Factors Associated with Progression in the London Pathway Project

Darrick Jolliffe, Jack Cattell, Annabelle Raza & Phil Minoudis

Abstract

Background: The London Pathways Partnership (LPP) Community Service is an approach to mainstreaming the identification of offenders with severe personality disorder to address their needs and reduce their risk.

Aims: To evaluate the result of the full-scale implementation of the LPP and evaluate factors associated with an offender's progression on the pathway.

Method: The data collected as part of the LPP project and OASYS data were used to evaluate who was screened into the pathway, and their progression on the pathway.

Results: Over 3,400 offenders were screened into the pathway in the first 48 months of its implementation but fewer were recorded as having progressed. It was not possible to determine whether this attrition reflected appropriate pathway action, inefficient service provision or weak recording procedures. Certain types of offenders were represented at progressive stages of the pathway. Those who had violent or sexual offences, had received custodial sentences, had more personality disorder indicators and were of higher risk were more likely to be found at progressive stages of the pathway. When probation areas began rolling out the service was also found to be related to pathway movement. Also, those of Non-White ethnicity were no less likely than those of White ethnicity to be recommended or referred for services, but were significantly less likely to start services.

Conclusions: The LPP attempts to balance breadth (covering all offenders being convicted in London) with depth (developing a feasible pathway for all offenders identified with severe personality disorder), and has done so with some success.

Implications: Future research should examine the continued rollout of the LPP service, and importantly the relationship between salient individual, risk and personality features, pathway inputs and measures of later reoffending.

Background

Despite evidence that offenders with personality disorder account for a disproportionate amount of serious and violent offending (e.g., Coid et al., 2007), the evidence base for successful interventions for such offenders is insufficient (e.g. Bateman and Gunderson, 2015; Khalifa et al., 2010; Livesay, 2007). Commissioned as part of the joint National Health Service (NHS) and National Offender Management Service (NOMS) funded Offender Personality Disorder (OPD) pathway programme, The London Pathways Partnership Community Pathways Service (LPP), is a pan-London approach to providing psychologically informed services to Probation for highly complex and challenging offenders who are likely to have a severe personality disorder (SPD) and who also pose a high risk of harm to others, or a high risk of reoffending in a harmful way.

The OPD (and the LPP) are progeny of the late Dangerous and Severe Personality Disorder (DSPD) programme which operated across high security hospitals and prisons in England and Wales from around 2000. A full historical account and an assessment of the benefits and limitations of the DSPD programme is beyond the scope of this paper (see Skett, Goode, Barton, 2017, this issue; Duggan, 2011). However, one of the key benefits of the DSPD approach was to focus resources on a small group of prolific, complex and challenging offenders who were more likely than similar others to cause significant societal harm. While previously identified in the academic research literature as life-course (Moffitt, 1993) or chronic offenders (Wolfgang et al.,1972), the DSPD approach encouraged the identification and treatment of such individuals by clinicians and practitioners.

The main limitations of the DSPD programme was arguably, the flip side of its proposed key benefit. That is, by microscopically focusing on the 'worst of the worst',

offenders located outside of the high-secure estate, and at different points in their criminal careers were more likely to be missed. At its worst, the DSPD programme identified (but perhaps not well, see Duggan, 2011) a problematic group of individuals who were already in prison, isolated them with other DSPD offenders in high-secure settings, and subsequently provided them with limited clinical support to address their needs.

In developing the OPD strategy the aim was to maintain the benefit of the original DSPD programme (the focus on complex PD offenders whose offending was suspected to be linked to personality disorder) while attempting to address its key limitations. This was to be accomplished by co-commissioning services that would support offenders through the journey from sentence to custody and/or community-based supervision and resettlement. Individuals that entered the pathway were to be mainly managed by the criminal justice system in either prison and/or in the community, with some services also provided in Secure Hospitals. The Offender Manager in the Probation Trust, in collaboration with the health service provider, was responsible for developing an offenders' pathway plan.

