TRACKING THE DEVELOPMENTS IN OFFENDER PERSONALITY DISORDER MODELS OF CARE FROM 2002 TO 2020

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A self indulgent ramble….

- 2002: PD, no longer a diagnosis of exclusion
- 2004: DSPD, an illness model
- 2012: OPD pathway, a public health model

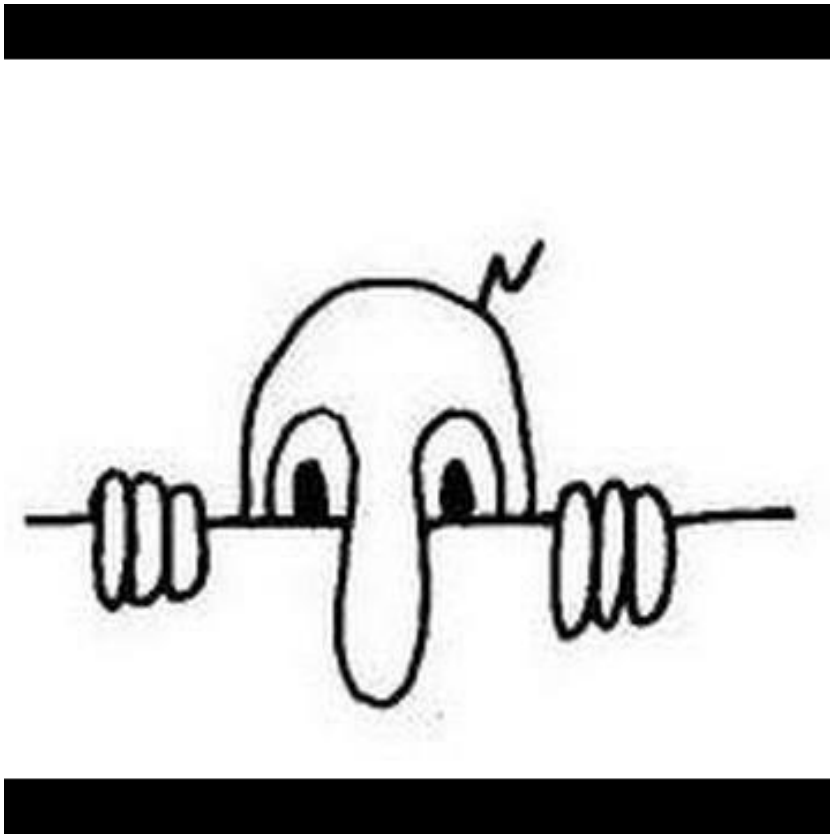
- Where are we now?

- What is the mechanism of change within the model?
  - Learning from research
  - Learning from failure

- Looking forward
  - Involvement of service users
  - The exclusion of sex offenders
  - Maximising impact

