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# Innovations in the treatment of offenders with personality disorders in forensic settings


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# University of what!?!

# Outline

- Personality disorders
- PD in forensic settings
- Pharmacological interventions
- Psychological interventions
- Offender treatment programmes
- Treatment pathways (UK PD Offender Pathway)

# Personality Disorder (DSM-V)

***A.*** *An enduring pattern of inner experience and behaviour deviating markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:*

- *cognition (perception and interpretation of self, others and events)*
- *affect (the range, intensity, lability and appropriateness of emotional response)*
- *interpersonal functioning*
- *impulse control*

***B.*** *The enduring pattern is inflexible and pervasive across a broad range of personal and social situations*

***C.*** *The enduring pattern leads to clinically significant distress or impairment in social, occupational or other important areas of functioning*

***D.*** *The pattern is stable and of long duration and its onset can be traced back at least to adolescence or early adulthood*

***E.*** *The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder*

***F.*** *The enduring pattern is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma).*

# Types and prevalence PD community

| Personality disorder | % population |
|---|---|
| **Paranoid** | **0.7-2.4** |
| Schizoid | 0.4-1.7 |
| Schizotypal | 0.1-5.6 |
| Antisocial | 0.3-3.0 |
| Borderline | 0.7-2.0 |
| **Histrionic** | **2.1** |
| Narcissistic | 0.4-0.8 |
| Dependent | 1.0-1.7 |
| Avoidant | 0.8-5.0 |
| **Obsessive-compulsive** | **1.7-2.2** |
| **All** | **4.4-13.0** |

(Coid, 2003)

# Prevalence primary and secondary care

- Main diagnosis for 5-8% of patients (Casey, 2000; Moran et al., 2000)
- Much higher if not just main diagnosis considered
- Psychiatric outpatients: Europe: 40 – 92%, USA: 45% and 51%, Asia: 1%/60% (Beckwith et al., 2014)
- Psychiatric inpatients: 40-50% (Girolamo & Dotto, 2000; Moran, 1999)

# Prevalence CJS & forensic

- UK data (Singleton et al., 1998):
  - 50% of female prisoners, 78% of male remand prisoners, 64% of male sentenced prisoners (Singleton et al., 1998)
- Systematic review of 62 international studies (Fazel & Danesh, 2002):
  - 65% of men and 42% of women PD (47%/21% ASPD)
- 2/3 of men in high secure care at least one PD (Blackburn et al., 2003)

# Types in forensic settings

| | DSM-IV |
|---|---|
| **Cluster A** “***Odd /eccentric***” | **Paranoid** |
| | Schizoid |
| | Schizotypal |
| **Cluster B** “***Dramatic***” | **Borderline** |
| | **Antisocial** |
| | Histrionic |
| | **Narcissistic** |
| **Cluster C** “***Anxious/ fearful***” | Dependent |
| | Obsessive-compulsive |
| | Avoidant |

