



Consultation on the Offender Personality Disorder Pathway Implementation Plan

*Developed in partnership with the Ministry of
Justice*



**Ministry of
JUSTICE**

National Offender
Management Service

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Offender Personality Disorder Consultation

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Consultation on the Offender Personality Disorder Pathway Implementation Plan

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Ministerial foreword

We all want to live in safe communities. This includes an expectation that public protection is the key aim in the management of high-risk offenders with serious personality disorders, who require a particular approach to reduce the risk of harm and further serious offending. These offenders have forms of personality disorder that make them much more challenging to manage than other offenders.

Having a personality disorder does not absolve responsibility for criminal behaviour, and all offenders will be held accountable for their actions. However, they also need to be offered treatment to help them lead less destructive lives.

The previous administration invested in services for those offenders with personality disorders who present the highest risk. The Coalition Government is now taking the learning from that early work to develop services and further improve public protection by:

- increasing the number of places available in prison for treating this group of offenders
- making the treatments and interventions they receive more effective.
- developing the workforce and equipping them with the right skills and attitudes to work with this high risk group of offenders.
- developing a pathway of interventions which will support management in prison and where necessary in the community

Under our plans, the National Health Service and the National Offender Management Service will take joint responsibility for these offenders and continue to work closely to address the issues that contribute to these offenders committing serious crimes.

This will contribute to the Ministry of Justice objectives of improving public protection and reducing reoffending and the recently published cross-Government Mental Health Strategy objective of improving psychological health.

Under our proposals, the current legislative framework will be unchanged, this means that where the only appropriate option for offenders with personality disorder is treatment in secure hospital services under the Mental Health Act, this will still happen. The same checks and balances will remain so the roles of the Parole Board, Multi Agency Protection Panels and First Tier Tribunals will not change.

We are convinced that by organising services differently, we will be able to increase current treatment capacity particularly in prisons and are confident that we can achieve this using the resources already invested in services by the NHS and NOMS. In addition, we will provide additional psychological support (in prisons and the community) for those offenders making progress, and strengthen oversight for those released from custody.

Our approach to reforming services for personality disordered offenders is governed by the need to protect communities from avoidable risk. It is based on the same principles as other government reforms, albeit with some modifications to take account of the particular challenges posed. These include:

- Identifying and assessing offenders who present the highest risk of serious harm to others and have the most complex needs early in their sentence
- Providing a pathway of services, including access to specialised personality disorder treatment and management

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- Basing each stage of the pathway on measurable outcomes and treatment that adheres to NICE guidelines
- NHS and NOMS commissioners making decisions about the location and detail of services. This takes account of the specialist nature and complexity of the services and is true to the Coalition Government's aims of devolving power and accountability to a local level.

This consultation asks for your views about the best way for the NHS and NOMS to reconfigure existing services in secure and community settings. As the Ministers responsible, we look forward to receiving your comments and responses to the questions posed in this consultation paper.

Paul Burstow, Minister of State for Care Services

A handwritten signature in black ink that reads "Paul Burstow". The signature is written in a cursive, flowing style.

Crispin Blunt, Parliamentary Under Secretary of State for Justice

A handwritten signature in black ink that reads "Crispin Blunt". The signature is written in a cursive, flowing style.

The Offender Personality Disorder Pathway Implementation Plan

Introduction

1. For some individuals personality disorder contributes significantly to their offending. Approximately two-thirds of prisoners meet the criteria for at least one type of personality disorder and a high proportion of cases are managed by probation. For a relatively small number of offenders, in its most severe forms, personality disorder is linked to a serious risk of harm to themselves and to others. These offenders have highly complex psychological needs that create challenges in terms of management, treatment and maintaining a safe working environment.
2. The implementation plan will reshape the pilot treatment and case management projects underway as part of the Dangerous and Severe Personality Disorder Programme (DSPD) and provide more long term protection of the public. Because treatments can be provided more effectively and at much lower cost in prison there will be a phased reduction in the size of the DSPD units in high secure hospitals and an increase in the number of treatment places in prisons as well as improved case management services. Overall the funding reconfiguration will lead to:
 - a significantly greater number of places available for treatment
 - more resources to identify offenders with severe personality disorders early in their sentence
 - progression places in prisons and in the community for offenders who have completed treatment
 - additional resources to improve the supervision of those offenders who are released into the community, and
 - a focus on developing a workforce across health, social care and criminal justice with the right skills and understanding to work effectively with this group of offenders.

This approach acknowledges that there is a joint responsibility for this population across the two organisations and that services should be delivered through coordinated and, at some stages, joint operations.

3. These prisoners often cause significant disruption, spending time in costly segregation and close supervision units. When in the DSPD programme work focuses on improving offender's motivation and engagement in treatment, learning to understand and control the impulses and strong emotions which are connected with their offending, and addressing aspects from the past that have had a damaging effect on their behaviour. The units work on factors such as learning to establish and manage pro-social relationships (perhaps for the first time), living within the boundaries and rules of the unit's community, and acquiring basic educational, occupational and life skills. The overarching aim is to prevent repetition of serious violent or sexual offending. However, one of the issues current programme is the need to clarify and improve the pathways out of the units,

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not least because these are currently affecting offenders' engagement with treatment. This is more true of the prison sites, from which progression routes are less well defined.

