



The University of  
Nottingham



Nottinghamshire Healthcare **NHS**  
NHS Trust

*Positive about mental health and learning disability*

# Psychotherapy for Personality Disordered Offenders

## Worth the effort? Worth the money?

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# The central question in psychotherapy

***What treatment, by whom, is most effective for this individual, with that specific problem, and under which set of circumstances?***

Paul, 1986

# Parsing Paul's question for the Personality Disordered Offender

- *What* Treatment? What form of psychotherapy
- *By whom?* ---delivered by which member of the MDT (or a non-health professional)
- *this* individual? – his personality disorder
- *With that* specific problem? – offending/mental disorder
- *In which* set of circumstances? Prison/secure hospital

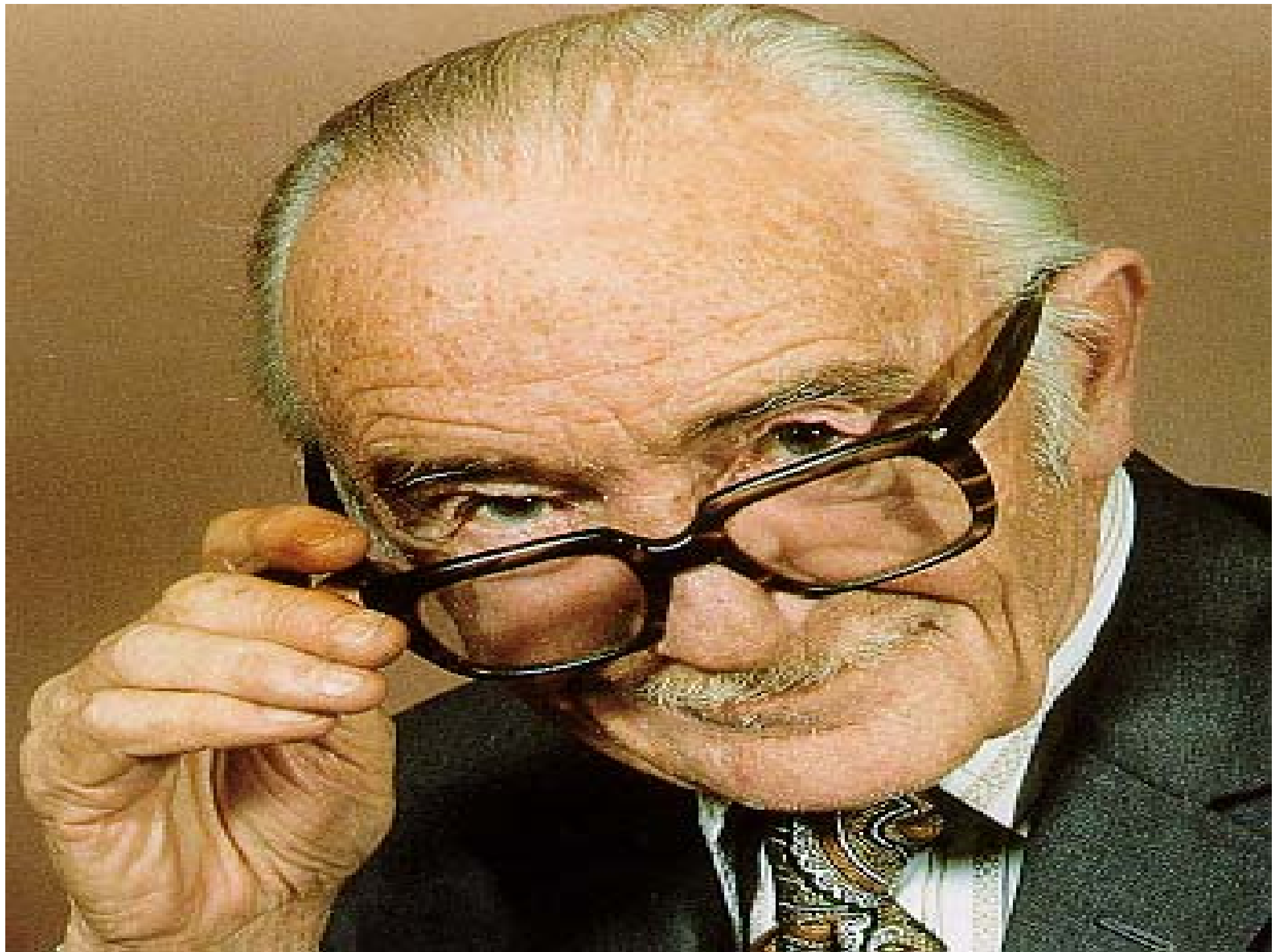
# The central question in psychotherapy

*What treatment, by whom, is most effective for this individual, with that specific problem, and under which set of circumstances.*

+

*at what Cost?*

**My title seeks to emphasise the  
difference between the 'QUALITY'  
of a service and its 'VALUE'.**



‘Effectiveness and Efficiency:  
Random Reflections in Health Services’

A.J. Cochrane (1977)

‘If we are ever going to get ‘optimum’ results from our national expenditure on the NHS we must finally be able to express the results in the form of the **benefit** and the **cost** to the population of a particular type of activity, and the increased benefit that could be obtained if more money were made available’.

# The National Health Service & a contented crematorium worker

‘...what fascinated him was the way in which so much went in and so little came out. I thought of advising to get a job in the NHS, it might have increased his job satisfaction ...’.

Cochrane, 1977

# What is good quality 'Evidence' and how should it be used?

- **EBM** is defined as ...the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.' (Sackett et al., 1996)
- Its usage has to be tempered when applying it to an individual patient by '...integrating individual clinical expertise with the best available external clinical evidence from systematic research.' (ibid)
- EBM can inform but never replace, individual clinical expertise (ibid).

