The Offender Personality Disorder Strategy

Executive summary

The Vision

To reduce the risk of serious harm to others and serious further offending;
To improve psychological health and wellbeing, and tackle health inequalities;
To develop leadership in the field of health, criminal justice and social care, and create a workforce with appropriate skills, attitudes and confidence.

The Population

Between 4 and 11% of the UK population has a personality disorder. For people in prison it is at least 61% with similar levels estimated for probation services. The strategy relates to the management of this group of offenders.

The Key Principles

- This population is a shared responsibility of a range of agencies, especially, NOMS and the NHS.
- Services should be delivered along a pathway of active interventions that are located in the community and in custody, which, for some offenders, will be life-long.
- Services should be located mainly in the criminal justice system, be psychologically informed, but primarily delivered through joint operations between NOMS and the NHS.

The Benefits

This strategy will provide:

- A more efficient use of existing resources to enhance public protection and access to psychological services for offenders with severe personality disorder;
- Across-sector, collaborative, evidence based, community-to-community pathway approach;
- Improved and earlier identification and assessment of offenders with PD;
- Improved risk assessment, risk and case management of offenders with PD in the community to support the “layered” approach to offender management;
- New intervention and treatment services commissioned at supra-regional, regional and local levels by the NHS and NOMS in secure and community environments;

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Improvements to the nationally commissioned treatment services in high security prisons, high secure hospitals and regionally commissioned democratic therapeutic community services in prisons;

The provision of progression environments in prisons and approved premises for offenders who have completed a period of treatment.

Outcomes

For offenders who present a high risk of serious harm to others with severe personality disorders:

- The risk of serious re-offending and harm to others is reduced;
- They are identified early in their sentence;
- Identified offenders have high quality formulations setting out clear treatment and intervention pathways;
- They enter into and complete planned treatment and interventions;
- Psychological health improvements and pro-social behaviours are evidenced;
- Offenders remain in or return to the community in a planned and safe manner.

For the workforce, by 2015:

- In excess of 10,000 people complete personality disorder awareness training;
- Each region has at least 100 trained trainers and at least 10 ex-service user trainers;
- At least 50 people, including service users, have completed the MSc or BSc in personality disorder of which five are from each NHS region.

The Delivery Plan

From April 2011, by the realignment of financial resources across the NHS and NOMS, specialised health and offender management commissioners will be given the opportunity to co-commission enhanced care pathways within prisons, secure NHS settings and the community to deliver enhanced personality disorder services to offenders. This will be supported by workforce training plans to improve capability and leadership of the workforce.

Stakeholder Engagement and Consultation

This has been planned to take place in two phases.

Phase one - As a part of the development of this strategy extensive work was undertaken to engage and consult with stakeholders working directly with, or with strategic responsibly for, offenders with personality disorder who present a high risk of serious harm to others. This included a range of professionals, clinical and non-clinical, commissioners, service providers, directors/chief executives of relevant organisations and service users. We have spoken to in excess of a thousand people and extensive written feedback was received and reviewed.

Phase two - With ministerial approval of the strategy, a broader consultation will take place from November 2010.
1. Personality disorder and offending behaviour

1.1. Personality disorder is a recognised mental disorder. The strategy is about all types of personality disorder experienced by offenders. The Diagnostic and Statistical Manual of Mental Disorders \(^1\) (DSM-IV) defines personality disorder as “An enduring pattern of inner experience and behaviour that deviates markedly from the individual’s culture.” DSM-IV describes ten personality disorder types, split into three clusters:

Cluster A – (‘odd or eccentric’) paranoid, schizoid, schizotypal;
Cluster B – (‘dramatic, emotional or erratic’) histrionic, narcissistic, antisocial, borderline;
Cluster C – (‘anxious and fearful’) obsessive-compulsive, avoidant, dependent.

1.2. The most common in criminal justice settings are antisocial and borderline personality disorder. The National Institute for Health and Clinical Excellence (NICE) has published guidelines that describe the challenges. People with antisocial personality disorder will exhibit “traits of impulsivity, high negative emotionality, low conscientiousness and associated behaviours including irresponsible and exploitative behaviour, recklessness and deceitfulness. This is manifest in unstable interpersonal relationships, disregard for the consequences of one’s behaviour, a failure to learn from experience, egocentricity and a disregard for the feelings of others.” (NICE, 2009)

1.3. “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” (NICE, 2009).\(^3\)

2. The future of the Dangerous and Severe Personality disorder (DSPD) programme

2.1. To support the development of this strategy, investment and delivery plans, the resources currently invested in the DSPD programme have been reviewed against three options: i) closing the programme, ii) making no changes, iii) re-investing the existing resources in a new strategic approach. The preferred strategic approach (iii) is described below. Background to the DSPD programme is provided in appendix C.

