Offender personality disorder strategy for women
Executive summary

Introduction
This document forms a part of the overall strategic approach for offenders with personality disorder. It fits together with strategies for men and workforce development, and plans for research and evaluation. Whilst the title indicates a broad target population we have prioritised those women who present the greatest risks to others and have the most complex psychological needs. As the strategic work is developed into delivery plans and commissioned, attention will be paid to complementary developments across the Department of Health, NHS, Criminal Justice System and elsewhere. These include changes to health and criminal justice legislation, new NOMS and NHS commissioning arrangements and other strategic developments for women.

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 gender specific skills, attitudes and confidence.

The Population
Women are 15.5% of the probation caseload and 5% of the prison population. The prevalence of personality disorder for women in prison is between 50 and 60%. 31% meet the criteria for antisocial personality disorder (ASPD), 20% for borderline personality disorder (BPD) and 16% for paranoid personality disorder; about 10% have obsessive-compulsive or avoidant personality disorders; 20% have ASPD and another one. The target population for this strategy are women who meet the following criteria:

- A current offence of violence against the person, criminal damage including arson, sexual (not economically motivated offences) and/or where the victim is a child; and
- Assessed as presenting a high risk of committing another serious offence; and
- Likely to have a severe form of personality disorder; and
- A clinically justifiable link between the above.

The Key Principles
- This population is a shared responsibility of a range of agencies, especially, NOMS and the NHS.

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1 This document refers to the ‘NHS’ and ‘mental health service’ providers. This is an important distinction where ‘NHS’ means the commissioner of services and ‘mental health service provider’ the providers who might be from the NHS or independent or voluntary sectors.
Services should be delivered along a pathway of active interventions that are located in the community, prison and secure mental health service. As far as it is possible, all required services should be provided in each location designed to meet health, offending, social care and other support needs.

Services should be located mainly in the criminal justice system, be psychologically informed, but primarily delivered through joint operations between NOMS and health providers.

The Benefits
This strategy will provide:

- A more efficient use of existing resources to enhance public protection, reduce serious re-offending and increase access to psychological services for offenders with severe personality disorder;
- 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 supporting 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;
- The provision of progression environments in prisons and approved premises for offenders who have completed a period of treatment.

Outcomes
By 2015, all women meeting the criteria for this strategy:

- Are identified early in their sentence;
- Have high quality formulations setting out clear treatment and intervention pathways;
- Where appropriate, enter into and complete planned treatment and interventions;
- Evidence psychological health improvements and pro-social behaviours;
- Remain in or return to the community in a planned and safe manner;
- Will have reduced rates of violent or sexual offending.

For the workforce:

- Gender specific personality disorder training is developed and delivered;
- All personality disorder training commissioned by NOMS or DH has a clearly identifiable gender specific element.

The Delivery Plan
By the realignment of existing financial resources across the NHS and NOMS, specialised health and offender management commissioners will co-commission enhanced care pathways within prisons, secure mental health settings and the community to deliver enhanced personality disorder services to women offenders. This will be supported by workforce plans to improve capability and leadership of the
workforce. Given the complexity of the pathway it is intended to pilot service delivery commencing in 2012/13 in East and West Midlands.

**Stakeholder Engagement and Consultation**

As a part of the development of this strategy work was undertaken to engage and consult with a limited number of stakeholders working directly with, or with strategic responsibly for, offenders who meet the criteria for this strategy. This included professionals in NOMS and from mental health service providers, clinical and non-clinical staff and commissioners. Wider stakeholder engagement and consultation will take place with a broader range of providers and service users before services are rolled out.
1. **Context: personality disorder, women and offending behaviour**

1.1. The prevalence of personality disorder for women in prison is between 50 and 60%. 31% meet the criteria for antisocial personality disorder (ASPD), 20% for borderline personality disorder (BPD) and 16% for paranoid personality disorder; about 10% have obsessive-compulsive or avoidant personality disorders; 20% have ASPD and another one.

1.2. The psychiatric morbidity study reported that, for men and women, “those with personality disorder of types other than antisocial were more likely to show evidence of functional psychosis or to have significant neurotic symptoms than those with no personality disorder or antisocial personality disorder only” and “were more than six times more likely to report drug dependence”. Those with ASPD were more likely than those without this disorder to have experienced segregation (twice as likely) or to have committed disciplinary offences. Personality disorder is linked to offending and challenges to the management of safe prisons. Whilst no studies were found that examined Probation managed caseloads, prevalence is likely to be substantial requiring account to be taken in offender management.

1.3. 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 4 (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.

1.4. 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)

1.5. “Borderline personality disorder is “characterised by significant instability of interpersonal relationships, self-image and mood, and impulsive behaviour. There

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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)\(^6\).

2. **A gender specific strategy**

The intention of the strategies for men and women is to focus on those who present a high or very high risk of serious harm to others; their primary objective is public protection. We believe that a pathway approach with interventions delivered in the community, prisons and secure mental health services is appropriate for both sexes, but that a model for women is different for that agreed for men for the following reasons:

2.1. **Offending:** Women account for only 5% (3,448 as at March 2011) of the prison population and 15.5% (24,890) of the probation supervised caseload\(^7\); only 3.2% (approximately 900) of women are assessed as presenting a high or very high risk of serious harm to others\(^8\). Early analysis of the NOMS caseload against the criteria for this strategy indicates that about 75% will have committed an offence of violence and, of these, two-thirds receive a community sentence. Almost all offending behaviour programmes addressing violent and sexual offending behaviour are delivered for men, with fewer opportunities for women to engage in accredited offence specific interventions. The criteria for women has, therefore, been expanded to provide treatment opportunities to those who might not otherwise receive them and to create a group of sufficient size to make a pathway viable.

