EXPLORING OFFENDER PERSONALITY DISORDER SERVICES WITHIN A HIGH SECURITY PRISON SETTING

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Abstract

This commentary presents publications relating to personality disorder services based within UK high security prisons. The Westgate Unit was evolving when this work was conducted and continues to do so. This offered unique and valuable opportunities to conduct high quality applied research and produce publications relating to a unique, high profile service. Limited publications had been produced in personality disorder services within the Prison Service compared to health settings, leading to the requirement to address this limitation. The publications' aims were to: (i) promote and communicate aspects of the service to internal and external professionals; (ii) inform stakeholder decision-making; (iii) inform practice and policy development, and; (iv) contribute to the literature-base. Varying methods are included within these submissions including a book chapter, descriptive publications, alongside qualitative and quantitative research studies. These publications were responsive to the limited available sample by the methods employed, particularly as large-scale research would not be feasible for a considerable time. The Westgate Unit's research strategy was being developed during the time these publications were being completed, resulting in these works either generating ideas within the strategy or exploring areas identified within the strategy. The main take-home messages from the presented publications relate to: the complexity of the population and their treatment needs; the requirement for responsivity-informed treatment and management; and the importance of multi-disciplinary input within personality disorder services. More specifically, findings from the research presented within these publications included: a high level of co-morbidity between personality disorder and clinical disorder diagnoses; narcissistic personality disorder being predictive of treatment dropout; and prisoners located on a new progression service hoping to achieve both progression and becoming part of a community. The communication publications included shared: clinical and clinically-informed practices employed by the Westgate Unit (highlighting the importance of an eclectic model of treatment for personality disorder); clinical responses to change in national policy in substance use intervention; and how approaches initiated by the Westgate Unit have been transferred and applied to both small, discrete units and main location settings within the high security prison estate. Resultant from the work within these

publications, the Westgate Unit expanded treatment-supportive services for this complex client group. Knowledge regarding the hopes and expectations of a new progression service informed the training and supervision of multidisciplinary staff and policy development. An (unanticipated) additional benefit from these works becoming published included networking opportunities both within and outside of the Prison Service and subsequent working relationships. Connections to local universities opened up mutually beneficial opportunities for the university and the prison. These publications made headway in terms of addressing gaps in the literature-base for prison-based personality disorder services and sparked further research.

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Author's Declaration

I declare that no outputs submitted for this degree have been submitted for a research degree of any other institution. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others.

Any ethical clearance for the research presented in this commentary has been approved. Approval has been sought and granted through the Researcher's submission to the HM Prison and Probation Service's National Research Committee (NRC).

I declare that the Word Count of this Commentary is 10,000 words.

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Introduction

Historically, personality disorders (or ‘character disorders’ as they were initially called in the 1950s) were not considered to be mental illnesses, rather they were seen to be behaviours resulting from an individual’s upbringing or weaknesses within their character. Treatment for character disorders was restricted to psychoanalysis at that time in psychology’s history, which was not always effective for relevant individuals. Personality disorders were first formally recognised as mental illnesses in the first Diagnostic and Statistical Manual of Mental Disorders (DSM) produced by the American Psychiatric Association (APA, 1952). The first two editions of the DSM reflected the general outlook of the field at the time which included Freud’s psychoanalytic theory (Kawa & Giordano, 2012). We can retrospectively say a limitation of this approach was that psychoanalytic theory was focussed on concepts that could not be measured or evaluated and therefore, were not testable. Testable predictions are required in order for a theory to be considered to contribute to science, in line with the Falsification Principle (Popper, 1959). Changes to subsequent editions from the DSM-III (APA, 1980) onwards ran in parallel with psychiatry embracing the ‘medical model’ where mental illness is considered to be a product of physiological factors, i.e. the same as physical illness. Additionally, both psychology and psychiatry had started to progress away from abstract Freudian concepts, which could not be tested via scientific methods. Cognitive-behavioural approaches were increasing in popularity and explored thoughts, feelings and behaviours, which could be measured and observed, and therefore tested. A significant change in the DSM-III was the introduction of a multi-dimensional format for developing diagnoses (Crocq, 2013). This meant that clinical syndromes were considered within one axis (Axis I) and personality disorders were placed on a separate axis (Axis II), alongside developmental and intellectual disorders. This enabled practitioners to explore an individual’s current state whilst simultaneously exploring pervasive and persistent personality traits. This change to personality disorders being considered distinct to clinical disorders sparked subsequent research which enabled relevant structured assessment tools to be developed. Further revisions have been made and the DSM is currently published in its fifth edition (DSM-5; APA, 2013). These later revisions have not had a significant impact

on the diagnosis of personality disorder and have been more relevant to other areas of mental health assessment.

Mental health legislation has significantly changed over time regarding its view of personality disorder. The Mental Health Act 1983 specified that in order to be detained, personality disordered individuals were required to meet the legal criterion of 'psychopathic disorder' and treatment had to be, "…likely to alleviate or prevent a deterioration" (Mental Health Act, 1983, p. 3.) of the conditions of such patients. 'Psychopathic disorder' was defined as, "A persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned" (Mental Health Act, 1983, p. 2). This meant personality disordered individuals deemed 'untreatable' were unable to be detained under the Mental Health Act at that time. A combination of factors led to this being amended in 1999. An inquiry into practices, systems and provisions within the Personality Disorder Unit at Ashworth Special Hospital highlighted the unit was unsustainable long-term and that there was no balance between security and intervention (Fallon, Bluglass, Edwards & Daniels, 1999). Fallon et al., (1999) recommended that 300 hospital places and 100 prison places be provided for severely personality disordered offenders within small units, in physically different accommodation to mentally ill individuals. Another key recommendation was for a change to the Mental Health Act 1983 to replace the classification of 'psychopathic disorder' with 'personality disorder'. Subsequent to this, the Home Secretary, Jack Straw called for changes to legislation. He informed parliament there was "a group of dangerous, severely personality disordered individuals from whom the public at present are not properly protected, and who are restrained effectively neither by the criminal law nor by the provisions of the Mental Health Acts" (Home Office and Department of Health, 1999).

Subsequent proposals were published regarding how to effectively manage this population (Home Office and Department of Health, 1999). The responses from relevant professionals to these proposals were subsequently presented in a White Paper detailing reforms to the Mental Health Act for individuals with "severe personality disorder" (H.M. Government, 2000). As well as suggesting changes to mental health legislation, it signposted to an "expansion of provision of specialist services" for Dangerous and Severe Personality Disorder (DSPD) over a three year

period. This included an increase of 140 further places within secure hospital sites and 180 places within prison establishments. These DSPD places were spread over four units: high security prison sites (HMP Frankland and HMP Whitemoor) and high security hospitals (Broadmoor and Rampton).

The DSPD 'pilot' began, employing an assessment process utilising established assessments relating to risk of re-offending and personality disorder. Personality was assessed using the International Personality Disorder Examination (IPDE: World Health Organisation, 1997) and the Psychopathy Checklist-Revised (PCL-R; Hare, 2003). The initial suitability criteria were presented by the DSPD Programme (2008) as:

- A significant/high risk of re-offending;
- The presence of a "severe" personality disorder (evidenced by either: a PCL-R score of 30 (95.8th percentile) and above; a PCL-R score of between 25 and 29 (85.2 – 94.4th percentile) combined with at least one personality disorder other than antisocial personality disorder; or two or more personality disorders (regardless of the PCL-R score) and;
- The presence of a "functional link" between the personality disorder and the risk of re-offending.

Each of the four DSPD sites developed their own treatment frameworks informed by the literature-base and existing practice. The evidence-base of 'what works' with this population has developed over time, with there being support for 'combining eclectic treatment methods' (Livesley 2012, p.17) within an integrated approach rather than focusing upon individual therapies. Livesley also promoted the importance of such therapy being structured and underpinned by a positive therapeutic alliance between the practitioner and the service-user. Existing practice taking place within services in Holland and Canada also informed aspects of DSPD services where appropriate, as there were differences in the legal systems.

Given the complex psychopathology of the population, it is not surprising that day-to-day, personality traits manifest within treatment settings in the form of treatment interfering behaviours which impact upon treatment engagement and completion (Atkinson & Tew, 2012; Sheldon & Tennant, 2011). After all, most DSPD prisoners

had been excluded from or deselected from mainstream treatment programmes. Based on this, the clinical frameworks offered by the DSPD sites had to consider ways to manage treatment interfering behaviours.

The DSPD pilot was not without limitations. Criticisms included there being a low amount of time within therapy, insufficient value for money and there not being ample understanding of ‘what works’ with this population (Burns et al., 2011; Tyrer et al., 2010; Völlm & Konappa, 2012). Following the DSPD pilot, a number of changes were made to the service provision following a consultation of relevant professionals within the health and social care sectors (Department of Health & NOMS, 2011). DSPD itself was considered to be a title with negative connotations, as well as it neither being a clinical diagnosis or legal designation. An additional limitation of the DSPD programme was that it did not have identified progression routes for ‘completers’ of the service to provide these individuals with an environment where they could utilise skills they had gained from treatment. These issues were subsequently addressed by the newly named Offender Personality Disorder (OPD) Pathway aimed at individuals with complex personality disorders. The DSPD unit at Broadmoor Hospital was decommissioned, enabling funding to be directed towards the OPD Pathway. Progression units were commissioned called Psychologically Informed Planned Environments (PIPEs) which opened in 2012. PIPEs were initially introduced for offenders who had completed high-intensity treatment so that they could generalise skills they had learnt within treatment within a structured regime supported by positive relationships with staff.

Newly appointed Offender Personality Disorder Pathway commissioners identified areas of development in 2014 regarding the suitability criteria presented above for the high security sites. Subsequent recommendations were made in order to bring high security sites’ criteria in line with the wider Offender Personality Disorder (OPD) Pathway. Following this, the Westgate Unit Clinical Director published a staff notice in November 2014 amending the second criterion to a ‘severe and complex personality disorder’ (measured by the IPDE and PCL-R) rather than having set PCL-R cut offs or a designated number of personality disorder diagnoses. The new criteria (representing services across the OPD pathway) was subsequently published in 2015 (NOMS and NHS England, 2015).

My Journey

I joined the Westgate Unit as a Trainee Research Psychologist in 2008. The Westgate Unit is a standalone, discrete unit located within HMP Frankland, Durham (a Category A establishment). The Westgate Unit opened in 2004 but limited research had been conducted into the service when I joined. One part of my role was to input into a common dataset, which all four DSPD sites entered demographic and risk related data for each prisoner/patient. This was centrally managed by a researcher in another site (The Paddock Unit, Broadmoor Hospital). The dataset quarterly outputs generated statistics about all four sites in terms of what the population looked like, assessment outcomes etc. This information was, however, rarely used to contribute to research studies by Westgate Unit staff, and the main intention was for it to contribute to larger, long term studies exploring: 1) what the population looked like in terms of personality features and risk and; 2) the impact of DSPD treatment on service-users' risk.

I initially started getting involved in discrete research projects relating to a suite of treatment interventions at the Westgate Unit (called Chromis) that had been accredited by the Correctional Services Advice and Accreditation Panel (CSAAP). Chromis comprised of the following distinct interventions:

- Motivation and Engagement (M&E): an individually delivered, non-risk focussed intervention;
- Cognitive Skills: a group based intervention with three modules exploring:
    - Cognitive skills;
    - Problem solving;
    - Handling conflict.
- Chromis Schema Therapy: An individual and group based intervention that identifies and challenges schemas through behavioural experiments and schema testing.

A colleague in another establishment was taking the lead on researching Chromis which contributed to her PhD. I contributed to this by collating data and providing

information specific to the Westgate Unit (e.g. the regime and the wider clinical framework). As I was based on site, this collaborative work was productive and I learnt a lot about conducting research and subsequently, publishing work (Tew, Dixon, Harkins & Bennett, 2012; Tew & Bennett, 2014; Tew, Bennett & Dixon, 2016; Tew, Bennett & Dixon, 2020). I also completed the (MRes) Psychology (between 2009 and 2011) and explored functions of self-harming behaviour within my thesis. This study identified a function of self-harm not present within the literature base and (with my supervisor's support), this study was published (Bennett & Moss, 2013) as well as my reflections on using qualitative methods with this population (Bennett, 2013). These positive opportunities related to research and resultant publications gave me the confidence to pursue further discrete research projects as part of my role, most of these leading to the works that appear within this submission. Although my current working role does not lend itself to working with colleagues as much as I previously did, we continue to collaborate in a number of areas. We co-review special editions for The Forensic Update (a British Psychological Society publication) and I review research proposals for LTHSE in HMPPS (which Dr Tew co-ordinates). We have recently commenced writing a chapter relating to 'pracademics' (practitioners involved in academia) in the criminal justice setting after our chapter proposal was successful. This has been a hugely positive working relationship for me, in terms of networking as well as my own development, which I am appreciative of.

I was aware that the prison sites were not conducting and disseminating as much research as the hospital sites that worked with the same population. The research that was being conducted was not always being disseminated outside of the unit and certainly not via peer-reviewed publications. This was surprising to me as I felt it was a unique and interesting service and so, learning from practitioners would be both valuable to share as well as being of interest to the audience that peer-reviewed publications would reach. During my time as a Trainee Psychologist, I learnt about the importance of the 'Scientist Practitioner Model' (Shapiro, 2002). This suggested that as well as practice being informed by literature, practitioners should equally be contributing to the literature-base. I considered it therefore of paramount importance to engage in the conduct and dissemination of research aligned with my role and promote the importance of this to colleagues.

The Publications

The following publications are not presented in chronological order. This is due to the intention to present the published works in a fashion that communicates a narrative of the factors within the service. Specifically, it makes sense to describe what the Westgate Unit offered and what the population looked like prior to discussing treatment provision, treatment dropout and progression services. It is of note that some pieces of work took longer to achieve publication than others, and so the years of publication are not always reflective of the chronological order the works were completed.

I wrote ***'The Westgate Service and Related Referral, Assessment, and Treatment Processes' (Bennett, 2015)*** to communicate the treatment framework employed at the Westgate Unit to practitioners at other units and beyond. I consulted the previous Clinical Director prior to planning this paper and learnt about issues that were faced by the staff initially developing the service. This included inaccurate and sensational reporting in the media regarding the facilities prisoners had access to on the unit. It was fascinating to consider the media spin of a new, high profile service, and made me consider how information can be portrayed by the media. I also wanted to promote the parts of the unit that complemented the treatment framework, such as the multidisciplinary team-working and the physical aspects of the unit designed to promote interaction whilst maintaining the security required in a high security prison. I also promoted the clinical case manager system where a consistent clinician was allocated to prisoners upon induction. The clinical case manager had responsibility for the prisoner's risk assessments, attendance at case conferences and post programme reviews. They would not deliver intervention in order to prevent bias in line with the 'Rice Report' (HM Inspectorate of Probation, 2006). The consistency provided by this approach encouraged positive working relationships, something which was novel to the population given their past experiences. A key factor within this was 'Therapeutic Alliance' (Ross, Polaschek & Ward, 2008). This model focussed upon interactions between: therapist characteristics; client characteristics; the treatment setting; and organisational requirements. Research indicates that therapeutic alliance can be achieved with this population (Polaschek & Ross, 2010) which is hugely beneficial given that personality disorder traits can include a lack of trust and stormy relationships.

The paper was well received by colleagues in and out of the service. The published paper was shared with professionals who were referring individuals to the service and sparked contact meaning that I could respond to queries and signpost to the appropriate colleague in the service if required. It was also helpful to share externally as our counterpart unit (The Fens, at HMP Whitemoor) offered a different treatment approach (a trauma-based approach), and so the different services could benefit different prisoners. Some practitioners assumed that both sites would offer the same treatment framework and were unaware each unit had unique and differing approaches to treatment for personality disordered individuals. The Fens' treatment model was 'cognitive interpersonal', a combination of psychoanalytic and cognitive behavioural therapies (Saradjian, Murphy & McVey, 2013). This approach emphasised the importance of 'emotional intimacy' and overcoming barriers in order to develop the therapeutic alliance, and subsequently maximise the probability of reducing risk (Murphy & McVey, 2010). The treatment framework offered at The Fens comprised of individual intervention and group-based therapy targeting emotional dysregulation, dysfunctional relationships, schemas and offending behaviour (Saradjian, Murphy & McNey, 2013). This treatment model was supported by the development of a therapeutic milieu and operational staff developing positive working relationships, operationally and whilst co-facilitating groups (McVey, Murphy & Saradjian, 2015). Evidence suggests that treatment attendance at The Fens was good (over 95%) but prisoners could often withdraw and re-engage with intervention. There was also a decrease in adjudications for individuals at the Fens and 15 out of 17 men experienced a decrease within violence risk assessment ratings (Saradjian, Murphy & Casey, 2010). This was promising research in terms of treatment effectiveness.

However, the Westgate Unit and its clinical framework have been reviewed since the publication of this paper and these changes are not presented in the literature base. I suggested these updates be published within the concluding part of the 2015 paper as I was aware that this was a key milestone in the Westgate Unit's evolution and a result of a review of Offender Personality Disorder Services as well as reviews carried out by the unit. Unfortunately, these changes have not been published due to a change in financial resourcing which led to there no longer being a dedicated team responsible for research and so, research is solely conducted by Trainee

Psychologists as part of their qualification. The service shares up-to-date information about its clinical provision within an information booklet that is shared with staff who can prospectively refer individuals to the service. The implication of this is that practitioners or probation staff can access this information but this information is unlikely to reach the audience in academia. The removal of a dedicated research team more widely limits the research that can be shared in the literature-base. This means that units in the Offender Personality Disorder Pathway most likely to produce published work are more likely to be managed by the National Health Service (NHS).

I was interested in further exploring what the Westgate Unit 'population' looked like, particularly as the assessment process explored both mental disorder (Axis I disorders) and personality disorder (Axis II disorders). I started to observe that behaviours psychologists would link to personality disorder diagnoses were sometimes also linked by Mental Health Nurses to mental disorder. I considered whether this could impact on diagnoses made by the two different disciplines, and if misdiagnosis was occurring, how this could impact upon someone's treatment pathway on the unit. I considered that exploring co-morbidity between diagnoses was warranted, particularly given the expense of a treatment place on the Westgate Unit. Additionally, this population was challenging to work with and their personality disorder traits often manifested in 'treatment interfering behaviours'. These behaviours would result in prisoners missing intervention sessions (e.g. self-harm warranting medical treatment) or not continuing treatment on the unit (either self-deselection or deselection by the service). Based on the above factors, I proposed to stakeholders a study that explored ***'Co-morbidity of personality disorder and clinical syndrome in high-risk incarcerated offenders' (Bennett & Johnson, 2017)***.

Before I explored the literature-base, I considered where co-morbidity might exist for this population. I did this in order to think about the issue initially as a practitioner (and what I saw day-to-day in my practice) with the intention of reviewing the literature base and considering the issue as a researcher based on what findings had already been identified in this area. My considerations included that of substance use contributing to traits within both borderline and antisocial personality disorder, so I expected there to be co-morbidity between these disorders. I also expected mood related disorders (such as depression) to be relevant to borderline

personality disorder given the relevance of emotions within this diagnosis. When I moved on to the literature review, I found that although similar research had taken place before, none of it had been conducted in the high security, personality disordered prison population. I was surprised by some of the identified links in the literature base, e.g. anxiety disorder was linked to most personality disorders – but I was particularly surprised by a link to narcissistic disorder, based on the individuals I had worked with. I was enthusiastic to identify whether similar findings would be uncovered by my study and whether this could inform treatment planning for our prisoners.

Although my findings did not mirror those extant in the literature-base, this was still an interesting outcome, particularly as substance misuse disorder was relevant to 80% of the study's sample and therefore could impact on understanding of treatment relevance for a high proportion of men on the Westgate Unit. The findings also revealed the complexity of the population that I had not anticipated. Given that the population were those found suitable for a personality disorder treatment service, it was not unexpected that 93% had a personality disorder diagnosis, but a significant amount of the sample had multiple personality diagnoses (94%) and both Axis I and Axis II diagnoses (81%). This confirmed the complexity of the population and therefore, the requirement to have specialist services with a high intensity and an eclectic treatment model. The downside to the investigation of such a complex population however, was the small sample size in some diagnostic groups for comparison purposes. This meant that I had to exclude five personality disorder diagnoses (there are only ten in total) which was disappointing but understandable given that the sample was personality disordered. Although further time in the future would have accrued a bigger sample size and increase the potential for required diagnosis of some personality disorders, this would take a significant period of time, and would never accrue a sufficient level of negative diagnosis for Antisocial personality disorder (10% of the sample) or positive diagnoses for Obsessive Compulsive personality disorder (3% of sample), Dependent personality disorder (4%) and Schizotypal personality disorder (7% of sample). So this would always be a limitation of the study exploring those suitable for a personality disorder treatment unit. I had to be responsive to this and therefore looked at the accepted 'clusters' of diagnostic categories as presented in table 1:

Table 1. Diagnoses of Personality Disorder (presented by cluster)

Cluster A (the "odd, eccentric" cluster)	**Cluster B (the "dramatic, emotional, erratic" cluster)**	**Cluster C (the "anxious, fearful" cluster).**
Paranoid	Borderline	Avoidant
Schizoid	Narcissistic	Dependant
Schizotypal	Histrionic	Obsessive-Compulsive
	Antisocial	

This was an alternative way to explore what I set out to as closely as I could without losing the sample size that I accrued because most omitted categories could be captured within clusters A and C. Not being able to explore cluster B as a whole did not fully eradicate the issue I was facing but again was unsurprising given that Antisocial and Borderline personality disorders were the most prevalent in the population. This approach did provide some interesting findings, an outcome that was positive for me to explore given I used alternative ways of analysing the data.

Other findings I explored supported aspects of the treatment model at the Westgate Unit. For example, 80% of the sample had a diagnosis of substance use disorder which warranted the provision of substance misuse treatment within the service. The findings also highlighted the need to provide treatment for clinical disorders which (as I presented in Paper 1), included treatment that could be accessed in the community such as Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT) and Eye Movement Desensitisation Reprocessing (EMDR). This confirmed the need for a multidisciplinary approach to treatment on the unit and emphasised that risk reduction work by psychologists and therapists needed to be complemented by the treatments available for clinical disorders.

At the time this study took place, the Westgate Unit was developing a ‘Research Strategy’ which included an increased level of networking with academics. This gave

me the opportunity to work with a psychologist employed by Teesside University which led to further prospects for me such as lecturing undergraduate and postgraduate students which was a valuable development opportunity. So, as well as exploring the research question I was interested in, this was also the start of working with academics more frequently. I was conscious that this rarely happens in HMPPS and therefore, a good opportunity to promote to colleagues. During a discussion with the psychologist from the university, I queried whether psychopathy would be more useful to explore alongside Axis I disorders but I had left the Westgate Unit prior to exploring this planned study. The dataset I generated was however later utilised to explore relationships between personality disorder and psychopathy. This study was completed by a postgraduate student and my previous co-author (Heron-Stamp & Johnson, 2017) which enabled some continuity between the two studies. The completed dissertation was subsequently shared with me and it was interesting to read that psychopathy levels were predictive of both borderline personality disorder and narcissistic personality disorder.

'Implementing evidence-based psychological substance misuse interventions in a high secure prison based personality disorder treatment service' (Bennett & Hunter, 2016) was written following a call for papers for the journal Dual Diagnosis, which intended to explore psychological interventions for co-morbid addictions and mental health problems. This was an excellent opportunity to share with a wider audience some interesting changes within substance misuse services on the Westgate Unit which were taking place at the time.

As identified in the previous publication, substance use disorder was the highest prevalence of Axis I disorder within the population, warranting the need for treatment for this within the Westgate Unit's treatment framework. Using substances can impact on whether prisoners are able to attend and meaningfully participate in treatment interventions and can therefore be a treatment-interfering behaviour. It would be unethical to facilitate intervention with someone under the influence of substances and could therefore risk progress being made by an individual. I started my career in substance misuse treatment in 2006 (as a Psychological Assistant) delivering an accredited drug-related group-based intervention with mainstream prisoners in a Category C prison. Part of my role at the Westgate Unit was to facilitate and later, treatment manage the group-based substance misuse

programme (‘Iceberg’). Iceberg was developed ‘in house’ as part of the clinical framework informed by the literature base for substance misuse treatment. Delivery methods included in the intervention were in line with the evidence-base for personality disordered offenders, meaning that it was not identical to mainstream interventions so that it could be responsive to the population. I was involved in reviewing and amending the Iceberg facilitator manual to incorporate improvements into it. During the time I was involved in substance misuse treatment, I had seen changes in national policy. When the 2010 drug strategy was introduced by the Government, it added “building recovery” to the already existing “reducing demand” and “restricting supply” aspects of the strategy. This meant peer support was introduced in order to complement psychologically informed interventions in order to incorporate the “building recovery” addition to the strategy (HM Government, 2010). The addition of recovery was based on literature that the strategy cited and included social, physical, human and cultural contributions to recovery (HM Government, 2010). Peer support would certainly be in line with the social contributions that this part of the strategy cited, in that this would be a resource an individual can call upon within a relationship with a peer mentor.

The introduction of the Recovery Model impacted on Prison Service drug treatment services and ‘SMART Recovery’ was introduced into establishments and replaced the accredited CBT-informed group work interventions. The Westgate Unit however, did not deliver mainstream accredited programmes and had to consider how they were going to adopt the changes in a standalone way for the intervention they had designed themselves. Stakeholders initially decided to continue running Iceberg at the Westgate Unit in order to complement SMART Recovery with a view to review this at a later date. I was asked to review both interventions and to identify the similarities and differences between the two. This is the point in time that Paper 3 was written (Bennett & Hunter, 2016). As indicated above, this publication was submitted in response to a call for papers in a special edition exploring co-morbid addictions and mental health problems. This was perfect timing to share this period of change within the literature-base whilst we were reviewing this provision.

I was aware of the resource impact of running two interventions on the unit. An additional factor in my mind was that a high number of our group members had been

in custody for a significant period of time prior to me commencing work with them. Due to them being in high security conditions, some found they had significantly reduced access to substances compared to the level experienced in lower security establishments. Although I was not naive enough to think that this would rule out the potential for substance-use completely, this would still limit the opportunity for accessing substances by our group-members. This meant that it was less likely for them to be required to use the skills they had learnt during intervention. Additionally, the majority of our population were serving indeterminate or life sentences and were a significant time away from being eligible for parole and for some, the opportunity of lower security prison conditions. It may have been more useful for those individuals to access drug-related interventions closer to release in order to adequately prepare them. Based on these two factors, there was an argument for them to access SMART Recovery and benefit from the peer-support aspect of this prior to (possibly) accessing other drug treatment support, if needed, on the lead up to their release. This review prompted me to make contact with other practitioners in the field of substance misuse intervention. This informed what I shared with stakeholders regarding current practice and appropriate options to inform their decision-making. A particular contact was the lead of a community-based substance misuse service, who shared current practice in community settings. This led to additional training opportunities for both the Iceberg team and the Substance Misuse Team, which was valuable.

As a consequence of the review, members of the Westgate Unit Senior Management Team decided to decommission the Iceberg intervention and continue with only SMART Recovery. Despite having delivered Iceberg for four years (and feeling invested in it), I did think it was important to move forward with new national policies – mainly as these were informed by research promoting modifications in how we treat this issue in prisons. It is also only right that psychologists' work is informed by the literature-base and I knew that this was the right way forward. It made me consider experiences I had early on in facilitating drug interventions (in a Category C establishment), where we used to facilitate visits from Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) to our group members as a 'support session' (i.e. outside of the manualised sessions). AA and NA sessions are run by ex-users themselves

and the group-members would often comment how they could identify with these ex-users and promoted more hope that ‘change is possible’. This is something that we would never be able to provide the prisoners with ourselves, and so these support sessions complemented our intervention and ultimately benefited the prisoners. This memory – although only anecdotal – reminded me of the importance of peer-support for addiction services. There is historical research exploring the impact of manualised, prison-based ‘12-step’ programmes (which were based on the principles of NA and AA), which have not been employed in prison establishments for a number of years now. There is not however, research about small scale support sessions comparable to what we offered at that establishment.

Since publication, this paper has led to networking with practitioners in other services. One example included contact instigated from a Trainee Forensic Psychologist based in a privately run service in Scotland in 2019. She had been tasked with evaluating substance misuse interventions available in the UK and abroad. This contact resulted in me discussing both interventions (and my knowledge of decommissioned mainstream interventions) with their Head of Psychology Services, who was planning the implementation of future substance misuse interventions for their service. This contributed to the intervention that was developed and implemented in that service.

‘***Personality factors related to treatment discontinuation in a high secure personality disorder treatment service’ (Bennett, 2015)*** came about after I became aware from updating our unit database that there was a high number of treatment dropouts on the unit, often related to the previously mentioned treatment interfering behaviours. Across treatment interventions in the Prison Service, facilitators and psychologists are encouraged to be responsive to prisoners in order to maximise the likelihood that they complete interventions. This is supported in the literature base by the Risk Need Responsivity model (Andrews, Bonta & Wormith, 2011) which states that intervention needs to be: matched at the appropriate level of *risk*; address the relevant treatment *needs*; and be delivered in a *responsive* way in order to maximise the likelihood of the client benefitting from the intervention. In addition to this, there was some influential research that suggested that treatment non-completers are more likely to re-offend in comparison to those who had not participated in intervention at all (McMurran & Theodosi, 2007). The authors present

potential hypotheses for these findings, including: 1) being removed from a programme by the service-provider could trigger anti-authoritarian attitudes or a lack of self-belief about the ability to change; and 2) the individual may have discussed risk-related factors and deselected before being able to learn the skills to manage these areas. It was considered that an individual could open up about areas of risk and that not equipping them with the skills to manage this could be detrimental to their risk. This understandably brought focus on treatment non-completers and highlighted the importance of maximising the likelihood of prisoners completing treatment in order to avoid their risk increasing as a result of non-completion. Aside from this, prisoner places on the Westgate Unit were significantly more expensive than in mainstream locations, and so there is also the financial consideration of treatment non-completion that would (understandably) be of interest to budget holders, stakeholders, and ministers as well as the tax-payer.

