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Working with people with personality disorder

Implementing an Offender Personality Disorder Strategy for women

Laura d'Cruz *is Senior Co-Commissioner for Personality Disorder Services for Women Offenders, National Offender Management Service.**

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.