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\(^1\) American Psychiatric Association (1994) Diagnostic and Statistical Manual of Mental Disorders 4\(^{th}\) edn, American Psychiatric Association, Washington, DC


\(^3\) National Institute for Health and Clinical Excellence (2009) Borderline Personality Disorder Treatment and Management http://www.nice.org.uk/Guidance/CG78
3. **The need for an offender personality disorder strategy**

3.1. Personality disorder is a recognised mental disorder, but an underdeveloped area of mental health. It affects many people in society, most of whom do not commit offences;

3.2. For some, however, it significantly contributes to offending and risk related behaviours. Approximately two-thirds of prisoners meet the criteria for at least one type of personality disorder (Stewart, 2008; Singleton, 1998). There is a link between personality disorder and a high risk of serious harm to self and others.

![Figure 1: estimated number of people with personality disorder](image)

3.3. People with personality disorder are discriminated against with access to services often denied, because they are stigmatised and regarded as a more difficult group with whom to work (Newton-Howes, 2008);

3.4. The failure to focus appropriately on issues relating to personality disorder is a barrier to the NHS and NOMS meeting its objectives of health improvement and public protection;

3.5. Services do not meet the levels of need and sometimes the service provided is inappropriate or ineffective, because of skills gaps in relation to personality disorder and the best ways to manage people with these types of complex need;

3.6. This can lead to the ineffective use of resources;

3.7. Consequently, there is a high level of unmet need and inappropriate expectations placed on offenders;

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*Newton-Howes, G., Weaver, T. & Tyrer, P. (2008)* Attitudes of staff towards patients with personality disorder in community settings *Australian and New Zealand Journal of Psychiatry* 42(7) 572-7
3.8. Managing this population is extremely challenging leaving staff feeling deskillled and undermined, and creating challenges in providing adequate clinical supervision resulting in increased rates of boundary violations, high attrition rates from programmes, and adverse potential impacts on interpersonal relationships;

3.9. A multidisciplinary response is required to effectively identify, assess, treat and manage the risks presented.

4. **Objectives of the strategy**

4.1. The offender personality disorder strategy supports the effective identification, assessment, treatment and management of a population of offenders who have complex needs. This contributes to outcomes of reducing the risk of serious harm to others, reducing serious re-offending, and improving pro-social behaviour and psychological health. The strategic objectives are:

4.2. **Principles**

i. **Shared responsibility**: Ensure that the personality disordered offender population is a shared responsibility of the CJS (Police, Probation, Prisons, Multi-Agency Public Protection Arrangements) and the NHS (forensic and non-forensic);

ii. **Joint operations**: Facilitate the management and collaborative delivery of services to this population through joint operations predominantly based in the CJS;

iii. **Whole systems pathway**: Ensure that planning and delivery is focused on a whole systems pathway across the CJS and the NHS;

iv. **Managed through the CJS**: Ensure that, other than in exceptional circumstance, offenders with personality disorder are managed through the CJS with the lead role held by Offender Managers;

v. **Research & evaluation**: Ensure that personality disorder related research, commissioned by DH and NOMS, is focused on evaluating reducing risk of harm to self and others, re-offending, and health and economic benefits;

vi. **Psychologically informed**: Ensure the pathway and treatment is psychologically informed and led by psychologically trained staff; that it focuses on relationships and the social context in which people live;

vii. **Prevention**: Ensure that the learning from the DH multi-systemic therapy pilot projects is incorporated into the offender pathway to contribute to breaking the intergenerational crime cycle;

viii. **Offender engagement**: Ensure that account is taken of the experiences and perceptions of offenders and staff affected by the pathway;

Service delivery:

ix. **Early identification**: Develop systems to identify offenders who present the highest risk of serious harm to others and have the most complex needs early in their sentence and receive appropriate assessments leading to an active pathway of intervention;

x. **Lifelong management**: Develop, for some offenders, arrangements for lifelong management as a part of a pathway of active intervention;
Existing systems and pathways: Work within and enhance existing systems and processes like Offender Management, Probation Service National Standards, the Care Programme Approach, MAPPA;

Specialised services: Provide access to specialised personality disorder services for these (viii) offenders;

Workforce development:

Highly skilled staff group: Ensure that staff working with a high harm population are highly skilled, supported and appropriately supervised;

Training: For all staff, make available appropriate awareness and skills training for working with personality disorder.

5. Achieving the strategic objectives

5.1. The strategy has two primary strands:

Part 1 - male and female offenders who present a high or very high risk of serious harm to others;

Part 2 - developing the capability of staff employed in health and social care, the Criminal Justice System (CJS) and the voluntary sector to work more effectively with people with personality disorder.