2.2. **Organisation:** As stated, a significant organisational difference relates to the smaller number of women compared to men who commit offences, receive prison or community sentences that include supervision, or present a high risk of serious harm to others. This creates challenges in terms of having sufficient numbers of participants in the right place, at the right time to deliver high quality interventions, and in ensuring that these interventions are appropriately gender specific taking account of the different needs of women. Improvement in access to community based PD services for those women with complex needs will be essential to addressing the risk of reoffending. As well as a strategy targeting a defined population of women, the delivery plan will include developing links with and influencing other strategy developments across DH, MoJ, other Government departments and the NHS.

2.3. **Personality disorder:** There are other important differences between men and women with personality disorder. It is likely that women will experience a

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significant degree of trauma as a result of domestic violence, separation from children and sexual abuse. Co-morbidity is common for offenders with personality disorder, usually of borderline personality disorder with mental illness; the experience of the Primrose Unit at HMP Low Newton is that, for women, personality disorder is most likely to be co-morbid with depression, anxiety and psychotic episodes. The role of health providers 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. Where working with men or women with personality disorder, 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.

2.4. Self-harm: Whilst 7% of men in prison self-harm, it is 30% for women with about 12,000 incidents a year\(^9\). Special consideration of self-harm is, therefore, required in developing any pathway or treatment programme for women build on NICE guidance for self-harm (under review, 2011)\(^10\). For women meeting the criteria of this strategy this will also seek to enhance the work already undertaken by Offender Health, self-harm and suicide programmes delivered in individual prisons, and support PSO 2700 - Suicide Prevention and Self-Harm Management.

3. Objectives of the strategy

3.1. The objectives are to:

- Identify women in scope for this strategy early in their sentence;
- Deliver high quality sentence plans setting out clear intervention and treatment pathways;
- Enter into and complete planned treatment interventions;
- Achieve evidenced psychological health improvements and pro-social behaviours;
- Remain in or return to the community in a planned and safe manner.
- Reduce the risk of further offences of violence against the person, criminal damage including arson, sexual (not economically motivated offences) and/or where the victim is a child\(^11\);

For the workforce, by 2015:

- To develop a gender specific workforce development programme;
- To have in place a three year plan for delivering gender specific personality disorder awareness training to staff working directly or indirectly on the pathway;

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\(^11\) A list of offences is provided in annex C.
3.2 Principles

3.3 This is a modified version of the principles of the wider offender personality disorder strategy taking account of issues specific to gender and personality disorder.

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 including other sectors like social care, voluntary and independent;

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, focuses on the gender specific issues related to 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, gender specific, informed by psychologically trained staff and based on the best available evidence; 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 and the impact of complex family related dynamics;

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. Case formulation: ensure that cases have a multi-dimensional formulation that is family orientated taking account of complex relational and social dynamics;

xi. Lifelong management: Develop, for some offenders, arrangements for lifelong management as a part of a pathway of active intervention;

xii. Existing systems and pathways: Work within and enhance existing systems and processes like Offender Management, Probation Service National Standards, the Care Programme Approach, MAPPA;
xiii. Transition: ensure that interventions contribute towards progressive transition through the pathway and that women are detained at the lowest level of security commensurate with the risk they present;

xiv. Specialised services: Provide access to specialised personality disorder services for women offenders which include outcomes relating to relationships, rehabilitation and recovery and focus on:

- the relationship between complex psychological disorders;
- complex emotional and relational dynamics;

xv. Service location: ensure that each site, appropriate to the setting, is able to provide the full range of services that this population may require;

Workforce development:

xvi. Highly skilled staff group: Ensure that staff working with a high risk of serious harm and/or risk of re-offending population are highly skilled, supported and appropriately supervised;

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

4. The strategy

4.1. The strategy has two primary strands:

Part 1 – The pathway - to provide an active pathway of intervention for women in the scope of the strategy (see below);

Part 2 – Workforce development – to develop the capability of staff employed in health and social care, the Criminal Justice System (CJS) and the voluntary sector to work more effectively with women with personality disorder.

5. Target population

5.1. The target population is women who meet the following criteria:

- A current offence of violence against the person, criminal damage including arson, sexual (not economically motivated offences) and/or against children; and
- Assessed as presenting a high risk of committing an offence from the above categories\(^\text{12}\); and
- Likely to have a severe form of personality disorder\(^\text{13}\); and
- A clinically justifiable link between the above.

**Age threshold:** 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

\(^{12}\) Arson and sex offences are committed in insufficient numbers for actuarial assessment tools to be valid. For these offences the risk of re-offending is likely to be based on a clinical judgement.

\(^{13}\) A severe personality disorder is likely to present as persistent and complex needs with regard to interpersonal functioning; emotion regulation; arousal; impulse control and ways of thinking and perceiving. It is associated with considerable personal and social disruption. The disorder is likely to appear in late childhood or early adolescence and is enduring.
between 18 and 24 years. Whilst personality disorder can be diagnosed with confidence in individuals 18 years and over it is good practice to exercise caution in the interpretation of findings if patients/prisoners have been incarcerated from a young age or have developmental or learning disabilities.