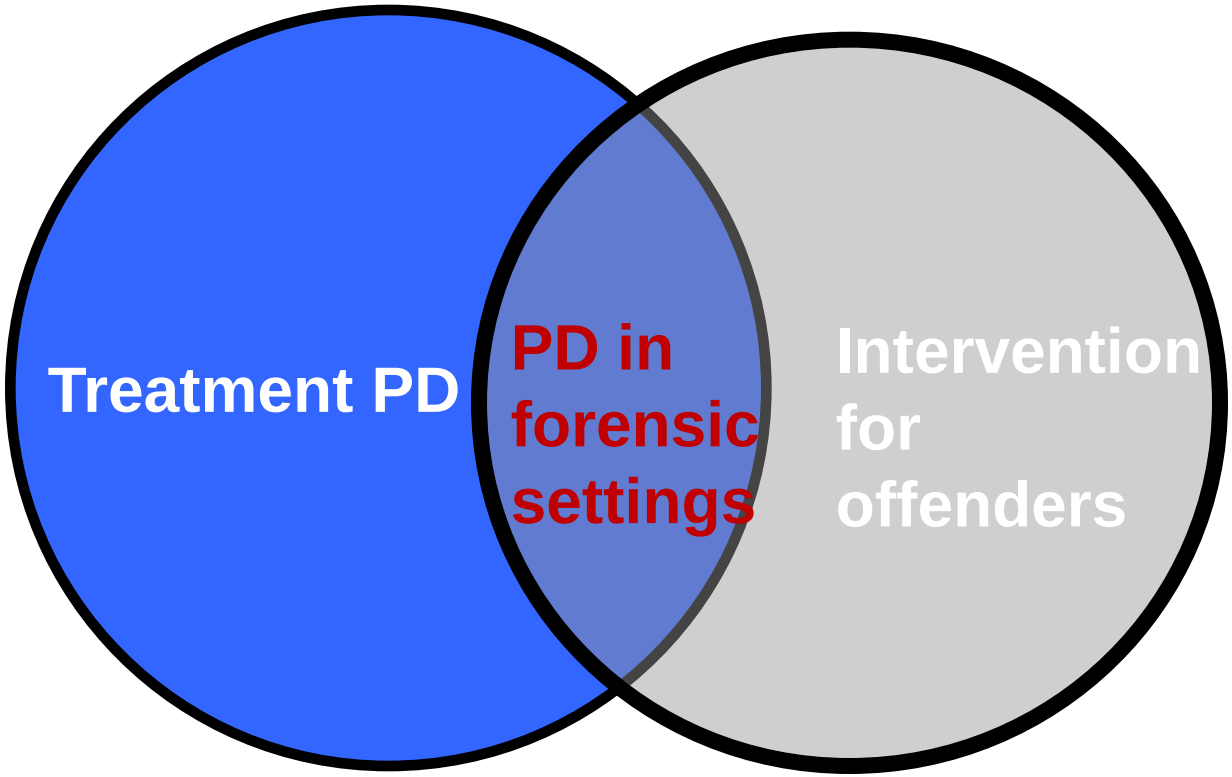
# Co-occurring difficulties

- Comorbidity
  - Both for other PDs and mental illness
  - Single PD diagnosis exception rather than norm
  - Substance abuse
- Associated with
  - Poor physical health
  - Mortality
  - Self-harm
  - Homelessness
  - Unemployment
  - Relationship problems
  - Offending
    - Violent offending (mainly Cluster B)

# PD and offending/violence

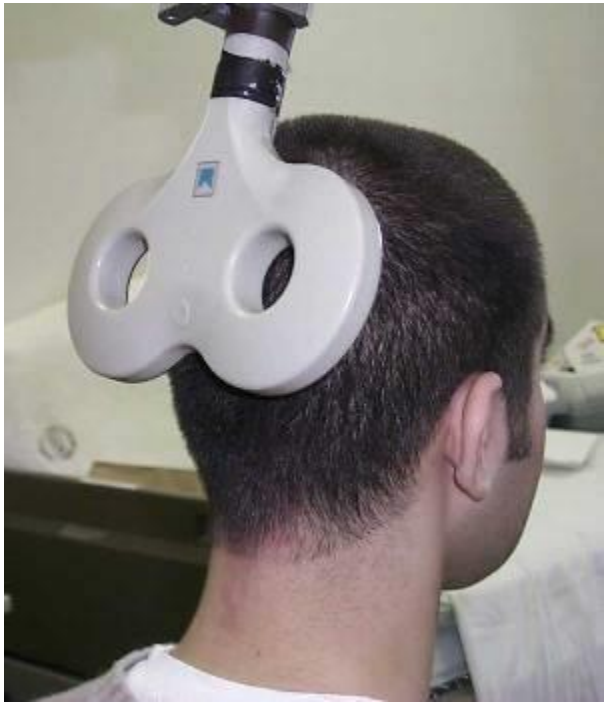
- General population (Coid et al., 2006)
  - 11% of those with any PD (as opposed to 7% in those without such diagnosis) self-report violent behavior in the past 5 years
  - Cluster B PD:
    - 10 times more likely to have criminal convictions
    - 8 times more likely to have been in prison
- Prison population (Roberts et al., 2010)
  - Earlier onset of offending: Schizoid PD, ASPD
  - More periods of imprisonment: Schizotypal PD, schizoid PD, ASPD, narcissistic PD
- ASPD: Nearly 4 times higher risk of serious violent reconvictions (Hiscoke et al., 2003)