# Where ought good quality ‘Evidence’ for Treatment come from?

As regards treatment, ‘...we should avoid non-experimental approaches ... since these routinely lead to false positive conclusions about efficacy... (so that) ... the systematic review of several randomised trials ... has become the “gold standard” for judging whether a treatment does more good than harm.’ (ibid)

# The Evidence for Psychological Treatments for PD: A systematic review of randomised controlled trials

- **Method:** 15 electronic databases were searched to Dec. 2006 for any RCT of a psychological intervention for PD.
- **Results:** This identified 27 trials for inclusion (52% on BPD; 7% on ASPD). The majority (93%) were in the community.
- **Results (cont.):** 15 (55%) produced positive findings. The theoretical underpinnings of the treatment varied widely from behavioural (i.e. contingency management for drug misuse) at one end through a range of CBT-type treatments to psychodynamic therapies at the other.

(Duggan et al., 2007)

***What treatment, by whom, is most effective for this individual, with that specific problem, and under which set of circumstances?***

Paul, 1986

Is this kind of evidence useful for the practitioner in making a choice for an individual patient?



## **In addition, there were a number of systemic weaknesses in this evidence.**

- **Being underpowered:** mean no. of participants was c. 28 in each arm of the trial.
- **Variable duration of treatment:** This ranged from 6 weeks to 3 years.
- **Outcome measures:** Use of too many outcome measures (100), many of which were not related to personality disorder (e.g. Axis 1 symptoms of anxiety /depression).
- **Further:** Only 4 (15%) included an economic evaluation

# What is the evidence base for Psychological Interventions for ASPD?

- Total number of Cochrane Trials for ASPD (to Sept. 2009) = 11 but six were excluded because they did not report on ASPD.
- Three of the five trials (Messena, 2003, Neufeld 2008 and Woodhall 2007) reported on reducing drug or alcohol misuse in those with ASPD rather than on ASPD itself.
- Two others (e.g. Huband, 2007, Davidson, 2009) reported on social functioning and violence reduction respectively. Neither showed that the active intervention conferred any benefit

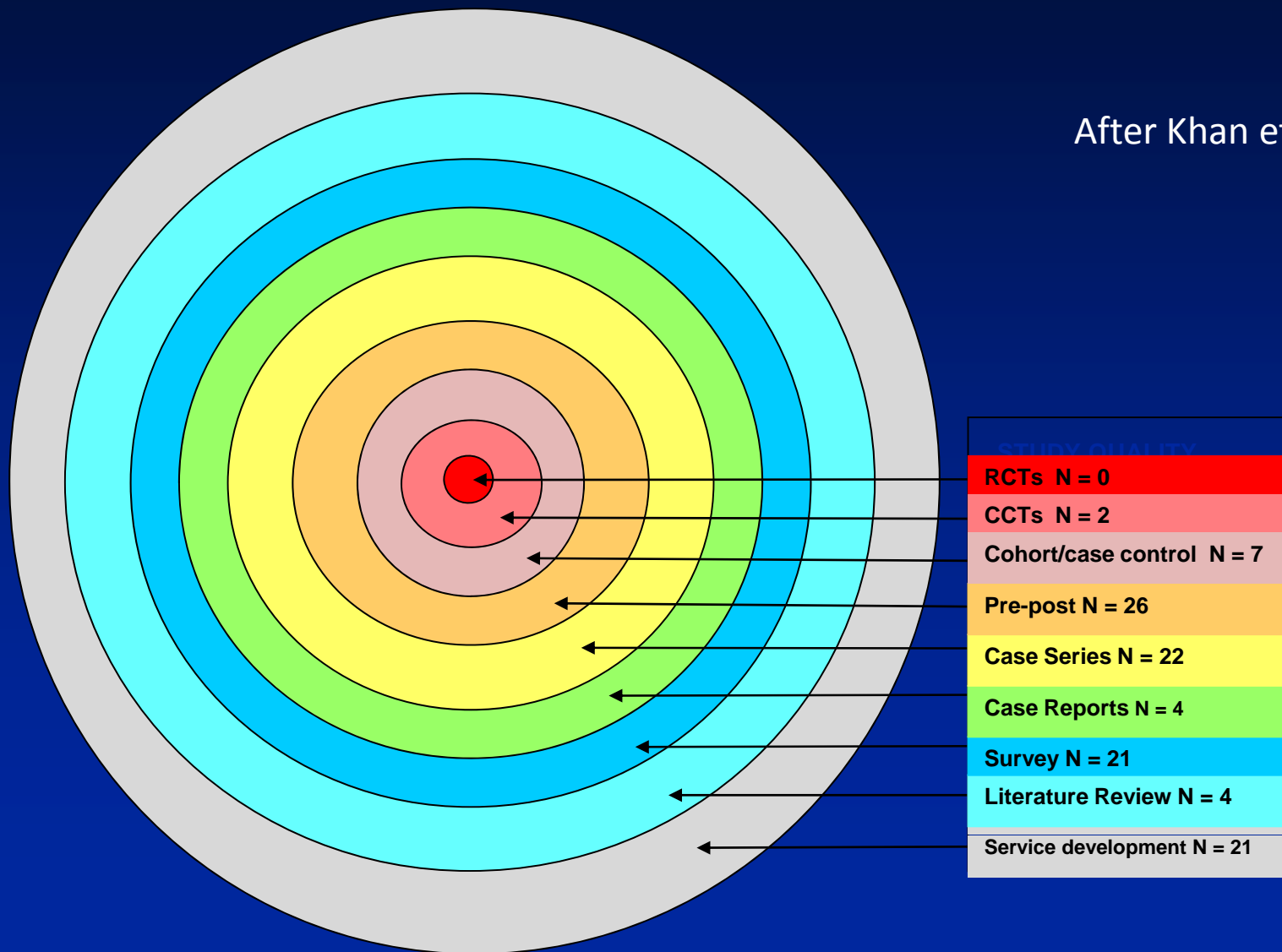
## Finally, what about the evidence from secure in-patient forensic services ?