5.2. **Young people:** 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.

5.3. **Special groups:** The population targeted by this strategy overlaps with groups specific to women in prisons, and their related strategies, frameworks, guidance and instructions. These are not distinct groups with some women meeting the criteria for more than one. Given the criteria of this strategy it will include some of the women in each group. As a priority, a file review will be completed of all women requiring closed supervision to ensure that, individually, they have been appropriately assessed by health providers and NOMS and, collectively, their needs are identified to inform the delivery plan.

5.3.1. **Restricted status** women (about 8 in August 2011) are those who are convicted or on remand whose escape would present a serious risk of harm to the public and who are required to be held in designated secure accommodation. They differ from Category A prisoners in that, although potentially dangerous if unlawfully at large, they are seen as lacking the capacity or propensity to plan or to effect an escape from secure conditions.

5.3.2. **Closed Supervision for Appropriate Women (CSAW)** (about 5) is for women who, because of their complex needs and risk to others are likely to need prolonged periods of individualised separation, care and close supervision.

5.3.3. The **central register** of women (about 20) whose behaviour cause disruption to the regime is for those who are unwilling or unable to live with others, and are likely to require lengthy periods of segregation or, her behaviour is significantly disturbing to other women, a risk to staff or is disruptive to the regime.

6. **Part one - The pathway**

6.1. The pathway is presented diagrammatically in annex B. Figure 1 indicates the service delivery provided in the community, each supra-region\(^4\) and nationally. Given the complexity of the pathway it is intended to deliver a pilot (annex F) commencing in 2012/13 in East and West Midlands.

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\(^4\) Final commissioning arrangements and geographical boundaries of the supra-regions are subject to re-organisations in the NHS and NOMS.
7. **Community:**

7.1. The community based provision for men and women is largely the same. However, gender specific training and interventions will be required. The delivery plan in each super-region will pay special attention to community based projects for women, building strong links with the voluntary sector and, where appropriate, the use of volunteers to provide individual support systems. The community part of the pathway consists of the components indicated in figure 2. A detailed service specification to assist commissioners has been developed.
7.2. **Workforce development**: this underpins all service delivery across the pathway. At its most basic level it is intended to increase the confidence and competence of staff and change attitudes to offenders with personality disorder. However, some staff require training to a higher level. This is targeted at offender managers, staff in Approved Premises, those providing consultation and support with pathway planning and anyone involved in the delivery of treatment interventions.

7.3. **Identification, assessment and pathway planning (including case formulation)**: The purpose is to enable offender managers to:

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

7.4. This will be managed by the Offender Manager and supported by a 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

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15 A list of approved premises and their capacity can be found at annex E
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 health services.

7.5. Each Probation Trust will require a joint agreement for men and women with a mental health service provider for these arrangements. The mental health service provider 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 mental health service provider 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.

8. Treatment interventions in secure settings

8.1. NHS high, enhanced medium secure, medium and low secure services: Rampton Hospital provides the National High Secure Healthcare Service for Women. It delivers 50 beds across four wards, two of which are specifically for women with personality disorder. The entry criteria include meeting:

- the requirements of the Mental Health Act;
- the entry criteria for a high (posing a grave and immediate danger to the public) or medium secure hospital;
- 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.

8.2. Prison settings\(^{16}\). For the target population the options in figure 1 have been identified. This is underpinned by workforce development, as described above.

8.3. National provision – this describes approaches for which only one service is likely to be required.

8.3.1. The Primrose Unit at HMP Low Newton, which was developed in 2006 as part of the Dangerous and Severe Personality Disorder (DSPD) Programme in England and Wales, to address the needs of women. The Primrose programme offers comprehensive treatment to help participants reduce the impact of personality disorder and reduce risk of re-offending. Treatment is cognitive behavioural in orientation.

8.3.2. Located at HMP Low Newton, a maximum of twelve residential places are available on the 40 bedded F Wing. The other occupants of F Wing are life sentenced prisoners. The Primrose participants are therefore integrated into the prison. Although the delivery of treatment takes place in a purpose built unit attached to F Wing, daily activities (residential, meals, recreation, education and spiritual) is delivered by the mainstream prison services.

\(^{16}\) A list of female prisons and approved premises and the number of places can be found at annex E.
8.3.3. A candidate for the Primrose Programme can be admitted for treatment if assessment confirms that:

- She 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
- She has a severe disorder of personality; and
- There is a clinically justifiable link between the disorder of personality and the risk of offending.

The specialist unit at Low Newton is for prisoners who present the highest risk of serious harm to others and have the most complex needs. The unit provides assessment and treatment provision for offenders serving a term of imprisonment who meet the target population criteria and most of:

- Have a history of serious violent and/or sexual offences;
- If they were in the community would present an imminent risk of serious harm to others;
- 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;
- Abuses trust or friendships, exploits others;
- Breached parole licence, bail conditions or community based sentences;
- 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;
- Are 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;
- 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.)

Priority will be given to prisoners who are ready to progress from restricted status or meet the CSAW criteria.

8.3.4. Democratic therapeutic community (DTCs): DTCs are an accredited offending behaviour programme. For women, a DTC is provided at HMP Send targeting female offenders with complex needs 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), 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.