# Evidence in forensic settings?



# Treatment?

# Treatment of PD: eclectic



# Pharmacological interventions for borderline PD

**Pharmacological interventions for borderline personality disorder (Review)**

Stoffers J, Völlm BA, Rücker G, Timmer A, Huband N, Lieb K

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# Pharmacological interventions for borderline PD

| Symptom | Medication |
|---|---|
| overall symptom severity | quetiapine |
| interpersonal problems | haloperidol<br>topiramate<br>valproate |
| impulsivity | lamotrigine<br>topiramate<br>valproate |
| suicidal / self-harming behaviour | flupenthixol deconate<br>omega-3 fatty acids |
| affective instability | aripiprazole<br>fluvoxamine<br>lamotrigine<br>olanzapine<br>valproate |
| intense anger | aripiprazole<br>haloperidol<br>lamotrigine<br>olanzapine<br>topiramate<br>valproate |
| transient psychotic symptoms | aripiprazole<br>olanzapine<br>topiramate |

Almost absent: Antidepressants

# Clozapine in BPD

- No RCTs
- Most recent literature review (Beri & Boydell, 2014)
  - 12 studies included
  - More severe disorder (in-patients, psychosis)
  - Positive effect on overall BPD severity, impulsivity, self-mutilation, number of days on enhanced observation, use of restraint and psychotic symptoms

- Currently RCT going on in UK (Crawford et al.)
  - Multisite, in-patients, including forensic
  - 6 months trial
  - 300 – 400 mg, titrated over 6 weeks
  - Against placebo


**Antiepileptics for aggression and associated impulsivity (Review)**

Huband N, Ferriter M, Nathan R, Jones H

- 14 RCTs included
- Sodium Valproate superior to placebo in men with impulsive aggression
- Phenytoin reduced frequency and severity of impulsive aggression in men, including prisoners
- Oxcarbazepine superior in verbal aggression and aggression against objects in out-patient men
- Carbamazepine superior in reducing self-harm in women with BPD

# Pharmacological interventions for antisocial PD

**Pharmacological interventions for antisocial personality disorder (Review)**

Khalifa N, Duggan C, Stoffers J, Huband N, Völlm BA, Ferriter M, Lieb K


- 8 trials included, 4 usable data for ASPD
- 8 different drugs used
- None recruited for ASPD, only one 100% ASPD sample
- 4 substance misuse as recruitment criterion
- Only 2 reported on relevant antisocial behaviours as outcome in ASPD separately
- All studies poor quality
- Phenytoin reduced impulsive (but not instrumental) aggression in prisoners

# Update of ASPD review (2018)

- 11 trials included (+3)
- 11 different drugs used
- None of the new studies reported findings specific to ASPD
- No new findings relevant to antisocial behaviours as outcome in ASPD
- In mixed groups:
  - Antiaggressive effects of fluoxetine in intermittent explosive disorder
  - Antiaggressive effects of tiagabine in community participants on probation/parole

# Psychological interventions for borderline PD

**Psychological therapies for people with borderline personality disorder (Review)**

Stoffers JM, Völlm BA, Rücker G, Timmer A, Huband N, Lieb K

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# Psychological interventions for borderline PD

- 28 studies included
- 13 different therapies studies
- Dialectical behavioural therapy most studied
  - Effective for overall severity and most individual symptoms, short variations might also work
- Also found to be effective
  - Schema focused therapy
  - Transference focused therapy
  - Mentalisation based therapy
- No evidence for other therapies, e.g. psychodynamic/-analytic, CBT, CAT

