 saw the brutal attacks against Lin, Megan and Josie Russell by Michael Stone, a diagnosed psychopath who did not satisfy the treatability criteria of the 1983 Mental Health Act and who could not therefore be detained indefinitely, constituting an unacceptable risk to the public. In 1999 a public consultation was launched into the better management of offenders with personality disorder, and in 2001 the first dangerous and severe personality disorder (DSPD) services in prisons and special hospitals were implemented.

Also in 2001 the NHS took over responsibility for providing health care to prisoners, and this involved providing a secondary mental health in-reach service to prisons, addressing severe and enduring mental illness. This was a significant breakthrough, but it failed to sufficiently address primary mental health needs and personality disorder, the products of the pains of imprisonment on top of the ravages of troubled lives, criminality, trauma and substance misuse. The inadequacy of this early mental health in-reach service was exposed by the Prison Reform Trust in their three year campaign 'Troubled Inside' between 2004 and 2007[2], by HM Inspectorate in a Thematic Report of the Mental Health of Prisoners in 2007[3] and by the Bradley Report in 2009.[4]

By this time DSPD services had been in place for several years and the UK was plunged into recession and the necessity of making financial savings. There was a need for a formal review of the performance of the four different treatment approaches operating in two different settings, as well as a need for step down services to support the progression of those nearing the end of their treatment. Emerging learning suggested that other personality disordered offenders not reaching the criteria for DSPD but nonetheless at risk of re-offending might also benefit from environments that could support pro-social change. All these events signposted the need for a new comprehensive strategy for the treatment and management of personality disordered offenders at all levels of security, in custody and through into the community. With the coming together of the Prison and Probation services into a single correctional service (NOMS) and with the NHS committed to National Standards for mental health care it became possible for best practice to be identified within a national strategy that spanned two government departments and three previous services, resulting in the Offender Personality Disorder Pathway (OPD Pathway), articulated in 2011 and currently being implemented. This is no mean achievement and one that needs to be celebrated. It promises to better meet the criminogenic and mental health needs of a significant proportion of the offender population and deliver considerably improved levels of public protection.

1. Psychiatric Morbidity among Prisoners: A summary report. (1997) Nicola Singleton et al. Government Statistical Service.
2. http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth/TroubledInside accessed 02.02.2015
3. The Mental Health of Prisoners: A thematic review of the care and support of prisoner with mental health needs. HM Inspectorate of Prisons, 2007.
4. The Bradley Report, 2009. London: Department of Health.

This special edition is intended to draw attention to this significant development which has ramifications for prison, probation and healthcare staff across England and Wales, and explain its progress and purpose. Nick Benefield and colleagues describe the new strategy and track the journey from the first DSPD units, through a review of DSPD policy to the present landscape of developing OPD services. The first indications are that there are likely to be 20,000 offenders eligible for the OPD strategy. Derek Perkins, Cath Farr, Jose Romero, Tim Kirkpatrick and Anisah Ebrahimjee review the learning from Broadmoor's DSPD service and its ongoing legacy within the hospital after the service ended; Lawrence Jones reviews the learning from Rampton's former DSPD service and charts its progress from a pilot for untreatable psychopaths to milieu informed trauma therapy; Faye Wood reviews treatment issues with DSPD prisoners in the ongoing Westgate unit at HMP Frankland and Christine Bull with Jenny Tew describe in more detail the elements of the Chromis programme that provide them with a level of choice and control over their options for change. Des McVey, Naomi Murphy and Jacqui Saradjian describe the ongoing therapeutic milieu approach to treating DSPD in the Fens unit at HMP Whitemoor and Kirk Turner and Lucinda Bolger describe the therapeutic features of the new Psychologically Informed Planned Environments (PIPEs) that are designed to support change along the OPD Pathway. Laura d'Cruz describes the pathway for women offenders with PD that promises a gender specific service from diagnosis through treatment, advocacy and support into the community, and Julia Blazdell and Lou Morgan from 'Emergence' bring the important perspective of female service users to the development and delivery of training for the staff working with women PD offenders.

There is a striking consensus of opinion among these articles, with all authors stressing the importance of providing treatment that is responsive to the particular needs of offenders with PD, its delivery within a therapeutic environment that supports change, consistent training and support for all disciplines of staff involved in treatment, and systems for managing staff that are able to prevent schisms developing within the treatment team. This edition contains some breakthrough learning and presents a developing strategy informed by this learning that has the capacity to deliver a quantum leap in service delivery and the potential to reverse a pervasive pessimism concerning the treatability of personality disorder.

This special edition has been jointly edited by Monica Lloyd from the PSJ Editorial Board and Dr Rachel Bell from HMP Holloway.

The Offender Personality Disorder Strategy jointly delivered by NOMS and NHS England

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The need and context for a new strategy

In 1996 Michael Stone attacked the Russell family, killing a mother and daughter, and leaving a second daughter Josie, with serious injuries. At this time to be detained under the Mental Health Act meant that you had to be deemed treatable. Many offenders perpetrating serious violence and sexual crimes were said to be *un*treatable; that the problems they presented were due to behavioural difficulties and/or psychopathy and personality disorder, and that therefore there was no place for them in a hospital. This was true for anyone showing signs of personality disturbance whether they were an offender or not, which left mental health services almost exclusively for those deemed mentally *ill*. Developments in Forensic Psychology were leading to better actuarial and diagnostic instruments such as the Hare Psychopathy Checklist — Revised,[1] and the HCR20[2] which provided a more reliable and consistent way to assess psychopathy and risk of serious harm. Through the 90s the What Works movement,[3] due largely to better statistical techniques such as meta-analysis, was revolutionising the way offending behaviour was addressed in prisons, describing for the first time the 'success factors' required in behavioural management programmes. So by the late 90s and into the new millenium there was the public and political will, coupled with a new science, for treating those committing serious offences. The Home Office initiated a public consultation in 1999 on the need for better management of offenders with severe personality disorders. The Dangerous and Severe Personality Disorder (DSPD) Programme[4] was launched in 2001, despite the term 'DSPD' having little scientific or diagnostic credibility. What can be said is that there are likely to be links between such acts of high harm to others and the genetic, psychological, and social determinants that underpin the diagnosis of personality disorder such as an abusive up-bringing. The DSPD pilot services were developed in three prisons, two high-secure and three medium-secure National Health Service (NHS) hospitals, and community treatment and case management services.

The next phase of strategic development for the management of offenders with personality disorder followed a stocktake of the DSPD Programme in 2007,[5] the completion of initial research into the potential to engage this challenging population,[6] and the publication of the Bradley Report on people with mental health problems or learning disabilities in the criminal justice system.[7] The original set of DSPD services provided too few placements for treatment, and a vast differential in cost between the hospital and prison pilots which did not appear to indicate improved outcomes from the much higher level of investment in the hospital sites. Follow-on, or 'step-down' services had not been factored into provision, leaving offenders stuck in high cost treatment places for many years, with other prisons and hospitals reluctant to take this demanding and difficult population. On balance, it was found that the prison sites offered better value for money. Lastly, it was clear that good multi-disciplinary working was critical to success and staff needed specialist knowledge and training, support and supervision in order to continue to work effectively. This training and support needed to be provided across the Criminal Justice and Health services and from high to low levels of security.

1. Hare R. D. 1991. The Hare Psychocopathy Checklist – Revised. Multi Health Systems. New York.
2. Webster C, Douglas K, Eaves D, Hart, S. 1997. HCR-20 Assessing risk for violence. Version 2. Simon Fraser University and BC Forensic Psychiatric Services commission. Vancouver.
3. Maguire J. 1995. What works: Reducing reoffending: guidelines from research and practice. Wiley. London.
4. Home Office and Department of Health.1999. Managing Dangerous Offenders with Severe Personality Disorder. London: The Stationery Office.
5. Ministry of Justice. 2007. The Review of the DSPD Programme. London: Ministry of Justice.
6. Ramsey M. 2011. The Early years of the DSPD programme: results of two process studies. Ministry of Justice. Research Summary, 4.
7. Department of Health. 2009. The Bradley Report. London: Department of Health.

Although the majority of this offender population are male, the need for a specific strategic plan for women was also recognised. This is described elsewhere in this journal by Laura d'Cruz the lead for the women's strategy in NOMS. The joint Department of Health (DoH) and the National Offender Management Service (NOMS) approach for men was put out for public consultation in February 2011,[8] and the Government response on implementation was published in October 2011.[9] The strategy for women followed shortly after.

Aims and Objectives of the new offender personality disorder strategy

The overall aim of this new strategy is to improve public protection and psychological health, building on the DPSD pilots, their evaluations and the lessons learned over the last decade. An overarching principle is that a whole pathway approach is needed rather than isolated services, that provides motivation and engagement, treatment and support post treatment. The main objectives or outcomes for the new strategy are:

- A reduction in repeat serious sexual and/or violent offending (men); or A reduction in repeat offending of relevant offences for female offenders (women)
- Improved psychological health, wellbeing, pro social behaviour and relational outcomes
- Improved competence, confidence and attitudes of staff working with complex offenders who are likely to have PD
- Increased efficiency, cost effectiveness and quality of OPD Pathway Services.

The strategy says it will deliver a more efficient use of existing resources to enhance public protection and provide access to psychological services. It is believed that the same level of resources that were deployed in the DSPD pilot sites can provide improved and earlier identification and assessment and many more treatment and progression places in prisons, approved premises and in the community linked into Probation.

It is a cross-sector, co-commissioned, collaborative, evidence based, community-to-community pathway approach which will lead to improved and earlier identification and assessment of offenders with PD, improved risk assessment, risk and case management of offenders with PD in the community. There will be new intervention and treatment services commissioned at national, regional and local levels by the NHS and NOMS in secure and community environments, improvements to the nationally commissioned treatment services in high security prisons and regionally commissioned democratic therapeutic community services in prisons. A new model of progression environments (Psychologically Informed Planned environments: PIPEs — see below for a definition) in prisons and approved premises for offenders who have completed a period of treatment is being put in place across custody and the community. Workforce development underpins much of the strategy, equipping staff across the offender pathway with the right skills and attitudes to work with this group of high-risk offenders. Those with co-morbid severe mental health problems where the requirements of the Mental Health Act are met and the NHS pathway is the most appropriate for their needs at that time, will continue to access hospital placements in high, medium and low secure conditions. Lastly, where possible, offenders identified as part of the Offender Personality Disorder pathway (OPD) pathway will be encouraged to attend existing accredited offending behaviour programmes (OBPs) including Democratic Therapeutic Communities.

As part of a longer term objective, related Department of Education and Department of Health programmes for young people and families will continue to be joined up with the offender personality disorder pathway to contribute to prevention and breaking the cycle of intergenerational crime.

The key principles

The strategy has been developed using principles from across a wide spectrum of practice and research evidence, from the learning of the DSPD pilots and recent guidance from the National Institute for Clinical Excellence on the treatment and management of personality disorders.[10,11]

The key principles underpinning the strategy are that the personality disordered offender population is a shared responsibility of NOMS and the NHS, and that planning and delivery is based on a whole systems pathway approach across the Criminal Justice System (CJS) and the NHS, recognising the various stages of an offender's journey from sentence through prison and/or NHS detention to community-based supervision and re-settlement. Offenders with personality disorder who present a high risk of serious harm to others will primarily be managed through the CJS with the lead role held by offender managers whether they are based in the community or prisons. Treatment and management will be psychologically informed and led by psychologically trained staff in NOMS and the NHS, focusing on

8. Department of Health and Ministry of Justice (2011a) Consultation on the offender personality disorder pathway implementation plan. Retrieved 8 March 2011 from http://www.parliament.uk/deposits/depositedpapers/2011/DEP2011-0319.pdf
9. Department of Health and Ministry of Justice (2011b) Response to the offender personality disorder consultation. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_130701.pdf
10. National Institute for Health and Clinical Excellence (2009a) Antisocial Personality Disorder: Treatment, Management and Prevention. London: NICE.
11. National Institute for Health and Clinical Excellence (2009b) Borderline Personality Disorder: Treatment and Management. London: NICE.

relationships and the social context in which people live. This draws from the existing evidence base from NICE guidance and research.[12] In developing services, account is taken of the experiences and perceptions of offenders and staff at the different stages of the pathway.

The target population for the pathway and the approximate need for services

The criteria for men and women are different due to their different needs, presentations, and behaviour. To ensure equality of access to services for women the entry criteria need to reflect the much *lower* numbers of women who are a high risk of harm to the general public, and the proportionately *higher* numbers of women offenders with mental health problems and self-harming behaviours. The entry criteria for the target population are:

Men

- ❒ At any point during their sentence, assessed as presenting a high likelihood of violent or sexual offence repetition and as presenting a high or very high risk of serious harm to others; and
- ❒ Likely to have a severe personality disorder; and
- ❒ A clinically justifiable link between the personality disorder and the risk; and
- ❒ The case is managed by NPS.

Women

Either the above criteria for men is met or:

- ❒ Current offence of violence against the person, criminal damage, sexual (not economically motivated) and/or against children; and
- ❒ Assessed as presenting a high risk of committing an offence from the above categories OR managed by the NPS; and
- ❒ Likely to have a severe form of personality disorder; and
- ❒ A clinically justifiable link between the above

The work to identify offenders who meet the pathway criteria is nearing the end of the first year of implementation. As of June 2014 approximately two thirds of the entire NOMS caseload (all offenders in the community on supervision or licence or serving a sentence of imprisonment) has been screened; of these, approximately 12,000 offenders meet the criteria. We estimate that once the entire case load has been screened, that this will rise to around 20,000 offenders. What is less clear at this stage of implementation is the scale of demand for PD services, given that many offenders with PD are not motivated to engage. However, the large number of offenders who satisfy the criteria highlights how important making the best use of the resource we have available is. It is also worth remarking that the criteria excludes medium and low risk of harm men, who in some cases may have equally severe personality dysfunction.

Workforce development

Workforce development underpins the OPD strategy by providing training designed to change attitudes to personality disorder and develop the skills and confidence of staff in working with people with complex needs. The training is available to all staff across the Criminal Justice System, health, social care and beyond, and supports the dedicated workforce development undertaken in dedicated PD services.

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What is on offer ranges from bespoke training designed and delivered by the Health partner working in the dedicated PD prison or probation PD service to the wider 'Knowledge and Understanding Framework' (KUF) 3 day awareness course for all staff, run jointly by NOMS / Health staff and 'Experts by Experience' — users of Personality Disorder services. Various tailored training resources have been developed to help staff working with specific groups, for example there is a women's KUF training for prison staff, a training programme for prison staff in general, and a young adult version in development. There are higher level modules (originally written for BSc and MSc courses), on offer that can be delivered as required to staff across localities.

The Pathway — a flexible holistic model

The one key feature of the pathway framework is the commitment to provide a consistent and coherent series of health interventions across the CJS and Health service, starting in the community, moving through the sentence and returning to the community at the end of sentence, via custody where applicable. Figure 1 below illustrates this movement.

The black background shows the four key objectives; workforce development, improved mental

12. Warren F, Preedy-Fayers K, McGauley G, Pickering A, Norton K, Geddes J R, Dolan B. 2003. Review of Treatments for Severe Personality Disorder. Home Office Online Report. 30.

health, improved public protection, and using resources efficiently. The pathway begins at the top of the diagram with case identification and pathway planning — the programme aims to identify offenders who fit the criteria at the earliest stage after sentence. From this both the OPD pathway and the sentence plan flow. The box illustrates a backdrop of risk management which is ever present. Once an offender moves into services, these will be Enabling Environments (see below for a definition). Depending on the plan for the offender, services will include pre-treatment 'preparation' PIPEs (Psychologically Informed and Planned Environments), PD treatment, traditional accredited offending behaviour programmes, Democratic Therapeutic Communities, post treatment support PIPEs, and active case management led by the National Probation Service (NPS) for men, and for women the NPS and Community Rehabilitation Companies (depending on their level of risk to the public).

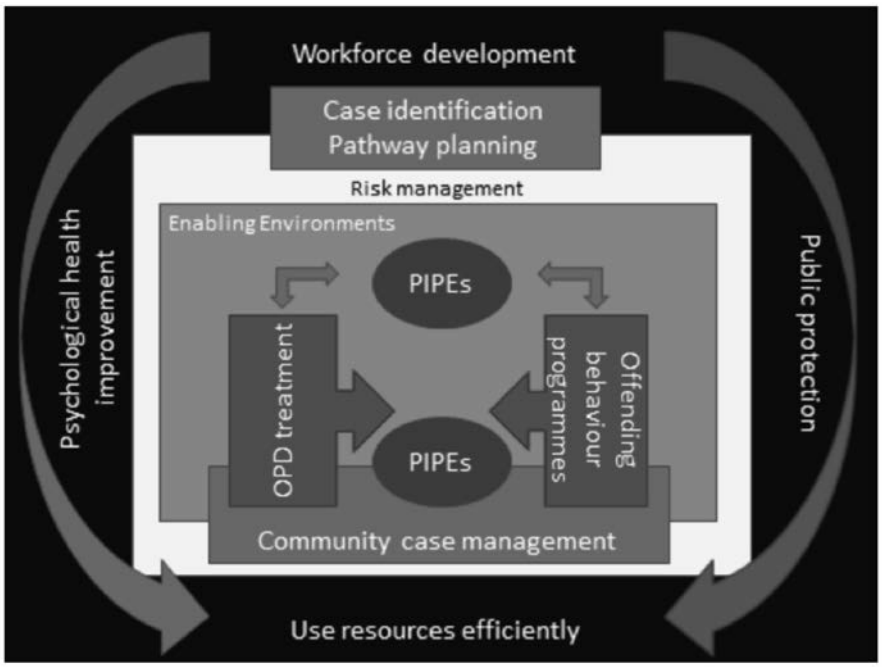

Figure 1. The Offender Personality Disorder Pathway and its key elements

In reality an offender may not engage with all or any services, or may need to move back and forth through services to make progress. A key aim of the pathway is to ensure that offenders' risk to others is effectively managed through their sentence, and where the offender does not engage or drops out of a programme, he/she is supported to re-enter at a later date or try an alternative form of support/treatment.

Case identification and Pathway planning

This describes the process of identifying those cases that meet the criteria for the pathway at the earliest possible opportunity. This process will involve using information from OASys, case files, and offending histories. Clinical support and advice is provided by the Health Service Provider (HSP) working in partnership with offender managers in probation. These staff will receive training as part of the Workforce Development strand of the programme to assist with this process and have access to case consultation, usually provided by a forensic or clinical psychologist. The screened caseload will include newly sentenced offenders and those who are already held on the caseload. The offender manager will work in partnership with staff from the HSP to discuss individual cases in more depth and make a decision on whether the offender meets the pathway criteria. Staff working in the prison, such as the offender supervisor, may also identify and refer cases to pathway services.

Once individuals have been identified as meeting the criteria for the pathway, the offender manager will work in partnership with the HSP to develop a Pathway Plan for each offender based on a process of Case Consultation and Formulation. This describes a process of targeted specialist advice and discussion between the staff from the HSP and the offender manager to consider the offender's psychosocial and criminogenic needs relating to their personality disorder and to make timely decisions about the sentence plan. Case formulation will always be recorded, but will vary in style depending on the complexity of the case and the urgency of the pathway plan.

A Pathway Plan will be developed for all offenders on the pathway, although the timing of when the offender receives the PD services indicated in the plan may vary depending on the needs of the offender (e.g. a newly sentenced prisoner with a very long custodial sentence may not be prioritised for receiving PD services immediately within their plan). The plan will be monitored and updated by the offender manager or the offender supervisor as necessary throughout the term of their sentence. It is anticipated that a significant number of offenders meeting the criteria will be unwilling and/or unable to participate in the specialist OPD services, due to either their personality pathology or an insufficient sentence length. In these circumstances, the formulation will focus on the effective management of the individual. This might include motivation and engagement, risk assessment, community case management, and/or compliance with licence or sentence conditions.

The case consultation, formulation and pathway plan will determine the appropriate management approach and interventions required for the offender and ensure that referrals are made to services at appropriate times. An offender may be referred immediately to a

treatment service or intervention, or may engage in other (non-treatment) services, such as a pre-treatment PIPE or motivational work. It should be noted that an offender may be referred to the whole range of services available across NOMS and the Health service as part of their Pathway Plan.

Intervention

The type of treatment services available to offenders can broadly be split into two categories: **PD Treatment Interventions** that are co-commissioned by the NHS/NOMS PD Team specifically for offenders with PD; and general **Offending Behaviour Programmes**, which are programmes that are accredited and commissioned by NOMS custodial commissioners to address an offender's criminogenic needs and reduce reoffending.[13] The order in which offenders access these services may vary.

Specific PD Treatment Interventions should aim to ensure an improvement in mental and emotional wellbeing, social circumstances and community ties associated with the reduction in risk of sexual or violent reoffending. Effective interventions will deliver an evidence-based service within a safe, supportive and respectful environment, employing a range of skilled, motivated, supported and multi-disciplinary staff to address offender's personality difficulties and behaviours. Available OPD treatment interventions are summarised in the Brochures of OPD Services (one for male services and one for female services) available from the OPD team on request.

Offending Behaviour Programmes

There is also a wide range of the traditional NOMS Accredited Offending Behaviour Programmes (OBPs). These address specific offence types, such as violence, sexual offending, substance misuse related offending and general offending behaviour. They are not suitable for all offenders and many with very complex interpersonal problems / PD may not have accessed them in the past, or may have dropped out because standard group work programmes are not responsive enough to the complex interpersonal problems that some offenders with PD present. The work by the offender manager to deliver more careful preparation and placement should ensure that appropriate programmes are offered at the right time and prevent early attrition. Most Accredited OBPs are potentially suitable for offenders with PD, but work on the complex interpersonal needs may need to be undertaken first or in conjunction with the programme in order to avoid offenders undermining the treatment and disrupting the programme for others. Democratic Therapeutic Communities (DTC) are an accredited prison OBP that are known to be particularly effective with PD offenders and will therefore play a key role in the OPD Pathway. The CARE (Choices, Actions, Relationships, Emotions) programme for women offenders is also delivered in conjunction with OPD services at Foston Hall and New Hall prisons, as is CHROMIS, an intervention designed to be responsive to offenders with high levels of psychopathic traits, delivered at HMP Frankland.

PIPEs and Enabling Environments

The offender manager and HSP may also refer an individual to a Psychologically Informed Planned Environment (PIPE). These are not a treatment; they are instead designed to enable offenders to progress through a pathway of intervention; supporting transition and personal development at significant stages of their pathway. An offender in a prison setting may either attend a 'Preparation PIPE' to help them prepare for the treatment environment; reside in a PIPE environment ('Provision PIPE') as they participate in treatment elsewhere, for example off the wing; or else attend on completion of a PD treatment or OBP in their sentence plan — 'Progression PIPE'. Additionally the PIPE model has been applied in a number of community based hostels known as Approved Premises PIPEs, supporting those who have been released from custody. Other Progression services are also being designed to support the pathway-based approach, including Enhanced Progression Units to help offenders move from prison back to the community (one is currently operational at HMP Belmarsh, serving London). Evaluation of the PIPE pilots found that their social climate was perceived as significantly more supportive, safe and cohesive than that of the same unit before the PIPE was introduced.[14,15] The social climate of the PIPE was measured using the EssenCES questionnaire.[16]

The Enabling Environments project is a quality mark and process that has been developed by the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI). It is a quality improvement mechanism to support services to increase the use of therapeutic principles to create positive living and working environments. A standards based Enabling Environments award leads to the establishment of a supportive, positive relational

13. See http://www.justice.gov.uk/offenders/before-after-release/obp
14. Turley C, Payne C, Webster S. (2013). Enabling features of Psychologically informed Planned environments. MOJ Analytical Services. Can be found at https://www.gov.uk/government/publications/enabling-features-of-pipes-research-report
15. Shearman, N. 2013. Evaluation of the Social Climate of PIPEs in prisons and approved premises. Internal Publication for NHS/NOMS.
16. Schalast N, Redies M, Collins M, Stacey J, Howells K. 2008. EssenCES, a short questionnaire for assessing the social climate of forensic psychiatric wards. Criminal Behaviour and Mental Health. 18(1) p 49-58.

environment[17] that all residential and treatment services in the OPD pathway are expected to achieve.