Here, it is important to have a strong evidence base because of

- (a) The ethical concern – the ‘Principle of Reciprocity’ ought to apply
- (b) These are high cost/low volume services (e.g. secure care services cost the NHS 1.2.b in 2009/10 – 18.9% expenditure on all adult mental health care).

How good is the evidence for treatment efficacy in secure services ?

After Khan et al. 2003



**‘It is quite remarkable for this area  
to find more review articles than  
original contributions based on the  
results of clinical trials.’**

Hesselink, (1995) complaining about the number  
of reviews of pharmacological treatments of PD  
(in yet another review)

## 2. The Evidential Problem

- There is an absence of good quality evidence as to ‘what works for whom’ in personality disordered offenders.
- Good quality trial evidence is unlikely to generate compelling evidence in the short-term because ...

Central to the scientific methodology of a systematic review is that one predefines in advance:

- **The Population** - No agreed definition
- **The Interventions** – very wide choice whose theoretical underpinning are uncertain as there are a number of different mechanisms linking aberrant behaviour to personality
- **The Comparison Group** – few properly controlled or powered trials
- **The Outcomes** - far too many outcomes measured, many of which are deemed irrelevant by users.

As a way forward, can I suggest the following – at least for defining the ...

- **Population**
- **Intervention/Comparator**
- **Outcome**

# 1. Defining the population Or when pragmatism rules

In the past (in England), those who travelled on trains with dogs, had to buy a dog ticket.

The question arose whether I had to buy a dog ticket when I travelled with a tortoise?

The conductor on the train gave me the answer:

“Cats is dogs and rabbits is dogs but  
tortoises is insects and travel free  
accordingly”

# Pragmatism is useful

‘Truth emerges more readily from error than from confusion.’

Francis Bacon, *Novum Organum*,

## Question:

In this connection, are revisions of DSM/ICD at this stage of our journey really helpful?

## Answer:

I doubt it!

## 2. On interventions

Is a Beauty Contest the best way of  
deciding this?

# Effective Treatments for BPD?

- Dialectic behavior therapy (Linehan, 1993): DBT
  - Linehan et al., (1993)
- Transference focused therapy (Clarkin et al., 1999, 2006): TFT
  - Clarkin et al., (2007); Levy et al., (2006)
  - Doering et al., (2010)
- Schema focused therapy (Young et al, 2003): SFT
  - Giessen-Bloo et al., (2006)
- Mentalizing based therapy (Bateman & Fonagy): MBT
  - Bateman & Fonagy, (1999, 2001)
- Systems Training for Predictability and Problem Solving: STEPPS (Blum et al., 2008)
- Cognitive analytic therapy (Ryle, 1997): CAT
  - Chanen et al., (2008)

# Psychological Treatments for BPD

Therapeutic Beauty Contest

DBT

TFT

CBT

SFT

MBT

Livesley, 2010

# Challenges to current Treatments for Personality Disorder

- Good quality evidence in favour of the superiority of any one intervention over another in a 'head to head' trial is surprisingly weak.

## Results of Trials when ...

These treatments were compared with well-specified psychiatric care designed for BPD:

– **McMain et al., (2009):**

- DBT versus general psychiatric management that included a combination of psychodynamically-informed therapy and symptom-targeted medication management based on APA guidelines
- No differences in outcome

– **Bateman & Fonagy, (2009):**

- MBT versus structured clinical management
- Outcome was similar; problems decreased faster with MBT

– **Chanen et al., (2008):**

- CAT versus manualized good clinical care
- No differences in outcome

# Challenges to current Treatments for Personality Disorder

- Good quality evidence in favour of the superiority of any one intervention over another in a 'head to head' is surprisingly weak.
- More importantly, there is little extra benefit when the experimental intervention is compared with good quality psychiatric care.
- Much of the psychotherapy outcome literature shows that it is the common rather than specific factors that explains most of the variance in the outcome (esp. the formation of a therapeutic alliance)

i.e. this is as much about the characteristics of the therapist as it is about the individual receiving the therapy

This explains why we have so many therapies

i.e. just as there has to be a good fit between the therapy and patient if the therapy is to be successful, there has to be a similar fit between the therapist and therapy if the therapy is to be successful. As we have a large variation among those who provide the therapy (i.e. the therapists), this is likely to generate a large variation in the therapies. Frank recognised this when he wrote as follows:

‘My position is not that technique is irrelevant to outcome. Rather, I maintain that ... the success of all techniques depends on the patient’s sense of alliance with an actual or symbolic healer. This position implies that ideally therapists should select for each patient the therapy that accords ...with the patient’s characteristics and view of the problem. Also implied is that therapists should seek to learn as many approaches as they find *congenial and convincing* ‘ (my italics).