8.4. **Supra-regional provision** - this describes provision that should be available in at least one prison per supra-region.

8.4.1. **CARE** - Choices Actions Relationships Emotions: CARE is an accredited offending behaviour programme designed for women who are at medium or high risk of violent re-conviction and who have two or more of the following needs:

- History of substance misuse problems;
- History of self-harming or suicidal behaviours;
- Mental health difficulties;
- Personality disorder diagnosis;
- Past difficulties in accessing or benefiting from help or treatment.

CARE aims to enable women with a history of violence and complex needs to better understand and reduce the risk they pose to themselves and others and to live a more satisfying and pro-social life.

CARE aims to reduce violence and aggression. By addressing needs related to violence CARE also responds to and addresses a complexity of needs including substance misuse, self-harm and suicidal behaviour, mental health and personality disorder and poor response to treatment. This integrated approach is supported by the literature on women and offending and recent reviews which advocate a holistic approach.

8.4.2. **Specialist personality disorder treatment interventions** – Provisions for women offenders unlikely to make progress in existing prison based interventions like CARE or a DTC, but fall short of the criteria for Primrose and do not require transfer under the Mental Health Act. A more specialist approach is required in order for them to make progress. This would be delivered by health, prison and probation staff:

- Providing extended assessments and case formulations;
- Addressing ambivalence and resistance to achieve shared goals;
- Delivering specific evidence based interventions including:
  - Psycho-education for personality disorder;
  - Emotional self-management;
  - Understanding risk assessments and risk management.

9. **Psychologically Informed Planned Environments (PIPES)**

9.1. PIPEs 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 will also be adapted to accommodate offenders preparing for treatment in a custodial setting.

9.2. 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.

9.3. The model for PIPEs has been specified and pilots in prisons for prisoners who have completed a period of treatment, and in probation approved premises for those being released from custody, are due to report in 2012. For women, the pilot sites are at HMPs Low Newton and Send.

10. **Arrangements for women offenders from black and minority ethnic groups**

10.1. 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. Further challenges relating to work with women are that about a fifth of women prisoners are foreign nationals (about 700) and 30% from ethnic minority groups (about 1,000); a higher proportion than the male estate.

10.2. 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.

11. **Arrangements for women offenders with co-morbid conditions**

11.1. 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 secure mental health service. 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

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disorder treatment should be in the prison system unless remaining in the NHS can be clinically justified.

11.2. 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.

12. Arrangements for offenders with learning disability

12.1. 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 a secure location 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.

12.2. 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 in 2011/12, in the first phase, for men.

13. Part two – workforce development

13.1. Workforce development is a critical part of strategies for men and women underpinning all service delivery. A workforce development strategy is being developed that will include gender specific requirements. Components of the wider strategy are summarised in annex D. Additional objectives for the workforce development part of the women’s’ strategy are to:

- Develop and deliver a gender specific version of the awareness level training course; and
- To ensure that the BSc and MSc have appropriate gender specific components.

The outcomes are that, for the workforce:

- Gender specific personality disorder training is developed and delivered;
- All personality disorder training commissioned by NOMS or DH has a clearly identifiable gender specific element.

13.2. 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 practise across the Criminal Justice System and beyond.

14. Commissioning arrangements

14.1. Commissioning arrangements are subject to the re-organisation in NOMS and the NHS. However, each supra-region will develop a co-commissioning plan for approval by the NOMS Director of Commissioning and Commercial and, subject to legislation, the NHS Commissioning Board.

15. Evaluation

15.1. 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.

16. Limitations

16.1. This strategy has the following limitations:

- The evidence base for personality disorder is at a relatively early stage of development compared to other areas of mental health. 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 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.

17. Next steps

<table>
<thead>
<tr>
<th>Objective</th>
<th>Date</th>
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<tbody>
<tr>
<td>Develop project plan</td>
<td>August 2011</td>
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<td>Define resources required to deliver the project</td>
<td>September 2011</td>
</tr>
<tr>
<td>File review of women meeting the criteria for CSAW</td>
<td>October 2011</td>
</tr>
<tr>
<td>Objective</td>
<td>Date</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Define and establish the governance arrangements at each level (nationally, sub-nationally and locally)</td>
<td>October 2011</td>
</tr>
<tr>
<td>Map the existing provision and current investment in relation to this population</td>
<td>October 2011</td>
</tr>
<tr>
<td>Identify the psychological health and offending needs of this population</td>
<td>October 2011</td>
</tr>
<tr>
<td>Deliver a plan for service user engagement that provides continuous and meaningful dialogue</td>
<td>October 2011</td>
</tr>
<tr>
<td>Describe the model for the community and at HMP Foston Hall</td>
<td>October 2011</td>
</tr>
<tr>
<td>Deliver an evaluation plan</td>
<td>October 2011</td>
</tr>
<tr>
<td>Deliver a commissioning plan</td>
<td>October 2011</td>
</tr>
<tr>
<td>Identify, consult and agree project plan with stakeholders</td>
<td>December 2011</td>
</tr>
<tr>
<td>Workforce development plan in place which is gender specific and tailored to the needs of staff working with offenders meeting the criteria</td>
<td>January 2012</td>
</tr>
</tbody>
</table>
18. Annex A – identification

**Women’s Offenders personality Disorder Strategy: ‘In scope’ criteria**

The target population is women who meet the following criteria:

- A current offence of violence against the person, criminal damage including arson, sexual (not economically motivated offences) and/or where the victim is a child; *and*
- Assessed as presenting a high risk of committing an offence from the above categories; *and*
- Likely to have a severe form of personality disorder; *and*
- A clinically justifiable link between the above.