Working life before 2002

An outward looking MSU

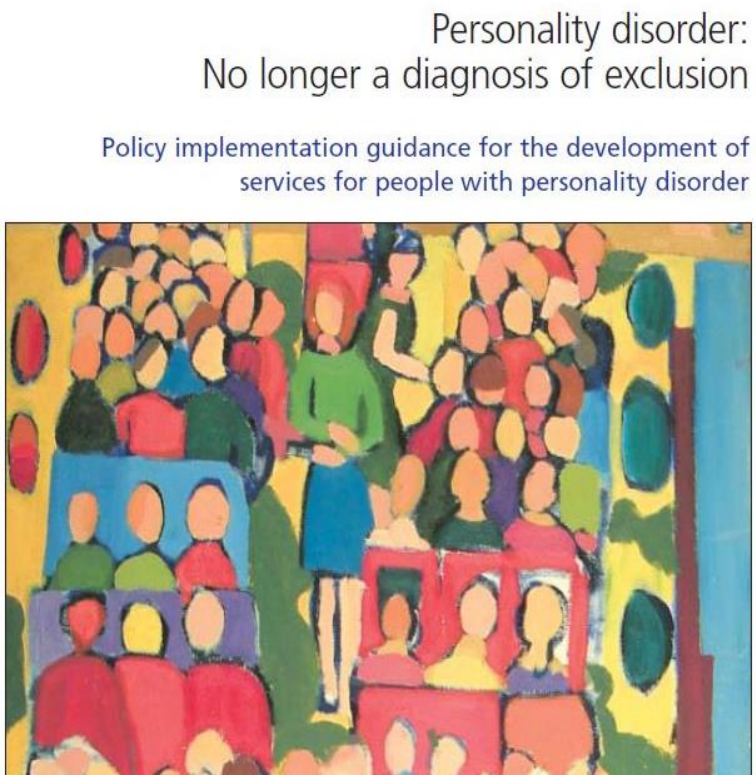


Consultation

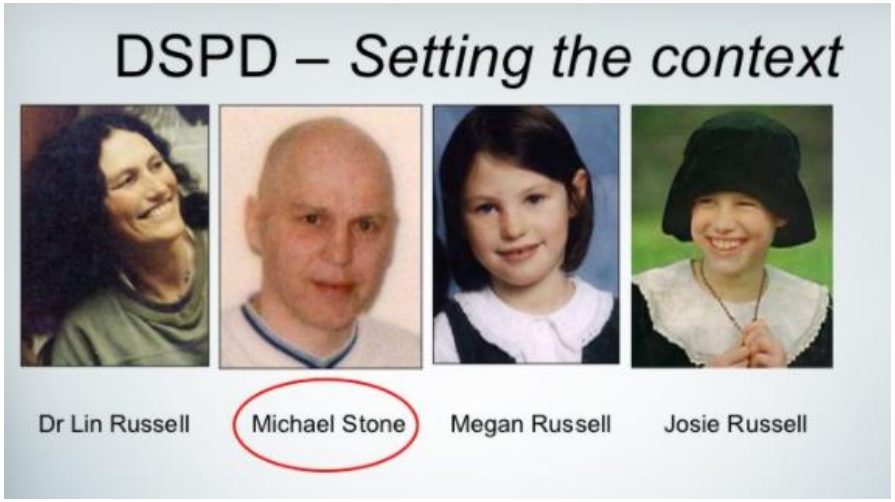
- Ignorance is bliss
- Really complicated offenders can do surprisingly well
- The interesting case of the bag of ice….