The high level of treatment dropouts was not surprising given that it was a service for individuals with complex psychopathology and a number of things could lead to treatment discontinuation (e.g. lack of motivation, threats/actual violence, having conflict with other prisoners, lack of evidence of progress). I was interested to know if there were any personality disorder or psychopathy diagnoses predictive of dropout. This would be valuable information given that that it was a personality disorder unit, and could open up further research to explore what was and was not effective with this client group. I was also conscious that the other high-security prison site (The Fens, HMP Whitemoor) operated a different (trauma-based) treatment model and future research could identify certain diagnoses to be more appropriately treated by either site. For example, borderline personality disorder is considered to be most strongly linked to childhood trauma (Herman, Perry & Van der Kolk, 1989).

When planning the study, I wondered whether borderline personality disorder would be most closely linked to treatment dropout, due to the nature of unstable emotions and potential for stormy relationships with others. I considered that such may lead to conflict with other prisoners, or reluctance to work with staff. Both could lead to disillusionment and choosing to deselect, or conflict serious enough to warrant being deselected by the service. As I included all prisoners who had been admitted to the service since it opened, there was a moderate sample size (n = 92). As with Paper 2,

there were a small number of participants in some personality diagnosis groups meaning they could not be included in the analysis. It would take a significant period of time to have sufficient numbers in these groups in order to be able to include them in the analysis, and so would continue to be a limitation for a significant number of years. These particular personality disorders would be so rare in a personality disorder treatment site (e.g. Obsessive Compulsive personality disorder) that knowing more about these disorder types would not be particularly helpful to the service given they were not likely to be located within the custodial setting, so I was not too concerned about this.

The analysis revealed that narcissistic personality disorder was most predictive of treatment dropout. I was interested in comparing this finding to the outcome of analysis with the psychopathy measure we employed on the unit (the Psychopathy Checklist Revised; PCL-R; Hare, 2003). This was because a lot of narcissistic traits are mirrored within Factor 1 of this psychopathy measure. Analysis showed that psychopathy (overall score) was not considered to be predictive of treatment dropout. Due to this, I could not conduct further analysis to explore aspects within the psychopathy scores, namely Factor 1 and Facet 1 within the PCL-R. These parts of the PCL-R specifically include narcissistic traits such as grandiosity and callousness. I found this to be interesting and unexpected and within my discussion, I made reference to these findings, and discussed that it is not so helpful to consider Antisocial and Narcissistic Personality Disorders as easily mapping over to parts of psychopathy. This is because although there are some traits in each diagnosis that are similar, this similarity is restricted to certain traits and other traits contribute alongside these to make a diagnosis. A limitation of this study was that I did not have sufficient “completers” of treatment in order to be able to compare these two groups with a logistic regression. I therefore compared treatment dropouts against a “non-dropout” group which I defined as anyone who had engaged and remained in treatment for at least two years. This led to sufficient numbers to complete the analysis, but ran the risk of some of these going on to be deselected from treatment after I had completed the research. In 2019, I went on to supervise a Trainee Psychologist who subsequently completed a similar research study exploring the impact of personality disorder on dropout (Singh, 2019). Miss Singh was able to include actual completers within her analysis given that six years had passed since

my data collection. This was therefore a great opportunity for me to see if the same results would be found when this study was conducted. Interestingly, this led to a slightly different result to my study, where no personality disorder type was considered predictive of dropout. This could be a result of the unit's approach to managing responsivity issues presented by individuals using the service (Wood, 2015). Treatment-interfering behaviours were managed through individualised 'responsivity plans' which were collaboratively developed with the prisoner. This would identify the specific behaviours that were problematic and identify ways the prisoner and staff could help to manage these. This individualised approach could identify ways to maximise the likelihood that individuals complete intervention, regardless of diagnoses.

'***Service users' initial hopes, expectations and experiences of a high security psychologically informed planned environment (PIPE)' (Bennett, 2014).***

As mentioned in the introduction, PIPE units were opened to offer progression opportunities for completers of 'high intensity' treatment who needed to generalise their skills they had learnt from treatment in a supportive and therapeutic environment. Although PIPEs are part of the Offender Personality Disorder Pathway, prisoners do not need to have a personality disorder diagnosis to be accepted onto a PIPE, which opens up the service to others who may benefit from such as service. HMP Frankland's PIPE opened in 2012. The PIPE was a small unit holding up to 20 prisoners compared to a mainstream wing of approximately 180. Similar to the units on the Westgate Unit, it is spacious and allows a lot of natural light. It is not a long 'spur' like a traditional wing, but square so that when prisoners' cell doors are opened, it promotes interaction with others as well as providing a good line of sight for staff for security reasons. The regime on the PIPE was partly comparable to mainstream wings (e.g. attendance at workshops) but also included regime activities that were new to the prisoners. This included 'creative sessions' (e.g. card making, reading group) as well as a weekly 'community meeting' where both prisoners and staff could raise issues that needed addressing on the PIPE. This was similar to the model employed in democratic Therapeutic Communities (TCs) elsewhere in the prison estate (Haigh & Pearce, 2017).

This was a rare and exciting opportunity to get involved in research in a brand new service and I hoped that my research would help to inform practice on the PIPE and beyond. My practice to that point had been informed by established literature and this was an opportunity to contribute to the literature base in line with the scientist-practitioner model by conducting a study in an applied forensic setting. There were other, Category B PIPEs in operation at that time, however this was the first Category A PIPE. I also felt enthusiastic about this as it was the first research project I had taken a lead on myself. When I was planning the research proposal for the key stakeholders, I was aware that staff were speculating that prisoners would be motivated to go to the PIPE solely in order to achieve downgrade from Category A security status. This had not been an issue for the Category B PIPE units (at HMP Hull and HMP Gartree) and so, presented a potential difference between services. Staff expected to receive referrals from prisoners who were "stuck" as Category A status for reasons such as their maintaining innocence or being considered to not have benefitted from treatment. The PIPE did not identify security downgrade as one of its aims, and clearly stated that it was not a treatment intervention and more aimed at providing an opportunity to consolidate skills from treatment. I was therefore fascinated to find out what expectations the prisoners had of the service. This led me to read about extrinsic and intrinsic motivation in the non forensic literature base and made me consider whether the prisoners' motivation was genuinely about achieving change or about achieving downgrade in security status.

In order to capture initial expectations, I interviewed prisoners in the first PIPE cohort. Most of them had been Category A security status for a number of years. Although some expressed motivation to generalise skills in order to achieve downgrade, there were other themes identified by this study. It was interesting to read the data supporting the theme of 'Being part of a community'. On reflection, these men had been in the prison system for a significant period on mainstream wings and had therefore not been part of a small, tightly-knit community or had a sense of belonging for a considerable amount of time. The difference in regime and environment (on a small, discrete unit) would have likely provided this increased sense of community.

The Clinical Lead used the findings of this study to inform staff development given that she was responsible for staff training as well as facilitating staff supervision. This

enabled her to structure her colleagues' expectations of the client group. The findings were also used within the PIPE unit's application for the Enabling Environments award which they achieved in 2013. As the Personality Disorder Pathway was expanding across the country in various settings both in prisons and in the community, I received queries from other psychologists intending to research similar areas within their own environment. One query was from a Trainee Psychologist at HMP Garth where a Category B personality disorder unit was opening. This was an interesting milestone for the Westgate Unit as it would be an alternative referral site to the Westgate Unit for Category B prisoners. We considered whether Category B referrals would be diverted to HMP Garth and whether our focus would be upon Category A referrals or inclusive of more complex Category B referrals as well. The Trainee Psychologist (Miss Hadden) contacted me about the approach I took to eliciting data within interviews and within our subsequent dialogue, she commented that she was interested (but dubious) about publication. This was a great opportunity to share my experiences and appreciation of publication and I was really thrilled to later read her study in a journal (Hadden, Thomas, Jellicoe-Jones & Marsh, 2016). Within this publication, I was cited as encouraging further research within personality disorder services. Prior to conducting the PIPE study, I had published an article (not included in this submission) about using qualitative methods with prisoners in the high security estate (Bennett, 2013). In this article, I communicated that qualitative methods can be used with individuals in high security prison conditions and can explore sensitive topics providing a depth of data that quantitative methods cannot deliver. This was based on my learning from the thesis study I undertook as part of the Masters in Research programme I completed at Northumbria University. This study explored the functions of self-harming behaviours amongst Westgate Unit prisoners (Bennett & Moss, 2013). This gave me some reassurance and confidence that I could ask prisoners who are potentially not going to get released, about progression and moving forward in their lives in a sensitive way. Given the clinical implications of this, it was important to share these reflections in the literature base and I was reminded of the importance of this learning within the PIPE research I conducted. Within the discussion, I recommended that the sample's expectations be reviewed. I felt this could aid understanding about whether prisoner expectations had been met or whether they changed over time (e.g. following their category status being reviewed, which occurs

annually for Category A prisoners). There was some interest in this proposed study from a colleague but this did not take place. I went on to present the findings of this paper at the BPS Qualitative Methods in Psychology Conference (2013) at the University of Huddersfield. Delegates I discussed the research with were researchers or academics rather than practitioners and therefore was a valuable opportunity to network outside of the practice setting and discuss things like research methods rather than practice with this client group.

Creating an Enabling Environment in High Security Prison Conditions: An Impossible Task or the Start of a Revolution? (Bennett & Tew, 2017).

Aside from treatment interventions and the complementary regime, culture is an important contributing factor to the success of the Westgate Unit. A number of strategies were introduced on the unit in order to foster a therapeutic environment that can support rehabilitation. These included the following:

The 'Conditions of Success' incorporated the following three approaches:

- Keep an open channel of communication;
- Be respectful at all times, no matter what;
- Participate constructively.

The 'Conditions of Success' were derived from approaches that had historically been implemented in mainstream interventions (Bush, Harris & Parker, 2016).

The 'Strategy of Choices' (Bush, 1995) was another tool employed on the unit to support the culture – this included:

- Someone's options and their consequences are made clear;
- They are free to make their own choice;
- We follow through on the consequences of their choice.

These aspects of the culture contributed to the Westgate Unit attaining the Enabling Environments (EE) Award in 2016. The concept of an Enabling Environment includes key features that provide a sense of a belonging for its staff and service-users through a focus upon effective relationships (Johnson & Haigh, 2011). The process and ethos of the Westgate Unit contributed to a review of practice across

the prisons comprising the then-called High Security Estate (HSE) within the Prison Service. This resulted in the HSE introducing the Rehabilitative ('Rehab') Culture strategy in 2015 and the related handbook to support its rollout (NOMS, 2015). A Rehabilitative Culture was defined as "all aspects of our culture: our ideas, behaviours and observable things, being hopeful and supportive of change, progression and desistance from offending" (NOMS, 2015, p. 9). This initiative included strategies that were already in use at the Westgate Unit such as the previously mentioned 'Strategy of Choices' and 'Conditions of Success'.

I was asked to co-author a book chapter about creating Enabling Environments in high security prisons with a colleague who I had already co-authored work with relating to the Chromis suite of interventions. This was a wonderful opportunity to utilise learning from a previous book chapter we co-authored (Tew, Bennett & Atkinson, 2015) where we shared learning regarding the treatment of psychopathic offenders. This was a valuable opportunity to utilise the learning from our previous chapter and apply to a chapter I was able to take a lead on. The call for chapters was for a book called 'Transforming Environments and Rehabilitation' and so we intended to communicate to the reader how the rehabilitative practices on the Westgate Unit contributed to practices across high security prisons. I commenced this chapter whilst working on the Westgate Unit, but during its final amendments and subsequent publication (September 2017), I had become qualified as an HCPC Registered and BPS Chartered Forensic Psychologist and was working within a 12-month secondment in the Close Supervision Centre (CSC) system which I had referred to within the chapter. The overall aim of the CSC system is "to remove the most significantly disruptive, challenging and dangerous prisoners from ordinary location, and to manage them within small and highly supervised units" (NOMS 2017, p.3). This enables assessments of risk and harm to be conducted with a view to complete intervention and identify a progression pathway back to normal location (NOMS, 2017). This job role was still within high security prisons but led me to work in other establishments with CSC units (HMP Full Sutton, HMP Wakefield and HMP Woodhill) as well as delivering training to prison officers in a national role rather than being dedicated to one establishment. This role enabled me to see in practice how the principles introduced at the Westgate Unit had been applied to the CSCs. I was able to observe in practice what I had referred to within the chapter, in that the

practices that were successful in a therapeutic milieu such as the Westgate Unit (where prisoners chose to be there and have access to a therapeutic environment) could also be implemented in a CSC (where prisoners do not choose to be there, may be under high unlock levels and need to be restrained by staff in order to prevent them being violent). These were completely different environments. The timing of this was beneficial towards the final amendments of the chapter as this was about environments across high security prisons, not just the Westgate Unit.

Discussion

The above publications capture work I completed whilst working within the OPD pathway, specifically within the high security prison setting. I have been able to complete a breadth of different types of analysis and publications within the experiences I have had as well as contributing to the literature-base. The research studies presented here increased understanding of co-morbidity between personality disorder and mental disorder, personality disorders predictive of treatment dropout and prisoners' hopes and expectations of a newly opened Category A PIPE unit. This helped to increase understanding about how the Westgate Unit's treatment framework was being received by prisoners and confirmed the importance of the treatment supportive services and responsivity planning. This was important given the resource allocated to the Westgate Unit, the ministerial and tax-payers' perception of this, and the changes that have taken place within this service since it opened in 2004. These research studies triggered further research which further explored gaps within the literature base. The other works presented within this commentary were published in order to communicate to both practitioners and academics in order to promote: work being carried out in personality disorder treatment services; changes within the service in response to changes in policy; as well as how work from personality disorder services were extended to the wider, Long Term High Security Estate (LTHSE).

I had unique opportunities within all these publications to contribute to the evolving literature-base of a specialist service that I may not have had within a mainstream prison setting. Very limited research had been conducted by the service and I was able to start to increase that. I shared some of my publications in team meetings

which was an opportunity to promote the positives of publication to colleagues. I am now a supervisor for others' research which is another avenue I have available to promote the importance of publication and sharing work external to the service. Some of these publications have also been presented at BPS conferences which promoted networking opportunities with others.

Throughout my studying and continuing professional development, I have learnt about the Scientist-practitioner model (Shapiro, 2002), which stipulates the importance of practice being informed by the literature base. The Scientist-practitioner model is however, symbiotic in that it also relies on practitioners contributing to the literature-base. Although conducting research is a required element of the qualification in forensic psychology, publishing work is not a priority for clinicians within the Prison Service. Historically, Trainee Psychologists often completed the research element of their training towards the end of their qualification, by which point, their motivation to seek publication had dwindled. New, alternative routes to qualification have been introduced and longer-term routes have been reviewed and I hope that the changes mean publications could increase in the future if supported by the organisation. The work I present within this commentary informed: 1) clinicians' practice; 2) stakeholders' decision-making about treatment provision; 3) policy development relating to an evolving service; 4) networking opportunities as well as 5) contributing to the developing literature base. The need for clinicians to be responsive to personality disordered prisoners was a key learning point from some of the works presented here. Additionally, the PIPE study findings were incorporated into the training and supervision of multidisciplinary staff and unit policies that were being written at the time of a new service. This related to the expectations that prisoners had of the service, and that there was more to their motivation than simply wanted to achieve downgrade from Category A to Category B security status. The literature base into high security prison personality disorder sites was limited, and continues to be so in comparison to personality disorder services within health services. A significant positive outcome that I did not expect to encounter was the networking opportunities I developed as a result of my work. As well as collaborating with psychologists in and out of HMPPS, I received queries from colleagues either about the content of my publications or queries about how to replicate the research within their own service. This helped me to develop further

both personally as well as professionally and helped my confidence at work to develop.

Trainee Psychologists continue to carry out studies related to the research strategy for the Westgate unit. One area of interest understandably relates to intervention. Mullan, Johnson & Tomlinson (2018) used qualitative methods to explore the Social Competence intervention. This study identified themes of ‘group cohesion’, ‘therapeutic alliance’ and ‘conflict of skill acquisition and application’. These findings are helpful for practitioners in terms of managing responsivity needs and promoting skills application. Further (unpublished) research has explored interventions using psychometric data. These studies were impacted upon by the COVID-19 pandemic, a time where research within HMPPS was initially halted and subject to restrictions when re-introduced. These studies explored the Social Competence intervention (Jennings, 2020), the Considering Change intervention (Riley, 2020) and DBT (Dunbar, 2021) using pre and post psychometric tests. Partial improvements were found within some social skills treatment need areas, no reliable change within emotional state psychometrics and no reliable change in treatment readiness as a result of these treatment interventions. A key limitation was the extremely small sample sizes.

Qualitative research at the Westgate Unit has explored collaborative formulation using interview transcripts, finding evidence to suggest that this approach developed insight and understanding into areas of risk as well as future motivation. This was in addition to having a positive impact on therapeutic alliance between staff and prisoners (Najah, 2020). A larger-scale study with progression data found that completers of the Westgate Unit treatment framework were more likely to progress to lower security settings in comparison to deselections (Wood, 2020). The implication of this was that treatment completion was considered to have a positive impact on later cost effectiveness of custody for these individuals, which is an understandable area of interest for commissioners.

Within the Prison Service, producing research and publications is not a priority for psychologists and priorities relate more to directed reports (e.g. by the Parole Board and therefore a legal requirement) and treatment completions for interventions. I consider it important for Prison Service practitioners to both increase their

contributions to the literature base as well as collaborating more with universities. This would contribute to bottom-up developments in the field and ensure that top-down directives are informed by the literature base. Additionally, the move to the national OPD pathway led to a national evaluation approach. The National Evaluation of Offender Personality Disorder Pathway (NEON) was commissioned by HMPPS and NHS England. The purpose of this was to explore the impact and cost-effectiveness of the OPD pathway by using data from services and other criminal justice databases accessed by HMPPS and health services staff (Offender Personality Disorder Programme, 2014). This research is due to be published in 2022 and will be the first large scale evaluation of the OPD pathway. This is likely to have an impact on the direction of OPD services and future research.

I am currently promoting the research culture within HMPPS as part of a group of psychologists in a research group in high security prisons. This is a relatively new group which enables me to review HMPPS research applications and act within a forum of like-minded psychologists. We share research and developments in the field in our respective departments. Those of us with or working towards research doctorates have written about our experiences which we will share more widely within HMPPS. Within my role as a reviewer for the Forensic Update (a publication of the BPS's Division of Forensic Psychology), I recently suggested running featured articles from individuals who have completed specific routes to qualification and individuals who have completed research qualifications. This was agreed by the editorial team and I have pursued articles for this themed feature. Promoting further research qualifications to practitioners in the field and alternatives to a traditional PhD (such as the 'top up' doctorate, developed for qualified practitioners and the PhD via Publication) is a great opportunity to highlight how we can bridge the gap between academia and practice within the field. I am collaborating with Dr Jenny Tew again in response to a recent call for chapters communicating the role of 'Pracademics' (individuals who are both practitioners and academics in criminal justice settings). Our chapter will focus upon the work carried out in the high security prison estate that have contributed towards doctoral level qualifications within this applied setting. This will be the first chapter that I have taken a lead on, which is a new challenge I am looking forward to.

On reflection of the work presented here, I have been inspired to maximise opportunities to publish work due to the people I have worked with in practice (within HMPPS) and within academia (whilst completing my Masters and subsequent collaborative opportunities). I hear colleagues reporting low confidence in conducting research and therefore feeling that their work would not be of value. Additionally, after completing a qualification over a long period of time they express a lower motivation to publish work. This is something I feel is important to redress within my supervisory work and have achieved with a colleague whereby she has submitted a manuscript for consideration by a journal. I hope that this approach will have a ripple effect with colleagues and other practitioners; with a view to promote that academia and practice need to co-exist and co-work in order to make the most out of both of our worlds.

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List of Appendices

DECLARATION OF CO-AUTHORSHIP OF PUBLISHED WORK

(Please use one form per co-author per publication)

Section A

Name of candidate: **Miss Alice Bennett**

Name of co-author: **Dr Darren Johnson**

Email address of co-author: **Darren.Johnson3@newcastle.ac.uk**

Full bibliographical details of the publication (*including authors*)**:**

Bennett, A., & Johnson, D. (2017). Co-morbidity of personality disorder and clinical syndrome in high-risk incarcerated offenders. *Journal of Forensic Practice,* 19(3), 207-216.

Section B

DECLARATION BY CANDIDATE (*delete as appropriate*)

I declare that my contribution to the above publication was as:

(i) principal author

My specific contribution to the publication was (*maximum 50 words*):

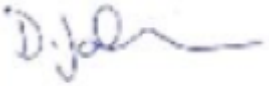
I completed the research study (literature review, ethics application, data collation, data analysis and write up/submission). Darren Johnson supervised this work throughout the duration of the study.

Signed:  (candidate) **08/12/2020** (date)

Section C

STATEMENT BY CO-AUTHOR (*delete as appropriate*)

Either **(i) I agree with the above declaration by the candidate**

Signed:  (co-author) **09.12.2020** (date)

northumbria UNIVERSITY NEWCASTLE

Northumbria University NEWCASTLE

northumbria UNIVERSITY NEWCASTLE

DECLARATION OF CO-AUTHORSHIP OF PUBLISHED WORK

(Please use one form per co-author per publication)

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Name of candidate: **Miss Alice Bennett**

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Email address of co-author: **melanie.gd.hunter@btinternet.com**

Full bibliographical details of the publication (*including authors*)**:**

Bennett, A., & Hunter, M. (2016). Implementing evidence-based psychological substance misuse interventions in a high secure prison based personality disorder treatment service. *Advances in Dual Diagnosis*, *9*(2/3), 108-116.

Section B

DECLARATION BY CANDIDATE (*delete as appropriate*)

I declare that my contribution to the above publication was as:

(i) principal author

(ii) joint author

(iii) minor contributing author

My specific contribution to the publication was (*maximum 50 words*):

I reviewed the literature base, consulted with colleagues in our Substance Misuse Team and Drug and Alcohol Recovery Team. I was Treatment Manager of the Iceberg programme and had amended the Iceberg facilitator delivery manual. These experiences enabled me to write the article. Melanie Hunter supervised the process throughout and the subsequent drafts.

Signed: A Bennett (candidate) 09/12/2020 (date)

Section C

STATEMENT BY CO-AUTHOR (*delete as appropriate*)

Either **(i)** **I agree with the above declaration by the candidate**

or **(ii)** ~~**I do not agree with the above declaration by the candidate for the following reason(s):**~~

Signed: M. Hunter (co-author) 2-1-2021 (date)

DECLARATION OF CO-AUTHORSHIP OF PUBLISHED WORK

(Please use one form per co-author per publication)

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Name of candidate: **Alice Bennett**

Name of co-author: **Dr Jenny Tew**

Email address of co-author: **jenny.tew@justice.gov.uk**

Full bibliographical details of the publication (*including authors*)**:**

Bennett, A.L. & Tew, J. (2017). Creating an Enabling Environment in High Security Prison Conditions: An Impossible Task or the Start of a Revolution? In: Transforming Environments and Rehabilitation: A Guide for Practitioners in Forensic Settings and Criminal Justice, 14, Eds: G. Akerman, A. Needs & C. Bainbridge. Taylor & Francis: London.

Section B

DECLARATION BY CANDIDATE (*delete as appropriate*)

I declare that my contribution to the above publication was as:

(i) principal author

(ii) joint author

(iii) minor contributing author

My specific contribution to the publication was (*maximum 50 words*):

I contributed information about the Westgate Unit (as I was employed there at that time) and Dr Tew contributed information about the wider High Security Estate (HSE) within the Prison Service (as she was in a national role across the estate at that time).

Signed:  (candidate) 29/12/2020 (date)

Section C

STATEMENT BY CO-AUTHOR (*delete as appropriate*)

Either **(i) I agree with the above declaration by the candidate**

Signed: .....  **.....**(co-author) **.....6/1/21 .....** (date)

The Westgate Service and Related Referral, Assessment, and Treatment Processes

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Alice L. Bennett[1]

Abstract

The formerly named "Dangerous and Severe Personality Disorder" (DSPD) units are no longer standalone services within the criminal justice system in England and Wales. These sites now provide personality disorder treatment services in the high-security prison estate as part of the new national Offender Personality Disorder (OPD) Pathway Strategy. The OPD Pathway intends to take responsibility for the assessment, treatment, and management of offenders who are likely to have a personality disorder and who present a high risk of re-offending (men and women) and serious harm to others (men). Further PD treatment and progression services are being commissioned in lower security prisons and in the community as part of the new PD Strategy. While the suitability criteria for the two male high-security PD treatment sites are the same, the individual units have their own assessment and treatment methods. This article aims to communicate the referral, assessment, and treatment methods employed within the prison-based Westgate Personality Disorder Treatment Service, HMP Frankland.

Keywords

personality disorder, psychopathy, assessment, treatment

The Treatment of Personality Disorder and Psychopathy

Effectively treating personality disordered offenders is challenging. Service providers are tasked with developing service-users' skills to appropriately manage dysfunctional aspects of their personality whilst targeting dynamic criminogenic needs that contribute to offending behaviour (Howells, Krishnan, & Daffern, 2007). A major barrier to

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achieving this aim is that high-risk personality disordered offenders have a propensity for low treatment "readiness." This can be due to low motivation to engage within therapy, resistance toward treatment (Howells & Day, 2007), mistrust of others, paranoia, and dominant interpersonal styles (Sheldon & Tennant, 2011). These factors have led to this population being considered "untreatable" due to their historical behaviour leading to either (a) them not being offered mainstream offending behaviour programmes on the basis that they were considered unable to benefit, (b) treatment failing to result in clinically meaningful change, or (c) inability to fully engage with treatment and/or attrition (Howells & Tennant, 2010).

The literature base relating to "what works" within this population is still developing meaning that it is still unknown as to which specific treatments are effective (Vollm & Konappa, 2012). Given that it will take time for treatment completers to be released into the community for a sufficient amount of time to evaluate the impact of treatment, it is currently difficult to identify which treatment processes can significantly impact upon recidivism rates. Despite the challenges of treating this population, the surrounding literature of "what works" with high-risk offenders with personality disorders is developing. The literature suggests that an "eclectic array" of treatment delivered in an integrated, systematic, coordinated way to provide a structure of generic therapy supported by specific interventions intended to target specific problems. Using phased treatment enables the focus of that treatment to change systematically through such a model (Livesley, 2007). Livesley's proposed structure has been incorporated into the treatment of psychopathic offenders (Wong, Gordon, Gu, Lewis, & Olver, 2012). This study presents treatment for psychopathic offenders comprising two components targeting interpersonal factors and criminogenic factors, reflecting Factor 1 and Factor 2 traits assessed with Hare's Psychopathy Checklist–Revised (PCL-R). Findings from this study provide evidence to suggest that this model provided positive treatment outcomes, supporting the notion of treatment efficacy for this population. Skeem, Polaschek, Patrick, & Lilienfel (2012) discuss what psychopathy is, its development, impact upon offending, and treatment outcomes. This review provides evidence to suggest that criminal behaviour can reduce as a result of treatment that adheres to the risk, need, and responsivity principle. In other words, appropriate treatment is intense to suitably match this high-risk population, targets criminogenic need, and is delivered in a format that maximises treatment engagement (Skeem et al., 2012).

Dangerous and Severe Personality Disorder (DSPD) Services

DSPD services were developed in England and Wales as a result of the Government taking responsibility for high-risk offenders previously considered to be untreatable and posing a high risk to the public. Four DSPD treatment units (two within high secure prisons and two within high-security hospitals) were subsequently developed with the intentions to target the following outcomes (Dangerous and Severe Personality Disorder Programme, 2008):

- Improved public protection,
- Provision of new treatment services improving mental health outcomes and reducing risk, and
- Better understanding of what works in the treatment and management of those who meet the DSPD criteria.

There have been a number of changes and restructuring to this service since the completion of its pilot phase (Department of Health & National Offender Management Service Offender Personality Disorder Team, 2011) and the introduction of the Offender Personality Disorder Pathway (Joseph & Benefield, 2012). This has included the decommissioning of DSPD services in hospital settings. In addition, "DSPD" is now redundant as a title. It has never been considered to be a clinical diagnosis and the negative connotations attached to the labelling of "dangerousness" were felt to be counterproductive to the service aims. This led to Westgate no longer being referred to as a DSPD unit and more appropriately being referred to as a Personality Disorder Treatment Service.