Overview of Pathway

Identification

In order to screen all those on London probation caseload when the pathway was introduced, and prospectively screen those being referred at sentence, an algorithm was developed, which facilitated automated screening of certain elements (see Minoudis et al 2012a). This included an assessment of both risk and personality disorder. Risk was assessed based on having any one of four criteria: (1) a sentence type (IPP or life sentence), (2) index offence (sexual or violent), (3) risk of harm rating (RoH) of high or very high from the Offender Assessment tool OASYS, or (4) RoH of medium with previous violent or sexual offences. Personality disorder was assessed based on endorsing 7 or more of 10 DSPD indicator items

in the standard offender assessment system (OASYS). These included items such as: 'Did any of the offences involve excessive violence/sadism?', 'Manipulative/predatory lifestyle' and 'Reckless/risk taking behaviour'. An offender could also meet the personality disorder criteria by being assessed as having two out of: 'childhood difficulties', 'history of mental health problems', 'self-harm/suicide attempts', 'challenging behaviour'. If an offender did not meet the criteria, but was considered appropriate due to their personality disorder or risk, they could still be placed on the pathway through clinical override. However, in practice this only occurred on an exceptional basis. The benefits and limitations of the identification process, and other methods of identifying potential personality disorder offenders is reviewed elsewhere (Minoudis et al., 2011; Shaw et al., 2012).

Identification of offenders was to be delivered in the community by offender managers in probation local delivery units (LDUs), supported by specially trained personality disorder probation officers and psychologists. This process commenced in different areas of London at different points, but by May 2014 the entire caseload of offenders had been retrospectively screened for eligible offenders. All new offenders were to be screened as early as possible in their sentence.

Case Consultation/Formulation

The offender manager was to work in partnership with the specialist psychologist and/or probation officer to develop a Pathway Plan for offenders who were screened-in, based on a process of case consultation and formulation. Case consultation and formulation is a process of targeted specialist advice to consider the offender's psychosocial and criminogenic needs relating to their personality disorder and to make decisions about the sentence plan (Hart et al, 2011). Case formulations were always recorded by offender

managers, but it was acknowledged that these might vary in style depending on the complexity of the case and the urgency of the pathway plan.

Pathway Plan

A Pathway Plan is the result of a Case Consultation/Formulation and was to be developed for those offenders screened into the pathway whom required recommendations for management/interventions, and to ensure that referrals were made to services at appropriate points in the offender's sentence. An offender could be referred immediately to a treatment, or could engage in other (non-treatment) services, such as a pre-treatment, psychologically informed planned environments (PIPEs) or motivational interviewing (for those in the community).

Recommended for Services/Referral to Services

As a result of a Pathway Plan an offender could be recommended for support services. Multiple services could be recommended and these could vary from a recommendation for support by a voluntary organisation, to attending a personality disorder or offending behaviour intervention. An additional step in the pathway is an offender manager making a referral to one or more of these services.

Service Access

The point at which an offender was to receive the services indicated in the pathway plan varied according to the circumstances of the offender. For example, a newly sentenced prisoner with a very long custodial sentence may not be prioritised for receiving services. Specialist service providers were commissioned (e.g., mentoring service) to provide support to offenders where deemed appropriate.

This paper reports on a snapshot of the full implementation of the LPP Community Pathways Service after at least 12 months of operation, and is therefore a follow-up of

Minoudis et al., (2012b) in which the first two years of the pilot in four areas of London was examined. This paper is a service evaluation aimed at providing a description of the characteristics of those offenders found in each progressive step of the pathway, and to explore the factors associated with pathway progression. It was hypothesised that offenders with greater personality disorder pathology and greater risk of harm would be over-represented at successive levels of the pathway

Method

Sample

Offenders were drawn from all London LDUs (n=24) probation caseloads. The date of implementation of the service varied with some areas commencing pilots in 2009 (e.g., Southwark) and other areas not starting until 2014 (e.g., Kew). There was considerable area variation in the experience of operating the PD pathway and also the engagement with the PD pathway.

Data

All information analysed for this paper came from two sources, the LPP dataset and the Offender Assessment System (OASYS). The LPP dataset was a centralised and ongoing record of individuals identified for the pathway and their progress. OASYS is the standard probation computerised risk and needs assessment device.

Procedure

Data linking took place in which those identified as being on the pathway were matched with OASYS data records. While far from a perfect in terms of missing information and possible errors, this data reflects a realistic view of data from an operational perspective (e.g., Howard and Dixon, 2013), rather than a research ideal. Although females were included as part of the pathway approach this paper focusses only on males.

The reliability and validity of OASYS data has been explored previously, and provides a wider range of information than the LPP dataset alone (e.g., age at first offence, scores on actuarial risk assessment devices; Howard and Dixon, 2013). Analyses suggested that compared to those who were excluded because of missing OASYS data, those retained were no different in age, but were more likely to come from certain LDUs. These sites included some pilot sites (see below) who may have been more engaged with the LPP service and therefore more conscientious in data entry. In support of this, those included were also less likely to have missing data (i.e., less likely to be missing on ethnicity and less likely to be missing on the personality disorder indicators).