Frank & Frank, 1991

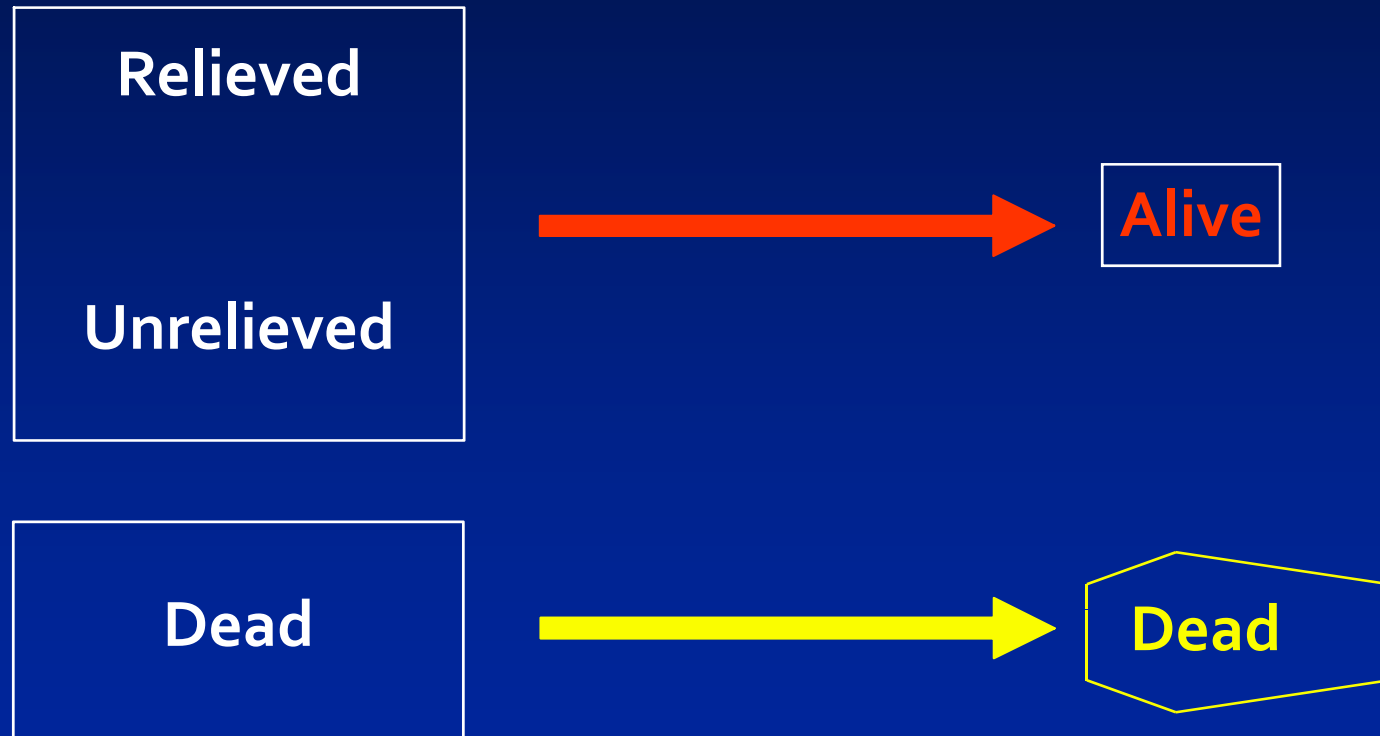
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Therefore, it seems to me unlikely that more clinical trials – even ‘head to head’ trials will produce the necessary evidence to change practice radically in the future.

### 3. Deciding on Outcome Measures

- What do you do when you have more outcome measures than patients in the trial?
- Consider the Nightingale Method

# Classifying Health Outcomes



After Kind, 2005

## Hospital surgery death rates to be made public

- UK first in world to publish data
- Major variations will be exposed

**John Carvel**  
Social affairs editor

The government is preparing to publish for the first time the death rates of patients undergoing major surgery at NHS hospitals in England, the Guardian has learned.

The move will expose alarming variations in the mortality rates of NHS trusts carrying out commonplace procedures, including hip and knee replacements and surgery of the oesophagus and abdominal aorta, the main blood vessel.

It will be the first time anywhere in the world that a government has systematically exposed the work of rival hospital teams, giving patients an opportunity to choose to be treated where their lives are least at risk.

The data, which is to be put up on the NHS Choices website during the summer, is expected to reveal a disproportionately high death rate in hospitals carrying out fewer operations, where the surgeons have less opportunity to hone their skills.

Ministers think publication of the figures will drive up standards by forcing trusts to improve performance or withdraw from medical specialties at which they do not excel.

At this stage the published data will give results for hospital units, not individual surgeons. But Ben Bradshaw, the health minister, has instructed that the NHS Choices website should eventually let patients compare the performance of individual surgeons and GPs, heralding a big switch in the balance of medical power in favour of the patient.

Until recently surgeons resisted the disclosure of mortality rates, arguing that it might discourage them from taking on riskier cases and lead to the loss of lives among patients who could have benefited from treatment.

The surgeons also disputed the accuracy of "hospital episode statistics" submitted by trusts to the Department of Health.

But ministers were impressed by a pioneering experiment by the Society

years ago, the surgeons have taken on more risky cases without any increase in the death rate.

They have acknowledged that they were persuaded to reveal the risk-adjusted mortality rates of individual surgeons after the Guardian lodged 36 applications under the Freedom of Information Act in 2005.

Sir Bruce Keogh, a heart surgeon and former president of the society, was recently appointed medical director of the NHS with responsibility for introducing openness to other branches of medicine.

At a private seminar at the Royal College of Surgeons on Tuesday he made it clear that ministers were no longer prepared to put up with excuses for continued medical secrecy. "There is no going back," he warned representatives of the medical colleges. "The department is not seeking your permission. It is merely seeking your help."