6. Part 1 - The strategy and action plan for offenders who present a high or very high risk of serious harm to others

6.1. This strategy provides a more effective approach to the management and treatment of a greater number of offenders that cause concern for public protection. The community based approaches will support MAPPA by identifying these offenders earlier, providing better quality assessments and formulations, and strategies for community management. Links will need to be built between Probation and Mental Health Trusts to ensure that the personality disorder related needs are met by appropriate psychological interventions for offenders who meet the criteria for forensic and non-forensic services.

6.2. A critical objective of the strategy is to deliver an active and effective pathway of intervention. This section describes each part of the pathway; it is also presented diagrammatically in appendix A. The diagram indicates the level of security, placement of services in the NHS or NOMS and the offender pathway. Services for women are in italics and described from paragraph 8. The strategy brings about the following changes:

6.3. DSPD Programme designation: The DSPD designation will be removed. To bring it in line with other strategies, the population in NOMS and the NHS will be described as those offenders with personality disorder who present a high or very high risk of serious harm to others.

Serious risk of harm is defined as “an event which is life-threatening and/or traumatic and from which recovery, whether physical or psychological can be expected to be difficult or impossible” (NOMS, 2007 p. 124). High risk of serious harm is defined as “there are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious”. Very high risk of serious harm is defined as “there is an imminent risk of serious harm. The potential event is more likely than not to happen imminently and the impact would be serious”. Of cases assessed as high and very high risk of harm, approximately 97.5% are in the first group and 2.5% in the second (unpublished data).
6.4. **Target population:** All offenders who meet the criteria for an assessment using the Offender Assessment System (OASys) and:

- have a severe personality disorder; *and*
- are assessed as presenting a high likelihood of violent or sexual offence repetition and high or very high risk of serious harm to others; *and*
- there is a clinically justifiable link between the personality disorder and the risk.

6.5. It is likely, due to the nature of the offending, that most of the target population will either be awaiting sentence or serving a term of imprisonment or subject to post-release supervision. It is estimated that about a quarter will be in the community. The focus of work, in most cases, will be in relation to offenders who do not have a formal personality disorder diagnosis, but were they to be assessed would meet the criteria. They will have complex needs consisting of emotional and interpersonal difficulties, and display challenging behaviour of a degree that causes concern in relation to their effective management. A more formal diagnosis is only required for some forms of treatment.

6.6. **Age group:** The age threshold for the strategy is 18 years and over. However, it should be noted there is only limited evidence for the effective treatment of people aged between 18 and 24 years. Below the age of 25 years individuals will not be expected to have matured to the point where diagnoses of personality disorders could confidently be made, nor do the current diagnostic tools generally apply.

6.7. For the management of young people (under 18 years) who can be identified as displaying behaviour that is of significant concern, which may be connected to their personality traits, this strategy will be further developed in 2011/12 in consultation with the Youth Justice Board and Secure Social Care. This will be led through the Emerging Personality Disorder and Young Offender Health Programmes in DH, building on the results of the randomised controlled trial of multi-systemic therapy for conduct disordered children, which is due to report in 2012.

6.8. **Early identification:** The purpose is to enable offender managers to:

- Identify those offenders who are likely to meet the criteria;
- Decide the cases on which NHS specialist advice should be sought;
- Ensure that sentence planning properly takes account of complex psychosocial and criminogenic needs relating to personality disorder.

6.9. **Screening:** All cases should be considered that meet the criteria for an OASys assessment and are subsequently assessed as presenting a high or very high risk of serious harm to others. Guidance on early identification and screening will be provided in a Practitioners Guide and the specifications for the pathway.

6.10. **Assessment, case formulation & sentence planning:** This will be managed by the Offender Manager and supported by a NHS clinical or forensic psychologist. The purpose is to undertake an assessment that facilitates the production of a case formulation to determine the interventions/treatment requirements and ensuring that referrals are made to appropriate services at the apposite time. It is not intended that the NHS resource will be used for tasks like formal Court assessments. Its purpose is to enhance offender management through a psychologically informed approach. This case formulation is essential and will directly inform pathway planning through either CJS or NHS services. Each
Probation Trust will require joint agreements with their local Mental Health Trust(s) for these arrangements.

6.11. **Community provision:** The NHS will provide to probation teams and Approved Premises a consultation service using a case formulation approach to help them understand the significance of personality disorder in offenders, develop risk management plans and identify practical strategies for enhancing positive engagement. The role of the NHS includes supporting probation staff to facilitate therapeutic approaches and may include joint case management. Models for community management and treatment will be specified building on the learning from a range of pilot projects in Liverpool and London.