Community Case Management

Community case management of the offender by the offender manager in the NPS or Community Rehabilitation Companies, and post-sentence arrangements will ensure that treatment gains are sustained and ongoing risks appropriately managed and monitored. This will be delivered though specific support to Approved Premises either in the form of a PIPE or through building on the approach to case consultation and formulation, and time limited 'joint casework' by the Offender Manager and HSP to those with the most complex needs. All women identified for the women's pathway will be offered independent mentoring and advocacy within community based services.

Programme Evaluation

The national evaluation of the Offender PD Pathway is a four year independent evaluation which will include an assessment of whether the new arrangements offer value for money. This started in August 2014. Other projects undertaken throughout 2013/14 include a two year evaluation of the Community Pathway in London (report will be available late 2015) and the first stage of an impact evaluation of the Democratic Therapeutic Communities (DTC). An initial PIPE evaluation has also been published (see above) and a full research and Evaluation Strategy and Work Programme has been agreed by the Joint NOMS and NHS England Offender Personality Disorder Programme Board.

Possible Future developments

The OPD programme grew out of the DSPD pilots and is testing new ways to deliver services to this population. Already we can see gaps in service provision. Properly managing treatment resistant and/or avoiding offenders is critical. However these are likely to be the majority of those who meet the PD pathway criteria and who will therefore continue to have significant mental health needs and be a risk to the public. Finding a way to work with this group will require further development and research before additional capacity can be provided.

Another gap is medium and low risk offenders with PD. From a mental health perspective, this group are the responsibility of Health and Justice co-commissioners in prisons within existing mental health in-reach services. In the community this group is the responsibility of Clinical Commissioning Groups who provide community forensic mental health and personality disorder services. Provision is therefore fragmented and a unifying secure and community strategy and commissioning framework is needed to improve access and equity of services across the country and to ensure efficient use of limited resources.

The current commissioned services provide an approach to enhancing the way in which probation services works with this population. Further development and roll out of community based treatment and approaches to complex case management, and better links with NHS Community Forensic Mental Health provision is needed.

Children and young people

The pathway approach has yet to be tested with children and young people. It is designed for adults aged 18 and over, though the Multi Systemic Therapy[18,19] pilots show promise in demonstrating that children and young people can make gains in tackling emerging complex needs and offending, when interventions are early, targeted, and use evidenced based practice. The START research trial includes a randomised control trial across 9 sites.[20] It is known that the transition from juvenile services to adult services is difficult for young people and especially when compounded by emerging personality difficulties. The pathway model used here has the potential to assist with this transition and could be applied to those at high risk of developing PD and serious offending.

Conclusion

The journey to the current strategy, and now its implementation have not been without problems. From both a political and clinical viewpoint this is an unpopular client group with whom engagement is difficult and for whom there is as yet no definitive evidence of treatment effectiveness. From a systems perspective the difficulties are around bringing together two independent organisations, NOMS and the NHS, both with different cultures and systems and both requiring independently and together to embed new ways of delivering services. What unifies them is the client group who require the help and support of both organisations together, and the compelling need to deliver more effective public protection.

17. See www.enablingenvironments.com 18 Henggeler S, Melton G, Brondino M, Scherer D,and Hanley J. 1997. Multisystemic Therapy with violent and chronic juvenile offenders and their families: the role of treatment fidelity in successful dissemination. Journal of Consulting and Clinical Psychology. 65(5), 821-833.
19. See www.mstuk.org
20. See www.ucl.ac.uk/start

DSPD ten years on at Broadmoor

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This article looks at the lessons learned from the Dangerous and Severe Personality Disorder (DSPD) service at Broadmoor. The staffing, policies and management practices that were implemented are discussed, many of which are still in place today after the decommissioning of the DSPD service in 2011. Our treatment and assessment model is described in comparison to the other DSPD units. It might be said that the DSPD service at Broadmoor was never really fully tested, with lower than anticipated referral numbers and limited options for moving patients on. The challenges of decommissioning and where to place our DSPD patients are discussed and how, if it were today, moving patients on would be easier within the national offender PD pathway. However, whilst Broadmoor may have been operationally more vulnerable than expected, lessons learned in the course of DSPD programme development have made lasting changes in the ethos of patient engagement, treatment delivery and risk management at Broadmoor.

Introduction

Following a number of national concerns about the unsafe management of Personality Disorder patients, a joint initiative from Department of Health and Home Office resulted in the development of the DSPD (Dangerous and Severe Personality Disorder) programme. Its objective was to meet the equal concerns of providing treatment and public safety.[1] Key events that led to this development included: (i) the Fallon enquiry into Ashworth's treatment and management of Personality Disorder (ii) the 1983 Mental Health Act requirement for the treatability of 'psychopathic disorder' and (iii) cases like that of Michael Stone who as an 'untreatable psychopath' was excluded from forensic mental health services and remained in the community free to kill Lynne and Megan Russell. This highlighted the inadequacy of evidence-based treatment for severely personality disordered patients. The case of Robert Oliver who declined admission by Broadmoor on the grounds that his paedophilic-motivated kidnapping, assault and killing did not constitute a mental disorder only fuelled the debate.

The DSPD challenges were twofold: to manage and alleviate personality disorder, including psychopathic traits, and to address criminogenic needs and reduce risk. Its development was controversial from the outset: some felt that the possibility of detaining a determinate sentenced prisoner beyond the expiry of sentence undermined basic human rights, and others argued that DSPD was not a clinical diagnosis nor a medical condition. In practical terms the new proposals were not substantially different from the prevailing Mental Health Act provisions other than treatability would be less restrictively interpreted.

To meet the DSPD criteria, there would need to be evidence of a severe personality disorder(s) and severe past offending (refer to table 1) with the two being functionally linked. The initial working definition of DSPD was set out in terms of an individual presenting with: (i) a significant risk of serious physical or psychological harm from which it would be difficult or impossible for the victim to recover; (ii) a significant disorder of personality; and (iii) the risk presented is functionally linked to the personality disorder. A series of guidelines were developed to support these criteria which included the use of DSM or ICD diagnosed personality disorders and/or high scoring on the PCL-R and use of empirically sound risk assessment instruments for quantifying risk of sexual or violent offending.

The origins of DSPD

The introduction of DSPD at Broadmoor

The national DSPD strategy was set up in two prison units (HMP Whitemoor and HMP Frankland) and two high secure mental health units (Broadmoor and Rampton). Two of the original architects of the DSPD proposals were Broadmoor staff: Dilys Jones then Consultant Forensic Psychiatrist acted as a Department of Health advisor and Derek Perkins, the then head of Psychology was seconded to the national DSPD planning

1. *Dangerous and Severe Personality Disorder (DSPD) High Security Services: Planning and Delivery Guide*. Home Office, 2004.

group. This group was tasked with drafting national guidelines for the four proposed units which were encouraged to develop individual identities and treatment regimes. On Broadmoor's part national and international visits informed the decision to adopt a Cognitive Behavioural Therapy (CBT) approach. This was based on the evidence base for this approach, that it did not require 'experts' and it was already developed and did not require a huge investment of time to design a new treatment model.

An outreach team consisting of a senior manager and clinical staff visited several high secure prisons to seek volunteers for the new service at Broadmoor. A small trial ward was set up in the main hospital (Bicester Ward) to receive the new patients as they were to have no contact with other patients in the main hospital and a new specifically designed unit 'The Paddock' was built and policies and procedures developed in close consultation with the staff group. The DSPD design group was always aware that the project may have a time-limited life and there was therefore much discussion about not only making the Paddock safe to accommodate this challenging DSPD cohort, but flexible enough to be reused for other types of patients should the service not continue.

There was an initial fear that these patients were very unusual and dangerous, partly no doubt because of their 'DSPD' label. However, with regard to day-to-day risk to self or others, the challenges were no greater than with other PD patients within the main hospital; DSPD patients' risk lay more in their risk to the public than in their day-today management. Due to a slow pace of admissions Broadmoor was not able to generate sufficient numbers of DSPD patients to form the relevant therapy groups and DSPD patients began to be placed in centralised therapy groups or treated individually on a bespoke basis and segregation gradually relaxed for general activities such as education, recreation and general rehabilitation groups.

Staffing, Management and Policy

Staff working in the DSPD unit required a high degree of personal resilience to maintain boundaries, survive hostility and manage conflict in a high secure setting. The early service at Broadmoor had a specific staff recruitment assessment centre solely for this purpose. A new strategy included recruiting Assistant Psychologists as well as Health Care Assistants into a new category of Therapy Assistants to work alongside the larger group of nurses. This innovation was only partly successful and resulted in tensions between Therapy Assistants and Staff Nurses. Despite efforts to ensure all clinical staff were involved in delivering therapy the new therapy assistants were not qualified to perform daily mandatory nursing duties which fell to the Staff nurses to complete and prevented them being as involved in therapy as the more junior Therapy Assistants. As the DSPD service became more embedded within the wider hospital such tensions dissipated and the later service operated more in line with the main hospital's recruitment procedure of 'recruit and place hospital-wide'.

Not only was the DPSD population difficult to treat, it also presented challenges with regard to their safe management and containment. Clinicians were presented with the risk of allegations and litigation, the threat of clinical boundary violations, and significant difficulties with therapeutic engagement. Broadmoor developed clear policies and procedures to ensure clinical work was supported, including enhanced communications between the clinical team and the security department to deliver effective intelligence gathering and risk management. We also adopted a harm minimisation approach and a learning culture which promoted open discussion and analysis of mistakes as well as successes, and this was regarded as essential in safeguarding both staff and patients.

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Multidisciplinary teamwork (MDT) was developed to a high level to manage the particular challenges of the DSPD population. Teams were required to include, amongst others, a psychiatrist, a nurse, a psychologist, a social worker, an occupational therapist, a therapy assistant and a security liaison nurse. It was imperative that the staff understood the imortance of team working, sharing information, being effective team players and feeling comfortable working as part of an MDT. Lessons from this continue to be used throughout Broadmoor to ensure all aspects of a patient's needs are reviewed and to support the staff who address them.

Another gain in working practices from our experience of working with DSPD has been the role of supervision and reflective practice in maintaining the effectiveness and healthy functioning of the team. Regardless of the format of therapy (1:1 or group format), each staff member received a minimum of one hour of formal clinical supervision and one hour of

management supervision per month; practices that continue today. Clinicians working with DSPD were continuously exposed to challenging interpersonal dynamics resulting in potential boundary breeches, vulnerability, team polarisation and splitting. Facilitated multidisciplinary team supervision and reflective practice enhanced team effectiveness and helped them to resolve conflict and disagreements. These forums, and a daily shift de-brief allowed teams to take 'protected time' to reflect on shared experiences of patient work and their approaches to clinical practice. This reduced professional isolation and allowed staff the space to explore problematic feelings and attitudes which had the potential to split the team.

Admissions into the new DSPD unit

The early DSPD patients recruited from their original prisons were keen to come to Broadmoor. Some were genuine volunteers seeking enhanced treatment and others saw Broadmoor as a better alternative to prison. Others were lifers well over their tariff who saw the move as a potential route out of confinement. This was a stark contrast to the later patients who were admitted involuntarily and sometimes near the end of their sentences. They were often antagonised by the circumstances of their admission and less cooperative.

The new system had a very clear and challengeable process of defining (i) Personality Disorder and Risk and (ii) the functional links between them. Despite the original guidance on establishing links between personality disorder and offending, it was not clear how a functional link could be determined beyond identifying that that patient belonged to two overlapping populations (personality disorder and serious violent/sexual offending). Demonstrating the presence of a functional link required clinical evidence that either treatment of the personality disorder led to a reduction in their violent or sexual offending, or that a period of deterioration in mental state (personality disorder presenting) was associated with more obvious offence paralleling behavior. Attempts were made to elucidate and standardise the identification of this functional link by means of an 'Aid to Decision Making' document *(refer to Table 1).*

Early on in the DSPD project, Broadmoor developed a policy of seeking to admit child sexual abusers and other sex offenders on the basis that (i) this group, especially child sex offenders, was of maximum concern to the public (ii) Broadmoor had expertise and facilities in working with such cases and (iii) such offenders would be less disruptive in the unit than other offenders. This view was possibly ill conceived as, although sex offenders typically posed little control problem in prison, the criteria for admission into DSPD treatment were a high PCL-R score or two PD diagnoses, disorders that are associated with high levels of interpersonal challenging behaviours. Although as the DSPD service at Broadmoor developed this over-representation of personality disordered sex offenders was challenged by national management in an attempt to better 'share the load' of difficult patients. Whilst this did reduce the number of DSPD sex offenders, Broadmoor still had a high proportion (76%) in comparison with the Rampton (44%), HMP Whitemoor (50%) and HMP Frankland (46%) units.

Unlike the other DSPD units, Broadmoor did not have a formal inpatient assessment process but assessed referrals in prison prior to making a selection decision (by means of the PCL-SV[2] and HCR-20[3]) by an outreach group of a psychologist, a psychiatrist and a nurse. In

Table 1: The criteria for admission to a DSPD unit.

To be meet the criteria, an individual needs to fulfil either criterion A or B and/or Criterion C

Criterion A	A score of 30 or above on the Revised Psychopathy Checklist (PCL—R; Hare, 1991) or
Criterion B	A PCL—R score of 25—29 plus at least one DSM—IV personality disorder diagnosis other than antisocial personality disorder
Criterion C	Two or more DSM—IV personality disorder diagnoses

Table 2: The minimum assessments required for admission to a DSPD unit

Domain	Assessment tool
Violence	Violence Risk Scale (VRS; Wong and Gordon, 1999—2003) Historical, Clinical and Risk Management (HCR—20) scale (Webster et al, 1997)
Sexual Offending	Risk Matrix 2000 (Thornton et al, 2003) Static 99 (Hanson and Thornton, 2000)
	Structured Assessment of Risk and Need (SARN; Thornton, 2002)
Personality disorder	The Revised Psychopathy Checklist (PCL— R; Hare, 1991) Psychopathy Checklist — Screening Version V (PCL—SV; Hart et al, 1995) International Personality Disorder Examination (IPDE; World Health Organization, 1997)

Source: Howells, Krishnan, and Daffern (2007). Challenges in the treatment of dangerous and severe personality disorder.

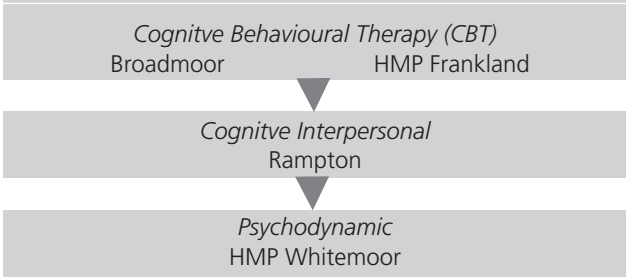
2. Hart, S., Cox, D. & Hare, R. (1995) *The Hare PCL:SV Psychopathy Checklist: Screening Version*. Multi-Health Systems.
3. Webster, C. D., Douglas, K. S., Eaves, D., & Hart, S. D. (1997b). HCR-20: Assessing the Risk for Violence (Version 2). Vancouver: Mental Health, Law, and Policy Institute, Simon Fraser University.

addition to being cost-effective, this integrated approach had the benefits of creating more confidence that patients coming in would be suitable and allowing access to treatment at the three month point of the initial Care Programme Approach (CPA), if not sooner. Broadmoor maintained this 'outreach' assessment team to complete a comprehensive initial assessment and formulation even after the 'Aid to Decision Making' document was introduced. This consisted of using semi-structured interviews and a standardized battery of structured assessments *(refer to Table 2)*.

Treatment

The different DSPD units were encouraged from the outset to develop different models of treatment (pending approval from the national board and compliance with a common core of requirements; *(refer to Figure 1)*.

Figure 1: The spectrum of therapeutic models used across the DSPD units.



Given the multidimensional nature of Personality Disorders and psychopathy, Broadmoor identified the need for a multifaceted but integrated treatment approach, consistent with Livesley's (2003) recommendations.[4] In keeping with the key elements of the DSPD strategy the psychological therapies used at Broadmoor attempted to integrate both the personality disorder and the offending behaviour/criminogenic needs (refer to figure 2 and 3) and an integrative cognitive behavioural treatment (CBT) approach was adopted. CBT has the advantage of capitalising on the cognitive strengths associated with the DPSD population and not requiring introspection or emotional experience. Guidance suggests that as it is the deficient interpersonal and affective facets of psychopathy and not the behavioural facets that present the poorest treatment prognosis.[5] More specifically CBT's collaborative 'personal scientist' approach empowers patients and is likely to appeal to the grandiose nature of psychopaths, their self-interest and their desire for novelty and control.[6]

As not all the DSPD population was anticipated to be high PCL-R scorers, we needed to ensure the therapeutic style was responsive to the whole spread of PCL-R scorers, and the CBT approach at Broadmoor was therefore shaped by a number of additional influences and therapies, including the phases of the Violence Reduction Programme,[7] Dialectical Behavioural Therapy,[8] the 'what works' literature,[9] Integrative and milieu therapy and Livesley's 4-stage process of change,[10] the 'Good Lives' principles,[11] the 'Risk Needs and Responsively' model,[12] and Schema focussed therapy.[13] The National Institute of Clinical Excellence (NICE 2003) service-user perspective were also incorporated into the delivery of therapy.

As the DSPD service developed, the profile of the DSPD population changed from a preponderance of antisocial and psychopathic traits for which the literature recommends CBT to more borderline traits, for whom the cognitive model was insufficient *(refer to table 3)*. As a result the treatment strategy changed to include approaches that included introspection such as Mentalization-Based Therapy[14] and the emotional domain such as Dialectical Behavioural Therapy (see footnote 8).

Motivation and Engagement

The nature of the DSPD criteria (high-risk, prior significant therapy interfering behaviours and high levels of resistance) together with the psychopathic traits of most of the patients (lack of insight, lack of therapeutic

4. Livesley, W. J. (2003) Diagnostic dilemmas in the classification of personality disorder. In *Advancing DSM: Dilemmas in Psychiatric Diagnosis* (eds K. Phillips, M. First & H. A. Pincus), pp. 153–189. American Psychiatric Association Press.
5. Hemphill, J.F., & Hart, S.D. (2002). *Motivating the unmotivated: Psychopathy, treatment and change*. In M. McMurran (Ed.), Motivating offenders to change: A guide to enhancing engagement in therapy (pp. 193-219). Chichester: Wiley.
6. Farr, C and Draycott, S (2007) "Considering Change": A motivational intervention for severely personality disordered patients. *Issues in Forensic Psychology, Special Edition,* 7, 62-69.
7. Wong, S. (2004) *The Violence Reduction Program*. Correctional Services Canada.
8. Linehan, M. M., Schmidt, H., Dimeff, L.A., et al (1999) Dialectical behaviour therapy for patients with borderline personality disorder and drug-dependence. American Journal on Addictions, 8 (4), 279-92.
9. McGuire, J. (ed.) (2002) *Offender Rehabilitation and Treatment: Effective Programmes and Policies to Reduce Re-offending*. John Wiley & Sons.
10. Livesley, W.J, (2003). *Practical Management of Personality Disorder*: New York: The Guildford Press.
11. Ward, T. & Brown, M. (2004) The good lives model and conceptual issues in offender rehabilitation. Psychology, Crime and Law, 3, 243–257.
12. Andrews, D. A. & Bonta, J. (2003) *Psychology of Criminal Conduct* (3rd edn). Anderson Publishing.
13. Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: a practitioner's guide*. New York: Guilford Press.
14. Fonagy, P. & Bateman, A. (2006). Mechanism of change in mentalization based treatment of borderline personality disorder. Journal of clinical Psychology, 62, 411-430.

Table 3: Demographics and Clinical Assessment of Broadmoor's DSPD in compared to other DSPD population

	Broadmoor	Other high secure DSPD population
Demographics		
Mean Age (sd)	38.2 (9.4)	36.7 (9.3)
% White	89 %	88 %
Clinical Assessment		
PCL-R Total Score	27.4 (4.8)	27.8 (5.2)
PCL-R Factor 1 Score	10.8 (2.8)	10.7 (3.0)
PCL-R Factor 2 Score	14.3 (3.2)	14.9 (3.2)
% Diagnosis		
Paranoid	48.1	26.7
Schizoid	3.8	7.0
Schizotypal	11.5	7.3
Antisocial	76.9	75.2
Borderline	46.2	43.7
Histrionic	9.6	6.0
Narcissistic	17.3	17.3
Avoidant	21.2	16.2
Dependent	1.9	1.8
Obsessive-compulsive	7.7	6.8

attachment, manipulative interpersonal style, and lack of personal responsibility) was a challenge to clinicians in terms of enabling patient motivation. These patients had anti-social interpersonal and cognitive skills but lacked the necessary motivation and/or ability to apply these pro-socially. Subsequently, one of the primary approaches to engage the DSPD population in therapy, using the theoretical model of the Considering Change programme, became early intervention to use the skills the patient already had to reduce the discomfort of cognitive dissonance produced by the interplay of self-evaluations, cognitive mechanisms, behavioural and outcome expectancies, personality traits, and aspects of the environment.

Such attempts were in keeping with recommendations that the cognitive skills of psychopaths should be utilized to enable them to understand the rationale underpinning their treatment (see footnote 5). Due to the challenging nature of the population, the reasons they cited for wanting to change, often extrinsic motivators, were represented as important stepping-stones towards making the change. In the same way, internalising the desire to change was, and still is, regarded as a therapeutic process rather than a treatment target in itself.

Broadmoor remains very much aware that the systems in which treatment programmes are embedded are important in establishing and maintaining motivation. All ward based staff were trained in core motivational skills as a means of mitigating a potentially hostile and coercive environment. To motivate the patients, further attempts were made to examine the costs and benefits of changing offending behaviour with reference to self and others. Despite the restricted empathic responses of the DSPD patients, referring to 'significant others' was also important in achieving change. Using a meaningful role-model had the advantage of levering self-interest as did working with general behaviours that they wanted to change in preference to their offence-paralleling behaviour (or inter-personal aggression).

The high levels of psychopathy associated with DSPD were viewed as responsivity factors in terms of the RNR model.[15] Treatment targets were represented as 'strengths', such as the psychopathic tendency to desire a sense of control and to seek sensation (be comfortable with novel situations). Utilising a personal-scientist approach and independent between-session tasks helped to create a sense of control, resulting in increased self-efficacy and personal responsibility for change. Equally, the patients' desire for status and their facility with impression management were capitalised upon through group declarations of change 'targets'.

Treatments outcomes

Positive changes did occur in response to treatment for the DSPD patients, but not for all. Change scores were developed at the point of leaving Broadmoor (for example of the 47 patients for whom repeat HCR-20 data was available, 68 per cent showed positive change on the dynamic (Clinical and Risk) items, 15 per cent showed no change, 17 per cent showed negative change and 28 per cent showed a change greater than 5. A striking difference between the DSPD patients and the patients in the main hospital was how well developed they were in talking about their diagnosis and offences, reflecting the transparent approach to treatment and significant investment made in orientating and engaging patients in treatment that included for example patients being actively involved in rating their own VRS and HCR-20.

Related to this, a seemingly paradoxical pre and post measure change occurred: as the DSPD patients progressed in therapy they gained insight and appeared to become more honest in their behaviour and attitudes, yet on paper this gave the impression that they had got worse. The Violence Risk Scale[16] and Violence Risk Scale: Sexual Offender version (VRS-SO)[17] were used as

15. Risk, Needs, Responsivity model, see footnote 12
16. Wong, S. C. P. & Gordon, A. (1999–2003) *Violence Risk Scale.* Department of Psychology, University of Saskatchewan. http://www.psynergy.ca
17. Wong, S.C.P. & Olver, M. (2010). The Violence Risk Scale and the Violence Risk Scale- Sex offender version. In R. Otto and K. Douglas (Eds.), *Handbook of Violence Risk Assessment.* Routledge.

measures of change on a six monthly basis, but this transpired to be too frequent. A pattern emerged in which progression through 'pre-contemplation' and 'contemplation' to 'preparation' were being evidenced by all, but at the point of 'preparation' the majority of patients flat-lined, and those who were able to progress on to the 'action' stage were unable to proceed to the 'maintenance' stage as this required them to be able to demonstrate their newly acquired skills in higher risk situations, opportunities that were not available within a high secure environment. The VRS and VRS-SO were probably not the best suited for such a high frequency of assessment, suggesting that either alternative tools more sensitive to change were required, or that such entrenched enduring presentations as severe PD do not readily lend themselves to change. These assessments were shared transparently with patients and completing them was very much a collaborative process, but this eventually became demotivating due to this being interpreted by patients as a lack of progress.