Keogh told the Guardian that the first batch of mortality data would be published "within weeks or months" – at the latest by September.

Disclosure of the mortality data of hospitals will be followed by the publication of a wider range of indicators showing the outcome of treatments across many branches of medicine.

Keogh has asked the medical directors of every hospital and mental health trust in England to send in examples of the performance statistics they use internally to assess the quality of their clinical teams. The department will select about 50 for debate within the medical community.

Once any statistical snags have been ironed out, they will be published on the NHS Choices website, probably during the spring of next year.

Keogh said the desire for openness was being driven by three imperatives for the next stage of NHS reform: health commissioners need better data on the quality of hospitals' performance; doctors need to demonstrate the quality of their work; and patients need information about quality to exercise choice about

## Labour cash crisis could bankrupt party leaders

**David Hencke**  
Westminster correspondent

Senior officials in the Labour party, including Gordon Brown, could become personally liable for millions of pounds in debt unless new donors can be found within weeks, the Guardian has learned.

The party has five weeks to find £7.45m to pay off loans to banks and wealthy donors recruited by Lord Levy, Tony Blair's former chief fundraiser, or become insolvent. A further £6.2m will have to be repaid by Christmas – making £13.65m in all. The sum amounts to two-thirds of the party's annual income from donations.

The figures are a conservative estimate as they do not include interest that will also have to be paid. A Labour source said that although the total debt was listed as £17.8m on the Electoral Commission website, the true level, with interest, was nearer to £24m.

The possibility that party officials and members of its national executive committee could become liable is being taken seriously by union leaders, and has been underlined by the decision of equity fund chairman David Pitt-Watson not to accept the post as Labour's general secretary.

Though he was Brown's candidate for the post, he declined the offer after receiving independent legal advice that he would be personally liable for repaying the loans and could be bankrupted if Labour's finances collapsed.

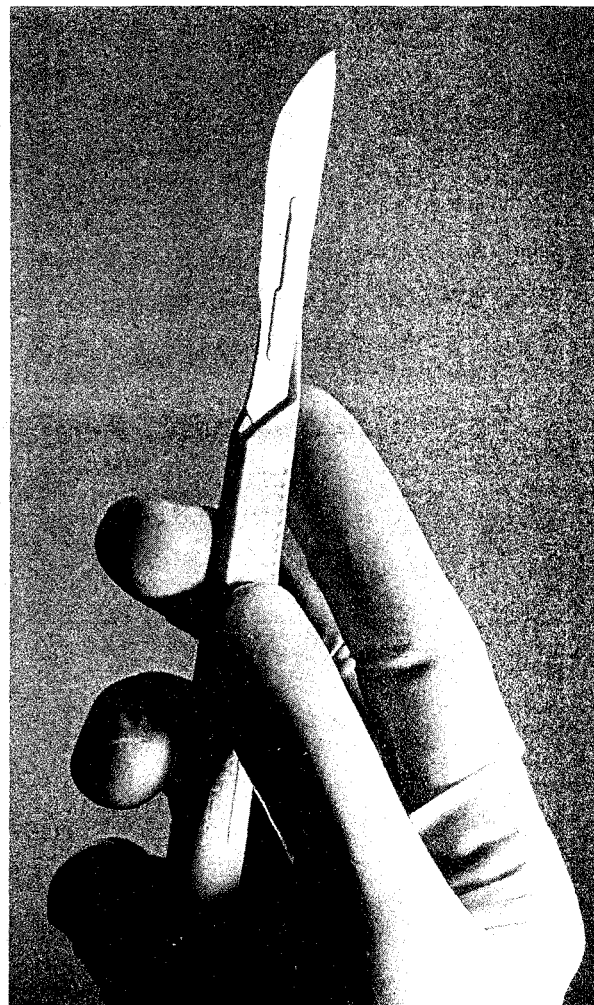
The advice from City solicitors Slaughter and May said unequivocally that leading party officials and members of the NEC would be "jointly and severally" responsible for the party's debt.

The reason is that the Labour party constitution is framed like a local club or society, and has no provision for limiting the liability of its officials or managers.

A Labour source said: "The party's constitution is like a five-a-side football club, or the local cricket club. The big difference is that the most club officials and managers could expect to have to fork out is an unpaid bill for hiring the pitch. In Labour's case, it's tens of millions of pounds."

The advice was the sole reason why Pitt-Watson, a committed Labour supporter and former Westminster City councillor, turned down the job this month.

But the reverberations inside the party



# Cox regression model of time to first re-conviction after discharge

**PD Diagnosis** + **Other Baseline factors** + **Treatment**

% PD Dimensional

b=1.039, p<0.05

PCL-R Total

b=1.061, p<0.05

PLC-R Factor 1

NS

PCL-R Factor 2

b=1.186, p<0.005

PCL-R Factor 2

b=1.136 P<0.05

No. previous convictions

b=1.072, p<0.001

Treatment

NS

Time to first re-conviction after discharge

# Hierarchical Linear Regression Model of Psychosocial Outcome after Discharge

PD Diagnosis

+

Other Baseline factors

+

Treatment

% PD Dimensional

NS

PCL-R Total

$b=-429, p<0.05$

PCL-R Factor 1

$b=-419, p<0.001$

PCL-R Factor 2

$b=-358, p<0.001$

PCL-R Factor 1

$b=-288, p<0.005$

Completing Treatment

$b=.354, p<0.001$

Psychosocial Outcome After Discharge

Finally, the Government is  
changing its focus from the Quality  
of Care to the Value of Care.

Muir-Gray 2010.



