Assisting NSW correctional centres in their management & treatment of offenders with a severe personality disorder and challenging behaviours

Personality & Behavioural Disorders Unit
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Outline

• Overview of PBDU and NSW corrective services
• Prevalence and management of PD in corrections
• Team model and composition
• Referral demographics
• Clinical procedures:
  – Eligibility
  – Referral and selection
  – Assessment/Intervention
  – Staff training and consultancy
• Evaluation protocol- key measures
Personality & Behavioural Disorders Unit

Recently established, multidisciplinary team providing expertise to correctional centres managing offenders with severe personality and behavioural disorders
NSW Corrective Services

- Manage offenders in a safe, secure & humane environment and reduce the risk of re-offending
- 31 correctional centres:
  - 8 maximum security
  - 13 medium security
  - 10 minimum security
- Approx 10,000 offenders in custody
- 66 Community Offender Services offices
- Approx 18,000 offenders in community
Prevalence of PD in Corrections

Female (NSW)
- 38-57%: ‘any personality disorder’
- 13-31%: Borderline
- 13-32%: Impulsive

Male (NSW)
- 36-40%: ‘any personality disorder’
- 13-19%: Borderline
- 19-21%: Impulsive (IPDE; Butler & Allnut, 2003)

Overseas/US data
- 30-60% male offenders diagnosed with BPD alone
- Up 70% diagnosed with ASPD
Severe PD in Corrections

• Higher risk of accidental death & suicide
• High security, restricted environments
  – segregated custody; safe/camera cell placement
  – Limited time out of cell/access to services/interaction with peers
• Disproportionate operational costs (IAT; medical escorts; use of force; ripple effect)
Severe PD in Corrections

• Source of occupational stress (Duff, 2006)
  – Reduced job satisfaction
  – Absenteeism
  – Staff turnover

• Prevents addressing offending behaviour, many at high risk (Howells, 2007)

• Institutional practices/staff behaviour inadvertently reinforce problem behaviour (Pannel et al 2003)

• Staff ‘splitting’: negative team ‘dynamics’
Team Composition

Multidisciplinary

- Team Leader
- Clinical and Forensic psychologists
- Behaviour Management Specialist
- Senior Assistant Superintendent (senior correctional officer)
- ? MH Nurse
Model of Service Provision

- Mobile ‘behavioural intervention team’
- Work collaboratively with correctional staff provide:
  - Functional analysis of problem behaviour
  - Develop & evaluate behavioural and other interventions
  - Staff consultancy and training
Background and Philosophy

• Positive model of change: ‘positive behavioural programming’
• Increase alternative, adaptive behaviours as well as reduce problem behaviour
• Safe progression of patients to less restrictive environment
• Opportunity to address their broader mental health and criminogenic needs
• Early first-stage treatment targets (Linehan, 1993)
Roles and Responsibilities

• Correctional centre management are responsible for making appropriate resources and staff available for the implementation of the agreed behavioural interventions.

• Once the behavioural intervention has been implemented and consistently maintained, the PBDU withdraws and thereafter provides a monitoring and supportive role to sustain its integrity and efficacy.
Eligibility

Defined operationally:

- Threatened or actual self-harm behaviour
- Threatened or actual harm to others
- Other behaviours which create a high demand on centre services and/or that affect the good management of the centre
- Previous attempts to address the challenging behaviour by the centre have not been successful and a higher level or intensive behavioural intervention is required
- Associated with a severe personality and/or other psychological disorder
Referral and Selection Process

• referrals need to be endorsed by either the General Manager or Manager of Security of the centre

• Priority will be based upon the:
  – Level of risk
  – Persistence/chronicity or escalation/deterioration
  – Overall disruption caused to the management of the centre
  – Need for classification progress
  – Date of release
Demographics

- Age: 16-40 years
- Gender: 27% female; 73% male
- ATSI: 27%
- Unsentenced 27%; sentenced 73%
- NGMI: 5%
- Most convicted of serious offence e.g. murder, aggravated assault, malicious wounding
Demographics

- Diagnosis: 55% BPD/traits; > 70% ASPD
- Co-morbidity: AOD; substance induced psychotic disorders; developmental disability; other major mental illness
- Extreme developmental or psychosocial adversity
- Most prescribed psychiatric medication e.g. antidepressant/anticonvulsants; antipsychotic, anxiolytics
Programme Strategies

- Engagement and Assessment
- Intervention and evaluation
- Through-care and maintenance
- Staff training and consultancy
Engagement and Assessment