4. The pathway approach will commit existing resources to identifying early in their sentence which prisoners would benefit from personality disorder treatments and interventions. Resources dedicated to assessment, case formulation and sentence planning will provide interventions for those prisoners who are ready and able to engage.
5. The development of personality disorder treatment units in Category B and C prisons will enable more prisoners to be treated. Our learning from the programme suggests that additional support is required for the benefit to participants to be fully realised. Progression units will therefore provide a pathway for those prisoners who successfully complete intervention and treatment programmes recognising the progress they have made. Staff members have additional training to develop an increased psychological understanding of their relational work with offenders.
6. Of the small number of prisoners who have completed the DSPD programme, most are still within the criminal justice system and few have been released into the community. However, those who have completed their sentence and are released are subject to MAPPA (Multi Agency Public Protection Arrangements) supervision to help ensure continuity of care and public protection. Police, probation and prison services are the responsible MAPPA authorities but a number of other agencies including mental health Trusts have a duty to co-operate in the development of comprehensive risk assessments and directing resources to best protect the public from harm.
7. The pathway approach will enhance MAPPA arrangements and offender management by providing additional help to probation teams and staff working with offenders in approved premises and in the community. As now, where prisoners meet the criteria of the Mental Health Act they will be detained in hospital.

Benefits

8. The Department of Health and Ministry of Justice believe that implementation of this plan will deliver the following benefits:
 - reduce the risk of serious harm to others and serious further offending;
 - improve psychological health and wellbeing, and tackle health inequalities;
 - develop leadership in the field of health, criminal justice and social care, and create a workforce with appropriate skills, attitudes and confidence.

The NHS Commissioning Board and NOMS will be asked to develop detailed metrics as the pathways are developed.

9. The pathway approach recognises that there is a joint responsibility for offenders with personality disorders across the NHS and National Offender Management Service (NOMS) and plans for services to be delivered through joint operations. Our proposals would:
 - improve the management of this population, including earlier identification and assessment,

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- provide evidence based psychologically informed interventions and progression units where offenders can be monitored in secure settings and the community.
10. By organising these services differently we will be able to significantly increase treatment capacity, mostly in prisons. In addition, we will aim to provide additional psychological support (in prisons and the community) for those making progress, and strengthening oversight for those released from custody.
11. The implementation plan has two strands: i) the management of offenders with personality disorder who present a high risk of serious harm to others; and ii) workforce development.

Context and case for change

12. Between 4% and 11% of the UK population has a personality disorder. For people in prison studies have estimated between 60% and 70%. The proportion of probation service managed cases has not been researched, however, similar levels are likely.

Personality disorder and offending behaviour

13. Personality disorder is a recognised mental disorder. This plan includes all types of personality disorder experienced by offenders. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)¹ currently 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, dependent².
14. Antisocial and borderline personality disorders are the most common in criminal justice settings. 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)³
15. 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)⁴.

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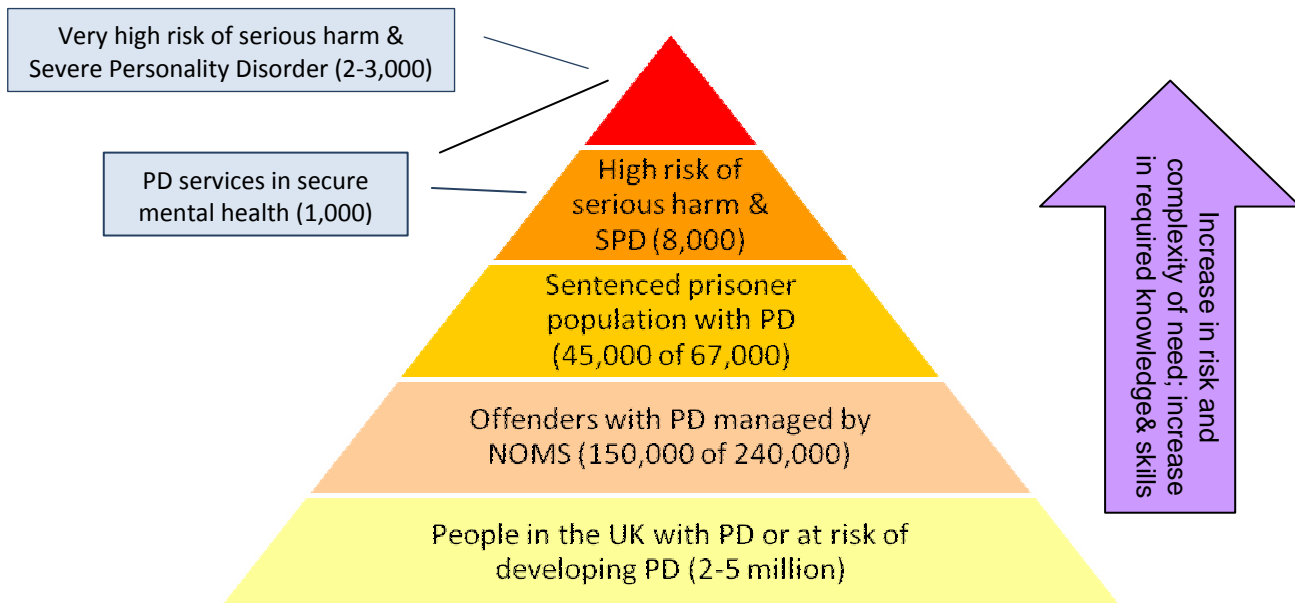
Who is the offender personality disorder pathway for?

16. The pathway is intended to meet the needs of all offenders who meet the criteria for an assessment using the Offender Assessment System (OASys); and who have a severe personality disorder; *and*
- are assessed as presenting a high likelihood of violent or sexual offence repetition
 - present a high or very high risk of serious harm to others;
 - *and where* there is a clinically justifiable link between their psychological disorder and the risks they pose.
17. It is likely, due to the nature of the offending, that most of the people who this pathway applies to, will either be awaiting sentence or serving a term of imprisonment or subject to post-release supervision, however a proportion will be managed in the community under the terms of their sentence. 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.
18. The age threshold for the services described in the pathway is 18 years. 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.
19. For the management of young people (under 18 years) who can be identified as displaying behaviour that is of significant concern, and may be connected to their personality traits, this approach will be considered in 2011/12 in consultation with the Criminal Justice System (CJS), Secure Social Care and other partners.