6.12. **Treatment in secure settings:** The following treatment options will be available for the target population in secure settings. It is anticipated, based on learning from the DSPD programme that a significant proportion will be treatment resistant or not ready to engage with treatment. Planning will be required to ensure that offenders enter treatment at the most apposite time in their sentence. Provided will be:

<table>
<thead>
<tr>
<th>a. <strong>High secure (category A) prison provision</strong> - Two units in high secure prisons for men and one for women.</th>
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</thead>
<tbody>
<tr>
<td>The specialist units at HMPs Whitemoor, Frankland and Low Newton are for prisoners who present the highest risk of serious harm to others and have the most complex needs. The units will provide assessment and treatment provision for offenders serving a term of imprisonment who meet the target population criteria and most of:</td>
</tr>
<tr>
<td>➢ Have a history of serious violent and/or sexual offences;</td>
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<td>➢ If they were in the community would present an imminent risk of serious harm to others;</td>
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<tr>
<td>➢ Are unable to fully acknowledge the degree of harm to others or minimises the impact on others; tend to blame others for their problems or circumstances;</td>
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<td>➢ Abuses trust or friendships, exploits others;</td>
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<td>➢ Breached parole licence, bail conditions or community based sentences;</td>
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<tr>
<td>➢ Are unlikely to make progress in other interventions and requires a more intense intervention from psychologically trained staff – change is unlikely to happen without it;</td>
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<tr>
<td>➢ Are unlikely to be very motivated, but likely to benefit from work to increase their motivation and engagement;</td>
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<tr>
<td>➢ May have excessively violent or sadistic aspects of offending;</td>
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<tr>
<td>➢ Have a minimum of three years still to serve. (Prisoners serving less than three years are unlikely to benefit from these treatment approaches. They will be subject to the usual management arrangements like MAPPA, enhanced by the community provision described above.)</td>
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<tr>
<td>Priority will be given to prisoners who are ready to leave a Close Supervision Centre or have previously had periods in segregation.</td>
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b. **High secure NHS provision** - Three personality disorder directorates; one in each high secure hospital (Rampton hospital also provides the national service for women).

Each high secure hospital (Rampton, Broadmoor, and Ashworth) will have a personality disorder directorate for men. Funding will be withdrawn from the DSPD unit at Broadmoor and the building available for the establishment of a designated personality disorder directorate. A transition plan will ensure that there are appropriate placements for current patients.

The Peaks Unit at Rampton Hospital will be used to support the transition to the new strategic arrangements. This facility will provide a short to medium term setting to manage the current DSPD population. Where the current capacity of the three PD directorates is not sufficient to manage this demand the Peaks will provide the necessary additional high secure capacity. Funding will be withdrawn from the Peaks unit when the transition process is complete. This is unlikely to be before 2014.

Assessment and treatment provision in the high secure personality disorder directorates will be provided for offenders who meet the target population criteria and the high secure prison criteria and:

- The requirements of the Mental Health Act;
- The entry criteria for a high secure hospital (posing a grave and immediate danger to the public);
- Are unlikely to make progress in treatment in a prison based facility;
- Their treatment can only be provided in the context of a secure psychiatric hospital.

Other than in circumstances that can be clinically justified, a patient will return to prison once their treatment objectives have been met.

c. **B & C category prisons for men, closed prison for women** – At least one personality disorder treatment unit per supra-region in a B or C category prison for men and one national unit for women.

On a supra-regional basis, a small personality disorder treatment facility will be created with approximately 40-60 places, depending on the availability of a suitable physical resource. One national unit will be established for women. The target population is those prisoners who fall short of the criteria of the high secure programme but, due to the complexity of their needs, are unlikely to progress through existing accredited programmes, including democratic therapeutic communities. Places will also be available for prisoners progressing from the high secure units at HMPs Whitemoor, Frankland and Low Newton and in the NHS whose treatment needs can now be met in conditions of lower security. The units will be delivered through joint commissioning of joint operations between NOMS and the NHS. The target date for opening the first two for men and one for women is April 2012.
d. Democratic therapeutic communities in prison (DTC) At least four prisons with democratic therapeutic communities for men and one for women (HMPs Blundeston, Dovegate, Gartree, Grendon, and Send).

DTCs are an accredited offending behaviour programme. They deliver in excess of 500 places across five prisons for male and female offenders with complex needs. The DTC provision is for offenders meeting the following criteria:

- **Risk** - Offenders assessed as medium, high or very high risk of serious harm to others and/or a medium or high risk of reconviction; Has an offending history which predominantly includes violence (including robbery) and/or sexual offences (however, other offending is also considered);

- **Need** - Has deficits in two or more of the following: Self-management, coping, and problem solving; Relationship skills/ inter-personal relating; Anti-social beliefs, values and attitudes; Emotional management and functioning;

- **Responsivity** – Must be: Motivated to participate in a programme based on therapeutic community principles; Willing to work as part of a community, participate in groups and be subject to the democratic process; Willing to commit to staying for at least 18 months; and reached the point in their lives when they say they are ready to change and appear so.