The Development of the Westgate Personality Disorder Treatment Service and Its Multidisciplinary Staff Team

The Westgate Service opened in 2004 and is a purpose built treatment unit located within HMP Frankland, Durham. HMP Frankland is one of eight establishments within the high secure estate located within the H.M. Prison Service in England and Wales. The Westgate Service provides a non-collusive regime (i.e., both violent and sexual offenders reside on the same unit). HMP Frankland was selected over other establishments as it had space to build a standalone unit large enough to house 80 prisoners. An expert advisory group (made up of forensic psychologists and psychiatrists) was consulted throughout the planning stages of the Westgate Service's treatment framework. Developers faced initial clinical opposition for a range of reasons. This was the first time that a treatment service of this kind had been developed in the United Kingdom after other services developed abroad were considered to have been unsuccessful. Given the infancy of the literature base regarding the treatment of personality disordered offenders, contrasting schools of thought were held both within the advisory group and between the advisory group and service developers. This required the Westgate Service's developers to present their evidence-based proposed model of treatment (including supporting theory based in Cognitive Behavioural Therapy [CBT] and Dialectical Behavioural Therapy [DBT]) to those allocating the service's funding.

A number of challenges were faced by the team of staff implementing the Westgate Treatment Service. Initially, operational pressures were experienced with initial low levels of occupancy. Despite the staff to prisoner ratio being high at this time, staff were tasked with developing treatment components and processes on the unit. Other historical and future challenges within referral, assessment, and treatment processes are detailed within relevant sections throughout the remainder of this article.

Treatment is supported by a structured regime comprising education, horticulture, and physical education sessions. The rationale for providing a varied regime that complements therapy are as follows: a varied regime would limit boredom susceptibility (a feature within psychopathy), audit requirements limiting treatment dosage, and the need to complement formal treatment (i.e., allowing opportunities to practice skills and explore learning within other environments). This mixed regime is delivered within an ethos based on the Good Lives Model (Ward & Brown, 2004), the Conditions of Success and Strategy of Choices. Prisoners are asked to adhere to the Conditions of Success during their time on the Westgate Service which is a strategy used as a way of setting expectations and boundaries to encourage meaningful engagement across the regime. The Conditions of Success are to constructively participate within the regime, two-way communication, and to be respectful at all times. The Strategy of Choices intends to encourage offenders to consider treatment as an "enhancement" as opposed to a "restriction" on their autonomy by using their need for "control and choice as a way of promoting self-responsibility and self-management." Potential participants are asked to choose to accept the conditions or choose not to participate (Harris, Attrill, & Bush, 2005).

Multidisciplinary working is at the heart of Westgate's regime meaning that assessment/treatment teams include psychologists, prison officers, nurses, therapists, and physical education instructors. A significant amount of resources were invested in the staff and training models employed at the Westgate Service. This was to ensure that appropriately skilled and trained staff were employed to develop and run the service in the most appropriate way. As well as expressions of interest being considered, potential staff are interviewed to ascertain whether the Westgate Service is an appropriate working environment. Westgate employees are expected to become involved with clinical work on the unit, with opportunities provided within all aspects of the service (referrals, assessment, treatment, and treatment supporting services). The unit's assessment and treatment processes are presented in Figure 1. An "Assessment and Development Centre" was developed for new staff to complete assessing skills through exercises in group work, report writing, communication, and during a semi-structured interview. This is how management identify appropriate staff to work with this challenging population as well as their individual areas of strength and development. This information informs recommendations regarding appropriate aspects of the clinical framework that staff can have the opportunity to become involved in. All staff are subsequently trained to work with this population either within treatment or the wider regime (such as within referrals, assessments, or supporting services on the unit). Training offered by the Westgate Service includes "Working With Psychopathic Offenders," "Conditioning and Manipulation Training," "Personality Disorder Awareness," "Attachment Styles Awareness," "Westgate Service/Chromis Treatment Awareness," and "Group Processes Awareness". Communication and information sharing is of paramount importance and encouraged by the recording of information within prisoners' electronic case note entries and multidisciplinary attendance at staff briefings (which occur three times a day).

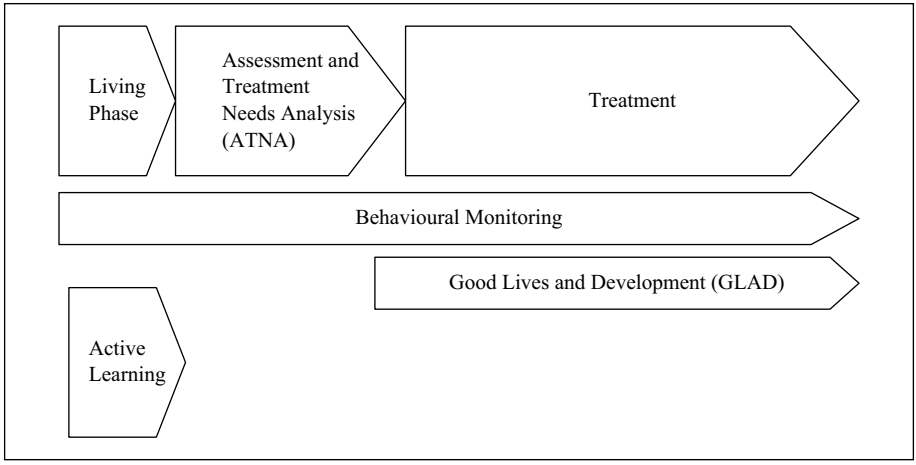

Figure 1. The Westgate service's assessment and treatment processes.

The Westgate Service is currently undergoing assessment for status as an "Enabling Environment", an award overseen by the Royal College of Psychiatrists. This initiative identifies key elements in a setting that can establish "a sense of connected belonging" (Johnson & Haigh, 2011) and involves 10 standards (belonging, boundaries, communication, development, involvement, safety, structure, empowerment, leadership, and openness).

Referral Process

The Westgate Service considers referrals from staff, typically Offender Supervisors; prisoners who wish to self refer are directed to do so through their Offender Supervisor. When the Westgate Service first opened, a number of unsuitable referrals were received, possibly due to the service being seen as a transfer option for prisoners residing in Segregation Units or displaying challenging/violent behaviour within custody. Referrals staff limited this issue through processes both internal and external to Westgate. Externally (as funding allowed at the time), Westgate staff promoted the unit and its services by conducting outreach work with both staff and prisoners across the prison estate. This provided awareness of this population to prison staff and informed them how to appropriately refer potential referrals. Internally, a referrals process was developed to ascertain suitability for admission. A standardised referral form is completed by the referrer and sent to the Westgate Service's multidisciplinary referral team and used as part of the screening process. This helps to help ascertain offence-related risk; the likely presence of personality disorder and psychopathy, and ultimately indications regarding the suitability of Westgate's treatment framework for the individual concerned. Sources of information can include: offending history, treatment reports, risk assessments, assessments of intelligence, security information,

adjudications, and behavioural observations. This information is reviewed at a monthly multidisciplinary referral panel where the decision is made whether to accept or reject referrals (or seek additional evidence if required). In addition to the above information, the panel take into consideration the offender's stage in sentence, tariff length, treatment compliance, motivation, and relevant security information. The referrals process intends to limit the number of receptions for whom Westgate is unlikely to meet their needs. With this, decisions made by the panel take into account the importance of offering appropriate services to individuals, the limited places available on the Westgate Unit, and the cost-effectiveness of the service.

The introduction of the Offender PD Pathway (Joseph & Benefield, 2012) led to part of the Westgate Unit to be re-rolled into a Category A Psychologically Informed Planned Environment (PIPE) in 2012, reducing the Westgate Service's capacity to 65. The Offender PD Pathway also increased treatment options for offenders likely to be diagnosed with a personality disorder which will impact on the referrals received by the Westgate Service. It is anticipated that offenders monitored under the Managing Challenging Behaviour Strategy (MCBS); and located within Closed Supervision Centres (CSCs); Category A establishments; and Segregation Units will become an increased source of referrals for the Westgate Service. This is due to the Westgate Service being appropriately placed to provide treatment services for high-risk offenders. This is anticipated to change the future population residing on the Westgate Service, including prisoners with longer tariffs.

Given the reduced levels of resources within the Prison Service, the Referrals Department has faced a number of challenges in encouraging the levels and suitability of referrals. Reduced funding has meant that outreach work carried out by Westgate staff has decreased. This includes work appropriately advertising the service, motivational work, and the administration of personality disorder assessment tools. This means that the referrals to the Westgate Service have required an increased level of information from the referring establishment including requests for the referring establishment to administer personality disorder assessments where possible. This has impacted on referrals received to the Westgate Service in two ways. First, referring establishments can become deterred from making referrals due to the increased work involved. Second, referrals with limited information require follow-up work from Westgate staff, resulting in offenders staying in the referral process for a longer period of time. To account for this, the Westgate Service has commenced joint referral panels run in collaboration with CSC sites with the intention of most appropriately identifying potential admissions.

The "Living" Phase

On arrival, prisoners commence the "living" phase on the Westgate Service and a unit induction is completed (similar to other prison establishments). The following "living" phase focuses on participation in what is referred to as the "complementary regime" and acts as a period of adjustment for the prisoner. The "complementary regime" comprises of non-treatment activities (e.g., education, horticulture, physical education).

The rationale behind this aspect of the regime is to develop prisoners' life skills by encouraging personal development, interpersonal skills, and engagement in a structured regime as well as provide purposeful activity across a range of domains. The "living" phase is a valuable opportunity for prisoners to develop working relationships with staff. This is with the aim of increasing sources of support for prisoners to maximise meaningful engagement within assessment and treatment processes. During the prisoner's induction (completed within 5 working days of him arriving on the unit), he meets his allocated clinical case manager. This is a clinician (either a Forensic Psychologist in Training or a Therapist) who is the prisoner's first point of contact should he have queries regarding the clinical framework. Clinical case managers complete reports for the parole or Category A board process and are consistently invited to attend any reviews and case conference related to the prisoner.

Behavioural Monitoring

From the "living" phase onwards, staff observations are integral to assessment and treatment processes on the Westgate Service. Observations in all areas of the regime can provide evidence of the presence/absence of personality traits (relevant to assessment) and the presence/absence of skills generalisation (relevant to treatment). On arrival to the Westgate Service, an individualised Key Indicator Profile (KIP) sheet is developed for the prisoner, including problematic behaviours that he has historically displayed. This is completed by members of the referrals team as they have transferable skills in identifying relevant problematic risk and personality-related observations from collating information in preparation for referral panels. The KIP sheet is available to all Westgate staff, which they reference when recording case note entries (should such behaviours be observed). Behavioural Monitoring contributes to the "observation" part of the triangulated approach towards assessment that is used on the Westgate Service. Measures are taken to limit the amount of discordant and subjective information recorded within staff observations. Staff training has been implemented to maximise objectivity within observations. In addition, Supervising Officers are responsible for weekly monitoring of the quality of case notes recorded by staff.

Assessment and Treatment Needs Analysis (ATNA)

The assessment process has been refined during the time that the Westgate Service has been running. To limit repetition, assessment teams use a "combined interview" schedule alongside the International Personality Disorder Examination (IPDE) interview. This elicits information required to administer the PCL-R and risk assessments utilised by the unit. This has reduced the assessment period used at Westgate. The detailed assessment of suitability for the unit starts after the "living" phase and is referred to as the ATNA. There are two aims of the ATNA process. These are (a) to assess for suitability for the Westgate Service and (b) identify relevant treatment needs. These are achieved within one merged process. This leads to a more efficient way of working, ensuring that a full and comprehensive risk assessment and treatment need analysis is

communicated to future treatment teams (either at the Westgate Service or at another establishment if the prisoner does not meet criteria). The criteria for the Westgate Service comprises of the following three factors (Dangerous and Severe Personality Disorder Programme, 2008):

- A significant/high risk of re-offending;
- The presence of a "severe" personality disorder (evidenced by either: a PCL-R score of 30 [95.8th percentile] and above; a PCL-R score of between 25 and 29 [85.2th-94.4th percentile] combined with at least one PD other than antisocial PD; or two or more PDs [regardless of the PCL-R score]); and
- The presence of a "functional link" between the disorder and the risk of re-offending.

Risk of violent recidivism is assessed with the Historical, Clinical, Risk Management - 20 (HCR-20): Assessing Risk of Violence (Webster, Douglas, Eaves, & Hart, 1997) and Violence Risk Scale (VRS; Wong & Gordon, 2000). Risk of sexual recidivism is assessed with the Violence Risk Scale: Sex Offender Version (VRS-SO; Wong, Olver, Nicholaichuk, & Gordon, 2003), Static 99 (Nunes, Firestone, Bradford, Greenberg, & Broom, 2002), and Risk Matrix 2000 (Thornton et al., 2003). Personality disorder is assessed using the IPDE (World Health Organization [WHO], 1997) and the PCL-R (Hare, 2003). The PCL-R is not used as a tool to assess risk. Treatment starters are subsequently "severely" personality disordered or psychopathic, and by default tend to have pervasive and persistent offending behaviour and therefore considered to be chronic or "life course persistent" offenders (Moffitt, 1993). Despite the above criteria identifying a specific population, there can be differences within this population. For example, the ATNA process can identify individuals suitable for the Westgate Service that are high scoring psychopaths but without personality disorders outside of the diagnosis of antisocial personality disorder. Conversely, suitable individuals can be severely personality disordered but not have excessively high levels of psychopathy. Personality disorder diagnoses and descriptions (according to the *Diagnostic and Statistical Manual* of *Mental Disorders* (4th ed., *DSM-IV*; American Psychiatric Association, 1994) are provided within Table 1 below, divided into three clusters.

The treatment needs analysis aspect of ATNA is derived on a narrative case formulation, resulting in the identification of motivators, destabilisers and disinhibitors for up to three significant offences within the prisoner's convictions. The rationale for using case formulation within the ATNA process is in line with the current literature base. This suggests that case formulation is increasingly being used with the personality disordered forensic population to provide understanding about the client's functioning and shape understanding of why offences were committed (Jones, 2010). Varying models of case formation are discussed within the literature with "situation level formulation" (Jones, 2010) being the format implemented within ATNA by conducting between one and three case formulations focusing on specific offences (including the index offence).

Table 1. Personality Disorder Diagnoses.

Cluster A (odd/eccentric)	Cluster B (dramatic/erratic)	Cluster C (anxious/fearful)
Paranoid Distrusting and suspicious interpretation of the motives of others	Antisocial Disregard for and violation of the rights of others	Avoidant Socially inhibited feelings of inadequacy, hypersensitivity to negative evaluation
Schizoid Social detachment and restricted emotional expression	Borderline Unstable relationships, self-image, affects and impulsivity	Dependant Submissive behaviour, need to be taken care of
Schizotypal Social discomfort, cognitive distortions, behavioural eccentricities	Histrionic Excessive emotionality and attention seeking	Obsessive-compulsive Preoccupation with orderliness, perfectionism, and control
	Narcissistic Grandiosity, need for admiration, lack of empathy	

The case formulation process provides insight into the functional link between identified personality disorder traits and risk. The "functional link" has previously been criticised for not being sufficiently defined within the developing literature base relating to personality disorder assessment. Suggestions have included that the functional link is (a) a "causal connection" that exists between the severity of the personality disorder, resulting in an increased risk of violence or (b) the covariation between the personality disorder and dangerousness (Duggan & Howard, 2009). The new Offender Personality Disorder Pathway requires "a clinically justifiable link between the personality disorder and the risk" (Joseph & Benefield, 2012; p. 213). Understanding of the functional link between personality disorder and risk informs subsequent treatment recommendations. Identified criminogenic treatment needs are consequently grouped into the domains of self-management, social and interpersonal, and offence interests/thinking processes. The evidence used to inform a prisoner's suitability is accrued by a triangulated approach including prisoner self-report and responses to psychometric tests, collateral, and staff observations (including Behavioural Monitoring). This ensures that a thorough review of available evidence is conducted, increasing the reliability and defensibility of the assessment process.

Psychopathy and personality disorder traits can manifest themselves in the form of treatment interfering behaviours which can impact upon treatment readiness and engagement (Howells & Tennant, 2010). The complexity of psychopathy and its comorbidity with mental disorder and criminogenic need means that psychopathic offenders are difficult to motivate and engage within treatment. This results in disruptive behaviour being observed regularly within this population (Hemphill & Hart, 2002). Psychopathic offenders are also less likely than non-psychopathic offenders to remain in treatment (Hemphill & Hart, 2002) indicating that this issue extends further than merely encouraging this population to commence treatment. The Westgate Service refers to these treatment interfering behaviours as "Responsivity Issues" (McGuire, 2001). Responsivity issues act as barriers to either physical attendance or

Table 2. Example Responsivity Issues and Associated Personality Traits.

Responsivity issue	Impact on engagement	Associated personality traits (from IPDE or PCL-R)
Self-harming behaviour	Limited attendance due to seeking medical treatment	Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour (Borderline PD)
Mistrust of others	Limited disclosures within sessions	Doubts about the loyalty or trustworthiness of others frequently expects, without sufficient basis, to be exploited, harmed, or deceived by others (Paranoid PD)
Boredom susceptibility	Limited attention within sessions	Prone to boredom (PCL-R)
Belief that treatment is beneath them	Superficial engagement in treatment	Grandiose sense of self-worth (PCL-R) Believes that he or she is "special" and unique and can only be understood by special or high-status people (Narcissistic PD)
Refusal to take responsibility for offending/changing future behaviour	Lack of skills generalisation, blaming others	Failure to accept responsibility (PCL-R)

Note. IPDE = international personality disorder examination; PCL-R = Psychopathy Checklist–Revised; PD = personality disorder.

meaningful engagement in treatment. Responsivity issues encountered with this population can be linked to emotional dysregulation, interpersonal problems, unhelpful thinking styles, attachment problems, impulsivity and sensation seeking, and symptoms of trauma. The previously described heterogeneity of this population emphasise the importance of managing responsivity within this population. Examples of responsivity issues linked to personality disorder and psychopathy traits experienced with this population are presented in Table 2.

ATNA identifies relevant responsivity issues as well as methods that the prisoner and future staff can use to manage these behaviours with the intention of maximising treatment engagement. This information informs an individualised Responsivity Plan which is reviewed and amended (as required) during the prisoner's progress through the treatment framework (Wood, in press). For some significant responsivity issues (e.g., significant self-harm or experience of trauma), a referral can be made to the Imminent Needs Service (described below).

Within the Westgate Service's wider regime, multidisciplinary case conferences are held on a monthly basis and can be requested on an ad hoc basis if required. This is a

minuted forum where formal decision-making regarding prisoners' engagement and management are made. Prisoners are usually raised at case conference to discuss assessment outcomes and recommendations, applications to leave the unit as well as management/clinical concerns impacting on engagement with treatment or the wider regime. The Westgate Service does not use a specific clinical tool to assess motivation to engage within clinical processes on the unit. Instead, any concerns about decreased motivation (at any time) trigger inclusion within a case conference where concerns and management strategies are discussed.

The Westgate Population

Considering all prisoners that have met the above suitability criteria and commenced treatment (between May 2004 and January 2014), the following breakdown of personality disorder and risk assessments represent this sample (n = 118). The average total PCL-R (Hare, 2003) score was 29.73 (range = 14.70-40.00; SD = 11.67). The average HCR-20 (Douglas & Webster, 1999) score was 31.68 (range = 23-40; SD = 11.30). The average number of definite PD diagnoses (as assessed by the IPDE; WHO, 1997) was 1.89 (with 29.55% being diagnosed with one PD, 40.91% diagnosed with 2 PDs, 18.18% diagnosed with 3 PDs, and 7.95% diagnosed with 4 PDs).

Good Lives and Development (GLAD)

GLAD is a scheme based on the Good Lives Model (Ward & Brown, 2004) and runs alongside treatment on the Westgate Service. The Good Lives Model suggests that individuals universally desire the same primary "human goods" attained via individually chosen methods (referred to as secondary goods). The GLAD scheme intends to encourage participants to set and achieve relevant treatment-related targets to promote the use of socially acceptable secondary goods. This scheme has historically been coordinated by Prison Officers working alongside clinical staff to identify personally relevant treatment-related targets. The GLAD scheme is currently being reviewed (following changes in staffing levels on the unit) with the intention of re-rolling a revised system. The aims of the system will remain the same but it is anticipated that the format that it will follow will alter to adapt with organisational changes. Historically, when a prisoner commenced treatment on the Westgate Service, an initial GLAD plan was developed. The GLAD plan detailed relevant treatment-related targets including skills the prisoner could generalise to achieve these goals. Similar to Behavioural Monitoring sheets, all staff had access to GLAD plans, enabling them to make reference to skills they have observed when recording case notes. GLAD plans were reviewed quarterly and targets reviewed and refined as a result of the prisoner's ability to generalise relevant skills.

A clinician and an appointed programmes manager have consulted prisoners residing at the Westgate Service to identify appropriate solutions to revise the system whilst incorporating service-user involvement. These contributions intend to maximise willingness to engage in the finalised process as well as encourage prisoners to contribute

Table 3. The Westgate Service's Treatment Framework.

Motivation and engagement	Psycho-education domain	Self-management domain	Social and interpersonal domain	Offence interests/ thinking processes	Progression domain
Chromis Motivation and Engagement	Psycho-Education	Iceberg (Substance Misuse) Emotion Modulation Chromis Creative Thinking Chromis Problem Solving Chromis Handling Conflict	Social Competence Relationship and Intimacy Skills	Chromis Schema Therapy Healthy Sex Programme	Progression and Maintenance Programme

to and take responsibility for aspects of their environment, in line with the Enabling Environments standards (Johnson & Haigh, 2011). The new system intends to have consistent intentions with the initial system but intends to adapt to staffing alterations in the service and respond to prisoners' suggestions for the system.

Treatment

If an offender meets criteria and Westgate is considered to be the most appropriate treatment option, it will be recommended that he remains on the unit to commence his individual treatment pathway. The Westgate Service offers a treatment framework (see Table 3) and associated supporting services. There has historically been call for the treatment providers of specific forensic populations (including psychopathic offenders) to prioritise the development of treatment components to effectively reduce offending within these populations (Polascheck, 2012). The Westgate Service treatment framework takes into consideration psychopathic and personality disorder traits, resulting in subtle differences when compared with mainstream prison treatment. Treatment groups are smaller (approximately five prisoners), sessions are shorter (1 hr), and supporting services and imminent need services encourage meaningful treatment engagement. The majority of formal treatment is based on the Risk Need Responsivity (RNR) model (Andrews & Bonta, 2010), incorporating multimodal, skills-based, cognitive behavioural methods. Treatment takes a mixed format of both group and individual sessions. Some treatment components form part of the Chromis programme (as presented by Tew & Atkinson, 2013), which is designed to reduce the risk of violence in psychopathic offenders. The Westgate Service was being planned and developed at the same time as the national Offending Behaviour Programme Unit was commissioning the development of a cognitive behavioural treatment programme targeting psychopathic offenders. Subsequent co-working between Chromis developers and Westgate Service developers resulted in the subsequent Chromis components. Chromis components were developed alongside other aspects of the Westgate Service, ensuring they were complimented within the finalised treatment framework. This

explains why aspects of Chromis are mirrored within other areas of the Westgate Service. The Chromis programme was accredited by the Correctional Services Accreditation Panel (now known as Correctional Services Accreditation and Advice Panel [CSAAP]) in 2005. Chromis was initially meant to be run in three of the four original DSPD sites but was only introduced at the Westgate Service (Burns et al., 2011). Other treatment components have been developed and adapted by Westgate clinicians. The length of time in treatment varies across participants and is dependent on individual treatment need requirements and responsivity issues. Westgate's treatment framework is delivered by multidisciplinary staff teams and although psychologically driven, is not solely facilitated by psychologists. This was an important factor within Westgate's treatment model and has proven to be successful in developing staff/prisoner relationships as well as developing a highly skilled pool of staff. This pool of staff includes discipline officers regarded as skilled facilitators and treatment managers.

The literature base recognises that the sequencing of the treatment of offenders should be considered within responsivity, particularly as "one size does not fit all" (Stephenson, Harkins, & Woodhams, 2013, p. 450). This literature also highlights the importance of motivational work being completed at the outset of treatment to maximise subsequent treatment engagement. The above treatment framework is not strictly completed in the above order but the treatment pathway has some sequencing requirements. The non-risk focused Chromis Motivation and Engagement and Psychoeducation components are consistently completed at the start of prisoners' treatment pathways as they act as foundations for subsequent risk-focused treatment. This is to motivate prisoners to meaningfully engage in treatment, to educate them about their personality traits and risk, increase awareness of appropriate boundaries and structure their expectations about the Westgate Service's treatment framework. Following this, the appropriate sequence for treatment is established, according to individual need with the Progression Domain always ending individual treatment pathways. Members of the Clinical Management Team meet on a monthly basis to plot and review profiled assessment and treatment for the Westgate Service. This process allocates both prisoners and staff teams/leads to aspects of the clinical framework. Factors taken into consideration are staff availability/training as well as group dynamics and recommendations regarding the sequencing of the prisoner's treatment pathway (from the prisoner's assessment team or clinical case manager).

Chromis Motivation and Engagement

Chromis Motivation and Engagement is delivered individually and aims to motivate prisoners to constructively engage in treatment and the wider regime provided by the Westgate Service. This is the rationale for why this component is completed early on in prisoners' treatment pathways. By using the Good Lives Model (Ward & Brown, 2004), facilitators are able to elicit what factors the prisoner cares about and how he tried to attain/achieve these historically. Personal relevance is encouraged with the aim that participants choose personally relevant change over compliance. In addition, the

skill of objectivity is facilitated with the intention of encouraging meaningful engagement and a more objective overview of their concerns, motivators, and goals (Tew & Atkinson, 2013).

Psycho-Education

Research has suggested that psycho-education informing personality disordered individuals about their traits can help to increase understanding about an individual's disorder and does not impact upon the therapeutic alliance within the treatment setting (Banerjee, Duggan, Huband, & Watson, 2006). This understanding was considered important prior to risk focused treatment being completed for participants to link personality traits to offending behaviour and criminogenic risk. Psycho-education was developed by Westgate clinicians to educate prisoners about personality disorder, risk, the Westgate Service's treatment framework and to set appropriate boundaries within treatment. Psycho-education is delivered in a group setting and comprises the following four modules:

- Introduction to Treatment: This provides an overview of treatment approaches on the Westgate Service. It aims to increase awareness of the skills employed by facilitators (Socratic questioning, reinforcement, modelling, respect, listening, and collaborative working).
- Boundary Setting Awareness: This explores previous boundary testing behaviour and its impact on goal attainment. It aims to increase prisoners' success in Westgate's treatment framework by understanding what a range of different boundaries are.
- Risk Assessment Awareness: This explains static and dynamic risk and explores prisoners' risk factors relevant to their treatment needs.
- Personality Disorder Awareness: Personality disorder and psychopathy traits are explained to prisoners who are then asked to link their own traits to their offending behaviour.

Self-Management Domain

The Self-Management Domain comprises treatment components delivered in a mixed group/individual session format and is designed to develop effective cognitive and self-management skills.

The Chromis Cognitive Skills components (Creative Thinking, Problem Solving, Handling Conflict) aim to develop thinking processes, more appropriately manage interpersonal conflict and lay foundations for future schema therapy work. The rationale for this is so that personally meaningful goals can be attained by prisoners without the use of verbal or physical violence. Creative Thinking introduces skills to make sense of and solve problems, attain goals, and limit boredom. Problem Solving aims to develop critical reasoning, problem definition and resolution. Handling Conflict explores ways of making sense of, avoiding and resolving interpersonal conflict. This

includes a "Life Map" where prisoners identify past key events and how their interpretations of these developed their views of themselves, others and life in general. This work informs subsequent schema therapy (Tew & Atkinson, 2013).

Iceberg is aimed at substance-related offending. This component introduces Prochaska and DiClemente's (1983) transtheoretical model of behavioural change to participants and Iceberg's format mirrors this "Stages of Change" model. Iceberg does this by exploring how to increase/maintain motivation to be substance free (cognitive change), identifying relapse prevention strategies (behavioural change) and necessary lifestyle modifications (long-term behavioural change) required to be substance free.

Emotion Modulation aims to increase participants' ability to appropriately manage emotions by encouraging skills to adjust or regulate how intense emotions are and how long they last. This includes increasing the ability to recognise emotions and their links to offending; education regarding the adaptive, healthy functions of emotions; exploring problematic emotions as a result of over-controlling and under-controlling emotions.

Social and Interpersonal Domain

This domain includes the Social Competence and Relationship and Intimacy Skills components. The Social Competence component is completed prior to the Relationships and Intimacy Skills component due to the former exploring skills that inform the latter. This means that social skills can be further explored and applied to intimate relationships.

Social Competence is designed to increase and develop the level of social skills. This is with the intention of interacting with others in a positive, pro-social way. This includes the following skills:

- To identify and monitor personal patterns of social behaviour.
- To enhance participants' competence in perceiving the social environment.
- To enhance participants' competence in social problem solving through accurate processing of social information.
- To enhance participants' ability to demonstrate and reflect on socially competent behaviour.
- To increase participants' self-esteem and self-confidence in social situations as a result of enhancing aspects of their social and interpersonal competence.

Relationships and Intimacy Skills aims to develop a range of skills required to develop and maintain healthy intimate relationships and friendships. These skills include the following:

- The ability to identify, monitor, and modify thinking patterns and related feelings and behaviours experienced within relationships;
- Appropriate ways to express feelings, perspective taking, negotiation, support seeking, and conflict management;

- Managing interpersonal difficulties within relationships; and
- Increasing confidence and self-esteem in relation to the formation, maintenance, and potential termination of relationships.