Ethics

Ethical approval for this study was granted by the London – South East Research Ethics Committee (Ref: 14/LO/0518).

Results

A total of the 3,414 offenders who had been screened into the pathway were identified on both the LPP dataset and OASYS, but only a total of 2,149 (63%) were recorded as having achieved the next step (case consultation). About 75% (1607) of those with a recorded case consultation had a pathway plan, but almost all (99% or 1586) of those with a pathway plan had service recommendations. Less than half of offenders with a recommendation for service were referred to a service (n=774) and less than half of those with a referral for service were recorded as having commenced a service (n=374). Unfortunately, it was not possible to discern whether the drop from the number identified to those with case consultation reflected a point for improvement in the operation of the pathway (i.e., case consultations not taking place), or poor recording (i.e., case consultations not being recorded as having taking place)[1].

The other, apparent, bottlenecks on the pathway (i.e., from number with recommendation to referral, and number with referral to starting a service), could also be the result of inefficient operation

[1] These figures does not necessarily reflect an assessment of pathway progression as offenders could be included in multiple categories.

of the pathway or the lack of recording. It was also possible that these reductions were influenced by where the offenders were physically located (e.g., long term incarceration) or their assessed psychological preparedness for pathway progression (e.g., not ready for services), and/or practical issues such as a lack of local service availability (no appropriate local PD services or a limited number of spaces for PD services). These were also points in the pathway that responsibility for the offender passed from PD practitioners to generic offender managers, who may have had fewer resources (e.g., time, experience) to direct specifically at moving PD offenders forward on the pathway.

Those who were screened in were placed into mutually exclusive (as opposed to aggregate) categories based on their maximum progression on the pathway. Figure 1 shows that 1,013 male offenders were recorded as screened-in and had no evidence of progressing any further along the pathway. Only a small number of offenders had progressed to having a pathway plan only, and more had progressed to having at least one recommendation (n=769), referral (n=444) or one service start (n=376). As this is only a still picture of pathway operation up to the maximum point recorded, this likely suggests that case consultation and pathway planning are relatively quick processes so fewer individuals are captured at these points.

Figure 1 about here

Table 1 shows the demographic and offence characteristics for those at different points in the pathway[2]. For example, those identified for the pathway had an average age of 28.6. This was not significantly different from the age of those at any other stage of the pathway. Because of missing data and small number of certain ethnicities (e.g., Mixed), ethnicity was classified as White or Non-White. Those who were Non-White were more prevalent at every point of the pathway except service

[2] For Tables 1 - 3 chi squared tests were used to compare categorical data (e.g., percentages) and t-tests or ANOVAs (Bonferroni's Post Hoc) were used for continuous data (e.g., age). Cohens d is presented as the measure of effect size.

starts. Compared to the proportion identified this difference was significant (chi squared= 13.5, p<.0001, d=.26).

Table 1 about here

Those who had a violent index offence were proportionally more likely to have a service start compared to those identified (chi squared = 4.0, p<.05; d=.14). Those with a sex offence were more prevalent at later stages in the pathway. Compared to those identified, the proportion of offenders with sex offences was significantly higher in Case Consultation, Pathway Plan, and Recommendation. The differences were greatest for Referral (chi squared = 34.1, p<.0001; d=.51) and Service Start (chi squared = 17.4, p<.0001; d = .38). There were higher proportions of those who received custodial sentences in each progressive stage of the pathway. This was particularly the case for Recommendations (chi squared = 46.6, p<.0001; d = .53), Referrals (chi squared = 38.0, p<.0001; d=.61) and Service Starts (chi squared = 26.5, p<.0001; d=.51). The average sentence length was significantly longer amongst those who had recommendations (t = 4.6, p<.05; d=.27), referral (t = 4.2, p<.05; d = .27) and Service Starts (t=3.8, p<.05; d = .26). There was evidence that those who had started services had been on the pathway for longer (t=2.4, p<.05; d = .14), but the differences were not significant for other comparisons.

Areas were classified into three categories based on the date they adopted the pathway approach. Those areas in the first wave had significantly more offenders with recommendations (chi squared=47.7, p<.0001; d=.41), referrals (chi squared=6.4, p<.05; d=.19) and service starts (chi squared=26.0, p<.0001; d=.38) compared to those identified. Those in the second wave had significantly higher proportions with service starts (chi squared=15.7, p<.0001; d=-.43), and those in the third wave had significantly lower proportions with recommendations (chi squared =55.8, d=-.38).