The following features are seen as **Critical Criteria** – their presence may act as a ‘trigger” for a formal assessment of whether a woman is to be managed within scope of the PD Strategy:

<table>
<thead>
<tr>
<th>Critical Criteria</th>
<th>Potential sources of evidence</th>
<th>Behaviour likely to be observed</th>
<th>Guidance/commentary</th>
<th>Link to offending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persistent and complex needs</td>
<td>Prison records Medical/healthcare records ACCT documentation CARATs assessments Other ‘specialist’ reports OASys</td>
<td>Co-occurring problems</td>
<td>Including any combination of experience in past or currently of mental health problems, substance misuse, self injury/suicide behaviours; challenging behaviour</td>
<td>Related to high levels of need, difficulties in coping, difficulties in regulating own behaviour, high levels of distress, mediators of violent behaviour, drug taking,</td>
</tr>
<tr>
<td>Violent behaviour and/or threats of violence</td>
<td>Staff observations Incident reports Offending history Adjudications</td>
<td>Physical assaults or threats to other people; self harm; damage to own property or living area</td>
<td>This may include physical violence, but also may be verbal. It may also be directed towards the members of staff, other women or physical environment, and include physical assault, bullying causing damage to their own property or own living area, or fire setting. May be assessed as being high risk of harm to others.- dangerous Environmental damage (fire setting, cell smashing, dirty protest)</td>
<td>Reactive acts of aggression to perceived interpersonal difficulties; directed at significant others; leading to personal violence offences and destruction of property</td>
</tr>
</tbody>
</table>
### Critical Criteria

#### Interpersonal relationships problematic

<table>
<thead>
<tr>
<th>Potential sources of evidence</th>
<th>Behaviour likely to be observed</th>
<th>Guidance/commentary</th>
<th>Link to offending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff observation</td>
<td>Interpersonal relationships</td>
<td>Difficulties in</td>
<td></td>
</tr>
<tr>
<td>Incident sheets</td>
<td>could range from being</td>
<td>interpersonal</td>
<td></td>
</tr>
<tr>
<td>ACCT reviews</td>
<td>demanding and overly</td>
<td>relationships</td>
<td></td>
</tr>
<tr>
<td>Adjudication reports</td>
<td>attached; attention seeking</td>
<td>ma range from</td>
<td></td>
</tr>
<tr>
<td></td>
<td>behaviour; challenging</td>
<td>being ‘over engaged’</td>
<td></td>
</tr>
<tr>
<td></td>
<td>difficult to manage; to being</td>
<td>demanding, over</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Multiple crises;</td>
<td>attached, needy for</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>attention, positive</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>regard; to being</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘under – engaged’</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>isolated, socially</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>excluding and</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>socially excluded.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Resource intensive;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>lots of practitioners</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>involved; huge</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>investment by staff</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>in time and emotion</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>matched by high</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>levels of disillusionment</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>in staff following</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>incidents</td>
<td></td>
</tr>
</tbody>
</table>

#### Resource intensive (context specific)

<table>
<thead>
<tr>
<th>Potential sources of evidence</th>
<th>Behaviour likely to be observed</th>
<th>Guidance/commentary</th>
<th>Link to offending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation relating to</td>
<td>Currently being managed by</td>
<td>Involvement of a</td>
<td></td>
</tr>
<tr>
<td>various schemes – CPA, ACT,</td>
<td>multiple care management</td>
<td>multiplicity of</td>
<td></td>
</tr>
<tr>
<td>MAPPA, OM Tier ; in reach</td>
<td></td>
<td>agencies, multiagency</td>
<td></td>
</tr>
<tr>
<td>Complex medication regimes</td>
<td></td>
<td>arrangements may or</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>may not be in place</td>
<td></td>
</tr>
</tbody>
</table>

The following are seen as being **co-occurring features** which illustrate a range of behaviours that women within scope may demonstrate. Evidence of these will be used to support the case for recommending that a formal assessment is under taken to see if the woman is to be managed within the PD strategy.