Whilst there was some improvement in motivation level, only a limited behavioural change was observed in DSPD patients. Due to their desire for novelty it may have been that these patients were willing to engage in the therapy when it was relatively new but less so as the treatment progressed. It was identified that to achieve this, individual consolidation sessions and opportunities for generalising skills to a broader environment was necessary. Therapy groups that offered a less formal 'skills workshop' style and more approaches that employed behavioural skills rather than cognitive restructuring were introduced. During this time, treatment recommendations were emerging in NICE guidelines re ASPD that where there is a high risk and a high need, the dosage of treatment also needs to be higher, as does the need for consolidation and opportunities for generalising skills to a broader environment (NICE 2009). This practice-based evidence and more formalised NICE recommendations continue to underpin the application of skills-based CBT to our PD population, particularly with patients who display high levels of psychopathic traits.

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Patients moving on

At the time of commissioning the DSPD service at Broadmoor, and only slightly remedied at the point of its decommissioning, the processes and resources for a patient to either 'step down' to lower security or across high security were limited. This made it very difficult for a patient, especially those on a Section 47/79 to move on from the DSPD unit. Medium Secure Units (MSUs) were resistant to taking on these patients and it was felt that this was due to their sexual offending history (sex offenders being the maximum concern to the public) and the DSPD label that was now attached to the patient. This was even more disquieting as it was not intended to be used as a diagnosis but as a term describing a patient at the point of entry into treatment. By definition therefore they would not be considered 'DSPD' at the point of exit.

Notwithstanding, Broadmoor was able to discharge 24 (31%) of their DSPD patients due to treatment progress prior to its decommissioning in 2011. Now, with the introduction of the Offender Personality Disorder pathway many of the issues that prevented patients from successfully moving on no longer exist. Clear 'step across' pathways are now in place as are pipelines to facilitate patients' downward pathway from a high secure setting up and eventually into the community.

Learning Points

In the nine years that DSPD was at Broadmoor, many lessons have been learned. First and foremost the lack of a continuous pathway from DSPD in a high secure setting to lower security was an issue. At that time the pathways that were in place were limited to MSUs which were very sceptical about accepting Broadmoor DSPD patients. Now, ten years on the National OPD Pathway Directory of Services (2014) addresses this key issue. At the time of writing, Broadmoor's PD patients have recently been given access to this Pathway Directory which lists a range of step-down services, including Psychologically Informed Planned Environments (PIPEs); probation approved premises and medium secure healthcare settings.

At Broadmoor it has now become established that our patients undergo a group therapy pathway in three phases (i) Therapeutic engagement that addresses a patients coping and cognitive skills; (ii) an 'active' treatment phase that restores mental health and addresses the risk behaviour(s); and (iii) relapse prevention in preparation for moving on. The benefits of being upfront with patients about the assessment process and its implications (for example sessions on understanding the nature of personality disorder) were identified in the DSPD project and still stands today.

Furthermore lessons have been learned about the clinical characteristics of psychopathy that would previously have generated therapeutic pessimism but that are now regarded as responsivity features, with some regarded as

strengths that can be channelled and optimised through a CBT approach rather than being exclusion criteria, as was the case in the years prior to DSPD.

There have also been lessons about engagement and the importance of integrating 'formal' treatment with the less formal parameters of a therapeutic milieu. Day-to-day interactions on the wards play out the PD-linked patterns of relating to others, and therefore these daily interactions in themselves offer opportunities for corrective experiences. Integrating this with more formal psychological therapy enables a more holistic service and one that helps to integrate a sense of self. This is akin to the Enabling Environments approach, something that the current Broadmoor PD service is seeking to gain accreditation in. The lessons learnt from our early DSPD experience have been central to our thinking around fulfilling the Enabling Environment criteria.

Finally, the decommissioning of Broadmoor's DSPD service was a contentious decision that was challenging in itself. Not all patients could be returned to prison. For some their determinate sentence had expired, while others who had made significant progress were unable to move on progressively. Only five of the DSPD cohort that needed to be placed in another service due to the decommission were admitted into the newly developed Personality Disorder directorate at Broadmoor (and a further two into the main hospital). Several were transferred to the Peaks Unit at Rampton, but for most of the rest the decision was whether to return them to prison or into the community. Ultimately, only two patients were discharged to the community following Mental Health Review Tribunals as after a cut-off date the decision came down to: if the patient was not suitable to be released into the community they would have to be sent back to prison regardless of how well they had progressed in DSPD treatment.

Did DSPD work?

Very early on at the national multi-agency level there was a rigid requirement that DSPD treatment should be located in high secure settings. Perhaps operationally Broadmoor was more vulnerable than expected and not up to the challenge of working in such as way with a range of a Personality Disorders. But the learning from these challenges, such as the importance of pro-active supervision, good teamwork and specific training in working with Personality Disorders, has been integrated into Broadmoor practices and continues to benefit current PD patients. It was the first of all the commissioned units to close, being decommissioned before it really began. It never received enough referrals, contrary to our original Clinical Director's assertion that 'if you build it they will come'. Experience proved that they will not unless they are sufficiently different to warrant detention in a specialist service, and it has become increasingly apparent that they were not. The commonalities between DSPD patients and the rest of the Broadmoor patients have far outweighed the differences, which suggests that a flexible clinical/forensic PD pathway across services and through into the community is actually what is required.

The Peaks unit:

from a pilot for 'untreatable' psychopaths to trauma informed milieu therapy

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--In this paper I will give a very personal account of what I think are the learning points from the dangerous and severe personality disorder (DSPD) pilot and then go on to think about the way forward for hospital based interventions on the offender personality disorder (OPD) pathway. I am a psychologist working on the Peaks unit, one of two former DSPD units set up in high secure hospital settings.

Back in the 1990s psychologist led treatments for people who had offended and who met criteria for a personality disorder diagnosis were virtually unheard of. The only provision specifically targeting the needs of this group, outside of secure hospitals, were therapeutic communities such as HMP Grendon Underwood and the Wormwood Scrubs Annexe — later to be re-named the Max Glatt Centre. The field of personality disorder treatment was a fairly esoteric area and was primarily staffed by medically oriented psychotherapists using a psychoanalytic and group analytic framework. The earliest change from this medical hegemony was in the Max Glatt Centre and was spearheaded by a little known psychologist Margaret Smith who skilfully made the case with the Governor of Wormwood Scrubs at the time for a psychologist to take up the management of the Max Glatt centre. This offered, as early as 1995/96 the opportunity to integrate new evidence based interventions addressing offending behaviour, dialectical behaviour therapy and schema therapy with the older analytic tradition. It also set an important precedent. Therapeutic interventions with this group no longer had to be delivered by medics within a specifically analytic approach; they could be effectively delivered by psychologists working as part of a clinical team.

Soon after this development Gareth Hughes, a psychologist and Ian Keitch, a psychologically minded psychiatrist at Rampton hospital piloted the personality disorder service. This was the first high secure hospital to separate out patients with a personality disorder diagnosis from the other patients and co-locate them in one place. During the Ashworth Fallon enquiry this service caught the eye of commissioners as a model of working that was different and offered solutions to some of the problems identified in the enquiry, and this made it attractive to them. Soon after this the Personality Disorder directorate, now using a clinical model developed by Todd Hogue — a former prison service psychologist — was given 'Beacon status' and commended as a model to be used elsewhere in the prison service and the NHS. The national DSPD service therefore grew out of the pioneering work of the Rampton personality disorder pilot.

In the course of its development a number of key learning points can be identified:

Lesson 1: Do not base policy decisions on evidence that is a) from one study b) where the treatment model is unusual and potentially unethical.

In 1999 when the Rampton hospital PD service was given Beacon status and work began to think about how to extend this model of working nationally there was little understanding of what kinds of intervention might work for this group. Typically at this time people with severe personality disorder or who were rated high on psychopathy measures were excluded from treatment in both hospital and prison settings. The common assumption was that 'psychopaths' were 'untreatable' and they were likely to get worse if gullible or naïve therapists were to engage them in efforts at bringing about change. This belief was largely driven by papers evaluating the therapeutic community at Penetanguishene in Canada and provides a salient lesson in how a single study can have a disproportionate impact on policy, particularly in the absence of other evidence. When this study was eventually re-examined it transpired that it was very unusual and ethically questionable. The regime at Penetanguishine was highly experimental and included 24 hour encounter groups and the use of LSD and Barbiturates in order to 'break down defences' to allow people to talk openly. The weight given to this study however was such that clinicians all over the world were persuaded that treatment would make people worse. The DSPD initiative flew in the face of this assumption and eventually replaced this belief with the proposal that some people who meet the diagnostic criteria for psychopathy could and would respond to intervention.

The learning that emerges from this is that basing new programmes on 'what the literature says' is less

reliable the smaller the literature base and the more eccentric the clinical model in question. Clinician policy makers need to resist the temptation to lean on studies simply because there are no other in the area in the belief that some evidence is better than no evidence.

Lesson 2: Neither the diagnosis of 'personality disorder' nor the construct of 'personality dimensions' are clinically useful.

For a long time the literature in this field argued about the merits of diagnosis versus dimensional models of personality disorder. In the event neither of these models have proven clinically useful; what clinicians actually use with this population are case formulations and personal narratives linking chronically traumatic pasts with distressing and 'criminogenic' biopsychosocial processes. A danger of relying on diagnostic categories is that other contributing factors from other domains are overlooked. There are also consequences for the evidence base. If diagnostic categories do not correspond with substantive and homogenous groups of disorders then it is unlikely that interventions will work reliably for these groups.

Increasingly practitioners have recognised the pervasive and significant impact of chronic histories of sexual, violent, emotional and neglecting abuse as the core problem for many of those accessing the PD service, to the extent that consideration has been given to renaming the Rampton unit a Chronic Trauma Service for people who have offended seriously, as opposed to a Severe Personality Disorder service. Whilst this change of name is unlikely to happen it reflects the culture and perspective amongst many clinicians working with this group.

Lesson 3: People with personality disorder diagnoses were being excluded from services everywhere, not just in hospital settings.

The final abandonment of the strategy of excluding people with personality disorder diagnoses from services on the ground that they were untreatable is perhaps one of the biggest achievements of the DSPD pilot. Once the assumption of 'untreatability' was challenged a significant population of people who had previously been excluded from services were at last able to access treatment.

The final abandonment of the strategy of excluding people with personality disorder diagnoses from services on the ground that they were untreatable is perhaps one of the biggest achievements of the DSPD pilot.

Those meeting PD diagnoses typically come from the most disenfranchised, disempowered and impoverished social backgrounds, often characterised by chronic experiences of adversity and abuse. Prior to the DSPD pilot they were very poorly catered for in terms of health services; now, ten years after the pilot began they are being offered services — whether from an offending background or not. Mortality rates for this population and their consumption of health services such as AandE are high. Treating this group therefore has the potential to offset other costs to the health and criminal justice systems.

Lesson 4: Service user involvement and strength based approaches offer substantially neglected but promising avenues of intervention for building social capital and reducing re-offending.

There is an increasing recognition that involving service users in the delivery and planning of interventions can be a more effective model for change. This was to some extent recognised in the therapeutic community model where the idea of the 'community as doctor' enlisted the strengths of the peer group to achieve change for its members. A similar approach has more recently been adopted by health services in the 'recovery approach', which dovetails well with strength based models of rehabilitation (or habilitation) such as the 'Good Lives' model that argues that a lifestyle in which the individual meets universal needs without offending displaces the need to offend.[1] This is very much part of the contribution of Occupational Therapists to the 'hospital model' who actively integrate a 'Good Lives' approach into their model of working.

Whilst this remains work in progress there is clearly a learning point here about patient involvement, non-prescriptive labelling and not investing 'programmes' and 'therapy' as being the main or even the central vehicle for change.

Lesson 5: Neither hospitals nor prisons are the best settings for meeting the needs of people with diagnoses of personality disorder.

Both prison and hospital cultures have their own long standing narratives that label and stigmatise their

1. Ward, T. and S. Maruna (2007) *Rehabilitation*. London: Routledge.

clients. If we were to develop services from scratch for those with these kinds of problems — in a context where resources were not an issue — we would avoid stigmatising and/or medicalising their problems or giving the label 'patient' or 'offender'.

In any other context we would not put people who have been sexually abused in the same environment as perpetrators of sexual abuse; or put victims of violence in the same settings as those who have perpetrated serious violence. The thought of suggesting to victims of offending that they share their accommodation and therapy groups with perpetrators would make us wince. Nor would we put those who the literature tells us are most likely to re-offend if they have an 'antisocial peer group' in settings where they are living cheek by jowl with other people who have offended. We would also be hard pressed to justify putting people who are suffering from the ravages of institutionalisation in highly routinized conditions of confinement for long periods of time.

The ideal solution would be to intervene in contexts where people are separated from others who have offended altogether and are offered the opportunity to live with non-offenders. The 'circle of friends' model attempts to achieve this to some extent with those who have been released.

What this thought experiment serves to highlight is the often unacknowledged impact of confinement on individuals attempting to change their lives. This creates two tasks: firstly to bring about change in offending behaviour and the ability to manage distress and secondly to develop skills and competencies in surviving confinement. Often these two agendas overlap but at times they do not. When people are doing particularly sensitive pieces of work on offending or trauma it is important that they are protected from some of the more invidious aspects of confinement to prevent escalating patterns of disengagement and reciprocal hostility.

Lesson 6: Clinically, single case methodology is the most useful approach to evaluation.

The relative lack of outcome studies for the DSPD pilot is puzzling. Whilst long term outcomes are a long way away in that few of those going through services have been discharged into the community, it would have been easier to make decisions about the future of the service if there had been more up to date and clinically meaningful data available to policy makers. Those studies that there were conducted heralded from the first five years of the pilot and did not necessarily reflect the perceptions of those involved in the services, or indeed the kinds of services that developed over time.[2] Clinically, moreover, there was a lot of learning that was not captured and could still be passed on if there was a more active approach to sharing learning from single case studies.[3]

When people are doing particularly sensitive pieces of work on offending or trauma it is important that they are protected from some of the more invidious aspects of confinement to prevent escalating patterns of disengagement and reciprocal hostility.

The future role of hospital based interventions

The differing needs presented by those with severe personality disorder highlights the importance of offering a hospital placement for those with co-morbid mental illness. In the model proposed here individuals with mental health problems would be allocated to hospital settings and individuals with 'pure' personality disorder to prison settings. Putting aside the problems associated with separating diagnoses into mental health and non-mental health categories, or indeed the problems of using a diagnostic framework in a service that is essentially formulation or case conceptualisation driven, it is proposed that several criteria be used for allocation to an enhanced high secure hospital setting:

a) Evidence that individuals have a presentation linked with complex trauma and re-traumatisation for whom it would be counter-productive and unethical to deliver interventions in a prison setting

b) Evidence that individuals have reacted badly to psychological interventions in the past, for example who have responded by offending or self -harming in the context of trauma or offence focussed work

c) Evidence of a disorder that significantly impairs an individual's capacity to engage in treatment as usual (TAU) as delivered elsewhere in the pathway

2. Howells K, Jones L, Harris M, Wong S, et al. (2011). The baby, the bathwater and the bath itself: a response to Tyrer et al.'s review of the successes and failures of dangerous and severe personality disorder. *Medicine, Science and the Law 51*(3):129-33.
3. Davies, J., Howells, K. & Jones, L. (2007). Using single case approaches in personality disorder and forensic services. *Journal of Forensic Psychiatry and Psychology*. 18(3), 353-367.

d) Those for whom there has not been an adequate formulation or case conceptualisation — or for whom there have been significant problems in making a diagnosis.

This paper will not examine criteria c and d. Here it is proposed that the core business of a high secure hospital setting for people who have offended and who have a personality disorder diagnosis is to work with the problems linked with chronic trauma when these cannot be addressed in a prison setting.

The ubiquitous theme of trauma in those with personality disorder diagnoses who have offended.

A recent review of case formulations for patients on the Peaks Unit identified chronic histories of trauma causally related to the offence in most of the population. Furthermore this study identified that clinicians were formulating offending behaviour as being largely underpinned by the cognitive, emotional and behavioural sequelae of repeated experiences of trauma. Indeed trauma was identified as a common factor in the development of both personality disorder and offending behaviour.

Much of the recent literature on personality disorder highlights its association with different kinds of trauma history. A number have identified clear links between different types of 'maltreatment' and different personality disorders. Similarly researchers are linking different kinds of offending with different kinds of trauma history. Whilst it is not the only causal factor it is proving to be a significant one that has been relatively neglected by practitioners in the past. Possibly this neglect has been driven by a reluctance to risk the possibility of people using their own abuse histories as an exculpatory narrative that allows them to avoid taking responsibility for their offending.

The traumatising and re-traumatising impact of imprisonment.

Therapy addressing trauma can be delivered in prison settings but there is much more chance of people being exposed to re-traumatising experiences due to the aspect of imprisonment that is about 'punishment'. A number of writers have highlighted the traumatising aspects of custodial settings and others have identified ways in which the justice system can consolidated and exacerbate 'delinquency'. The following have been identified:

a) Deprivation of opportunity to be exposed to 'normative experiences' promoting a sense of mastery and competence, providing experiences of prosocial relationships or fostering a positive identity.

b) Incarceration leads to development being 'arrested'.

c) Involvement with the CJS may be a 'traumatic stressor' particularly for those already suffering from some form of PTSD. A number of researchers have provided evidence to support the contention that abuse is prevalent within adult prisons; inmates may experience significant levels of victimisation involving verbal, physical, sexual, and/or emotional abuse.

d) Behavioural or psychological dysregulation in reaction to memories and experiences linked with trauma that may provoke overbearing limit setting measures from the institution (punishment) that further exacerbate distress and/or offending behaviour.

e) People may also become newly traumatized whilst in detention through being victims of or witnesses of violence, gang-fights, sexual assaults and/or peer suicide attempts.

Researchers have identified increased exposure to antisocial peers and disruption to community contact in prisons as a problem for prisoners. They argue that this limits the opportunity for reinforcing societal norms and expectations through exposure to adaptive and prosocial interactions, in contrast with hospital based settings.

Lambie and Randell (2013) write *'Although it is possible that positive rehabilitative effects can be achieved in a confinement setting, the nature of confinement, as well as the negative impacts that it may have, can greatly limit the rehabilitative potential of such placements. Incarceration environments are often characterized by victimization, social isolation, and unaddressed or exacerbated mental health, educational, and health needs. These factors may limit rehabilitation and have damaging effects that contribute to recidivism and other unfavourable outcomes'*. [4]

Whilst it can be argued that a number of these factors are also present in hospital settings, the underlying philosophy of care focussing on rehabilitation, recovery and treatment is potentially less likely to trigger these reactions than the prison setting that has a more or less explicit model of retribution and punishment as well as rehabilitation.

According to Ward and Maruna (see ref 1), the aim of rehabilitative interventions in conditions of confinement should be to develop a prefiguring 'good life' **in their place of confinement** where the individual is offered the opportunity, as far as is possible, to develop skills in meeting all their needs in a non-offending manner. Hospital based treatment models are aimed at a more comprehensive attempt to provide such 'normative experiences'.

Having worked in a prison based therapeutic community within a larger prison setting I am all too aware of the ways in which the external prison culture

4. Lambie, I. & Randell, I. (2013) The impact of incarceration on juvenile offenders. *Clinical Psychology Review* 33 (2013) 448–459.

intrudes — even if there is a strong and genuine commitment amongst staff and inmates on the unit to a therapeutic culture. There are inevitable rubbing points like visits, gym, weekends when non-unit staff are brought on to the unit due to low staffing, senior managers who are not 'onside' or simply do not understand or agree with the treatment model. Maintaining a 'psychologically informed environment' consistently in this setting presents a real challenge. Often these kinds of incursions into the treatment milieu can be used as 'grist for the mill' for therapeutic work but, for the least engaged and most vulnerable to trauma related anti-authority reactions these incursions can be the *'straw that breaks the camel's back'*.

The need for specialist trauma focussed, trauma aware, non-custodial settings for people who have failed to respond to treatment as usual.

There is no evidence base yet for the treatment of chronic trauma/re-traumatised individuals and consequently there is a need for trauma focussed interventions for this group to be developed. The evidence underpinning the NICE guidelines for working with PTSD are based on single event traumas, for example people struggling with flashbacks and intrusive memories associated with an accident or an episode experienced in the context of military combat. Most of the Peaks population have experienced multiple traumatic experiences and might be better described as re-traumatised or experiencing chronic trauma. They differ also in that they have also experienced 'treatment as usual' and have not responded to this or dropped out so that they were not able to show whether or not TAU would work for them.

Whilst some interventions focussing on trauma and its impacts on beliefs and patterns of relating — using a Cognitive Analytic Therapy, EMDR or Schema focussed model — have been used to some effect, there are also some who have responded poorly and have responded by acting out or self-harming. There is room still for interventions that address the fragile mental state of those suffering from chronic trauma. These need to target both chronic personality traits and offending behaviour.[5]

The psychological mechanisms linking trauma with offending of different kinds is beginning to be clarified.

The psychological mechanisms linking trauma with offending of different kinds is beginning to be clarified. Waxman e al (2014) identify links between different kinds of abuse and different kinds of personality disorders; however they do not describe any putative psychological mechanisms underpinning this.[6] They do propose however that *'borderline and schizotypal PDs were most strongly predicted by sexual abuse, antisocial by physical abuse and avoidant and schizoid by emotional neglect'*. To the extent that there is a direct association between the kind of abuse experienced and the diagnostic criteria for the disorders they claim resulted from it (borderline PDs are prone to sexual acting out, antisocial PDs to violent behaviour and avoidant and schizoid PDs to emotional detachment) there are some implicit suggestions as to what kinds of mechanisms might be at play.

In contrast a wide range of mechanisms linking trauma to delinquency have been identified in the literature. Kerig et al highlight many of these:[7] At a biological level there is increasing evidence that there is often a long term impact on brain neurochemistry, structure and function following the experience of a range of different kinds of trauma. These can mean that an individual is less able to inhibit behaviour and finds it harder to curb impulsive urges. Biological stress systems can also be left in a state of high reactivity that can create a context where some kinds of offending are more easily triggered.

Trauma can also impact on the emotional processes linked with offending. Repeated experiences of trauma can leave an individual either more prone to affect dysregulation or to emotional numbing, acquired callousness and experiential avoidance. Another impact can be a significant difficulty in recognising and responding to emotional states in other people.

This interpersonal insensitivity can be reflected in thinking processes also. Trauma related cognitive processes linked with offending identified in the research include: interpersonal processing deficits, rejection sensitivity, alienation, moral disengagement, stigmatization associated with shame and self-blame, cognitive immaturity, deficits in recognition and

5. Moore, E., Evershed, S., Kilkoyne, J. & Jones, L. (2013) *A Clinical Model for Working With Personality Disorder in High Security Hospitals*. Unpublished internal document.
6. Waxman, R.,Fenton, M.C., Skodol, A.E.,, Grant, B.F. and Hasin, D. (2014) Childhood maltreatment and personality disorder in the USA: Specificity of effects and the impact of gender.Personality and Mental Health; 8(2): 30-41.
7. Kerig P.K. and Becker S.P. (2010) From Internalizing To Externalizing: Theoretical Models Of The Processes Linking PTSD To Juvenile Delinquency. In Sylvia J. Egan (Ed.), Post-Traumatic Stress Disorder.

response to risk, 'futurelessness' and delinquency as adaptations.

Interpersonal processes linked with trauma that have been shown to impact on propensity to offend include: disrupted parent-child relationships, friendships, disrupted peer relations and disrupted romantic attachments, suggesting that it is the impact of trauma on attachment that mediates the relationship between trauma and offending. Attachment experiences when abusive or severely disrupted often result in people not being able to care about or understand what other people are feeling or thinking. The ability to understand other people's minds is developed in the context of a secure attachment; not having this experience results in a diminished capacity to think about one's own mind — and other people's minds.

Chronic trauma and their sequelae associated with developmental abuse present differently in the context of different personality traits and influence significantly the way in which trauma and attachment problems are played out. Research suggests that serious antisocial behaviour can be the result of a combination of a genetically determined 'fearless temperament', abuse, loss and disorganised attachment. The case for trauma awareness in therapeutic regimes is thus overwhelming.