The DSPD programme and case for change

20. The impact of personality disorder is an underdeveloped area of mental health. It affects many people in society, most of whom do not commit offences. For some, however, it significantly contributes to offending and risk related behaviours. Approximately two-thirds of prisoners (figure 1) meet the criteria for at least one type of personality disorder (Stewart, 2008⁵; Singleton, 1998⁶). There is a link between personality disorder and a high risk of serious harm to self and others. Of those assessed as presenting a high risk of serious harm to others approximately a quarter, at any given time, will be managed in the community.

Figure 1: estimated number of people with personality disorder



Based on an analysis of 11,636 cases in OASys assessed as presenting a high or very high-risk of serious harm to others sentenced between 2005 and 2009.

21. People with personality disorder are discriminated against. Access to services in prison and in the community are often denied, because they are stigmatised and regarded as a more difficult group with whom to work (Newton-Howes, 2008⁷). This failure to focus appropriately on issues relating to personality disorder is a barrier to the NHS and NOMS meeting their respective objectives of health improvement and public protection.
22. These offenders have highly complex psychological needs that create challenges in terms of management, treatment and maintaining a safe working environment for staff. These challenges are currently being addressed largely through the DSPD programme.
23. The current DSPD projects include:
 - high security prison units at Whitemoor, Frankland and Low Newton (for women)
 - high secure hospital units at Broadmoor and Rampton
 - three NHS medium secure units (two in London and one in the North East)
 - six community projects piloting models of risk assessment and case management
24. The current annual operating costs for the programme within the NHS and CJS are estimated at around £69m. This comprises the spend in high security prisons, high secure hospitals, medium secure hospital units and community care places, with the majority of the expenditure within high security settings. Cost per patient place within the high secure hospital units is broadly in line with the cost of other patients within the high secure hospital system (around £300,000 per annum). Operating costs for the male prison DSPD units are significantly lower than those of the secure hospitals (around £85,000 per place per annum, of which about £35,000 p.a is related to treatment costs).

Options considered by the Government

25. The Coalition Government has taken forward the previous Government's plans to review the DSPD pilot programme and consider the way forward. Ministers considered three options:

Option 1 – strategic change to re-model services on a pathway model

26. This scenario uses the pathway approach described in paragraph 43. By disinvesting funding of the pilot DSPD units at Broadmoor, Rampton and the three Medium Secure services and organising these services differently we will be able to significantly increase treatment capacity, mostly in prisons. In addition, we will aim to provide additional psychological support (in prisons and the community) for those making progress, and strengthening oversight for those released from custody.

Option 2 – no change, mainstream DSPD pilot services

27. This scenario would see no changes to the current service provision. Our modelling suggests that this is the most expensive approach per individual and that it would deliver fewer completed treatments and poorer outcomes than option 1.

Option 3 – stop all funding for the DSPD programme from the criminal justice system and close NHS funded DSPD units

28. Within the CJS this would lead to the closure of the DSPD units in Whitemoor, Frankland and Low Newton. Given the difficulty of dealing with these offenders, alternative approaches would be required to limit the disruption caused by them within the prison estate. This would include an increased use of segregation units and Close Supervision Centres.

29. The specialist DSPD units at Broadmoor and Rampton would be closed, with prisoners moved to personality disorder directorates in the same hospitals (at similar costs as the DSPD programme), medium secure NHS hospitals or back to the prison system. Only those prisoners who meet the requirements of the Mental Health Act would be treated in hospital, but the number of referrals may increase as a result of the absence of provision in prisons.

30. Modelling to test the different scenarios suggests that the financial savings from stopping the programme are minimal and that there would be an increase in the numbers of untreated offenders with PD held in high security and category B prisons and a greater use of segregation and Close Supervision Centre units. Whilst the least expensive option in terms of direct spend, option 3 would increase costs elsewhere within the CJS and provide fewer completed treatments than either of the other scenarios.

Options analysis

31. Options 2 and 3 each present significant risk in economic and clinical terms due to poor outcomes for individuals and increased costs to the health and justice systems as a whole. They would also entail increasing the risk of losing public confidence in the

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protection afforded long term.

32. The Government has decided that option 1 represents the greatest opportunity for improving and sustaining psychological improvement, reduction in risk and improved behavioural outcomes based on the evidence from the DSPD and other international modelling. It also represents the most efficient and sustainable use of existing financial and workforce resources currently being made.
33. The Department of Health and Ministry of Justice believe that option 1 will better deliver the benefits and provide:
 - A more efficient use of existing resources to enhance public protection and access to psychological services. We believe that the same level of resources can provide up to 570 treatment places in prisons and 820 progression places in prisons, approved premises and the independent sector
 - A cross-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
 - Improvements to the nationally commissioned treatment services in high security prisons 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.
34. The Department of Health/National Offender Management Service joint offender personality disorder team has consulted informally over the last year with a range of professionals, clinical and non-clinical, commissioners, service providers, directors/chief executives of relevant organisations and service users about the pathway approach and received extensive feedback confirming wide support for the approach.
35. We are now consulting formally, asking for your views on the Government's initial thoughts about the development of service pathways. The consultation process provides an opportunity for all interested parties to comment on how best to ensure continuity of care through the development of effective service pathways across custodial settings and in the community, to improve care, protect the public and make the best use possible of the available resources.