Thinking Processes and Offence Interests

The preliminary identification of schemas within the Chromis Cognitive Skills components informs the Chromis Schema Therapy component. This component is split into three phases. Phase one (delivered individually) identifies unhelpful schemas held by the prisoner via a case formulation approach. Mind maps and thought records help to explore how schemas developed in the past and how they are maintained in the present. This formulation informs phase two of the component (delivered in a group format) where behavioural experiments are designed and implemented to test out the validity of unhelpful beliefs as well as newly constructed beliefs. Phase three aims to prepare the prisoner for progression by consolidating learnt skills and encourage ongoing schema testing (Tew & Atkinson, 2013).

As the Chromis programme was designed to reduce the risk of violence within psychopathic offenders, sexual offending treatment needs have not historically been addressed by this treatment domain. Prisoners who have completed Westgate's treatment pathway with ongoing treatment needs in sexual offending have been recommended to complete work specifically addressing this need area after they have progressed from the Westgate Service. The Westgate Service piloted the Healthy Sexual Functioning Programme which has since been revised into the Healthy Sex Programme (HSP). Across the custodial setting, HSP aims to be completed following treatment needs in cognitive distortions, minimisation and pro-criminal attitudes have been addressed. HSP involves individually delivered behavioural modification which aims to change residual deviant sexual interests that can be present for some offenders after these other sexual offending treatment need areas have been addressed. Lessons learnt from the implementation and pilot of this treatment have included the adjustment of delivering 1.5-hr sessions within the Westgate Service's regime. In addition, some manualised session content has been found to replicate other aspects of the Westgate Service treatment framework. For example, exercises relating to developing skills in problem solving, relationships and attitudes may not be necessary to complete if the prisoner is considered to have made meaningful progress within these treatment need areas within other aspects of the Westgate Service's treatment framework. Facilitators have therefore tailored exercises to be as meaningful as possible to participants.

Progression and Maintenance Programme

Given that no set progression pathway was initially developed for DSPD programme completers, the developers of the Westgate Service included a Progression Domain within the proposed treatment framework. This component is consistently delivered at the end of a prisoner's treatment pathway on the Westgate Service. The Progression

and Maintenance Programme explores issues related to resettlement and "step down" from the high-security estate. This encompasses support processes such as parole conditions, vocational training, and community networks. Relapse prevention plans are developed within the component which focus on personally relevant high-risk situations.

Treatment Supporting Services

Imminent Need Services

Due to the complex nature of personality disordered offenders, responsivity issues can interfere with treatment engagement. The Imminent Needs Services provide voluntary treatment designed to support participants in managing their responsivity issues to maximise treatment benefits. These therapies can be run alongside the other treatment components discussed above. Referrals for these services are discussed within Imminent Need Services meetings attended by psychologists, therapists and mental health nurses trained in the available treatments offered by the Westgate Service. This means that the most appropriate service is matched to the participant on a case-by-case basis. The following treatments are included within the Imminent Need Service.

CBT. CBT was introduced on the unit with the aim to reduce individuals' emotional distress by helping them to identify, examine, and modify the distorted and maladaptive thinking underlying the distress. CBT intends to target Axis I disorders so prisoners can appropriately manage difficult emotions/unhelpful beliefs which act as barriers to treatment that inhibit engagement. CBT is delivered individually and prisoners are allocated to specifically trained clinicians. An assessment period is negotiated between the prisoner and clinician and treatment sessions follow this targeting specific problems working towards collaboratively identified goals.

Challenges experienced by CBT therapists on the Westgate Service have included the increased level of time required to resolve difficulties targeted in treatment in comparison with community-based CBT services which would aim to run over a set number of sessions. The extended amount of treatment at the Westgate Service leads to a concern that prisoners could become dependent on clinicians to solve encountered problems. Clinicians manage this by being time bound and goal specific within treatment. Observed difficulties about implementing this treatment with this population is that it can be challenging to differentiate between target behaviours and the manifestation of personality disorder traits, highlighting the complexity of personality disorders.

DBT. DBT is designed for individuals diagnosed with borderline personality disorder (Linehan, 1993) which manifests itself within personality traits likely to have three consequences: (a) threaten life, (b) manifest as treatment interfering behaviours, or (c) threaten quality of life. The DBT team is made up of specially trained clinicians and discipline officers. DBT is delivered via individual and group sessions. Prisoners

attending DBT sessions are asked to complete diary cards on a weekly basis which record any situations where their behavioural responses have threatened life, treatment engagement, or quality of life. Individual sessions are facilitated by an allocated clinician and discipline officer. These sessions are guided by any unhelpful behaviours recorded within diary cards. Facilitators then encourage prisoners to identify solutions and generalise skills in response to these situations. Group sessions are facilitated by any two members of the DBT team and intend to provide a supportive, "validating" environment for prisoners. These sessions aim to facilitate and generalise skills for regulating emotions, tolerating distress, being successful in relationships, and being mindful (self-aware).

The DBT team have faced challenges implementing this service within a custodial environment. Within the community, DBT clients would have the option to have 24-hr access to their therapist should an emergency situation arise. This is referred to as "crisis intervention." Applying this theoretical aim of DBT to the practical secure setting is not possible given the physical restrictions of the environment. DBT guidelines recommend that clients do not have contact with their therapist for 24 hr after an incident of self-harming behaviour. This is difficult to uphold within custody as H.M. Prison Service Safer Custody requirements are to assess and have subsequent interactions to manage prisoners' self-harming behaviours. In addition, aside from borderline personality disorder, prisoners attending DBT can be diagnosed with other personality disorders and psychopathy traits. As this client group has a range of functions of self-harming behaviour including interpersonal influence, status seeking and sensation seeking (Bennett & Moss, 2013), conditioning and manipulation can feature within behaviours that would be otherwise be considered as triggering a crisis. This means that the function of crisis intervention for some prisoners could contravene its aims. DBT therapists have managed this issue by agreeing with prisoners that they can request crisis intervention support for a maximum of 1 hr per week which is solely aimed at resolving the crisis that the prisoner is experiencing. The restrictive nature of prison and its regime can limit which skills prisoners can implement in prison which would not be problematic in the community setting. This can make some crises particularly distressing for prisoners.

Eye Movement Desensitisation and Reprocessing (EMDR). EMDR is an innovative treatment developed for individuals who suffer from posttraumatic stress disorder (PTSD). It is delivered in an individual format. Trauma can lead to the experience of extreme emotions that can overwhelm the brain and impact on all aspects of life. EMDR assists individuals who have suppressed distressing memories/images associated with past trauma. EMDR provides prisoners with the opportunity to re-process these memories so they have less of an impact on their day-to-day life (Shapiro, 2001). The rationale for including this treatment within the Westgate Service's treatment framework is to help prisoners improve their focus and engagement in treatment on the unit, which may be asking them to think about their past. Challenges faced by EMDR therapists to date include that some prisoners have developed robust defence mechanisms (also strongly linked to offending behaviour) which have made it challenging to explore past memories.

Mental health team—Care programme approach. Prisoners on the Westgate Service are allocated a named Nurse from the Healthcare team. This service can identify mental health requirements of individual prisoners. This can trigger referrals to relevant treatment services. These can include other imminent need services available on the Westgate Service or support from a psychiatrist.

Skills Rehearsal Group

The Skills Rehearsal Group is a weekly group where participants have the opportunity to further practice skills from treatment within a safe, therapeutic environment. This is with the intention to practice skills that prisoners are finding difficult to master to encourage skills generalisation. Any staff can refer a prisoner to the Skills Rehearsal Group, as well as prisoners self-referring. Attendance however is voluntary as it is viewed as a supportive service to prisoners.

Active Learning

Active Learning differs from group room-based treatment by nature of its experiential learning approach and gym-based setting. The "Introduction to Group Working" sessions are offered to prisoners in the pre-assessment "Living Phase." Through active participation in practical exercises, participants are introduced to elements of group work which will help to maximise treatment engagement. These elements include communication, personal disclosure, managing group dynamics, problem solving, planning, team work as well as giving and receiving feedback. In addition, the sessions provide participants and staff the opportunity to work together and build positive relationships. The provision of Active Learning is currently under review with the aim to explore whether it could be used effectively at other points during treatment to increase group cohesion.

ATNA Update

ATNA Update acts as a review of progress partway through and at the end of a prisoner's treatment pathway at the Westgate Service. The timing of the ATNA Update is not identical for all participants due to the individualised treatment pathway but intends to take place approximately halfway through the treatment pathway. The case formulation developed within ATNA is reviewed as well as the dynamic risk items on the VRS and HCR-20 and identified responsivity issues. Again, a triangulated approach using prisoner self-report, responses on psychometric tests, collateral and staff observations (including Behavioural Monitoring and GLAD) is used within this process. This process results in identified areas of progress and ongoing need for prisoners, informing subsequent recommendations with respect to treatment, management and supervision. These recommendations can include the completion of offence specific treatment at a progression site.

Progression

At the outset of the introduction of DSPD services, funding was not allocated to implement progression options dedicated to completers of the DSPD treatment frameworks. Staff at the Westgate Service developed working relationships with staff at HMP Altcourse (a Category B site within the private sector) to develop a progression option for completers of the treatment pathway. This work involved training Altcourse staff to have an increased awareness and understanding of personality disorders and psychopathy as well as the treatment framework completed by prisoners progressed on to their Foinavon Wing. Since this time, the Offender PD Pathway (Joseph & Benefield, 2012) has been introduced offering a range of potential progression sites for Westgate "completers." Following the introduction of the Offender PD Pathway in England and Wales (Joseph & Benefield, 2012), an increased number of personality disorder services across health and secure settings are being introduced. One of Westgate's four units was re-rolled into the only Category A PIPE in May 2012. Although this reduced the Westgate Service's capacity, this change enabled a provision for Category A completers from the Westgate Service and other treatment services within the Prison Service.

Progression options for Westgate Service completers currently include the following: PIPEs based at HMP Frankland (Category A), HMP Garth (Category B, non-sexual offenders), and HMP Hull (Category B, sexual offenders). In addition, progression sites have included the Foinavon Wing at HMP Altcourse as well as mainstream prison sites to address outstanding treatment needs within the domain of offence-related interests. Treatment "completers" engage in progression planning prior to transferring to progression sites to maximise their ability to generalise learnt skills from treatment.

Research and Evaluation

The impact of what was referred to as DSPD services on long-term rates of re-offending is unknown given the limited number of treatment completions released into the community environment. It is also (realistically) considered that long-term evaluation impact of DSPD services will take time (Department of Health & National Offender Management Service Offender Personality Disorder Team, 2011). The lack of completions residing in the community means that reconviction data are not available to evaluate service effectiveness at this time. At the time of writing, the Westgate Service's treatment completions totalled 25. This increasing sample has allowed scope for small scale initial evaluation. As completers have progressed on to other settings, this has allowed initial short-term evaluation of treatment services at the Westgate Service which will be summarised here.

A case study exploring initial Chromis completions who had transferred to progression sites has been conducted (Tew, Dixon, Harkins, & Bennett, 2012). This study aimed to evaluate changes in anger and aggression within a sample of five completers. Self-report (psychological test) information, documented staff observations and adjudication information was used within this evaluation. This case study found evidence

to suggest that after progressing from the Westgate Service, participants experienced a decline in self-reported anger as measured by the Novaco Anger Scales and Provocation Inventory (NAS-PI; Novaco, 1994). Expected rates of violence (calculated by using the frequency of historical violent incidents and time located at the Westgate Service) were compared with actual rates of violence. Participants were found to be involved in fewer incidents of physical aggression than expected but higher than expected levels of verbal aggression (Tew et al., 2012). Further research is ongoing with the same cohort of five participants to qualitatively explore engagement and the lived experience of Chromis treatment. A study intending to explore the functions of self-harming behaviour on the unit also found evidence to suggest that treatment on the unit led to an ability to verbalise insight into their self-harming behaviour. It was considered that this was either to insight being increased as a result of treatment or treatment assisting prisoners in disclosing this information (Bennett, 2013).

Research has also explored treatment dropout at the Westgate Service (Bennett, in press) given that personality disordered and psychopathic prisoners can be challenging to engage in treatment. This study identified that a diagnosis of narcissistic personality disorder was (just) significantly related to treatment dropout. No other personality disorder diagnoses, PCL-R total or factor scores were related to treatment dropout. This was considered to provide evidence to suggest that the Westgate Service can engage individuals with a range of personality disordered diagnoses in treatment, supporting the use of responsivity planning and management on the unit. Given the small sample sizes available, qualitative research may be considered a valuable research methodology within this population, particularly as it has been observed that sensitive subjects can be explored with this population in an ethically appropriate way whilst providing detailed insight of participants (Bennett, 2013).

Up until January 2014, 25 prisoners had completed the Westgate Service's treatment framework. Twenty of these completers had reduced their risk as assessed by the HCR-20 (Douglas & Webster, 1999), with an average reduction of 2.28 across all 25 completers. Eight of the 25 completers had experienced reductions in security category. Although none of these reductions were for the Category A completers, they had either been transferred to complete mainstream sexual offending treatment or to a PIPE site to assist their skills generalisation. This provides evidence to suggest that Westgate Service treatment completers can experience reduced risk, which is particularly beneficial given the chronicity of this specific offending population and the impact this has on cost and resources accrued by crime. In addition, treatment completers can attain progression to lower security (and less cost intensive) settings or continuation through the Offender PD Pathway.

The Offender PD Pathway's research and evaluation strategy is being jointly developed by the Department of Health and the National Offender Management Services. Aside from this, the Westgate Service also hopes to build on the developing literature by exploring the impact of other treatment components. It is hoped that this will increase understanding about "what works" with this challenging population. Given the previously discussed changes to the referrals process and limited scope to complete outreach work, the unit intends to research the referrals process. This is with the

aim of increasing knowledge and understanding about which referrals are most likely to meet the service's criteria and limiting the number of referrals that do not subsequently meet criteria.

Future Directions for the Westgate Service

Given the recession's influence on Government funding cuts within the Prison Service in England and Wales, a number of changes have impacted upon the regime, staff structure and levels at the Westgate Service and will continue to do to. This has led to decreased staffing levels through staff not in post not being replaced as well as voluntary redundancy packages being accepted by experienced and skilled staff. This means that training and supervision has been required to further develop staff to replace these roles. Education provision is being reduced on the unit. This is due to the unit not being able to guarantee required numbers of prisoners attending set education sessions due to treatment taking priority on the unit. Senior management at the Westgate Service are currently making efforts to agree new terms with education providers and exploring the option of developing structured sessions that can be run by staff on the unit. This would provide opportunity for prisoners to engage in creative work and further develop their skills.

Funding is currently secured for the Westgate Service until 2015, and is therefore likely to be subject to scrutiny and processes such as benchmarking which is being carried out across the Prison Service estate. This means that the service needs to continue to provide value for money and prove cost-effectiveness to individuals allocating funding. Staffing cuts have meant that there no longer was a dedicated department to research the effectiveness of the service. It is still intended for service evaluation to take place however. This will be implemented through a range of ways including: clinical staff who are required to complete research studies as part of their professional training; external researchers; and the Offender PD Pathway's research and evaluation strategy. It is hoped that developing professional relationships with academic institutions will allow increased opportunities for further research and evaluation to take place. Research priorities for the unit include: the effectiveness of treatment components (particularly those not already explored within Chromis evaluations); the effectiveness of the referrals process; other benefits of treatment on prisoners (e.g., impact on quality of life). Metrics used to explore treatment effectiveness could include proven adjudications, behavioural observations, and self-report (via psychological tests). As previously discussed, it is anticipated that the Westgate Service will experience a change in population as a result of other personality disorder services opening within the Offender Personality Disorder Pathway (Joseph & Benefield, 2012). This means that the service is likely to need to revisit service effectiveness in order to evaluate "what works" with this population.

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Co-morbidity of personality disorder and clinical syndrome in high-risk incarcerated offenders

Alice Bennett and Darren Johnson

Abstract

Purpose – *In light of the clinical importance of understanding co-morbidity within offender populations, the purpose of this paper is to examine the prevalence and comorbidities of clinical disorder (Axis I) and personality disorder (Axis II) within a sample of high risk, male offenders located in a high secure, prison-based personality disorder treatment service.*

Design/methodology/approach – *The study utilised clinical assessment data for both Axis I diagnoses (Structured Clinical Interview for DSM-IV) and Axis II diagnoses (International Personality Disorder Examination) of 115 personality disordered offenders who met the criteria for the treatment service between 2004 and 2015.*

Findings – *Co-morbidity between Axis I and Axis II diagnoses was high, with 81 per cent of the sample having co-morbid personality disorder and clinical disorder diagnosis. The most prevalent Axis I disorder was substance misuse, and Axis II was antisocial, borderline, and paranoid personality disorder. Following χ^2 analysis, Cluster A personality disorder demonstrated co-morbidity with both mood disorder and schizophrenia/other psychotic disorder. Paranoid, schizoid, narcissistic, and avoidant personality disorder demonstrated a level of co-morbidity with Axis I disorders. There was no association found between the clinical disorders of substance use and anxiety with any personality disorder within this sample.*

Practical implications – *In part these results suggest that certain Axis II disorders may increase the risk of lifetime Axis I disorders.*

Originality/value – *The findings of no co-morbidity between the clinical disorders of substance use and anxiety with any personality disorder within sample are inconsistent to previous findings.*

Keywords *Personality disorder, Co-morbidity, Offenders, Axis I, Axis II, Clinical disorder, High risk*

Paper type *Research paper*

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Introduction

Recognition and understanding of co-morbidity is fundamental in the assessment of offenders (Blackburn, 2000); the presence of one disorder can affect the "treatment, course and phenomenology of another" (Tyrer *et al.*, 1997). The co-morbidity between Axis I and Axis II diagnoses within a forensic population has previously been examined in high secure hospitals (Coid, 2003; Blackburn *et al.*, 2003), inpatient samples (Oldham *et al.*, 1995), prisoner samples (Coid *et al.*, 2009), and community-based samples (Links and Eynan, 2013).

The most prevalent findings in studies examining associations between Axis I and Axis II disorders is that a diagnosis of depression is significantly (and positively) associated with borderline personality disorder. This finding has been observed within varying forensic samples (Blackburn *et al.*, 2003; Coid, 2003; Coid *et al.*, 2009; Links and Eynan, 2013; Oldham *et al.*, 1995; Skodol *et al.*, 2011). For example, 35 per cent of a general prison population in England and Wales had diagnoses of borderline personality disorder and depression (Coid *et al.*, 2009). Within high secure hospitals in England, this figure has been as high as 61 per cent (Coid, 2003). A consistent association has also been observed between mood disorders and varying Axis II disorders (Oldham *et al.*, 1995, Blackburn *et al.*, 2003; Coid, 2003).

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Relationships between schizophrenia and personality disorder also features within the literature (Coid, 2003; Coid *et al.*, 2009). This includes co-morbidity with schizoid personality disorder in the general prison population (Coid, 2003), as well as co-morbidity with paranoid and schizotypal personality disorders within the general prison population (Coid, 2003) and the high secure psychiatric population within the UK (Coid *et al.*, 2009). This suggests that Cluster A personality disorder diagnoses and schizophrenia co-exist to a significant level within forensic samples.

Substance use disorders have been identified as the most prevalent Axis I syndrome and having the highest co-morbidity with personality disorder within the UK prison population (Coid *et al.*, 2009). A plethora of studies have identified co-morbidity between substance use disorder and antisocial personality disorder within UK forensic samples in the general prison population (Coid *et al.*, 2009), and high secure settings (Blackburn *et al.*, 2003; Coid, 2003). A diagnosis of borderline personality disorder has been shown to be related to a diagnosis of substance use disorder within UK prison populations (Coid *et al.*, 2009) and high secure hospitals (Blackburn *et al.*, 2003). These findings are predictable given that substance use behaviour is an identified trait within the criminal lifestyle aspect of antisocial personality disorder and the potentially self-damaging behaviours within borderline personality disorder. Research has identified substance use disorders as being co-morbid with paranoid, obsessive compulsive and avoidant personality disorders within the UK prison population (Coid *et al.*, 2009). Substance use has also been found to be comorbid with histrionic personality disorder within both inpatients and outpatients in the USA (Oldham *et al.*, 1995), and narcissistic personality disorder within a mainly community focussed review of US samples (Links and Eynan, 2013).

More varied evidence exists for the presence of co-morbidity between anxiety disorder and various personality disorders across the literature base. This includes narcissistic (Coid *et al.*, 2009; Links and Eynan, 2013); schizotypal (Coid *et al.*, 2009; Blackburn *et al.*, 2003); obsessive compulsive (Coid *et al.*, 2009); avoidant (Coid *et al.*, 2009; Links and Eynan, 2013; Blackburn *et al.*, 2003); antisocial (Links and Eynan, 2013; Hodgins *et al.*, 2010), borderline, dependant (Links and Eynan, 2013); and paranoid personality disorders (Blackburn *et al.*, 2003). This indicates there is varying evidence for the presence (and absence) of co-morbidity between Axis II and anxiety-related Axis I disorders within differing samples.

Scant evidence is present within the literature base relating to somatoform disorders' co-morbidity with personality disorder. Specifically, somatoform disorder has been identified as having co-morbidity with borderline personality disorder within UK high-security psychiatric populations (Blackburn *et al.*, 2003; Coid, 2003). Outside of forensic psychiatric populations, somatoform disorders have been found to be co-morbid with borderline personality disorder in a sample of American personality disordered inpatients (Zanarini *et al.*, 1998).

Whilst these findings have yielded valuable insight into the co-morbidity of forensic samples, it is imperative to acknowledge restrictions on the generalisability of these findings, taking into account that co-morbidity is likely to vary according to the population in which it is studied. To the researchers' knowledge, there is no study to date that has exclusively explored the prevalence of co-morbid diagnoses within high-risk incarcerated offenders diagnosed with complex personality disorders. Therefore, it is concluded that there is an important gap in the literature must be explored. Increasing the understanding of co-morbidity within this specific population is pertinent at present. That is, the Offender Personality Disorder Pathway (Joseph and Benefield, 2012) has been introduced in England and Wales with the intention of providing a progression pathway (across security levels) for offenders likely to be diagnosed with a personality disorder. This pathway was necessitated by approximately two-thirds of offenders being considered to meet the criteria for at least one diagnosed personality disorder (Department of Health, National Offender Management Service Offender Personality Disorder Team, 2011).

The Offender Personality Disorder Pathway includes services within the high secure prison estate based at The Westgate Unit at HMP Frankland (which provides a treatment approach based on cognitive behavioural therapy; Bennett, 2015) and The Fens Unit at HMP Whitemoor (which has a cognitive interpersonal-based treatment model; Saradjian *et al.*, 2013). Criteria for meeting these services include offenders who:

- pose a high risk of re-offending;

- have been diagnosed with complex personality disorder (which can include the presence of psychopathy); and
- have a functional link between their personality disorder diagnoses and their offending.

The discernible presence of clinical disorders and personality disorders can impact severely on treatment engagement for these high-risk complex individuals. These manifest in the form of treatment interfering behaviours (Howells and Tennant, 2010) which impact and impede on engagement and ultimately treatment efficacy. The Westgate Unit uses a permutation of the physical environment, regime, and responsive psychological intervention in order to manage the critical impact that treatment inferring behaviours have on engagement and risk reduction (Bennett, 2015; Wood, 2015). It is unknown at present, however, to what degree clinical disorder, and co-morbidity of personality disorder and clinical disorder exists within this specific population. Given that some domains of clinical disorder are mirrored within specific personality disorder traits, some co-morbidity would be expected. Therefore, broadening understanding would facilitate responsivity management and the allocation of appropriate assessment and/or treatment for this specific group of high-risk offenders. Thus, this study was exploratory in nature with an aim to examine the prevalence of clinical disorders and the extent to which personality disorders, and clinical disorders co-exist within a sample of male offenders who have met criteria for a high-risk, high need, personality disorder treatment services.

Method

Sample

Participants were male personality disordered offenders ($n = 115$) who had met criteria for prison-based, high secure personality disorder services and were located on a treatment unit specifically designed for this client group. The sample represents all available male participants who were admitted to the treatment unit and went on to meet criteria since it opened in 2004 and up until the point of data collection in 2015. Participants included within the research sample had all provided informed consent for their assessment data to be used for research purposes.

Procedure

This was a retrospective study where participants' demographic and assessment data were selected for the purpose of the study. Participants had been assessed by a multidisciplinary team of qualified professionals upon admission with a standardised assessment procedure. Axis I disorders were assessed using the Structured Clinical Interview for DSM-IV for Axis I Disorders (First *et al.*, 1997). These were administered by either a qualified mental health nurse or a qualified psychiatrist from the multidisciplinary team. Axis II disorders were assessed using the International Personality Disorder Examination (Loranger, 1999). These were administered by a team of trained clinical staff (including trainee psychologists and therapists) led by a forensic psychologist practitioner whose role was to provide clinical oversight and supervision of the assessment process. For the purposes of the present study, diagnoses of personality disorder were coded into two categories: absent or present (probable diagnoses were recoded into present). The clinical assessment procedures for both Axis I and Axis II diagnoses was based upon interviews and a review of file records consisting of criminal history records and family background data. In addition, Axis I and Axis II diagnoses are completed independent of one another for all prisoners.

Analysis

The analytical strategy included the completion of χ^2 analysis to determine the difference in frequency distribution between Axis I and Axis II diagnoses. Additionally, odds ratios from 2×2 (presence vs absence of diagnosis) tables were calculated. The χ^2 statistic was used to determine the significance of each odds ratio. To reduce the risk of chance capitalisation, Bonferroni correction was used for the χ^2 tests and a significance criterion of $p < 0.05$ was used throughout.

Results

A review of the demographic characteristics of the sample showed that the majority of the sample were white in ethnicity (95 per cent) with the remaining 5 per cent comprising participants of black, Asian or of mixed race. The mean participant age on admission was 35.58 years (SD = 14.38). In terms of marital status, 86 per cent of the sample were single on admission to prison, followed by married/cohabiting (6 per cent), divorced/separated (6 per cent), widowed (1 per cent) with data not recorded for 1 per cent of the sample. The majority of participants (62 per cent) had been convicted with a life sentence, followed by indeterminate for public protection sentences (20 per cent) and determinate sentences (18 per cent). Offence specific characteristics highlighted that 62 per cent of the sample had an index offence of physical violence and 38 per cent of the sample had a sexually violent index offence.

Axis II and Axis I disorders

The prevalence of personality disorder in the sample was large, with 93 per cent of the participants receiving at least one Axis II diagnosis. Eight participants were diagnosed with no personality disorders but had met criteria for the treatment service based on psychopathy level. Co-morbidity of Axis II disorders was more common than single diagnosis: of the 107 offenders given a personality disorder diagnosis, 94 per cent received multiple diagnoses. The mean number of diagnosed personality disorder diagnoses was 2.67. The most frequently diagnosed personality disorder was antisocial ($n = 104$), followed by borderline ($n = 70$), and paranoid ($n = 38$). Most personality disorders were found in Cluster B disorders. The co-occurrence of individual and clustered Axis II disorders is displayed in Table I.

The prevalence of Axis I disorders was also high with 87 per cent of the sample having at least one Axis I diagnosis. The most frequently diagnosed category was substance use disorders ($n = 92$, 80 per cent), followed by anxiety disorders ($n = 54$, 47 per cent), and mood disorders ($n = 30$, 26 per cent).

Categorical overlap of Axis I and II disorders

As evident in Tables I and II, several of the diagnostic categories have low base rates and diagnostic categories with fewer than ten cases were omitted from the analysis (Hart and Hare, 1989). This resulted in five categories being omitted including two Axis I (somatoform and adjustment clinical disorders) and three Axis II (schizotypal, dependent, and obsessive-compulsive personality disorders). Nevertheless, the omitted personality diagnoses

Table I Co-occurrence of Axis II disorder within the sample

	Categorical diagnosis n (%)
Axis II cluster	
Cluster A	47 (40.87)
Cluster B	108 (93.91)
Cluster C	27 (23.48)
Axis II disorder	
Paranoid	38 (33.04)
Schizoid	17 (14.78)
Schizotypal	7 (6.09)
Antisocial	104 (90.43)
Borderline	70 (60.87)
Histrionic	12 (10.43)
Narcissistic	32 (27.83)
Avoidant	23 (20.00)
Dependant	4 (3.48)
Obsessive compulsive	3 (2.61)

Note: $n = 115$

Table II Co-occurrence of Axis I disorder within the sample

Axis I disorder category	*Categorical diagnoses n (%)*
Mood	30 (26.09)
Schizophrenia and other psychotic	15 (13.04)
Substance use	92 (80.00)
Anxiety	54 (46.96)
Somatoform	4 (3.48)
Adjustment	2 (1.74)

Note: $n = 115$

were captured within both Cluster A and Cluster C diagnostic categories. Due to Cluster B personality disorders having the highest level of diagnosis, there were not sufficient participants without a Cluster B personality disorder diagnosis to explore relationships between Cluster B personality disorder diagnoses and clinical disorder categories. Specific Cluster B personality disorder diagnoses (including antisocial and borderline personality disorders) were, however, explored within other analyses (see Table III). Levels of co-morbidity between cluster diagnoses and clinical disorders were as follows. A significant positive trend was found between Cluster A and mood disorder ($\chi^2(1) = 4.191$, $p = 0.041$) and between Cluster A and schizophrenia/other psychotic disorder ($\chi^2(1) = 4.75$, $p = 0.029$) with odds ratios of 0.42 and 0.29, respectively.

In total, 93 (81 per cent) of participants had diagnoses within both Axis I and Axis II disorders. With regards to the overlap between Axis II and clinical disorder category, a significant trend was found between paranoid personality disorder and mood disorder ($\chi^2(1) = 7.552$, $p = 0.006$) and between borderline personality disorder and mood disorder ($\chi^2(1) = 9.208$, $p = 0.002$) with odds ratios of 0.31 and 0.21, respectively.