2002. PD: no longer a diagnosis….

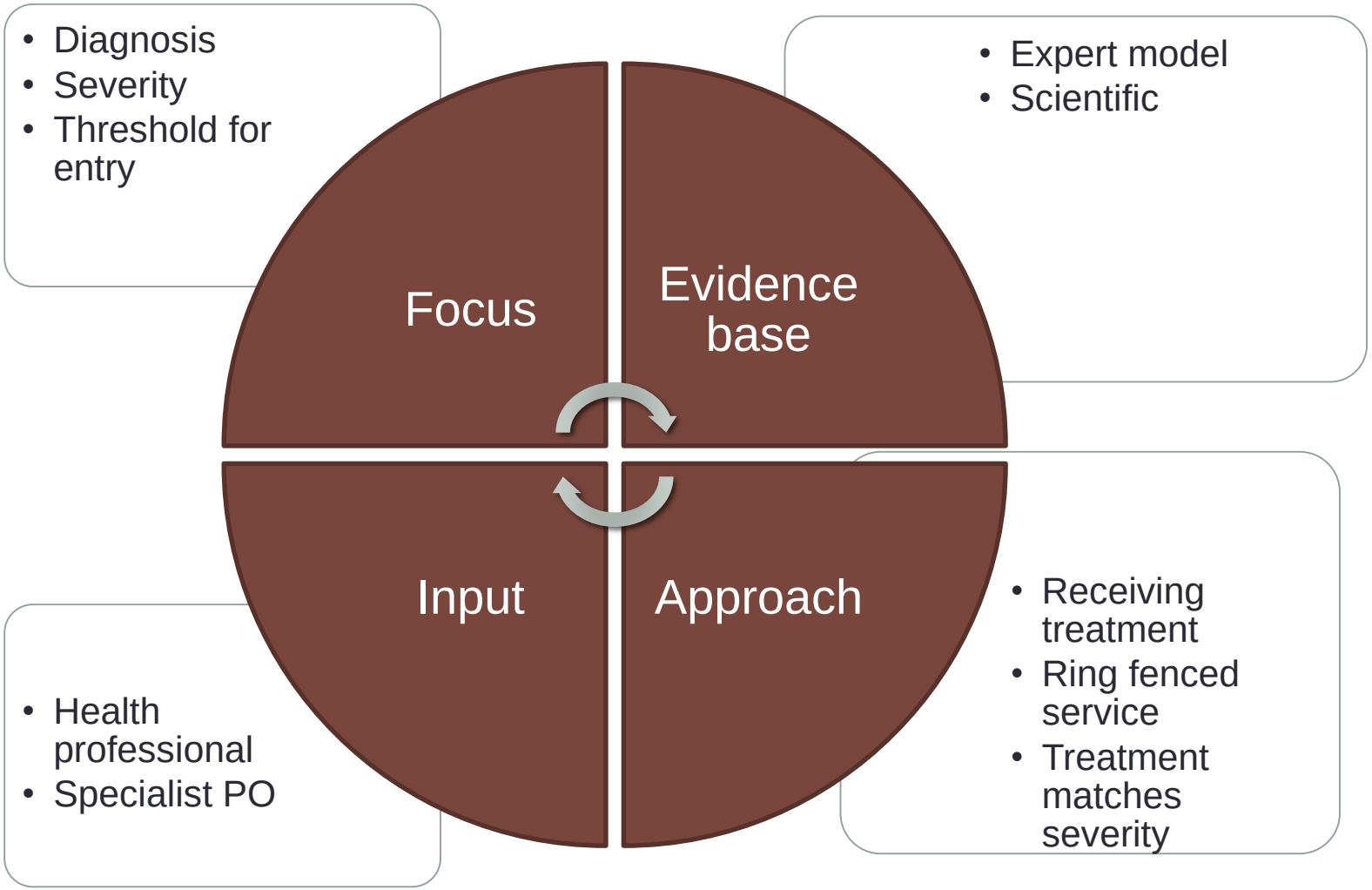
The pleasure of peer discussion



But the power of politics



2004 (roughly): DSPD, an illness model



Reviewing DSPD

Advantages

- Attracted money
- Interested and enthusiastic staff group
- Tried out range of therapies
- Benefited a handful of complex prisoners (the 10% who get through therapy?)

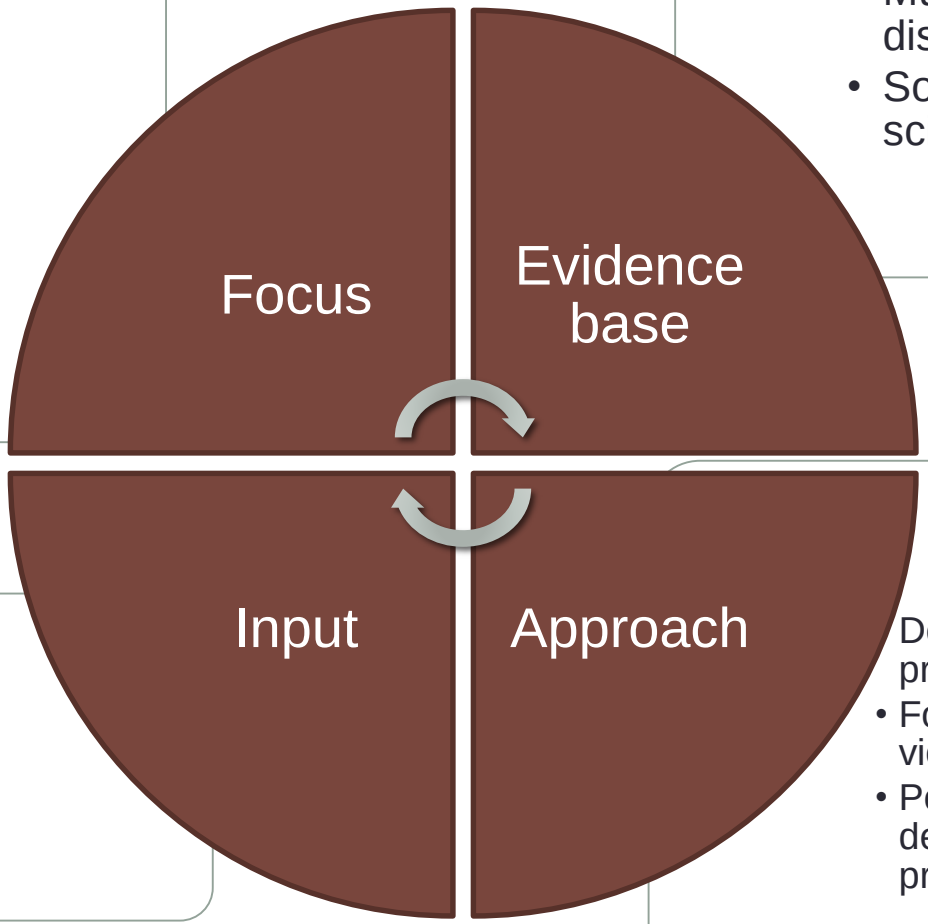
Disadvantages

- Impossible to demonstrate effectiveness
- Some catastrophic staff boundary issues
- Inward focused
- Unfair
- Limitations of hospital as a route out of dangerousness