Table 2 shows the personality features of those in the various pathway categories. For example, those Identified had an average of 7.36 out of the 10 possible DSPD items. There was evidence of an increase in the number of PD indicators for offenders in line with pathway progression.

That is, those who were identified had significantly fewer PD indicators than those who received a case consultation (t=3.6, p<.05; d=.18), recommendations (t=3.3, p<.05; d=.16), referrals (t=4.3, p<.05; d=.25) and service start (t=2.5, p<.05; d= .15). Also, those recommended (chi squared=9.1, p<.05; OR=1.4), referred (chi squared=22.5, p<.0001; d=.38) and who started services (chi squared=25.0, p<.0001; d=.34) had a higher proportion of childhood difficulties than those identified. A similar pattern of significant results was found for referral and services starts for mental health difficulties and difficult behaviour and for service starts for those with self-harm. Those with recommendations had, on average, a significantly greater number of the four additional PD indicators (3.4, p<.05; d=.17), as did those with Referrals (t=5.6, p>.05; d=.33) and Service Starts (t=6.9, p<.01; d=.43). Those who were put on the pathway through clinical override, were over-represented in the Referral category (chi squared = 4.5, p<.05; OR=1.5), and the Service Start category (chi squared=7.1, p<.05, OR=1.7). Generally, those with more indicators of personality disorder were found at later stages of the pathway.

Table 2 about here

Of the individuals who were identified (Table 2, first column), only 5 (0.05%) were of low risk[3] and only 7 (0.07%) were of very high risk. There was some evidence that, perhaps, those of very high risk were over-represented at the case consultation stage (1.5%), referral (3.0%) and service start stages (1.6%), but the numbers were small. Those of medium risk became less prevalent at the Recommendation (chi squared = 27.7, p<.0001; d=-.28), Referral (chi squared=54.0, p<.0001; d=-.51) and Service Start stage (chi squared = 41.0, p<.0001; d=-.49). Those of high risk were significantly more prevalent at these stages.

Table 3 shows the criminal history factors associated with the different categories of the pathway. For example, of those identified, over 49% had a first offence recorded before the age of 13.

[3] Those of low risk may have entered the pathway through the process of clinical override, or those who entered the pathway at a higher level of risk but were subsequently downgraded.

There was however, no evidence that there were differences in proportions of those with different ages at first offence between the various pathway categories. The OASYS General Reoffending Predictor (OGP) and OASYS Violence Predictor (OVP) predict the likelihood of nonviolent and violent proven reoffending respectively, by combining information on the offender's static and dynamic risk factors (Howard, 2009). Those Identified were of higher risk on both the OGP and OVP than those who had a service start, but this difference was not statistically significant.

Table 3 about here

Overall the bi-variate analyses suggested that those with certain demographic characteristics, from certain areas, and with certain offence types may have been more likely to progress to the action phase (recommendations, referrals and service starts) of the pathway. Similarly, those with more extreme personality difficulties and of higher perceived risk of harm may have been more likely to progress.

In order to identify factors that independently predicted successful operation of the pathway logistic regression was used to predict Recommendations and/or Referrals[4] using ethnicity, area, offence type, sentence type (prison v community), time on the pathway, number of DSPD items, number of PD indicators, Risk of Harm and OGP score.

Table 4 about here

The results (Table 4) suggested that an individual's risk was a key factor in pathway progression. That is, an offenders risk of harm, their offence type (violent or sexual), and being sentenced to prison independently increased the likelihood of having recommendations or referrals. In addition, their personality pathology, based on the number of PD indicators predicted pathway progress. Interestingly, the number of DSPD items did not predict pathway progress, but being allocated to an area that had greater experience with the pathway was also identified as an

[4] Service Starts were not included because those operating the pathway did not control when an individual might start services.

important independent predictor, while number of days that the individual was on the pathway was not.

When service starts were predicted using the same method, the same six variables (violent offence, sex offence, first wave, prison sentence, PD indicators, high risk) were again independently and significantly related, however, White ethnicity was also significantly predictive of service starts (Exp(B)=1.7, p<.0001).

Discussion

This research described the characteristics of offenders screened into the LPP Community Pathways service and examined pathway progression in relation to demographic, risk and offence information. The independent influence of these variables on pathway progression was also examined.