With regards to Axis II and individual clinical disorders, significant trends were found between paranoid personality disorder and major depressive disorder ($\chi^2(1) = 3.873$, $p = 0.049$), hallucinogen abuse ($\chi^2(1) = 10.062$, $p = 0.002$), and specific phobia ($\chi^2(1) = 4.184$, $p = 0.041$). Schizoid personality disorder was significantly related to alcohol abuse ($\chi^2(1) = 3.914$, $p = 0.048$). Borderline personality disorder was significantly related to major depressive disorder ($\chi^2(1) = 5.598$, $p = 0.018$) and dysthymic disorder ($\chi^2(1) = 4.842$, $p = 0.028$). Narcissistic personality disorder was significantly related to alcohol abuse ($\chi^2(1) = 3.977$, $p = 0.046$), and avoidant personality disorder was significantly related to major depressive disorder ($\chi^2(1) = 4.398$, $p = 0.036$). Similar to previous results, relatively low odds ratios were calculated for these relationships (see Table V). Most notable, however, was a higher odds ratio for the association between narcissistic personality disorder and alcohol abuse (2.57) (Tables IV and V).

Table III Associations between personality disorder clusters and clinical disorder categories

Personality disorder (cluster)	*Co-morbid clinical disorder category*	*χ^2 value*	*df*	*p*	*Odds ratio*
Cluster A	Mood	4.191	1	0.041*	0.42
	Schizophrenia and other psychotic	4.750	1	0.029*	0.29
	Substance use	0.229	1	0.633	0.79
	Anxiety	1.788	1	0.181	0.60
Cluster C	Mood	2.668	1	0.102	0.46
	Schizophrenia and other psychotic	1.134	1	0.287	0.53
	Substance use	1.252	1	0.263	0.48
	Anxiety	0.038	1	0.846	1.09

Notes: $n = 115$. *$p < 0.05$

Table IV Associations between personality disorder diagnoses and clinical disorder categories

Personality disorder diagnosis	*Co-morbid clinical disorder category*	χ^2 *value*	*df*	*p*	*Odd ratio*
Paranoid	Mood	7.552	1	0.006*	0.31
	Schizophrenia and other psychotic	3.210	1	0.073	0.38
	Substance use	0.409	1	0.522	0.71
	Anxiety	2.306	1	0.129	0.55
Schizoid	Mood	0.068	1	0.795	1.17
	Schizophrenia and other psychotic	0.029	1	0.865	1.15
	Substance use	0.250	1	0.617	1.37
	Anxiety	1.256	1	0.262	1.83
Antisocial	Mood	0.365	1	0.546	1.48
	Schizophrenia and other psychotic	2.010	1	0.156	0.23
	Substance use	0.053	1	0.819	1.20
	Anxiety	0.025	1	0.873	1.10
Borderline	Mood	9.208	1	0.002**	0.21
	Schizophrenia and other psychotic	1.278	1	0.258	0.50
	Substance use	0.759	1	0.384	1.55
	Anxiety	1.307	1	0.253	0.65
Histrionic	Mood	1.687	1	0.094	0.45
	Schizophrenia and other psychotic	2.010	1	0.156	4.38
	Substance use	0.053	1	0.819	0.83
	Anxiety	1.906	1	0.167	0.42
Narcissistic	Mood	1.944	1	0.163	0.53
	Schizophrenia and other psychotic	0.424	1	0.515	1.56
	Substance use	2.690	1	0.101	2.23
	Anxiety	0.836	1	0.360	0.68
Avoidant	Mood	3.100	1	0.078	0.42
	Schizophrenia and other psychotic	0.633	1	0.426	0.60
	Substance use	0.531	1	0.466	0.62
	Anxiety	0.052	1	0.820	0.90

Notes: $n = 115$. *$p < 0.01$; **$p < 0.005$

Table V Significant associations between personality disorder diagnoses and clinical disorders

Personality disorder diagnosis	*Co-morbid clinical disorder*	χ^2 *value*	*df*	*p*	*Odds ratio*
Paranoid	Major depressive disorder	3.873	1	0.049*	0.31
	Specific phobia	4.184	1	0.041*	0.32
	Hallucinogen abuse	10.062	1	0.002**	0.27
Schizoid	Alcohol abuse	3.914	1	0.048*	0.35
Borderline	Major depressive disorder	5.598	1	0.018*	0.11
	Dysthymic disorder	4.842	1	0.028*	0.13
Narcissistic	Alcohol abuse	3.977	1	0.046*	2.57
Avoidant	Major depressive disorder	4.398	1	0.036*	0.28

Notes: *$p < 0.05$; **$p < 0.005$

Discussion

A high prevalence of lifetime DSM-IV Axis I psychiatric morbidity was found, with 87 per cent of the sample meeting criteria for at least one Axis I disorder. This supports similarly high prevalence within personality disordered samples within high-security hospital settings (94 per cent; Blackburn *et al.*, 2003). This high prevalence highlights the clinical complexity of this population and the importance of accurate clinical assessment to ensure that these distinct disorders are treated appropriately. This would ensure that treatment resources are allocated effectively and maximise risk reduction, ensuring that an efficient and successful treatment

model is implemented. The finding that substance misuse was the most prevalent type of disorder is consistent with other studies with forensic participants (Coid *et al.*, 2009), with research in high secure hospitals highlighting depression as the most prevalent Axis I diagnosis, followed by alcoholism and substance misuse disorders (Coid, 2003). This finding supports the need for substance misuse interventions within personality disorder treatment services.

The high percentage of offenders with at least one Axis II diagnosis (93 per cent) was expected given the inclusion criterion for the treatment service where this study was based. In comparison to the general prison population (Coid *et al.*, 2009), this figure is 28 per cent higher. Antisocial personality disorder was the most prevalent personality disorder in the current sample (90.43 per cent). This is markedly higher than levels of antisocial personality disorder found in samples of males and females in high secure hospital samples (55 per cent; Coid, 2003) and the general prison population (50 per cent, Coid *et al.*, 2009). This is of interest in terms of the current study given the associations between features relevant to this study's sample (namely, antisocial personality disorder and psychopathy) and risk of (particularly violent) offending (Skilling *et al.*, 2002).

The co-morbidity between Axis I and Axis II disorders was high, with 80.87 per cent of the sample having diagnoses within both Axis I and Axis II disorders. Cluster A personality disorder was strongly associated with mood disorder and schizophrenia/other psychotic disorders. Further analysis illustrated that mood disorder was significantly related to paranoid (Cluster A) and borderline (Cluster B) personality disorders. Additionally, paranoid personality disorder and major depressive disorder were considered to have co-morbidity. It has been suggested that paranoid personality disorder and mood disorders are significantly related within prison samples (Oldham *et al.*, 1995; Coid *et al.*, 2009); although this finding has not been replicated within high-security hospital samples (Coid, 2003). Borderline personality disorder and depression have been considered to be associated within general forensic, as well as high-security hospital settings (Coid, 2003; Coid *et al.*, 2009), providing evidence to suggest that this was the finding most consistent with the literature base. A diagnosis of Cluster C personality disorder (which accounted for 23 per cent of the sample) was not considered to be significantly linked to any Axis I disorders. However, within this cluster, avoidant personality disorder was positively linked to a diagnosis of major depressive disorder. This mirror findings from a high-security hospital sample (Coid, 2003); yet the same finding was not identified within the general prison population (Coid *et al.*, 2009). These findings emphasise the clinical importance of personality disorder services being guided by research exploring their specific population – either prison or hospital – and research from general prison populations should be used tentatively. This further supports research and evaluation strategies within the Offender Personality Disorder Pathway.

No association was found between substance use disorder and personality disorder diagnosis within the present study. This was unexpected given that substance use is assessed within diagnoses of both antisocial and borderline personality disorders. This is inconsistent with existing research (e.g. Coid *et al.*, 2009) that identified alcohol misuse disorder as the most co-occurring Axis I disorder with Axis II disorders within a general prison-based population. It is probable that this finding is due to substance use disorder being highly prevalent across this sample and personality disorder diagnosis could have been unable to differentiate between those diagnosed with a substance misuse disorder and those who are not. Further research could inform our understanding of "what works" within substance use treatment provided for this population. The "complex personality disorder" criterion for the unit where the study took place considers psychopathy as well as a diagnosis of personality disorder. Given this, it may be that one aspect of psychopathy (which relates to a "chronically unstable, antisocial and socially deviant lifestyle") may be more closely linked with substance misuse disorder than personality disorder.

Interestingly, anxiety disorders were not considered to hold co-morbidity with any personality disorder within the current study. A more varying range of evidence supports the presence of co-morbidity between anxiety disorder and various personality disorders across the literature base. This includes: narcissistic (Coid *et al.*, 2009; Links and Eynan, 2013); schizotypal (Coid *et al.*, 2009; Blackburn *et al.*, 2003); obsessive compulsive (Coid *et al.*, 2009); avoidant (Coid *et al.*, 2009; Links and Eynan, 2013); antisocial (Links and Eynan, 2013; Hodgins *et al.*, 2010); borderline, dependant (Links and Eynan, 2013); and paranoid personality

disorders (Blackburn *et al.*, 2003). This suggests there is varying evidence for the presence (and absence) of co-morbidity between Axis II and anxiety-related Axis I disorders across samples.

When exploring specific clinical disorders, significant relationships were found between paranoid personality disorder and specific phobia, as well as hallucinogen abuse: schizoid personality disorder and alcohol abuse; borderline personality disorder and major depressive disorder and dysthymic disorder; narcissistic personality disorder and alcohol abuse; and avoidant personality disorder and major depressive disorder. This supports the need to treat clinical disorders in order to manage treatment interfering behaviours, thus maximising treatment engagement.

Limitations

Several methodological limitations are present within this study. First, due to analysing secondary data collected over a lengthy period of time, no examination of inter-reliability could be carried out. Second, the study relied on data from one clinical service in the UK and consequently is limited by a potential lack of representativeness. Third, due to the lower prevalence of some personality disorder and clinical disorder diagnoses within the sample, not all diagnoses could be explored restricting a comprehensive examination of potential interactions between multiple diagnoses. Additionally, the study explored categorical data in that a diagnosis of personality disorder or clinical disorder was considered to either be present or absent. Exploring the severity of personality and clinical disorders could develop findings from the current study further by using personality disorder dimensional scores as well as the severity of clinical disorders. The research strategy at the Westgate Unit intends to analyse data in order to contribute to ongoing evaluation. High psychopathy levels is a feature of this sample and to the best of our knowledge, no published study has examined the association between psychopathy, Axis I and Axis II disorders, thus warranting further exploration to develop further clinical insight into this specific population.

Conclusions

Despite the limitations, this study has provided insight into the prevalence of clinical disorders and the extent to which personality disorders, and clinical disorders co-exist within a sample of high-risk personality disordered offenders. Advancing this understanding is valuable given the association between clinical disorder, personality disorder, and risk of re-offending (Skilling *et al.*, 2002). It is hoped that further research can continue to build upon the current findings in order to extend this understanding further within this specific population. Thus, in part this study indicates that certain Axis II disorders may increase the risk of lifetime Axis I disorders and as such the findings must be applied to practice. This highlights the need to consider co-occurring diagnoses within treatment and risk management planning given the impact this can have on the treatment of personality and/or clinical disorder (Tyrer *et al.*, 1997).

Implications for practice

- The prevalence of clinical disorders accentuates the importance of personality disorder treatment services providing therapy to address the clinical disorder symptoms that can interfere with personality disorder and risk focussed treatment.
- Accurate assessment of personality disorder and clinical disorder is likely to reduce the risk of misdiagnosis and ensure the most appropriate treatment options are employed for both disorders.
- The prevalence of co-morbidity within the sample emphasises the need for multidisciplinary staff working with this population to be suitability equipped to assess, treat, and manage both types of disorder. Specifically, by seeing personality disorder and clinical disorders as distinct disorders that both require accurate and effective assessment and treatment within this challenging population.
- Given the introduction of the Offender Personality Disorder Pathway (Joseph and Benefield, 2012) and its continuing development across settings and security levels, these implications could inform wider services within the pathway and consideration for resources allocation for treatment. Specifically, these implications could inform stakeholders' decision making relating to both treatment provision and priorities.

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Implementing evidence-based psychological substance misuse interventions in a high secure prison based personality disorder treatment service

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Abstract

Purpose – *The purpose of this paper is to describe the need for substance misuse treatment with high risk, personality disordered prisoners and the implementation of two evidence-based psychological interventions aimed at addressing substance misuse within a high secure, personality disorder treatment unit and potential future evaluation options.*

Design/methodology/approach – *In addition to the literature base evidencing the need for substance misuse treatment with this population, the Iceberg and "InsideOut" interventions are presented. These interventions adopt a risk reduction and health intervention approach, respectively. This includes explanations of how they came to be implemented within a prison-based personality disorder treatment service and potential ways to evaluate these services.*

Findings – *Evidence-based psychological interventions can be implemented for this population whilst being responsive to changing government priorities for substance misuse treatment. The organisation's research strategy includes an intention to evaluate these interventions in order to inform future delivery.*

Practical implications – *The high levels of co-morbidity between personality disorder and substance misuse disorders in the high-security prison estate highlights the need for substance-related treatment for this population. Given the responsivity issues relevant to personality disordered offenders, the format of delivery of evidence-based psychological interventions has to be considered.*

Social implications – *The initial development of evidence-based psychological interventions for this service resulted from the dangerous and severe personality disorder pilot and subsequent introduction of the offender personality disorder pathway. Further developments have occurred alongside the revised National Drug Strategy introduced by the UK Government in 2010. This strategy directed a progression within drug and alcohol treatment services promoting that mutual aid be provided alongside the delivery of treatment interventions in order to maximise the probability of service-users maintaining abstinence from substance use.*

Originality/value – *This paper discusses the application of evidence-based psychological interventions for substance use within a high secure, personality disordered population which has developed as a result of ministerial changes within the treatment of both substance misuse and personality disorder.*

Keywords *Treatment, Offenders, Prisoners, Personality disorder, Substance use disorders*

Paper type *Conceptual paper*

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Introduction

This paper aims to communicate the need for substance misuse treatment with high risk, personality disordered prisoners; the implementation of two evidence-based treatment components within a high-secure personality disorder treatment service (PDTS); changes to

this service in light of government policy recommending increased throughcare provision for substance using offenders; and future evaluation options.

Substance use, risk, criminogenic need and custodial policy

Substance misuse has been linked to offending behaviour in a range of ways. Substance-related offending includes offences committed under the influence of substances; offences being committed in order to fund substance use and; offences arising from the dealing and distribution of substances (Blackburn, 2003; NHS, 2009). Aside from acquisitive crime, violent and sexual offending can be linked to substance use, meaning that "substance use" is included as a factor in a range of risk assessment tools, including the violence risk scale (VRS) (Wong and Gordon, 2000), the HCR-20 (Douglas *et al.*, 2013) and the VRS – sexual offender version (Wong *et al.*, 2003). However, not all individuals who misuse substances commit crime and not all offenders misuse substances. This means that there is a specific forensic population that treatment providers have been tasked with developing, delivering and evaluating treatment for. Levels of substance use vary across substance using offenders (Weekes *et al.*, 2013), meaning that one size does not fit all in terms of treatment, supporting the widely accepted theory that the appropriate levels and intensity of offending behaviour treatment should be provided in order to maximise treatment outcomes including risk reduction (Bonta and Andrews, 2007). This theory underpins evidence-based psychological interventions with the offending population. McMurran (2007) and Bahr *et al.* (2012) explore the evidence-base in depth and highlight the most effective treatment methods for treating substance use as being: therapeutic communities, cognitive behavioural therapy (CBT) and pharmacotherapy (e.g. methadone maintenance). These methods of working have been incorporated into substance misuse services made available within the prison service in the UK.

The 2010 National Drug Strategy highlighted the extent of the problematic issue of substance use within the custodial setting (HM Government, 2010) which directed the need to reduce the supply and demand for drugs due to the "societal harm, including crime, family breakdown and poverty" that drug use causes. Within its drug strategy, the government aimed to reduce the demand and supply of drugs as well as increase the throughcare available for those accessing support to address substance misuse issues. The Home Office (2011) implemented "continuity of care" for substance using offenders, ensuring that regardless of whether they are transferring from/to any other setting (court, another establishment, the community) that criminal justice integrated teams take responsibility for the continuity of care provided for relevant offenders. Throughcare is not exclusively concerned with substance-related issues for offenders but also lifestyle modifications that can help to increase success in relapse prevention. Kerbs and Jolley (2010) discuss these as "co-occurring needs" across the continuum of the criminal justice system. For example, offenders progress from custody to supervised community conditions to unsupervised community living, leading to an increase in responsibility throughout. These protective factors include the requirement to secure employment, accommodation and support networks which Kerbs and Jolley (2010) suggest should also be targeted within substance misuse treatment.

The 2010 National Drug Strategy directed the progression of substance misuse treatment towards the addition of mutual aid being introduced alongside existing treatment interventions and a planned pilot of drug recovery wings. The recommendation to increase the use of throughcare through mutual aid aimed to maintain cognitive and behavioural changes made by offenders and thus minimise the likelihood of relapse. Historically in the UK, "mutual aid" has solely taken the form of the 12-step approach employed within alcoholics anonymous and narcotics anonymous. The proposed government changes, however, were that mutual aid in the criminal justice setting would take the form of prisoners considered to be "in recovery" from substance misuse taking the role of mentors or "Recovery Champions" alongside more formal treatment.

Self-Management and Recovery Training (SMART) Recovery is an internationally run organisation providing a network of evidence-based psychological interventions and self-help meetings. In line with the aforementioned government changes, SMART Recovery was rolled out across the prison estate following its initial pilot (MacGregor and Herring, 2010). SMART Recovery replaced previous substance-related offending behaviour treatment programmes, which were mainly CBT

based. SMART Recovery targets individuals identified as having problematic substance misuse and is abstinence oriented (although it does welcome participants taking prescribed medication). "InsideOut" is SMART Recovery's manualised, group-based intervention delivered in the criminal justice setting and encourages throughcare being secured by participants in order to maintain a drug-free lifestyle within the community setting. Throughcare is achieved through ongoing mutual aid being provided after "InsideOut" has been completed (SMART Recovery UK, 2011).

Substance misuse within the personality disordered population

The literature exploring the effectiveness of offending behaviour treatment programmes called for increased understanding into what types of treatments are effective with which types of offender (Lipton *et al.*, 2002). A specific sub-group within the offending population is that of personality disordered offenders. This population is of increased interest to service providers in the criminal justice setting given that two-thirds of offenders are considered to meet the criteria for at least one diagnosable personality disorder (Singleton *et al.*, 1998; Department of Health and Ministry of Justice, 2011), warranting the subsequent introduction of the offender personality disorder pathway (Joseph and Benefield, 2012). Aside from the previously mentioned risk assessments, personality assessment tools employed within the offender personality disorder pathway also capture substance misuse. The psychopathic trait of "need for stimulation/proneness to boredom" features within the Psychopathy – Checklist Revised (PCL-R) (Hare, 2003) and the borderline personality disorder trait relating to engagement in potentially "serious self-damaging behaviour" is assessed within the International Personality Disorder Examination (World Health Organization, 1997). This indicates that substance misuse is considered within formal assessment of personality disorder as well as risk assessments and warrants substance-related treatment for the personality disordered offender population.

Personality disorder and substance misuse commonly co-occur. McMurran (2008) presented evidence from international samples highlighting that individuals with substance use disorders are also likely to have a personality disorder diagnosis. In terms of offending, O'Driscoll *et al.* (2012) found significant evidence to suggest that personality disorders and substance-related disorders were key factors associated with higher levels of re-offending and a strong level of comorbidity between the two. This link was considered to be due to substance misuse exaggerating or exacerbating traits associated with personality disorder diagnoses (e.g. levels of aggression or impulsivity may be heightened). Other research within the literature base has highlighted specific personality disorder diagnoses associated with substance use. Alcohol and crime have been found to be most highly associated with Cluster B personality disorders (McMurran, 2008). This is not surprising given that Cluster B personality disorder diagnoses feature both borderline and antisocial personality disorders. In terms of co-morbidity levels, research suggests that 53 per cent of personality disordered individuals have a lifetime alcohol misuse diagnosis and 47 per cent have a lifetime drug misuse diagnosis (McMurran, 2008). Despite the evidence suggesting that substance use can exacerbate personality disorder traits, this will not always increase risk of offending. Some suggest that traits such as impulsivity, antagonism and the antisocial factor of the PCL-R (Hare, 2003) are pivotal in the relationship between personality and substance use (McMurran, 2008).

The requirement for substance misuse treatment with high risk, personality disordered offenders

When the four dangerous and severe personality disorder (DSPD) sites were set up in two high-secure hospitals (Broadmoor and Rampton) and two high-security prisons (HMP Frankland and HMP Whitemoor), each site was given responsibility for developing their own treatment frameworks as part of the piloted DSPD initiative. The Westgate PDTS – based at HMP Frankland (Durham) – developed its own evidence-based psychological model of treatment after consultation with an expert advisory group of psychologists and psychiatrists (Bennett, 2015). The Iceberg (substance misuse) treatment intervention was later developed as part of the Westgate PDTS's clinical framework. Recent research has explored Axis I-Axis II co-morbidity amongst the population of Westgate PDTS prisoners meeting the unit's suitability criteria. This

suggested that aside from an overall 87 per cent level of Axis I-Axis II co-morbidity, substance misuse disorders were the most frequently identified Axis I disorder with 80 per cent of this sample receiving a diagnosis (Bennett and Johnson, 2016). This confirms the need for substance misuse treatment services being available for this client group. Aside from the criminogenic need of substance misuse being relevant to this population, consideration into the format of treatment is warranted. Personality disordered individuals have a higher probability of general treatment non-completion compared to the non-personality disordered population (McMurran *et al.*, 2010). This could be due to personality disorder traits manifesting themselves in the form of treatment interfering behaviours (or "responsivity issues") (Howells and Tennant, 2010). Additionally, the PCL-R (Hare, 2003) incorporates the trait of "need for stimulation/proneness to boredom". In response to these personality factors, the Westgate PDTS delivers its treatment within one hour sessions; smaller group sizes of upto five participants; delivered by staff that have completed relevant training (Tew and Atkinson, 2013; Wood, 2015). This treatment approach is used in order to maximise treatment engagement. Additionally, prisoners' responsivity issues are identified and specific management strategies are put into place. This is done collaboratively with each individual to limit the negative impact these responsivity issues can have on treatment engagement (Wood, 2015; Bennett, 2015). After the completion of the DSPD pilot, the offender personality disorder pathway was introduced (Joseph and Benefield, 2012). These changes (in addition to the aforementioned custodial policy changes) have led to changes in the implementation of substance misuse treatment at the Westgate Unit. These are discussed below.

Evidence-based psychological substance misuse interventions at the Westgate PDTS

The Westgate PDTS currently offers two group-based interventions targeting the risk area of substance misuse. The Iceberg component (developed by Westgate staff experienced in delivering substance use treatment in mainstream prison settings) and the more recently introduced SMART Recovery "InsideOut". These two components are underpinned by differing treatment perspectives which share the ultimate aim of achieving abstinence. These treatment perspectives comprise a risk reduction approach (Iceberg) and a mental health approach (SMART Recovery). The intention behind continuing to deliver the Iceberg component in addition to the "InsideOut" component, was to provide a treatment pathway for personality disordered prisoners who require support for substance misuse. For example, a prisoner may complete the Iceberg component early on during his Westgate treatment pathway and may be recommended to complete the "InsideOut" component prior to progressing on to a lower security setting in order to provide additional support for substance misuse problems.

The Iceberg component

After prisoners are admitted and have integrated into the Westgate Unit's regime, they are offered an assessment and treatment needs analysis (ATNA) which determines whether the Westgate Unit can address their treatment needs as well as identifying a treatment plan (Bennett, 2015). At this point, the Iceberg component could be recommended as part of a prisoner's treatment pathway. Additionally, the ATNA informs the sequencing of interventions within a prisoner's treatment pathway in order to be responsive to individual need. The Iceberg component was adapted from mainstream custodial substance misuse treatment for use with the specific population of personality disordered offenders. It is a manualised treatment intervention which adopts a risk reduction approach and is based on CBT principles. Its facilitator team has, to date, comprised of prison officers, mental health nurses and forensic psychologists. Iceberg has been running at the Westgate PDTS since 2006. The Iceberg manual was reviewed following consultation with both component completers and Iceberg facilitators, via focus groups and reviewing post session debriefs. This consultation informed the revised (and shorter) Iceberg component, reflecting that out of session work could be used more to maximise generalisation and to reduce unnecessary repetition within the component. The aims of the component and the treatment needs it addresses were unchanged which was informed by the literature base and after consulting a subject matter expert in the field. The revised Iceberg component was first delivered in 2013 and is 29 sessions long incorporating 26 group and three individual

sessions. This also includes a pre-group session. The content of Iceberg is spread over three modules exploring:

1. Enhancing/maintaining motivation (nine sessions): these sessions explore and enhance motivation to change views on substance misuse or strengthen changes that participants have already made. Participants are asked to plot a "Life Review" to identify factors related to the development of their substance use, including any times of abstinence. Participants are introduced to the transtheoretical model of change (Prochaska and DiClemente, 1994) in order to highlight that cognitive and behavioural change can vary throughout an individual's life. Using this model helps participants to identify further changes required to facilitate or maintain change, which helps to end the module with goal setting.
2. Relapse prevention (15 sessions): participants are introduced to the CBT-informed Iceberg model. This model explains the concept of (observable) behaviours being connected to individuals' thoughts and feelings which are unobservable and therefore "under the surface". This is followed by exploring the effect that thoughts and beliefs have on substance use behaviour. The focus of relapse prevention is to develop skills and techniques to manage situations that are high risk for substance using behaviour. These skills relate to emotion management, problem solving, challenging thinking processes and social skills. Participants are presented with the opportunity to learn and practice skills relevant to substance misuse treatment need areas. In one of the individually facilitated sessions, participants are supported to develop a relapse prevention plan for one of their personally relevant high-risk situations. This informs a subsequent skills practice which is run during a group session. This is in line with role-play guidance specifically developed for treatment facilitators wherein a facilitator takes a "director" role and the roles within the skills practice can be taken on by the other facilitator and/or other group members (Daniels, 2005). This enables participants to practice relevant skills in a safe environment prior to generalising them as and when required.
3. Lifestyle modification (four sessions): this explores positive lifestyle changes that can be made within the areas of leisure, employment and educational opportunities. This is with the intention of minimising the likelihood of relapse and maximising the likelihood of participants achieving and remaining in the "maintenance" stage of change (Prochaska and DiClemente, 1994). Given that Westgate prisoners tend to be serving life sentences, this can focus on time within future prison establishments as well as in the community.

At the end of the component, participants' progress is reviewed and compiled in a post component treatment report summarising their areas of strength and development. In line with the established "What Works" literature (Andrews, 1995), areas of development inform post component objectives. These are reviewed by facilitators 12 weeks after completion of the component. This promotes ongoing skills generalisation and allows opportunities to target ongoing treatment need areas, which can be followed up by Westgate's substance misuse team if necessary. These are evaluated from both self-reported information and staff observations. Iceberg facilitators make use of multidisciplinary team settings such as staff briefings in order to orientate staff to observe, for examples, of skills generalisation. Individual progress is also assessed using the drug and alcohol versions of the drug taking confidence questionnaire (DTCQ) (Annis *et al.*, 1997) which are administered pre and post the Iceberg component.

At the time of writing, 54 prisoners have completed the Iceberg treatment since it was first introduced in 2006.

SMART Recovery ("InsideOut")

Complementary to Iceberg's risk reduction approach is SMART Recovery, which is a mental health focused intervention. SMART Recovery employs an approach encompassing: rational emotive behaviour therapy, CBT and motivation enhancement therapy. The rational emotive behaviour therapy (Ellis, 1993) approach means that the programme accepts that cognitive processes and belief systems can influence feelings and (addictive) behaviours. This is in addition to promoting a "self-help" approach to therapy. The programme developers claim that SMART Recovery "evolves" alongside the developing evidence base of psychological interventions, meaning that it employs some of the "most evidence-based methods available" (SMART Recovery UK, 2012, p. 3). This is

done in partnership with individuals "in recovery" and qualified psychologists. "InsideOut" is delivered by "champions" who are staff of various disciplines who have had experience of delivering group work and who have completed the SMART Recovery Champion Training (SMART Recovery UK, 2011). At the Westgate PDTS, this provision is provided via a dedicated Substance Misuse Team of trained prison officers, healthcare and psychology staff. This team is overseen by an operational manager, a nurse manager and chartered forensic psychologist (who provides clinical supervision). The Substance Misuse Team on the Westgate Unit also offers a range of interventions under the supervision of qualified clinical staff. This includes provision for individual treatment for complex cases; voluntary drugs testing; acupuncture; stress management; and guided visualisation. Due to the estate wide introduction of SMART Recovery, all Westgate prisoners were reviewed in order to ascertain need for the "InsideOut" treatment programme through the use of a triage system to identify and prioritise treatment need.