To better facilitate movement along the offender pathway, DTCs will develop a regional focus with some communities linked to regions. This is intended to create better links between DTCs and Offender Managers to ensure awareness of the programme, early referrals of appropriate offenders, and an understanding of support and treatment needs as a part of onward progression, as appropriate.

e. Medium secure NHS provision - For those patients for whom the NHS pathway is appropriate, medium and low secure step-down enabling progression from the PD directorates of the high secure NHS services.

Funding will be gradually withdrawn from the DSPD personality disorder medium secure units in London and the Northeast from April 2011. NHS specialised commissioners will need to consider future arrangements for these services and medium and low secure step-down where the NHS pathway is appropriate.

f. Other accredited offending behaviour programmes – Accredited offending behaviour programmes, as commissioned by DOMS.

The majority of offenders with a personality disorder who participate in treatment will continue to progress through accredited programmes in prisons and the community. These are designed to reduce re-offending by addressing criminological characteristics. Personality disorder is rarely assessed and the programmes are not designed to meet these specific needs. Training will be available for staff responsible for the development and delivery of these programmes through the Knowledge and
Understanding Framework (KUF). In the future development of the KUF consideration will be given to any specialist training needs. This is expected to contribute to improving take-up and reducing attrition rates through a better understanding of the difficulties posed by personality disordered offenders in using intervention programmes.

g. Psychologically Informed Planned Environments (PIPES) - One or more PIPES per region; at least two national PIPEs for women.

These will provide offenders with progression support following a period of treatment in custody or in Approved Premises upon release from prison. This work supports a pathway approach to the management of high risk offenders. Following successful evaluation of pilot sites, the PIPE model will also be adapted to accommodate offenders preparing for treatment in a custodial setting.

PIPEs are specifically designed environments where staff members have additional training to develop an increased psychological understanding of their work. This understanding enables staff to further develop a safe and facilitating environment that can retain the benefits gained from treatment, test offenders to see whether behavioural changes are retained and support offenders to progress through the system in a planned and pathway based approach.

In the first instance, the model for PIPEs will be specified and piloted in 2010-2012 in Prisons for prisoners who have completed a period of treatment, and also in Probation Approved Premises for those being released from custody. During this period an evaluation will be completed. The next stage of development will consider the use of the PIPE model pre-treatment, and a plan developed for further roll out of regional pre and post-treatment PIPE services, if effective, from 2012-13.

7. Alternative commissioning arrangements

7.1. The resources for re-investment created by the withdrawal of funding from some of the DSPD services in the NHS will be gradually devolved to regional NHS Specialised Commissioners. With the NOMS Directors of Offender Management they will co-commission the offender pathway through local, regional and supra-regional personality disorder services. As a part of the planning for the use of these devolved resources, commissioners should consider the feasibility of including other expenditure that is used directly or indirectly with an offender personality disorder population. These might include offending behaviour programmes, medium and low secure placements for offenders with personality disorder, NHS and NOMS psychological services, etc. A target for this strategy is that the use of high, medium and low NHS secure placements for personality disordered offenders will reduce, thereby improving the coherence and continuity of the offender pathway.

7.2. From April 2011, the pathway will be developed in four regions with wider rollout from 2014 onwards. Criteria for first wave regional selection will be developed by December 2010.

7.3. Government policy is currently developing in relation to the funding, resource allocation and commissioning by the NHS and the CJS. Once these and the
timescales for new arrangements have been clarified further guidance will be provided. Options for the commissioning of this pathway, within the new structures in NOMS and the NHS, will seek to support the joint approach and shared resources.

8. Arrangements for women offenders

8.1. The service provision described above relates to men and women with differential provision, where appropriate, as indicated in italics in appendix A. A significant organisational difference is due to the smaller number of women who present a high risk of serious harm to others. They, therefore, require a local and national approach rather than regionally based provision. The focus at the specialist units is more likely to relate to women who have committed offences of arson and an increasing number of female sex offenders.

8.2. A large number of women receive short prison sentences. This is partly because the offending is often related to deception, dishonesty, drugs and prostitution, and criminal histories tend to be shorter. However, this does not mean that the levels of psychological disturbance and mental distress will be any less. A different approach to men is required in order to break the cycle of frequent returns to prison with too little time to intervene. Improvement in access to community based PD services for those women with complex needs will be essential to addressing risk and reoffending.

8.3. There are other important differences between men and women with personality disorder. It is likely that women will experience a significant degree of trauma as a result of domestic violence, separation from children and sexual abuse. They are more likely to self-harm and present a high risk of suicide. Co-morbidity is common, usually of borderline personality disorder with mental illness; the experience of the Primrose Unit at HMP Low Newton is that these are most likely to be depression, anxiety and psychotic episodes. The role of the NHS is critical with the need for short and long-term prison transfers to hospital. Clinical psychology and psychiatric input will be required in prisons to address these complex needs. High quality management supervision is of particular importance to help staff manage the feelings such work evokes in them as well as ensuring that they understand the underlying causes of the offenders seemingly inexplicable behaviour.