‘Every advance in medical science creates new needs that did not exist until the means of meeting them came into existence. ‘...there is virtually no limit to the amount of medical care an individual is capable of absorbing ...’

Enoch Powell *Medicine & Politics*, 1966.

# Comparing costs and benefits

**BENEFITS**

*(After Kind,  
2005)*

lower

same

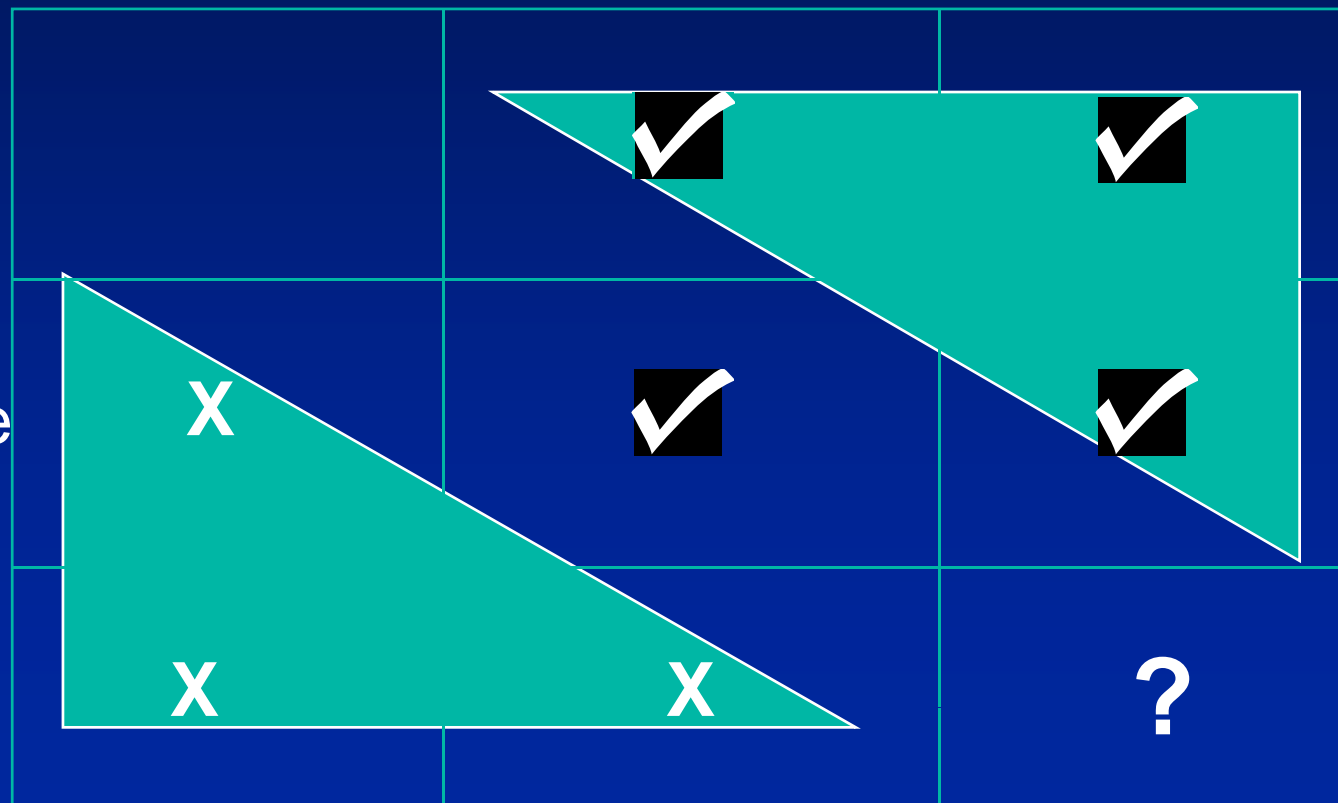
higher

**COSTS**

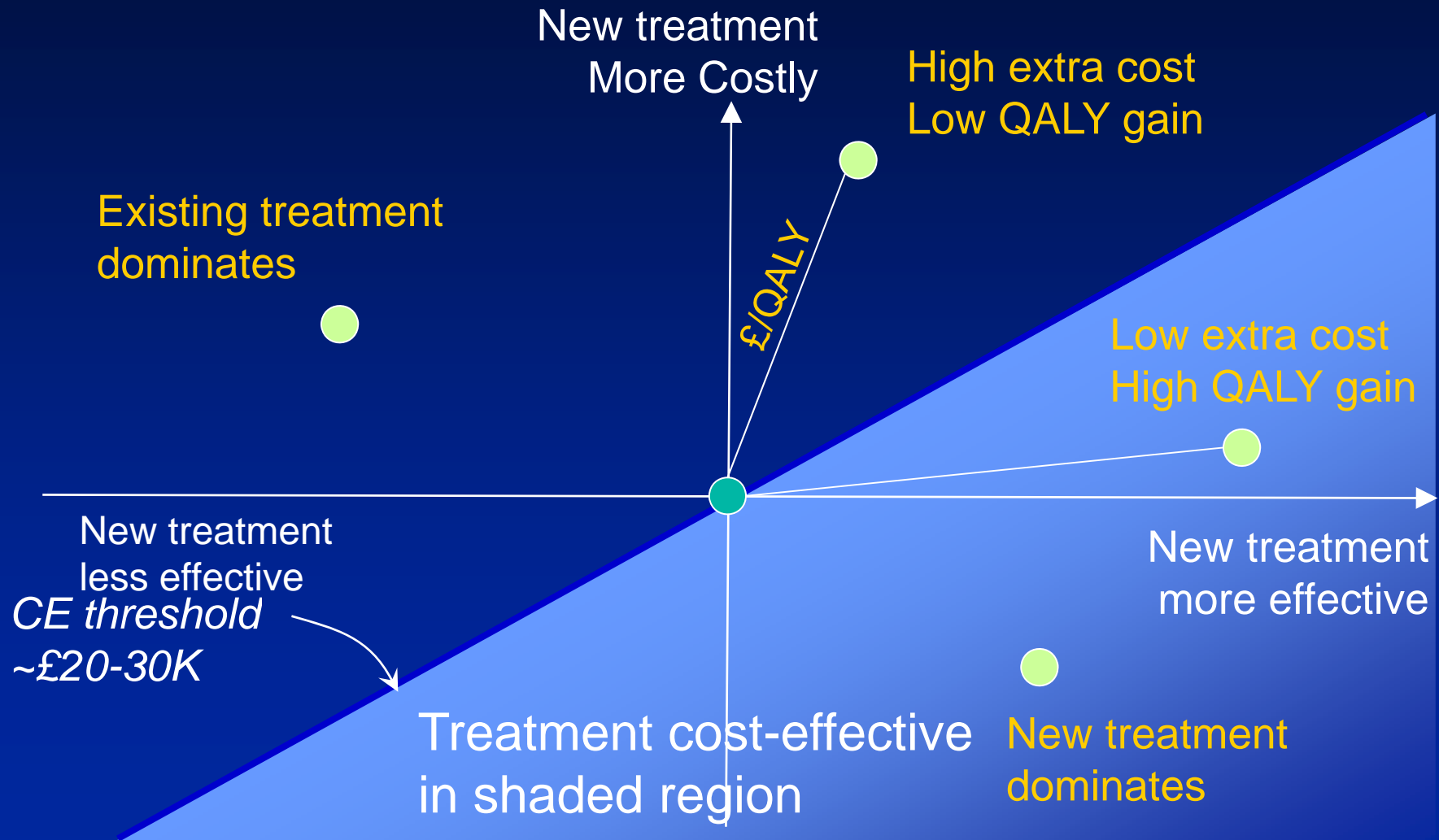
lower

same

higher



# Cost-effectiveness plane



(d) This emphasis on cost benefit for personality disordered offenders provides mental health services with an opportunity if

- It could demonstrate that the intervention could reduce re-offending (as an outcome)
- And that this reduction was associated with a cost saving.

# Variations in effect sizes (McGuire, 2004)

The figure shows effect sizes for selected types of interventions from meta-analytic reviews, to illustrate the range of findings obtained.

In the graph, the vertical line represents zero change (no difference between experimental and control samples). Bars extending to the right represent *increases* in recidivism amongst experimental samples relative to controls. Bars to the left represent *reductions* in recidivism.