The aspect of SMART Recovery that is currently being implemented by the Westgate PDTS is the "InsideOut" group-based intervention which comprises of 24 group-based sessions (including two introductory sessions). "InsideOut" is a psycho-educational treatment programme that focuses on the development of skills and techniques designed to maximise the probability of becoming and staying substance free. It was devised with the offending population in mind and therefore encompasses criminal as well as addictive behaviours. It was designed to complement SMART Recovery meetings which provide mutual support for participants. One cohort of peer-led support has also run, which consisted of a group of five participants attending weekly sessions for a nine week period. Due to the Westgate PDTS providing treatment for longer term sentenced prisoners, the immediate focus of throughcare includes future prison establishments that prisoners progress on to. "InisdeOut" was developed around the SMART Recovery "four-point programme", incorporating the following:

1. Point 1: building and maintaining motivation (three sessions): this comprises what factors are important for participants, the costs and benefits of change and goal setting related to substance use. Participants achieve these aims by completing a hierarchy of values (a list of things most important to the participant), a "Cost Benefit Analysis" and setting specific measurable achievable realistic (SMART) goals.
2. Point 2: coping with urges (seven sessions): this increases understanding into urges and how to manage them which is achieved by participants exploring patterns within their substance using behaviour. Participants are also introduced to high-risk situations and how to appropriately manage these.
3. Point 3: managing thoughts, feelings and behaviours (seven sessions): participants explore cognitive distortions and belief systems that justify substance use and ways to challenge these. This is followed by identifying the role of anger, stress and depression within substance use and how to manage these without resorting to substance use. Skills taught within this aspect of the programme include identifying unhelpful decision making and skills such as disputing irrational beliefs, delay, escape, accept, substitute and using mindfulness to manage stress.
4. Point 4: living a balanced life (five sessions): this relates to the development of a pro-social support network and culture and maintaining changes through SMART Recovery skills. The mutual aid aspect of SMART Recovery is introduced at this stage in order to encourage skills generalisation.

Although the mutual aid aspect of SMART Recovery is not currently running at the Westgate Unit (due to staffing changes in the team and training requirements for new team members), peer-led sessions are planned for the near future.

Evaluation

Future evaluation of Westgate's substance misuse remit (exploring both Iceberg and SMART Recovery) is currently being planned. The Westgate Unit's clinical management team recognise that there is some overlap between both Iceberg and SMART Recovery, which is something that is intended to be explored within future evaluation. The Westgate Unit's treatment framework and its components have evolved since the unit opened in 2004 and it could be that Iceberg does not

need to run in addition to SMART Recovery. Evaluation into this will therefore inform the clinical management team how to prioritise treatment resources and any changes to substance misuse treatment provision at the Westgate Unit.

Some research into other treatment components which are offered by the Westgate Unit has already been undertaken. This has focused on prisoners who have completed their entire treatment pathway and progressed to lower security establishments (Tew *et al.*, 2012). The authors recognise a limitation in that the contribution of individual treatment components cannot be distinguished. The Westgate Unit's research strategy attempts to address this limitation. Future evaluation could explore: psychometric data; drug testing data and institutional information (such as adjudication data). Both the drug and alcohol versions of the DTCQ (Annis *et al.*, 1997) are administered pre and post the Iceberg component. This data could explore any significant changes in confidence levels following completion of the Iceberg component and increase understanding into whether the component is more effective for individuals with particular personality disorder diagnoses or aspects of psychopathy.

Given the length of time that SMART Recovery has been internationally implemented, research on a larger scale level is now surfacing. A recent study has explored reconviction outcomes of SMART Recovery and "Getting SMART" (training provided to service-users to become facilitators under supervision) with a large sample of Australian prisoners (Blatch *et al.*, 2016). This study compared prisoners who had attended either SMART Recovery, Getting SMART or both programmes against a matched comparison group during a four year period. Participation in "Getting SMART" was significantly associated with lower time to first general reconviction (8 per cent) and violent reconviction (13 per cent). Findings for participants attending both programmes concluded that reconviction rates were significantly lower for general crime (21 per cent) and violent crime (42 per cent). The authors go on to cite that just 20 hours in attendance at either SMART programme was sufficient in detecting a significant therapeutic effect on participants. This provides encouraging evidence of the effectiveness of SMART Recovery within a large sample of the general offending population. Given that the population at the Westgate Unit is high risk and mainly life sentenced prisoners, reconviction research will not be feasible in the immediate future (Tew *et al.*, 2015). This would make it difficult to replicate a study similar to Blatch *et al.* (2016) to explore the potential impact of SMART Recovery. This is not to say that effective research cannot be conducted by the Westgate Unit in the future and current plans intend to address this. Given the limited staffing resources available for research within the Westgate Unit, efforts have been made to initiate and establish working relationships with academic departments and local research networks. This is with the view to engage in evaluation and co-production with research experts and inform future clinical practice. The starting point within this is to complete a process evaluation of the Iceberg component, similar to what has been reported for other Westgate treatment components (Tew *et al.*, 2015). This would increase understanding into the group of prisoners who have been offered the Iceberg component (including starters/non-starters and completers/non-completers), their levels of engagement and any outcomes that can be evidenced. This will increase understanding into who has engaged in Iceberg to date and trigger future research in this area.

Conclusion

In conclusion, the high risk, personality disordered population have a need for substance misuse treatment. Treatment is offered by the Westgate PDTS, a high-security prison site within the offender personality disorder pathway. This is in line with both the criminogenic need of this client group and government policy for tackling substance misuse problems. Future research will evaluate the impact of this service and this will be disseminated within the developing literature base[1].

Note

1. In line with the Westgate Unit's research strategy, the authors would like to invite any parties interested in establishing a research connection to make contact. This would be with a view for evaluation and co-production.

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Personality factors related to treatment discontinuation in a high secure personality disorder treatment service

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Abstract

Purpose – *The purpose of this paper is to explore the range of personality disorder diagnoses and levels of psychopathy as assessed by the Psychopathy Checklist-Revised (PCL-R) associated with treatment discontinuation in a sample of adult male prisoners.*

Design/methodology/approach – *Data from 92 male offenders in a high secure prison personality disorder treatment unit was analysed. PCL-R and personality disorder diagnoses were predicted as being related to increased treatment dropout.*

Findings – *Having a diagnosis of narcissistic personality disorder was related to treatment dropout, but PCL-R total scores were not. There was a trend for a diagnosis of antisocial personality disorder being associated with remaining in treatment.*

Research limitations/implications – *The current study highlights that narcissistic personality disorder can be associated with treatment dropout, warranting further exploration as to why this is the case.*

Practical implications – *Managing responsivity issues for those presenting with a personality disorder diagnosis could be effective in maximising treatment engagement from this specific offender group.*

Originality/value – *Although treatment dropout has been explored previously, this is the first study to explore treatment dropout at a specialised unit designed specifically to provide treatment for this client group.*

Keywords *Personality disorder, High security, Personality factors, Psychopathy, Treatment discontinuation, Treatment dropout*

Paper type *Research paper*

Introduction

Non-completion of treatment programmes in prison has various implications for treatment services including the negative impact on staff, for other offenders attending treatment, service cost effectiveness and denial of the service to others (McMurran *et al.*, 2010). Improved completion rates could lead to significant cost savings to forensic treatment services (Sampson *et al.*, 2013). This is particularly important given an economic climate focused on cost efficiency and reducing costs. In addition, there is evidence to suggest that treatment non-completers have higher rates of recidivism than untreated offenders (McMurran and Theodosi, 2007). Therefore, better understanding of treatment dropout would help both service providers and service users, as well as serve the wider public with regards to more effectively protecting the community.

There is an increased likelihood that offenders who meaningfully engage in (and subsequently benefit from) behaviour treatment programmes present with reduced offending rates and in turn a reduced risk of harm to the public (McMurran and Theodosi, 2007). Understanding which offenders are most likely to withdraw from treatment therefore becomes important. Offenders who are more likely to encounter difficulties in the engagement and completion of treatment

programmes provided within criminal justice services are thought to be those diagnosed with personality disorders (McMurran *et al.*, 2010). Personality disorders are patterns of behaviour or experiences that significantly deviate from what is expected from the individual's culture. These deviations manifest themselves within the areas of: cognition, affect, interpersonal functioning and impulse control and cause challenges for the individual concerned and those they come into contact with (American Psychiatric Association, 2013). This is particularly the case if the offender has an above threshold score on a psychopathy measure. Psychopathy is a personality type represented by traits presenting a pattern of interpersonal, affective and socially deviant behavioural features (Hare, 2003). There is overlap between psychopathy and personality disorder with Hart and Hare (1989) reporting evidence that ratings of antisocial, histrionic and narcissistic personality disorders were significantly associated with total psychopathy scores as well as Factor 1 psychopathy scores (i.e. affective and interpersonal characteristics), while Factor 2 scores (i.e. relating to an unstable, antisocial lifestyle) were significantly related to antisocial personality disorder ratings alone. Thus, psychopathy could reasonably represent an accumulation of personality disorder traits worthy of exploration in treatment attrition.

Taking personality disorder in the first instance, the combination of re-offending risk and personality disorder may affect treatment readiness and/or responsivity issues (Howells and Tennant, 2010). The literature on the non-completion of treatment for those with a personality disorder is developing both in terms of health and criminal justice services (e.g. McMurran *et al.*, 2010). However, this small, but growing body of work has started to provide some insights concerning non-compliance of treatment, for example, those with a personality disorder who complete psychological treatment have higher levels of rational approaches to problem solving (McMurran *et al.*, 2008). The limited literature base has, nevertheless, only just started to examine the potential impact of specific personality disorders relevant to treatment dropout among offenders. This is illustrated by McMurran *et al.* (2010) work which systematically reviewed 28 studies exploring non-completion of psychological or psychosocial treatment programmes developed for both offenders and non-offenders with personality disorder. It was identified in this review that non-completion of treatment was related to a range of risk and personality factors. Discontinuation of treatment was associated with some specific personality disorder categories but also an accumulation of disorders. The individual categories of avoidant, borderline, obsessive-compulsive, histrionic, antisocial, dependent and non-specific personality disorders were each associated with treatment dropout, as were the personality disorder clusters A (i.e. paranoid, schizoid, schizotypal) and B (i.e. antisocial, borderline, histrionic, narcissistic).

Other studies in addition to McMurran's review have continued to explore treatment non-completion in a range of personality disorder treatment services. Sheldon *et al.* (2010) explored dropouts from a high secure hospital treatment programme. They found the main factors relating to non-completion were: affective: general distress of the patient or specific emotional reactions to previous offending, such as shame; volitional: pursuing goals other than treatment; and cognitive: negative self-efficacy beliefs and negative evaluations (low trust) of staff and the programme. Research into personality disorder treatment dropout among the offending population in the UK prison setting is in its infancy, highlighting a benefit of the current study in developing a foundation within this specific research area. Other research exploring a psychosocial programme aimed at a non-forensic personality disordered adult population identified borderline personality disorder as a predictor of programme non-completion (Martino *et al.*, 2012). Samuel *et al.* (2011) examined treatment dropout following nine months' residence in a community-based residential Therapeutic Community (TC) for those with personality disorder – within both the first 30 days and overall. Borderline personality disorder related to discontinuation at any stage and antisocial personality disorder and histrionic personality disorder to early dropout only.

Moving onto the concept of psychopathy and non-completion in treatment, it has been found that there is a relationship between treatment attrition and psychopathy, although this usually focuses on psychopathy in isolation from personality disorder (at least disorders wider than antisocial personality disorder), which is interesting considering the potential overlap between these concepts. Exploration of the relationship between psychopathy scores and treatment

non-completion has also, like personality disorder, provided mixed evidence. McCarthy and Duggan (2010), for example, compared completers and non-completers in a medium security hospital unit. Their findings suggest that completers had lower scores on the Psychopathy Checklist-Revised (PCL-R; Hare, 2003), accounted for by Factor 2 rather than Factor 1 scores. Cullen *et al.* (2011) explored non-completers among "mentally disordered" offenders, finding evidence to suggest that treatment non-completion could be predicted by higher PCL-R Factor 2 scores and/or a diagnosis of antisocial personality disorder. The emotional disorder facet linked to Factor 1 of the PCL-R has also been linked to increased treatment dropout within a sample of sex offenders (Olver and Wong, 2011).

Thus it appears there is sufficient evidence to suggest that both personality disorder and psychopathy are associated with treatment attrition. The current study aimed to explore whether these concepts were related to treatment dropout from a personality disorder service based in a high secure prison setting. The literature to date has produced mixed findings and with a combination of forensic and non-forensic personality disorder treatment providers. This limited the nature of the directional predictions that could be made within the current study. Nevertheless, there was a sufficient basis on which to predict that personality disorder diagnoses and increased PCL-R scores would be associated with increased rates of treatment dropout. Due to the inconsistent findings within the literature, predictions relating to specific personality disorder diagnoses or PCL-R factors could not be made.

Method

The local ethics committee of the personality disorder treatment unit where the study took place approved the study.

Participants

In total, 92 participants were included. Participants were taken from a sample of adult male offenders resident at some point in the high secure prison personality disorder treatment service since it opened in 2004 until the point of data collection (November 2013) and who had begun treatment. The unit was a specialised unit with 65 beds available at any one time. An anonymised data set was taken from the unit's master database which included PCL-R scores and personality disorder diagnoses. Criteria for admission to the service (as laid out by Dangerous Severe Personality Disorder (DSPD) Programme, 2008) were:

- A significant/high risk of re-offending;
- Presence of a "severe" personality disorder (evidenced by either: a PCL-R score of 30 (95.8th percentile) and above; a PCL-R score of between 25 and 29 (85.2th-94.4th percentile) combined with at least one PD other than antisocial PD; or two or more PDs (regardless of the PCL-R score)); and
- The presence of a "functional link"[1] between the disorder and the risk of re-offending.

Participants were then allocated to one of two groups within the current study, according to progress: "dropout" ($n = 41$) or "non-dropout" ($n = 51$). "Dropouts" were offenders who subsequently left treatment for any reason and had not returned to treatment at the time of data collection. "Non-dropouts" were offenders who had engaged and remained in treatment in the unit for at least two years by the time of data collection.

Treatment programme description

The personality disorder treatment service is part of a pathway developed to support offenders likely to have personality disorder through custody settings into the community (the Offender Personality Disorder Pathway, Department of Health and Ministry of Justice, 2011). Its treatment framework is described in detail elsewhere (Bennett, 2014; Tew and Atkinson, 2013). In summary, treatment includes components based on cognitive behavioural methods in the form of both group and individual sessions and components designed to maximise treatment engagement. Risk focused treatment was preceded by a programme referred to as the

Chromis Motivation and Engagement component designed to set treatment goals (Tew and Atkinson, 2013) as well as psycho-education, designed to provide an understanding of personality disorder as well as set treatment expectations and boundaries.

Additional support for individuals experiencing treatment interfering behaviours ran in parallel to the range of other treatments on the unit where the study took place. "Imminent Need Services" are voluntary treatment services designed to support participants in managing their responsivity issues to maximise treatment benefits (Bennett, 2014). This service includes Dialectical Behavioural Therapy (Linehan, 1993) for unstable affect, Cognitive Behavioural Therapy which targets Axis I disorders that leads to emotional distress, and Eye Movement Desensitisation Reprocessing (Shapiro, 2001) therapy that assists with reprocessing traumatic memories. In addition, the unit had responsivity management strategies inside and outside of the treatment room (Wood, 2015). These included "responsivity planning", where treatment interfering behaviours and management strategies were collaboratively identified between staff and offenders. Additionally, multidisciplinary working and staff training had been developed to promote awareness and management of this population.

Results

In total, 41 participants had discontinued treatment and 51 had either completed treatment or remained in treatment until the end of the study. The mean total PCL-R score overall was 30 (range 15-40); it did not differentiate the groups (see Table I). Four participants were without categorical personality disorder diagnoses recorded in the master database, two because the assessments were considered invalid and two for reasons unknown. Diagnoses are otherwise shown in Table I.

Logistical regression tested PCL-R total score and personality disorder diagnoses in order to evaluate whether they could predict treatment dropout in the sample. Bivariate analyses were conducted between treatment continuation status ("dropout" vs "non-dropout") as well as personality categories and PCL-R scores. In line with the appropriate procedure for logistic regression, a model including only the constant was analysed first. Within this model, the χ^2-statistic was 6.69 and not significant ($p = 0.4$ ns). This meant that when excluded from the model, none of the variables were identified as making a significant contribution to the predictive power of the

Table I Demographic, PCL-R and personality disorder diagnosis data for "Dropouts" and "Non-Dropouts"

Demographic data	*"Dropout", n = 41*	*"Non-dropout", n = 51*
Age (years)		
Mean	42.5	41.9
SD	11.53	7.84
Sentence type		
Determinate	10	2
Indeterminate/life	31	49
Sentence length/tariff (years)		
Mean	8.5	9.0
SD	5.26	5.25
Psychopathy	*"Dropout", n = 41*	*"Non-dropout", n = 51*
PCL-R total scores		
Mean	30.0	29.5
SD	4.39	4.63
Personality disorder diagnoses	*"Dropout", n (%)*	*"Non-dropout", n (%)*
Paranoid personality disorder	14 (36.8)	16 (32)
Schizoid personality disorder	5 (13.2)	7 (14)
Antisocial personality disorder	30 (78.9)	46 (92)
Borderline personality disorder	21 (63.2)	30 (60)
Narcissistic personality disorder	14 (36.8)	9 (18)
Avoidant personality disorder	7 (18.4)	10 (20)

model. For this reason, the analysis was terminated at this stage. The statistics are reported in Table II.

Logistic regression was then performed with treatment continuation status as the dependent variable; only those independent variables that accounted for more than 90 per cent of this outcome in each category were included. These were presence or absence of diagnoses of paranoid, schizoid, antisocial, borderline, narcissistic and avoidant personality disorders (categorical variables) and PCL-R total score (continuous variable). Narcissistic and antisocial personality disorders were independently associated with discontinuation of treatment at the 10 per cent level ($p = 0.06$ and $p = 0.09$, respectively). In order to explore these further, an additional logistical regression was conducted with narcissistic and antisocial personality disorders as independent variables. Results are indicated in Table III.

A test of the full model against a constant only model was statistically significant, indicating that the predictors (as a set) reliably distinguished between "dropouts" and "non-dropouts" ($\chi^2 = 7.28$, $p = 0.03$). The Wald criterion demonstrated that only narcissistic personality disorder made a significant contribution to the predictive power of the model ($p = 0.04$). Antisocial personality disorder was considered to make a significant contribution to the model but only at a 10 per cent level of significance ($p = 0.08$). The odds ratios suggest that when the variable of narcissistic personality disorder increases, the odds of treatment dropout increases. As the variable of antisocial personality disorder increases, the odds of treatment dropout decreases (although only a trend).

Discussion

The current study aimed to explore whether PCL-R scores and/or presence of personality disorder was associated with treatment dropout within a sample of adult male offenders who had met the criteria for the personality disorder services in the high secure estate. The current study provided no evidence to suggest that PCL-R scores were related to treatment dropout within this sample thus not supporting the prediction that increased PCL-R scores would be associated with treatment dropout. Partial evidence was found for the prediction that personality

Table II Logistic regression analysis for variables not in the equation

Predictor variable	*Roa's efficient score statistic*	*df*	*p*
PCL-R total score	0.15	1	0.69
Paranoid personality disorder	0.11	1	0.73
Schizoid personality disorder	0.00	1	0.92
Narcissistic personality disorder	3.54	1	0.06
Antisocial personality disorder	2.85	1	0.09
Borderline personality disorder	0.08	1	0.77
Avoidant personality disorder	0.00	1	0.96
Overall statistics	6.69	7	0.46

Note: $n = 92$

Table III Logistic regression with antisocial and narcissistic personality disorders as predictors

	B	*Wald*	*Lower confidence interval (95%)*	*Odds ratio*	*Upper confidence interval (95%)*
Included					
Constant	0.31				
Antisocial PD	−1.19	3.13	0.88	3.27	12.17
Narcissistic PD	1.02	4.05	0.13	0.36	0.97

Note: $n = 92$

disorder diagnosis would be associated with treatment dropout, with narcissistic personality disorder significantly related to treatment dropout and a trend for a diagnosis of antisocial personality disorder being related to staying engaged in treatment. No other personality disorders were, however, associated with treatment dropout.

This study contributes to research exploring the association between personality disorder diagnoses and treatment dropout (McMurran *et al.*, 2010). It adds to a mixed evidence based which could be explained in part by the high variance of treatment frameworks utilised across personality disordered offenders captured in the research studies. Research findings in this area of study could arguably be dissimilar due to the difficulties in generalising from the specific population and treatment programme studied as opposed to represent a true indication of variance across disorders.

The finding that narcissistic personality disordered offenders are more likely to become treatment "dropouts" is arguably expected when the individual traits which comprise narcissistic personality disorder are considered. For example, those with narcissistic personality disorder may consider themselves to be without treatment needs or feel that treatment is insufficiently "special" enough to capture their unique qualities. In addition, narcissistic traits associated with a lack of empathy or remorse for their actions (e.g. offending) could make those with narcissistic traits uninterested in making clinically meaningful change through treatment. These suggestions would be supported by the criteria of narcissistic personality disorder which includes having a grandiose sense of self-importance, a sense of entitlement and difficulties in appreciating impacts on others (American Psychiatric Association, 2013).

The traits of narcissistic personality disorder may also be challenging to clinicians' ability to tolerate difficult behaviour and presentations. Future research could explore clinicians' attitudes and tolerance towards service users with varying personality disorder diagnoses to explore whether this is the case and whether this has informed treatment dropout. It could highlight a supervision and training need for clinicians in order to effectively work with this challenging population. Indeed, McMurran *et al.* (2010) identified two studies that recognised narcissistic personality disorder as being predictive of treatment dropout. This is significant to reflect upon given the findings of the current study where it does appear there is something fairly unique concerning the presentation of such a personality and sustained meaningful engagement in treatment.

McMurran *et al.* (2010) also highlight research suggesting that Cluster A and Cluster B personality disorders (that latter which would include narcissistic and antisocial personality disorders, amongst others) were predictive of treatment dropout from a psychotherapy treatment programme. Cluster B is often referred to as the "dramatic cluster" and it would seem that it is only personality disorders from this cluster that has been found to associate with treatment dropout in the current study.

The lack of association with PCL-R total scores was, however, of interest and inconsistent with previous research (e.g. McCarthy and Duggan, 2010; Cullen *et al.*, 2011). One possible explanation for the PCL-R not being related to treatment dropout when aspects of personality disorder were could be due to the PCL-R capturing a broader range of challenging personality disorder traits whereas it is the more specific set of traits (e.g. narcissistic) which is more relevant than the more global personality concept of psychopathy. Furthermore, despite a moderate sample size of 92, the limited variance within PCL-R total scores (see Table I) may be an alternative reason for the lack of significance within this predictor: the sample were simply too uniform on this measure to allow for differences to be detected. This is a limitation with using the total PCL-R score only but a challenging one to overcome for the current study since it is only the total score which can warrant suitability for admission to high secure personality disorder treatment services within the population under study.

Although the sample acquired was moderate in size, it was taken from a specialised unit and covered a nine-year period for potential inclusion. Nevertheless, there remain limitations as to what the current study could achieve. The low prevalence of some personality disorders in either the "dropout" or "non-dropout" categories meant that not all personality disorder diagnoses could be included as predictors within the logistic regression. Future research could revisit these

more minority personality disorder groups when a larger sample size becomes available in order to increase understanding about treatment dropout within other personality disorder clusters. The diagnoses used in the current study were also broad measures of personality constructs focusing on an overall diagnosis and not differences within such a diagnosis. Future research could expand on this further by looking at specific personality disorder traits, and also psychopathic traits and facets, in order to increase understanding of personality traits associated with treatment dropout. Furthermore, exploring personality functioning in addition to personality disorder, thus mirroring developments in the DSM-V Alternatives Model (American Psychiatric Association, 2013) where functioning as well as traits are considered important, would represent a valuable avenue for future research to employ.

Overall, the current study was able to provide some evaluation of personality disorder diagnoses and levels of psychopathy and how these related to treatment dropout. It highlighted the importance in capturing individual diagnoses and exploring concepts beyond a PCL-R score in offenders detained within high security in order to ascertain what could promote treatment dropout. It also highlights the importance of not presuming that personality disorder, and its related concepts, automatically associate with increased risk of exiting treatment; it suggests there are differential relationships evidenced between personality disorders in relation to treatment engagement.

Implications for practice

- Offenders with a diagnosis of narcissistic personality disorder may be more challenging to engage in treatment when compared to those without these diagnoses.
- Managing responsivity issues posed by offenders with a personality disorder of this nature in order to maximise their treatment engagement and extend knowledge of effective practice is important. This understanding would help increase the probability of narcissistic personality disordered offenders completing treatment and subsequently have the potential to impact positively on rates of reoffending.
- To focus on the individual personality disorder diagnosis as a potential factor linked to treatment dropout as opposed to generically considering "personality disorder" as a factor automatically associated.

Note

1. The term "functional link" refers to an evidenced relationship between the presence of personality disorder and offending, in this case violent offending.

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Service users' initial hopes, expectations and experiences of a high security psychologically informed planned environment (PIPE)

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Abstract

Purpose – *The purpose of this paper is to explore service-users' hopes and expectations of a psychologically informed planned environment (PIPE) located in the high-security prison estate.*

Design/methodology/approach – *A semi-structured interview was used to explore the hopes and expectations of five male Category A PIPE prisoners. Interviews were transcribed verbatim and thematic analysis was used to analyse the data.*

Findings – *Analysis resulted in two overall themes: "Progression" and "Being Part of a Community". Relevant sub-themes were considered to portray processes within these two wider themes.*

Practical implications – *In applying these findings to practice, this study provides evidence that places value on the current referral process which ascertains prisoners' motivations to attend the PIPE.*

Originality/value – *This is the first known study that explores service-users' hopes and expectations of the pilot PIPE service. The PIPEs are included within the recently introduced Offender Personality Disorder Pathway.*

Keywords *Community, Category A, Offender Personality Disorder Pathway, Progression, Psychologically informed planned environment (PIPE), Service-users expectations*

Paper type *Research paper*

Introduction

The Offender Personality Disorder (PD) Pathway was developed to support offenders' passage from various criminal justice or community health settings through to the community. This pathway was to be funded by existing resources in order to attain benefits at no additional cost to the taxpayer. Funding previously allocated to a decommissioned Dangerous and Severe Personality Disorder (DSPD) high-secure hospital site was subsequently reinvested into the resulting Offender PD Pathway. This led to two high-secure prison sites and one high-secure hospital continuing to provide DSPD provision in a more cost-effective way (Department of Health and Ministry of Justice, 2011). Following a review of the Offender PD Pathway Implementation Plan, a response was made detailing the aim to address the needs of high-risk offenders through collaborative working between the Department of Health and National Offender Management Services (Department of Health and Ministry of Justice, 2011). One aim of the pathway was to provide "additional support to those who have completed programmes" (Taylor, 2012). In order to provide such support, psychologically informed planned environments (PIPEs) were developed and implemented in prisons and community-based approved premises. PIPEs are purposely developed environments staffed by an identified team who are specifically trained to have a "psychological understanding" of offenders. This understanding

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enables staff to provide "a safe and facilitating environment that can support offenders to retain the benefits gained from treatment, to test offenders to see whether behavioural changes are retained and to facilitate offenders to progress through the system in a planned and pathway-based approach" (Joseph and Benefield, 2012). Despite previous DSPD funding being reallocated within the Offender PD Pathway, PIPE services are not exclusively for prisoners who have met DSPD criteria. PIPEs were developed for individuals who have completed high-intensity treatment. It is recognised by service developers however, that "two-thirds of offenders meet the criteria for at least one personality disorder" (Department of Health and Ministry of Justice, 2011), identifying the need for PD services at a range of levels, not solely within high-secure services. Individuals identified as being personality disordered or psychopathic present with responsivity issues that interfere with treatment engagement. This is due to the pathology and behaviour presented by such individuals which previously deemed them unsuitable for treatment (DSPD Programme, 2008). Responsivity issues include anti-authoritarian attitudes, unpredictable behaviour, emotional reactions and inappropriate problem solving (Coid, 1998) as well as cognitive distortions and low motivation to attend treatment (Lord, 2010). These responsivity issues mean that staff selection, appropriate treatment and supportive services are of paramount importance within PD services (DSPD Programme, 2008; Lord 2010).

A Guide to Psychologically Informed Planned Environments produced by the Department of Health and Ministry of Justice (2012) suggests that the specific aims of the PIPE service include:

- to encourage positive relationships/co-working with staff;
- to promote skills generalisation;
- to provide a structured regime;
- to encourage prisoners' contribution to the environment;
- to encourage goal setting; and
- to encourage the socialisation of service-users.

The aims of the PIPE have some similarities with other services developed for offenders. For example, the Therapeutic Community (TC) ethos encourages the development of social relationships to bind community members and increase co-working with staff. Individual and collective responsibility of TC residents is also encouraged, with the intention to increase accountability (Cullen, 1997). Research within community-based PD services have similarly emphasised the importance of therapeutic working with staff, considered important to encourage change (Jacobs *et al.*, 2010). Despite PIPE services currently being within the pilot phase, developers are making efforts to evaluate the initial implementation of the service. Amongst other areas, this includes the perceptions of the service by service-users (Rahim, 2013). Since PIPE's initial implementation, additional sites have been opened accommodating different offender groups. One particular offender group catered for within one of these sites includes Category A prisoners. A Category A prisoner is defined as "a prisoner whose escape would be highly dangerous to the public, or the police or the security of the State, and for whom the aim must be to make escape impossible". Category A prisoners are reviewed annually by a security panel, where the decision is made as to whether prisoners should be downgraded to Category B status (National Offender Management Service, 2011). Gaining an understanding of this specific group is valuable given the limited post-treatment progression options for Category A prisoners. This would contribute to the developing literature base of the PIPE pilot.

