ASSOCIATION OF DIRECTORS OF ADULT SOCIAL SERVICES (ADASS) RESPONSE TO CONSULTATION ON THE JOINT DEPARTMENT OF HEALTH / NATIONAL OFFENDER MANAGEMENT SERVICE OFFENDER PERSONALITY DISORDER PATHWAY IMPLEMENTATION PLAN

The Association of Directors of Adult Social Services (ADASS) represents Directors of Adult Social Services in Local Authorities in England. As well as having statutory responsibilities for the commissioning and provision of social care, including the safeguarding of vulnerable adults, ADASS members often also share a number of responsibilities for housing, leisure, library, culture, arts, community services, and increasingly, Children's Social Care within their Local Authority.

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

1. Critical questions- where does the pathway fit with short term offenders or those released with little or no supervision: and at what stage is the assessment undertaken for a personality disorder (PD)?
2. In order to make an appropriate sentence proposal to the sentencing court, all assessments need to be completed prior to sentencing and should usually be completed within the timescales directed by national standards.
3. Will the assessment for a PD delay sentencing? If the assessment is completed post sentence then there is the risk of inappropriate sentencing. Once an assessment is completed and a PD identified who is responsible for directing the format of the sentence. This is usually completed by the Offender Manager who will specify to the sentencing court what Cognitive Behaviour programmes will be completed as part of the sentence. With the identification of a PD post sentence the information presented to the court pre-sentence will be inaccurate and the initial sentence plan no longer valid.
4. The principles appear to have a sound balance between agencies involved with offenders with PD;
    - It is correct that the case management role is held by offender managers who have a whole system overview of these cases
    - Addressing PD is a crucial in a prison setting because it is seen as being so prevalent.
    - Whole systems/ continuity of care is absolutely to be applauded and fully supported however this is only possible if community services exist at all levels.
    - Psychological interventions for this particular client group is a long term commitment - and the if the community pathway is to deliver the longer term benefits it needs to be recognised that wider community support and services are still patchy.
    - There is may be difficulties in ensuring that the needs of the agencies are met in a coordinated manner. For example, what priority will treatment for PD be given in a prison setting and how can movement around the system be limited to achieve treatment outcomes.
5. Whilst the increase in places is to be applauded it appears to only represent 3% of the estimated sentenced prisoner population with PD (based on Figure 1). **This comment applies to questions 1 and 2**

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

1. A PD is estimated to be present in 60 – 70% of offenders in a custodial setting and based upon the estimated current prison population, the number of offenders with a PD could be anywhere in the region of 56,000.
2. With this in mind how will services be directed/prioritised? If this is based on risk will it be generalised risk or risk presented as an element of the current offence? If it is generalised risk then there is the complication of sentencing being based on a mental health condition rather than an offence leading to sentencing not matching the offence and an inequality in sentencing.
3. There is no current trigger contained in OASyS to prompt a PD assessment. Where do schemes similar to criminal justice diversion schemes fit into this pathway as a preventative measure?

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

1. More information is required (detailed task role out of service provision, are services going to tender with partnership agencies etc) in order to provide an informed comment.
2. The timetable is challenging if robust commissioning / contracting arrangements are to be observed specifically implementing and embedding new pathways and decommissioning existing services (particularly de-commissioning of large DSPD units and associated costs)

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

1. An appropriate "gatekeeping" system needs to be implemented to ensure consistency of sentencing to ensure proportionality of sentence and that offenders are sentenced on their current crime and not their mental health.
2. There needs to be a commitment from mental health service providers prior to the point of sentencing to ensure early diagnosis. With early diagnosis where does the pathway fit with the mental health treatment requirements of the community order sentencing.
3. The question remains as to who will direct the sentence. This should still remain with the offender manager but with many areas prohibiting travel by OM's to custodial establishments as a cost cutting exercise there will be the temptation for health services to lead sentencing. This will not provide consistency in terms of end to end sentencing.
4. Will additional resources be provided to home probation areas in order for OM's to attend sentencing planning/reviews/post programme reviews etc?
5. It is important to recognise that effective psychological interventions are achieved where there is continuity – not just in the treatment approach but in the relationship between the user and the therapist – this may have an impact on the benefits achieved in the longer term.
6. Defining clearly where the boundaries lie between PIPES and NHS commissioned providers both in and out of secure care. Potential mis-match between community PIPES and the expertise in the local health economy regarding personality disorder. Lessons could be learned by examining processes in anti-libidinal prescribing for sex offenders, as probation and NHS encountered interface problems in this area historically.

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

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

1. The critical element is early identification prior to sentencing, without this there is the risk of inappropriate and disproportionate sentencing.
2. Does the proposed pathway aim to increase the skill provision of all professionals including offender managers, offender supervisors, programme tutors, hostel staff or will it create a specialised provision within sentence management. If not will there be information provided on dedicated roles and responsibilities?
3. The programme may deliver benefits associated with more effective case management and potentially therefore reduce re-offending if treatment is appropriate and timely. This may depend on the skill of the offender manager in identifying need and referral rates. Potentially has large benefits here. KUF is good example.
4. The Offender Pathway will contribute to the delivery of the benefits but must be considered within the context of the 'whole system' of services required to support someone through prison and the relationship with other pathways.

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

1. Using existing facilities should be cost effective, however the concern will be, as always capacity to deliver given the complexity of the target population. The absence of effective long term community support will reduce significantly the benefits achieved in prison.
2. An impact assessment would assist in understanding what the new pathway will mean for mainstream community mental health and social care services. Any new service cannot be considered in isolation.
3. Early identification of Personality Disorder is key - identifying patients with PD in police custody is a key stage, however the 'whole system' across the Criminal Justice System could deliver greater long term benefits – we would welcome early consideration of the management of younger people who are displaying behaviours of significant concern.

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

1. There is considerable reference to joint responsibility but at the moment patients in the average Cat B/C prison are being failed because it is not clear what responsibility NOMS and the NHS have for PD in a general prison setting- this needs to be rectified.
2. Joint commissioning is possible but needs to be done against this background of defined and understood responsibility. Ideally there has to be pooling of resource and joint accountability to succeed

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

No comments to this question

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

1. This would depend completely on the criteria for successful completion. Short term versus long term and the method of assessment.
2. It is suggested that reconviction be considering as a measure for success, but this needs to take into account timescale, whether reconviction related to similar offending and a "sliding scale" of seriousness?
3. Payment by Results is complex, particularly for mental health where treatment costs are not the only costs that will deliver a care package and for this group – particularly in the community some of the enabling interventions will be delivered from a range of statutory and non-statutory agencies.

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

1. Resources in localised areas ensuring reintegration into the home community, with access to localised support systems and local custodial settings ensuring family support remains to prevent isolation and further mental health difficulty.
2. Women are over represented in custodial environments already for a number of discriminatory reasons which are well documented. Further stigma by labelling a PD on such individuals may again contribute towards a disproportionate sentence.
3. Jointly commissioned services that follow females through the pathway would be most appropriate and effective for a community to community pathway.

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

1. With over representation within the criminal justice system already in existence unintentional bias needs to be addressed prior to the implementation of such a pathway as this may further contribute to this identified imbalance.
2. Equality of sentence and assessment must be ensured and appropriate systems of "gatekeeping" prior to sentencing must be implemented in a consistent and accountable method nationally.

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

Please see response to question 11.

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

We will need to ensure that there is an equitable distribution of training and access to training across all areas and agencies, including users and carers.

General comments

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

No comments to this question

Phil Lloyd – ADASS National Lead for Adult Offenders
May 2011