There was clear indication of pathway movement for offenders with severe personality disorder, which is a key aim of the OPD Strategy (NOMS and DH, 2015). Progressing these high risk PD offenders has been a significant challenge in the past (e.g., Bradley, 2009), and acted as the impetus for reforming government policy for working with personality disordered offenders. This research provides some indication that the current pathway approach is gaining headway.

The current research also suggested that higher risk offenders with more personality disorder features were increasingly represented in progressive stages of the pathway. This reflects well on the service provision, particularly as a key critique of the DSPD programme, which preceded this Strategy, pointed to the low numbers of offenders who had benefited from costly interventions (Tyrer et al., 2010). This is the first evidence that the Community Pathways service is identifying and progressing the target group, although further investigations would be needed to clarify whether these offenders are more representative of the intended population than was achieved by DSPD services. However, the early indications are positive; high risk violent and sexual offenders were more likely to be recommended, referred and to start services and nearly half the offenders identified had recorded a

conviction before the age of 13, a feature strongly associated with persistent and prolific offending (Moffitt and Caspi, 2001).

The degree of pathway movement reflected a mixed picture. There were high numbers of offenders identified for the pathway, with over 3,400 offenders screened in and located on both datasets. Significantly less received a case consultation (N=2,149), the first stage of intervention on the Pathway. Large declines continued at each stage of the pathway, with the number of recommendations dropping by half at the stage of referral and half again for service starts. The timing of this evaluation in relation to the implementation of the service should be considered here; the DPSD evaluations cautioned that early evaluation of services may not represent long term effectiveness (Barrett and Tyrer, 2012). The available evidence supported this theory as earlier rolled out areas of London had significantly more recommendations, referrals and service starts compared to areas established later. Earlier rollout also independently predicted pathway progress suggesting this expertise may be being developed.

There may be more than one reason for the fluctuation in numbers recorded at various stages of the pathway. This finding may not be surprising given that priority was given to identification in the initial phase of developing the service, which was in line with the OPD Strategy recommendation to focus on early identification (NOMS and DH, 2015). In addition, the pilot evaluations of these services indicated that roughly half of the offenders identified were appropriate for pathway intervention; for a combination of reasons related to readiness for services and having an existing appropriate sentence plan (Minoudis et al., 2012b). Therefore, a large proportion of those screened in may not necessarily be expected to receive further input from the service, and one might expect to see marked differences in the numbers when those identified were compared to the number with pathway plans.

There were interesting findings related to specific groups of offenders. Comparatively fewer sex offenders were represented on the pathway at all stages, despite the proportions increasing significantly with pathway progress. This may have been related to an emergent sex offender pathway,

which had yet to receive investment in services. Moreover, several existing prison Pathway services excluded sex offenders, which may have dissuaded practitioners from attempting to progress larger numbers of these cases. In a similar way, the greater progress seen in prison over community services may have reflected a lack of investment in community Pathways services at the time of the evaluation.

Reflecting positively on the service, those of Non-White ethnicity were proportionally represented at most every stage of the Pathway. This is it is a marked improvement compared to the DSPD programme which was dominated by White offenders (DH and MoJ, 2010). Reflecting less positively, however, those of Non-White ethnicity were significantly less likely to commence services, and this was true controlling for all other significant features which predicted pathway progress. Unfortunately, it was not possible to explore this finding in greater depth with the data available. This finding may reflect systemic discrimination in service provision (e.g., Bradley, 2009), or equally, ethnic differences in motivation to commence services. Non-White offenders may lack motivation because service are commonly not culturally compatible (e.g., Glynn, 2014). Further research to explore the reasons behind this disproportionality in representation at service access is clearly indicated, and would benefit immensely from a more nuanced definition of ethnicity than the blunt dichotomy available for this study.

Generally, the Community Pathways service appeared to be identifying the intended population, with an increased focus on those presenting with multiple indicators of personality disorder and higher risk of harm at progressive stages of the Pathway. However, there was no evidence that higher levels of risk of reoffending (violent or general) were being prioritised at progressive stages. This is, perhaps, unsurprising considering the screening algorithm included risk of harm and personality disorder only, and did not include items associated with likelihood of reoffending (general or violent). Perhaps measure of risk of reoffending could be incorporated into a revision of the identification process. It should be noted, however, that while the prevention of all

reoffending amongst this population would be an ideal (but probably not realistic) goal, the OPD strategy prioritises preventing reoffences of serious harm.