Service-users' views are being explored increasingly within the literature base surrounding forensic services. Some research has provided evidence to suggest that staff may rate intended implementation aims of a service more highly than service-users (Corlett and Miles, 2010). Such research surrounding service-users' perspectives of mental health services is deemed valuable considering that such views "can inform professional responses to their complex needs" (Coffey, 2006). Previous research has explored service-users' expectations of pilot services in high-secure custodial settings (including DSPD services). Crews (2006) found evidence to suggest that participants' expectations of a high-secure DSPD pilot site were only partly

congruent with the stated aims of DSPD services. The main discrepancy was that participants considered that they needed to "tick boxes" during their time on the programme in order to achieve their expectation of risk reduction and ultimately, release into the community. This study completed subsequent follow-up research, indicating that service-users' expectations of the DSPD service became more congruent with the aims of DSPD following positive change through treatment (Crews, 2006). Deci and Ryan (2008) discuss differing types of motivation, namely "intrinsic motivation" (where an individual carries out a behaviour as it is interesting or satisfying to them) and "extrinsic motivation" (where the behaviour is carried out to avoid punishment or attain a reward). This is relevant when exploring prisoners' hopes and expectations of a service as motivation could impact upon an individual's hopes of a service. Deci and Ryan (2008) also discuss "autonomous motivation" (where someone behaves fully with choice) and "controlled motivation" (where an individual behaves with the experience of external pressures) which is also relevant to prison-based research given that prisoners have sentence planning targets allocated to them during their time in custody. These targets need to be met in order to achieve a reduction in risk, lower secure conditions and ultimately, release. Autonomous motivation is said to be facilitated by the factors of competence, autonomy, and relatedness which appear to run parallel to the above aims of the PIPE.

As PIPE admission criteria includes the completion of high-intensity treatment, it was considered beneficial to explore offenders' hopes and expectations for the PIPE and how well these mirror the aims of the PIPE. An increased understanding of prisoners' expectations of the PIPE and whether these are congruent with the developers' aims of the PIPE was considered beneficial given that PIPEs are currently being piloted. Increased understanding of prisoner expectations was deemed useful to inform PIPE policy makers, PIPE staff training, prisoner inductions, staff selection and prisoner selection. The current study was therefore designed with the intention to explore prisoners' hopes and expectations of a Category A PIPE.

Method

Participants

Participants were five male prisoners (aged between 29 and 63, mean 42.40 years) located on a high-secure PIPE unit. Four participants were serving life sentences and one participant was serving an Indeterminate Sentence for Public Protection. Tariff lengths were between six and 17 years with the mean tariff length being 12.20 years. Index offences across the sample included both violent and sexual convictions. Treatment previously completed varied across participants. This included programmes targeting thinking skills, sexual offending, anger management with one participant previously completing the DSPD programme. Opportunity sampling was used in participant selection. Prospective participants were selected on the basis that they had been located on the PIPE unit for less than four weeks. This criterion was specified at the outset of the study in order to elicit initial expectations of the PIPE. During the recruitment stage, potential participants were provided with an information sheet describing the aims and format of the study. Participants were assured anonymity and confidentiality (provided no individual was at risk of harm) which is Prison Service policy. One prisoner declined to participate at the recruitment stage. At the start of interviews, participants were encouraged to provide their honest expectations. The interviewer (who did not work on the PIPE) informed participants that there were no right or wrong answers and there would be no positive or negative outcomes, regardless of participants' opinions.

Location of the study

The study was conducted at a self-contained Category A PIPE integrated within a mainstream prison establishment. In addition to PIPE's general criteria that admissions should have completed high-intensity offending behaviour treatment, this unit was deemed suitable for prisoners who:

- were Category A male prisoners aged at least 21 years;
- had a minimum of twelve months to serve on their sentence or be serving an indeterminate sentence;

- could manage any mental problems (if applicable) on mainstream prison location;
- had sufficient intellectual ability to engage in mainstream prison regime activities;
- were adjudication free and had shown stable behaviour/consistent motivation and engagement in his sentence plan for at least six months prior to referral; and
- were not being monitored via an Assessment, Care in Custody and Teamwork (ACCT) document (a Prison Service protocol following when a prisoner is at risk of self-harm or suicide).

The PIPE unit incorporated a "mixed regime", i.e. prisoners on the unit had transferred to the PIPE from both mainstream and "Vulnerable Prisoner" (VP) wings. VPs are prisoners that are segregated from mainstream prisoners for their own protection. This can due to the nature of their offences (meaning that a high percentage of VPs are sexual offenders), debt to other prisoners, etc. (Flynn, 2002). The PIPE's regime included components such as structured sessions, creative sessions, key-worker sessions and wing forums. Running parallel with these sessions were the ongoing encouragement of skills development, building relationships and achieving goals.

Data collection and analysis

Ethical approval was granted by senior management of the PIPE. The study utilised a semi-structured interview incorporating mainly open-ended questions designed to explore prisoners' expectations of the PIPE. The interview schedule can be made available on request to the author. Interviews were recorded using a Dictaphone and transcribed verbatim. Thematic analysis was used to analyse data in the six steps described by Braun and Clarke (2006). These phases are presented in Table I.

A second coder was used in order to maximise reliability of the study's findings. Both coders independently completed phases 1-3 and discussed their identified themes within phase 4. This discussion led to identified themes being refined and assisted to prepare for phase 5. These finalised themes were developed into a thematic map (Figure 1).

Results

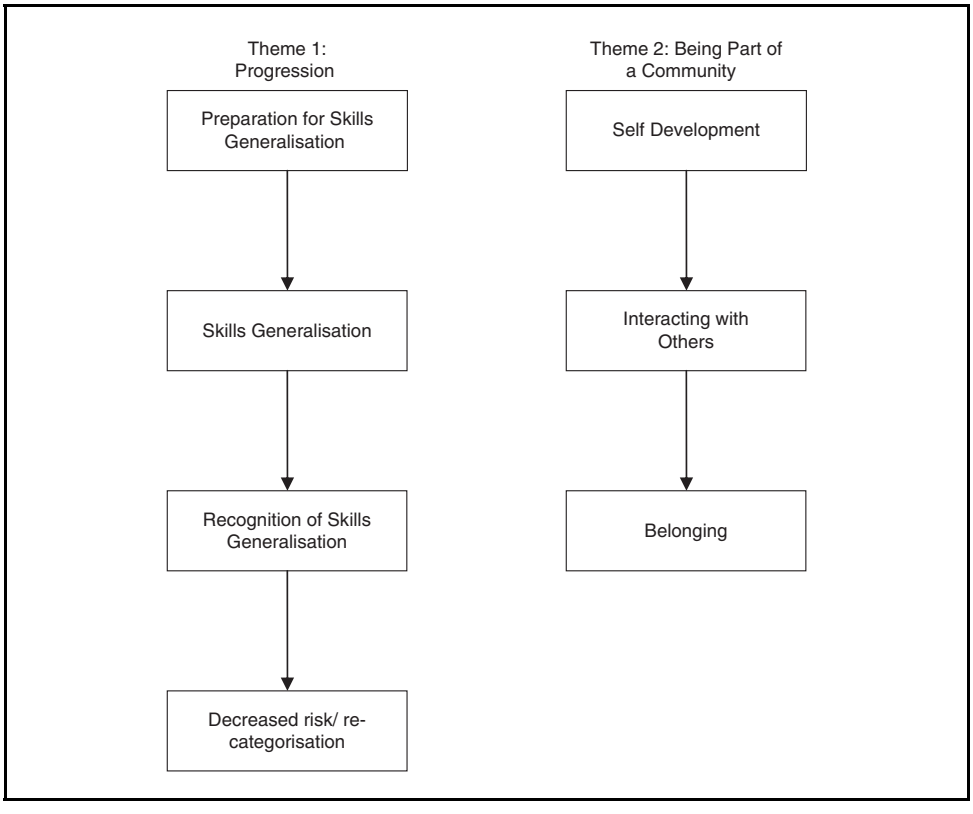
Thematic analysis led to two overarching themes across the data: "Progression" and "Being Part of a Community". Analysis identified sub-themes which were a process of the wider themes (see Figure 1). The two wider themes are presented below with the relevant sub-themes and explanations of how these were considered a process of the overall theme. Codes following quotations (e.g. "P1") denotes participant number.

Table I Phases of thematic analysis

Phase	*Description of the process*
1. Familiarising yourself with the data	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme
4. Reviewing themes	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic "map" of the analysis
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis

Source: Braun and Clarke (2006)

Figure 1 Thematic map presenting participants' hopes and expectations of a Category A PIPE



Progression

The theme of "Progression" included sub-themes that ultimately led to longer term reduction of risk of re-offending and progression to lower secure conditions. More specifically, identified sub-themes indicated that participants hoped that the PIPE would prepare them for skills generalisation and encourage them to engage in skills generalisation. They verbalised hope that their skills generalisation would be recognised by staff and subsequently reflected within future risk reports. The longer-term hope was that these factors in turn, would lead to decreased risk or a continuation through the offender pathway.

Preparation for skills generalisation

Participants verbalised expectations that the PIPE would assist to develop intrinsic factors required for skills generalisation. It appeared that these factors were necessary in order for an individual to be able to successfully generalise skills. An example of these factors was self-understanding required to maintain behavioural changes. One participant felt this understanding would help him to recognise situations high risk for behavioural lapses so that he could generalise skills in that situation:

> What's important to me is getting a better understanding of myself, so when I know things are getting out of control, I can know what signs to look out for (P5).

Despite verbalising their awareness and knowledge of skills attained from treatment, some participants hoped their time on the PIPE would increase their confidence in their ability to successfully generalise skills:

> Be confident in using [skills] (P2).

Both self-understanding and increased confidence in skills generalisation were relevant expectations for one participant. He also discussed the hope that the PIPE would help him to

accept previous negative life events. He felt that regularly reliving these events were acting as a barrier for him to be successful:

> I hope to have a better understanding of me, have more confidence in myself and I probably won't be living in the past so much as I'm doing now (P5).

When considering this sub-theme within the wider theme of "Progression", preparation for skills generalisation (through increase of confidence and self-understanding) appeared necessary in order to effectively generalise skills on the PIPE.

Skills generalisation

Participants across the sample reported expectations about PIPE being an environment where they could regularly generalise skills previously attained from treatment. This included the hope that skills generalisation would become second nature:

> I can practice the skills more (P2).
>
> You practice things everyday even though you're not realising it (P5).

Participants appeared to be realistic about the taxing nature of skills generalisation, suggesting that the PIPE would be a challenging environment for them. Participants anticipated that they may not instantly be competent within skills generalisation. They referred to staff's role within the ongoing development of effective skills generalisation, including the provision of constructive feedback. There was hope that this staff support would assist in becoming effective within skills implementation:

> I'm always out of my comfort zone […] so this is a big test for me (P5).
>
> Even if you do something that isn't right, they come and let you know about it in a constructive way. Whereas on [a mainstream] wing, they just let you carry on and do what's wrong and they'll just be writing stuff about you and not telling you, but on here, they come and speak to you first (P2).
>
> If you did something that say, wasn't clever, I dunno, you just switched on somebody, like had an argument over nothing, they'll pull you and say "you went about that the wrong way, try doing it another way", they work really hard, I can't praise them enough (P5).
>
> If they've let you know, you can work on it […] you know not to do it again (P2).

With regards to the wider theme of "Progression", skills generalisation appeared imperative to participants in order to be able to benefit from the PIPE setting. The hope that others would recognise the implementation of skills was the next sub-theme within the process of "Progression".

Recognition of skills generalisation

Participants verbalised the hope that meaningful cognitive and behavioural changes they had made resulting in regular generalisation of skills would be recognised, monitored and guided by staff. Subsequent hopes discussed by participants were that these changes would be reflected within documented observations and risk reports. Participants made reference to them previously not being able to evidence their changes in mainstream prison establishments:

> The Cat A board says there's nothing more you can do […] they need to see the evidence, I couldn't evidence it (P5).
>
> I want good reports, for people to think well of me (P1).

There was recognition that PIPE staff would provide an increased level and frequency of monitoring of skills generalisation. Comparisons were made between staff's monitoring of skills generalisation on the PIPE and mainstream prison wings. There was considered to be more frequent monitoring on the PIPE which participants expressed hope that their use of skills would be more accurately monitored:

> If they are reporting weekly […] they are going to be showing where you are putting in the skills you have learnt (P4).
>
> They don't really monitor you on the wing as closely as they do on here. So you get monitored more (P2).

> When I realised what this was all about when I landed here, it was brilliant because they evidence everything that you do (P5).

Comparisons between PIPE staff and mainstream staff extended to the knowledge of skills participants were generalising on the PIPE. Participants attributed this to either the lack of knowledge of mainstream prison staff or the increased experience of PIPE staff, which included previously facilitating psychologically based treatment programmes within prison:

> If you behave yourself down there you've got your weekly history sheets wrote up saying "behaves well on the unit" […] if I used the skills, the staff down there don't really know the skills, I got the same […] "behaves well on unit" […] it wasn't reflected in any way, shape or form the six and a half years I spent […] learning skills (P4).

> The majority of [PIPE staff] know the skills, what you learn, the techniques […] they understand […] when the weekly reports come, hopefully they will be marked down and monitored (P4).

The expectation that skills generalisation would be recognised by others extended to professionals' opinions communicated within risk reports. This hope related to reports acknowledging progress made within treatment:

> [Reports] will show a truer picture of the person I am now, not the person was when I came in […] I think it's a lot more important to show in more detail the person I am after the treatment I have received (P4).

> Try and prove to [the Category A board] that we are changing, we want to change and try and better ourselves (P5).

This provided evidence to suggest that participants placed importance on the PIPE being able to demonstrate their ability to implement skills from treatment and recognise any changes since completing treatment.

Decreased risk/re-categorisation

Participants verbalised hopes that the PIPE would help them to make progress within their progression pathway. For two participants, this was as straightforward as the hope to be downgraded from Category A status and longer term progress:

> To see if I can come off the Cat A book […] make some progression through the system (P1).

> I want to get released. I want to get my Cat B, get released (P2).

Participants verbalised hopes to reduce their risk, despite recognising that this was not an aim of the PIPE:

> Hopefully I'll be going to a Category B [prison], that's what I'm hoping, or at least lowered my risk anyway in some ways […] They're not guaranteeing you cat B (P2).

The PIPE was seen by some participants as being one stage within their offender pathway. Two participants verbalised hopes that they would be able to progress on to the next stage of their pathway after their time on the PIPE, which they hoped would be Category B sites. These hopes included: to progress to a lower security PIPE or to re-engage in treatment in a TC:

> I would like one day to come off the book and go to a Cat B PIPE unit (P3).

> I want to get to a TC to get the help that I need (P5).

Some participants hoped to progress through the system in order to develop relationships with their outside support network. Being in a lower category establishment would reveal more options of prisons geographically closer to home. Additionally, one participant cited security procedures within a Category A establishment to be the reason that he did not request visits at present:

> I'm just hoping to come off the Cat A book, so I can go to another prison […] closer to home. See my family (P1).

> I wouldn't want a visit when I'm an A Cat when you've got to sit behind glass. I don't want that, I want to be closer to home then I can sort my visits out (P3).

Two participants stated that being downgraded from Category A status was not an explicit hope or expectation of the PIPE. Risk reduction was however, related to their main hopes for their time on the PIPE. One participant was previously being "disappointed" at limited progress made when he was located at a pilot treatment site. His main expectation was related to his risk reports communicating changes that he made from previous treatment:

> I'm not expecting to get re-categorised […] I'm here to hopefully get what I feel is important, my paperwork showing a true reflection of the person I am now, not the person I was (P4).

With regards to the other participant, he wanted to progress towards a (Category B) TC but was adamant that being downgraded from Category A status was not his expectation of the PIPE. When asked to clarify this during the interview, the participant explained that he was motivated to progress towards the TC in order to re-engage in further treatment and continue to address his risk:

> It's not just about coming off the book, I don't care about that, all I want is the help I need to stop me hurting somebody else […] I'm trying to get the help that I need. That's my priority (P5).

This sub-theme included participants' hopes that the PIPE would help them to make progress within reducing their risk and moving forward through their progression pathway. Participants' motivation for this was either to develop/maintain relationships with their families or to continue to address their risk. Participants appeared to consider lower security settings to be able to facilitate these goals. One participant did not expect to get re-categorised as a result of being located on the PIPE which he attributed to disappointment from previously being located on a pilot treatment site.

Being part of a community

The second overall theme identified across the data related to participants hoping to become part of a community during their time located on the PIPE. Again, this theme appeared to be a process of sub-themes for participants (see Figure 1). These sub-themes related to intrapersonal self-development which would enable participants to pro-socially interact with others on the PIPE. Expectations to improve interpersonal interactions were linked to a longer-term sense of belonging within the community on the PIPE.

Self-development

Participants identified intrapersonal factors they hoped to develop during their time on the PIPE. These areas of self-development were considered to contribute to the longer-term expectation to become valued within the PIPE's community. These areas of self-development included an increase in self-confidence:

> I got to be more confident (P3).

Other areas of intrapersonal development included developing independence. Given the security provisions within a mainstream Category A prison, participants had not previously had the opportunity to develop skills that would be routine within the outside community setting. They made reference to this and identified hopes to develop skills including cooking and engaging in vocational work such as horticulture:

> You can do your own cooking here if you want to do your own cooking. You can do the independent thing and cook for yourself (P1).

> I'd like to learn to cook. I know the basics but if I want a curry, I don't know how to make a curry (P3).

> You've got more opportunity on here as well […] the horticulture guy was saying "if you want, you can combined it and do landscaping" (P2).

One participant hoped to increase his independence within other aspects of the PIPE regime. He discussed the weekly group forums held on the PIPE where individuals can present ideas of how they spend their time on the PIPE and pursue these for the community. He referred to an experience of his contribution being valued and how he felt independent by taking his idea forward:

> You're getting independence from putting something forward and leading it (P1).

Despite being intrapersonal in nature, the areas of self-development referred to by participants appeared important to participants as they could contribute to the PIPE community. These areas of development were considered to assist in individuals' abilities to interact with others within their PIPE community.

Interacting with others

Expectations to interact with others was identified as a sub-theme that contributed to the wider theme of "Being Part of a Community". Participants discussed expectations to interact more with other prisoners and to have pro-social interactions with other prisoners. This included being supportive to each other:

> Everyone can help each other, advise each other (P1).

Reference was made to respectful interactions between prisoners on the PIPE and interactions with different types of people:

> Everyone's more like, polite, laid back, talks to you erm, with respect (P2).

> You can talk to different kinds of people (P3).

Two participants verbalised hope to have increased interactions with other prisoners during their time on the PIPE:

> Wherever you go, you're next to someone so you have to be more sociable, makes you more sociable (P2).

> I need to come out of my shell a bit more (P3).

This sub-theme related to the expectation of increased frequency of interactions and improved quality of interactions on the PIPE. Interpersonal interactions were considered to contribute to the wider community aspect of the PIPE.

Belonging

Participants verbalised hope that over time, they would belong to the community on the PIPE and be considered valued members within this setting. This included expectations to attain friendship, support and connections with other prisoners on the PIPE and work as part of a team:

> Everyone pulls together and works as a group […] it's all part of teamwork up here (P5).

> I would like to be connected with other inmates here (P3).

> Friendship, honesty, help if I need it, assistance (P1).

The integration of violent and sexual offenders on the PIPE was referred to by participants. For one participant who has resided on a vulnerable prisoner wing prior to being located on the PIPE, he identified hopes that he would become integrated with mainstream prisoners. He referred to occasions where mainstream prisoners had interacted with him despite knowing that he had been located on a vulnerable prisoner wing:

> Them ones from the main, I can't believe some of them, they come up and chat (P3).

Participants appeared to hope to be valued within the PIPE community. For one participant, he hoped that this sense of belonging would develop during his time on the PIPE and continue in the community setting should he get released:

> At least somebody's listening to you […] usually when you say something, nobody takes a blind bit of notice […] they've forgotten as soon as you go out the door. But here, when you have your word, when you speak up there like, it's noted, it's written down, you can discuss it (P1).

> I would like to be able to work and live in a community to sort of show that I can do that, show that I can be a contributing member […] to show that I can be somebody who has a place to fit in […] seen in some way as a valued member in society in prison then maybe it's something I can do outside prison (P4).

The theme of "Belonging" was considered to encompass factors indicating that participants were valued, contributory members of a community. This included hopes to develop friendships, support networks, engaging in teamwork and acceptance from others.

Discussion

The current study intended to explore the hopes and expectations that prisoners held about a Category A PIPE and to explore whether these were congruent with the aims of the PIPE. Thematic analysis identified two overall themes which were "Progression" and "Being Part of a Community". Identified sub-themes appeared to demonstrate the process of the wider themes (see Figure 1).

The theme of "Progression" incorporated hopes that the PIPE would help to prepare and guide participants to effectively generalise skills. Participants did not expect to be immediately competent at skills generalisation and anticipated constructive criticism and support from staff in order to develop this. Participants recognised the psychologically informed training and previous treatment experience of PIPE staff which they placed value upon. There were hopes that successful skills generalisation would be recognised, monitored and recorded by PIPE staff which would subsequently contribute to a reflection of changes made within formal risk reports. There was evidence to suggest that some participants hoped to reduce their level of risk or become re-categorised as a result of being located on the PIPE. Motivation to reduce risk for some, however, was fuelled by a desire to improve familial relationships or address ongoing areas of risk within future treatment available in a lower security setting. The theme of "Progression" appeared to mirror "competence" which Deci and Ryan (2008) discuss as a factor that facilitates autonomous motivation and the end goal of lower secure conditions itself would secure increased autonomy for individuals. In terms of comparing these sub-themes to the intended aims of the PIPE, expectations within the theme of "Progression" were considered to complement the PIPE's aims of promoting "skills generalisation", "goal setting" and encouraging "co-working" with staff (Department of Health and Ministry of Justice, 2012). The aims of the PIPE do not specifically include aspirations to re-categorise or reduce the risk of PIPE service-users. All participants in the current study verbalised some hope to progress to lower secure settings, motivation for which included to access other services within the offender pathway or improve the quality of relationships with family members. This suggests that underlying motivators to "get off the book" vary across individuals but such motivators can encourage the desire to maintain change. Despite PIPEs not having the explicit aim of risk reduction, it is reasonable to consider that should the attainment of the PIPE's aims be achieved, a subsequent reduction in risk could occur as a by-product of this attainment.

The second identified theme of "Being Part of a Community" included hopes that individuals could develop intrapersonal skills that would assist them to make a meaningful contribution to the PIPE community. This included the hopes to increase self-confidence, independence and make use of opportunities to demonstrate leadership. There were expectations that participants would interact more on the PIPE than in mainstream sites and that they would experience an increased quality of interactions. These factors ultimately contributed to the hope that participants would feel that they belonged within a community and were considered valued and contributing members. Existing PIPE aims that appeared to be reflected within this theme were "goal setting", the encouragement of "prisoners' contribution to the environment" and "socialisation" of PIPE prisoners (Department of Health and Ministry of Justice, 2012). This theme also mirrored the factor of "community" which Deci and Ryan (2008) identified as a factor facilitating autonomous motivation within individuals. This theme also appeared to replicate the TC's intention to encourage "communalism" and socially "binding" together of residents (Cullen, 1997).

Qualitative methodology was favoured over quantitative methods during the planning of the current study. Due to the PIPE unit only recently being opened and its gradual population of prisoners, the limited sample size meant that quantitative methodologies were unsuitable for this study. Additionally, it was considered that a semi-structured interview would accrue a greater depth of data when exploring participants' hopes and expectations of the PIPE

compared to quantitative methods. Procedures were put in place in order to maximise the reliability of the current study. Thematic analysis was employed within the study and was carried out in line with guidance from Braun and Clarke (2006). A second coder was used in order to increase the reliability of the study. The subsequent findings provide initial insight into service-users' expectations of a recently opened Category A PIPE within a pilot service.

Generalising the current study's findings across the PIPE population would present limitations in light of the specific sub-group of participants in the current study (Category A prisoners). This does, however, provide future direction for the developing PIPE literature base. Given that the current study took place at the only Category A PIPE site that currently exists within the National Offender Management Services, it would be beneficial to explore whether identified themes are replicated within other PIPE sites. It was questioned whether Category A PIPE prisoners may have different expectations and hopes for the PIPE due to less offender pathway opportunities being available in comparison to lower category establishments. It could be feasible that Category A prisoners consider the PIPE to be their main option to enable their progress within the criminal justice system. In terms of future research, it could be beneficial to re-visit the current sample's expectations of the PIPE in order to evaluate any longitudinal changes over time which has been observed in other pilot sites in high-secure settings (Crews, 2006).

The findings of the current study are applicable to practice within PIPE services. First, if this small sample is representative of PIPE service-users as a whole, it shows promising evidence that their hopes and expectations have congruence with the aims of the PIPE. This indicates that the aims of the PIPE have been appropriately communicated to relevant individuals. Second, the only expectation of service-users that was not congruent with the PIPE's aims was the hope to attain risk reduction or a downgrade from Category A status. This finding indicates that participants continue to have hopes that the PIPE will help their progression through the criminal justice system despite it not being an explicit aim of the service. Despite these factors not being congruent with each other, these findings provide insight into the sample's motivation to progress. Motivators did not solely include a desire to "get off the book" but also included the hope to access further custodial-based treatment and improve the quality of external relationships. This has implications to the referral process utilised within the PIPE in terms of what motivation referrals have for attending the PIPE. An individual with intrinsic motivation to effectively generalise skills in order to achieve pro-socially goals as a result of intrinsic, behavioural change is likely to differ to an individual who has extrinsic motivation to reduce their risk. This leads to consideration of the impact on self-referrals if/when a prisoner is downgraded from Category A status whilst located on the PIPE. This emphasises the value and importance of ascertaining prisoners' motivations within the PIPE referral process. This is not to say that a particular group of prisoners are unsuitable for a high-security PIPE but could inform individual clinical recommendations such as motivational work conducted either prior to or during an individual's time on the PIPE. It is hoped that the current study complements upcoming research and contributes to a foundation for future research within the pilot PIPE services.

Practical implications

- The aims of the PIPE appear to have been appropriately communicated to relevant individuals, providing evidence that the promotion and referral processes have been effective.
- Participants continue to hope that the PIPE with assist their progression through the criminal justice systems despite this not being an explicit aim of the PIPE.
- Participants hope to become integrated within a community, being considered valued and contributing members of that community.
- Continuing to ascertain whether prisoners' motivations to attend the PIPE are intrinsic or extrinsic will be important.

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14

CREATING AN ENABLING ENVIRONMENT IN HIGH SECURITY PRISON CONDITIONS

An impossible task or the start of a revolution?

Alice. L. Bennett and Jenny Tew

Introduction

An effective 'Enabling Environment' achieves a set of standards that focus on effective working relationships to create a sense of belonging. Achieving an Enabling Environment within a prison setting may be considered unfeasible, particularly with high-risk and/or personality disordered prisoners and the necessary security requirements for this population. However, serious consideration of this aim is warranted given the needs of these individuals and the introduction of the Offender Personality Disorder Pathway, bringing an increase in service provision for those likely to have a personality disorder diagnosis. Services are further enhancing their provisions in order to provide Enabling Environments for the high-risk prisoner population. The Westgate Unit, a high security personality disorder treatment service, applies Enabling Environment principles within its working. Its psychological underpinnings, staffing models, regimes and physical environment complement this approach and lessons learnt from this have increased ways of working therapeutically with this specific client group. This has resulted in the Westgate Unit achieving the Royal College of Psychiatrists' Enabling Environment Award. The Westgate Unit's work, along with its ongoing evaluation, has also prompted a surge of motivation and action towards applying several of the core principles from the Westgate Unit to other High Security Prison settings, creating further Enabling Environments and developing the culture of the whole of the High Security Estate to become more rehabilitative.

The concept of an Enabling Environment comprises key features that establish and maintain a sense of belonging through a focus on relationships (Johnson & Haigh, 2011). Enabling Environments can be created in a broad range of settings, including secure forensic ones such as prisons. It can be challenging to establish an Enabling Environment within the secure and punitive environment of a prison but

notwithstanding this, connectedness and positive working relationships can still be achieved in these settings. High security prisons house some of the most disruptive and complex individuals within the prison system. These establishments necessarily employ strict levels of security procedures to ensure that prisoners cannot escape and that their behaviour is safely managed while they are in custody. On the face of it, it would seem that high security prisons and Enabling Environments are completely incompatible with each other. Surely ideas such as power and authority being open to discussion and spontaneity being encouraged would undermine the order and control needed to safely operate such establishments? However, one unit within a high security establishment has found that, not only is an Enabling Environment possible, it actually assists in achieving the Prison Service aims, including the maintenance of security levels. The Westgate Unit within HMP Frankland opened in 2004 and now has the Enabling Environment Award. The work of Westgate is contributing to a review of the culture across the whole of the High Security Prison Estate and the translation of a number of the principles to other prisons and units.

This chapter briefly outlines the context for the Westgate Unit and the nature of its population. It then describes how the Enabling Environment principles are being applied in this setting, the learning over the last ten years related to creating an Enabling Environment for this population and how this is starting to be used across the High Security Prison Estate.