• Comprehensive, multimodal assessment:
  – Review of existing data, file and collateral information
  – Discussion with relevant staff
  – Clinical & psychometric assessment (where appropriate)
  – Behavioural observation
Functional Analysis of Challenging Behaviour

• Strong evidence for functional approach to problem behaviour
  – Developmental disorders (Didden, et al, 1997)
  – DBT for problem behaviours associated with BPD (Linehan, 1993)
  – More recently inpatient/incarcerated severe PD (Daffern, 2007)

• Problem behaviour served a purpose in past but now no longer adaptive

• Often serves multiple functions: resistant to change of extinction
Functional Analysis of Challenging Behaviour

• Data is collected on entire sequence of problem behaviour including antecedents and consequences

• Elicit underlying function/purpose of behaviour

• Use structured guide to FA (ACF, Daffern 2006)
  – Reduce time required to complete traditional idiographic assessment
  – Simplifies decision-making process by identifying the most common functions of aggression

• Use sequential hypothesis testing to evaluate interventions
Common Functions- Aggression
(Daffern et al, 2008)

1. Demand avoidance
2. To force compliance
3. To express anger
4. To reduce tension
5. To obtain tangibles
6. To reduce social distance (attention seeking)
7. To enhance status or social approval
8. Compliance with instruction
9. To observe suffering
10. Seeking sensation
11. Sexual gratification
Common Functions- Self-harm (Klonsky, 2007)

1. Affect-regulation
2. Anti-dissociation
3. Anti-suicide
4. Interpersonal influence
5. Interpersonal boundaries
6. Self-punishment
7. Sensation seeking
Functional Analysis of Challenging Behaviour

• In practice, FA is difficult to implement
• Reliant on direct contact staff:
  – Recording data as behaviour occurs
  – Providing reliable retrospective report in interview
• Hence validity of many FA s are limited by missing or distorted data
• Establish effective data collection procedures in host centres
Multi-Modal Data Collection

• Direct behavioural observation
  – Direct (unobtrusive), live video, pre-recorded video
• Semi-structured clinical interview with staff
  – Custodial, JH, OS&P
• Semi-structured clinical interview with offender (if appropriate)
• File/incident report review
  – Running sheets, MNF, officer reports, RIT forms, IRM, JH file etc
Integrated Behaviour Management Plans

• Collaborate with correctional staff to develop individualised behavioural interventions
• Behavioural interventions modify either or both:
  – antecedent ‘trigger’ (i.e. environmental changes), or the
  – consequences that ‘reinforce’ the behaviour (e.g. staff behaviour)
• Operationally feasible and sustainable
• Team work and consistency from single plan that integrates variety of stakeholders
Integrated Behaviour Management Plans

• Skills-based training to assist patient to develop alternative, pro-social behaviours
• Behavioural progress to be matched by proportionate, incremental progression or security reduction within the centre
• Reductions in security/increased freedom may function as
  – ‘positive reinforcement’ for behavioural changes
  – ‘graded exposure’ to improve self-management and self-regulation skills
Integrated Behaviour Management Plans

- Progression may include
  - Placement/security management within the centre
  - Socialization/integration with other patients
  - Participation in general wing activities e.g. education, specialised exercise etc.
  - Increased contact with non custodial staff e.g. OS&P; JH
  - Progression to a ‘step-down’ or mainstream unit with support
Additional Interventions (work in progress)

- PBDU recently organized training of 20 correctional psychologists in DBT (Hunter Mental Health)
- Currently working with these psychologists and other specialist units in the implementation of a DBT informed programme within DCS
Throughcare and Maintenance

- Phased withdrawal of PBDU and progression to less restrictive management
- Assist in adapting behaviour interventions to other settings
- Ensuring generalization of behaviours
- Liaison with external services e.g. DADHC etc.
- Follow up consultancy, booster training
Staff Training and Consultancy

- Strong relationship between staff attitudes (towards PD and CB) and quality of care provided (Duff et al, 2006):
  - Rigid staff attitudes associated with staff pessimism, provision of less help and increased negative emotions
  - Increased behavioural knowledge reduced staff reported depression and anger immediately following an incident

- Thus behavioural interventions that do not address staff attitudes and attributions of patient behaviour may be ineffective
Staff Training and Consultancy

• PBDU provides a modularized, flexible training format to meet needs of correctional centres
• Foundation training for all correctional centre staff
• Target training for those who manage challenging behaviours (e.g. regular staff within relevant units)
• Special issues: ‘Addressing staff splitting’
Evaluation protocol
(work in progress)