8.4. The strategy for women offenders with personality disorder requires further development and this will take place between November 2010 and June 2011. This will give consideration to the wide range of local options and how an integrated pathway can be supported. Specialist services for women may consist of:

- The Primrose unit at HMP Low Newton;
- A democratic therapeutic community at HMP Send;
- A new treatment unit for women who fall short of the entry criteria for Primrose and are unlikely to be suitable for a DTC;
- PIPES in women’s’ prisons and Approved Premises;

Supported by,

- The development of gender specific components to the personality disorder Knowledge and Understanding Framework;
Central team support to the development of NOMS and NHS strategies and service delivery that enable women to effectively engage in prison based interventions and community based services across all sectors;

Further consideration of a rolling programme building on the evidence established through prison based pilots and the NICE guidance for borderline personality disorder.

9. **Arrangements for black and minority ethnic groups**

9.1. Black African and black Caribbean populations tend to be over-represented in psychiatric services for people with mental illness, but under-represented in services for people with personality disorder when compared to white British people. In mainstream mental health services there is evidence that BME groups receive less access to psychological services and similar prejudice may affect referral to specialist services. Personality disorder tends to be undetected and, therefore, untreated. This is reflected in the population in the current DSPD units and DTCs. However, in an unpublished review of probation cases in one area it was found that there were no differences between black and white groups in terms of the proportion of prisoners that appeared to meet the DSPD criteria. There would appear to be an issue of discrimination here that should be addressed through existing local policies and procedures.

9.2. Research has largely emphasised the critical gaps in knowledge relating to prevalence, aetiology and treatment and the possible differences in the onset of conduct disorder. Future research commissioned by NOMS or DH relating to personality disorder will need to ensure that this is addressed. The specification of the pathway will ensure that black and ethnic minority groups are appropriately considered, especially during early identification in the CJS (requiring systematic methods of identification), sentence planning and the case formulation phase.

10. **Arrangements for offenders with co-morbid conditions**

10.1. Many offenders with personality disorder will also have a co-morbid condition of personality disorder with a severe mental illness and/or substance misuse. The treatment of these other conditions should be in line with the relevant NICE guidance. For those with severe acute symptoms the overriding priority will be to transfer the person from prison to an appropriate NHS secure facility within the required timescales. Following treatment of the mental illness a decision will need to be made based on clinical need, as to continuing to treat the personality disorder in the NHS or returning the patient to prison. The overriding principle is that the personality disorder treatment should be in the prison system unless remaining in the NHS can be clinically justified.

10.2. For people with antisocial personality disorder who misuse drugs, in particular opioids or stimulants, psychological interventions in line with recommendations in

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the relevant NICE clinical guideline should apply. For people with antisocial personality disorder who misuse or are dependent on alcohol, psychological and pharmacological interventions in-line with existing national guidance for the treatment and management of alcohol disorders should apply. For people with antisocial personality disorder who are in institutional care and who misuse or are dependent on drugs or alcohol, referrals should be made to a specialist therapeutic community focused on the treatment of drug and alcohol problems.

11. Arrangements for offenders with learning disability

11.1. A low level of IQ should not in itself preclude assessment in relation to the pathway or admission to any of the services. Each treatment service should look at each case on its individual merits and attempt to adapt their procedures accordingly. An onward referral to a specialist learning disability service in secure condition or the community should only take place where it is felt that the person referred will be unable to engage with the assessment and treatment processes because of a learning disability.

11.2. New models of treatment and management for those offenders with PD and learning disability are being developed through current DSPD pilot services at Rampton hospital and in Newcastle. Also, as a part of the development of this strategy a contextualised version of the democratic therapeutic community programme has been developed and was provisionally accredited in June 2010 for three years by the Correctional Services Accreditation Panel. Options will be explored for the delivery and evaluation of this programme.

12. Evaluating the strategy

12.1. This strategy creates a new approach to the management and treatment of offenders with personality disorder. An offender personality disorder research strategy will be developed by November 2010 including a specification for an independent evaluation of the pathway rather than of individual treatment approaches. This will identify outcomes for the short, medium and long-term, which will be the basis for commissioning future service developments. These outcomes will relate to both mental health and criminal justice objectives.

13. Part 2 - The proposals and action plan for workforce development

13.1. The offender personality disorder pathway will be underpinned by training designed to change attitudes to personality disorder and develop the skills and confidence of staff in working with people with complex needs. Whilst this supports the work with offenders who present a high risk of serious harm to others, it is also intended to improve practice across the Criminal Justice System and beyond.

13.2. The Knowledge and Understanding Framework (KUF - appendix B) is designed to meet the needs of all staff that may come into contact with someone with a personality disorder, for example, Accident & Emergency, GP surgeries, drug and alcohol agencies, the housing sector, social work, child protection, the police, nursing, psychiatry, etc. This part of the strategy, therefore, sits across health, social care, the social exclusion agenda, the CJS and the voluntary sector. It enables staff in all these areas to work more effectively when they encounter with people with complex needs.

