Title: Personality Disorder Pathway Implementation Plan **IA No:** 7030 **Lead department or agency:** Department of Health **Other departments or agencies:**	**Impact Assessment (IA)** **Date:** 30/11/2011 **Stage:** Final **Source of intervention:** Domestic **Type of measure:** Other

Summary: Intervention and Options

RPC Opinion: RPC Opinion Status

Cost of Preferred (or more likely) Option				
Total Net Present Value	**Business Net Present Value**	**Net cost to business per year** (EANCB on 2009 prices)	**In scope of One-In, One-Out?**	**Measure qualifies as**
£-227.4m	N/A	N/A	No	NA

What is the problem under consideration? Why is government intervention necessary?

Offenders with severe personality disorders are amongst the most difficult prisoners to manage and they present the highest risk of harm within prisons and in the community. The previous administration piloted services in the NHS and high secure prisons. Learning from these services shows that a more comprehensive appoach is required with improved identification of personality disordered offenders, treatment followed by support and management for them within prisons and on their release. Current arrangements mean that only a small number of the most challenging and complex cases receive appropriate management and treatment.

What are the policy objectives and the intended effects?

A more efficient use of existing resources to enhance public protection and access to psychological services for offenders with severe personality disorder.
This approach will ; reduce the risk of re-offending and serious harm to others, ensure identified offenders have high quality formulations setting out clear treatment and intervention pathways which they enter into and complete, lead to psychological health improvements and pro-social behaviours evidenced by offenders, ensure that offenders remain in or return to the community in a planned and safe manner, develop a workforce with the knowledge, skills and leadership to provide the required services. □

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

Option 1 No change to the structure, location or organisation of existing services.
Option 2 Stop the DSPD programme and decommission services. Services for a small number of prisoners would be commissioned by the NHS and provided in secure hospitals. This would lead to a reduction in the number of people receiving treatment and more expensive options for managing the most severe personality disordered offenders within high security prisons.
Option 3 (the preferred option) Develop a new strategy decommissioning hospital DSPD units and providing a pathway approach from the community, through custodial settings and back into the community. The norm would be for services to be provided primarily in prisons and probation however those who need to be treated in hospital would continue to be so. This is the preferred option as it increases the number of people who receive interventions using existing resources and does so at a lower unit cost

Will the policy be reviewed? It will be reviewed. **If applicable, set review date:** 01/2015

Does implementation go beyond minimum EU requirements?			No		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	**Micro** No	**< 20** No	**Small** No	**Medium** No	**Large** Yes
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:** N/A	**Non-traded:** N/A	

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) that the benefits justify the costs.

Signed by the responsible Minister: Date: 12 Dec 2011

Summary: Analysis & Evidence

Policy Option 1

Description: Develop a new strategy 9option 3 above).

FULL ECONOMIC ASSESSMENT

Price Base Year 2010	PV Base Year 2011	Time Period Years 4	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	**High:** Optional	**Best Estimate:** -£227.4m

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate	£31,200.000		£51,600,000	**£227,364,468**

Description and scale of key monetised costs by 'main affected groups'

New treatment places in prisons (£50,000 per place x 400 places - total of £20,000,000 pa by year 4)
Progression places (£3,000 per place x 820 places - total of £2,460,000 pa by year 4)
Early identification and assessment (total of £4,000,000 pa by year 4)
Community management and suppport (total of £10,000,000 pa by year 4)
The total net present value has been uplifted by 2.4 to reflect the opportunity cost and DH practice.

Other key non-monetised costs by 'main affected groups'

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate				

Description and scale of key monetised benefits by 'main affected groups'

An additional 400 treatment places and 820 places providing ongoing psychological support for offenders who have completed treatment. The costs are outlined above.

Other key non-monetised benefits by 'main affected groups'

In addition to improving the psychological health of offenders, there are wider benefits for society derived from improved public protection, reductions in re-offending and cost savings for the criminal justice system.