• Difficulties conducting RCTs in forensic mental health setting (Davis et al, 2007)
  – Case flow/total no. of patients may be too small
  – Organizational and ethical difficulties with random allocation
  – Heterogeneity of population
  – Heterogeneity of interventions and treatments
  – Participants not blind to experimental condition
  – Long term nature of treatment
Evaluation protocol
(work in progress)

• Single-case design may be a more suitable model
  – Under-utilized but has long history in clinical practice
  – Emerging journals and guidelines (e.g. APA)

• Causal inference can be made about interventions if/when:
  – Clear measurement rules and analytic procedures
  – Clear identification of components of treatment
  – Using and analysing baselines appropriately
Key measures

• Personality Diagnostic Questionnaire- 4
• Daily Risk Assessment (adapted Ogloff et al 2006)
• Offender Behaviour Scale (adapted Silver et al 1987)- both incident & time period
• Assessment & Classification of Function (Daffern, 2008)
• Offender Service-Use Scale
• Clinical measures: TBA
Personality Diagnostic Questionnaire- 4

- Screens for DSM IV Personality Disorder diagnoses
- 110 item
- Self administered
- 20-30 minutes to administer
- Diagnoses need to confirmed by clinical interview
- Acceptable overall accuracy in prison populations (Davison et al, 2001)
Daily Risk Assessment
(DASA, Ogloff et al 2006)

- 7 item scale
  - Irritability
  - Verbal threats
  - Sensitive to provocation
  - Easily angered requests denied
  - Unwilling to follow directions
  - Impulsivity
  - Negative attitudes

- One of few scales that measure ST/24 hour risk
Daily Risk Assessment  
(DASA, Ogloff et al 2006)

- Includes items most strongly associated with inpatient violence
- ‘Dynamic factors’ that are amenable to change
- Hence contribute to treatment planning
- Only validated on a forensic psychiatric population
**Offender Behaviour Scale** (adapted OAS, Silver & Yudosky 1987)

- Both Incident Specific and Time Period
- 5 categories
  - Verbal Aggression
  - Physical Aggression- Objects
  - Physical Aggression- Self
  - Physical Aggression- Others
  - Inappropriate Sexual Behaviour
Offender Behaviour Scale (adapted OAS, Silver & Yudosky 1987)

• Measures severity & frequency
• Validated on range of different populations
• Good psychometric properties when used by raters with minimal training
• Group rating better than individual
Assessment & Classification of Function (Daffern et al, 2006)

- Structured scheme to guide functional analysis
- Reduce time required to complete traditional idiographic assessment
- Simplifies decision-making process by identifying the most common functions of aggression
Assessment & Classification of Function (Daffern et al, 2006)

1. Demand avoidance
2. To force compliance
3. To express anger
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Assessment & Classification of Function (Daffern et al, 2006)

• Pilot reliability studies indicate that acceptable levels of reliability
  – intra-class correlation for single rater is .64
  – Intra-class correction for rater averaged .94

• Results from Dangerous & Severe Personality Disorder Units (UK) (Daffern, et al 2006)
  – Highlight the importance of affective states (Anger expression & Release tension) even in antisocial/psychopathic offenders
  – Cf to index offences, function among inpatients was more likely to include social status needs
Offender Service-Use Scale

- Placement (safe/camera/segregation/normal cell)
- Specialist staff (RAINT/IAT/additional staff)
- Use of force (Low/Med/High)
- Use of force type (physical/mechanical/chemical)
- Access to programmes
- Escorts (clinic/hospital/EHR/HR)
- Internal charges
- Additional to normal out of cell times
Obstacles

• Resistance from correctional management
  – Concerns about loss of control/ ‘exposure’
  – Suspicion about non-custodial staff
  – Lack of support of management plans

• Resistance from base-grade staff
  – Poor record keeping
  – Suspicious about general data collection procedures
  – Failure to adhere to plans consistently
Obstacles

• Staffing issues:
  – irregular staffing
  – ‘splitting’ between staff
  – Many staff have themselves been assaulted/targeted by offenders

• Industrial issues: unions provide parameters for many plans

• Lack of options for progression
Summary

• Offenders with severe PD and challenging behaviours are often placed in high security, restrictive settings and limited access to services.
• These behaviours tend to be resistant to change and require intensive intervention.
• PBDU works collaboratively with centre-based staff using existing resources to develop effective behavioural interventions which enhance the good management of the centre.