Work on trauma and offending behaviour amongst people with personality disorder diagnoses can result in a process of 'getting worse before getting better'. A common reaction to trauma work and to offence focussed work is to engage in self-harm or offending behaviour that ranges from substance misuse (as a strategy to cope with difficult emotions) to serious violence (assaulting peers because they remind them of people who have abused them for instance). In the absence of new coping skills — or during the process of acquiring them — people can resort to previous ways of coping. In order to contain this process and prevent it from early discharge from treatment specialist settings need to be able to offer the following:

a) A 'trauma aware' staff team who know how to work with and understand the manifestations of trauma as they are played out on the ward

b) Clinical practitioners who are able to conceptualise case material in such a way as to make sense of chronic trauma in the context of offending and self-harm

c) A setting that actively avoids triggering trauma related memories in the way that people work.

The case for psychologically informed prisoner environments

The key task in working out what kinds of treatment pathway might be best suited to an individual is to identify potential 'traumagenic' responses to specific regime components in different settings. This should enable us to identify what kinds of regime are most appropriate for which individuals. There is evidence that certain toxic responses to regimes are linked with specific reactions to trauma elicited by these regimes. Consequently we need a typology of trauma-triggering regime features to help think about what location is best suited for a particular individual. The following table outlines some of these regime features.

VULNERABILITY (ABUSE IN CHILDHOOD, ABUSE IN CUSTODY)	TRAUMA TRIGGERING REGIME FEATURE	PRISON	HOSPITAL	REACTIONS
Traumatic memories of being secluded / restrained / assaulted / by people in uniform; Some trauma acquired in military context	People wearing uniforms	Prisons typically require staff to wear uniforms and follow quasi-military model of discipline	No longer require staff to wear uniforms but do increasingly require things like ID badges	Mistrust and assaults on staff particularly those wearing uniforms
History of being sexually abused sometimes with ongoing urges to take revenge	Being non-sex offender located with Sex Offenders	Generally, but not always, sex offenders separated from other offenders	Sex offenders located with non-sex offenders	Assaults / urges to assault sex offenders. Use self-harm to keep abuse away. Use self-harm as alternative to being violent
History of being assaulted, scalded, attacked by non-sex offenders for being a sex offender	Being a sex offender located with non-sex offenders	Generally, but not always, sex offenders separated from other offenders	Sex offenders located with non-sex offenders	Panic and fear of engagement Deception and concealment of offending from fellow residents
Abused in groups by groups of people. Being locked away alone. So only feel safe — alone	Being required to attend groups	Context specific but little individual work available	Context specific but individual work generally available	Panic in groups — act out to avoid group context. Act out to evidence 'indomitability'
Abuse involving a range of 'discipline' narratives (physical and psychological)	Being subject to 'discipline'	Explicit discipline agenda within a punitive narrative	More a 'boundary' model within a clinical narrative	Attacks on people 'imposing discipline'

Witnessing violence • Being violently abused • Being preoccupied with violent urges and wanting to join in violence	Being witness to violence	Violent incidents high in some settings	Fewer violent incidents in most settings	Panic, self-harm to get away, self-harm to show dominance, self-harm to keep abusers away
Attachment difficulties abandonment / rejection	Changing care teams a lot	Range of contexts involving significant change in care team	Some focus on continuity of care as part of clinical model	Mistrust, stuck in phase of testing relationships
History of abuse	Having to disclose abuse to police	Imperative to do this implemented rigorously	Imperative to do this implemented rigorously	Violence, self-harm
Neglectful care leading to poor boundary maintenance and acting out	Low levels of staffing and observation	Staff resident ratios lower	Staff resident ratios higher	Acting out to elicit care
Being 'in care', repeated changes in carers, imprisonment as young person, deprivation of opportunity to be exposed to 'normative experiences	Deprivation of opportunity to be exposed to 'normative' experiences	Limited regime resources impedes this	Regimes focussing on building whole lifestyle through multi-disciplinary team model	Delays in emotional, social and educational development. Low self-esteem and poor definition of future possible self outside
Neglectful care. Being locked in room for long periods of time as a child	Social isolation	Range of contexts leading to different levels of isolation, including segregation as punishment	Isolation for short periods with close monitoring	Pattern of increasing withdrawal

Conclusions

This analysis and discussion suggests a need for specialist trauma focussed interventions in high secure settings. Whilst there are some locations in the prison service where excellent work of this type is being delivered — I am thinking particularly here of the DSPD units and, in a different way, prison therapeutic communities — there are some people for whom prison based interventions are going to be very difficult simply because of the nature of the environment. There are also some people who don't manage well in hospital settings (anecdotally there is a high representation of people who have been sexually abused returning to CSCs from hospital setting as a consequence of not being able to cope with being co-located with people who have offended sexually). Colleagues at Whitemoor Fens Unit have indicated that people with borderline and histrionic personality disorder traits who are at risk of self-harm and/or suicidal ideation might be better placed in secure hospital settings.

Rather than waiting to see if trauma interventions can be delivered in prison settings and then only moving them to hospital if things don't work out it might be useful to identify those for whom a hospital placement would be the most appropriate and useful drawing on the findings of research into PD and from the experience of clinicians who have been delivering treatment to those with PD diagnoses over the last ten plus years. Hopefully this paper has suggested some ways of thinking about these issues.

Working with Personality Disordered Offenders:

responsivity issues and management strategies

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Early days of the Dangerous and Severe Personality Disorder services (DSPD)

The issue of how to protect the public from those who pose them a risk as a result of a severe personality disorder has long been a contentious one. The issue first gained public attention following Michael Stone's conviction in 1998 for the murder of Lin and Megan Russell. Following this awareness was raised of the need to provide treatment for psychopathic and personality disordered offenders, with a view to ultimately reducing re-offending within this population. In 2001, The Government made a pledge to provide more places in high secure hospitals and prisons for the management and treatment of men whose risk of serious offending was linked to severe personality disorder. The formerly named Dangerous and Severe Personality (DSPD) Programme brought together the Ministry of Justice (originally part of the Home Office), the Department of Health, Her Majesty's Prison Service and the National Health Service to deliver new mental health services for people who are, or have previously been considered dangerous as a result of a severe personality disorder(s). The aims of the DSPD programme, as set out in the Dangerous and Severe Personality Disorder (DSPD) High Secure Services for Men Planning and Delivery Guide1 are:

- ❒ better public protection
- ❒ provision of new assessment and treatment services improving mental health outcomes and reducing risk
- ❒ better understanding of what works in the assessment and treatment of those whose severe personality disorder presents a high risk of serious offending

Four units were set up, each capable of housing approximately seventy male patients/prisoners: in Broadmoor and Rampton high-secure hospitals, and in Frankland and Whitemoor high-secure prisons. Of the four original sites, only the two prison service units continue to provide treatment services. The decision was made to shut the hospital sites after an evaluation found that there was a 'significant difference in cost between' between the hospital and prison based services, and it was felt that 'the prison units were better placed to provide the right context for treatment delivery and with a lower ratio of staff to prisoners'.[2] One of the remaining prison sites is the Westgate Unit at HMP Frankland which will provide the focus of this paper. The units at HMP Frankland and HMP Whitemoor now form part of the wider national Offender Personality Disorder Pathway which intends to take responsibility for the assessment, treatment and management of offenders who have some level of personality disorder.[3]

Westgate Personality Disorder Treatment Services

In order to be admitted for treatment on to The Westgate Unit, an offender must meet the following criteria:

- ❒ More likely than not to commit an offence that might be expected to lead to serious physical or psychological harm from which the victim would find it difficult or impossible to recover;
- ❒ Has a severe disorder personality disorder, and
- ❒ A link can be demonstrated between the disorder and the risk of reoffending.

Criteria for severe personality disorder will have been met if the individual has:

- ❒ A high or very risk of violent and/or sexual reoffending (measured by Risk Matrix 2000, Static 99, VRS, VRS-SO HCR-20
- ❒ A severe and complex personality disorder (measured by IPDE and PCL-R)
- ❒ A link between his personality pathology and the offences he commits (assessed by the development)

Treating Personality Disordered Offenders

Personality disorders are associated with ways of thinking and feeling about oneself and others that

1. Dangerous and Severe Personality Disorder (DSPD) High Secure Services for Men Planning and Delivery Guide (Department of Health, Ministry of Justice & HM Prison Service, 2008).
2. Response to the Offender Personality Disorder Consultation (Department of Health, Ministry of Justice, 2011).
3. Joseph, N. & Benefield, N. (2012). A joint offender personality disorder pathway strategy; An outline summary. *Criminal Behaviour and Mental Health,* 22 (3), 157-232.

significantly and adversely affect how an individual functions in many aspects of life. They fall within ten distinct types, categorised into three clusters based on their typical characteristics (the clusters do not include Psychopathy, although this is still considered to be a personality disorder). Figure 1 shows the Personality Disorders as classified by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).[4] This is the standard classification of mental disorders used by mental health professionals.

Figure 1: Classification and Characteristics of Personality Disorders

Cluster A (odd or eccentric disorders)

• *Paranoid Personality Disorder*
Characterised by an exaggerated sensitivity to rejection, resentfulness and distrust. Neutral and friendly acts of others are often misinterpreted as being hostile or harmful.

• *Schizoid Personality Disorder*
Characterised by a lack of interest in interpersonal relationships, preference for a solitary lifestyle, secrecy, and emotional coldness.

• *Schizotypal Personality Disorder*
Characterised by a need for social isolation, unusual behaviour and unconventional beliefs such as a belief in magic or extra sensory abilities.

Cluster B (Dramatic, emotional or erratic disorders)

• *Antisocial Personality Disorder*
Characterised by a disregard for social rules, norms and cultural codes, as well as impulsive behaviour and indifference to the rights and feelings of others.

• *Borderline Personality Disorder*
Characterised by emotional instability, rigid thinking and chaotic relationships. Also includes instability in mood, interpersonal relationships, self-image, identity and behaviour.

• *Histrionic Personality Disorder*
Characterised by a pervasive and excessive pattern of emotionality and attention-seeking behaviour.

• *Narcissistic Personality Disorder*
Characterised by extreme focus on oneself, and is a maladaptive, rigid and persistent condition that may cause significant distress and functional impairment.

Cluster C (Anxious or fearful disorders)

• *Avoidant Personality Disorder*
Characterised by a pervasive pattern of social inhibition, feelings of inadequacy, extreme sensitivity to negative evaluation and avoidance of social interaction.

• *Dependent Personality Disorder*
Characterised by a pervasive psychological dependence on other people to aid decision making and provide reassurance. These individuals are lively, dramatic, enthusiastic and flirtatious. They may be inappropriately sexually provocative, express emotions with an impressionistic style, and be easily influenced by others.

• *Obsessive-Compulsive Personality Disorder*
Characterised by a general psychological inflexibility, rigid conformity to rules and procedures, perfectionism, moral code, and/or excessive orderliness.

• *Psychopathy / Psychopathic Personality Disorder*
Characterised by enduring dissocial or antisocial behaviour, a diminished capacity for empathy or remorse, and poor behavioural controls or fearless dominance.

As is demonstrated above, each personality disorder is associated with different types of problematic thinking styles and behaviours, some of which have been shown to impact on the extent to which someone can meaningfully engage with, and benefit from treatment. These are known as Treatment Interfering Behaviours (TIB's) or Responsivity issues. It is these problematic aspects of functioning which have contributed to this population previously being considered 'untreatable' insofar as mainstream Offending Behaviour programmes are concerned.[5] It should be noted that these behaviours are not necessarily treatment needs in themselves, but aspects of an offender's behaviour which if left unmanaged, could create a barrier to the participant effectively engaging in treatment. Figure 2 shows some of the most typical responsivity issues experienced by personality disordered offenders, and some of the aspects of treatment which research suggests work well with a PD population.

Figure 2

What makes treatment difficult
- Low boredom threshold
- Impulsivity
- Wanting to be seen in the best light at all times
- Resentment of authority
- Feeling that skills cannot realistically be tested for many years

4. American Psychiatric Association, (1994). *Diagnostic and Statistical Manual of Mental Disorders (4th ed)* DSM-IV. Washington DC: American Psychiatric Press Inc.
5. Salekin, R. T., & Worley, C., & Grimes, R. D. (2010). Treatment of psychopathy: A review and brief introduction to the mental model approach for psychopathy. *Behavioural Sciences & the Law, 28* (2) 10.1002/bsl.928.

- Tendency to see things that happen to them as beyond their control
- Scared of change
- Difficulty collaborating with both clinical and operational staff (mistrust)
- Lack of motivation

What PD offenders want

- To feel treatment is relevant
- Choice and control over treatment
- Transparency
- Status
- Treatment which holds their interest
- Treatment in areas that matter to them
- Safety to disclose information
- Focus on future vs. past

Management Strategies for Working with PD offenders

Hemphill and Hart[6] stated that 'Treatment providers should devote attention to developing interventions that take into account the unique motivational strengths and deficits of psychopathic offenders', similar to those described in figure 2, and this was an ethos that the team responsible for the development of the regime at the Westgate Unit strongly adhered to. Indeed time was taken to ensure that not just the formal treatment aspect of the Westgate Unit, but also the regime to run alongside formal treatment was designed with the specific needs of a personality disordered population in mind. The following regimes and management strategies were designed to help offenders manage their own individual responsivity needs, with a view to motivating and encouraging them to actively participate in treatment designed to reduce their risk of re-offending.

The Conditions of Success / Strategy of Choice

The regime at the Westgate Unit is based on strategies which are designed to structure prisoners' expectations and set boundaries. The Conditions of Success are: To participate constructively within the regime; Keep an open channel of communication; and be respectful at all times. The Strategy of Choices is a technique which 'uses psychopathic offenders need for control and choice as a way of promoting self-responsibility and self-management'.[7] The Strategy challenges offenders to see treatment as an 'enhancement rather than a restriction' and demands that they make a conscious choice whether to participate and accept The Conditions of Success, or not to accept them and thereby make the decision not to participate. Harris et al.[7] describe the central message of the strategy as being 'we can't make you change, and we don't intend to try. But if you are willing to learn we can teach you how to change'. In this way, participants are encouraged to take responsibility for their own placement and success within treatment by being given the choice of whether to engage and adhere to the Conditions of Success or to be seen to be deselecting themselves.

The complementary regime

Prior to a prisoner being assessed for suitability within Westgate Personality Disorder Treatment Services, there is a period of assimilation onto the unit which is known as the 'Living Phase'. This phase lasts between approximately 6-12 months, and it is during this time that prisoners have a chance to get to know staff and become more familiar with the unit and its regime prior to their assessment taking place. Given what we know about personality disordered offenders having a tendency to get bored easily and to engage in sensation seeking behaviour as a result, it is important to avoid drop outs at this stage and ensure that there is ample opportunity for prisoners to remain occupied. The complementary regime was therefore designed to run alongside formal assessment and treatment sessions, and to contribute to the therapeutic environment on the unit. The core day on the Westgate Unit is divided into four hour long sessions, two in the morning and two in the afternoon. This is again to accommodate the short attention spans of personality disordered prisoners. In addition to this, all staff/prisoner contact is delivered on a 2:1 basis; this is to guard against the conditioning and manipulation of staff, and to protect them against potential false allegations of improper behaviour. There is an expectation that prisoners will participate in the complementary regime and are encouraged to choose a variety of activities from those described in figure 3. Prisoners are encouraged to interact with staff and other prisoners, again contributing to the therapeutic environment.

Figure 3 — Complementary Regime

Education

- Links to formal therapy
- Art
- Craft
- Guitars

Other purposeful activity

- Yoga

6. Hemphill, J. F., & Hart, S. D. (2002). Motivating the unmotivated: Psychopathy, treatment, and change. I M. McMurran (Ed.), *Motivating offenders to change: A guide to enhancing engagement in therapy* (pp. 193-219).
7. Harris, D., Attrill, G., & Bush, J. (2005). Using choice as an aid to engagement and risk management with violent psychopathic offenders. *Issues in Forensic Psychology*, 5, 144-151.

- Mindfulness/meditation
- Drama Group
- Music workshops
- Reader group
- Discussion group
- Charity workshop

Physical Education

- Dedicated PE staff
- CV / weights room
- Sports Hall
- Multi-turf area

Horticulture

- Three areas
  - — Greenhouse
  - — Flower beds
  - — Allotments

Responsivity Planning

Any prisoner who is found suitable for placement on the unit following their assessment undertakes the Responsivity Planning Process as part of the assessment process. This commences with a review of the prisoner's readiness for change and responsivity needs. The responsivity plan involves generating a formalised plan identifying specific needs, as well as strategies to manage these. The plan intends to maximise the likelihood that participants can get the most from treatment by structuring their expectations (and those of staff) about what will take place upon the occurrence of typical treatment interfering behaviours. The plan aims to understand what responsivity needs the participant may have, how they manifest themselves and the likely impact on treatment and assessment. The Responsivity Plan draws upon available information about the participant's responsivity needs collected from previous assessment and treatment reports. This is integrated with further information derived during the criteria assessment process and the Motivation and Engagement modules of treatment (discussed below). Participant self-reports and behavioural observations made on the unit, may also be combined within the plan. The responsivity needs identified in the Responsivity Plan may be apparent during sessions. They may also relate to unit-based behaviours that impact upon treatment by limiting the capacity of the prisoner to make it into the treatment room. The second aim of the plan is to set management strategies to reduce the impact of treatment interfering behaviours and increase motivation to engage. Strategies may be employed either by treatment staff, unit staff or the participant. These strategies are agreed between the participant and assessment facilitators during the assessment phase and then carefully monitored thereafter. Figure 4 shows a typical responsivity plan.

Active Learning: Introduction to group working

Active learning is an activity-based intervention based upon the idea of experiential learning (learning by doing). Within the Introduction to group working participants complete five sessions over the period of five weeks in the 'Living Phase' when they are not engaged in formal treatment, but are settling in to the Unit. The primary purpose of these sessions is to prepare the participants for formal group treatment with the introduction of group skills/topics which promote group working such as communication, trust, planning, personal disclosure and

Figure 4: Typical responsivity plan

Treatment Interfering Behaviours	Interaction of PD	Responsivity considerations	Management strategy
Tendency to go off on a tangent during session and steer conversation away from the task. Also has a tendency to avoid answering questions directly	**PCL-R** — Grandiose sense of self-worth	Mr X does, by his own admittance have a tendency to 'ramble'. It appears that at times this is an attempt to control the direction of a session. Lately Mr X has begun to show more awareness when this is happening.	**Mr X:** To continue to self-monitor his behaviour in order to minimise disruption to others within session. To accept feedback from staff. **Staff:** To provide Mr X with feedback when he is attempting to divert staff from their line of questioning. Staff to refocus him on the task when necessary.

team work. These sessions also develop the therapeutic alliance, trust and rapport between participants themselves and staff who will likely work together in the future.

Good Lives and Development (GLAD) Scheme

GLAD is part of the complementary regime on the Westgate Unit and is a motivational tool which encourages prisoners to take responsibility for their own progress in treatment. The scheme is based on the Good Lives Model[8] which states that all human beings work towards achieving goals known as the Good Life Goals. The model states that if we are achieving the goals which are important to us, then we are likely to see ourselves as having a good life. The GLAD scheme is a supporting service to the treatment framework offered at the Westgate Unit, running alongside formal treatment. The initial GLAD plan is developed after the prisoner has met criteria for the Westgate Unit and commenced treatment. GLAD targets are identified collaboratively between the prisoner and the GLAD team made up of officers and psychology staff. GLAD targets are relevant and individualised to prisoners' areas of development and all members of the multi-disciplinary team are encouraged to access the individual's GLAD plans and comment on their progress in achieving their targets. This enables prisoners to effectively work towards generalising the skills they have learned in treatment. The GLAD system is currently being revised with plans for it to be replaced with Key Worker sessions whereby prisoners will engage in regular sessions with their personal officer and their psychology case manager.

Treatment Programmes

In order to accommodate the complex needs of personality disordered offenders, treatment programmes on the Westgate Unit were based on the 'What Works' literature[9] but were designed specifically with the responsivity of PD offenders in mind. Formal treatment programmes are based on the principles of Cognitive Behavioural Therapy and delivered in both a group and on an individual basis. Noteworthy is the reduced group sizes (maximum 5) in comparison with mainstream Offending Behaviour programmes. This is in order to better accommodate and manage specific responsivity issues, and to encourage better group dynamics. Some of the treatment components on the Westgate Unit form part of the Chromis programme (see Footnote11 and the article by Bull and Tew in this edition). The Chromis programme was developed specifically to meet the needs of psychopathic offenders and their response to treatment, for example becoming bored and disinterested in treatment, seeing no reason to change or failing to adhere to the boundaries of treatment.[10] The programme asks that participants be open to learning new skills, it does not aim to change the goals of participants, but rather, modify the way in which they achieve them.[11] Other treatment programmes have subsequently been developed in-house by Westgate clinicians. Figure 5 shows the treatment framework at the Westgate Unit including both Chromis and Westgate specific programmes. Each programme is listed under the relevant Treatment

Figure 5: Westgate Unit Treatment Framework

Motivation and Engagement	Psycho-education Domain	Self-Management Domain	Social and Interpersonal Domain	Offence Interests/ Thinking Processes	Progression Domain
Chromis Motivation and Engagement	Psycho-education	Iceberg (Substance Misuse) Emotion Modulation Chromis Creative Thinking Chromis Problem Solving Chromis Handling Conflict	Social Competence Relationship and Intimacy Skills	Chromis Schema Therapy	Progression and Maintenance Programme

8. Ward, T & Brown, M (2004). The Good Lives Model and Conceptual Issues in Offender Rehabilitation. *Psychology, Crime and Law, 10* (3), 243-257.
9. McGuire, J (2001). What works in correctional intervention? Evidence and practical implication. In G. A. Bernfield, D.P. Farrington & A. W. Leschied, (Eds.), *Offender Rehabilitation in Practice: Implementing and evaluating effective programmes* (pp. 25-44). Chichester: Wiley.
10. Tew, J & Atkinson, R. (2013). The Chromis programme; from conception to evaluation. *Psychology Crime & Law*, 19 (5-6), 415-431.
11. Tew, J. (2012). Chromis: Not just a fish. *Forensic Update*, 105. 25-28.

Domain. Imminent need services run alongside the Treatment Framework and can be offered to suitable prisoners at any time during the course of their treatment pathway.

Motivation and Engagement

As in the figure above, the Chromis Motivation and Engagement programme is amongst the first of the programmes delivered as part of the treatment framework. Delivered on an individual basis, the programme uses the Good Lives Model and is designed to:

- ❒ Begin the process of building therapeutic relationships
- ❒ Understand what is important to participants in order to increase relevance of treatment efforts
- ❒ To enhance motivation towards developing skills to give participants more choice and control in life
- ❒ To encourage greater personal responsibility and objectivity
- ❒ To begin to understand participants' unique motivational strengths and deficits in order to inform treatment approaches, therapeutic style and management strategies.

The essential elements of the Motivation and Engagement component are introducing the concept of the Good Lives themes and employing the strategy of choices, with the premise that at this stage, participants do not commit to changing their lives, but commit to learning skills which allow the choice of doing so.

Imminent Needs services

The purpose of the imminent needs service on the Westgate Unit is to help stabilise prisoners and support them to engage or re-engage with treatment on the Westgate Unit. In addition, the service supports prisoners to engage meaningfully and safely in all aspects of the unit regime. The following services are available and run alongside assessment and treatment on the unit.

❒ *Cognitive Behavioural Therapy (CBT)*

This is a brief problem focussed and collaborative therapy that promotes the individual becoming their own therapist. This therapy identifies and challenges thoughts and beliefs that influence feelings and behaviour. CBT is used to treat a variety of disorders including panic disorder, health anxiety, social phobia, generalised anxiety disorder, obsessive compulsive disorder and depression.

❒ *Eye Movement Desensitization and Reprocessing (EMDR)*

This therapy involves the use of eye movement in order to reduce the intensity of disturbing thoughts. EMDR therapists help individuals to process their traumatic memories by using a process that involves repeated left-right (bilateral) stimulation of the brain whilst noticing different aspects of the traumatic memory. Bilateral stimulation appears to mimic what the brain does naturally during dreaming or REM (rapid eye movement) sleep. This seems to directly influence the way that the brain functions and helps to restore normal ways of dealing with problems, that is information processing. Following successful EMDR treatment, memories of such events are no longer painful when brought to mind and what happened can still be recalled, but is no longer upsetting. EMDR is used to treat, Post Traumatic Stress Disorder (PTSD), grief and loss, anxiety, fears and phobias, adult and childhood trauma, sexual abuse, disturbing memories, depression and stress.