A plan to increase provision and improve treatment

Objectives of the offender personality disorder pathway

36. The main objective in implementing the offender personality disorder pathway is to improve public protection but it also directly contributes to other MoJ and DH strategic objectives of: reducing reoffending, improving psychological health and well-being and tackling health inequality.
37. Implementation of the plan will be through the effective identification, assessment, treatment and management of a group of offenders who have complex needs. This in turn contributes to the benefits of reducing the risk of serious harm to others, reducing serious re-offending, and improving pro-social behaviour and psychological health.

Principles

38. The objectives are supported by the principles to be adopted, the services that will be delivered and the development of the workforce. NOMS and the NHS will improve the management and delivery of services to this population through the development of joint services, predominantly based within the CJS, which ensure that
- the personality disordered offender population is managed as a shared responsibility of NOMS and the NHS
 - planning and delivery is based on a whole systems approach across the CJS and the NHS recognising the various stages of an offender's journey, from charge, conviction, prison, post release supervision and resettlement.
 - offenders with personality disorder are primarily managed through the CJS with the lead role held by Offender Managers
 - 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
 - outcomes from related programmes for young people and families are incorporated into the offender pathway to contribute to breaking the intergenerational crime cycle
 - in developing services account is taken of the experiences and perceptions of offenders and staff at the different stages of the pathway
 - these services will be evaluated focusing on the principles above

Q1 To what extent do you support the principles underpinning the offender personality disorder pathway?

Q2 Do you think the principles support the delivery of the benefits?

Service delivery and implementation

39. The implementation plan will need to ensure that as services develop they:

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- work within and enhance existing systems and processes such as Offender Management, Probation Service National Standards, the Care Programme Approach, MAPPA etc
- develop improved systems to identify offenders who present the highest risk of serious harm to others and have the most complex needs early in their sentence
- provide appropriate assessments leading to an active pathway of intervention for these offenders, including access to specialised personality disorder treatment and management services
- provide, for some offenders, arrangements for lifelong management as a part of a pathway of active intervention, and
- continue to provide the developing international evidence base for effective criminological and psychosocial practice.

40. To ensure the benefits of reconfiguration are fully realised the entirety of the pathway should be in place within a supra regional system. Taking account of the services already in place and the availability of staff, we propose to develop pathways across the North of England (the current North East, North West and Yorkshire & Humberside regions) and the South (London South East and South West). Development in the third or Central supra region (East of England, East Midlands, West Midlands and Wales) will take account of the early work in the other two areas.

41. In developing the workforce we will maximise use of the Knowledge and Understanding Framework (KUF) – a training programme designed to meet the needs of all staff that may come into contact with someone with a personality disorder. We will to ensure that:

- for this high harm population staff are highly skilled, supported and appropriately supervised
- appropriate awareness and skills training is available for all staff across the NHS/NOMS pathway working with personality disordered offenders.

42. The indicative investment plan in the table below gives an example of the timetable for implementing the pathway approach. .

Indicative Pathway Implementation Investment Plan

	2011-12	2012-13	2013-14	2014-15
Funding provision (expenditure subject to detailed decisions by specialist commissioners in the NHS and NOMS) ¹ (A)	£69m	£69m	£69m	£69m
Transition funding for ongoing DSPD related services (B)	£61m	£46m	£35m	£31m
Funds available to support new offender pathway joint commissioning (C = A-B)	£8m	£23m	£34m	£38m

¹ includes £7m of NHS funding for non-forensic PD services from 2011-12

Q3 Is the indicative timetable for developing the pathway approach realistic?

An interventions pathway for personality disordered offenders

43. This section describes each part of the pathway based on current evidence including guidance provided by NICE on personality disorder.
44. **Screening and early identification.** The purpose is to enable offender managers to:
- identify those offenders who are likely to meet the criteria (as defined in paragraph 17)
 - 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 their psychological personality disorder.
45. All cases 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, should be considered. Guidance on screening and early identification will be provided in a Practitioners Guide primarily for probation and prison officers but of use to others who work with this group.
46. **Assessment, case formulation, sentence and intervention planning.** This will be managed by the Offender Manager and supported by clinical and forensic psychologists from the NHS and NOMS. The assessment supports the formulation of the case management strategy, including the interventions/treatment requirements and ensuring that referrals are made to appropriate services at the appropriate time. Its purpose is to enhance offender management through a psychologically informed approach and will directly inform pathway planning through either CJS or NHS services.
47. **Community provision and case management.** The NHS will need to ensure there is a consultation service using a case formulation approach to help probation teams and staff working in approved premises understand the significance of personality disorder in offenders, develop risk management plans and identify practical strategies for enhancing positive engagement. The NHS will also need to support probation staff in facilitating interventions, which may include joint CJS and NHS case management. Effective models for community management and treatment will be developed, building on the learning from a range of pilot projects in Liverpool and London.
48. **Treatment in secure settings.** A range of treatment options will need to 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 appropriate time in their sentence. When fully implemented the offender personality disorder pathway will provide:
49. **High secure (category A) prison provision:** 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. These units will continue to be maintained. Assessment and treatment will be provided for offenders serving a term of imprisonment who meet the target population criteria, have a severe form of personality disorder and most of the following additional criteria:
- Has a history of serious violent and/or sexual offences;

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- If in the community would present an imminent risk of serious harm to others;
- Is unable to fully acknowledge the degree of harm to others or minimises the impact on others; tends to blame others for their problems or circumstances;
- Abuses trust or friendships, exploits others;
- Breached parole licence, bail conditions or community based sentences;
- Is unlikely to make progress in other interventions and requires a more intense intervention from psychologically trained staff – change is unlikely to happen without it;
- Is unlikely to be very motivated, but likely to benefit from work to increase their motivation and engagement;
- May have excessively violent or sadistic aspects of offending;
- Has 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.)
- Priority will be given to prisoners who are ready to leave a close supervision centre or have previously had periods in segregation.