### 1. Current Behaviour

#### PD associated behaviours

<table>
<thead>
<tr>
<th>Potential sources of evidence</th>
<th>Behaviour likely to be observed</th>
<th>Guidance/commentary</th>
<th>Link to offending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff observation</td>
<td>The woman may display</td>
<td>In reality, the</td>
<td>Related to</td>
</tr>
<tr>
<td>Formal pd assessments</td>
<td>behaviours associated with</td>
<td>majority of these</td>
<td>domestic abuse,</td>
</tr>
<tr>
<td>Psychometrics – PCL-R</td>
<td>borderline personality</td>
<td>women are unlikely</td>
<td>and expressive</td>
</tr>
<tr>
<td></td>
<td>disorder, such as:</td>
<td>to have ever had a</td>
<td>impulsive</td>
</tr>
<tr>
<td></td>
<td>Intense, changeable moods;</td>
<td>formal pd</td>
<td>aggression. May</td>
</tr>
<tr>
<td></td>
<td>unstable relationships;</td>
<td>assessment.</td>
<td>also offend</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>as means of</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>drawing others</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>attention to</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>internal distress</td>
</tr>
<tr>
<td>Lack of control over her emotions</td>
<td>Staff observations</td>
<td>Staff observations</td>
<td>May appear dissociated or some women will experience</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Prison record</td>
<td>Mood swings; intense and seemingly unrelated to what has been happening to her; moods shifting rapidly. Unable to manage her own emotions of feelings; unable to control, manage emotions; unable to find appropriate ways of meeting emotional needs.</td>
<td>She may be shown by seemingly ‘over reacting’ to the ‘normal’ pressures of life; being very changeable emotionally, swinging quickly from one emotional state to another; becoming quickly agitated, distressed, angry; but emotions may subside as quickly. May contribute to her difficulties in relationships with others</td>
<td>Impulsive acts of recklessness as a means of emotional regulation Eg substance misuse; self harm</td>
</tr>
<tr>
<td>Incident reports</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjudications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthcare records</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detached/dissociated</td>
<td>Staff observations</td>
<td>Seeks to lack emotional reactions; blocks out emotions or feelings; does not express emotions; flat; detached.</td>
<td></td>
</tr>
<tr>
<td>Staff observations</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

intense, tempestuous attachments; particular sensitivity to rejection/abandonment; self-image unstable and variable; express feelings of emptiness; attempt to regulate distressing feelings with impulsive behaviours, including alcohol/drug abuse, self harm And/or Anti-social pd behaviours: Hostility to others; dismissive of close attachments; instrumental, explosive aggression, childhood conduct disorder; impulsivity; irresponsibility; frequent rule breaking

Characterised by childhood conduct disorder; rule braking; violent impulsive offending
<table>
<thead>
<tr>
<th>Category</th>
<th>Observation Source</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flashbacks to early trauma/drug use</td>
<td></td>
<td>detached during flashbacks; distressed preoccupied following them</td>
<td>flashback to early traumatic events; this will affect their capacity to respond to other people and they may come across as being detached or 'dissociated' from that is going on around them at the time</td>
</tr>
<tr>
<td>Acts out her distress/neediness</td>
<td>Staff observation</td>
<td>Repeated and dramatic expressions of distress, that appear objectively out of proportion to events.</td>
<td>Fire-setting, self harm and other actions which result in containment and being restrained, physically contained by others</td>
</tr>
<tr>
<td>Impulsivity /lack of control</td>
<td>Staff observation</td>
<td>Examples of impulsive behaviour, or frustration, distress or anger if asked to wait for things; wants her problems solved or needs met immediately</td>
<td>This will be demonstrated by the woman acting on impulse without regard to the consequences, or by her being unable/willing to wait for things. This may result in frustration or distress, and increased emotional response to delays or seeming frustration</td>
</tr>
<tr>
<td>Challenging behaviour and rule breaking</td>
<td>Prison record</td>
<td>Examples of rule breaking and challenging authority in current situation</td>
<td>They may also be a history of rule breaking and anti-social activity</td>
</tr>
<tr>
<td>Disruptive to the regime</td>
<td>Prison record</td>
<td>There will be evidence of incidents and/or adjudications; women having difficulty being with other women, so may not be able to cope on normal location, work with other women or attend education; there may be a record of incidents with other women and /or adjudications relating to these. incidents of problems</td>
<td></td>
</tr>
<tr>
<td>2. Historical or current</td>
<td>Potential sources of evidence</td>
<td>Behaviour likely to be observed</td>
<td>Guidance/commentary</td>
</tr>
<tr>
<td>-------------------------</td>
<td>--------------------------------</td>
<td>-------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Experience of abusive &amp;/or domestic violence</td>
<td>OASys, Sentence Plan, Healthcare records, ACCT records, Self disclosure</td>
<td>Mary appear depressed and anxious; may experience flashbacks; may self harm</td>
<td>A woman’s abuse history may also affect her current relationships including those with other women in prison</td>
</tr>
<tr>
<td>History of substance misuse</td>
<td>OASys, CARATs assessments</td>
<td>Behaviour may be affected while withdrawing; flashbacks</td>
<td>Including alcohol, illegal and prescribed drugs;</td>
</tr>
<tr>
<td>History of &amp;/or current Mental health difficulties</td>
<td>Healthcare records, OASys, Prison record</td>
<td>Depressed; anxious; May have psychotic symptoms’ on occasion</td>
<td>Many women will not have had a formal psychiatric assessment, or meet the level of ‘severe and enduring’ required for In reach involvement</td>
</tr>
<tr>
<td>History of not coping; same pattern seen in current situation</td>
<td>Staff observation, Incident reports, Healthcare notes, Education/work reports, OASys</td>
<td>Evidence that she finds it difficult to cope with the normal regime</td>
<td>History of not coping with the normal stresses of day to day life, of having ‘failed ‘ at everything they have tried, such as at school, coping either family, holding down a job.</td>
</tr>
<tr>
<td>Difficulties in accessing help or engaging in interventions</td>
<td>Prison Record, Treatment Manager notes, Sentence plan reviews</td>
<td>May not put self forward for interventions; may refuse offers of help; Starts an intervention, but rarely (if ever) completing Failing to keep appointments</td>
<td>This may be in her history, as well as in current situation</td>
</tr>
</tbody>
</table>
| Periods of stability but not maintained | Staff observations  
Prison record  
Healthcare records | She may settle in one prison or unit and seem to be ‘doing well’ then seemingly unpredictably her behaviour will change, becoming unsettled and challenging again. Very demanding and draining for staff who can feel perplexed, and disappointed when these changes occur |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3. Relationships</strong></td>
<td><strong>Potential sources of evidence</strong></td>
<td><strong>Behaviour likely to be observed</strong></td>
</tr>
</tbody>
</table>
| Lack of empathy / lack of awareness of impact on others | Staff Observations  
Incident reports  
Prison record  
OASys | Examples of where she seems to disregard the impact her behaviour has on other women or staff; may come across as callous, emotionally detached or lack of concern for others, lack of empathy |
| Manipulative/ bullying | Staff observations  
Prison record  
Healthcare records | Coercive/bullying towards other women; ‘splitting’ staff groups by moving attachments around staff group leading to conflict. |
| Sensitivity to changes in their relationship with others | | Overly concerned if people do not react to her as she expects; paranoid; easily upset and distressed as a result |
| | | Relationship with others may be unstable and intense, with a heightened sensitivity to changes in the relationships, leading to extremes of behaviour with people with whom they have developed relationships – at times (overly) friendly, dependent, with positive regard; at others rejecting, angry; and frequent fears of abandonment. |
| Socially isolated; excluding others and being excluded | Unwilling to take part in group activities; can only spend short time with others; spends most time on her own, or with one preferred companion; monopolises that preferred companion | Other women can actively exclude her also as she is difficult to be with and may exclude her from their activities and company |