Key assumptions/sensitivities/risks **Discount rate (%)**

Risks
Impact and effectiveness of current changes to the NHS
Assumptions
That the NHS Commissioning Board takes responsibility for commissioning the health component of the offender personality disorder pathway
That the National Offender Management Service retains a regional commissioning process.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: N/A	**Benefits:** N/A	**Net:** N/A	No	Zero net cost

Evidence Base (for summary sheets)

The problem under consideration

The problem under consideration can be summarised as money to treat and manage offenders with severe personality disorders is not being used efficiently or effectively.

Personality disorder (PD) is an under developed area of mental health. It affects many people in society, most of whom do not commit offences. For some, however, personality disorder significantly contributes to offending and risk related behaviours. Approximately two thirds of the prison population (based primarily on self reporting) are thought to have at least one personality disorder. Of this group, around 8,000 have been assessed by the National Offender Management Service (NOMS) as presenting a serious risk. A smaller group, thought to be around 2,000 at any given time, are assessed as presenting a very high risk and have serious personality disorders.

The previous administration developed the Dangerous and Severe Personality Disorder (DSPD) programme to manage those with the most severe forms of PD. A policy decision was taken to develop pilot services in prisons and secure hospitals with the understanding that costs would vary between the pilots due to different staffing requirements, the interventions and therapy provided, organisational structures and overheads. More detail about the differences in staffing structures is provided in table 2.

The coalition government is taking the learning from the DSPD programme to improve the public sector commissioned services provided for personality disordered offenders and in doing so will reduce the risk of re-offending and improve psychological health. Our plans are based on using the same level of funding more effectively.

Policy objective

The policy aims to use the same level of resources more effectively and in doing so improve public protection, treatment and the psychological health of this group of offenders. Implementation of the offender personality disorder pathway is expected to:

- identify prisoners with personality disorder early in their sentence
- ensure identified offenders have high quality formulations setting out clear treatment and intervention pathways
- ensure offenders enter into and complete planned treatment and interventions
- evidence psychological health improvements and pro-social behaviours
- increase the criminal justice system's capacity to manage this group of offenders
- reduce the risk of serious re-offending and harm to others
- retain or return prisoners to the community in a planned and safe manner
- develop a workforce across NOMS and the NHS with the right skills, experience and leadership.

The response to the consultation suggests broad outcomes but leaves the quantification of the metrics to be determined by NOMS and, subject to legislation, the NHS Commissioning Board.

The Consultation

Between 17th February and 12th May 2011, the Department of Health and National Offender Management Service consulted formally about an implementation plan for their proposed Offender Personality Disorder Pathway. The policy team held four consultation events to encourage interested organisations and individuals to submit responses. The policy team also sought the views of offenders in prisons, secure psychiatric hospitals and in the community. A total of 91 responses were received almost all of which supported the development of pathways of services to improve the identification, assessment, management and treatment of offenders with severe personality disorders.

We now intend to take forward our plans to implement the offender personality disorder pathway, starting new operations in 2012/13.

Rationale for intervention

The Government provides funding for the DSPD programme in both the NHS and NOMS. The changes to contracts and priorities required to implement the pathway approach will move money between organisations and would not happen without Government setting the overall policy.

Description of the DSPD programme

Background - The National Health Service (NHS) and National Offender Management Service (NOMS) between them currently spend around £69m per year to fund the DSPD programme.

The programme provides services in high security prisons, a women's prison, high secure hospitals, medium secure hospitals and in the community. The majority of the resources are used to fund the high secure units. Three of the five high secure units are purpose built (Broadmoor, Rampton and HMP Frankland). This was a substantial component of the first phases of the delivery of the programme. The total capital investment for the programme as a whole was £128m.

There are currently 286 places in use in high secure settings. Current usage and maximum capacity are shown in table 1.