❒ *Dialectical Behavioural Therapy (DBT)*

DBT was initially developed to treat chronically-suicidal females with Borderline Personality Disorder (BPD) who were typically difficult to treat, and had high treatment drop-out rates. DBT was developed for working with a population characterised by behaviours that jeopardise their own safety, interfere with treatment, disrupt their environment or seriously reduce their quality of life. The therapy is designed to enable prisoners to become more 'stable' by equipping individuals with skills to increase their self-awareness, and to manage their own behaviour, emotions, and thinking. Treatment targets include decreasing suicidal behaviours, decreasing therapy interfering behaviours, decreasing unit destructive behaviours, decreasing quality of life interfering behaviours and increasing interpersonal and problem solving skills.

❒ *Westgate Unit Mental Health Team Care Programme Approach*

The Care Programme Approach (CPA) has been utilised on Westgate to ensure that those with complex needs remain in contact with services throughout their sentence and upon release. The CPA approach is a Department of Health (DOH) policy that is designed to ensure those with complex needs remain in contact with NHS services in prison and when they are released. All prisoners will be allocated one member of the nursing team within around a week of their arrival. The mental health team are involved in encouraging mental health promotion and wellbeing, promoting individual's independence, assessment of mental health, assessment of risk to self and others, medication monitoring, individual care planning and relapse prevention.

Staff selection

Staff of all grades and disciplines are actively involved in the development and implementation of the clinical framework and there is an expectation that all staff contribute to the therapeutic environment

regardless of whether or not they deliver treatment. It is important therefore that the right staff are recruited. Operational staff must express an interest in working on the unit, and must undertake an interview to assess their suitability. All staff regardless of grade then undertake a development centre which is designed to assess four different competencies: Problem Solving, Team Playing and Networking, Communicating Clearly and Analytical Skills. Staff are then given recommendations for which roles they would suit best on the unit, and a skills development plan.

Staff Training and Development

Staff training is an integral part of the Westgate Service and training is provided to all staff irrespective of role. The training is designed to provide the fundamental knowledge and skills needed to work with Westgate's prisoner population. Having staff across all disciplines trained in this way contributes to the holistic approach to therapy on the Westgate Unit, ensuring that staff have a shared understanding of the complex needs of this population. Training offered includes:

- ❒ Motivational Interviewing
- ❒ Cognitive Behavioural Therapy (CBT) foundation course
- ❒ Working with Psychopathic Offenders
- ❒ Knowledge and Understanding Framework
- ❒ Awareness Training:
  - Personality Disorder
  - Risk assessment
  - Treatment/Intervention specific
- ❒ Conditioning and Manipulation
- ❒ Attachment training

Having all staff appropriately trained to work with a PD population ensures that information can be shared openly and effectively between departments, resulting in a fully transparent approach between staff. This is done in a variety of ways including daily MDT briefings, the production of prisoner profiles and the regular use of C-Nomis.

Evaluation

Evaluation of the long term effect of treatment on the Westgate Unit is yet to be undertaken; this is due to there only being a small number of Westgate completers who have been released into the community. However there have been a number of completers who have progressed on to lower security establishments. This has enabled an initial evaluation into changes in aggression and anger[13]. The findings of this study suggested that the prisoners involved experienced a reduction in self-reported anger and incidents of physical aggression but had higher than expected levels of verbal aggression after leaving Westgate. Tew et al[12] state that 'these findings offer cautious optimism for the effectiveness of Chromis' and by proxy, the Westgate Unit as a whole. As the offender PD pathway expands across the Prison Service, lessons can be learned about the effectiveness of the approach taken by the Westgate Unit to working with personality disordered offenders and managing their complex needs.

12. Tew, J., Dixon, L., Harkins, L. & Bennett, A. (2012). Investigating changes in anger and aggression in offenders with high levels of psychopathic traits attending the Chromis violence reduction programme. *Criminal Behaviour and Mental Health*, 22, pp. 191–201.

Chromis:

Beyond the treatment room

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Introduction

Research and practice has thankfully moved on from the blanket idea that individuals with high levels of psychopathic traits are not able to benefit from treatment or that treatment makes them worse.[1] While the evidence regarding response to treatment is still developing there is good reason to believe that these individuals are able to benefit from the right treatment.[2] That said, it has been found that they may not gain as much benefit from treatment as those with lower levels of psychopathic traits.[3] One possible reason for this is that those with a high level of psychopathic traits are less likely to generalise and maintain skills learnt in treatment than those with lower levels.[4]

This article concerns a programme that was designed specifically for those with high levels of psychopathic traits to help them reduce their risk of violence.[5] Chromis was developed for the Dangerous and Severe Personality Disorder (DSPD) initiative and now operates within the Offender Personality Disorder (OPD) Pathway[6] and continues to run within the Westgate Personality Disorder Treatment Service[7] at HMP Frankland. There follows an outline of some of the elements of Chromis, its context and its progression strategy that support the ongoing generalisation of the skills introduced in the programme to participants' everyday lives on the unit and beyond.

Chromis consists of a series of related but independent treatment components specifically designed for this client group. It starts with a Motivation and Engagement (MandE) component that makes use of the Good Lives Model[8] to establish what is important to the individual. Following this, the formulation phase of Schema Therapy is undertaken and used to inform the rest of treatment. The following phases of the Schema Therapy component and the three cognitive skills components are all delivered according to identified need and in whichever order and pace is most suitable for the individual depending on the degree to which they need to consolidate learning through generalisation exercises before moving on. Components are delivered via a combination of individual and group sessions that are designed to help participants challenge their core beliefs and develop and test out new skills to achieve their aims pro-socially. This core phase of treatment can take between two and a half to three years including assessment and preparation for progression.

A consistent approach

With the aim of making treatment meaningful and personally relevant Chromis begins with a twelve session component dedicated to understanding what motivates the individual and what they want out of their lives. For participants to want to adopt the skills from treatment they need to see some benefit for themselves in doing so. Chromis was developed alongside the DSPD initiative and was from the outset embedded within the purpose-built Westgate unit. This allowed the application of the core underlying principles across treatment and the wider regime and a consistent multi-disciplinary approach to the generalisation of skills. Treatment sessions and tasks built into the different components of Chromis focus specifically on identifying how the participant can generalise their skills. The use of thought records and conflict diaries, and the development of an individual problem list all help to make treatment meaningful to participants. Planned behavioural experiments within cognitive behavioural schema therapy make use of situations in the participant's daily life on the unit to

1. Rice, M. E., Harris, G. T., Cormier, C. A. (1992). An Evaluation of a Maximum Security Therapeutic Community for Psychopaths and Other Mentally Disordered Offenders. *Law and Human Behavior*, 16, 399-412.
2. D'Silva, K., Duggan, C., & McCarthy, L. (2004). Does treatment really make psychopaths worse? A review of the evidence. *Journal of Personality Disorders*, 18, 163-177.
3. Thornton, D., & Blud, L. (2007). The influence of psychopathic traits on response to treatment. In H. Hervé, & J. C. Yuille (Eds.), *The psychopath: Theory, research and practic*e. (pp141-170). New Jersey: Lawrence Erlbaum Associates Inc.
4. Blud, L. M., Thornton, D. & Ramsey-Heimmermann, D. (2003). Psychopathy and response to cognitive skills programmes: Analysis of OBPU research data. Unpublished report for Her Majesty's Prison Service.
5 . ew, J. & Atkinson, R. (2013). The Chromis programme: from conception to evaluation. *Psychology, Crime & Law, 19*(5-6), 415-431.
6. Joseph, N. & Benefield, N. (2012). A joint offender personality disorder pathway strategy: An outline summary. *Criminal Behaviour and Mental Health*, 22, 210-217.
7. Bennett, A. L. (2013). *The Westgate Service and Related Referral, Assessment and Treatment Processes*. International Journal of Offender Therapy and Comparative Criminology. Published online 13 June 2014.
8. Ward, T & Brown, M. (2004). The good lives model and conceptual issues in offender rehabilitation. *Psychology, Crime, & Law*, 10, 243-257.

challenge their thinking, practise underdeveloped skills and address overdeveloped behaviours. Following completion of each component there is a formal review which further integrates Chromis within the Offender Management process. Key staff involved in the participant's progression contribute, and significant others are invited to attend. This review has been specifically designed to ensure that the participant's achievements are celebrated and are appropriately reflected within the sentence planning review process and OASys,[9] so that the participant leaves Chromis with a greater sense of involvement and *choice and control*. As part of the final phase individuals are involved in developing their own risk management plans.

Choice and control are core principles. Programme components have been designed to reinforce the message that the development of pro-social skills offers the individual greater *choice and control*, underpinned by the Strategy of Choices.[10] The narrative supporting this is 'We can't make you change, and we don't intend to try. But if you are willing to learn we can teach you how to change'. Of course, offering a choice means that we have to accept that offenders are free to choose not to change. In effect the strategy says, 'we will accept your choice, whatever you choose'. However, in accordance with the transparency principle, the Strategy of Choices requires facilitators and offenders to collaboratively identify the options and their consequences. It is the offender's choice with regard to which option they pursue and it is the facilitator's responsibility to ensure the consequences of their choice are followed through.

This *collaborative and transparent* approach helps to engage offenders with high levels of psychopathic traits and avoid their mistrust; reducing the opportunity for game playing and manipulation. The strong emphasis on collaboration seeks to promote feelings of control. The programme is *future focused*, enabling offenders to concentrate on how they'd like their lives to be. Individualising treatment in this way enables participants to see *personal relevance* in the programme. In response to participants' poor tolerance of boredom it uses *novel and stimulating* material avoiding repetition, and sessions last no longer than an hour. Sessions also use examples that demonstrate the *status and credibility* of the skills being discussed.

In addition to adopting a consistent set of principles all staff are selected, trained and supported in an approach that embeds Chromis within the Westgate unit. Treatment and risk reduction is seen as everyone's role and responsibility and the unit is using the Chromis development centre for the selection of staff. All receive 'the Chromis working with psychopathic offenders' training to ensure that the environment offers a consistent approach and that everyone understands and supports the skills, techniques and approaches covered in treatment.

A behavioural monitoring system

Behavioural Monitoring uses a structured and specific set of guidelines for evidencing the risky behaviours displayed by participants. It starts with the identification of behavioural indicators for each participant from a dataset linked to treatment targets. These are then integrated into the wider Westgate treatment needs areas by staff on the unit and regularly monitored by staff from all disciplines working with the participant, providing an overview of their progress against their treatment targets. To support this, the behavioural monitoring system has been incorporated into P-NOMIS[11] by staff on the unit.

The Chromis team have also developed a tool to monitor behaviour linked to each individual's specific risk factors. This was piloted and refined in conjunction with unit staff and implemented across the whole unit through a phased approach in 2009. It helps to ensure that judgements about an individual's progress and risk are backed up by the objective monitoring of their risk behaviour over significant periods of time. It provides a structure for reviewing response to treatment, making treatment relevant to current problems and informing ongoing treatment targets. The tool is designed not just to help assess progress but also to assist the two way process of linking unit behaviour into treatment and generalising treatment across life on the unit.

In accordance with the core principles of Chromis, the behavioural monitoring system offers an opportunity for dialogue, collaboration and transparency about how risk is assessed. It can also help promote the relevance of treatment to an individual by encouraging them to self-monitor and apply the skills they have learned in treatment.

The Progression and Resettlement strategy

For Chromis to be successful, support in generalising skills for participants is not only needed within treatment but over their subsequent progression and final resettlement. Participants are likely to have difficulties with their motivation and/or their ability to transfer learning from treatment to different environments. The programme therefore supports this through a progression strategy that ensures that the goal of living a pro-social life

9. The Offender Assessment System within the National Offender Management System (NOMS).
10. Harris, D., Attrill, G., Bush, J. Using choice as an aid to engagement and risk management with violent psychopathic offenders. *Issues in forensic psychology, 5*, 144-151.
11. The IT system that supports individual case management.

with reduced risk to others is consolidated and carried forward over time. The strategy focuses on enabling participants to continue to generalise their skills over different contexts and provides them with support and feedback on their progress. It continues the process of behavioural monitoring and regular and collaborative assessment of responsivity, risk and need. Particular emphasis is placed on identifying and responding to any emerging resettlement needs and consolidating the individual's risk management plan developed in the final phase of Chromis Schema Therapy.

The Progression and Resettlement strategy provides structured co-ordination of participants' pathways from the high security treatment site once they have completed the core phase of the programme. A number of different pathways are now available, including lower security prisons, secure hospitals and a range of community services. These are being expanded through the Offender Personality Disorder (OPD) Strategy that includes the provision of Psychologically Informed Planned Environments (PIPEs).[12]

The strategy is also tightly embedded within the National Offender Management Model so that treatment is integrated with the participant's sentence plan to provide continuity and effect a smooth transition and progress. The local management team at the Chromis delivery site is required to have a designated Progression Lead whose main task is to ensure that participation in treatment is integrated into the overall sentence planning process. This person also has a key role to play in promoting links between Chromis and wider resettlement services, and ensuring that learning from the programme is incorporated into future offender management decisions. Links between the Progression Leads at the delivery site and the receiving site are critical to ensuring that staff at the receiving site understand what Chromis entails.

Throughout Chromis each participant also has routine contact with their Offender Supervisor to ensure that the wider staff team are aware of the progress being made by the participant. This liaison is again undertaken in an open and collaborative way. The strategy is therefore responsive to the context in which an offender lives, the conditions under which he serves his sentence and the circumstances under which he will eventually be released. It includes mechanisms for documenting and communicating progress and risk within and across agencies and services, to fit with both Multi-Agency Public Protection Arrangements (MAPPA) and the NHS Care Programme Approach.

As part of ensuring a consistent approach and providing the best environment for supporting the maintenance and continuation of progress made in treatment, Offender Managers and staff from the PIPE (or other step down provision) are invited to attend the Chromis 'Working with Psychopathic Offenders' training. There are also a range of materials available to treatment and progression sites which explain the goals, content and approach taken by the Chromis programme. These can be used to inform staff and Offender Managers/Supervisors about the aims, format and ethos of the programme. Sites are free to adapt materials to suit local circumstances and to meet the requirement to deliver local awareness training.

The challenges in implementing a progression strategy

Following up each participant's involvement in Chromis and integrating this into their overall sentence plan through the offender management process poses significant challenges. The responsivity needs of this complex population, including the individual characteristics of violent offenders with high levels of psychopathic traits bring with them a number of issues that need to be acknowledged and carefully managed. Some examples are:

- A potential *unwillingness or inability to generalise skills.* The concern is that although participants are able to learn and demonstrate pro-social skills during structured treatment, because they see little personal relevance in their use they fail to employ them pro-socially outside of the treatment setting.
- If an individual's particular goals and motivation are not clearly understood and treatment is not responsive to these things then there is the potential that some participants will *misuse these skills* in an anti-social or harmful manner.
- There are likely to be some *difficulties obtaining honest disclosure* from participants about their concerns, difficulties and setbacks. This sharing is necessary to achieve effective progression with participants.
- Given some of the interpersonal aspects of psychopathy such as an ability to lie, con and manipulate, there is often a concern that some individuals may *fake treatment progress or in some way manipulate staff assessments of their risk*.
- The need for *status* continues to be an important consideration. For some, prison provides an ideal environment in which to gain status, through the notoriety of their crimes, their willingness to use violence or through challenging the system. A place in a hostel with a menial job is a far cry from the status they can achieve in custody and by remaining 'dangerous'.

Making progression work in practice

In order for the Chromis progression strategy to be realised in practice with such a population it needs to be

12. Turner, K., & Bolger, L. (2013). A Guide to Psychologically Informed Planned Environments. NOMS, DoH & NHS England.

underpinned by close adherence to the treatment principles. This means supporting the individual to generalise internal risk management skills, but at the same time recognising where external risk management by correctional services and health staff is also required. This balance between self-management and external management of the individual and their environment is supported by the ongoing use of the Strategy of Choices with an emphasis on transparency. Fundamentally, the Strategy of Choices is a risk reduction strategy. Choosing to behave disruptively or disrespectfully will have a set of consequences for an individual that will include greater emphasis on external risk management. This in turn will produce a reduced range of choices and less personal control for the individual. In this way the strategy is *transparent* about each offender's right to choose his own path, but also about society's right to choose to protect itself from violence.

It is particularly important, therefore that the progression strategy provides comprehensive support and monitoring of offenders' appropriate use of skills across time and in different contexts. A significant development for supporting this process is the introduction of PIPEs within the OPD pathway across custody and community sites. Staff are required to maintain a difficult balance of healthy scepticism whilst still being hopeful and supportive regarding change, recognising achievements where they occur. This is supported by the ongoing integration of information from different sources regarding the individual's behaviour and any difficulties post treatment. Progression sites are made aware of the principles of choice, status and credibility and are supported in finding ways to help individuals maintain these things.

Given the critical nature of supporting the generalisation of skills in maintaining progression for this population, post programme provision has to be developed and monitored with the same rigour as other aspects of the programme, with implications for *assessment, staff training, monitoring and evaluation.* Close liaison takes place therefore between the Chromis Progression Lead and the NOMS and NHS Co-Commissioners of the OPD Programme through regular meetings with the lead co-commissioners, and attendance at Personality Disorder Services support meetings and PIPE leads support meetings.

For progression and resettlement to be effective there needs to be ongoing close working between the key services of Prison, Health and Probation, and the involvement of other agencies and organisations linked to treatment for substance abuse, housing, benefits, training or employment. It will also often involve working with the participants' significant others, family or friends to develop the protective factors that help offenders desist from further offending. This aspect is particularly important given the need to counteract any anti-social peer influences which may exacerbate the individual's risk. The strategy requires that all those involved in the participant's sentence planning and management have a thorough understanding and awareness of the Chromis programme and the treatment environment that the participant has experienced. Careful consideration needs be given to the potential role of family and social networks in either reducing or enhancing risk. For some, family and friends may operate as a risk factor rather than a protective factor, and some family members and friends may also be at risk from these individuals. Ongoing consideration of these safety issues is required.

In addition, alongside supporting individuals to manage their risk themselves and identifying where external management is required, it is important to pay attention to re-integration. Resettlement needs such as housing, employment and substance use are also addressed so that they do not undermine the successful reintegration of the individual.

Conclusion

It was known at the outset that the generalisation of skills beyond treatment would be an issue for the Chromis population. However, over ten years of programme implementation there has been considerable learning in relation to progression issues. The main learning has been that, contrary to what some might believe, being open and collaborative in relationships with offenders with high levels of psychopathic traits is a successful approach to addressing and managing risk. Open and collaborative practice can still be achieved within the boundaried practice required for highly psychopathic individuals to change whilst their problematic behaviours are managed.

The lessons from Chromis are ongoing, as with all evidence based interventions. It has already led to new practice, and the learning carries on. Continuing liaison between the Chromis team, Westgate and the OPD Pathway helps to ensure that this learning is shared between purchaser and provider and that there is consistency in the approaches taken. It also allows the information and training offered to all staff supporting treatment and progression to be regularly updated to include the most recent findings from the review of practice.

From Management to Treatment:

Changing and Maintaining a Therapeutic Culture in a High Secure Prison

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

Context

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

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

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

Difficulties in achieving and sustaining cultural change

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

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

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

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

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

A framework for achieving and sustaining cultural change

Instilling Belief

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

Protecting Staff and Patients/Prisoners

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

Providing a Safe Structure

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

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

Changing From Management To Treatment

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

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

Treatment Model

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

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

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

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

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

Reporting on Succeses

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

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

Protecting staff and patients/prisoners

Therapeutic Milieu

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

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

Training

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

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

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

Supervision

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

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

Reviewing Critical Incidents

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

Providing a safe structure

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

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

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

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

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

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

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

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

Governance

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

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

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

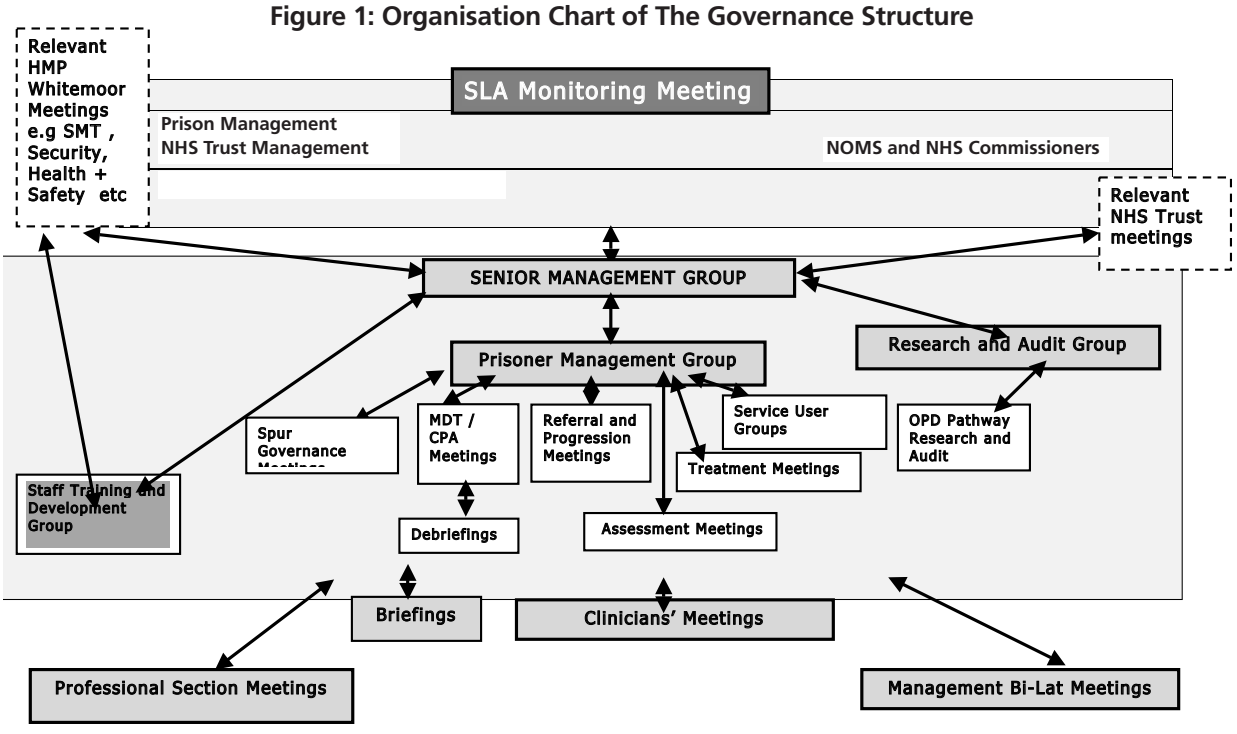
Operational Policy

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

Struggles

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

Figure 1: Organisation Chart of The Governance Structure



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

Protecting the culture

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

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

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

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

The Future

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

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

The provision of PIPEs — Psychologically Informed Planned Environments

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At the heart of the Offender Personality Disorder (OPD) Strategy (Joseph and Benefield, 2012)[1] lie a number of principles which inform the shape of service delivery and approaches taken to working with offenders with complex needs and personality disorder. These principles, which include the expectation that all services should be delivered through joint operations and be 'psychologically informed', are underpinned by a strategic intention to develop and promote appropriate relational conditions when working with and providing a pathway of services for offenders with personality disorder (PD).

Since 2009, the NHS/NOMS OPD team have been developing specifications and service models to support the creation of suitably informed, tailored environments which promote effective progression through a pathway of intervention, particularly for offenders likely to meet the diagnostic criteria for Personality Disorder. In the implementation of such a pathway it was decided that in order to be effective a new response was required which focussed on the physical, social and cultural environment the offenders were living in.

A new service model that developed in response to this was the Psychologically Informed Planned Environments approach, known as PIPEs. The PIPEs model is a developmental approach that is currently in operation across both community and custodial settings.

PIPEs are defined as 'specifically designed, contained environments where staff members have additional training to develop an increased psychological understanding of their work' (MOJ and DH, 2012).[2] This understanding is intended to enable staff working within a PIPE service to create an enhanced safe and supportive environment facilitating the personal and social development of its residents. The aim is to achieve this through engendering a focus on the quality of relationships that exist within the service, with a particular emphasis on the provision of the 'experience' that residents encounter both on a daily basis and throughout their time in the service.

The nurturing of these relationships and experiences are a key aspect of the PIPE approach. The intention is to help develop a capacity within PIPE residents to form and maintain positive pro-social relationships and to learn to manage the internal, personal responses to their lived experience. The approach seeks to encourage offenders to meet previously unmet needs in a pro-social way, acknowledging the impact of emotional deprivation and seeking to redress it.