<table>
<thead>
<tr>
<th>Co-occurring features: Impact on staff and her physical environment</th>
<th>Potential sources of evidence</th>
<th>Behaviour likely to be observed</th>
<th>Guidance/commentary</th>
<th>Link to offending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotionally draining for staff</td>
<td>Women: 'high maintenance' &amp; demanding; unpredictability; Staff: burnout, stress, frustration; undermining</td>
<td>Working with women within scope can be very demanding and draining on staff who invest a lot in their relationship with the woman. They may use this relationship as a means of persuading her not to engage in challenging, disruptive or destructive behaviours; but because of the difficulties in sustaining progress with these women, they will often be disappointed, frustrated. Staff may experience a range of strong emotions when they feel 'let down' by the women.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of clarity of expectations/ realistic goals</td>
<td>Staff: lack of coordination of efforts; lack of direction; little evidence of progress</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk of harm to others</td>
<td>Incidents reports Adjudications Staff observation</td>
<td>Physical &amp; verbal violence directed at self or others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Damage to property and physical fabric</td>
<td>Incident reports adjudications</td>
<td>Evidence of environmental damage: her own property, living area; fire setting; dirty protest, flooding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>---------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
19. Annex B – the pathway diagram
20. **Annex C – Offences**

Women who are eligible for services provided by this strategy will currently be serving a sentence having been convicted of one or more of the following offences and assessed as presenting a high risk of committing a further offence from this list. A number of these offences are committed too infrequently for the actuarial measures to have validity. In these circumstances the risk assessment will largely be based on a clinical judgement. The number indicates the offence code:

**Violence Against the Person**

1. Murder
2. Attempted murder
3. Threats, conspiracy, or incitement to murder
4. Manslaughter
5. Wounding and other acts endangering life (felonies)
6. Endangering railway passengers
7. Endangering life at sea
8. Malicious wounding and other like offences (misdemeanours)
11. Cruelty to or neglect of children
12. Abandoning children under two years
13. Child abduction
37. Aggravated taking of a vehicle
103. Aggravated assaults
104. Assault
105. Common and other types of assault
108. Cruelty to animals
109. Cruelty to or neglect of children

**Sexual offences**

17. Indecent assault on a male
19. Rape
20. Indecent assault on a female
21. Unlawful sexual intercourse with girl under 13
22. Unlawful sexual intercourse with girl under 16
23. Incest
24. Procuration
25. Abduction
74. Gross Indecency with Children

**Burglary**

29. Aggravated burglary of a dwelling
31. Aggravated burglary of a building other than a dwelling

**Robbery**

34. Robbery and assaults with intent to rob

**Theft and handling**

37. Aggravated taking of a vehicle

**Criminal damage**

56. Arson
57. Other criminal damage
58. Other criminal Damage
59 Threat and possession with intent to commit criminal damage
149 Criminal and malicious damage

36 Kidnapping

62 High treason

63 Treason felony

64 Riot

65 Violent disorder

66 Other offences (against the State and Public Order)

80 Absconding from lawful custody
21. **Annex D – Workforce development**

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.

In addition, frontline staff and their managers will require training to a higher level to increase their knowledge and skills for working with this population. For the staff in specialist roles this will include providing case consultation, case formulation, delivering training, motivation and engagement and joint casework.

The Knowledge and Understanding Framework 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.

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.