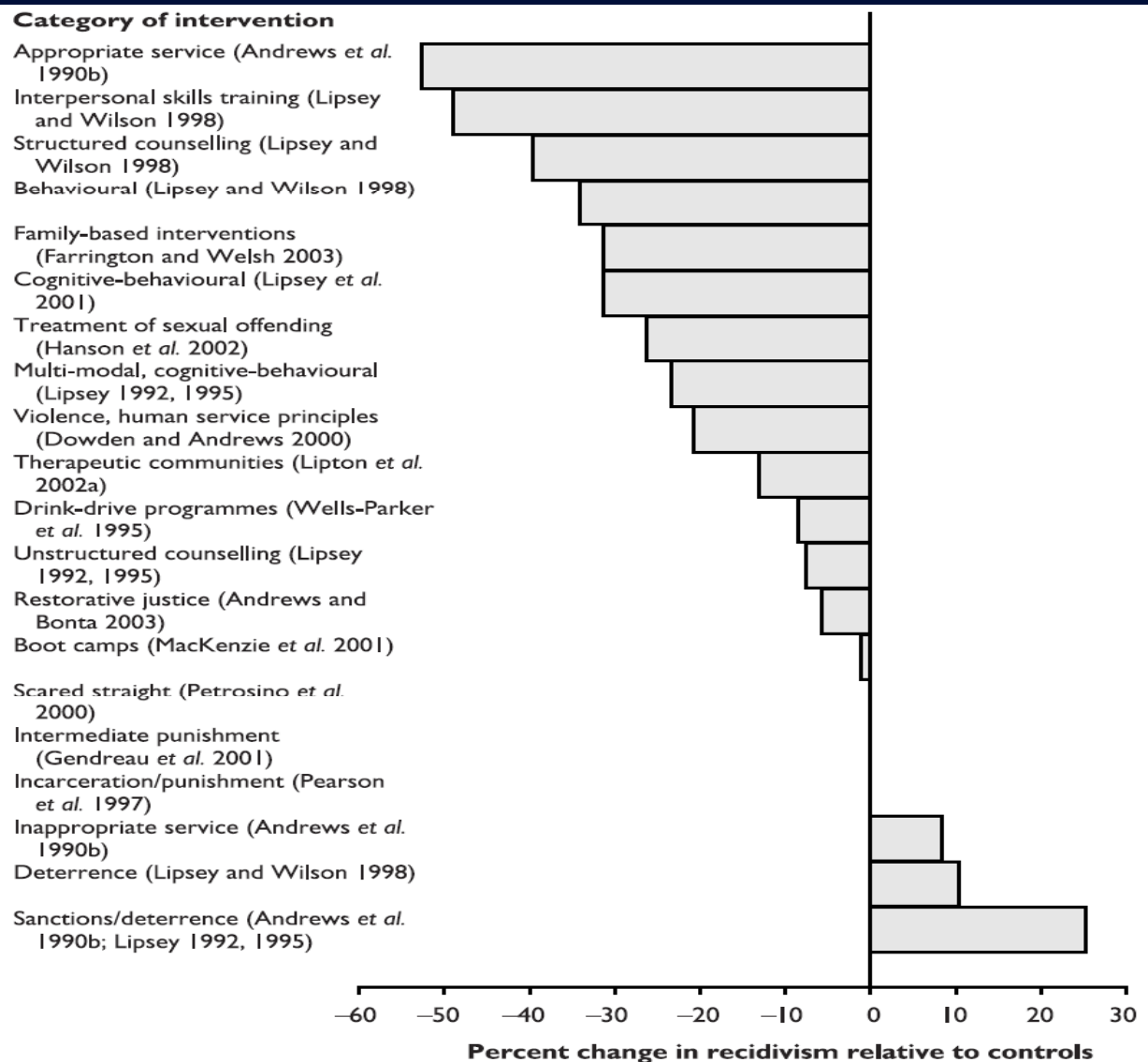


Figure 6.1 Illustrative variations in effect sizes

# The Comparative Costs and Benefits of Programs to Reduce Crime.

Aos et al., 2001.

## What Aos et al. did and why they did it:

- (a) Systematically analysed the evaluations of criminogenic programs to determine whether the program benefits (as measured by the value to the tax payer, and to the victim of the programs expected effect on crime) are likely to outweigh the costs.
- (b) ‘These estimates can help decision makers in directing scarce public resources **toward** economically successful programs and **away from** unsuccessful programs ...’

**Figure 1: Net Economic Benefits of Programs Designed to Reduce Crime, Monetary Values in 2000 Dollars**

Net economic benefit (cost) per participant, thousands of dollars.

*The lower value in the range is the taxpayer estimate,  
the higher value includes crime victim benefits,  
the point in the middle is the average.*

-\$40 -\$20 \$0 \$20 \$40 \$60 \$80 \$100 \$120 \$140



# What they found

Type of Program	Effect size	Cost of program/head	Net benefit for tax payer	Net benefit for tax-payer & victim
Quantum opportunities program	-0.31	\$18,964	-\$8,855	\$16,428
Multi-systemic therapy	-0.31	\$4,743	\$31,681	\$131,918
In-prison therapeutic community	-0.05	\$2,804	-\$899	\$5,230
CBT Sex Offender Treatment	-0.11	\$6,246	-\$778	\$19,534
Intensive supervision	-0.03	\$3,296	-\$2,250	-\$384
Reasoning & Rehabilitation	-0.07	\$308	\$2,202	\$7,104

# Cost Results

- All costs shown are average per person

Year	Completers	<i>Cumulative</i>	Non-Completers	<i>Cumulative</i>	Difference	Cumulative Difference
1	£168,234	£168,234	£170,614	£170,614	-£2,380	-£2,380
2	£124,741	£292,975	£132,018	£302,631	-£7,277	-£9,657
3	£99,368	£392,343	£110,603	£413,234	-£11,235	-£20,892
4	£84,513	£476,856	£98,435	£511,669	-£13,922	-£34,814
5	£75,776	£552,632	£91,312	£602,981	-£15,535	-£50,349

- Deterministic model
- Based on transition probabilities generated from Arnold Lodge follow-up data.

The Future?

Positive Aspects of the future will be a reliance  
on

- **Networks – rather than Hierarchies**
- **Use of new Technologies.**

Muir-Gray, 2010

# Organisation and Planning of Services

MDOs with PD make contact with several agencies (incl. CJS, Housing, Social Services etc.) Hence there is a need to establish care pathways and improve interagency working through the development of **Managed Care Networks**.