Future research which examines the impact of risk of harm, PD, risk of reoffending and other relevant factors to the prevalence, frequency, and types of reoffending for this unique population is needed to determine to what extent the pathway approach is achieving its main goal of protecting the public.

Limitations

It was not possible to determine whether data about pathway progression was missing due to recording procedures or poor recording. That is, missing data could equally reflect an individual waiting to progress on the pathway, an individual who is being held at the most appropriate pathway stage, or incomplete recording (i.e., true missing). This may have affected the accuracy of the categorisations made about which pathway stage an offender achieved. Future research could explore this issue by surveying probation decision makers about how they input information for specific cases. The data collection mechanism for the pathway could then be modified to clarify why data might be missing. There were also challenges in matching data across the two datasets, which resulted in a considerable amount of data loss, and may have restricted the analyses to specific types of offenders, perhaps limiting generalisability.

Conclusions

This evaluation was the first study to attempt to understand the factors that predict pathway flow for OPD offenders. The pathway identified a large number of a diverse group of offenders with multiple indications of personality disorder and significant risk of harm; although it seemed the Pathway had not been incorporating likelihood of offence repetition in the case identification process. This was not an investigation into the effectiveness of an intervention for high-risk offenders with severe personality disorder, but with continued data collection the LPP Community Pathways service would

be in a position to provide answers to such questions. The results generally support the OPD Strategy and represent a marked improvement in previous efforts to manage and treat this challenging group (e.g. Burns et al., 2006). There are several learning points for research and practice, including revision to the screening process to incorporate reoffending predictors, exploratory research into the drop off in service starts for ethnic minorities and an investigation into the potential interactions between the individual (demographic, personality disorder, offence, criminal history factors) and work on the pathway on later measures of reoffending.

References

Bateman, AW, Gunderson, J, Mulder, R. (2015). Treatment of personality disorder, The Lancet 385: 735–743.

Coid J, Yang M, Ullrich S, Zhang T, Roberts A, Roberts C, Rogers R, Farrington D (2007). Predicting and Understanding Risk of Re-offending: The Prisoner Cohort Study. Research Summary 6. London: Ministry of Justice.

Barrett, B, & Tyrer, P (2012). The cost-effectiveness of the dangerous and severe personality disorder programme. Criminal Behaviour and Mental Health *22*: 202-209.

Bradley, K (2009). The Bradley Report. London, Department of Health.

Burns, T, Yiend, J, Fahy, T, Fazel, S, Fitzpatrick, R, Sinclair, J & Montes, M V (2006). Inclusion for DSPD: Evaluating Assessment and treatment (IDEA). *IDEA*, *2009*.

Department of Health and Ministry of Justice (2010). The Offender Personality Disorder Strategy

Duggan, C (2011). Dangerous and severe personality disorder, The British Journal of Psychiatry 198: 431-433.

Glynn, M. (2014). Black men, invisibility, and desistance from crime: Towards a critical race theory from crime. London: Routledge.

Hart

Howard PD, Dixon L, (2013). Identifying change in the likelihood of violent recidivism: causal dynamic risk factors in the OASYS violence predictor. Law and Human Behavior, 37:163-174.

Khalifa, N, Duggan, C, Stoffers, J, Huband, N, Vollm, BA, Ferriter, M, & Lieb, K (2010). Pharmacological interventions for antisocial personality disorder. Campbell Collaboration Review.

Livesley, JW (2007). The relevance of an integrated approach to the treatment of personality disordered offenders. Psychology Crime and Law 13:27-46

Minoudis P, Shaw, J, Bannerman A, Craissati J (2012a) Identifying personality disturbance in a London probation sample. Probation Journal 59:23-38.

Minoudis, P, Shaw, J, & Craissati, J (2012b). The London Pathways Project: Evaluating the effectiveness of a consultation model for personality disordered offenders. Criminal Behaviour and Mental Health 22: 218-232.

Moffitt, TE (1993). "Life-course-persistent" and "adolescence-limited" antisocial behavior: A developmental taxonomy. Psychological Review. 100: 674-701.

Moffitt, T E, & Caspi, A (2001). Childhood predictors differentiate life-course persistent and adolescence-limited antisocial pathways among males and females. Development and psychopathology 13: 355-375.