50. **High secure NHS provision:** specialist personality disorder directorates for men in each of the high secure hospitals (Rampton hospital also provides the national service for women). Assessment and treatment provision in the high secure personality disorder directorates will be provided for offenders who meet the target population criteria, 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);
- Their treatment can only be provided in the context of a secure psychiatric hospital.

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

52. **Category B & C prisons for men and closed prison for women:** At least one (and up to three) personality disorder treatment units per supra-region in category B or C prisons for men and one national unit for women. Each unit will provide a treatment facility with approximately 40-60 places, depending on the availability of a suitable physical prison resource. 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 from the NHS whose treatment needs can now be met in conditions of lower security. The target date for opening the first two for men and one for women is April 2012.

53. **Accredited offending behaviour programmes:** The majority of offenders with a personality disorder who participate in treatment will continue to progress through

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accredited programmes in prisons and the community that are designed to reduce re-offending by addressing criminological characteristics. Personality disorder is rarely identified 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 KUF. 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.

54. Accredited programmes include a form of social therapy called Democratic Therapeutic Communities (DTCs). These provide a long term intensive, residential offender behaviour intervention for prisoners who have a range of offending behaviour risk areas, including moderate to severe personality disorders and complex emotional and interpersonal problems. Each community operates on a participative, group-based approach, where the prisoners, with the help of staff, actively monitor the behaviour of its members. There are four prisons with DTCs for men and one for women (currently HMPs Blundeston, Dovegate, Gartree, Grendon, and Send). In total DTCs provide in excess of 500 places for male and female offenders with complex needs. The DTC provision is for offenders who have the capacity to engage in this type of treatment programme and meet specified risk and need criteria.
55. To better facilitate movement along the offender pathway, DTCs will develop a regional focus. 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.
56. **Medium and low secure NHS provision:** for those patients for whom the NHS pathway is appropriate, medium and low secure step-down units enabling progression from the PD directorates of the high secure NHS services. An increasing number of community forensic services are providing appropriate treatment and management for offenders with personality disorder in community settings. These services provide a range of interventions recommended by NICE guidance.
57. In addition to the interventions pathway, Psychologically Informed Planned Environments (PIPEs) will be developed providing: 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. Following successful evaluation of pilot sites, the PIPE model can also be adapted to accommodate offenders preparing for treatment in a custodial setting.
58. PIPEs are specifically designed environments, providing high levels of expectation and support towards improving pro social behaviour where staff members have additional training to develop an increased psychological understanding of their relational work with offenders.
59. 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.
60. In the first instance, the model for PIPEs will be 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

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PIPE services, if effective, from 2012-13. The pathway is also presented diagrammatically in annex B

Q4 The pathway approach is intended to provide an appropriate mechanism for the management of offenders with personality disorder. What do you see as the critical factors contributing to its success?

Q5 Do you agree that the implementation of the offender personality disorder pathway is likely to deliver the benefits of

- Reducing the risk of serious harm to others and serious further offending;
- Improving psychological health and wellbeing, and tackling health inequalities;
- Developing leadership in the fields of health, criminal justice and social care, and
- creating a workforce with the appropriate skills, attitudes and confidence.

Q6 Are there any other costs and benefits involved in implementing the pathway approach?

Commissioning

61. Funding and commissioning arrangements for offender PD services are currently through separate structures in NOMS and specialised commissioning arrangements in the NHS, although the programme is coordinated by a joint DH / NOMS team. To support the delivery of the proposed approach they will need to commission a Quality Standard from NOMS and NICE and develop it into commissioning guidance for the NHS Board GP consortia and NOMS.

62. With changes to commissioning systems the NHS Commissioning Board and NOMS will be asked to develop detailed metrics for offender personality disorder outcomes as the care pathways are developed. At a local level, and based on commissioning guidance, NHS & NOMS commissioners will need to agree the services necessary to deliver the new pathway and negotiate the most effective use of expenditure on the psychological treatment of personality disorder in offender populations.

63. It is hoped that joint commissioning decisions will over time encourage pooling of resources where appropriate. This service development approach will need to be supported by the commissioning of workforce training plans to support service developments with improved capability and leadership in the workforce.

64. As announced in the Spending Review, the Government intends to identify particular opportunities to expand the use of payment by results in prisons. This will link payment to the outcomes achieved, rather than the inputs, outputs or processes of a service. For example, it may allow for greater innovation and flexibility in delivery models. In developing existing and new services within the offender personality disorder pathway there may be opportunities to introduce payment by results, for example in the provision of treatment PD services, PIPEs or DTCs.

Q7 Is a joint commissioning approach the most effective mechanism to deliver the objectives and benefits of the offender personality disorder pathway?

Q8 Are there appropriate alternatives to supra-regional commissioning for this pathway ?

Q9 Are services within the offender personality disorder pathway suitable vehicles for payment by results commissioning arrangements?

Services for women

65. There are also a small number of women who present a high risk of serious harm to others for whom a similar approach to that described for male offenders should be taken. A large proportion of women offenders receive short prison sentences. This is partly because their offending is related to deception, dishonesty, drugs and prostitution, and their criminal histories tend to be shorter. However, this does not mean that the levels of psychological disturbance and mental distress will be any less.
66. The strategy for women offenders with personality disorder requires further development and we will work with partners who provide services for women. This work will give consideration to the wide range of national initiatives for women offenders, local options and how an integrated pathway can be supported involving greater emphasis on gender specific treatment models and community case management, treatment and support. Services for women may consist of:
- Interventions to break the cycle of frequent returns to prison by improving access to a community to community pathway
 - 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;
 - The development of gender specific components.

