PRISON SERVICE
JOURNAL

March 2015 No 218

Special Edition

Working with people with personality disorder

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

*This article is jointly provided by **Nick Benefield**, former Joint Lead OPD programme, NHS England; **Nick Joseph**, Senior Co-Commissioner OPD Programme, NOMS; **Sarah Skett**, current Joint Lead, OPD Programme NHS England; **Sarah Bridgland**, Senior Research and Evaluation Manager, OPD Programme, NOMS; **Laura d'Cruz**, Senior Manager, Women's OPD Pathway, NOMS; **Ian Goode**, Joint lead, OPD Programme, NOMS; **Kirk Turner**, Senior Co-Commissioner, Therapeutic Environments, OPD Programme, NOMS.*

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.

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.

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).

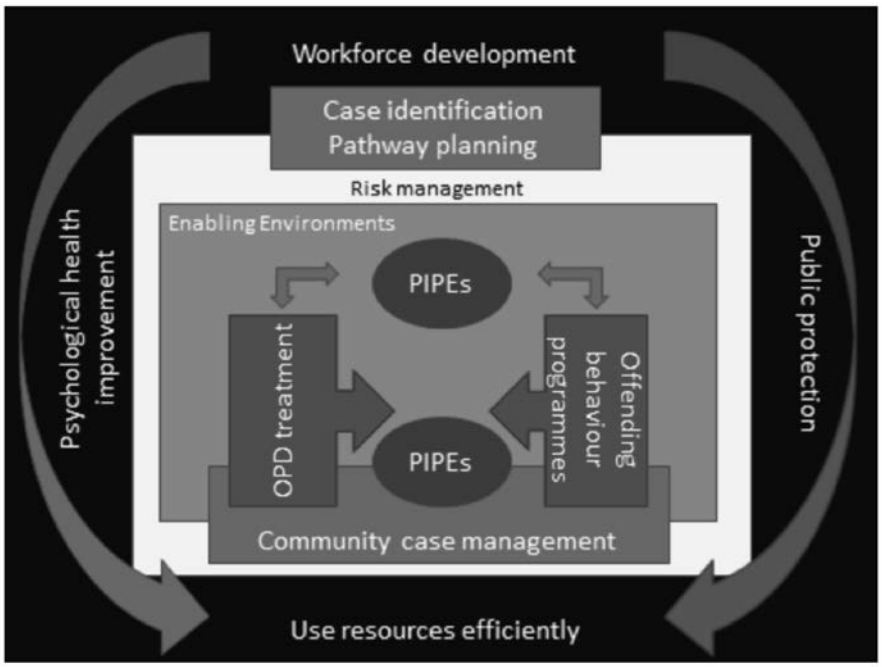

Figure 1. The Offender Personality Disorder Pathway and its key elements

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