**Background**

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:
Annex E – Prisons and approved premises for women

Certified normal accommodation available and population by establishment – August 2010

<table>
<thead>
<tr>
<th>Establishments for women</th>
<th>CNA</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Askham Grange</td>
<td>126</td>
<td>120</td>
</tr>
<tr>
<td>Bronzefield</td>
<td>527</td>
<td>482</td>
</tr>
<tr>
<td>Drake Hall</td>
<td>315</td>
<td>296</td>
</tr>
<tr>
<td>Downview</td>
<td>358</td>
<td>336</td>
</tr>
<tr>
<td>East Sutton Park</td>
<td>98</td>
<td>84</td>
</tr>
<tr>
<td>Eastwood Park</td>
<td>326</td>
<td>313</td>
</tr>
<tr>
<td>Foston Hall</td>
<td>283</td>
<td>232</td>
</tr>
<tr>
<td>Holloway</td>
<td>496</td>
<td>459</td>
</tr>
<tr>
<td>Low Newton</td>
<td>276</td>
<td>224</td>
</tr>
<tr>
<td>Morton Hall</td>
<td>392</td>
<td>306</td>
</tr>
<tr>
<td>New Hall</td>
<td>386</td>
<td>373</td>
</tr>
<tr>
<td>Peterborough (for male &amp; female)</td>
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<td>353</td>
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<tr>
<td>Send</td>
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<td>270</td>
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<tr>
<td>Styal</td>
<td>451</td>
<td>409</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>4,676</strong></td>
<td><strong>4,257</strong></td>
</tr>
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<table>
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<tr>
<th>Probation Trust</th>
<th>Name</th>
<th>Location</th>
<th>Beds</th>
<th>DDA beds</th>
<th>Public/Independent</th>
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<tbody>
<tr>
<td>Bedfordshire</td>
<td>Chaucer Road</td>
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<td>17</td>
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<td>Merseyside</td>
<td>Adelaide House</td>
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<td>Greater Manchester</td>
<td>Hopwood House</td>
<td>Heywood</td>
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<td>Elizabeth Fry</td>
<td>Reading</td>
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<td>Crowley House</td>
<td>Selly Oak</td>
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<tr>
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<td>Ripon House</td>
<td>Leeds</td>
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</table>

20 Disability Discrimination Act
Annex F

Early thinking on a pathway for women offenders with personality disorder in the mid supra-region

Target population
The target population is women who meet the following criteria:

- A current offence of violence against the person, criminal damage including arson, sexual (not economically motivated offences) and/or where the victim is a child; and
- Assessed as presenting a high risk of committing another serious offence; and
- Likely to have a severe form of personality disorder; and
- A clinically justifiable link between the above.

The pathway

| Early identification | 1. A simple screening process is required post-sentence to identify women likely to meet the entry criteria. This could be applied by, in the community, offender managers and court based staff, and in prisons by staff in healthcare, discipline and offender management. The purpose of this stage is to flag women who require further consideration; |
| | 2. Gender specific workforce development is required for all staff over a period of time. However, those who are likely to apply the screen would be a priority; |
| | 3. Offender Managers in the community and Offender Supervisors in the prison (Foston Hall) have primary responsibility for early identification. A secondary layer for identification will be through offender health and discipline staff. |
### Pathway planning: assessment, case formulation and sentence planning

A Multi-Profession Team is required, which works across community and the prison. It will review identified women to determine whether they meet the entry criteria and support Offender Managers and Offender Supervisors. This team will consist of Offender Managers, health based psychology and prison staff and work across community and the prison (Foston Hall). The role of the team is to provide:

1. Case consultation;
2. Workforce development;
3. Case formulation to produce an individualised pathway plan, which considers need and the stitching together of a sequence of appropriate interventions.
4. The team will be supported by a consultant forensic psychiatrist and a consultant clinical psychologist.

### Treatment interventions & PIPES (Psychological Informed Planned Environments)

In a prison a range of options are available for this population: do nothing, transfer to the NHS (medium (Arnold Lodge or independent sector) or high security (Rampton hospital)) , the CARE programme (to commence shortly at Foston Hall), the Democratic Therapeutic Community at HMP Send, the Primrose project at HMP Low Newton.

Foston Hall's approach is for all women to be off the wings during the day participating in a range of structured activities. Consequently, the preferred model consists of:

1. one or more wings becoming PIPES/enabling environments;
2. converting the Old Boiler Room to a suitable physical environment to deliver a day centre type model. A flexible programme would be developed that enabled the delivery of individualised plans. Women could attend from a few hours per week to a number of days depending on their needs. This would include focus on: relationships, ensuring that their time is appropriately occupied, motivation and engagement, preparation for accredited programmes.
3. Training for all staff across Foston Hall and Probation Trust in East and West Midlands to change attitudes, confidence and competence in working with this population; develop an enabling environment.
<table>
<thead>
<tr>
<th>Case review: supporting MAPPA, parole applications &amp; offender management</th>
<th>The above processes are designed to support and enhance existing systems and arrangements for case review, Parole applications and MAPPA.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review &amp; (for some) lifelong management</td>
<td></td>
</tr>
</tbody>
</table>
| Mental Health Service provider/NOMS joint case management arrangements for the most complex offenders | There are a range of organisations already working directly or indirectly with this population. However, this is patchy in terms of consistency of approach and geography. There is one approved premises for women in the supra-region in Birmingham – (Crowley House, Selly Oak – 20 places). The community part of the MPT will consist of a number of specialist offender managers with a reduced caseload working with a health based psychologist to provide:  
  - Case consultation;  
  - Gender specific workforce development;  
  - A limited amount of joint casework with the specialist offender manager holding a caseload of women meeting the criteria;  
  - Deliver, where there are sufficient numbers, a group based programme;  
  - Provide the above, if appropriate, to the approved premises.  
  - Work with the Women’s centres to develop a cohort of volunteers trained to work with and support this population in the community. |