Q10 What is required to deliver an effective community to community pathway for women?

Services for BME offenders

67. 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 people⁸. 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.
68. Research into links with ethnicity has largely emphasised the critical gaps in knowledge relating to prevalence, aetiology and treatment^{9 10} and the possible differences in the onset of conduct disorder. 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.

Q11 What additional factors could improve access for BME offenders in this client group?

Arrangements for offenders with co-morbid conditions

69. Many offenders with personality disorder will also have a co-morbidity of 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 principle is that the personality disorder treatment should be in the prison system unless remaining in the NHS is clinically necessary.
70. For people with antisocial personality disorder who misuse drugs, in particular opioids or stimulants, psychological interventions in line with recommendations in 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.
71. A learning disability 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 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 for PD because of their learning disability.
72. New models of treatment and management for those offenders with personality disorder and learning disability have been developed through services at Rampton hospital and in Newcastle. Also, as a part of the development of the pathway 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 evaluation and extension of this programme.

Q12 What further steps could be taken to improve the provision of services for personality disordered offenders who also have a learning disability?

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Developing the workforce

73. The offender personality disorder pathway will be underpinned by training designed to change attitudes 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 CJS and beyond.
74. The Personality Disorder Knowledge and Understanding Framework (KUF) (annex A) is designed to meet the needs of all staff who may come into contact with someone with a personality disorder, working in, for example, Accident & Emergency, GP surgeries, drug and alcohol agencies, the housing sector, social work, child protection, prisons, probation and the police.
75. By promoting the KUF and developing the workforce who come into contact, manage and care for offenders with personality disorder we will
- build capacity and sustainability
 - develop leadership in the field
 - establish the KUF in the core baseline training of key occupations and staff groups, including in the voluntary sector
76. By 2015, to achieve these objectives we would expect to see:
- in excess of 10,000 staff drawn from the NHS, NOMS and the voluntary sector complete the KUF core training
 - At least 50 people, including service users, will have completed the MSc or BSc in personality disorder.
77. We are also committed to further review of the KUF materials ensuring that they take account of developments in the field and the training needs of specific groups.

Q13 Will the KUF provide the desired improvement in knowledge skills and leadership for personality disorder services? What else may be required?

Consultation process and next steps

The responses to the consultation will be used to improve the evidence base and help develop a strategy for the management of personality-disordered offenders. An impact assessment and the Departments' response to this consultation exercise will be published later in the year. Please send responses to the consultation, preferably using the template at annex D to pdconsultation@dh.gsi.gov.uk.

Offender Personality Disorder Consultation

Summary of the consultation questions

- Q1 To what extent do you support the principles underpinning the offender personality disorder pathway?
- Q2 Do you think the principles support the delivery of the benefits?
- Q3 Is the indicative timetable for developing the pathway approach realistic?
- Q4 The pathway approach is intended to provide an appropriate mechanism for the management of offenders with personality disorder. What do you see as the critical factors contributing to its success?
- Q5 Do you agree that the implementation of the offender personality disorder pathway is likely to deliver the benefits of
- Reducing the risk of serious harm to others and serious further offending;
 - Improving psychological health and wellbeing, and tackling health inequalities;
 - Developing leadership in the fields of health, criminal justice and social care, and creating a workforce with the appropriate skills, attitudes and confidence.
- Q6 Are there any other costs and benefits involved in implementing the pathway approach?
- Q7 Is a joint commissioning approach the most effective mechanism to deliver the objectives and benefits of the offender personality disorder pathway?
- Q8 Are there appropriate alternatives to supra-regional commissioning for this pathway?
- Q9 Are services within the offender personality disorder pathway suitable vehicles for payment by results funding arrangements?
- Q10 What is required to deliver an effective community to community pathway for women?
- Q11 What additional factors could improve access for BME offenders in this client group?
- Q12 What further steps could be taken to improve the provision of services for personality disordered offenders who also have a learning disability?
- Q13 Will the KUF provide the desired improvement in knowledge skills and leadership for personality disorder services? What else may be required?

References

- ¹**American Psychiatric Association (1994)** Diagnostic and Statistical Manual of Mental Disorders 4th edn, American Psychiatric Association, Washington, DC
- ²DSM IV and ICD 10 are currently being reviewed
- ³**Stewart, D. (2008)** The problems and needs of newly sentenced prisoners: results from a national survey <http://www.justice.gov.uk/publications/problems-needs-prisoners.htm>
- ⁴**National Institute for Health and Clinical Excellence (2009)** Antisocial Personality Disorder Treatment, Management and Prevention <http://www.nice.org.uk/Guidance/CG77>
- ⁵**National Institute for Health and Clinical Excellence (2009)** Borderline Personality Disorder Treatment and Management <http://www.nice.org.uk/Guidance/CG78>
- ⁶**Singleton, N et al, (1998)** Psychiatric Morbidity among Prisoners in England and Wales <http://www.statistics.gov.uk/statbase/Product.asp?vlnk=2676>
- ⁷**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
- ⁸**Leese, M. et al (2006)** Ethnic differences among patients in high-security psychiatric hospitals in England *British Journal of Psychiatry* 188, 380-385
- ⁹**Ndegwa, D. (2003)** Second expert paper: Social division and difference: Black and Ethnic Minorities NHS *National Programme on Forensic Mental Health Research and Development*
- ¹⁰**McGilloway, A. (2010)** A systematic review of personality disorder, race and ethnicity: prevalence, aetiology and treatment *BMC Psychiatry* 2010 10:33