Table 1 - Maximum capacities of the High Security services

Host institution	Opened	Physical Capacity	Current Numbers held (June 2009)[1]
Broadmoor Hospital	October 2005	48	39
Rampton Hospital	March 2004	70	50
HMP Whitemoor	2001	70	61
HMP Frankland	May 2004	86	76
HMP Low Newton (women)	December 2006	12	12
Total High Security		286	238

The programme as a whole currently provides:

- the five high secure units
- 52 places at three medium secure hospital units: one in Newcastle and two in London
- community services:
    - one based in Liverpool, which provides a risk assessment and case management service to manage and treat high risk prisoners who are coming out of prison on licence and are registered at MAPPA (Multi Agency Public Protection Agreement) level 2 and 3.
    - Others in London where NHS psychologists support probation staff in the identification, assessment and management of this population.

Assessment of costs for all high security services in hospital has shown that the cost per bed in hospital DSPD units is £292,000 (NHS High Secure Commissioning data), broadly the same as for other high secure psychiatric patients. Places in prison DSPD units cost around £85,000 (DH/NOMS offender personality disorder team)

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The case mix in high secure hospitals and prisons is broadly similar and the cost differential can not be explained by complexity or severity. There are significant variations in establishment numbers, professional salary costs, differential hotel and capital charges and different 24-hour operational flexibility and requirements. Additionally the legislative frameworks for the NHS and NOMS have differing cost impacts. The table below compares units of broadly the same size.

[1] 48 prisoners / patients were recorded as not actively in treatment in June 2009

Table 2 Comparison of staffing levels in a prison and a hospital DSPD Unit

	Baseline workforce	
	n	(% of total)
Rampton (TOTAL)	278	
Core therapy team	23	(8.3)
Secondary therapists	89	(32.0)
Frontline staff	141	(50.7)
Management/Admin	20	(7.2)
Whitemoor (TOTAL)	140	
Core therapy team	17	(12.1)
Secondary therapists	41	(29.3)
Frontline staff	61	(43.6)
Management/Admin	21	(15.0)

DH/NOMS data

The Department of Health and National Offender Management Service evaluation of the services, based on the available research and organisational experience, suggests from the point of view of both the men and the staff, that the units in prisons seem on balance to be more successful in providing the right kind of context for successful delivery of treatment (and with fewer resources) than the hospital-based units.

Defining personality disorder and the link to offending behaviour

Personality disorder is a recognised mental disorder. The Diagnostic and Statistical Manual of Mental Disorders[2] (DSM-IV) defines personality disorder as "An enduring pattern of inner experience and behaviour that deviates markedly from the individual's culture." DSM-IV describes ten personality disorder types, split into three clusters:

Cluster A – ('odd or eccentric') paranoid, schizoid, schizotypal;

Cluster B – ('dramatic, emotional or erratic') histrionic, narcissistic, antisocial, borderline;

Cluster C – ('anxious and fearful') obsessive-compulsive, avoidant, dependent.

The implementation plan is applicable for all types of personality disorder experienced by offenders, the most common of which are antisocial and borderline personality disorder.

The National Institute for Health and Clinical Excellence (NICE) has published guidelines that describe the challenges. People with antisocial personality disorder will exhibit "traits of impulsivity, high negative emotionality, low conscientiousness and associated behaviours including irresponsible and exploitative behaviour, recklessness and deceitfulness. This is manifest in unstable interpersonal relationships, disregard for the consequences of one's behaviour, a failure to learn from experience, egocentricity and a disregard for the feelings of others." (NICE, 2009)[3]

'Borderline personality disorder is "characterised by significant instability of interpersonal relationships, self-image and mood, and impulsive behaviour. There is a pattern of sometimes rapid fluctuation from periods of confidence to despair, with fear of abandonment and rejection, and a strong tendency towards suicidal thinking and self-harm. Transient psychotic symptoms, including brief delusions and hallucinations, may also be present. It is also associated with substantial impairment of social, psychological and occupational functioning and quality of life. People with borderline personality disorder are particularly at risk of suicide" (NICE, 2009)[4].