Staff training and development is at the heart of this approach; promoting a reflective culture and ensuring that psychologically informed practice is embedded at the centre of day to day operations, not something that is seen as an additional layer of intervention provided by 'specialist staff'.

Supporting services to consider and understand these practices enables them to reflect upon appropriate relational strategies which aim to provide an environment conducive to helping participants to thrive.

The genesis of the PIPE model formed part of a response to the specific need for progression services for men and women who had completed intensive interventions, in particular the DSPD[3] programme. This requirement highlighted the wider system need for a service which would pay attention to the transition between services within a pathway; an experience that is known to be destabilising or pose a particular risk to those with attachment difficulties, common amongst people with a PD diagnosis. Guidelines for working with Borderline Personality Disorder (NICE, 2009)[4] describe that it should be anticipated that strong emotions or reactions may be evoked at the end, or on withdrawal of a treatment or service.

1. Joseph, N and Benefield, N (2012) 'A joint Offender Personality Disorder Pathway Strategy: an outline summary' *Criminal behaviour and Mental Health*, 22: 210-17.
2. MOJ & DH. (2012). *A Guide to Psychologically Informed Planned Environments (PIPEs) Version 1*. Ministry of Justice and Department of Health: London.
3. The Dangerous and Severe Personality Disorder Programme.
4. National Institute for Health and Clinical Excellence (2009). *Borderline Personality Disorder: Treatment and Management* [CG78]. London: National Institute for Health and Clinical Excellence.

A model was required to provide a supportive, rehabilitative progression environment to assist those who were completing intensive interventions and finding themselves in new and unfamiliar environments without the supporting ethos or people they had relied upon. It was at this stage that some offenders, having learnt new skills in their treatment programmes, were not necessarily psychologically equipped to deal with the environmental and relational changes they were experiencing. In Livesley's (2003)[5] work which considered the management of people with personality disorder, he describes the impact of having a disparity between the environmental factors present in the receiving service and those that are required when progressing on from treatment. The uncomfortable internal responses experienced by the offender, including feeling alienated or misunderstood, could elicit a strong and negative reaction or a return to former ways of managing distress, potentially losing gains made in treatment, in order to cope.

It became apparent that additional treatment at this point in an offender's pathway was probably not what was required, but rather a supported opportunity to reflect upon and apply what been had been learnt to date, integrating this into their daily functioning. The early application of the PIPE model and approach therefore focussed on the post-treatment or 'progression' points in the system.

The ideas and theory that underpin the idea of a PIPE are not new; however they have been reconstructed and developed from the core concepts of long established environmental approaches, such as the work of Democratic Therapeutic Communities, described by Haigh (1999).[6] The PIPE model builds upon a group analytic foundation and the wider theoretical field which considers 'relational' responses to psychological problems, including recognition of conscious and unconscious processes. It is inspired by the work of Donald Winnicott (1960)[7] and seeks to provide the 'good enough' conditions required in order to help individuals to thrive.

The PIPE model also incorporates more recent developments such as the Royal College of Psychiatrists' Enabling Environments initiative,[8] and aligns with similar developments in the promotion of psychologically informed practice in the housing and homelessness sector (Johnson and Haigh, 2011).[9]

In accordance with the wider OPD strategy, the PIPEs model adopts a bio-psychosocial understanding of personality disorder, in particular the relationship between the individual and their environment, and all relationships that exist within this context. This understanding encourages the consideration of how the psychosocial environment can contribute to the effective management of offenders and support strategies for reducing risk, whilst improving psychological health and wellbeing.

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The installation or creation of such an environment in a criminal justice setting presents a tension, both culturally and systemically. Whilst there are clear examples of good, high quality relational practice within the criminal justice system, these are often reliant upon the individual qualities of members of staff. The wider application of this approach across a whole environment however presents a considerable challenge for any establishment or organisation. Even with wholesale agreement between staff and residents, the required provision of experience, and the development of an appropriate milieu is unlikely to naturally occur in such environments without introducing a clear framework, tools and structured processes.

These processes are needed to support and protect the development of a positive relational culture. In such settings there are a number of obstacles which can get in the way of consistent and quality relating, such as longstanding operational practices, cultures and organisational processes or pressures. PIPEs therefore need to actively work with the wider 'institutional' environmental context in which they are located, taking into account what could present as less-helpful (but common) aspects of institutional settings. They need to consider how these impact on the way in which staff and

5. Livesley, W.J. (2003). *Practical Management of personality disorder*. New York: The Guildford Press
6. Haigh, R. (1999) 'The quintessence of a therapeutic environment. Five universal qualities' in P Campling and R Haigh (eds) *Therapeutic Communities: Past Present and Future*. London: Jessica Kingsley Publishers.
7. Winnicott, D. (1960). The theory of the parent-child relationship, In*ternational Journal of Psychoanalysis*, 41.
8. Further information on Enabling Environments can be found at http://www.enablingenvironments.com
9. Johnson, R., and Haigh, R. (2011). Social psychiatry and Social Policy for the 21st Century: new concepts for new needs. *Mental Health and Social Inclusion*. 15 (1). Pier Professionals Ltd. p17-23.

residents respond to their own experiences, and to explore new ways of working in light of this.

Application of the PIPE Model

PIPEs now exist in a number of different settings across the criminal justice system. The first PIPE services opened in 2011, initially with discreet wings in five prisons operating as progression services, and two Approved Premises in the community; each working towards the same model and approach. A full PIPEs model description was developed in conjunction with these services and finalised in 2013. The model is not a prescriptive manual for the delivery of the service, but outlines the core components and clinical framework that each PIPE service is working towards. The model itself can be applied in different settings and at different points in a pathway of services. It should be focussed on particular points where offenders are trying to make changes and consider the provision of necessary environmental conditions to support this.

There are currently four different applications that have been commissioned.

- ❒ Preparation (Pre-Treatment)
- ❒ Provision (Whilst In-Treatment)
- ❒ Progression (Post-Treatment)
- ❒ Premises (Approved Premises in the Community)

All PIPE services share a common approach, and have a focus on psychosocial relating; aiming to improve social integration and social functioning. They will all have a focus on the experience of transition, irrespective of which part of the pathway they are located.

Table 1 below provides a brief description of each application as it is currently delivered (NHS and NOMS, 2014).[10]

The PIPE approach complements the NOMS 'new ways of working' agenda, particularly the 'Every Contact Matters' strand, which seeks to make every interaction in prisons worthwhile and productive. It also aligns with a more recent focus on the quality of the rehabilitative environment which has seen NOMS offending behaviour programmes adopt an increased focus on the importance of the host physical and social environment when measuring the quality of their delivery.

PIPEs however are different from what is usually considered to be 'treatment' in this context. Treatment is often thought to be something that is done to you or given to you, and when considering reducing re-offending it is the term usually applied to mainstream offending behaviour programmes. The term itself obviously has much wider applications within health services. PIPEs contribute to a wider treatment pathway for men and women, as opposed to providing a specific 'treatment' or a particular brand of therapy; they instead focus on supporting residents to make sense of their

Table 1: Applications of the PIPE model

PIPE Service	Description
Preparation PIPE	A (prison) residential pre-treatment service focussing on treatment readiness (responsivity), motivation, engagement and exploration of barriers to treatment.
Provision PIPE	A (prison) residential service which provides an appropriate and supportive environment for those undertaking treatment in a different setting (e.g. for those in a day treatment service). A provision PIPE provides the core environmental conditions of a PIPE, whilst supporting residents to actively consider skills and learning being explored through treatment. A provision PIPE service works closely with the treatment teams and clinicians.
Progression PIPE	A (prison) residential post-treatment service that supports residents in consolidating and generalising their treatment gains, putting new skills into practice and demonstrating improvements in behaviour. Residents will have successfully completed a treatment programme (usually one of high intensity).
Approved Premises PIPE	A whole-premises approach, focussing on a psychosocial understanding of residents, and supporting effective community re-integration and resettlement. PIPE Approved Premises will integrate model requirements into the core functions of the premises and aim to provide new experiences and pro-social opportunities for its residents. The population will include a range of offenders at different stages of the pathway, for example a mix of those who have completed interventions and those who have not.

10. NHS & NOMS. (2014). *A Guide to Psychologically Informed Planned Environments (PIPEs) Version 3*. Ministry of Justice and Department of Health: London.

experience through a consistent relational framework and access to new ideas and opportunities. It is essential that there is a whole-environment understanding of the approach, and that this is shared between all staff and residents.

The PIPE model is delivered through a combination of core components and key ingredients which support the development and facilitation of a positive relational ethos.

A PIPE is an identified and discreet environment, with an identified staff team, which operates on a 24/7 culture. The service needs to be integrated into the core function of the environment, whether that is an existing prison wing or approved premises hostel. An increased provision of frontline staff is also required, supporting delivery of the core components, outlined below. Each PIPE appoints a Clinical Lead, who is embedded into the service's operation, having a daily presence in the service. The Clinical Lead for a PIPE is usually a qualified Psychologist but can be a qualified, accredited and experienced mental health professional such as a psychotherapist with forensic and group analytic experience. All staff and residents in the PIPE service need to have a shared understanding about the function of the service, its aims and approach. Operationally, the provision and protection of staff is critical to successful PIPE delivery, and all staff should be trained and supervised. Challenges such as those caused by cross deployment from and to other services need to be actively mitigated by host organisations.

All staff and residents in the PIPE service need to have a shared understanding about the function of the service, its aims and approach.

Core Components

There are six core components in the PIPE model, described briefly below:

Enabling Environment — Each PIPE service is required to work towards the Enabling Environments award which has been developed and validated by the Royal College of Psychiatrists. Participation in this process provides the PIPE with a mechanism for considering the relational processes that occur within it, and to consider the involvement of service users and staff when developing a shared ownership of the social environment. Working to ten environmental standards, the award process provides a solid relational footing for the PIPE service to build upon. The process also recognises qualities and strengths that may already exist. In addition to these standards, PIPEs will have an increased focus on the concept of 'ordinariness', thinking about how positive relational experiences can exist outside of the structured environment and support capacities for the development of a 'good enough' life that can be sustained or developed in other settings.

Staff Training — As described above, the training and development of staff is a critical component of the PIPE model delivery. All staff are trained in working with people with Personality Disorder, undertaking the Knowledge and Understanding Framework awareness level (Institute for Mental Health, 2015)[11] as a minimum. Staff also receive training on the creation of an enabling environment, and working with and understanding groups. The training and development of the staff team is overseen and developed by the local Clinical Lead and can include training specific to the application of the PIPE. Examples include Pro-Social modelling, working with Offence Paralleling and use of the Good Lives model (Ward et al, 2007).[12]

Staff Supervision — All staff are required to participate in both group and individual supervision processes. Facilitated by the Clinical Lead, the group sessions usually occur each week and provide an opportunity for staff to make sense of their work, and the relational dynamics that are present. Presentation and reflection of a case study is also common practice. The model of supervision follows a Group Analytic approach, described by Brown (2014)[13] in which each of the Clinical Leads is supported by attending their own group and individual supervision with an experienced group analyst. Each staff member also receives individual clinical supervision each month.

Key Worker Sessions — Each resident is allocated a key worker with whom they meet regularly, usually once each week for an hour. In prisons the Key Worker is also the personal officer. This provides the opportunity to support the development of positive relationships between offenders and staff, to consider the experience of participation in the PIPE regime, as well as planning for progression and transition through

11. Institute for Mental Health (2015) Personality Disorder — Knowledge and Understanding Framework. [ONLINE] Available at: http://www.personalitydisorderkuf.org.uk. [Accessed 13 December 2014].
12. Ward, T., Mann, R. & Gannon, T. A. (2007) The good lives model of offender rehabilitation. Clinical implications. Aggression and Violent Behaviour 12, 87–107.
13. Brown, M, (2014). Psychologically Informed Planned Environment — PIPE: A Group Analytic Perspective. *Psychoanalytic Psychotherapy*, 28, 345-354.

the system. Residents and their key workers also reflect on formal and informal interactions on the unit and may consider the benefits of attending some of the voluntary sessions on the PIPE. Key Workers are supported to deliver this in a psychologically informed way by the Clinical Lead. Specific approaches, such as the 'Good Lives' model, are often used to support Key Workers in delivering this component.

Socially-Creative Sessions — These are planned occurrences in the week which provide service users and staff the chance to engage in a task, an activity or a shared experience that promotes relational engagement and development. They usually occur in informal ways and at social times, such as evenings and weekends, and they support a promotion of a sense of community within the PIPE environment. These sessions are attended voluntarily, but include both staff and service users working alongside each other. Group sizes can range from very small to the whole environment. There remains a challenge of balancing what are publicly acceptable activities with the provision of new, sometimes nurturing, developmental and relational experiences. Socially-creative sessions can often be the component of the PIPE model that 'feels' different for the participants. These sessions seek to embed, or in some cases trial, a culture of authentic service user involvement. They present a vehicle for the safe provision of new experience and expression, through contained, supportive and ultimately positive interaction with others. Each service designs and implements its own Socially-Creative sessions, relevant to its current population and state of growth.

Structured Sessions — Structured sessions offer a formal opportunity for PIPE residents and staff to interact in a group setting. They provide an interface between the individual and the host organisation, affording opportunities for discussion, and to consider potential for the offender to have a positive influence over their own lived environment. Sessions are regular and timetabled, usually one session per week, and are tailored to each PIPE environment. They usually take place in smaller fixed groups of up to 10 residents. They present a formal opportunity to enhance or revisit previous learning and to share experiences. They can also provide exposure to group processes when preparing people for treatment and attention to transition processes, amongst other issues. In a prison setting these sessions are a mandatory requirement, however in Approved Premises they are not compulsory although residents are encouraged to participate, particularly when first arriving in the hostel.

In addition to the six core components, each PIPE service considers the opportunities it provides for shared enrichment activities. Often occurring in the context of socially-creative sessions, the provision of enriching personal experiences supports PIPE services in the delivery of a holistically considered approach. Usually delivered through partnership with an external agency or creative arts organisation, these activities provide mediums for emotional expression and understanding, consider opportunities that may be available in the community, or purely to expose residents to positive and nurturing experiences that they may never have encountered previously. One example of an 'enrichment' activity currently active in PIPEs is the provision of 'Shared Reading' experiences. These are facilitated sessions, delivered by the Reader Organisation's trained reader practitioners where a short story or prose is read aloud to participants, and opportunities presented for discussion of the narrative. Whilst providing the experience of having a story read aloud to them, which some offenders may never have experienced, it also offers the chance to relate to characters and stories in the text, and to share this experience with others.

PIPEs are not exclusively for those diagnosed with personality disorder, but are designed to work with those who present complex needs.

Service Outcomes

All PIPE services, in all applications, are working to support the overall high level outcomes of the OPD Strategy which aims to bring about a 'reduction in repeat serious sexual and/or violent offending (for men) or a reduction in repeat offending of relevant offences (for women)' and improve 'psychological health, wellbeing, pro-social behaviour and relational outcomes'. PIPEs are not exclusively for those diagnosed with personality disorder, but are designed to work with those who present complex needs. Some prison based services will have local criteria, directed by their commissioners.

In accordance with the high level aims of the OPD strategy, PIPEs are designed to contribute to the improvement of the competence, confidence and attitudes of staff working with complex offenders who are likely to have Personality Disorder related needs and also strive to increase the efficiency, cost effectiveness and quality of OPD Pathway Services.

Additionally, PIPEs are specifically looking to evidence improvements in offenders' quality of relationships and their relationship skills, as well as improving or sustaining improved levels of institutional behaviour. They aim to deliver a range of intermediate

outcomes that support the high level strategic aims (Bolger and Turner, 2014).[14]

In particular to:

- ❒ Improve offenders' access and progression through services; and ensure effective risk management.
- ❒ Improve staff and offenders understanding of behaviour, risk factors and effective management strategies
- ❒ Bring about a reduction in number and severity of incidents of general and violent misconduct
- ❒ Bring about a reduction in number and severity of incidents of self destructive behaviour
- ❒ Improve the effectiveness of OPD pathway services through meaningful involvement of service beneficiaries

As part of the national evaluation of the OPD Strategy, each of these outcomes will be considered and supporting studies will continue to contribute to a growing understanding of the PIPE model, its efficacy and its potential.

An early pilot research study, undertaken by the National Centre for Social Research (Turley et al, 2013),[15] provided a qualitative investigation of the key enabling features of PIPEs and the perceived benefits of participating in PIPEs. They concluded that; 'Establishing and maintaining supportive relationships between staff and offenders were seen as key to PIPE delivery'. A number of smaller studies have also been published, looking qualitatively at early experiences of PIPEs and PIPE staff (Bond and Gemmell, 2014).[16]

Overview

As PIPE services have begun to develop, they have been observed to form their own identity and have demonstrated creativity and innovation. They have established themselves as part of a wider system, with a view to supporting the effective movement through a clear pathway. Each application of the PIPE model provides something new to the OPD pathway.

Through delivery of a structured and planned environment, which aims to create and facilitate a 'good enough' experience, PIPEs present a range of new opportunities within the Criminal Justice System. This approach aims to support offenders to thrive, to succeed at each stage of their pathway of services and to support the delivery of the high level outcomes of the OPD strategy.

Through maximising the relational potential from 'ordinary' situations and experiences, and promoting a culture of pro-social living, each new PIPE service should develop to provide a sophisticated environment that supports effective progression and transition for those with complex needs and Personality Disorder. As one PIPE resident commented in their newsletter; *'[The PIPE is] a wing with more thoughtfulness than others…it will give you an opportunity to be yourself'.*

14. Bolger, L. & Turner, K. (2014) *Psychologically Informed Planned Environments: Model Description Version 1.2*. London: National Offender Management Service NHS England.
15. Turley, C. et al (2013) *Enabling Features of Psychologically Informed Planned Environments*. NatCen Social Research, Ministry of Justice Analytical Services, London.
16. Bond, N and Gemmell, L (2014). Experiences of prison officers on a Lifer Psychologically Informed Planned Environment. *Therapeutic Communities*, 35, 3, 84-94. Emerald: Bingley, United Kingdom.

Implementing an Offender Personality Disorder Strategy for women

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Policy officials are developing a separate strategy for women… and establishing plans for modelling the pathway in one part of the country. Options for gender specific training will also be explored…

Such was the fairly dry commitment made in the Government's response to the public consultation on the offender personality disorder strategy in October 2011.[1] It is fair to say we have come a long way since that pledge was made: following the development of the women offender personality disorder strategy[2] by a working group of clinicians, officials, criminal justice practitioners and commissioners completed in late 2011, we have gone beyond 'modelling' in just one area of the country to national roll-out across England and Wales; we have provided three new prison-based treatment services, two new Psychologically Informed Planned Environments in women's approved premises, enhanced community-based services for women, and independent mentoring and advocacy services across a large part of the country; we have also delivered a range of gender-specific workforce development products.

While we are still firmly in the developmental phase, our vision for the pathway (see Figure 1) is starting to become a reality, thanks to an innovative and dynamic programme of joint commissioning between NOMS and NHS England, which focuses on shared criminal justice and health outcomes. This article provides a reflection on the process of implementing the programme for one of the most complex offender groups and at a time of remarkable change within both the health and criminal justice sectors.

I came into role as implementation manager for the women offender personality disorder strategy in November 2011. Throughout the last three years, my role has taken me to prisons, approved premises, secure hospitals, women's centres and supported accommodation; into discussions with operational and managerial staff about the gaps the strategy needs to fill; and into the extraordinarily complicated lives of women offenders struggling with an array of problems, linked and exacerbated by difficulties caused by personality disorder. While sites and services differ considerably in the environments they offer and their models of care and management; and while staff and women report a variety of experiences and have a wide range of suggestions for improvement; some messages have become a constant, and continue to ring true as strategy implementation progresses and evolves.

'Women are not just oddly shaped men'

Firstly and unsurprisingly, I am told time and again how different women are to men: how women are

Figure 1: A vision for the women offender personality disorder pathway

At the core of the vision are *community-based services* offering workforce development, case identification, case formulation, case consultation and joint case management with regard to each woman within the target group, regardless of whether she is in prison custody, residing in approved premises or under probation supervision.

Each woman will have an *individualised and gender-responsive pathway plan*, aiming at improvements in health and offending behaviour outcomes. Each woman's plan should stitch together a series of appropriate interventions on a *community-to-community pathway model* and include the opportunity to receive *mentoring and advocacy* from an independent provider.

Some women will require a higher level of support or treatment and will enter into *existing and planned interventions*. These interventions will be provided as joint health/criminal justice operations; within relationally secure, enabling environments; by staff with appropriate skills and confidence, who are psychologically informed and understand the gender-related needs of women.

Service users will be involved in the design, delivery and review of services.

* With grateful acknowledgement to Nick Benefield, Sarah Skett, Ian Goode, Nick Joseph, Kirk Turner, Alexandra Avlonitis and Sarah Bridgland.

1. Available here: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_130701.pdf
2. Available here: http://www.womensbreakout.org.uk/documents/external-documentation/

more open emotionally; how they have a greater multiplicity of complex need and chaos in their lives; how they are more often a greater risk to themselves than others; how their primary concerns often relate to their responsibilities towards others, rather than themselves. Perhaps most memorably, 'Women are not just oddly shaped men.' But this is not just anecdotal.

Research tells us that women offenders frequently have multiple, complex needs relating to their psychological well-being, which include trauma and abuse, low self-esteem, physical and mental health problems, drug and alcohol misuse, parenting and childcare, relationships and self-harm/suicide.[3] The research on women's pathways to offending highlights an interaction between unhealthy relationships, trauma, mental illness and substance abuse. Women's offending also tends to involve an emotional element associated with victimisation, substance misuse, low self-esteem and poor mental health. Women offenders have significantly higher rates of poor mental health compared to male prisoners, with high levels of co-morbidity of borderline personality disorder with mental health difficulties that include depression, substance misuse, post-traumatic stress disorder, obsessive compulsive disorder, eating disorders, psychosomatic conditions and, sometimes, psychotic-like symptoms.[4]

Women are generally convicted of fewer crimes than men and are less likely to pose a risk of harm to others. The majority of women move in and out of the criminal justice system and between different parts of the system very quickly, thus presenting difficulties in how to intervene in a meaningful, sustained way. Women are also more likely to have caring responsibilities for dependent children, which has significant implications for the care of their children whilst in custody, and underlines the importance of focussing attention on family relationships.

Of particular relevance is the fact that the nature of personality disorder is different for women offenders. It is estimated that between 50 per cent and 60 per cent of women in prison have personality disorder, slightly lower than the figure for men, which is around two-thirds.[5] However, much higher rates of borderline personality disorder are found within female samples.[6] The following extract from National Institute for Health and Clinical Excellence (NICE) guidelines demonstrates how pervasive and impairing a diagnosis of borderline personality disorder can be:

> *[Borderline personality disorder is] characterised by significant instability of interpersonal relationships, self-image and mood, and impulsive behaviour. There is a pattern of sometimes rapid fluctuation from periods of confidence to despair, with fear of abandonment and rejection, and a strong tendency towards suicidal thinking and self-harm. Transient psychotic symptoms, including brief delusions and hallucinations, may also be present. It is also associated with substantial impairment of social, psychological and occupational functioning and quality of life. People with borderline personality disorder are particularly at risk of suicide.*[7]

All of the above differences have affected the implementation of the women's strategy in two key ways.

Firstly, we have established different pathway entry criteria for women offenders. Had the women's strategy focused, like the men's, on offenders with severe personality disorder who are a high risk of serious harm to others and at high risk of violent or sexual offence repetition, only a very small number of women — perhaps as few as 200 — would have been identified. This would not only have hindered the development of an effective pathway for women (because there would have been too few in the right place at the right time to make a pathway approach viable), but it would also have failed to fill the yawning gap between the level of need and the availability of interventions for women who do not necessarily present a risk of harm to others, but who have significant personality difficulties linked to their offending. In other words, there was an 'equity of provision' issue that the strategy aimed to address. It was therefore decided that women offenders did not need to be high risk of harm to others to gain entry to the offender personality disorder pathway. Instead, the criteria are as shown in Figure 2, which we estimate will bring between 1,000 and 1,500 women in scope:[8]

3. Emma J. Palmer & Clive R. Hollin, 'Criminogenic need and women offenders: A critique of the literature,' Legal and Criminological Psychology, Vol. 11, Issue 2, 2006.
4. As summarised in the service delivery plan for the Personality Disorder Service at HMP Eastwood Park, Avon & Wiltshire NHS Partnership Trust & HMP Eastwood Park, unpublished, 2014.
5. Singelton *et. a*l., "Psychiatric morbidity among prisoners," Department of Health, 1997.
6. J. Danesh, "Serious mental disorder in 23,000 prisoners: a systematic review of 62 surveys," *The Lancet, 359-545-550*. Also J. Coid, N. Kahtan, S. Gault, S. Jarman, "Patients with personality disorder admitted to secure forensic psychiatry services," *British Journal of Psychiatry* 175: pp.528-36.
7 . National Institute for Health and Clinical Excellence (2009) Borderline Personality Disorder Treatment and Management http://www.nice.org.uk/Guidance/CG78
8. Please note the criteria are currently under discussion and therefore subject to change.