2012: OPD pathway strategy, a public health model

- Entire OPD population
- Entire staff group
- Primary prevention of risk associated with population

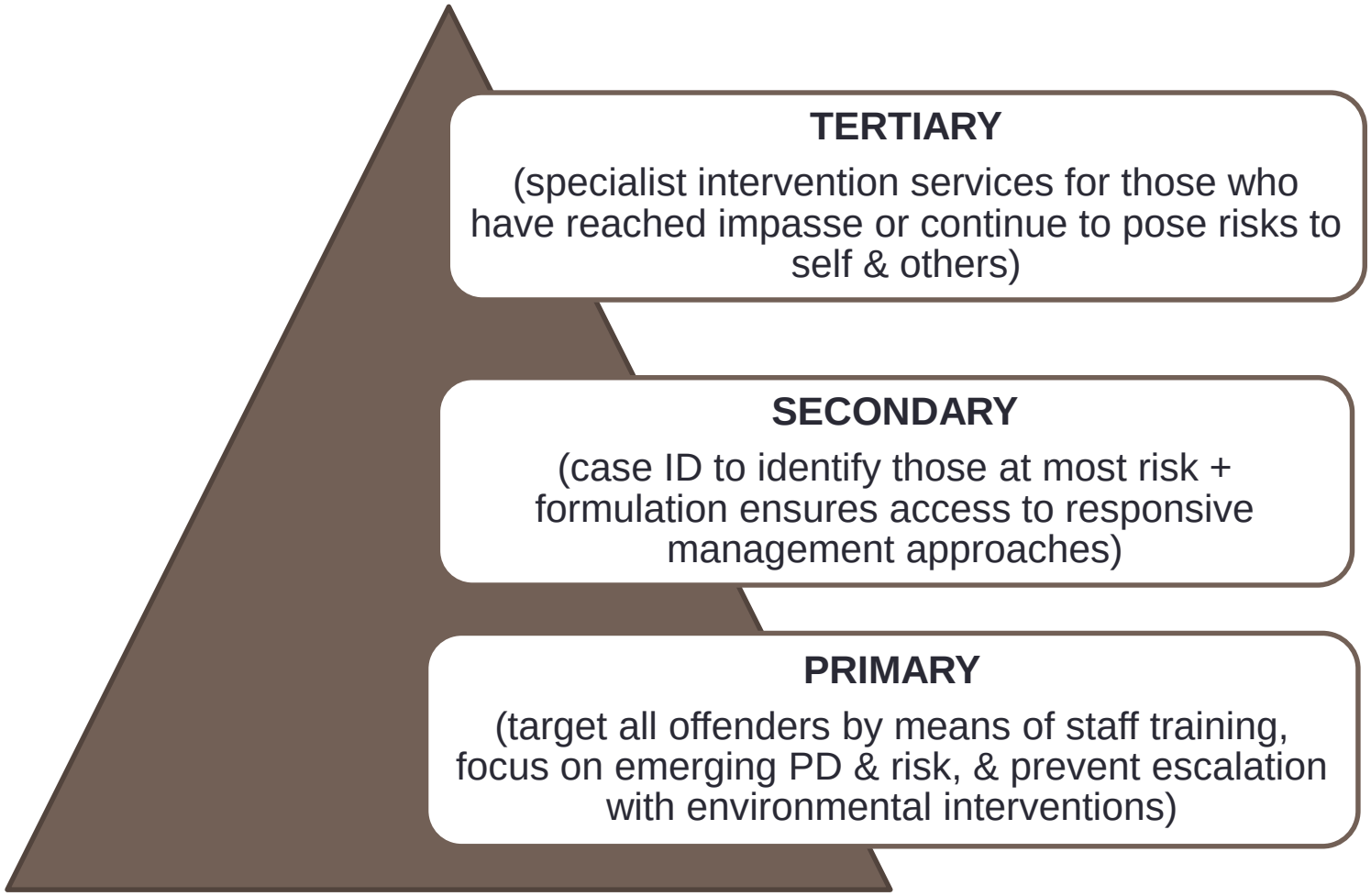
- Multi-disciplinary
- Social sciences



- Health partnered equally with CJS

- Define magnitude of problem
- Focus on modifiers for violence
- Population-inclusive development of prevention strategies