[2] **American Psychiatric Association (1994)** Diagnostic and Statistical Manual of Mental Disorders 4th edn, *American Psychiatric Association, Washington, DC*

[3] **National Institute for Health and Clinical Excellence (2009)**Antisocial Personality Disorder Treatment, Management and Prevention *http://www.nice.org.uk/Guidance/CG77*

[4] **National Institute for Health and Clinical Excellence (2009)**Borderline Personality Disorder Treatment and Management *http://www.nice.org.uk/Guidance/CG78*

Description of options considered

Option 1: No Change
This scenario assumes that PD services will continue to be clustered in a number of discrete units addressing small numbers of offenders held in high security, medium security and community settings.

Option 2: Stop the DSPD programme and decommission services
Under this option, all the DSPD units would close. Prisoners would be managed in segregation and close supervision centres within prisons unless they meet the criteria of the Mental Health Act when there would continue to be provision in the secure psychiatric hospital estate.

Option 3: Strategic development and service reconfiguration
Under this option, there would be a managed decommissioning of the DSPD units at Broadmoor, the NHS medium secure units and Rampton. The released money would be used to increase the number of treatment places and develop a pathway of services in prisons and the community.

Consideration of the options and costs

Option 1 - the presumption is that the allocation of financial and service resources would largely remain the same as now. Staying with the existing model would not address any of the policy objectives and would result in the continued use of a system with a difference in cost between prison DSPD units (an annual cost of £85,000 per place) and NHS DSPD units in high secure psychiatric hospitals of (£292,000 per place).

Option 2 – closure of all the DSPD programme would initially release £54 million for the NHS and £15 million for NOMS. However closing the programme would not remove the issues of:

- how the criminal justice system should manage offenders with complex problems who have committed serious violent and or sexual offences
- how the NHS should work with the criminal justice system to provide treatment for this group of prisoners
- how to reduce the likelihood of re-offending
- the likely judicial reviews if all management and treatment of offenders with severe personality disorders were to be withdrawn
- how to take forward the policy objectives of improving both public protection and the psychological health of this group of offenders.

Within prisons, we would expect to see significant increased use of close supervision centres which are more expensive than DSPD units (£90,000 per annum above the cost of a high secure prison place compared to £30,000 for DSPD units – unpublished Ministry of Justice data). Managing these high risk offenders within the prison estate without providing targeted interventions would also be likely to lead to an increase in the level of disruption, put pressure on the capacity of segregation units and more transfers of prisoners between prisons.

Within the NHS there would also continue to be provision for prisoners who meet the requirements of the Mental Health Act. These beds within the secure psychiatric hospital estate would cost a similar amount to beds in the existing DSPD units. It is also likely that the removal of specialist DSPD units from prisons would lead to an increase in the number of referrals of prisoners for psychiatric assessments under the Mental Health Act and potentially little reduction in the overall number of prisoners being treated in hospital.

Option 3 - This option sees the same amount of resources used in a different way. Increased priority is placed on identification and assessment of prisoners, the de-commissioning of the hospital DSPD units, more treatment places in prison, new support for offenders moving along the interventions pathway and investment in the training and development of the workforce. The costs for this preferred option are explained in more detail below.

Description and costs of the preferred option

Adoption of the preferred option would see investment in regional pathways in the North (North East, North West, North Wales, Yorkshire and Humber) Central (West Midlands, East Midlands, East of England) London and the South (South East and South West). The Investment in new services is dependent on funding being released by de-commissioning the existing NHS based DSPD units. Table 3 below gives our best estimate of the cash flows.