# A Managed Clinical Network – Definition

‘These are linked groups of health professionals and organisations from 1<sup>o</sup>, 2<sup>o</sup> and 3<sup>o</sup> care and social services and other services working together in a **coordinated manner** to ensure an **equitable** provision of high quality, clinically **effective** care.’

Baker & Lorimer 2000

# Relevance of a MCN for those with PD.

- PD is a disorder across **the life span** so that its service provision needs to be integrated.
- **A large number of agencies are involved** in providing for this group in addition to MHS (incl. CJ, SS, Housing etc.). These are often operating with different agendas and languages.
- The provision of psychological therapies by often **rivalrrious professional groups** (e.g. psychiatrists, psychologists, nurses etc.) needs to be managed in a sensible and effective manner.

However, the critical element of a **Managed Care Network** is that it has to be **Managed** (i.e. a relinquishing of clinical autonomy ‘for the greater good’) and it remains to be seen if practitioners are willing to do so

## Finally, there is the importance of wider dissemination as ...

- Recent policy initiatives suggest that there will be a move away from delivering services from the few carefully diagnosed personality disordered in secure services to the many in the community and in prison.
- This will place a huge strain on equipping the workforce (many of whom will come from a non-mental health background (e.g. CJS, SS, Housing etc )with the necessary skills. How is this to be done as there are?

Here, the Knowledge and Understanding Framework (KUF) developed and funded by the DoH/MoJ, will be of value as it uses new technologies. For instance...

- Here are two video clips that would encourage staff to:
- (a) improve their communication skills with MDOs with PD
- (b) recognise splitting within a clinical team.

Hence, while we live in perilous times, I believe that by (a) re-configuring services more appropriately together with (b) an active use of the modern technology; we (i.e. you) will be able to meet the challenge of satisfying the needs of a group that had been previously excluded from what health care services can offer.

Thank You