Annex A - 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;

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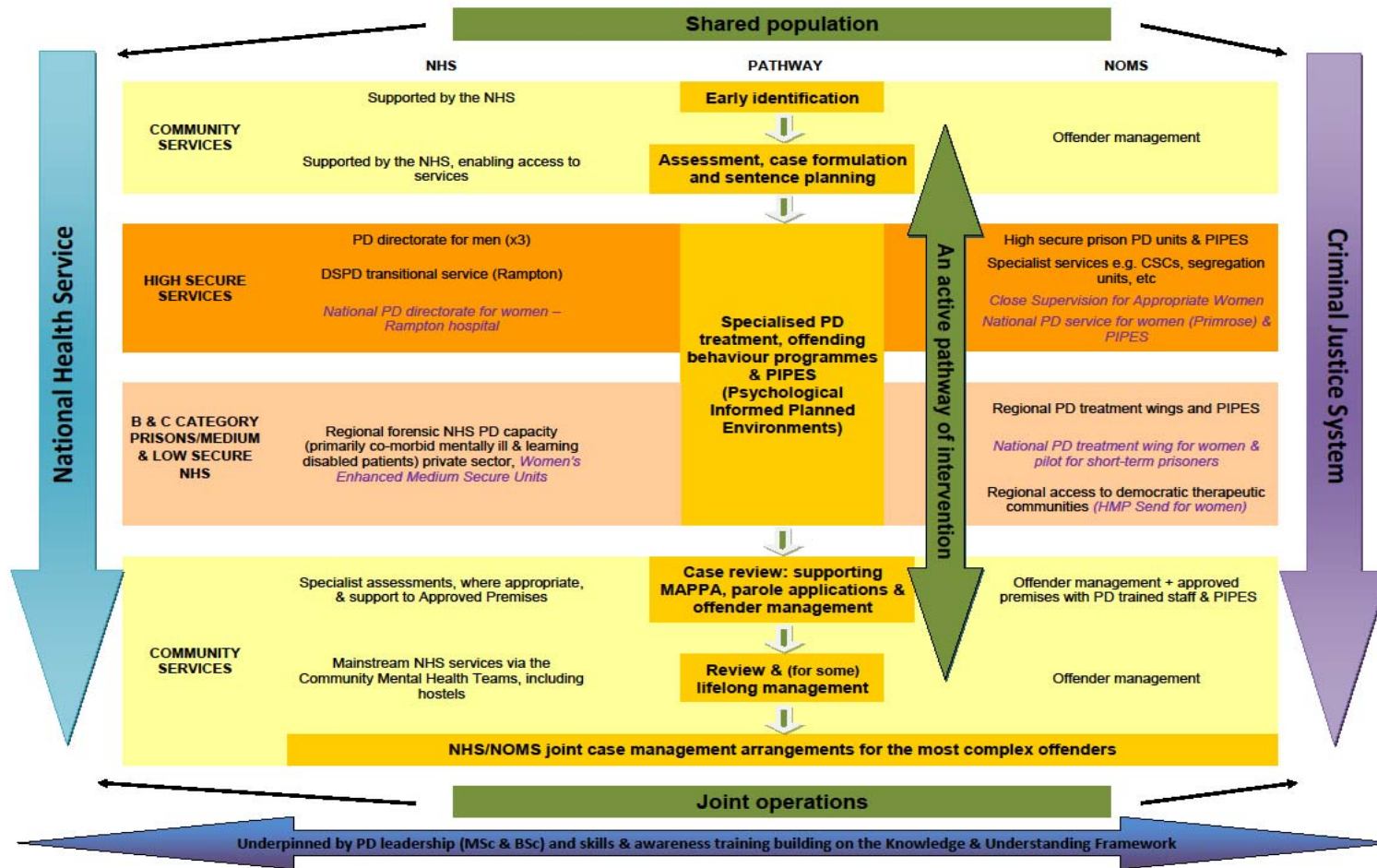
- Developing self-awareness and critical reflection skills.

The six modules are outlined in the table below:

KUF awareness level modules

Module 1	Learning about personality disorder	Module 4	Equipping the organisation
Module 2	Labelling, myths and impacts	Module 5	Understanding different perspectives
Module 3	People, past and present	Module 6	Positive outcomes and responses

Annex B – Offender Personality Disorder Pathway



Annex C - The Consultation Process

Criteria for consultation

This consultation follows the 'Government Code of Practice', in particular we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks with consideration given to longer timescales where feasible and sensible;
- be clear about the consultations process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation;
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the code of practice is on the Better Regulation website at:

[Link to consultation Code of Practice](#)

Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please

contact Consultations Coordinator
Department of Health
3E48, Quarry House
Leeds
LS2 7UE

e-mail consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

We manage the information you provide in response to this consultation in accordance with the Department of Health's [Information Charter](#).

Offender Personality Disorder Consultation

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

Summary of the consultation

A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Consultations website at <http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm>

Annex D – The Consultation Reply Form

CONSULTATION ON THE JOINT DEPARTMENT OF HEALTH / /NATIONAL OFFENDER MANAGEMENT SERVICE OFFENDER PERSONALITY DISORDER PATHWAY IMPLEMENTATION PLAN

Reply Form

[Closing date for responses: 12 May 2011]

Please fill in and/or tick the appropriate response.

Response form

Name

Contact address

Organisation representing (if appropriate)

Postcode

Contact telephone

Email

Before submitting your response to the Department, please make sure that it has been saved in a name [for example YYshire probation trust] that will make it easier for us to track. Many thanks.