Table 3 : Cash flows- preliminary estimates

	2011-12	2012-13	2013-14	2014-15
	£m	£m	£m	£m
NHS - non-forensic	7	7	7	7
NHS - DSPD – Bundle	34	34	34	34
NHS - DSPD - PCT baseline	13	13	13	13
NOMS - DSPD – baseline	15	15	15	15
Total Funds (A)	**69**	**69**	**69**	**69**
Planned Expenditures				
Existing Services transition phase				
Decommissioning DSPD - Broadmoor	16	2	0	0
DSPD – Rampton	16	16	16	12
DSPD – Prisons	15	15	15	15
DSPD - Medium Secure Units	15	15	7.5	0
NHS - non forensic	7	7	3.5	0
Sub total Existing Services (B)	**69**	**55**	**42**	**27**
Funds available to support pathway commissioning (C= A - B)	**0**	**14**	**27**	**42**
New Services Expenditure by Supra Region (example)				
North East/North West/Yorkshire/North Wales	0	3.4	8.9	14.0
London	0	2.4	4.5	5.6
South East/South West/South Wales	0	4.9	5.9	9.0
Eastern/East and West Midlands	0	2.0	6.2	12.0
Central Policy Implementation Team	0	0.4	0.4	0.3
Research and Evaluation Programme	0	0.3	0.5	0.5
National workforce training programme (KUF)	0	0.6	0.6	0.6
Sub total New Services (D)	**0**	**14**	**27**	**42**
Total Planned Expenditures (rounded)	**69**	**69**	**69**	**69**

By 2014/15 each of the supra-regional pathways will consist of:

Early identification – this involves identifying offenders who are likely to meet the entry criteria for the strategy near the beginning of their sentence through the use of screening processes, case consultation and workforce development. For each supra-regional pathway, additional resources will be provided to identify those offenders that are: likely to meet the criteria, decide the cases on which specialist advice should be sought; and to ensure that sentence planning properly takes account of complex psychosocial and criminogenic needs relating to personality disorder.

Based on the results of the screening, a smaller number will be identified as meeting the criteria and will require enhanced assessment, case formulation and sentence planning.

Assessment, case formulation and sentence planning - This process will be managed by the NOMS offender manager and supported by a clinical or forensic psychologist. The assessment and case formulation determine the interventions/treatment requirements and ensure that referrals are made to PD or other treatment services at the appropriate time. Based on current observations that only about half of all those assessed as needing specialist PD treatments will be motivated to engage, the number of cases that will come forward in each supra-region for special treatment is estimated around 650 each year. This is an important assumption that will be kept under careful review.

Early estimates by the DH/NOMS policy team, based on the costs incurred by the London pilots, indicate that each supra-region requires around £1m per annum by year 4 to fund these two stages of the pathway.

Strengthened community case management – Mental health services will provide a consultation service to probation teams and approved premises to help them understand the significance of personality disorder in offenders, develop risk management plans and identify practical strategies for enhancing positive engagement. The role of the specialist provider includes supporting probation staff to facilitate therapeutic approaches and may include joint case management. Models for community management and treatment will be specified, building on the learning from a range of pilot projects, such as the Resettle Pilot in Liverpool. It is assumed that most offenders receiving management or treatment in the community will be MAPPA 3 (Multi Agency Public Protection Agreement) offenders.

The pathway financial model assumes that a total of around £2.5m per annum is needed to fund these activities for each supra-region.

Treatment Options for the most complex and highest risk offenders in Custody

Each supra-region will have access to the national PD treatment options. These will be a mix of existing services within the Criminal Justice System, such as the PD treatment units in the High Secure Prisons (Whitemoor and Frankland) and Low Newton for women. For some offenders there will also be access to the NHS High Secure hospitals (Ashworth, Broadmoor and Rampton) personality disorder directorates where they meet a number of criteria, including the requirements of the Mental Health Act.

Each supra-region will also develop, over time, new PD treatment services within Category B and Category C prisons. It is estimated that each unit will comprise around 40-50 places and will cost up to £50,000 per place per annum, over and above, the cost of operating the existing prison places.