The prison context

Her Majesty's Prison Service (HMPS) is part of the National Offender Management Service (NOMS). Its aim is to protect the public by keeping in custody those committed by the courts, helping them to lead law abiding lives both while they are in prison and after release. Despite the aims of the Prison Service, including the rehabilitation of individuals, it has been noted that prisons have a number of features that are detrimental to therapy and therefore to rehabilitation (Day & Doyle, 2010).

Following some high profile security breaches Lord Mountbatten conducted an inquiry into prison security in 1966. A notable recommendation from his report was the introduction of a system of security classification for prisoners (Home Office, 1966). Rather than having one maximum security prison, as Mountbatten proposed, a number of dispersal prisons were created that would house the most dangerous and highest security risk prisoners. As such the High Security Estate (HSE) was formed.

The Prison Service HSE is made up of eight establishments across the country. Its population includes Category A prisoners, whose escape would be highly dangerous to the public, the police or the security of the state and for whom the aim must be to make escape impossible (NOMS, 2013). The HSE also incorporates five Close Supervision Centres (CSCs) within its establishments. These are small, highly restrictive, self-contained units that manage those whose behaviour poses a significant risk to others or the good order of the establishment; these may or may not be Category A prisoners. Additionally, the Department of Health and Ministry

of Justice recognise research suggesting that approximately two-thirds of those who have committed offences meet the criteria for at least one personality disorder (Department of Health & NOMS, 2011), warranting specialist services for this client group within the HSE.

The Offender Personality Disorder Pathway

The Dangerous and Severe Personality Disorder (DSPD) programme was launched in 2001. Its background has been well documented (for example, Howells, Krishnan & Daffern, 2007). This initiative delivered services for individuals who presented a high risk of re-offending linked to severe forms of personality disorder. The underpinning philosophy of the DSPD programme was that public protection would be best served by addressing the mental health needs of a previously neglected group. Part of this service was a purpose-built unit (The Westgate Unit) within HMP Frankland, an HSE prison in the north-east of England.

In 2011, the Department of Health and Ministry of Justice started a new approach to working with individuals with severe personality disorders, moving away from the previous DSPD programme (see www.personalitydisorder.org.uk/criminal-justice/about-dspd-programme/ and www.dh.gov.uk/health/2011/10/offender-personality-disorder-consultation-response/ for more details). This new strategy is co-commissioned by the Commissioning and Commercial Directorate in NOMS and NHS Specialised Commissioners and is known as the Offender Personality Disorder Pathway (Joseph & Benefield, 2012). The new pathway recognises the various stages of an individual's journey, from conviction and sentence to community supervision and resettlement, and ensures that treatment focuses on relationships and the social context in which people live. Within the reconfiguration from DSPD to the pathway model, Westgate continues to deliver the same service but with slightly amended suitability criteria.

The Westgate Unit population

The Westgate Unit is a 65-bed purpose-built standalone unit offering a personality disorder treatment service for high-risk, male prisoners. The unit is separated into three discrete units. The suitability criteria for the Westgate Unit have slightly changed since it originally opened in line with the Offender Personality Disorder Pathway model (Joseph & Benefield, 2012). The current suitability criteria comprises three factors: being at high or very high risk of violent and/or sexual reoffending; having a severe and complex personality disorder as measured by the International Personality Disorder Examination (IPDE) (Loranger, 1999) and the Psychopathy Checklist – Revised (PCL-R) (Hare, 2003); and a functional link between personality pathology and offending behaviour. This final factor is assessed by the development of a case formulation. Previously, the suitability criteria specified a minimum number of personality disorder diagnoses on the IPDE along with a minimum score on the PCL-R. The new focus on *complexity* of personality

disorder means that the service is better able to meet the needs of the intended population within the pathway model.

At the time of writing, 265 men have been admitted to the Westgate Unit for assessment. Eighty-two per cent of this group have been serving a life or indeterminate sentence, higher than the level of indeterminate prisoners in the wider DSPD population (Kirkpatrick et al., 2010). Prisoners accepted for the Westgate Unit have an average PCL-R score of 29.76, indicating a level of psychopathic traits higher than the general UK prison population (Cooke, Michie, Hart & Clark, 2005). They also have an average of three personality disorder diagnoses according to the IPDE.

This is clearly a high risk and complex population. Research suggests that levels of psychopathic traits relate to compliance with institutional rules and regimes (Leistico, Salekin, DeCoster & Rogers, 2008), and response to treatment (Tew, Harkins & Dixon, 2013). It is also the case that those with personality disorders have been found to struggle to engage in and complete treatment programmes (Howells & Tennant, 2010). Individuals with high levels of psychopathic traits have been found to be less likely to generalise and maintain skills learnt in treatment than those with lower levels of these traits (Blud, Thornton & Ramsey-Heimmermann, 2003).

All these issues make the environment of treatment for the Westgate Unit particularly significant. Establishing effective working relationships with this client group, as well as repairing them when they inevitably encounter problems, is challenging. In the treatment setting these difficulties have been linked to fear of trusting staff and showing vulnerability within treatment (Timmerman & Emmelkamp, 2006). This highlights the importance of incorporating standards into the environment in order to maximise opportunities for a sense of connected belonging to be promoted and developed.

Enabling Environments

The idea of Enabling Environments comes from the recognised need to have an increased psychological awareness within health and social environments (Johnson & Haigh, 2011). Enabling Environments are designed to promote a sense of belonging and opportunities to develop and learn new skills through establishing positive and supportive relationships (NOMS & NHS England, 2015). The Royal College of Psychiatrists introduced the Enabling Environment Award as a mark of an organisation that is particularly successful in this aim. The award is made up of a set of ten standards that they identify as necessary for a nurturing social environment, namely Belonging, Boundaries, Communication, Development, Involvement, Safety, Structure, Empowerment, Leadership and Openness. These standards are each made up of a number of criteria that outline how the standard can be achieved for 'recipients' and 'providers'. Organisations submit a portfolio of evidence of how these standards are met in order to achieve the award. When compiling their portfolio, the Westgate Unit found that a number of Enabling Environment standards could be achieved, despite the high secure setting, and they gained the Enabling Environments Award in 2016.

The Westgate Unit as an Enabling Environment

The Westgate Unit offers a range of structured interventions including the Chromis suite of programmes (Tew & Atkinson, 2013) and treatment components that have been specifically developed by Westgate Unit staff (Bennett, 2015). In order to manage responsivity issues and treatment interfering behaviours presented by this population, there is also an Imminent Needs Service and Supporting Services (Wood, 2015; Bennett, 2015). While this formal work is essential, it was recognised from the start that successful rehabilitation of this challenging population requires a broader approach than this. Offending behaviour programmes are only as good as the environment they are delivered in (Blagden & Thorne, 2013; Woessner & Schwelder, 2014) with an institution's culture being found to impact on both programme engagement and effectiveness (Lipsey & Cullen, 2007). As already highlighted, the nature of the Westgate population brings added reasons as to why the environment is a significant issue. This broader focus makes the unit a therapeutic environment as opposed to a programmes unit.

The unit incorporates physical features, psychological theory and a structured regime which supports the balance required to achieve an Enabling Environment within this high security prison context.

Physical features

Firstly, the physical environment is an intentionally built, standalone unit that provides a spacious environment with a great deal of natural light relative to older, mainstream wings. This helps to facilitate elements of the structure and boundaries standards for everyone on the unit. The layout provides good visibility around the unit which can contribute to a feeling of safety for all. The unit is separated into three discrete units, creating smaller 'communities' for both staff and prisoners to operate in. This facilitates the development of relationships and helps individuals have more involvement in how their unit looks and runs.

Psychological theory

The core principles of treatment on Westgate are embedded across the whole unit. They provide consistency across the whole regime and offer opportunities for skills generalisation. This contributes to the core principles of ensuring control and choice; understanding complex needs and personal relevance; being future focused; working collaboratively and transparently; providing novelty and stimulation; and recognising the need for status and credibility (Tew, Bennett & Atkinson, 2014).

As part of operationalising these principles, everyone on the unit is asked to abide by the Conditions of Success. These are three simple conditions that aim to help break down barriers and promote collaborative working. The conditions are: keep an open channel of communication; be respectful at all times, no matter what; and participate constructively. Everyone is required to comply with these, staff, prisoners

and visitors, and everyone has the right, and responsibility, to appropriately challenge those who do not. This means that prisoners can question staff if they feel they have not been respectful to them or if they have not communicated what is happening.

Responsibility and active engagement are encouraged through the Strategy of Choices (Bush, 1995). This is a communication strategy that combines exercising authority with respect for someone's right to make their own decisions. It was developed to set boundaries and promote self-responsibility in group work with anti-social, anti-authority people in prison and is employed across Westgate. The strategy requires staff to define someone's options and the consequences of those options followed by asking the individual to choose what they are going to do. This encourages individuals to take responsibility for their own decisions without giving them permission to break the rules. The use of choice has been identified as an effective way of supporting the engagement and risk management of individuals with high levels of psychopathic traits (Harris, Attrill & Bush, 2005).

The Empowerment standard of the Enabling Environments Award encompasses the idea that power and authority need to be open to discussion. This is understandably problematic in a high security prison setting where staff are responsible for maintaining security and safety. While the Conditions of Success allow prisoners to challenge staff who they feel do not keep an open channel of communication or who do not speak to them respectfully, this did not initially sit well with some prison officers in the service who believe that prisoners should be told what to do and be made to do it, without question. While it is challenging for some staff to accept being questioned by prisoners, over time officers on the Westgate Unit who have adopted this approach have found that it can be helpful. One member of staff has reflected, "it makes you think as you forget how you come across sometimes. We sometimes expect them to do things we don't always do ourselves". It also helps the conditions have more genuine meaning; if staff did not have to treat prisoners in the same way then it would undermine the conditions and simply reinforce any negative views and resistance that prisoners may have towards authority. Staff sharing this learning has helped to bring others on board.

Staff have also highlighted that this approach has enabled them to see what prisoners really want and what they are capable of. In addition, the Conditions of Success, managed through the Strategy of Choices, actually help to provide the balance that is needed between control and flexibility required for an enabling and rehabilitative environment. This balance is a critical part of what makes a prison effective. As one officer reflected:

> If you give people a choice they think about things more. When prisoners have a choice they're more considered, there's less conflict, less damage and vandalism and less adjudications. You don't come to work expecting fights or trouble all day.

This was a view supported by prisoners; as one commented, "there's a lot more trust here and it makes you want to not mess up". Despite the restrictive nature

of prisons and the need for staff to retain overall control, prisoners can be asked to make genuine choices in most situations, for example, whether or not to agree to rules as a condition of taking part in a particular activity, or whether or not to follow a simple request. Choosing not to comply leads to less attractive consequences than choosing to comply. It is likely that choosing not to comply will lead to increased external management by the prison and therefore reduced control and choice for the individual.

Westgate officers are still prison staff first and foremost and so are still required to ensure the good order and discipline of the unit. As such they may have, for example, to physically restrain prisoners at times, something that may seem at odds with the Enabling Environment approach. However, they have found that going back and discussing situations with prisoners after the event, explaining why things happened and helping the individual to consider what they could do differently next time does help to maintain open and supportive relationships within clearly defined boundaries. These relationships help to manage incidents and individuals and make a better atmosphere for everyone.

While prisoners questioning staff brings some challenges, staff questioning each other is also not an easy process. To operate effectively and for staff to challenge each other in a meaningful way, forums needed to be provided for this to be done in a safe and contained manner. This allows for relationships among the staff team to be maintained and even strengthened through this process. It has also been noted that there needs to be relevant consequences for staff, just as there are for prisoners, for those who choose not to work in this way. Prisoners observe how members of staff treat each other and are sensitive to any apparent inequalities in how the conditions are applied.

The Westgate Unit and the treatment within it incorporate the Good Lives Model (Ward & Brown, 2004). This is a strengths-based approach to rehabilitation. The Good Lives Model says that we all try and achieve certain things in our lives and people offend as they do not know how to achieve these things in a more positive way. Staff and prisoners work collaboratively to identify personally meaningful goals that prisoners can work towards and progress is reviewed against these. This approach helps staff to get to know what prisoners really want, helps to engage prisoners with something that really matters to them, and empowers them to develop the positive aspects of their lives.

The regime

The Westgate Unit's regime is responsive to its specific population and, as far as the high security setting will allow, is highly compatible with the Enabling Environment standards. For example, prior to engaging in the assessment process, prisoners spend a period of time in a 'living phase'. This allows new prisoners time to get to know staff and each other, encouraging the development of working relationships (Wood, 2015) and encouraging involvement in the unit's structured and varied regime. This time helps some prisoners feel safe to discuss their treatment needs and have

opportunities to practise skills from treatment in the wider environment when the time comes. This initial phase of the regime involves non-treatment aspects such as physical education, horticulture and education (Bennett, 2015). In addition to this complementary regime, prisoners in this living phase are encouraged to gain experience in group work through Active Learning sessions. These are informally delivered, psychologically underpinned, group sessions that constitute part of the clinical framework. The aim of Active Learning is to prepare prisoners for engagement with group-based treatment components. Within Active Learning, prisoners have the opportunity to explore and practice skills related to communication, trust, planning, personal disclosure and teamwork in an informal, practical environment such as the unit's sports hall. These sessions are delivered by a combination of clinical and physical education staff (Bennett, 2015; Wood, 2015).

Staffing

Staff selection, training and knowledge have been critical to the success of this way of working with this population (Atkinson & Tew, 2012). Maintaining boundaries, safety and structure while still supporting empowerment, belonging and involvement for this population requires skill and resilience. Everyone needs to understand and agree with the unit's ways of working, meaning that there is a significant investment in selecting, training and supporting appropriate staff.

The importance of relationships and clear and consistent leadership on Westgate is also applied to the unit's staffing model. Each unit within Westgate has a dedicated operational staffing team. A relatively recent change within the staffing model has been for a chartered psychologist to be allocated responsibility to each unit. This has helped to have a consistent clinical lead alongside operational staff during forums such as individual unit briefings. These psychologists also coordinate a rota of weekly prisoner case formulations. These sessions ensure that each unit's staff team are psychologically informed and attuned to individuals' relevant behaviours that may be manifestations of their personality traits. More widely, a multidisciplinary staffing group is employed throughout all aspects of the clinical work conducted on the Westgate Unit. This means that teams responsible for referrals, assessments and treatment delivery are staffed by multidisciplinary teams which aid decision-making and information-sharing (Bennett, 2015). It has been found that officers can experience conflict in balancing their therapy and security roles (McManus, 2010; Polen, 2010), an issue also reported by Westgate staff. This ongoing tension requires training and support that is sensitive to both elements, something that the multidisciplinary approach across all levels of staff helps to support.

In order to structure expectations appropriately, this model of working is introduced to Westgate prisoners during the induction process where multidisciplinary staff introduce themselves as relevant to the prisoner. Each prisoner is allocated a 'key worker cluster' of prison officers (as opposed to one personal officer being allocated which is practice within mainstream establishments). Accounting for shifts and annual leave this helps to maximise the chance that there is a key worker officer

on duty daily for each prisoner. Additionally, all prisoners are allocated a clinical case manager (either a trainee psychologist or a therapist), an offender supervisor (responsible for organising sentence planning and associated risk reports) and a clinical nurse specialist (responsible for mental health assessment and support). This staffing model ensures consistent staff are involved with each prisoner and encourages the development of a therapeutic alliance (Ross, Polaschek & Ward, 2008) between prisoners and relevant staff.

Learning from the Enabling Environments Award process

The Westgate Unit's approach to treating its client group provides ways of achieving Enabling Environments standards within high security conditions. However, compiling this evidence highlighted areas for further learning and development which triggered some changes. For example, the therapeutic aspect of the Westgate Unit has increased with the introduction of creative sessions in June 2015. This complements Enabling Environments standards of Belonging, Development and Involvement. While this occurred as a result of a prison-wide requirement to increase the level of prisoners' meaningful activity within establishments, senior management chose to fill this additional regime time with more therapeutic activity (as opposed to clinical or generic work activity) in the form of creative sessions.

Creative sessions are underpinned by the development of strengths (or protective factors), in line with the Good Lives Model, complementing the risk-reducing aims of treatment. It is not just the content of these sessions that is compatible with the Enabling Environments ethos but also the process of their development as these sessions were planned and implemented by a staff/prisoner team in consultation with the senior management team. This was the first time a staff/prisoner steering group had been employed on the unit and it was found that this approach greatly helped to effectively introduce the sessions. Sessions needed to be linked to the 'Good Lives' goals and/or the Enabling Environments standards and in light of government budget cuts, needed to require little or no cost to the organisation. The joint approach to planning and development helped to ensure they were both relevant and realistic. Currently the creative sessions include album review club, mobile team challenge, comic book club, and classical music club. Additionally, craft sessions such as making cards and Christmas decorations accrue funding which is invested back into these projects.

After being accustomed to their prison officer roles within a structured prison regime, it took time for staff to adjust to the freedom of being creative and autonomous within these new sessions. This was shown through staff's preference for a small number of sessions with the intention of expanding more widely over time. This was in contrast to senior management who wanted as many options as possible in order to provide prisoners with a range of choice. Some creative sessions have been less popular due to them competing against established sessions within the regime such as gym sessions. At the time of writing, this difficulty is being explored, with options of having dedicated time within the core day for creative sessions or

more choices available over time. As a result of being in a high security environment, barriers needed to be addressed for the successful implementation of these creative sessions. For example, security and health and safety requirements meant that all ideas had to be risk assessed prior to being implemented. This required a significant amount of planning and multidisciplinary work but, perhaps surprisingly, there have been no insurmountable concerns raised to date.

At the time of writing, key worker sessions are also being piloted on the Westgate Unit. These form part of the Supporting Services offered by the unit. These sessions occur every 4–6 weeks, attended by the prisoner, an officer from their key worker cluster and the prisoner's clinical case manager. Additionally (when relevant), offender supervisors and clinical nurse specialists also attend. Key worker sessions have the following aims:

- To establish and maintain effective staff–prisoner relationships
- To maximise effective multidisciplinary teamwork in relation to prisoners
- Preparing prisoners for clinical milestones (assessment, treatment and progression planning)
- Highlighting areas of progress (for example skills generalisation).
- Identifying ongoing areas of need, resulting in goal setting

These therefore also contribute to the Enabling Environments standards of Belonging, Development and Involvement. Staff running these sessions have autonomy over which of the key worker session aims are prioritised, informed by their current knowledge and contact with the prisoner. Goals are set collaboratively and reviewed in subsequent sessions. The role of a key worker officer also allows for check-in contact to take place between sessions if necessary. Once the pilot is complete it will be evaluated, considering the perspectives of staff and prisoners and the aims of the sessions. This will allow any necessary amendments to be made.

A further development informed by collating evidence for the Enabling Environments Award has been that each of the three units now holds community meetings. These are weekly and are co-run between staff and prisoners. These meetings provide a further forum for prisoners to raise ideas about how to improve the environment and regime, staff to pass on information about any developments, events or changes and anyone to question things that may have happened. Contrary to the fear that these meetings may generate security and disciplinary problems for staff to deal with they have actually helped the units to feel safer and more stable.

Awareness of the Enabling Environment standards has also helped to increase the input that prisoners have over their physical environment. In prison the environment is tightly controlled as part of maintaining security, particularly within high security establishments. Prisoners on one unit asked to personalise their communal space, a request initially seen as problematic by staff. However, after asking prisoners to show how this would link to the Good Lives goals, ways were found to manage the security issue associated with the materials required to do this. It was agreed to focus on the appearance of the pillars in the central area of the unit. The prisoners

themselves decided how these should be decorated and took responsibility for the highly detailed murals that have been painted on each pillar.

While there are many ways in which Westgate achieves the Enabling Environment standards, there are notable limitations within a high secure forensic setting that should be acknowledged. The requirement of security restrictions, boundaries and a structured regime limit opportunities to offer spontaneity to staff and prisoners, part of the Development standard of the award. One timetabled creative session is based on the prisoners' own units, where prisoners and staff are responsible for identifying how to spend this session. This and other similar opportunities allow for some spontaneity within the structured regime. Whilst this difficulty with spontaneity within High Security Estate processes is acknowledged, prisoners are encouraged to try new activities and are certainly supported to understand their risk and risky behaviour, also elements of the Development standard.

Is it successful?

There is a programme of research being completed to consider the impact of the Westgate Unit regime as a whole and elements within it (Tew et al., 2014). While the impact of this approach with this population in this setting is still being formally evaluated there are encouraging findings emerging, findings that further highlight the importance of the environment.

Considering the difficulties this population have engaging in treatment it is encouraging to note that the components of a core treatment programme on Westgate, the Chromis programme, have a completion rate of between 82 per cent and 98 per cent (Tew et al., 2014) suggesting that individuals are supported within sessions and on the unit to complete the treatment that they start. It is also encouraging that the regime monitoring recording the number of activity hours delivered each week show that prisoners are also engaging in the wider regime (Tew et al., 2014).

While engagement is encouraging, this is only part of the picture in terms of establishing whether an environment is enabling for individuals. Considering the lived experience is also important and research on the Westgate Unit has been exploring this area. For example, Tew, Bennett, Dixon & Harkins (2015) examined Chromis participants' experience of treatment and their time on Westgate. The individuals all found treatment challenging but worthwhile and all felt they had made changes as a result of this experience. Notably they highlighted that while it was down to their own determination why they completed treatment, the staff, other participants and the environment were seen as 'make or break' factors that impacted on their ability to achieve this. This further highlights the importance of relationships and the wider environment for engagement and progress in treatment.

Research specifically looking at the lived experience of Category A prisoners at Westgate found themes that were congruent with core elements of an Enabling Environment (Preston, 2012). This study identified three relevant, super-ordinate themes: 'Identity within a social world', 'Embracing change' and 'Maintaining stability throughout change'. Preston considered these to encapsulate the nine core

elements of an Enabling Environment that existed at the time. This suggests that Westgate is successful at providing this type of environment for these individuals.

Looking specifically at one element of the Westgate Unit regime a thematic review of the art classes offered found themes that related to cooperating with others, staff and the regime, working within set boundaries and getting acknowledgement for their work (Bilby, Caulfield & Ridley, 2013). These are all areas relevant to Enabling Environments (Johnson & Haigh, 2011) and desistance from offending (McNeill, Farrall, Lightowler & Maruna, 2012). At the time of writing, a research study exploring the lived experience of Westgate's first staff/prisoner steering group is also in progress. It is hoped that this will further inform our understanding of the impact of service-user involvement on the unit and guide decision-making about how best to continue with this.

Alongside this work it is important that evidence is gathered regarding generalisation of treatment gains across the whole regime as part of assessing progress in treatment and the effectiveness of the environment. Considering the nature of the population this helps to ensure individuals can 'walk the walk and not just talk the talk'. There are a number of studies highlighting the positive impact of treatment for individuals (for example Tew, Bennett & Dixon, 2015; Tew, Dixon, Harkins & Bennett, 2012 but work is still ongoing and research to date has not included comparison groups.

Taking the learning out to the wider High Security Estate

While it is acknowledged that the evaluation of the Westgate Unit remains ongoing, the benefits, at least in the short term, of this approach for staff, prisoners and the service as a whole cannot be ignored. As a result, some of the underpinning principles of the Westgate Unit have already been taken and successfully applied to the regime of a Close Supervision Centre (CSC). The CSC at HMP Full Sutton, a high security prison in Yorkshire, opened in January 2014 and offers a management and progression function. In contrast to the Westgate Unit, CSCs house prisoners who do not necessarily agree to be there. Despite this, prisoners engage in a regime with the aim of lowering their risk and progressing out of the CSC system. For many, this progressive step involves the Offender Personality Disorder Pathway. Full Sutton's CSC unit now successfully employs the Conditions of Success and Strategy of Choices within its regime alongside working as collaboratively as possible with prisoners and involving them in their own care and the running of the unit. This includes prisoners having an element of choice in how they spend some of their time, within specified boundaries, and them having forums to contribute ideas for further improving the regime and environment. The development of this unit shows that even in the most restrictive of environments prisoners can be communicated with openly, empowered to take active responsibility for themselves and their environment and engage in as much purposeful activity as security will allow.

A clinical review of the CSC provision made recommendations for elements of this approach to be applied across all CSCs, with the regimes of these units

all encouraging as much social interaction and active engagement as operational requirements will permit. Units are creative in how communication can be encouraged even when prisoners cannot physically be together, for example through how they work with staff, the use of message boards and having situations where prisoners can see and talk to each other while still being physically separated. The CSC service is currently in the process of applying for Enabling Environment status, with each site applying individually but the service as a whole working together to achieve this.

The HSE is not aiming to re-create Westgate across its establishments; this would neither be helpful or appropriate. However, elements of this approach do form part of the wider work across HSE to develop a more rehabilitative culture. This work builds on the work of Alison Liebling and colleagues, particularly their work within the HSE (for example Liebling & Arnold, 2012).

NOMS first commissioning intention is to 'Enhance public protection and ensure a safe, decent environment and rehabilitative culture' (NOMS, 2014). There is a significant overlap in the essential core elements of what makes a culture rehabilitative and what makes an environment enabling. An Enabling Environment and a rehabilitative culture both require clear boundaries and a sense of safety, everyone getting involved to make things better, hope in the possibility for change, and the development of personal responsibility alongside collaborative working. The quality of our relationships is critical to both. Several prisons are now working towards having particular wings or units recognised as Enabling Environments.

The HSE is working with staff and prisoners to raise awareness of the importance of our culture, including elements of the existing culture that are rehabilitative and should be expanded and those that hinder rehabilitation. This is with the aim of engaging everyone in the process of change. While active engagement is part of an Enabling Environment and is necessary for cultural change, involving a wide range of staff and prisoners in this work helps to ensure that it is more successfully embedded into the establishment, rather than being a cause championed by few that quickly gets forgotten. Trying to change the culture and ethos of a place takes time. Given the elements that make up culture it also does not lend itself well to being created and maintained through structured systems of targets and audits. The prison service culturally recognises and rewards concrete tasks and outcomes and so there has been work done at a senior manager level to raise awareness of why a 'one size fits all' approach is not helpful to achieving meaningful change and why a careful balance is needed between providing guidance while still allowing individuals in each prison, who know the establishments best, to determine how to practically interpret and implement this and at what pace to do it at.

Work is underway to embed the Conditions of Success and Strategy of Choice across all eight prisons. As is the case on Westgate, this will help the principles from treatment become embedded across the prison, which supports a number of the Enabling Environment standards. HSE prisons are also reviewing the extent to which prisoners can be actively engaged in their own sentence and the prison environment. Rehabilitative culture committees, with prisoner representatives, are

leading on the implementation of these strategies. Despite the high levels of security, HSE sites are involving prisoners in a number of ways, identifying how the regime and environment could be improved and delivering initiatives such as peer worker schemes and interventions awareness sessions to staff and prisoners. Significant processes such as the Category A review process have also been reviewed to make them more empowering and supportive. Increasing engagement, individual responsibility and a sense of hope all help make the process more enabling. It can also improve the stability of institutions as frustrations over long-term imprisonment and complex routes for progression impact on prisoner violence (Liebling & Arnold, 2012). This work is also requiring the HSE sites to work together to share their experiences and learning, to help generate hope for change and to sell the benefits of this work for everyone in this setting.

There are challenges to applying the principles of a discrete enabling and rehabilitative environment such as Westgate to a whole prison. To a certain extent staff and prisoners on Westgate choose to be there and accept it is a treatment unit aimed at helping prisoners address their offending behaviour. Many staff and prisoners across high security are more sceptical or even suspicious of such a focus. Prisons have found that careful selection of key people to lead this work is critical. As suggested in the literature (Tait, 2011), where there are resilient people who explicitly promote the attitudes, beliefs and behaviours associated with this approach in their day-to-day interactions and are able to inspire this in others, there seems to be more genuine acceptance from others. To help initiate this significant shift in the prisons at a time of financial uncertainly and political change, there has also been a focus on generating hope for change. As part of this staff from Westgate and Full Sutton CSC have visited other prisons and shared their experiences of working in this way. Sharing their initial concerns and how they adapted to this from their previous officer role has helped to allay some people's fears and sell the very real benefits, particularly for staff, of going through this change.

This sharing of experience has in itself contributed to the development of the Openness standard for Westgate and the Full Sutton CSC. This process has included the need for evaluation of their work as well as staff and prisoners sharing their experiences and learning, with staff visiting other units, discussing how they have managed the difficulties they faced in developing this type of environment within a high secure setting. The units have also welcomed a wide range of visitors to show how they put the theory into practice and to allow prisoners to voice their experiences of what is important in establishing and maintaining an effective rehabilitative environment.

Conclusion

The Westgate Unit's development has led to the Enabling Environment Award being achieved within a personality disorder unit in a high security prison. Whilst implementing some of the areas discussed here can be challenging, particularly for whole HSE establishments, they actually work to support the aims of the HSE rather than compromise them. They are compatible with improving institutional behaviour,

supporting the progression of prisoners and helping to reduce long-term segregation, all key aims of the prison service. They promote an ethos that encourages this population to meaningfully take personal responsibility and engage in assessment and treatment processes as well as the wider regime. They also encourage relationships that are critical for reducing risk and in the effective day-to-day management of a prison.

While this work, particularly the expansion to the wider HSE, is clearly ongoing, the very fact that this work has been considered and is starting to be implemented represents a significant shift in how the service works with these populations, for the benefit of staff and prisoners. If HSE prisons can develop more rehabilitative cultures and specific units can effectively work towards being Enabling Environments, then this approach is possible in any setting.

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