# Psychological interventions for antisocial PD

**Pharmacological interventions for antisocial personality disorder (Review)**

Khalifa N, Duggan C, Stoffers J, Huband N, Völlm BA, Ferriter M, Lieb K

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- 11 trials included, 5 usable data for ASPD
- Individuals mainly recruited for substance abuse disorders
- 11 different therapy modalities
- For ASPD: CBT, problem solving, contingency management, DWI
- Only one study impulsivity, 2 anger, 2 aggression, 2 reconviction as outcomes
- No positive effect on these outcomes for any groups
- ASPD
  - Social functioning: CM
  - Substance use: CM, CBT,DWI

# Update of ASPD review (2018)

- 18 trials included (+7), 8 with usable data for ASPD (+ one with over 75% ASPD participants)
- 16 different psychological interventions
- New interventions
  - Impulsive lifestyle counselling
  - Rationale emotive behavioural therapy
  - DBT
  - Schema therapy
- No new findings relevant to antisocial behaviours (anger, impulsivity, aggression, reconvictions) as outcome in ASPD
- Other outcomes in ASPD
  - Social functioning: schema therapy
  - Substance use: impulsive lifestyle counselling
  - Mental state: DBT

# Effective treatments for offenders

Health Technology Assessment 2012; Vol. 16: No. 3
ISSN 1366-5278

**A systematic review of prevention and intervention strategies for populations at high risk of engaging in violent behaviour: update 2002–8**

JC Hockenhull, R Whittington, M Leitner, W Barr, J McGuire, MG Cherry, R Flentje, B Quinn, Y Dundar and R Dickson

# Interventions for offenders

- 198 studies (51 RCTs), 2002 – 2008
- 94 different types of intervention
- Positive effects
  - Atypical antipsychotics, mood stabilisers
  - CBT based psychological interventions
- Differential effects
  - More successful in those with mental disorders

# Helpful aspects in offender programmes

- Risk Needs Responsivity principle
- Focus on criminogenic needs (dynamic)
- Focus on skills
- Focus on motivation
- Multimodal
- Both 1:1 and group work
- Importance of trusting relationships
- Focus on positives (Good lives model, social capita)
- Treatment integrity

# Adaptations for treating PD in forensic settings

- General principles
- Adaptations
  - Gender
  - Psychosocial deprivation
  - Risk to others
  - Coerced treatment
  - Setting specific restrictions (contact to therapist, self disclosure)
  - Due to pathology (comorbidity, trauma, etc.)
  - “Amplifying distress”
  - Motivation
- Impact on staff

# DSPD

- “Dangerous and severe personality disorder”
- Target population: Severe PD (+ psychopathy) + high risk
- 300 beds in 4 settings, 2 prisons, 2 high secure hospitals
- Opened in 2004
- Some evaluation, slow to show evidence
- Closed down in 2016

# PD Offender Pathway

- Replaced by PD Offender Pathway (NHS + Ministry of Justice)
- Delivery of less intensive services to more people
- High likelihood of serious reoffending + severe PD
- Estimated 20 000 people
- “Psychologically informed approach”
- Identification, formulation, case management under supervision, whole systems approach
- Training of probation officers in PD and formulation, supervision/consultation with psychologist -> improved management
- Screening into pathway, development of pathway
- Treatment services in prison and community – focus on CJS
  - Psychologically informed prison environments
  - Offender programmes
  - Therapeutic Communities
  - Only exceptionally health care

# Airport Terminal of the Personality Disordered


- Schizoid - wears sunglasses & headphones to discourage conversation
- Paranoid - conducts own luggage search after security clearance
- Schizotypal - refuses to get on any flight numbered with a 3 or a 7
- Histrionic - announces own birthday on P/A system during flight
- Antisocial - hides contraband in little old lady's carry-on; retrieves it after the flight
- Borderline - punches check-in attendant when not allowed a free upgrade to first class
- Narcissistic - sews four stripes on suit jacket to impersonate the pilot
- Avoidant - volunteers to help flight attendants serve meals
- Dependent - starts an in-flight daycare service in her row
- Obsessive-Compulsive - arranges passengers numerically by aisle before boarding
- Passive-Aggressive - boards early; has six pieces of carry-on luggage