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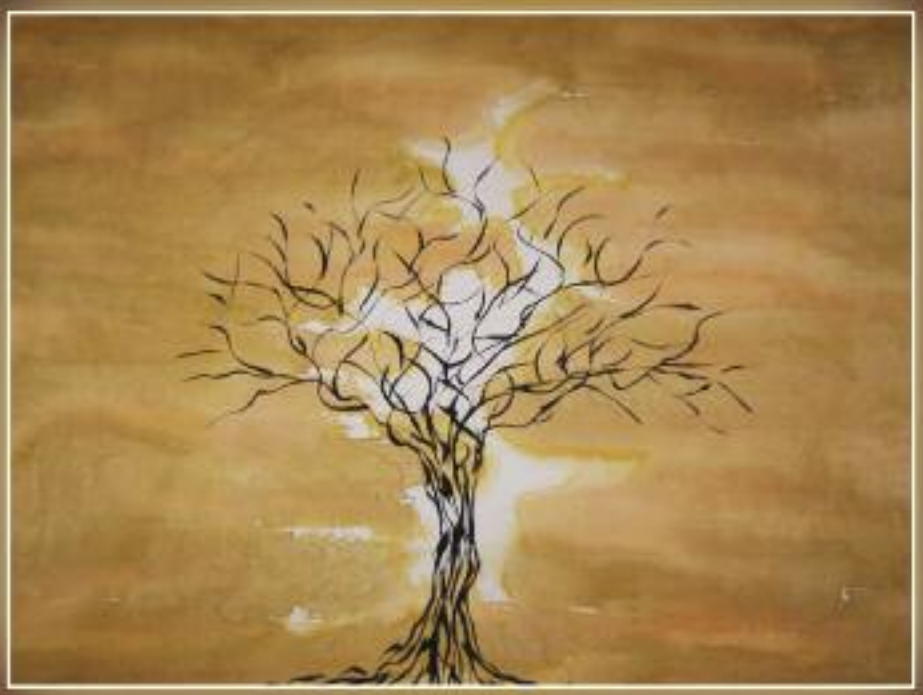

Special Edition

Working with people with personality disorder

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.