OPD as a public health model



Reviewing the OPD pathway

Advantages

- Huge influx of staff into specialist PD skills/services
- Almost completely uniform delivery of the model across England & Wales
- Pathway focus
- Accessibility for the 90% who don't get through therapy

Disadvantages

- Political change can overwhelm in one fell swoop
- Has the sharing of a limited resource led to a loss of impact?
- The constant pull back to a residential/treatment focus
- Believing in something can be dangerous….

Why keep the focus on the community?

- The community matters because
  - It's where sexual & violent re-offending happens
  - It's where the offender locates his hope
  - It's where the offender has an opportunity to be loved by others
  - It's where our failures are most vivid
  - It's where we learn most quickly to stay focused
  - It's where most of the OPD offenders are located
  - It's where the public live, and
    - They want humane secure treatment for prisoners, but
    - They don't want it to be too successful
    - They won't give jobs to our service users
    - They won't let them live next door
    - They don't want them to have children
  - But there are some fantastic volunteers out there…

Why bother with the evidence base?

- We know (a snapshot of my favourite findings)
  - Therapists are very poor at predicting outcomes in terms of risk
  - Actually patients/offenders are better at doing it
  - Static risk (+ score for PD/adversity) is a stronger predictor of outcome than completing therapy, unfortunately
  - Emotional abuse in childhood + one other childhood problem = easy & very robust red flag for re-offending/non completion as an adult
  - Self report measures don't predict anything, don't bother (except maybe locus of control)
  - Badly behaved psychopathic offenders have better outcomes after interventions than well behaved ones
  - Do not deploy resources on low risk offenders, they do badly in treatment (even though there are other reasons for therapy)
  - Everyone gives up offending eventually, it's about timing

  - And as for serious further offences….

London probation SFO research (The Probation Journal) – it's the context that matters

- 100 SFO incidents per year
- None of the risk tools (actuarial or SCJ) predicted SFOs
- Only 50% had violent convictions
- 70% had possession of an offensive weapon
- More rapes by antisocial offenders than sexual re-offending
- 33% catastrophic violence by burglars & robbers
  - Drug users but not intoxicated
  - 'just in case' weapon or standing in the kitchen
  - Victim behaves unexpectedly (doesn't let go of bag)
  - Panic + adrenalin + trapped

Failures – remember your own catastrophes (but keep the guilt under control)

- 26 years in the job
- 1 x sadistic sexual offender, repeated rather quickly
- 1 x sadistic homicide, almost repeated after 30 years
- 1 x life threatening rape, expected from the moment he got unescorted leave from hospital

  - Progress in treatment was hugely misleading
  - 'I looked at the fridge door with my relapse prevention plan on it, it said ring Jackie; I hesitated for a moment, but I picked up the knife and rope and set out to meet her'
  - I'm nervous about sadism!
  - Good staff are traumatised and leave the service
  - Dammed if you do, dammed if you don't