Freedom of Information

We manage the information you provide in response to this consultation in accordance with the Department of Health's [Information Charter](#).

Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes. The relevant legislation in this context is the Freedom of Information Act 2000 (FOIA) and the Data Protection Act 1998 (DPA).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

Offender Personality Disorder Consultation

The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties. However, the information you send us may need to be passed on to colleagues within the UK Health Departments and/or published in a summary of responses to this consultation.

I do not wish my response to be passed to other UK Health Departments

I do not wish my response to be published in a summary of responses

Please indicate all the countries to which your comments relate:

UK-wide *and/or:*
England *Northern Ireland*
Scotland *Wales*

Are you responding: - *as a member of the public*
- *as a health or social care professional*
- *on behalf of an organisation*

Country of qualification

Please indicate as appropriate:

UK Other EEA Rest of World

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Area of work:

NHS	
Social Care	
Private Health	
Third Sector	
Regulatory Body	
Professional Body	
Education	
Trade Union	
Local Authority	
Trade Body	
Other (Please give details)	
Independent Contractor to NHS	
Manufacturer	
Supplier	
Other (where relevant)	

If you are responding on behalf of an organisation, please indicate which type of organisation you represent:

NHS	
Social Care	
Private Health/Independent Sector	
Third Sector	
Regulatory Body	
Professional Body	
Education	
Trade Union	
Local Authority	
Trade Body	
Other (Please give details)	

In which of the following areas do you live: (please tick one box only)

North East	
North West	
West Midlands	
South East	
London	
Humber/Yorkshire	
East Midlands	
East of England	
South West	
No answer	

1 What is your sex? *

Tick one box only.

Male

Female

Prefer not to say

2 Date of Birth *

e.g.

03 06 1975

3 Are your day to day activities limited because of any health problem or disability which has lasted, or is expected to last at least 12 months?

The Disability Discrimination Act (DDA) defines a person with a disability as someone who has a

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physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day to day activities.

Tick one box only.

I have a longstanding illness

I have a disability

Prefer not to say

4 Do you look after, or give any help or support to family members, friends, neighbours or others because of either long term physical or mental ill-health/disability or problems related to old age?

Tick one box only.

Yes

No

Prefer not to say

5 What is your ethnic group?

Tick one box only.

A White

British

Irish

Any other White background, write

B Mixed

White and Black

White and Black African

White and Asian

Any other Mixed background, write

C Asian, or Asian British

Indian

Pakistani

Bangladeshi

Any other Asian background, write

D Black, or Black British

Caribbean

African

Any other Black background, write

E Chinese, or other ethnic group

Chinese

Any other, write below

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5 What is your religion or belief?

Tick one box only.

Christian includes Church of Wales, Catholic, Protestant and all other Christian denominations.

- | | |
|-------------------|--------------------------|
| None | <input type="checkbox"/> |
| Christian | <input type="checkbox"/> |
| Buddhist | <input type="checkbox"/> |
| Hindu | <input type="checkbox"/> |
| Jewish | <input type="checkbox"/> |
| Muslim | <input type="checkbox"/> |
| Sikh | <input type="checkbox"/> |
| Prefer not to say | <input type="checkbox"/> |

Other, write below

6 Which of the following best describes your sexual orientation?

Tick one box only.

Only answer this question if you are aged **16** years or over.

- | | |
|-------------------|--------------------------|
| Heterosexual / | <input type="checkbox"/> |
| Lesbian / Gay | <input type="checkbox"/> |
| Gay Man | <input type="checkbox"/> |
| Bisexual | <input type="checkbox"/> |
| Prefer not to say | <input type="checkbox"/> |

Other, write below

**CONSULTATION ON THE JOINT DEPARTMENT OF HEALTH / NATIONAL OFFENDER
MANAGEMENT SERVICE OFFENDER PERSONALITY DISORDER PATHWAY
IMPLEMENTATION PLAN**

Consultation Questions

Q1 To what extent do you support the principles underpinning the offender personality disorder pathway?

Comments

Q2 Do you think the principles support the delivery of the benefits?

Comments

Q3 Is the indicative timetable for developing the pathway approach realistic?

Comments

Q4 The pathway approach is intended to provide an appropriate mechanism for the management of offenders with personality disorder. What do you see as the critical factors contributing to its success?

Comments

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Q5 Do you agree that the implementation of the offender personality disorder pathway is likely to deliver the benefits of

- Reducing the risk of serious harm to others and serious further offending;
- Improving psychological health and wellbeing, and tackling health inequalities;
- Developing leadership in the fields of health, criminal justice and social care, and
- creating a workforce with the appropriate skills, attitudes and confidence.

Comments

Q6 Are there any other costs and benefits involved in implementing the pathway approach?

Comments

Q7 Is a joint commissioning approach the most effective mechanism to deliver the objectives and benefits of the offender personality disorder pathway?

Comments

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Comments

Offender Personality Disorder Consultation

Q9 Are services within the offender personality disorder pathway suitable vehicles for payment by results funding arrangements?

Comments

Q10 What is required to deliver an effective community to community pathway for women?

Comments

Q11 What additional factors could improve access for BME offenders in this client group?

Comments

Q12 What further steps could be taken to improve the provision of services for personality disordered offenders who also have a learning disability?

Comments

Offender Personality Disorder Consultation

Q13 Will the KUF provide the desired improvement in knowledge skills and leadership for personality disorder services? What else may be required?

Comments

General comments

Do you have any other comments you would like to make in relation to this consultation?

Before submitting your response to the Department, please make sure that it has been saved in a name (*For example yshire probation trust*) that will make it easier for us to track. Many thanks.