A number of operational and treatments models will be developed within custodial settings, for example treatment might be undertaken on separate and discrete treatment wings or alternatively, day care units might be appropriate, with prisoners returning to normal location at the end of the day. Under the separate wing approach, existing prison wings will be used which will avoid the need for new building and additional capital expenditure, although there is likely to be the need for small scale adaptations. The choice of model will be driven by developing evidence of clinical effectiveness and improved outcomes.

Each supra-region would develop 2 or 3 prison based specialist PD treatment units (depending on the size of wing or day care centre) at appropriate establishments at a total annual operating cost of up to £7.5m. Across all supra-regions by 2015, there will be a total of around 400 places at between 6 to 9 category B and C prisons that will require funding of around £20m per annum.

Progression Units (PIPEs)

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

The pathway requires that at least three PIPES per supra-region are provided, plus two national PIPEs for women. These will provide offenders with progression support following a period of treatment in custody and/or in Approved Premises. This work supports a pathway approach to the management of high-risk offenders. Assuming successful evaluation of pilot sites in September 2012, the PIPE model will also be adapted to accommodate offenders preparing for treatment in a custodial setting, including their willingness and ability to engage in treatment.

Each PIPE costs around £3,000 per place each year over and above the running cost of a prison wing or approved premise. Each PIPE will normally be around 40-60 places for prisons and around 25 places in an Approved Premises. Nationally, there will be 820 places costing around £2,460,000 per annum to operate.

Nationally provided services

The policy is based on four pathways developing services but there are a number of areas where a national input is required. Workforce development, research, evaluation, and assistance with implementation of pathway development are expected to account for around £1.4 million in 2014/15.

Contingency

The process and timing for de-commissioning and investing in new services is complex. We have had to make assumptions about costings and timescales that may not be a applicable for all areas of the country. For planning purposes, and in line with HM Treasury Green Book guidance, we have allowed for a contingency to cover operational risk, which we have estimated at 10% of the anticipated national spend. The table below summarises the anticipated spend in year four based on the information above

Table 4 – anticipated national spend in 2014/15 by pathway area

Service	Anticipated National spend in 2014/15
Early identification	£4,000,000
Assessment, case formulation and sentence planning	
Strengthened community case management	£10,000,000
Treatment in custody	£20,000,000
Progression Units	£2,460,000
Nationally provided services	£1,400,000
Contingency	£4,140,000
Total	£42,000,000

Transition costs

Transition costs of £6 million have been agreed for the decommissioning of the pilot DSPD unit at Broadmoor with £4 million in the current financial year and £2 million in 2012/13.

Based on current planning assumptions any costs associated with Rampton will fall outside the period covered by this impact assessment.

Costs for the medium secure units have been estimated as being a similar pro rata level to those at Broadmoor with £5 million over 2012/13 and 2013/14 available for transition.

Some of the non-forensic services are expected to change their focus and be incorporated within the supra-regional pathways but £2 million over 2012/13 and 2013/14 will be available for transition costs.

Workforce development

Developing the skills of the workforce who work with personality disordered offenders is crucial to the success of the policy. Some of the costs are included within funding for services but the nationally provided services includes funding for staff to complete the Knowledge and Understanding Framework Awareness Level training.

Summary costs

The summary of costs at page 1 is derived from the anticipated spend in each year (table 3) with additional costs of £3 million over the four year period for the opportunity cost of staff attending the Knowledge and Understanding Framework Awareness Level training.

Benefits of the pathway model

NICE guidelines

The NICE guidelines on anti-social personality disorder (National Institute for Health and clinical Excellence 2009) accept that the evidence for health service costs is limited and identifies the following reasons: paucity of research in the area, the difficulty in interpreting the evidence caused by the prevalence and number of co-morbidities, problems with diagnosis and the fact that many people who are treated are under duress.