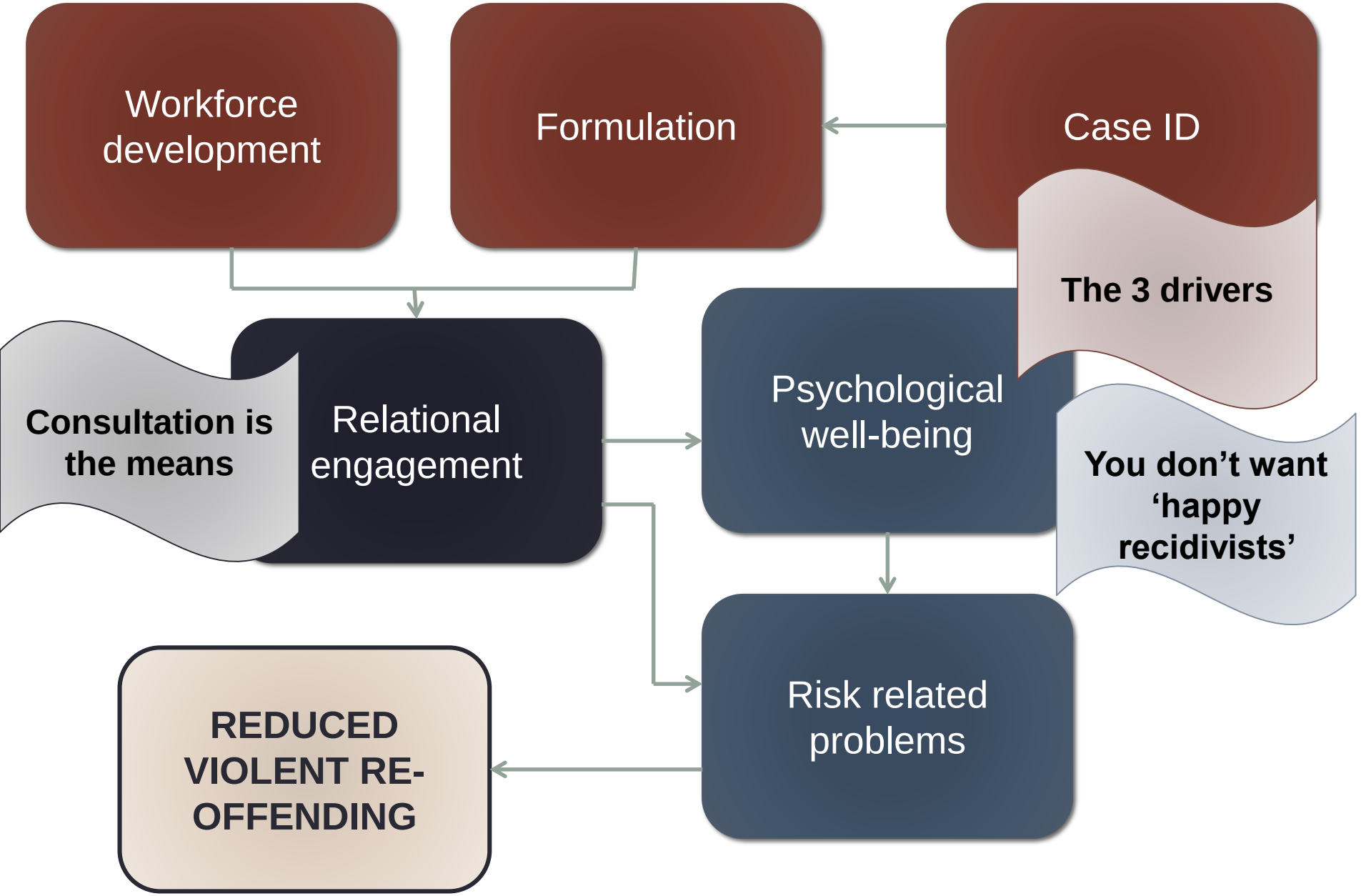
- NOTE on suicides in forensic mental health – prickly, paranoid men who cannot talk about their distress.

Learning from failure

- Don’t focus on ‘successes’
- Watch out for ‘believing in what you do’
  - Just because someone completes an intervention doesn’t mean it helped
  - Services automatically drift towards taking individuals who will ‘succeed’
  - Complacency sets in, and before you know it, someone is questioning your worth
- Shifting the focus to failures, staying in touch
  - Follow up all 500 PD sex offenders over 15 years
  - Keep checking which DHP (PD residential) offenders fail
  - Greater intervention focus on triggers to failure, than on traditional risk factors
  - Never close a case after a failure
    - Offenders change more in response to our response to failure (letters, visits etc) than in response to the intervention itself

Returning to the OPD pathway

- 4 high level outcomes
  - Reduce sexual and violent re-offending
  - Improve psychological well-being
  - Improve workforce competence & confidence
  - Deploy limited resources efficiently
- Do these 4 outcomes need re-formulating to provide a more explanatory model for the hypothesised mechanism of change within the OPD pathway?



3 OPD pathway things to worry about going forward

- Inadvertently colluding with the socio-political exclusion of sex offenders
  - From provision & treatment PIPES
  - From medication
  - From the MBT RCT (despite the research evidence)
  - From integration into therapeutic communities
  - From opportunities for 'good lives' via 3rd party disclosure
- A slightly 'fluffy' approach to involvement of service users
  - Purposeful, meaningful, inadvertently excluding and/or undermining of progression into the community, risky
- Enthusiasm & commitment obscuring the need to anticipate a hostile funding environment: evidencing the **maximum impact** achieved with **minimal resources** deployed in the most **efficient manner**