13.3. The proposals have the following objectives:
To build regional capacity and sustainability;
To develop leadership in the field;
To establish the KUF in core baseline training of key occupations and staff groups;
To establish the KUF as core training in Voluntary Sector organisations working with people with a personality disorder, whether or not they are a personality disorder specific service;
To further develop the KUF materials to ensure that they take account of developments in the field and the training needs of specific groups;
To establish audit and quality control arrangements.

13.4. The intended outcomes are that by 2015:

- In excess of 10,000 member of staff will have completed the KUF core training (a third from each of NOMS, the NHS and the Voluntary Sector);
- Each region will have at least 100 trained trainers (a third from each of NOMS, the NHS and the Voluntary Sector);
- The training for the relevant professions and workforces contributing to the integrated PD offender pathway will include, as a minimum, PD awareness training building on the KUF. Each profession and workforce will have a clear plan for its inclusion in core or post-qualifying training;
- Each region to have at least 10 ex-service user trainers;
- At least 50 people, including service users, have completed the MSc or BSc in personality disorder of which five are from each NHS region.

14. The limitations of the offender personality disorder strategy

14.1. This strategy has the following limitations:

- The evidence base for personality disorder is at a relatively early stage of development. The strategy will need to adapt as the knowledge base develops over the coming years;
- The priority for resources in the strategy is offenders assessed as presenting a high or very high risk of harm to others with personality disorder. Low and medium risk offenders have not been targeted with specialist treatment. For this group the focus is on workforce development. This is likely to identify a significant amount of unmet need and potential additional pressures on local NHS forensic and non-forensic services;
- Whilst this strategy will lead to an increase in the number of offender personality disorder treatment beds, most people who are identified early in their sentence will not receive treatment. This might be for a range of reasons, for example, the individual not being ready for treatment, unmotivated, inability to meet their needs in the time available, etc. The emphasis here will be on appropriate safe management that, primarily, focuses on public protection.
- Work has been undertaken to assess the level of need for secure NHS beds. However, it is impossible to do this with absolute accuracy. This is a risk that will require careful monitoring.
15. **Next steps**

15.1. To augment the strategy supporting strands of work will be completed between now and March 2011. These will be made available once they have reached an appropriate stage of development:

<table>
<thead>
<tr>
<th>Task</th>
<th>Timetable</th>
</tr>
</thead>
<tbody>
<tr>
<td>A transition plan based on a clinical audit of current prisoners and patients in the Dangerous and Severe Personality Disorder (DSPD) programme</td>
<td>Completed</td>
</tr>
<tr>
<td>A review of democratic therapeutic communities in prisons</td>
<td>Completed</td>
</tr>
<tr>
<td>An implementation plan for incremental delivery from April 2011 - March 2015</td>
<td>September 2010</td>
</tr>
<tr>
<td>An investment plan for the effective use of existing resources</td>
<td>September 2010</td>
</tr>
<tr>
<td>A document containing advice to NHS and NOMS commissioners on commissioning the pathway for offenders with personality disorder</td>
<td>October 2010</td>
</tr>
<tr>
<td>A practitioner guide provided, primarily, but not exclusively, for Offender Managers on working with high risk of harm offenders with personality disorder</td>
<td>October 2010</td>
</tr>
<tr>
<td>A specification of progression units using a Psychologically Informed Planned Environment (PIPE) model and a plan developed for their piloting and evaluation</td>
<td>November 2010</td>
</tr>
<tr>
<td>A research strategy</td>
<td>November 2010</td>
</tr>
<tr>
<td>Consultation process</td>
<td>February 2011</td>
</tr>
<tr>
<td>Specifications for each stage of the pathway (excluding PIPEs)</td>
<td>March 2011</td>
</tr>
</tbody>
</table>
Appendix A – high risk of serious harm to others

[Diagram of the shared population and pathways between NHS, PATHWAY, and NOMS, detailing the processes for assessment, case formulation, and sentence planning, as well as the management of offenders through high secure prison PD units & PIPES, regional PD treatment wings, and joint case management arrangements for the most complex offenders.]

Underpinned by PD leadership (MSc & BSc) and skills & awareness training building on the Knowledge & Understanding Framework.
Appendix B – The Knowledge and Understanding Framework

In December 2007 the Department of Health commissioned the development of a national framework to support people to work more effectively with personality disorder. The partnership awarded the contract comprises:

- the Personality Disorder Institute based at Nottingham University,
- the London based Tavistock and Portman NHS Trust,
- Borderline UK, the largest service user and carer support group in the UK focusing on the needs of those living with the experience of personality disorder, now part of ‘Emergence’ Community Interest Company, and
- the Open University, the largest provider of work based education and e-learning materials in the UK.