The guidelines also recognise that the harm caused by an individual's antisocial personality disorder, and therefore the benefit of providing treatment, extend beyond the impact on the individual. It extends not only to immediate family members, but to society at large. Extended harm therefore leads not only to high levels of personal injury and financial damage for victims but also to increased costs of policing, security, and so on. As stated in the rationale for intervention, if the offenders on the DSPD programme were to re-offend the offences committed would likely be serious and high cost.

The guidelines' description of health service resources and other costs concludes by saying 'efficient use of available healthcare resources is required to maximise the benefits for people with these conditions, their family and carers, and society in general.'

The NICE guidelines include a cost analysis to assess whether the costs to the NHS of providing Reasoning and Rehabilitation, a group based cognitive behavioural skills intervention, to adults with offending behaviour are offset by future cost savings resulting from reduction in re-offending behaviour in this population. They found that these programmes are potentially cost effective in the UK setting. Besides the clinical benefits to adults with offending behaviour, they may produce net cost savings to society, resulting from reduction in offending behaviour. The Guidelines Development Group (GDG) judged that it would be reasonable to conclude that such interventions were likely to be effective for people with antisocial personality disorder. The GDG went further and considered that it would be possible to extrapolate these findings to people who meet criteria for DSPD and therefore concluded that cognitive and behavioural interventions would likely be moderately effective in this population. However, it was also felt that the intervention would need to be adapted in order to be beneficial for people with DSPD. The adaptation should extend the duration and nature of the intervention (for example, concurrent individual and group sessions), provide booster sessions and continued follow-up and close monitoring.

NICE found that the existing evidence on the cost effectiveness of psychological therapies in the treatment of people with borderline personality disorder (National Institute for Health and Clinical Excellence 2009) is limited and weak. Their systematic search of economic literature identified a few studies that assessed the cost effectiveness of a number of interventions covered in this chapter. The results of most studies were characterised by a high degree of uncertainty and could not lead to firm conclusions regarding cost effectiveness. Moreover, in some cases results across studies were inconsistent. NICE felt that further research is needed.

Measuring benefits in the DSPD programme

The DSPD programme uses short, medium and long term measures to chart the effectiveness of interventions. Short term measures include improvements in completing treatment assessments, motivating offenders on risk reduction programmes and a reduction in incidents of violence, adjudications and self harming. Medium term measures include improvements in offenders' engagement in treatment, pro-social behaviour and reductions in impulsivity. Long term outcomes will mainly focus on no repetition of serious offending. There are some signs to indicate improvements in short and medium term outcomes, however, it is too soon to provide a definitive answer on long term outcomes.

Reducing re-offending

The relatively small number of offenders who present a very high risk of harm to themselves and others are among the most difficult to manage in the prison population. If they do re-offend, it is likely to be a serious offence of a sexual or violent nature. The Ministry of Justice uses information developed by the Home Office (The economic and social costs of crime against individuals and households 2003/04 - Home office Online Report 30/05. London: Home Office; 2005) to calculate the social and economic cost of crime. Homicide at £1.5 million per offence has the highest cost but the methodology used groups other offences rather than identifying each one separately. Also due to the relatively short timeframe of the current DSPD programme and the absence of a control sample it is not possible to quantify the number or level of offences that could be prevented by offenders progressing along the offender personality disorder pathway.

Benefits of the pathway approach

The pathway approach will provide:

- A more efficient use of existing resources to enhance public protection and access to psychological services
- A cross-sector, collaborative, evidence based, community-to-community pathway approach
- Improved and earlier identification and assessment of offenders with PD
- Improved risk assessment, risk and case management of offenders with PD in the community to support the layered approach to offender management
- New intervention and treatment services commissioned at supra-regional, regional and local levels by the NHS and NOMS in secure and community environments;
- Improvements to the nationally commissioned treatment services in high security prisons and regionally commissioned democratic therapeutic community services in prisons;
- The provision of progression environments in prisons and approved premises for offenders who have completed a period of treatment.