National Offender Management Service and NHS England (2015). *The Offender Personality Disorder Pathway Strategy*. (https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/02/opd-strategy-nov-15.pdf) Downloaded 13th October 2016

Shaw J, Minoudis P, Craissati J (2012). A comparison of the standardised assessment of personality – abbreviated scale and the offender assessment system personality disorder screen in a probation community sample. Journal of Forensic Psychiatry and Psychology. 23: 156-167.

Skett S, Goode I, Barton S (2017). A joint NHS and NOMS offender personality disorder assessment strategy: A perspective from five years of operation. Criminal Behaviour and Mental Health (in press).

Tyrer, P, Duggan, C, Cooper, S, Crawford, M, Seivewright, H, Rutter, D, & Barrett, B (2010). The successes and failures of the DSPD experiment: the assessment and management of severe personality disorder. Medicine, Science and the Law. 50: 95-99.

Wolfgang, ME, Figlio, RM, & Sellin, T (1972). Delinquency in a Birth Cohort. Chicago: University of Chicago Press.

Figure 1. Number of Male SPD Offenders' Pathway Progression (N=3,414)

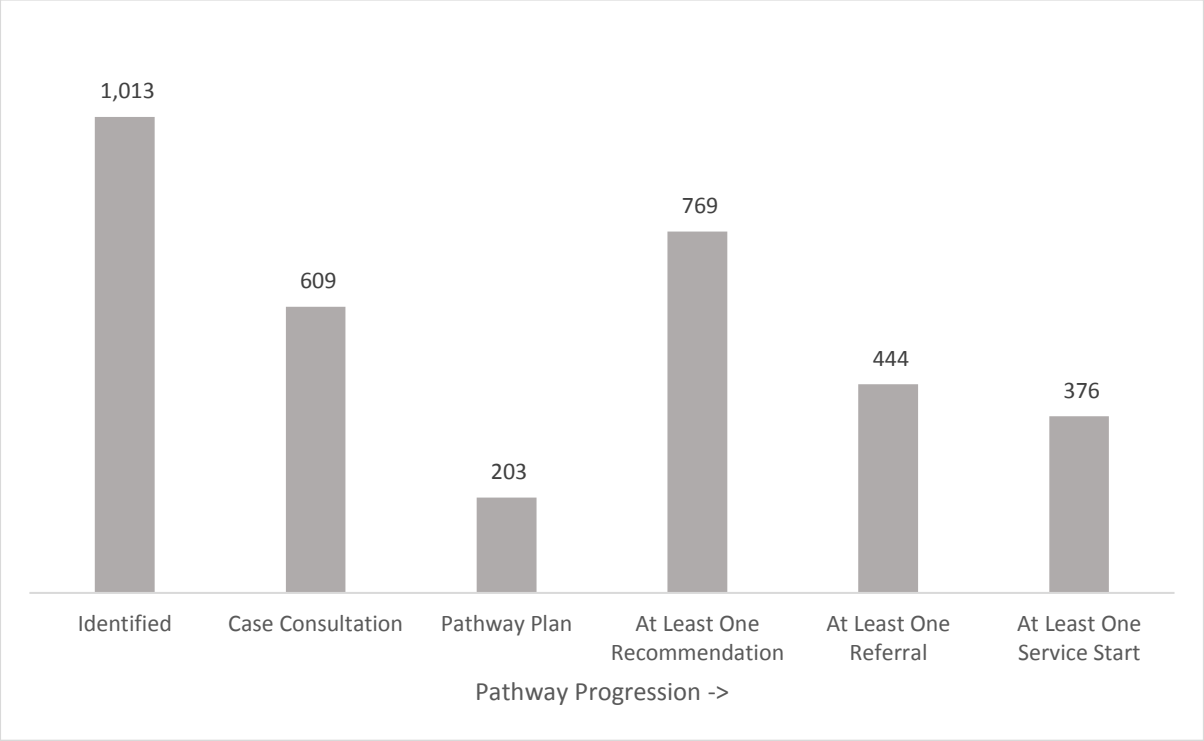

Table 1. Demographic and Criminal Offence and Level of Progress

	Identified	**Case Consultation**	**Pathway Plan**	**Recommendation**	**Referral**	**Service Start**
	N=1,013	**N=609**	**N=203**	**N=769**	**N=444**	**N=376**
	M	**M**	**M**	**M**	**M**	**M**
Average Age	28.6	28.7	28.4	30.1	30.5	30.7
Ethnicity	**%**	**%**	**%**	**%**	**%**	**%**
White	41.6	38.6	46.9	41.7	47.2	52.9
Non White	58.4	61.4	53.1	58.3	52.8	47.1***
Offence Type	**%**	**%**	**%**	**%**	**%**	**%**
Violence against the person	42.1	44.9	37.2	42.7	44.5	48.1*
Sexual offence	9.4	12.3*	14.6***	15.6***	20.7***	17.6***
Robbery	20.8	19.6	24.1	20.3	18.6	21.5
All other offences	27.7	23.3	24.1	21.4**	16.1***	12.8***
Sentence Type	**%**	**%**	**%**	**%**	**%**	**%**
Community	23.2	14.6	16.3	10.6	9.3	10.7
Prison/Remand	76.8	85.4***	83.7*	89.4***	90.7***	89.3***
	M	**M**	**M**	**M**	**M**	**M**
Av. Sentence Length	49.0	54.2	53.7	61.4*	62.2*	60.9*
	M	**M**	**M**	**M**	**M**	**M**
Av. No. of Days on Pathway	522.8	535.5	535.6	540.5	502.7	555.0*
Area	%	%	%	%	%	%