Figure 2: Entry criteria for the women offender personality disorder pathway

Women offenders who:

- Have a current offence of violence against the person, criminal damage including arson, sexual offences and/or where the victim is a child; and
- Are assessed as presenting a high risk of committing an offence from the above categories OR are managed by NPS; and
- Are likely to have a severe form of personality disorder.[9]

There should also be a clinically justifiable link between the offending and the personality disorder.

Secondly, we have supplemented the core set of principles for the offender personality disorder strategy (described elsewhere in this Journal at pp. 5-6) with a number of gender-specific criteria that we apply to all planning, commissioning and service provision for women offenders. These criteria[10] are designed to ensure that every level of strategy implementation is truly gender-responsive; that is:

> *…reflect[ing] an understanding of the realities of the lives of women and girls and… address[ing] and respond[ing] to their strengths and challenges.*[11]

Building on evidence that at-risk women need intensive support that deals with the whole range of their complex and interrelated needs,[12] and chiming with the conclusion of the Corston Report that women offenders require a multi-agency, woman-centred and holistic approach,[13] we specify that services offer individual needs assessment; look at each woman as a whole, not just at her offence; and acknowledge a woman's expertise in her own 'story'. This should contribute to the development of a formulation-based understanding of the problems that is meaningful to each woman, and a coherent pathway plan that addresses her specific issues. We also require that all women's services be informed by the knowledge that most women will have experienced some degree of trauma in their lives.

Being truly gender-responsive means for us, not simply modifying existing programmes for men, as can so often be the case in offender services, but designing, from scratch, interventions specifically for women, which take into account all those things that we know makes them different to men. Importantly, it also means helping women to improve their self-esteem and self-worth through self-care and opportunities for self-improvement; stressing their resilience, competencies and strengths; and giving hope that things can be different.

We aim to move away from *service-centric* provision, focused on rigid and exclusive eligibility criteria, to *woman-centric* services that are inclusive and responsive to individual need and that fully engage service participants in all elements of service design, delivery and review. Our services should specifically reach out to those women who others exclude as being too difficult. Such women are likely to have experienced years of rejection — by family, partners, professionals *and* services — and will have low expectations of others' willingness to 'stick by' them. They will test the boundaries and often push away the help at hand. We do not underestimate how difficult it will be for staff to engage with this highly challenging client group, and then repeatedly re-engage, with compassion and resilience, in the face of stagnation, failure and breakdown.

It follows that staff working on the women offender personality disorder pathway will require specialist gender-specific training that gives them the skills, knowledge and confidence they need in order to work most effectively, and in a psychologically informed way, with female service users. Staff will also require supervision, reflective space and support to help keep themselves healthy and motivated. One of the early actions of the programme was to commission the Institute of Mental Health, with the service user-led third sector organisation, *Emergence*, to develop gender-specific versions of the main training products available on the offender personality disorder pathway as part of the Knowledge and Understanding Framework (KUF). The new 'W-KUF' suite of courses includes gender-specific awareness level training on personality disorder, as well as Bachelors and Masters level modules. While the W-KUF products have been widely welcomed and well received to date, it is fully expected that they will be supplemented by locally delivered workforce development that is specific to the intervention being delivered and to the women in that service. Examples would be training in trauma-informed practice, de-escalation, self-harm management and formulation. A large proportion of workforce development will also be 'on-the-job' training, shadowing, coaching and informal support and guidance offered within the context of a joint health/criminal justice operation.

9. A severe personality disorder is likely to present as persistent and complex needs with regard to interpersonal functioning; emotion regulation; arousal; impulse control and ways of thinking and perceiving. It is associated with considerable personal and social disruption. The disorder is likely to appear in late childhood or early adolescence and is enduring.
10. The criteria are encapsulated in the 'Specification for Services for Women Offenders likely to have Personality Disorder,' available on request from pd@noms.gsi.gov.uk. The Specification is based on an NHS England template, but sets out joint health and criminal justice outcomes.
11. Stephanie Covington & Barbara Bloom; see: http://centerforgenderandjustice.org/
12. Cabinet Office Social Exclusion Task Force Short Study on Women Offenders, May 2009.
13. A Report by Baroness Jean Corston of a Review of Women with Particular Vulnerabilities in the Criminal Justice system, 2007. Available here: http://www.justice.gov.uk/publications/docs/corston-report-march-2007.pdf

Connections to people and places

The second message that has resonated throughout the process of implementing the women offender personality disorder strategy is how important stable and consistent staff-offender relationships, built up and maintained over time, and provided within a known environment, are for women offenders. A regular perception seems to be that once women become attached to their environment and the people within it they are often reluctant to leave and break those attachments. In a prison context this often means that women prisoners express reluctance to move cells, wings or prison. In the context of women under community supervision, women's mobility can also be affected by financial, family and transport constraints.

This will chime for many who are aware of 'attachment theory',[14] which is often used to understand the development of personality disorder. For many women, their early childhood attachments will have been highly insecure and disorganised, later mirrored in problematic relationships throughout adulthood, perhaps including conflict, loneliness, rejection and unhappiness.[15] The challenge for the women offender personality disorder pathway is to provide positive relational experiences — ones that encourage emotional growth, increase women's sense of wholeness and stability, and help them to develop a more robust sense of self.[16] As above, these relationships should also 'stick by' the woman in times of setback and in the face of often very difficult and challenging behaviour. The consequences of failing to do so are summed up neatly by J. B. Miller:

> *Women stay with, build on, and develop in a context of connections with others. Indeed, women's sense of self becomes very much organised around being able to make and then maintain affiliations and relationships. Eventually for many women the threat of disruption of connections is perceived not just as a loss of a relationship, but as something closer to a loss of self.*[17]

Our understanding of the importance for women of their connections to people and places has had significant implications for the implementation of the strategy.

Firstly, we have made a commitment that all women identified for the women offender personality disorder pathway should be able to access an independent, flexible, gender-sensitive, needs-led, and highly individualised mentoring and advocacy service. Mentor-advocates will provide experience of relational support throughout women's pathway journeys, which is reliable, consistent and continuous over time — be that in custody or the community, or straddling the transition between the two. The service will place particular emphasis on motivation and engagement; addressing practical issues (including family, housing, debt); navigating and accessing services (including education and employment); and self-esteem and empowerment. So far, we have commissioned small-scale mentoring and advocacy services in London (provided by *Women in Prison* and *St Giles' Trust*) and Birmingham (provided by *Anawim* women's centre), but also on a much larger scale across the whole of the North of England and North Wales (provided by *Together Women Project*). One of the major deliverables for the next two-three years will be to roll out mentoring and advocacy services across other regions.

Figure 3: Case study — mentoring and advocacy service

Together Women Mentoring and Advocacy Service for women in the North of England and North Wales

The Together Women Mentoring and Advocacy service provides emotional and practical support to women around a range of issues including accommodation, finance and benefits, children and families, substance misuse, personal safety, education and training, mental and physical health, motivation and social inclusion. Providing up to 150 places for women from the North of England and North Wales, support is offered to women for an average period of two years. Each woman receives a full needs assessment and co-produces an individualised support plan. One-to-one support is offered on a weekly basis, and women also have the opportunity to take part in courses, groups and activities around personal development, social inclusion and employability. Women are supported to access a variety of specialist and community support including local women's hubs and services. Support is offered through flexible appointments, visits and telephone contact. Advocacy is provided on behalf of or for the women to help resolve issues, access services and ensure communication across agencies.

14. Originating in the work by John Bowlby, 1907-1990; e.g. *Maternal Care and Mental Health*, World Health Organisation, 1951.
15. Craissati *et al,* 'Working with personality disordered offenders: A practitioner's guide,' NOMS & Department of Health, January 2011, pp.21-33. Available here: https://www.justice.gov.uk/downloads/offenders/mentally-disordered-offenders/working-with-personality-disordered-offenders.pdf
16. Service delivery plan for the Personality Disorder Service, Avon & Wiltshire NHS Partnership Trust & HMP Eastwood Park, unpublished, 2014.
17. J.B. Miller, *Towards a New Psychology of Women*, Penguin, 1986.

Secondly, in terms of treatment provision in custody, we are commissioning multiple, small services around the country, several of them with an 'outreach' function, which mean that our services are taken as far as possible to the woman (or at least closer to her), rather than expecting her to move to access the service. This approach also supports the wider Government commitment to keep women prisoners as close to home as possible.[18] More specifically, we have committed to introducing up to four new regional personality disorder treatment services for women prisoners. Operated jointly by the prisons and selected health partners, with significant third sector input too, three of these are now operational: at Foston Hall, New Hall and Eastwood Park prisons. These services supplement our national personality disorder treatment service — Primrose at HMP&YOI Low Newton. Primrose has been operational since 2006, when it was set up as part of the Dangerous and Severe Personality Disorder programme. It is now an integrated part of our pathway and an important pathway option for that small number of women who pose a high risk of harm to others.

Figure 4: Case study — Treatment Services

Nexus Personality Disorder Service, HMP&YOI Eastwood Park

Delivered jointly by Eastwood Park prison and Avon and Wiltshire Mental Health Partnership NHS Trust, the Nexus Service offers a total of 30 treatment places, on a residential, daycare and outreach basis. To reflect the population at Eastwood Park, women eligible for the Service may be either convicted or remand offenders, and may be serving short sentences. The therapeutic approach offered by Nexus is based on an attachment model of care. Women's individualised care plans guide their treatment pathways: a phased approach begins with pre-treatment activities (orientation, psycho-education, crisis management planning, goal setting and motivational work), moving to stabilisation and progressing to trauma-focused work. The weekly structure maximises women's access to vocational and educational opportunities.

Primrose Service, HMP&YOI Low Newton

Delivered jointly by Low Newton prison and Tees, Esk and Wear Valleys NHS Foundation Trust, Primrose is designed to offer a range of psychologically informed interventions tailored to meet the individual needs of 12 prisoners who present the highest risk of serious harm to others and who have the most complex needs. Primrose aims to reduce risk to self and others, and to provide women with pro-social life skills which enhance their physical, emotional, spiritual and mental wellbeing. Interventions include Dialectical Behaviour Therapy (DBT), Trauma Recovery Empowerment Model (TREM©), Life Minus Violence — Enhanced (LMV E™), individual specialist offence focused work, art therapy, psychiatric sessions and other life skills and creative sessions.

In addition to specific treatment interventions, and in line with the holistic approach described above, women's pathway plans are also likely to include access to NOMS accredited Offender Behaviour Programmes (OBPs). Two OBPs that have particular relevance for women on the offender personality disorder pathway are CARE (Choices, Actions, Relationships, Emotions; an accredited OBP for women with a violent offence and complex needs, including personality disorder; offered at HMP&YOI Foston Hall and HMP&YOI New Hall) and the Democratic Therapeutic Community model (offered at HMP Send).

Thirdly, *within* each service, the relational aspect is key. This means women's services providing consistency of practitioners with whom the woman has contact wherever possible (and where this is not possible, preparing and supporting women to prepare and cope with disruptions);[19] providing opportunities for shared experiences between staff and service users that promote collaboration and shared ownership of the task at hand (for example, shared cooking, eating and reading, and authentic service user involvement in the development, delivery and review of the service); and support for the development of positive peer-to-peer relationships and peer support schemes.

Two initiatives being introduced by the offender personality disorder strategy particularly underline and embody the value of healthy, pro-social interpersonal relationships between all who live and work within them: Psychologically Informed Planned Environments (PIPEs) and Enabling Environments (EEs).[20] It is therefore perhaps not surprising that women's services have enthusiastically embraced the PIPE and EE concepts, and new PIPEs and EEs are being introduced in female sites at a proportionally higher rate than in male sites.[21]

18. https://www.gov.uk/government/publications/a-new-approach-to-managing-female-offenders
19. Parry-Crooke, G. & Stafford, P., *My life: in safe hands? Dedicated women's medium secure services in England* (2009).
20. The EE concept was devised by the Royal College of Psychiatrists.
21. PIPEs: Two prison PIPEs, at Low Newton and Send, have been operational since 2011 offering progression support to women who have completed OBPs or treatment services. Since September 2014, Low Newton has additionally offered in-treatment PIPE places, while Send will additionally offer pre-treatment PIPE places from April 2015. Two of the six women's approved premises have adopted the PIPE model: Crowley House in Birmingham and Edith Rigby House in Preston; in July 2015, HMP&YOI Eastwood Park plans to open a pre-treatment PIPE wing. EEs: All prison wings and centres where treatment is delivered are working towards the EE award: at Low Newton, Send, Foston Hall, Eastwood Park and New Hall — as are selected wings at HMP&YOI Styal in Cheshire, HMP&YOI Bronzefield in Middlesex, HMP&YOI Holloway in North London and HMP&YOI Peterborough; and Elizabeth Fry, Bedford, Adelaide House and Ripon House approved premises. HMP Drake Hall in Staffordshire is one of two prisons (the other is the male prison, HMP Frankland) trialling a whole-prison EE.

The combined ambition of these new and existing services, interventions and initiatives[22] is that all ten women's closed prisons and all six women's approved premises are engaged with the offender personality disorder pathway in some capacity. By spreading our interventions widely, we aim not only to provide opportunities for the highest number of women to participate, but also to do so in a way that gives them timely access as close to home as possible, without the need for frequent moves and disruptions, facilitating them to build healthy connections to others, and to learn, develop and practise relational skills they will be able to use in the community.

Continuity in the community

The third and final message to be explored in this article is how critical it is that we get the community part of the pathway for women right. Modelling carried out during the strategy design phase revealed that, because of the way the entry criteria for the women offender personality disorder strategy are defined, most women identified for the pathway will be in the community rather than in custody at any one time: some 60 per cent. This includes women who have been released from prison and are on licence, but mostly women who received community sentences and who did not receive a prison sentence at all. Having appropriate arrangements in place to support them in the community was one of the key messages that female offenders emphasised during the public consultation on the offender personality disorder strategy.[23]

I have already described the mentoring and advocacy services being introduced for women offenders on the pathway, which will play a key role in providing continuity across custody and community boundaries and in tackling the interconnected issues that have the potential to destabilise a woman's effective reintegration into the community. But the programme is also jointly commissioning enhanced community-based services for women offenders in selected areas, supplementing the case identification, consultation and formulation services commissioned for all offenders, male and female, commissioned in 2013. To date, these enhanced services are available in Birmingham, Yorkshire, Cambridgeshire and Lancashire. The type of work undertaken is perhaps best illustrated by the case study presented in Figure 5, which comes from the Yorkshire/Humber Personality Disorder Offender Pathway Partnership (PDOPP).[24] It helps to demonstrate the complexity of a typical women's case, the need for joined-up working between a range of agencies, and the power of a comprehensive formulation.

Figure 5: Case study — Jenny

Jenny was referred to the PDOPP whilst still in prison serving a 2-year custodial sentence for Arson. There was no previous diagnosis of personality disorder on file, but the screening process reflected a long-standing pattern of self-harm, heavy alcohol use, unstable accommodation, internal chaos, highly abusive and exploitative relationships with men, as well as a tendency to use interpersonal violence herself. There were indications that she had experienced little by way of emotional nurturance or stability of care and may potentially have been sexually abused as a child and prostituted as an adult. She became a mother at a young age, although her children were later removed from her care due to neglect and domestic violence within the home.

The referral came ahead of Jenny's transfer from prison to her home town via an Approved Premises (AP). As formulation work commenced between Jenny's offender manager (Kate) and the PDOPP psychologist, it was soon identified that housing options would be limited due to Jenny's index offence.

The PDOPP team liaised with the Local Authority and Offender Housing Support Provider to identify a suitable property and on-going support plan. In line with the formulation, Jenny was released from the AP on temporary licence in order to view the available property, strengthen her ties with her home-town, and to give her a sense of control within the process. She was also introduced to the local women's centre and encouraged to access their services post-discharge as a way of increasing pro-social supports. These measures helped to strengthen the supervisory relationship between Jenny and Kate, an essential process as she had been allocated a number of Offender Managers throughout her sentence which mirrored her disrupted childhood attachments.

The PDOPP team and Kate met Jenny at the Approved Premises in the week of her release. Jenny was supported to make a claim for benefits, and furnishing, and to access clothing grant by her keyworker at the AP. The psychological formulation had proposed that Jenny felt worthless, with no sense of belonging or clear self-identity. She had never had a stable home of her own, and possessed very few personal belongings. She was wearing prison-issue

22. The 'Brochure of Women Offender Personality Disorder Services' details all the services and is available on request by emailing pd@noms.gsi.gov.uk.
23. https://www.gov.uk/government/news/offender-personality-disorder-consultation-response.
24. Ramsden *et al*., 'Yorkshire/Humber Personality Disorder Offender Pathway Partnership (PDOPP). Annual Review,' Humberside, West Yorkshire, South Yorkshire, York & North Yorkshire Probation Trusts and Leeds & York Partnership NHS Foundation Trust. With thanks to Lisa Maltman, Forensic Psychologist & Emma Turner, Specialist Housing & Resettlement Worker, at the PDOPP service.

clothing, including her underwear, which potentially compounded her negative self-view. The formulation also highlighted the tendency of others (including professionals) to make decisions on her behalf thus maintaining her helpless, powerless and incompetent self-perception, so the task of the team was to resist the urge to do everything for her.

Jenny currently receives up to seven hours of support per week. The team around her has identified some early successes. She settled quickly into her new home and felt safe enough there to relax into a bubble bath on the first night. The flat is immaculate and she proudly shows off her 'palace' to visitors. Her Housing Support Worker supports her to engage in activities outside of the home such as a horticulture group, and has helped her to access dental work and to purchase clothing and furnishings which reflect her personal taste. All of these measures are intended to enhance her self-esteem and decrease social isolation. The local MAPPA panel felt reassured enough with her progress and support package to discharge her from their panel arrangements. She has been living in the community now for 4 months and Kate believes that being able to think with the PDOPP about her wider needs was a vital feature of her successful transition to date.

To conclude, and in summary, we are making good progress towards meeting the strategic targets of the women's strategy, namely:

- ❒ To commission up to four new regional personality disorder treatment services in prisons, in addition to the existing Primrose service
- ❒ To support the further roll-out of the CARE and Democratic Therapeutic Community accredited offending behaviour programmes
- ❒ To introduce EEs and PIPEs in prisons and approved premises
- ❒ To ensure that co-commissioned community-based offender personality disorder services throughout the country include specific consideration of the different needs of women offenders
- ❒ To provide independent mentoring and advocacy services to all women offenders meeting the pathway entry criteria
- ❒ To develop and commission gender-specific workforce development programmes.

Of course, there is still a long way to go. The list above does not perhaps capture the ambition and scale of the cultural and systemic change we are hoping to effect, which inevitably requires time to embed. Our new services are at fledgling stage and still building up to full capacity; the flow of women through the pathway is also still fairly tentative. We have yet to fully define the women's pathway for London and the South East; and further work is required to ensure that the right women are being identified for the pathway, and that there is a gender-specific approach to doing so. The pathway is being built on ever-shifting organisational sands, and with the major structural changes currently underway within Probation services, we are yet to fully understand how the pathway will operate when most women meeting our criteria are managed by the new Community Rehabilitation Companies. The strategy has yet to find an answer to the thorny question of how to address the accommodation needs of women meeting our criteria living or moving on in the community, often complicated by arson-related offending behaviour, abusive relationships and/or considerations around children or dependents. Likewise, we need to consider in more depth early intervention with girls and young women, and preventative work with adult women at risk of escalating personality difficulties and related offending behaviour. Finally, we need to find out if our approach actually works, and establish a virtuous circle of learning and service improvement, using local and national evaluation as well as service user feedback.

Despite this long list of future challenges, there remains optimism about this new approach, which many have said is long overdue. The achievements to date would not have been possible without the expertise and enthusiasm of a group of talented and committed practitioners who are working, in swelling numbers, on the developing women offender personality disorder pathway across England and Wales. There can be no doubt about the shared determination to make a difference for a group of women who have, to date, often been seen as untreatable and un-engageable, and rejected as being 'too difficult' to help.

Developing personality disorder training — a collaborative process

(Co-production as a Process for Developing and Provoking Learning)

Julia Blazdell *and* ***Lou Morgan*** *work for Emergence, a service user[1] led organisation which aims to support those affected by the issues associated with personality disorder and complex psychological needs.**

Introduction

Over the past two years Emergence has been involved in a number of different aspects of the Offender Personality Disorder Strategy and Pathway. This article provides a summary of some of these activities, focusing on our experience of co-developing and co-delivering training for staff who work with women offenders (WKUF and WKUF+) and our role in developing bespoke training for women Listeners. The article will draw out some of the benefits that involving people with lived experience of personality disorder can bring to this work and will look at what can be learnt from it and how involvement of service users in criminal justice settings can be developed.

Emergence is a national service user led organisation, which means that the majority of staff and Directors have personal, lived experience of the issues associated with personality disorder. Some have been formally diagnosed, some relate to the difficulties it describes but reject the diagnostic label and some have used health services in the community, been through forensic or criminal justice services or chosen alternative routes for managing their difficulties. The key feature which unites the organisation despite this diversity of experience is a commitment to supporting others affected by personality disorder and challenging the stigma and discrimination associated with the diagnosis. We work directly with others who have personality difficulties, but crucially we also recognise that staff working in the field and the family and friends of those with personality difficulties, are also deeply affected. As a result much of our work is aimed at supporting these groups to develop their understanding and resilience and to respond effectively to those of us with issues referred to as personality disorder.

Emergence works across the field of personality disorder, striving to address issues of concern at a national level whilst also working regionally and locally in a broad range of activities from running arts-based social groups to collaborating in major research projects as well as training, organisational/ team consultation and evaluation We have worked in this field for many years (formerly as Borderline UK) and through our work we try to dispel myths about personality disorder, encourage genuine understanding and crucially, support the inclusion of often unheard voices in the field through championing their involvement. We strive to ensure that people who have lived with personality disorder help shape the way we understand this set of difficulties and consequently, how people are supported and in the context of the criminal justice system, how people are managed.

Emergence and the Personality Disorder Pathway

The work we have undertaken as part of developing the Personality Disorder Pathway similarly spans a range of activities including providing a service user perspective to the tendering process for some of the new services; undertaking consultations with women in prisons and staff to help shape the direction of developments under the PD strategy, and co-developing and co-delivering training to support the professional development of staff. It is the latter which will be the focus of this article but it is helpful to understand this work as part of our wider efforts to support the development of service user involvement within the Personality Disorder Pathway.

In partnership with the Institute of Mental Health (IMH) we have co-developed and co-delivered three new training packages for staff working in the women

* With grateful acknowledgement to Paul Aston, Neil Gordon, Anna Motz, Cholena Mountain and Donna Smart at Emergence and the Institute of Mental Health.

1. We use the term 'service user' to refer to people with lived experience of personality disorder from all settings. In health this refers to 'clients' or 'patients', whereas within criminal justice settings it is an alternative to 'prisoner' or 'offender'. We recognise the power of language to shape how we view one another and as such prefer the term service user. Although it is far from ideal we believe it is more neutral than the alternatives currently on offer.

offender personality disorder pathway, or in services related to the pathway. These are the Women's Knowledge and Understanding Framework (W KUF), a single day basic awareness training, designed for staff working at all levels and in any role in services which are linked to the pathway. This has now been successfully piloted across three sites with extremely positive evaluation results. This package is supported by the WKUF+, a more intensive four day training designed for staff working directly with women on the pathway, predominantly in prison settings. In addition to these staff packages we have worked alongside the IMH to develop and deliver basic awareness training for women living in prison who hold a peer support role, known as Listeners.