We expect that the outcomes for personality disordered offenders will be:

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

The preferred option also provides a focus on workforce development which will lead to increased understanding of personality disorder in the NHS, CJS and other services such as housing and benefits with unquantifiable benefits from reduced costs due to disruption and disturbance.

Consultation responses about benefits of the pathway approach

Respondents to the consultation on the offender personality disorder pathway implementation plan suggested that the preferred option would result in:

- improved working between NOMS and the NHS as a result of the organisations having joint responsibility for offenders with severe PD. This improvement would have a wider impact and benefit for other prisoners with mental health problems
- improved sentence planning along a pathway. This would reduce instances of breakdown in arrangements and consequential detrimental impact on offenders' mental health
- increased value for money and targeted use of resources to reduce risk as a result of the whole pathway approach being used
- a potential reduction in the need for close supervision centres and escalation of security for prisoners on the pathway
- a reduction in the number of recalls to prison from offenders being managed in the community

The first three of the listed benefits would be extremely difficult to quantify.

We have not attempted to estimate the possible reduction in costs from prisoners receiving treatment for their personality disorder as opposed to being managed in close supervision centres. However the annual cost for a place in a close supervision centre is the cost of a high secure prison place plus £93,000, whereas the cost for a personality disorder treatment place at the same level of security would be £30,000.

Data for the benefit derived from reducing the number of recalls to prison is taken from the Impact Service, a partnership between Camden and Islington NHS Foundation Trust and London Probation Trust. (British Psychological Society Forensic Update No.104). The service aims to reduce the number of recalls to prison of offenders managed in the community. Where Public Protection Unit (PPU) probation officers received support from the NHS to develop their psychological understanding and change the way they interacted with offenders the number of recalls fell by 49%. Allowing for the cost of the service, the project made a cost saving of over £300,000 by reducing the number of recalls by 29 (49%) for 2010/11 compared with 2009/10. The cost saving is calculated using

- the average length of recall for PPU offenders (153 days based on a Howard League study in 2006)
- average cost of sending one person to prison (£41,000 per year)
- cost of a 1 year community rehabilitation order (£3,000).

The strategy will be subject to a research and evaluation review and the implementation of the strategy will be subject to performance management review. The strategy review will seek to increase the knowledge in relation to working with this offender PD population, the evaulation will look at the effectiveness of the strategy in terms of delivering its intended outcomes. The performance management review will measure the extent to which the specifications are delivered and to advise managers on how to rectify any problems identified.

Risks and assumptions

The risks common to all the options are that:

- the evidence base is still developing and further research could result in a change in direction
- the impact of system change in the NHS may affect development of the pathway
- a high profile event leads to pressure for a change in policy
- continuing pressure on public sector budgets results in decreased funding in the longer term.

In addition for option 3 (the preferred option) there is an overarching risk that the pathway approach may not work as expected meaning that

- re commissioning of services along the pathway may not work to the projected timescales
- the number of completed treatments may be lower than anticipated.

Administrative burden and policy savings calculations

Removing the DSPD programme and developing the new strategy will not have an impact on the administrative burden or policy savings calculations.

Wider impacts

Competition None of the options considered would have an impact on competition.

Small firms None of the options considered would have an impact on small firms.

Greenhouse gas emissions. None of the options considered would have an impact on greenhouse gas

Wider environment issues environmental issues. None of the options considered would have an impact on wider

Health and well being section of society. However, there are unlikely to be public or community concerns about potential health impacts, increased demand on services or a disproportionate effect on any group. All three options aim to improve the psychological health of a stigmatised

Human rights offenders/patients on the grounds they are being denied access to appropriate interventions to reduce their risk. Stopping the DSPD programme under option 3 may be challenged by

Justice There are no implications from the justice impact test.

Rural proofing None of the options considered would have an impact on rural issues.

Sustainable development None of the options considered would impact on sustainable development.

Statutory equality duties The equality impact assessment is available as a separate document.

Micro / small business micro/small businesses. Implementation of the preferred option would not have an impact on