First wave	19.9	22.5	19.7	34.5***	25.9*	33.0***
Second wave	17.7	18.4	14.8	20.9	17.1	9.0***
Third wave	62.4	59.1	65.6	44.6***	57.0	58.0

* p<.05, **p<.01 ***p<.0001 compared to Identified

Table 2. Personality Features and Level of Progress

	Identified	**Case Consultation**	**Pathway Plan**	**Recommendation**	**Referral**	**Service Start**
	N=1,013	**N=609**	**N=203**	**N=769**	**N=444**	**N=376**
	M	M	M	M	M	M
Av. No. OASYS DSPD Items	7.36	7.57*	7.37	7.55*	7.67*	7.54*
Additional PD Indicators	**%**	**%**	**%**	**%**	**%**	**%**
Childhood Difficulties	71.3	70.0	70.4	78.2***	83.3***	84.7***
History of Mental Illness	37.0	32.3	34.7	40.9	46.7***	49.7***
History of Self-Harm	29.5	28.5	28.1	32.6	34.5	42.1***
Challenging Behaviour	36.2	33.9	30.7	40.4	44.8***	45.3***
	M	**M**	**M**	**M**	**M**	**M**
Av. No. Additional PD indicators	1.70	1.60	1.63	1.89*	2.10*	2.20*
	%	**%**	**%**	**%**	**%**	**%**
Clinical Override	7.5	5.5	8.9	9.7	10.9	12.0
Risk of Harm	**%**	**%**	**%**	**%**	**%**	**%**
Low	0.5	0.2	0.5	0.0	0.5	0.3
Medium	40.0	35.9	37.9	27.8***	19.9***	21.3***
High	59.0	62.4	60.6	71.3***	76.6***	76.8***
Very High	0.7	1.5	1.0	0.9	3	1.6

* p<.05, **p<.01 ***p<.0001 compared to Identified

Table 3. Criminal History and Level of Progress

		Identified	Case Consultation	Pathway Plan	Recommendation	Referral	Service Start
		N=1,013	N=609	N=203	N=769	N=444	N=376
		%	%	%	%	%	%
Age at first offence	18+	23.9	25.3	24.1	26.2	22.5	26.7
	14 - 17	26.6	24.2	23.1	22.4	25.2	24.9
	13 or <	49.6	50.5	52.8	51.4	52.3	47.9
		M	M	M	M	M	M
OGP Score		52.0	51.0	53.1	51.2	51.1	50.5
		M	M	M	M	M	M
OVP Score		48.8	48.0	48.5	48.0	47.7	47.8

* p<.05, **p<.01 ***p<.0001 compared to Identified; OGP=Offender General Reoffending Score; OVP=Offender Violence Reoffending Score

Table 4. Independent Predictors of Recommendations and/or Referrals

Variable	B	S.E.	Exp(B)	Sig.
White Ethnicity	0.071	0.087	1.073	n.s.
Violent Offence	0.178	0.09	1.195	0.048
Sex Offence	0.392	0.131	1.481	0.003
First Wave	0.583	0.097	1.792	0.0001
Prison Sentence	0.532	0.115	1.702	0.0001
PD indicators	0.268	0.036	1.307	0.0001
DSPD Screen Score	0.059	0.037	1.061	n.s.
High Risk	0.471	0.096	1.601	0.0001
OGP Score	-0.004	0.003	0.996	n.s.
Days on Pathway	0	0	1	n.s.
Constant	-2.048	0.31	0.129	0