Each of these packages has been co-produced, via a genuinely equal collaboration between Emergence and the Institute of Mental Health; that is between people with lived experience of personality disorder (i.e. service users) and people with clinical experience of working in the field of personality disorder (i.e. staff). An authentically collaborative relationship is central to co-production and is based upon a shared understanding that one anothers' skills and experience, whilst different, are of equal value. It is based on the idea that bringing together these different perspectives facilitates a richer understanding and more nuanced approach to the task.

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These training packages are an adaptation of a national training programme, known as the Knowledge and Understanding Framework (KUF) which begins at awareness level and includes BSc and MSc programmes of study. The KUF was commissioned by the Department of Health and Ministry of Justice to address a skills gap identified in the policy document 'Personality Disorder; No longer a Diagnosis of Exclusion' (NIMHE 2003).[2] It was developed in 2007 and since roll out began in October 2008 has reached over 30 000 people. It has been extensively evaluated and continues today with national support from NOMS. This framework is based on the principle of co-production and this is at the heart of all levels of the programme. Emergence has extensive involvement in the MSc and BSc programmes, with awareness training being co-facilitated by two trainers, one with lived experience of personality disorder and the other with experience of working in the field of personality disorder. The co-production and co-delivery of the KUF is widely recognised as a key feature of its success and this is replicated in the newer, related packages: the WKUF, WKUF+ and the Listener training.

The development of these training packages can be understood in terms of phases of work and the next section will explore the impact of co-production on each of these phases.

Consultation Phase

In the winter of 2012, Emergence was approached by NOMS to undertake a consultation with staff and women at three prison sites where there were extensive plans for development as part of the women's offender personality disorder strategy implementation. We undertook focus group style workshops with staff and separately with women living on site, as well as distributing questionnaires across the prison to explore views and perspectives on where developments were most needed, what shape these might take and to identify priorities for staff training.

Many of us within Emergence have experience of being consulted in a tokenistic and ineffective way. As such, we are acutely aware of the frustration of giving time and effort to a process which then seems to have little bearing on what happens next. Drawing on this experience we built into the consultation process simple steps which helped to ensure participants were kept informed about what arose from their input and how the information they provided was being used. This included return visits to the sites to feedback on the findings of the consultation and what was being done with the information, providing written feedback which was distributed to those unable to join the sessions in person, and contributions to the Pathway newsletter. Additionally we worked closely with NOMS to support the development of an action plan arising from the recommendations which has been used to shape further work and inform the development of services. Of most relevance for this particular article are the ways

2. National Institute for Mental Health England (2003) Personality Disorder: No longer a Diagnosis of Exclusion. Policy Implementation Guidance for the Development of Services for People with Personality Disorder. London.

in which the consultation informed the design of the training packages.

Co-Design Phase

The findings from the consultation formed the basis for the development of the WKUF and WKUF+ training with the topics identified as most important to staff and women living in the prisons forming the backbone of the training content. Furthermore, the actual method of facilitation was also shaped by the views gathered. The consultation demonstrated considerable crossover in the priorities identified by the staff and the women; their views about what was needed for the training were entirely congruent with one another and as such it was relatively simple to design the training based around these issues. In addition, consulting with the women highlighted the need for training that could be rolled out across the prison to challenge the stigma and negative attitudes often experienced by women with personality difficulties. It was felt strongly that this needed to be available and suitable for all staff regardless of role; that would be equally meaningful for Governors as for ancillary staff. As a result the WKUF materials are designed with 'elasticity', so that the materials can be taken simply at face value or explored in much more depth depending on the trainee. They contain simple key messages which can be used for guidance but that can also provide a doorway to more complex concepts which participants can choose to engage with depending on their existing knowledge. In this way the materials have the potential to stretch those more familiar with the topic but equally work for those with less experience. Regardless of an individual's starting point it was clear from the consultation that a key requirement of the training would be to develop a shared understanding of personality disorder, how and why women might develop these difficulties and stimulate a curiosity about apparently challenging behaviours. As a result the training is based on an experiential facilitation model, avoiding didactic methods of imparting information and instead encouraging group discussion, reflection and engagement with the complexity of the issues around personality disorder.

The findings from the consultation formed the basis for the development of the WKUF and WKUF+ training with the topics identified as most important to staff and women living in the prisons forming the backbone of the training content.

The task of bringing together the information gathered from the consultation and developing these into a training package which addressed the identified priorities was undertaken jointly by service users from Emergence and staff from IMH working collaboratively together. To support this equal collaboration responsibility for completion and the quality of the materials was shared equally. Colleagues from both organisations worked together to ensure the end product reflected an amalgamation of perspectives whilst maintaining consistency throughout. As a result the process took longer than it might have done if one organisation undertook the work independently, as is usually the case when collaborating with others. This of course also had resource implications and required funding so that both parties were appropriately paid for their work. Additional time and space was also needed to sit together and work issues through. This generated a degree of pressure for everyone concerned and highlighted the need to plan for this additional time when agreeing deadlines and planning for the roll out of the training.

As one individual involved states:

It would undoubtedly have been quicker to do it myself, but it wouldn't have been anywhere near as rich. And I enjoyed the process much more too, because I was learning as well as designing the learning of others — as we discussed topics and ideas I came to realise just how much of what I understood about personality disorder comes from one particular point of view, loaded with assumptions, and far from neutral.

As well as the increase in time this quote highlights the importance of the collaborative process and its potential to disrupt taken for granted ways of thinking and understanding, for both staff and service users. One member of the IMH team talked of how she initially felt very cautious, keen not to appear insensitive to the experience of her service user colleague. In this way she described the presence of the service user as acting as a kind of 'superego'. Although initially challenging she discussed how this was also rewarding, encouraging her to explore the way she thought about

people with personality disorder and the way she articulated issues. She felt this was an invaluable process supporting her to develop skills essential to delivering awareness training. This went beyond a fear of being politically incorrect or insensitive and is better understood as prompting a critical engagement with existing ideas and ways of articulating these. This mirrors the process that the training is intended to stimulate for participants, one of critical engagement with the topic. This suggests that the value of embedding co-production and co-delivery is not simply in the end product but in the process itself.

Parallels between the experience of co-production and training outcomes

We have seen how the process of co-production can provoke us to reconsider our existing ways of understanding the concept of personality disorder, those with this diagnosis and how we frame this through our use of language. Such questioning is inevitably destabilising, placing us in the uncomfortable position of 'not knowing' in an arena where we might have felt assured and confident before. We suggest that whilst personally challenging this is a valuable process which enables us to refine the way we understand personality disorder and remain open to new ideas and different perspectives. There is a clear parallel between this process as experienced by colleagues engaged in co-production and that which is being asked of trainees. We suggest that this parallel experience enables facilitators to connect with, relate to and better support training participants as they navigate through the personal challenge of examining their own views and experiences. As service user facilitators our experience is that this is very helpful in avoiding a sense of blame or feelings of attack in the invitation to training participants to consider how they think about, make sense of and talk about the issues associated with personality disorder. Instead this is a shared endeavour with both trainers and participants engaged in a process of discovery and learning.

One of the main aims of the WKUF, WKUF+ and Listener training is to challenge the stigma and negative attitudes often expressed towards people with issues and behaviour patterns associated with personality disorder. Once again a symmetry can be drawn between the impact of co-producing the training and its intended outcome. A staff colleague from the Institute of Mental Health discussed with us how easy it is to lose empathy and humility over time and how working collaboratively with service users was helpful to restoring or retaining this. The process of building relationships with service users as colleagues prompted her to think about collaboration as an antidote to the tendency for workers to locate 'otherness' in their client group: to, in effect, understand them as distinct or different — as the 'abnormal' to everyone else's 'normal'. Instead, by working closely together on a shared task, a range of commonalities and shared experiences can come to light, a relationship built, acting as a potent reminder of the individual behind the label. Or as an Emergence colleague commented: 'it's all about putting the person back into personality disorder'. This is far from a one way process; as a service user facilitator myself, my own preconceptions and sense of 'difference' to staff has also been challenged and I have become much better able to see beyond the job title and connect with the person.

One of the main aims of the WKUF, WKUF+ and Listener training is to challenge the stigma and negative attitudes often expressed towards people with issues and behaviour patterns associated with personality disorder.

The challenge and significance of building relationships through the process of co-production should not be underestimated in this field. Difficulties commonly associated with personality disorder are predominantly centred around relationships, which can often become fraught and problematic. As such, the opportunity afforded to both parties in a collaborative relationship to come together outside of the usual therapeutic/management frame offers a chance for growth and development to both. In addition the positive impact of working together, considering one another's view point and building empathy across identity boundaries inevitably is reflected in the training materials themselves. The collaborative relationship acts as a corrective to the natural impulse to pathologise those with personality difficulties in a prison setting. The shared humanity discovered in the collaborative relationship is reflected in the humanising of the material, such that the training materials maintain a consistent focus on the fact that we are thinking and talking about people with a complex set of problems often arising from extremely difficult early life experiences.

Delivery Phase

The co-production of the training is maintained within the delivery phase through a model of co-facilitation; all training is delivered by a pair of trainers, one with lived experience of personality disorder and one with experience of working professionally with people with these types of difficulties. Once again responsibility is shared equally with the expectation that delivery will be shared to ensure that both have an equal role across the span of the training.

One of the benefits of this model is that for many participants the training is the first time they will have encountered someone with a diagnosis of personality disorder outside a purely offending frame of reference. Many people we have met as part of this work have been unaware that lots of people with personality disorder live in the community and that it is possible to have personality difficulties but live in a state of wellness (which some may choose to call recovery). One Emergence colleague recently said:

> *I sometimes think to myself, I would love some of those prison officers to see me now……I would love to say 'things have changed completely now. You'd be really surprised and amazed and maybe even proud with how things are in my life now'.*

Understanding that there is hope for people with personality difficulties, that lives can be transformed with the right help and support, is a key message in the training which is embodied in the service user trainer.

Understanding that there is hope for people with personality difficulties, that lives can be transformed with the right help and support, is a key message in the training which is embodied in the service user trainer. Throughout the training participants are faced with a living example of the reality that it is possible for people with personality disorder to change, to grow and to build a functional life worth living. This new experience of people with personality difficulties is both powerful and crucial to enable staff to gain a sense of hope and to hold onto this for those experiencing difficulties — people who will struggle to keep hold of it for themselves. The value of staff providing a sense of hope to people is articulated here by a colleague from Emergence talking about his own time in prison:

> *For me, I never saw any light at the end of the tunnel. I saw my life being like that for the rest of it, however long it lasted. So giving hope is a big thing. Saying: 'This doesn't have to be the rest of your life. It can change. You have to put some work in. And with the right support and so forth, it can change'. So giving hope is a big one for me.*

Just as the materials themselves are enhanced by the different perspectives the collaborating organisations bring to the table, so the co-delivery of the training provides a more nuanced, complete picture by virtue of combining perspectives. There is an expectation that both trainers will to some degree share their personal experience, for staff trainers this is focused on their emotional experience of making sense of people's behaviour and confronting the painful issues of neglect, abuse, violence, self-harm and so on, on a daily basis; whereas service user trainers draw on their personal experience to help flesh out and explain the key concepts and ideas in the training. In this way the training remains balanced and firmly grounded in the reality of the work and what it means to live with personality disorder.

Furthermore, since it is delivered by two people, an opportunity is created for the facilitators to enter into dialogue, sharing differences in experience and views which can then be opened up to the group. This has been a very effective approach to stimulating curiosity and encouraging thoughtful engagement with the issues. We believe this to be crucially important on two counts. Firstly, because the training is time limited and cannot provide answers to all the difficulties and dilemmas that staff will face. However we can model the value of thinking issues through together, prompting the group to hold an open, honest dialogue and thereby encourage staff to value their own reflective stance and one another as resources to support them in working effectively with people in distress. Secondly, because differences in perspective and experience between the trainers, alongside a willingness to explore this, brings to life the reality that to work effectively with people with personality disorder, one need not hold firm to a position of knowing or have a head full of 'facts' but instead need a particular state of mind; one of compassionate curiosity and reflection (Meeting the Challenge, Making a Difference 2014).[3]

Conclusion

The role of service user/prisoner involvement within custodial settings is often hotly contested and is without doubt fraught with challenges. Throughout this article we have focussed on the value of joining together different perspectives and the opportunities this creates for transforming the way we make sense of one another, the way we think about the issue of personality disorder and the way we facilitate learning in this area. We have explored how embedding co-production in each phase of work brings about benefits and learning opportunities for both the training team and participants alike. We have demonstrated that often there are clear parallels between the experience of co-production and the training outcomes which enable facilitators and participants to diffuse some of the difficulty of learning about such an emotive topic. We have discussed how co-design and co-delivery enables the key messages of the training to be modelled and embodied in the relationship between service user and staff trainers and in the differences between them. Crucially we hope we have demonstrated that co-production takes us along unexpected paths of learning and development, creating a bridge for meaningful relationships to emerge which enhance our skills and affirm our humanity.

3. Department of Health/NHS England (2014) *Meeting the Challenge, Making a Difference: Working Effectively to Support People with Personality Disorder in the Community.*

Reviews

Book Reviews

Globalisation, crime and imprisonment

Prison Realities: Views from around the world (Special edition of The South Atlantic Quarterly)
Edited by Leonidas Cheliotis
Publisher: Duke University Press (2014)
ISBN: 0038-2876 (paperback)
Price: $16.00 (paperback)

Globalisation and the challenge to criminology
Edited by Francis Pakes
Publisher: Routledge (2014)
ISBN: 978-0-415-68607-5 (hardback) 978-0-415-64352-8 (paperback)
Price: £80.00 (hardback) £24.99 (paperback)

Re-imagining imprisonment in Europe: Effects, failures and the future
Edited by Eoin Carroll and Kevin Warner
Publisher: The Liffey Press (2014)
ISBN: 978-1-908-30856-6 (paperback)
Price:£23.95 (paperback)

Transformations in communications and transportation have enabled more rapid and accessible connections across the globe. However, globalisation does not solely refer to these technical changes. It also refers to the political dimension, in which trade and capitalist modes of exchange have been enabled and accelerated through these developments. There has also been a cultural dimension, in which neo-liberal ideas, rooted in capitalism are spread around the world through media, governmental action and the pressure of commercial organisations. Globalisation is therefore often used to describe a not only greater connectedness and movement, but also greater homogenisation across the world and the domination of Western capitalist ideas and practices. The three books discussed here all explore the nature, limits and potential of globalisation in relation to criminal justice and imprisonment, albeit they adopt different methods and speak to different audiences.

Francis Pakes, Director of the Research Centre for Comparative and International Criminology at the University of Portsmouth, offers the most straightforward academic overview of the issues. His collection includes contributions from leading scholars covering a diverse range of criminological issues including organised crime, international finance, terrorism, migration and genocide. The collection draws out some of the contradictions and conflicts inherent in globalisation. In particular, the collection is premised upon the basis that globalised practices have not swept aside all that has gone before but instead they co-exist alongside and intersect with deeply held local practices and cultures. The book is squarely aimed at an academic audience and provides a useful overview of some key areas.

In contrast, the dazzling collection produced by Leonidas Cheliotis, now at London School of Economics, offers a range of detailed ethnographic accounts of prisons around the world. These accounts offer a rich picture of everyday life in prisons, whilst also linking this to wider issues and using these to illuminate big theoretical ideas. The studies include temporary release in Greece, the interrogation of Palestinians, a mass hunger strike in California and gangs in Honduras. Each article evokes a powerful sense of place, bringing the reality of imprisonment to life. These articles also cast light upon the broader issues of the tensions between globalisation and local cultures, and between power and resistance. This book is profoundly rewarding but also leaves a sense of unease about the dynamics of domination and inequality that it so expertly reveals. This collection is at the leading edge of international critical criminology.

The final book by Eoin Carroll, of the Jesuit Centre for Faith and Justice in Dublin, and Kevin Warner, a former prison educationalist, has a more narrow focus and also draws more heavily upon contributions by practitioners. It therefore has a particular view of prison reform, largely drawing upon liberal approaches which aim to ameliorate the pains of imprisonment and humanise the prison environment, rather than situating this within a deeper critique of power and inequality. There are exceptions; it is always fascinating to read contributions by Professor Andrew Coyle, distinguished prison governor and one of the founders of the International Centre of Prison Studies, and Baroness Jean Corston, author of an impressive and radical blueprint for the future of women's imprisonment. These are examples of people who have worked within the system in order to achieve change, despite the frustrations and compromises that this inevitably entails.

Together, these three books offer differing perspectives on globalisation, crime and imprisonment. They all reveal the tensions between dominant ideas, such as commercial competition and popular punitiveness, and more deeply-seated local cultures and practices. Although globalisation affects everyone to a greater or lesser extent, people are not the passive victims of this, but instead engage collectively and individually. At times they accept and perpetuate global ideas and practices, but they also resist and adapt. Understanding globalisation requires a close reading of the various tensions that shape our world and also attention to the potential for individuals to act with agency.

Dr Jamie Bennett *is Governor of MP Grendon and Springhill.*

Book Review

Pain and Retribution: A Short History of British Prisons 1066 to the Present

By David Wilson
Publisher: Reakton Books (2014)
ISBN: 978-1-78023-283-6
Price: £20

The ambitious publication by a well-known criminologist provides, as the title suggests, a concise history of a large topic. About half of the content of the book is devoted to examining pre-1945 with most of that concentrating on the modern prison from the late eighteenth century onwards. The latter half of the book concerns the post-1945 period which has been researched more thoroughly by criminologists than historians. It is commendable that the writer is endeavouring to contribute to academic efforts underway to bridge the divide between historical and criminological investigation of the prison in Britain. I'm sure such interdisciplinary work will bring forth new insights and perspectives. In this publication that endeavour has in part been undertaken through the use of theories of moral panics and legitimacy and in part through concentration upon the experience of the prisoner. This is effective but the writer underestimates the extent to which historians as well as criminologists have made use of these theories in their examinations of the operation and impact of this institution. Also, significant research has already been conducted to uncover the experience of the prison using autobiographical material. Nevertheless, this book includes interesting and very readable examinations of autobiographical sources, including where possible multiple accounts giving differing perspectives on the same period which works well. Therefore, this publication has contributed to further establishing the efficacy of this subjective approach.

It has to be said that the exploration of the period since 1945 is more questioning and more confidently written, largely because of the wealth of secondary material drawn upon. That half of the book includes consideration of the introduction of security categorisations, the occurrence of major prison disturbances, the development of therapeutic endeavours at Barlinnie and Grendon Underwood, the toughening of regimes from 1992 and prison privatisation. Importantly, the value of media representations of the prison are also recognised and discussed. This is a subject on which the author has published widely and he asserts convincingly that even fictional prison television programmes can have an influential role in raising public understanding.

This publication is worthwhile purchasing as an initial introduction to the history of the prison and gives a very useful starting point regarding particular sources and theories. Efforts are made to genuinely reflect the 'British' in the title with limited but interesting case studies concerning events in Scotland and Ireland. Some of the broad interpretations of historical change are debatable, such as the extent and velocity of the shift towards reform following the Gladstone Committee Report of 1895, but this text does cover many of the most crucial issues affecting prisons in Britain in the past and present.

Alyson Brown *is a History Professor at Edge Hill University.*

Book Reviews

Inside perspectives

The good prison: Conscience, crime and punishment

by Gerard Lemos
Publisher: Lemos &and Crane (2014)
ISBN: 978-1-898001-75-1 (paperback)
Price: £8.99 (paperback)

The last asylum: A memoir of madness in our times

by Barbara Taylor
Publisher: Hamish Hamilton (2014)
ISBN: 978-0-241-14509-8 (hardback)
Price: £ £18.99 (hardback)

Servant of the Crown: A Civil Servant's story of criminal justice and public sector reform

by David Faulkner
Publisher: Waterside Press (2014)
ISBN: 978-1-909976-02-3 (paperback)
Price: £19.95 (paperback)

Insider accounts of prisons and other forms of detention have a long history. These works have come from a variety of perspectives,

including those subjected to detention, such as Oscar Wilde's *The Ballad of Reading Gaol*, those working in prisons, such as Alexander Maconochie's accounts of Norfolk Island and his famous 'mark system', to reformers visiting prisons and agitating for change, such as John Howard and Elizabeth Fry. As can be deduced from these distinguished names, historically such offerings have been influential and respected. However, more recently there has been a proliferation of insider accounts including a host of ex-prisoner biographies ranging from celebrity prisoners such as Jeffrey Archer and Vicky Price, to glamourizations of career criminals. A few of these contributions have stood out, in particular Erwin James' insightful and poignant columns published in *The Guardian*. Prison staff have also published their views and experiences, ranging from academic works to more personal pieces, again with significant variations in quality. The three books reviewed here offer examples of more serious-minded and credible insider accounts, illustrating the diversity of the field, its strengths and weaknesses.

Gerard Lemos, a distinguished figure who has held a vast array of public appointments, now heads up Lemos & Crane, a private company working in the field of social reform. The book sets out to offer a blueprint for 'The good prison', based on constructive regimes that develop a sense of 'conscience' in prisoners and offer financial incentives for them to change their ways and avoid offending. Such a view sits squarely within the neo-liberal orthodoxy. In particular, the book does not question the social structures that underpin and shape the use of imprisonment. Prison populations are largely drawn from the poorer sections of society, yet the harms and moral wrongdoing of powerful groups do not result in the wide use of imprisonment. This is ignored in this book and instead those in prison are painted as lacking in conscience and moral fibre, which can then be injected into them by 'the good prison' and through their entanglement in capitalist society (ironically the very society which has created and sustained their marginality). Whilst organisations such as Lemos & Crane do creditable work, this book illustrates the limitations of their approach, with a narrow perspective that overlooks wider social structures and at times constructs a patronising view of prisoners.

In contrast, Barbara Taylor offers a poignant and novel account of the decline of the large asylum system for those suffering mental ill-health. Taylor is a distinguished historian, whose career and life was interrupted in the 1980s and she experienced devastating ill-health, which led her into alcoholism, self-destructive behaviour and periodic incarceration in hospitals. Her book brings together a frank account of her time in and out of hospitals, extracts from her psychoanalysis sessions and also a history of the end of the asylum system, which she was participating in as she underwent treatment on the cusp between the closing of the hospitals and the creation of 'care in the community'. The range of resources and material she draws upon brings a new dimension to the work and opens up a range of perspectives, both personal and social. Taylor is alert to the issues of power and inequality, both within the mental health system, where again those at the margins of society disproportionately end up, and within the enclosed social world of the hospital where she, as a middle class and successful woman, must negotiate her identity and place. The book closes with some reflections upon the asylum system and the decommissioning of the hospitals, interestingly, Taylor argues that whilst the institution was in need of reform, there should be a place for residential care for those, like her, who need help and support as part of a journey back to health. This is an innovative and poignant book that offers a profound insight into psychotherapy and mental health.

The final of these three books is by David Faulkner, a senior civil servant who played a significant role in criminal justice policy between the 1960s and 1990s. He has published a number of scholarly books and articles on governance and criminal justice since his retirement, but this book is a more personal account of his time as a civil servant. The period of his service saw a shift from the liberal-humane post-War consensus to the more politicised and punitive approaches of later years, as well as the transformation of the civil servant from moral and intellectual mandarin to the business-like managerialist of the contemporary world. The incremental changes of these decades are neatly captured. Although this book is written in the objective, detached and measured tones of a life-long civil servant, there is a personal story that cannot be contained and seeps through every page. Towards the end of the book, Faulkner describes his role:

I became used to situations where I had to do things I would prefer not to do or where things I would like to do were unaffordable, impracticable or politically unrealistic, but there was always some space for officials to take initiatives of our own and act on them (p.158).

This captures the essence of the critical insider. It is a position in which one must accept a constrained and compromised position, but there is the opportunity to search out niches, and occasional vistas, in which personal values can be expressed. Throughout the book, Faulkner's personal values come through, just as they did in his practice. Rather

than a faceless bureaucrat, Faulkner shows that there is a space for the humane practitioner to have an impact.

Although these three books are written by authors with vastly different experiences and perspectives, they all offer insider accounts of those with close personal experience of imprisonment and detention. These books show the limitations and potentials of such accounts. At their weakest they can be myopic and narrow, unable to see beyond the system as it exists, but at their best, they offer a poignant insight into the messy battle of ideas that takes place within each individual and at the heart of society.

Dr Jamie Bennett *is Governor of Grendon & Springhill.*

PRISON SERVICE JOURNAL

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The *Prison Service Journal* is a peer reviewed journal published by HM Prison Service of England and Wales. Its purpose is to promote discussion on issues related to the work of the Prison Service, the wider criminal justice system and associated fields. It aims to present reliable information and a range of views about these issues.

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