This educational development work builds upon the aspirations articulated within the policy guidance documents “No longer a Diagnosis of Exclusion and Breaking the Cycle of Rejection” published in 2003. The key goal is to improve service user experience through developing the capabilities, skills and knowledge of the multi-agency workforces in health, social care and criminal justice who are dealing with the challenges of personality disorder.

The completed multilevel educational package includes the following:

- Personality Disorder Virtual Learning Awareness Programme (‘Raising Awareness’)
- Validated Undergraduate Degree Programme (‘Developing Understanding and Effectiveness’)
- Validated Masters Degree Programme (‘Extending Expertise, Enhancing Practice’)

These high quality educational programmes will be delivered by leading practitioners and service user consultants. The awareness level programme has a number of packages available including a Train the Trainers version. The BSc and MSc programmes are available as single stand-alone modules (suitable as units of learning such as for Continuous Professional Development), or as whole programmes with associated qualifications.

Awareness Level Framework

The awareness level programme is the foundation element of the Knowledge and Understanding Framework and provides students with the underpinning knowledge and understanding required to work more effectively with service users with a diagnosis of personality disorder. The awareness level programme is made up of six online modules assessable through a virtual learning environment. The modules have been designed with underpinning principles to guide the activities and learning.

These principles are:

- Starting with the perspectives of people who are doing this work and using these services;
- Connecting service users past experiences with their current behaviours;
- Making sense of reactions and responses within different contexts;
- Developing effective communication skills;
- Developing sensitivity to service user experience;
- Understanding organisations and the importance of teamwork;
- Developing self-awareness and critical reflection skills.

The six modules are outlined in the diagram below:

<table>
<thead>
<tr>
<th>KUF awareness level modules</th>
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<tbody>
<tr>
<td>Module 1 Learning about personality disorder</td>
</tr>
<tr>
<td>Module 2 Labeling, myths and impacts</td>
</tr>
<tr>
<td>Module 3 People, past and present</td>
</tr>
</tbody>
</table>
Appendix C – The Dangerous and Severe Personality Disorder Programme

Background

Whilst this strategy relates to all offenders with a personality disorder, it builds upon the DSPD programme and provides a more effective use of the resources currently invested. The DSPD programme was implemented following a Government consultation in 1999. The proposed changes in legislation and service organisation were in order to meet “the challenge to public safety presented by the minority of people with severe personality disorder, who because of their disorder pose a risk of serious offending” (Home Office/Department of Health, 1999, p.4).  

The underpinning philosophy of the DSPD programme is that public protection is best served by addressing the psychological aspects of mental health needs of a previously neglected group. The target outcomes of the programme are to:

- improve public protection;
- provide new treatment services improving mental health outcomes and reducing risk; and
- better understand what works in the treatment and management of those who meet the DSPD criteria, developing the policy and delivery evidence base to enable the future shape of such services to be decided.

HMP Whitemoor began admitting prisoners to a converted wing of the prison in September 2000. Purpose built units for men opened at HMP Frankland and Rampton hospital in 2004 and at Broadmoor hospital in 2005. (Broadmoor also opened an interim unit of 10 beds from 2003). A 12-bed unit for women opened in 2007 at HMP Low Newton. There are also pilot NHS medium secure and forensic community personality disorder teams in London and the North East and a joint NOMS/NHS pilot in the North West.

A candidate for the DSPD high secure units can be admitted for treatment if assessment confirms that:

- s/he is 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; and
- s/he has a severe disorder of personality; and
- there is a link between the disorder and the risk of offending

These criteria are unlikely to have created a new population which is distinctly different from other prisoners transferred to hospital under the Mental Health Act 1983’s former category of psychopathic disorder. Whilst there may be some differences these are likely to be outweighed by the similarities. Both the DSPD programme and the new strategy aim to increase the availability of appropriate treatment for people with personality disorders so that more may be helped as voluntary patients or, if appropriate, under compulsion under the 1983 Act.

Little research so far has been published that indicates the effectiveness of these services. This is partly due to the challenges of setting up this kind of service, the complexity of prisoner/patient needs and the length of time required for treatment of

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these types of disorders. However, a considerable amount has been learnt. These, and the NICE guidelines, inform the strategy.

During the development of the DSPD programme it was apparent that working effectively with a personality disordered population, in the long-term, would require significant changes in attitudes, and an increase in the confidence and competence of staff. In 2007, the Department of Health invested in the development of the Knowledge and Understanding Framework (appendix B). This has resulted in a high quality accredited training programme for all occupations and staff groups from relatively short courses to BSc and doctorate.

Further information about the DSPD programme and personality disorder (services, training, research, resources, etc.) can be found at [www.personalitydisorder.org.uk](http://www.personalitydisorder.org.uk).